The Australian Community Psychologist

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General Information

Editorial

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Holding the Tenth Trans-Tasman Conference in Community Psychology in Sydney 2006 was always going to be a challenge. Although Sydney was at the forefront of developments in community psychology in its early days in Australia, there is no postgraduate program in New South Wales to provide the ongoing energy and renewal that has been on tap in Western Australia and Victoria, and to a lesser extent in Queensland. So it was something of a surprise to have at least three Sydney universities represented in the conference program, together with a range of community organizations from across the state. There has always been a rich vein of grassroots practice and consumer activism represented in the APS Community College's small membership in NSW. Perhaps it has been a well-kept secret until now that community psychology there has managed to subvert disciplinary borders more successfully than elsewhere – criminology, health sciences, community development, education, Indigenous studies . . .

The Sydney Conference came together in less than six months, and forged its own place in the folklore of Trans-Tasman conferences - Pakatoa, Maralinga, Rotorua, Yarrabah, Toodyay, Hamilton, Melbourne, Hillarys Harbour (Perth), Tauranga. This is not the place to revisit the conference itself, but I do want to acknowledge the work of all the contributors to the Conference Committee: Meg Smith, Di Clarke and Rosemary Pynor in Sydney, Lynne Cohen in Western Australia, and a bevy of indispensable student helpers from the University of Western Sydney, Sydney University and University of Notre Dame Australia, Sydney Campus. We also very much appreciated the support of Peter Dean at UNDA, the Community College National Committee and the APS National Office staff.

Parallel to the conference planning, the prospect of the proceedings constituting the next issue of the Australian Community Psychologist emerged. All conference presentation proposals had been subjected to a review process, and each of the papers submitted for the Proceedings special issue was further reviewed by at least two referees. The review panel included Adrian Fisher, Heather Gridley, Carol Tutchener, Rosemary Pynor, Lynne Cohen, Harriet Radermacher, Chris Sonn, Lyn O'Grady, Stephen Fyson, Grace Pretty, Meg Smith, Briony Kercheval, Catherine D'Arcy, Di Clarke, Anne Sibbel, Felicity Wright, Grace Pretty, Brian Bishop, Bridget Monro, Debra Rickwood, Ann Dadich and Kristy-Lee Riley. Thank you all for the serious consideration and constructive feedback you offered. And special thanks to Carol Tutchener, who was meticulous in setting up a data base of manuscripts and sending them out for review, and to Anne Sibbel who waited patiently as production editor for the drip feed of completed articles.

Nine papers survived the review and revision process. While not representative of the entire range of keynote addresses, symposia, workshops, themed discussions, posters, planning sessions and processing activities that took place at the conference, they are certainly indicative of some key debates and research hotbeds in Community Psychology within Australia and beyond. We are delighted with their freshness nearly twelve months on from the conference, and congratulate all the authors for the way they have managed to balance accessibility with intellectual and critical challenge. We have also included in this issue a full set of abstracts of the papers, workshops and posters that made up the program for *Less talkin', more walkin': the Tenth Trans-Tasman Conference in Community*

Psychology.

The Conference program was organised around four streams/themes:

'Nothing so practical as …' – Theoretical developments influencing community psychology practice

'Working together for deadly outcomes' – Community psychology and Indigenous people

'Journeys with consumers' - Recent developments in mental health policy and practice

'Conversations that cross borders' - International agendas in community psychology

For the Proceedings, we have collapsed these streams into two, each of which is introduced by one of the keynote addresses to the conference. As such, the two papers can serve as signposts to this edition of *ACP*, marking the genealogy of community psychology, whose 'parents' have often been loosely identified as community mental health and applied social psychology.

Appropriately for a Trans-Tasman venture, the first group of papers is headed by a keynote presentation from Aotearoa New Zealand. Hilary Lapsley and Heather Barnett from the Mental Health Commission in Wellington are joined by young consumer Shona Clarke to report on an investigation into young adults' first experience of a disabling mental health crisis and their first use of adult mental health services. Ann Dadich's paper on self-help support groups for young people experiencing mental health problems continues the focus on young consumers. The paper is drawn from Ann's doctoral research that won the 2005 APS Robin Winkler Award for excellence in a project in the field of applied community psychology. Rosemary Pynor extends the self-help/mutual-help discussion to the disability field, where she talks about the challenges of reconciling empowerment rhetoric with everyday realities of supporting disabled people's participation in self-help organizations. The paper by Celeste Galton and Gerda Alberts Muller takes a practitioner perspective on a Personal Support Program that attempts to apply community psychology principles to the implementation of the Federal Government's *Welfare to Work* program. And finally, Shelley O'Keefe and Sheree Freeburn describe the processes involved in developing, trialling and evaluating a partnership model of

service delivery on epilepsy and seizure management to be culturally appropriate for Aboriginal communities.

Although two of these papers are research reports and the others are more practice-oriented, all are located in community settings, and all place the rights, voices and needs of those most affected by the experience of crisis, health problems, oppression and/or disability as their central consideration.

The second group of papers comes under the very broad banner of 'theory', and is introduced by Grace Pretty's inspiring keynote – a virtual walking tour of her own career history across two continents (and hemispheres), paralleled by theoretical developments in community psychology that continue to have relevance – and invite caution – in 21st century, mid rural crisis Queensland. Brian Bishop and Alison Browne have written two papers, one of which revisits Kurt Lewin's much-quoted but often decontextualised and misconstrued observation that 'there is nothing so practical as a good theory'. Their second paper borrows the concept of iatrogenesis to consider the unintended consequences of interventions within natural resource management contexts – perhaps the largest scale 'practice setting' imaginable for community psychologists. Jenny Sharples' unusually reflective paper takes a critical look at how mainstream psychological theories can be readily co-opted to serve dominant political agendas. I read this one just as I came across a truly Orwellian draft proposal to use Prochaska and DiClemente's motivational interviewing (designed to assist decision-making in the context of problem behaviours such as substance use or gambling) to persuade asylum-seekers to return to their country of origin, so Jenny's paper helped me to put words to the shiver down my spine.

It is all too clear that these two groupings of papers immediately trouble the binary separation of theory and practice, as did the presence at the Sydney conference of a larger than usual number of community workers and service consumers – it seems more accurate to suggest that community psychologists (and fellow travellers) in Australia and New Zealand have not been above or afraid of tackling real-world problems, nor have they turned their back on theoretical

considerations once they find themselves working at the coalface of community practice. We were proud of both the quality of presentations and the processes that supported them in making the Tenth Trans-Tasman Conference in Community Psychology so memorable for visitors and locals, veteran and neophyte community psychologists alike. We are equally proud of this special "Proceedings" edition of *ACP,* which brings together research and practice in community psychology, and encapsulates some of the most pressing theoretical and political issues confronting the field.

> [Close cooperation between theoretical and applied psychology] can be accomplished ... if the theorist does not look toward applied problems with highbrow aversion or the fear of social problems, and if the applied psychologist realizes that there is nothing so practical as a good theory. (Lewin, 1951, p. 169, cited in Bishop & Browne, this issue, p.69).

Unfortunately we were not able to include an abstract or adaptation of the extraordinary keynote address by Bevan Cassidy, Nywaigi Warrior, and 2003 Recipient of the Neville Bonner Award as the National Indigenous Universities Teacher of the Year – and indeed, those who were present would acknowledge that it would be impossible to do justice in print to his multi-dimensional presentation. But it seems fitting to end this editorial with Bevan's opening words, and in doing so, to acknowledge the traditional owners of the land on which we gathered in Australia's first colonial city in April, 2006:

I am a Nywaigi Warrior

I acknowledge the Aboriginal and Torres Strait Islander Nations and its peoples as the sovereign owners of this land, Australia and the Torres Strait Islands.

I acknowledge all of you, Aboriginal and Torres Strait Islander peoples in this place as representatives of your nations, as representatives of your peoples.

I acknowledge the owners of this land, the Wathaurong nation and its peoples!

There is a great challenge that stands before us at the crossroads in our collective moral spirit as Australians.

There is a great challenge that stands before us as Aboriginal and Torres Strait Islander nations and its peoples.

And there are two great mindsets that shaped our histories as
Aboriginal and Torres Strait Islander peoples
That has shaped our existence as Aboriginal and Torres Strait Islander peoples.
That will shape our future as Aboriginal and Torres Strait Islander peoples.

One has the reputation of a modern civilisation,
A Western Civilisation,
That has created the world's present systems and institutions
Its histories, its cultural institutions, its social institutions, its political institutions,
Passed down through the generations through its hierarchal systems.
Passed down through the generations through its written traditions.

The Other,
Has the reputation of the World's Oldest Living Adaptable Civilisation
Of co-existence with its environment, with its communities, with its spirituality.
Its histories, its cultural institutions, its social institutions, its political institutions,
Passed down through the generations through its oral traditions.

Yet
Both must ask the question if there is a mutual respect and understanding of the grave realities
That we face as a modern nation
That we face as a modern people.

Both are worlds apart but must be understood.
Both must be understood to bring their worlds together.
Both must be willing to change a system of

thinking to effect a system change.
Both must learn from the lessons of the past to
teach the lessons for the future.

And
Both must be willing to step into the unknown to
address the known.
That is the benefit of education! That is the
objective of education!

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Tenth Trans-Tasman Conference in Community Psychology

Thursday 20th - Sunday 23rd April 2006
The University of Notre Dame Australia
Broadway Campus, Sydney

Worldviews, citizen power and control: Emerging Issues from Natural Resource Management Research in the East Kimberley
Browne, A., Bishop, B., & Bellamy, J. (Curtin University)
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For diverse reasons, there has been increasing recognition nationally, and internationally, of the importance of incorporating local and regional Indigenous and non-Indigenous community voices in Natural Resource Management (NRM), to 1) inform policy and research directions and content, and 2) to improve the 'uptake' of the outcomes of research and policy approaches. Commonly, participatory, collaborative and multidisciplinary projects are suggested as ways of incorporating the understandings of scientists, policy makers and lay advocates in NRM. The Ord Bonaparte Program (OBP) is a large scale, multi-disciplinary, collaborative research model in the East Kimberley region of Western Australia that was established to inform ecologically sustainable development and the management of natural resources within the region. This poster is based on the findings from the evaluation project of the OBP. It focuses on the impacts that divergent understandings of participatory and collaborative research had for different groups involved, particularly how involvement of these diverse groups highlighted and reinforced issues of citizen power and control operating within local, regional and international NRM contexts.

SYMPOSIUM

The role of Sense of Community and Sense of Belonging as protective factors for school success.
Cohen, L., & Pooley, J. (Edith Cowan University)
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Symposium abstract
During their time at school, children are exposed to a number of risk factors that may result in depression, suicide, offending, and truancy. The literature suggests that students who develop a close connection with their school are more likely to succeed during their school years. Sense of community and sense of belonging are important as protective factors that may influence the levels of risk. The school community is an ideal environment in which to examine the contribution of a sense of community and a sense of belonging as protective factors. In this presentation two papers are presented which are based on a longitudinal study of risk and protective factors and the relationship between sense of community and sense of belonging.

Critiquing the School Community: A Qualitative Study of Children's Conceptualizations of their School
Pooley, J., Breen, L., Pike, L., Cohen, L. (Edith Cowan University) & Drew, N. (University of Notre Dame Australia)

Schools are becoming increasingly accountable for the successful educational outcomes of students. However, little attention is paid to the personal development of students in such areas as self efficacy, participation, competence and self-determination. In this study, forty-six children aged from 9 to 12 years were interviewed to ascertain their conceptualisations of the school community. The responses of the students indicate that they characterise their school with responses that are closely aligned to the adult conceptualisations of sense of community as purported by McMillan and Chavis (1986). Examples include the people within the school, schools as places for activities and interaction, a place for safety, cooperation, influence and functionality. In order to ensure the psychological well being of the children, they should have a role in the decision making processes

of the school as well as in curriculum design.

Sex, drugs and rock and roll – the rocky road through high school

Cohen, L., Pike, L., & Pooley, J. (Edith Cowan University)

This study explored the transition of children from the last year of primary school through the first years of high school. The study examined the role of a sense of belonging as a protective factor to minimize risk and enhance resilience of the children. This study is part of a longitudinal study in which students have been participating for five years. A number of psychosocial assessments were conducted yielding information about depressive symptomatology, self perception, coping skills, and a sense of belonging. The outcomes of this ongoing research has particular relevance for understanding the transition from primary to high school and for the development of interventions designed to minimize risk and promote well being within the schools and for young people in general.

Productive and fun activities in struggling communities: Bringing the future into the present

Dowrick, P. (University of Hawaii at Manoa)
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The purpose of this session is to illustrate principles of creating futures in disadvantaged communities, and bring participants' ideas and experience into the mix. My job as a community-based psychologist operates in the context of at-risk communities: families and schools with socio-economic disadvantages, people with disabilities, ethnic and linguistic minorities, sometimes in developing countries. In the last 10 years, we have set up programs in community learning centres, technology centres, etc. What people (some 30,000, mostly children) learn and what they engage in by having fun, provide protective factors and reduce risk factors. Within each of these activities, we create explicit images of future success. We provide the right level of challenge, and enable people to see themselves being successful where they normally

fail. Some images are explicit—e.g., videos of reading fluently, making friends, persevering under stress. Other positive images are implied by interpersonal interactions. We included images of sustaining programs beyond the external funding. Individuals were widely successful. The sustainability plans were not. Success depends on strategies to bring the images of the future into the present. These strategies include the 90:10 rule, recasting error correction as focused learning from success, and use of technology to place interventions in the most challenging settings. Programs have been sustained, in many cases, through unexpected means.

Cross-sector collaborations for health and safer communities: *What, How, and Why?*

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Cross Sector Collaborations function as mechanisms for change in health, social and community development. Although emphasis has been given on outcomes, not much has been written about processes within cross sector collaborations that foster change. Using a case study methodology, this research explores how a cross sector collaboration of organisations, professionals and individuals work toward the facilitation of health and safety of a local community in a local government area of the City of Port Phillip of Victoria in Australia. This presentation reports on findings and data collected over 3 years, which shows that a key outcome of the cross sector collaboration processes and functions relate to the identifying, negotiating, reframing, and development of shared understandings about and actions on health, social and community issues. The cross-sectoral or interdisciplinary nature of the collaboration supports the development of mechanisms and contexts for negotiating coordinated change initiatives, which are based on shared values, trust, relationships and reciprocity. Importantly, the change that cross sector collaboration achieves is often unacknowledged because it lies beyond the planned and immediate objective outcomes. The

implications of cross sector collaborations as change mechanisms are explored in terms of its process and function in policy development and implementation in health, social and community work.

Pathways to Commitment or Alienation: The possibility of sequential steps within Psychological Sense of Community

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The research involved examining the nature of the transition that students experienced in progressing to junior high school from primary school. Students' experiences were chosen as the focus of the research because the issue of substance being investigated was that of alienation. Theoretical frameworks, based on constructions of psychological sense of community, were designed to see how readily the experience of alienation could be mapped as the antithesis of increasing psychological sense of community. The main methodology that was used was the qualitative procedure of discourse analysis, implemented over a three-year period. During this time, 33 focus group interviews with 120 student leaders were recorded, transcribed and analysed. The key findings of the research include the establishment of critical concerns of students. These critical concerns were articulated as psychological sense of community categories of interest, with positive and negative discourse descriptors being developed for each category. The categories of interest were arranged into a sequential pattern that described pathways to increasing commitment or alienation.

Women, culture, religion, men and family violence

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Our beliefs, values, thinking and behaviours are influenced by the cultural and religious teachings we subscribe to. Culture and religion play an important role in shaping our behaviours and the relationships between males and females. Various theories attempted to explain the violence perpetrated by men against women. Individuals are the focus of some theories in an attempt of looking for personal explanation such as mental health, alcohol and drugs, stress, external factors, the victim's role, religion reasons and cultural practices and beliefs. Culture and religious beliefs are the focus of others. This presentation is a study of domestic violence (DV) as a gender based crime in an attempt to enhance our understanding of this social crime perpetrated against women from the mainstream communities and from minority groups in Australia and in other countries. This presentation also provides an analytical view on cultural attitudes and on past and current strategies adopted by various authorities in responding to DV. Proving that DV is a gender-based crime does not discount the influence of religion and cultural beliefs and practices. As there are few research papers that closely examine the extent and impact of DV affecting the women from Arabic speaking communities, it is anticipated that this presentation may lead to further research into this area within the Arabic speaking communities.

Re-gendering community psychologies and re-generating feminisms: How far have(n't) we come?

Gridley, H. (Victoria University) & Thomas, K. (Curtin University)
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Community psychology and feminism share similar social critiques and advocate similar change models. However these similarities may not match the realities of practice. This forum is the first of a series of locally based conversations taking place within community psychology throughout 2006. Participants are invited to consider several guiding questions as they relate to gender equity, social justice and human rights within their own communities. Guiding questions for reflection and discussion include:

• How are our commitments to feminist values evident in our research and practice?

• How do we enact gender equity in our work as researchers, consultants, practitioners and teachers?

• What local initiatives or achievements in the area of human rights for women would you like to celebrate and share with other psychologists?

• How can the pedagogy of psychology be

better directed in ways that ensure future generations can contribute towards improving the lives of women?

Our over-arching argument is that psychologists can serve as better champions for global and local social justice when their work is infused with feminist perspectives.

Blending Agendas: The whirl and grind of joint sector work

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Joint sector and whole of government are terms embedded in the vocabulary of New Zealand social policy. Although agencies have requirements re joint sector work, and acceptance of the collaborative model, most do not have the necessary resources or systems in places. Staff involved in joint sector project work volunteer on top of core roles because the approach is implicit in their professional or agency practice, or they simply have optimism. Managers have little to help assess how and where to can gain best strategic advantage from the black hole of staff time lost to joint sector project work. Three agencies in Auckland (Health, Education, and Child, Youth and Family) joined up to evaluate three projects involving all their agencies. The aim was to evaluate the successful factors in the joint sector process in order to improve these intensive group processes with long term timeframes and uncertain outcomes. The findings from the reflections of 57 joint sector participants are discussed in this process evaluation. Success factors and barriers are examined in relation to previous research. The discussion of findings from this Auckland study will be of interest to others struggling to capture the kernels of best practice in the whirl of joint sector activity.

Responding to media representations of working class men

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This paper documents the tendency of New Zealand media to disseminate negative representations of working class men as unintelligent, violent and irresponsible abusers.

We consider the ways in which such representations also manifest in psychological research and how this creates a sense of negative accusations towards working men that can be harmful and restrict men's participation in community life. This paper draws upon insights from ethnographic observations, life narrative interviews, photographic techniques and media diaries, which have been compiled collaboratively with 15 Maori and Pakeha men. These materials are used to illustrate how these men often appropriate aspects from media representations in order to make sense of their own lives, relationships, and community participation. In the process these men reproduce and then resist negative media accusations. We discuss why our research into the positive relationships and community contributions of working class men who are not in trouble needs to explore negative media representations as a shared symbolic backdrop or contextual social representation for participants' lives.

Australian-Muslim Adolescent Identity

Hussein, T. & Fisher, A. (Victoria University)
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The purpose of this research was to explore Australian-Muslim adolescent identity. Semi-structured interviews exploring self-identification and concept; sense of belonging; positive and negative attitudes towards one's own ethnic group; ethnic involvement/social participation; and cultural practices were conducted with 37 (14 female, 23 male) Year 9 students from two Islamic colleges in Victoria. Results indicated Australian-Muslim identity to be a multidimensional concept. Divergent identity patterns appeared related to factors including length of time in Australia, exposure to and involvement in Australian society, and experiences of racism and hostility. In conclusion, the research has shed light on Australian-Muslim adolescent identity. In turn, this light has both reinforced and challenged existing theories on identity, culture, and ethnicity. However, a significant limitation of the study was that interviewees were recruited from Islamic colleges. To understand Australian-Muslim identity, participants should be recruited

from mainstream and other religious affiliated secondary colleges.

Going walkabout together through the suburbs
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'Going Walkabout Together Through The Suburbs' (GW3TS) focuses on group interaction and support, plus Life Journalling with Volunteer Buddies among a group of about 30 young adults (18-35 yrs). Participants are from a community of people living with mental health challenges and/or intellectual disability, teamed up with people living without these challenges, but with plenty of other life issues. The supported inquiry-style, participative action research process aims to contribute to reforming rehabilitation through modelling community-based, self-help, peer support group processes. Our experience has been that the original intention, to highlight paired fortnightly journalling, has become secondary to the actual dynamic "in-community", and I am now exploring how to describe that process, in order to share with others the elements of creating and supporting such safe, trusting, self-help environments in any community setting. Such approaches have been discussed with different community mental health rehabilitation services around Sydney over the past two years, in a shared exploration of better ways to engage people in community-based, self-help rehabilitation.

An exploration of 'sense of community' and well being in urban versus rural Aboriginal and non-Aboriginal communities.
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One group that is attempting to maintain their sense of community through cultural cohesion is the Australian Aboriginal people. Very little appropriate research with Aboriginal samples has been carried out to date due to a lack of culturally appropriate and sensitive measurement tools. A new culturally sensitive measure has been developed which allows for the identification of Aboriginal people at risk for depression and suicide. This measure, along with an instrument which assesses the degree to which people have a strong sense of community, is used to examine if a psychological sense of community is related to well being. Research questions include: Are there differences in levels of sense of community between rural versus urban, Aboriginal versus non Aboriginal communities? Is sense of community related to depressive symptoms? Methodological issues include the veracity and reliability of findings when non- Aboriginal researchers conduct research with Aboriginal communities. These issues are discussed and debated along with the implications and potential future directions of research in this area.

"Walk a mile in my shoes"
Muller, J. (Griffith University)
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Using a new and exploratory visual methodology, which has its basis in qualitative research (Neuman, 1997, Patton, 2002) and visual ethnography (Pink, 2001), this presentation explores, from a consumer's perspective, the quality of life of people who have mental illness and live in the community. Using image-text (Mitchell, 1994), the photographic images and narratives can both bring new information that together creates a synergy otherwise overlooked in traditional text-based and quantitative research and offers a more 'sensually complete' methodology (Warren, 2002). Specifically, a visual methodology, in the tradition of social documentary images, is used to investigate 'what it feels like to be mentally ill and to live in the community'. The research will be used to increase understanding and awareness and promote social action. It will also be used to extend current psychological methodologies into the visual – as a process of exploration and triangulation. The presentation takes the format of a photographic exhibition.

Policies and Paradigms in Indigenous

Psychology: De-colonising Practice
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This paper reports on a research project exploring the history of relationships between government policies towards Indigenous Australians, patterns of psychological research with Indigenous Australians, the impact of this relationship on how psychologists engage with Indigenous communities and clients and the implications for professional education of psychologists. Psychology is often portrayed as being located within the dominant Western paradigm of a positivist orientated experimental science. For example, Tyler (2002) argued that there is a historical 'racist cultural bias' permeating the structures of the discipline and shaping psychology's narratives, perspectives, and scientific and professional standards. Historically there has been a close relationship between government policies towards Indigenous Australians, the paradigms adopted by psychologists researching in Indigenous contexts and psychological practice. This relationship has been reflected in short periods of intense research and publishing activity, occurring at around the same time as significant changes in government policy towards Indigenous Australia followed by long periods of relative inactivity. This relationship is further reflected in similarities between the assumptions underlying the policy frameworks and the models and assumptions applied in psychological research and practice. The paper examines the extent to which research activity and paradigms adopted by psychologists intersect and co-vary with prevailing government policies, the impact of these relationships on psychologists and their Indigenous clients and the implications for the training of psychologists.

Less talkin', more wheelin': Exploring the challenges for community psychologists doing research with disabled people
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The social model of disability requires that research about disability should be controlled and managed by disabled people themselves.

Traditional research has tended to marginalise disabled people, and the outcomes have been meaningless and irrelevant to them. Three years ago I approached a small disability advocacy organisation with a view to conducting participatory action research and to examine its value as an empowering research practice. In this presentation, I describe some of the challenges and tensions that emerged, particularly around negotiating my role in the research. I also examine how deeply entrenched ableist attitudes served to perpetuate the barriers to participation for disabled people and reinforced the tendency to victimise disabled people. This study revealed how disability discourses maintain inequities in power, and consequently hinder attempts to do research in empowering ways with disabled people. Until this is recognised, community psychology research and practice may fail to be meaningful and empowering for disabled people. Through this presentation, I seek to extend the discussion around 'decolonising methodologies' (which has tended to focus on Indigenous issues) to encompass disability issues. I also hope to encourage and promote the use of critical reflexivity to explore how community psychologists can work in more participatory and empowering ways.

Consumer and carer voices on the role of relapse prevention in the recovery process for people with mental illness
Rickwood, D. (University of Canberra)
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This paper reports the views of the consumers and carers who were part of a national consultation on the role of relapse prevention in the recovery process for people who have experienced mental illness. There is a growing focus on the need for prevention to be included as a routine component of treatment and continuing care; yet, feedback shows that frequently this is not the case, and that too often the experience of consumers, and their families and carers, is of a crisis-focussed mental health system that doesn't respond early enough to avert further episodes of illness. Progressing the understanding and implementation of prevention approaches has been a priority of the National Mental Health Promotion and Prevention

Working Party, and they auspiced a major national consultation in late 2004 around the role of relapse prevention. Three documents have recently been released that report on this work—a monograph, framework, and report of the national consultation. The focus of this paper is on what consumers and carers said about how they incorporate preventive activities as part of the recovery process.

Living with mental illness in Australia: Changes in policy and practice affecting mental health service consumers
Smith, M. (University of Western Sydney)
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The movement of large numbers of people from psychiatric hospitals in the 1960s changed the face of mental health services in Australia. This paper explores some of the issues facing people living with mental illness in the community today and the impact of social policy, legislative change and funding of services on their lives, with particular reference to New South Wales. The growth of support and advocacy groups in the 1970s and 1980s, and their role alongside psychologists and other health workers in bringing about change in the provision and type of mental health services, are examined. Opportunities for advocacy and real input into the quality of service provisions have increased, and many people living with disabilities are active in contributing to policy development and advocacy services. However, the level of funding of mental health services and the resources available to care for people living with mental illness in the community still remain low and, in many cases, inadequate to provide proper quality care for people living with mental illness.

Interfacing Alternative and Complementary Well-being Ways for Local Wellness: Intercultural Peacehealing
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The paper outlines actions whereby the nurturers of psycho-social and other forms of well-being in the First, Third, and Fourth Worlds may engage together in supporting people in the aftermath of man-made/natural disasters in ways that enrich

local ways, and have positive second and third order consequences that detract from the well-being of no one involved, and that do not compromise local self help. The paper also has implications for supporting oppressed Indigenous/small minority people in the region in the context of the ongoing fragmenting and disintegrating of their culture, in their place, by dominant elements. The paper outlines the evolving of community psychology practice at Fraser House Psychiatric Unit at North Ryde Hospital and the interfacing of this practice with Indigenous psychologies of the East Asia Oceania Australasia Region. The Laceweb, an informal network of Indigenous and Oppressed Small Minority psycho-social healers is presented as an example of local Well-being self-help and mutual help action (refer 'Cultural Keyline' and other material at www.laceweb.org.au).

New Roles for Community Psychologists
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This paper identifies new roles and work opportunities that may emerge for community and clinical psychologists and clinical sociologists as Workcover care providers of self-help and mutual help amongst claimants. The implications of the Victoria Workcover Act requiring providers to use a bio-psychosocial model is discussed and a recent doctoral thesis on research on the bio-psychosocial model in the 1960s is introduced as a resource for Community and Clinical Psychologists (and Clinical Sociologists) interested in exploring working in, or researching this emerging field. Wellnet, a Community Based Organisation that may form a Biopsychosocial Support Network is introduced.

Learning to Grin and Bear It: Nurturing a social movement from the footpath up
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This interactive workshop explores how community psychologists can participate in yet another revolution.   It welcomes everyone's experiences of changing the culture of their own street and discusses attempts by community

psychologists to improve neighbourhood social cohesion on the streets of inner-Melbourne. The work, conducted via the City of Port Phillip Council, has involved a series of novel and, dare we say it, fun, projects, such as street parties and Smiles per Hour, to counter the ebbing away of local neighbourhood connections in a time of increasing individualism, busyness, household security, fence heights, and geographical dispersion of the extended family. The workshop critically reflects on a psychologist's role in the common process of community building and explores the challenge of re-kindling good ol' community spirit without resorting to grand visions of either nostalgia or utopia. It also covers the pragmatics of evaluation, communication, sustainable project design, processes of building partnerships with others in the community and the trials of transforming a topic that was initially dismissed as flippant, into one now regarded by many as profound.

Community Psychology, the AIDS Epidemic and Ideology – No More Uncommitted Relationships!
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Even with the limited testing that has been conducted globally, 45 million people have been identified as HIV positive. In South Africa alone this number represents 5 million of the total population of 40 million. Much global funding is based on the ABC approach to AIDS prevention (Abstinence, Be Faithful, Use Condoms) - a coherent ideology that is both similar to, and raises challenges for, empowerment approaches that claim to be value neutral but are actually ideologically based. In Sub-Saharan Africa, the area hardest hit area by the epidemic, up to 75% of all HIV cases are women and less than 20% of them have access to contraception. The HIV epidemic highlights the destruction wrought by community theories and policies that are gender and power 'neutral' or naïve. It also raises a number of questions about how we walk and talk empowerment within Community Psychology. These questions are imperative for developing approaches that can be up-scaled to regional, national and global levels and include, but are not limited to: What

are the current levels of social justice walk and talk in the discipline? What is the next step for enactment? To whom should Community Psychologists be devoting relational commitment?

Community centred health promotion and prevention: Conceptual and methodological considerations
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In this paper, I introduce the concept of *community centred health promotion*, which in this context, refers to a strategy that is tailored to suit a particular community; and involves community members. Literature on the history and meaning of health promotion, evidence based health promotion, community engagement and community governance is reviewed to illuminate and support the concept. Doctoral research to be undertaken as part of a National Health and Medical Research Council (NHMRC) public health scholarship is also outlined. The research will support a social model of health and involve the development of a community health evidence base in stage one, including the construction of a state-wide health database, analysis of health status and determinants of health, and development of profiles of community health needs. This evidence base will be used to engage a sample of community members and health/ community service workers in the development of appropriate community specific plans of action in stage two. Stage three will reflect on the outcomes of stage one and two and evaluate the potential of the research program to be extended to other areas in Victoria and to the broader Australian context. Conclusions about the viability of *community centred health promotion* and the place of health promotion in community psychology will be made.

Applying HEAT to meet the training and employment needs of local youth
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The number of early school leavers in Boroondara, Port Phillip and Stonnington municipalities is 29% higher than the State

average for Years 9 and 10. Most schools focus on achieving high academic results, and there are few non traditional learning programs, or relevant training and employment programs, for less academically inclined young people. HEAT (Hospitality Employment and Training) is an innovative twelve week program which takes vocational learning out into the local community and industry. It is designed to interrupt the slide into long term unemployment and associated problems such as poor health, crime and homelessness, that many disengaged young people face. HEAT offers work experience and accredited hospitality industry qualifications. Additionally, there is a strong emphasis on welfare, career guidance, and post-program support as, for many in the target group, becoming job ready requires much more than just acquiring work-related skills. The large, fast-growing City of Port Phillip hospitality industry is an excellent medium for re-engagement, as it is exciting, varied and offers local casual, part-time and full-time work. Early HEAT results are presented, with details of how action research evaluation is used to continuously fine-tune and develop a model that can be replicated by other community groups.

A comparison of Sense of Community with family, friend and significant other social support as predictors of subjective well-being.
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This study examined whether sense of community (SoC) significantly predicts subjective well-being (SWB) beyond that afforded by family, friends and significant other support. The sample included 464 adults aged 18-82 years (M= 44.4, SD=15.42). Participants resided in a diverse range of inner and outer suburbs of Melbourne. The cognitive and affective components of SWB were measured using the Satisfaction with Life Scale and the Positive and Negative Affect Schedule respectively. The Multidimensional Scale of Perceived Social Support was used to measure family, friend and significant other social support. The Sense of Community Index was used to measure SoC. Multiple regression analyses indicated that SoC did significantly

predict SWB beyond that of the other social support variables for positive affect, negative affect and satisfaction with life. SoC was negatively correlated with all three SWB variables. Possible explanations for this inverse relationship will be discussed. For example, it is likely that SoC influences city and country people differently (different cognitions, behaviours and feelings). Consequently community practitioners cannot assume that SoC will foster positive qualities in every community. Some communities may be utilising other sources of support such as friendship and may deem this sufficient in the promotion of SWB.

ROUND TABLE DISCUSSION

What is SoC and is it universally consistent?
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Common definitions of sense of community (SoC) refer to feeling connected, supported, safe and important within a community. SoC also involves a sharing of common values and goals about the community. Since the conceptual work of Sarason (1974) advances regarding our understanding of SoC have occurred both conceptually and empirically. For example McMillan and Ryan (1986) have developed a model of SoC and Chavis, Hogge, McMillan and Wandersman (1986) have constructed a corresponding measure, the Sense of Community Index. However, it is agreed among SoC researchers that more work is needed as there are conceptual inconsistencies and existing measures do not meet satisfactory psychometric standards. Clarification of the constituents of SoC is first needed. What does SoC mean to people? What empirical evidence is there to support this position? It has been found that SoC (as it is currently measured) is important to individual well-being but such benefits are dependent on several factors such as the location and size of the community. One of the main questions for discussion concerns whether city and country people have a different understanding of what SoC entails? More specifically does SoC transcend geographical qualities and can a universal measure of SoC be developed?
Building Humour Through Rapport: A

Qualitative Study

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This study addresses the connection between
humour and rapport. With the use of a
qualitative methodology the study investigates
how the appropriate use of humour can build
rapport in a variety of settings and gains a
greater understanding of how this phenomenon
works. The author also reports benefits of
increased rapport. Through the use of
autoethnography the author provides in-depth
accounts of various instances when he has
utilized humour to build rapport in his own life.
The incorporation of personal experiences and
stories helps illustrate the subjectivity of
humour and increases understanding of the
numerous situations in which humour can
positively affect rapport. To achieve a more
objective understanding of the phenomenon, six
professional comedians were utilized as
participants and interviewed. Participants
provided an account of the multiple effects of
humour in both their professional and social
life. Their experiences were interpreted through
a grounded theory analysis, resulting in the
development of four themes. The four themes
are then discussed and evaluated with the use of
participants' and the author's personal
experiences. The four themes presented are:
defuse – when humour is used to defuse a tense
situation; deflect - when humour is used as a
deflective technique; evaluate – using humour
to evaluate beliefs, attitude or boundaries;
revealing – using humour to reveal your
opinion, thoughts or beliefs. All themes provide
an account of a different situation and
approaches in which humour can positively
influence rapport and the benefits of increased
rapport. The author's hope is to not only
increase understanding of this phenomenon by
demonstrating the connections between humour
and rapport but also illustrate the effectiveness
of autoethnography in psychological research.

Journeys with Young Adult Mental Health Consumers: A Narrative Research Project[1]

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The New Zealand Mental Health Commission recently conducted an investigation into young adults' first experience of a severe mental health crisis and their first use of adult mental health services (Barnett & Lapsley, 2006). The project involved 40 interviews with mainly Maori, Pakeha and Pacific young adults (aged 18-29 years) in urban and rural settings. Around two-thirds had experienced psychosis and one-third other mental health difficulties. Narrative and thematic techniques allowed us to describe the journeys taken by young adults through analysing their talk about:
- *the development of mental health problems (childhood and adolescence; seeking help for distress);*
- *first encounters with adult services (most often in the form of an admission to an acute inpatient unit);*
- *ongoing assistance from services, including early intervention and cultural services; and*
- *factors that supported or hindered recovery.*

In another sense, research is a journey and this study involved consultation with mental health services, and particular consultation processes with Maori and Pacific advisors, services and communities. The paper culminates with the observations of one young adult who contributed to the study.

Every year around 18,000 young adults between the ages of 18 and 29 years are in contact with New Zealand's mental health services. For over 7,000 young adults it will be their first contact. Sometimes this will involve only one or two appointments, perhaps for an assessment, but for many the contact will come about as the result of a severe mental health crisis and mark the beginning of a significant period of service use.[2] Young adulthood is the peak time of first presentation to adult mental health services, and young adults are one of the biggest age groups seen by mental health services.[3]

Although approximately one fifth of the New Zealand adult population may have a mental health condition at any one time (Oakley-Browne, Wells & Scott, 2006), the nation's free mental health services are designed for the 3 percent of the adult population who are most severely affected by disabling mental health problems. However, the target has not yet been achieved (Mental Health Commission, 2005), suggesting that many young adults are not accessing the mental health services they need.

Anecdotal evidence suggests that those who are in crisis, have very severe symptoms, are already known to the service or have a psychosis spectrum disorder are most likely to gain access. Young women, who form the majority of those with non-psychosis spectrum diagnoses, including depression, post-traumatic stress disorder, anxiety, eating disorders, self-harm and maternal mental health issues, may be particularly under-catered for in our mental health system.

The route into mental health services is frequently through assessment by a crisis service, then admission into an inpatient unit. Compulsion is often used, with around half of those in New Zealand inpatient settings under the Mental Health Act Compulsory Assessment and Treatment Act 1992 (Mental Health Commission, 2003). On discharge, most would be referred to generic community mental health services, which would then refer some clients to more specialised services.

Mental health services have their own unique culture, with rules and expectations that may be

foreign and difficult for a newcomer to understand. This means that at a time of great emotional, mental and spiritual turmoil, young women and men who make their first entry into the mental health services must learn to negotiate their way through unfamiliar territory, becoming known as "service users", "tangata whaiora" or "mental health consumers".

At times of mental health crisis, it is almost certain that the socially prescribed tasks of young adulthood will be disrupted. These tasks include gaining autonomy from parental authority, establishing independent lives, commencing tertiary education, gaining employment and developing careers, gaining financial independence, travelling overseas, becoming citizens who vote, learning to drive, developing adult relationships and starting families. These disruptions, as well as the special characteristics of this population, need to be taken into account by mental health services, and so do, in terms of presenting issues and needs (e.g., Castle, McGrath, & Kulkarni, 2000; Harrop & Trower, 2003; Lewinsohn, Pettit, Joiner Jr., & Seeley, 2003; Martindale, Bateman, Crowe, & Margison, 2000; Porter, 2002). This is especially because young adults are a distinctly separate population form child and youth up to age 18, and they also have needs that are distinct from adults over 30 (Harrop & Trower, 2003).

The Mental Health Commission's Young Adult Project

Research Aims

Given the unique needs of young adults in relation to mental health, this narrative research project was designed to explore young adults' first experience of a severe mental health problem, first use of publicly funded mental health services and their recovery journeys.

Research Perspectives

The project sits in the context of the emerging recovery research paradigm in mental health (Anthony, Rogers, & Farkas, 2003; Deegan, 1996; Goldsack, Reet, Lapsley, & Gingell, 2005; Lapsley, Nikora, & Black, 2002; Onken, Dumont, Ridgway, Dornan, & Ralph, 2002). Recovery research has two major areas of focus. It investigates:

• factors and processes significant in the recovery of individuals;

• recovery-promoting elements within

services, as well as other features of social life relevant to recovery (Lapsley, 2005).

Recovery is a process resting on a wide range of factors involving personal agency, social connectedness and social participation, as well as assistance from mental health services (Lapsley, Nikora and Black, 2002). It is essentially defined from the experience of service users, who are regarded as pivotal in defining recovery research priorities and in being involved in recovery research.

The Young Adult project used narrative theory and techniques to conceptualize and analyze the interviews (Crossley, 2000; Deegan, 1996; Lapsley, 2005; Lapsley et al., 2002; Richards, 1999). Narrative research often uses open-ended interview techniques that encourage people to making use of story-modes that convey the way they understand and make sense of their experience over time. Narrative research is particularly appropriate to recovery research, since recovery is often conceptualised as a journey (Lapsley, 2005; Lapsley et al., 2002; O'Hagan, 2003).

Young Adult Consultation

Consultation was a key to the success of the project. The Mental Health Commission has a Service Users Advisory Group, but it had no members under 30 years of age. The researchers established a young adult advisory group made up of young adults from service user organisations or organisations with peer support workers. Their input into the design of the research was sought, and we tapped their ideas on establishing inclusion and exclusion criteria, and identified issues to explore during interviews. We also received feedback on research protocols such as the letter of introduction, information form, consent and research brochure, ensuring appropriate language and ways of presenting the information. One consequence of the consultation was improving input to the Commission from this age group. Another was that Shona Clarke, the leader of a National Youth Consumer Advisor project, joined us for conference presentations and peer reviewed the research report.

Maori and Pacific Consultation

Consultation with Maori and Pacific mental health services and communities was also a key to the project's success. It was necessary, in order

to gain ethical approval from a national health ethics committee, and also integral to Mental Health Commission processes. Commission projects involve advice from a *kaumatua* (Maori elder) and Maori advisor, as well as a Maori reference group. We also have a Pacific reference group. Following consultations, it was decided that we should employ a Maori and a Pacific consultant to negotiate with Maori and Pacific services, respectively, in order to identify potential participants, and to interview Maori and Pacific participants.

We wished to interview some Maori young adults from a rural area, and this was facilitated by our Maori advisor's networks, in particular her *whakapapa* (lineage), knowledge of local *tikanga* (customs) and fluency in *te reo* (Maori language). This opened the door to the local Maori community for the Maori interviewer. Some issues arose in preliminary discussions. One was that local Maori wanted *kaumatua* (elders) and *whanau* (family) present during the interviews with young adults. This highlighted a disparity between Treaty of Waitangi partnership obligations and professional ethics, in relation to privacy and safety issues for the interviewees. It was decided that our Maori advisor would act as kaiawhina (caretaker) during the interviews instead of kaumatua or kuia (male and female elders). Whanau could be present if interviewees wished, and this occurred on several occasions. Interviews were offered in te reo Maori, although all were conducted mainly in English, though many Maori terms and phrases were used throughout. Interviews also took longer than usual, because time was taken to share whakapapa and share food with whanau when interviewers went to people's homes.

The Pacific consultant held an information evening at a Pacific health service to present the research to Pacific leaders, communities, families and service users. The Pacific service did not require any of their key workers to explain the project individually to participants, but gave brochures to potential participants and passed on names of those who were willing to be interviewed.

When it came to analysing the interviews, we realised that it would have been better if we had budgeted for the interviewers to be part of this

process. The narrative framework encouraged us to organise the research findings in a way that described mental health journeys, with their stages, that best applied to the whole group. This, along with the ethical necessity for "anonymising" details of participants and their stories, meant that Maori and Pacific stories were not highlighted as distinctively as they might have been with some other approach to research. This was disappointing to some of those involved in the consultation process.

Overall, our experience on the project showed the importance of having Maori and Pacific consultants who have respect and standing in their local communities; indeed, access to the rural area would not have been possible otherwise. We were pleased that our processes resulted in our project being strongly informed by Maori and Pacific voices, and we are convinced that the interviews would have been less rich if they had been conducted by interviewers of different ethnicities to the participants.

Participants

Forty young adults were interviewed. Most were currently in contact with mental health services and all had recently had their first experience of severe mental health problems during adulthood. Selection criteria were non-random and involved selecting for diversity, resulting in a varied group of interviewees. They came from four District Health Board areas and they had used a wide range of mental health services. Half were men, half were women, and there was a range of ethnic identities, with 17 people identifying as Pakeha or New Zealanders, 14 as Māori, seven as Pacific and two as Asian. Two-thirds had mental health problems that fell into the psychosis spectrum group, including schizophrenia and bipolar disorders. Mental health issues for the remainder included affective, anxiety, personality, eating and post-traumatic stress disorders. Overall, the profile of our interviewees was quite close to the profile of New Zealanders in that age group who make significant use of services.

Research Findings

Research findings are briefly summarised here. They are now available in the published research report (Barnett and Lapsley, 2006):

- Most interviewees told us about family

environments, as well as particular childhood and teen experiences, that contributed to their later experience of mental ill health. Abuse, emotional insecurity and loss were key contributors, and most said they had no one to talk to.

- Nearly all participants described a lengthy process of declining mental health - typically over a year or more - before reaching a mental health crisis. "Going downhill" usually involved:

  a sustained build-up of emotion, resulting from adverse childhood/early teen experiences

  traumatic or stressful life events during late teens/early adulthood, compounding these adverse early experiences.

  a series of significant life events in close succession

  no one to talk to.

- A significant proportion of participants (85%) began to misuse alcohol and/or illegal drugs to deal with emotional pain, often in their early teens.

- Effective interventions into problem family situations had not occurred, even where abuse was being experienced. Few participants saw child and adolescent mental health services. During the "going downhill" period, some sought help, or had help sought for them, but there were barriers to reaching mental health services, and primary care or counselling help was insufficient.

- Participants were often driven into crisis because of barriers to accessing mental health help. Crisis usually involved suicidal behaviour or a family crisis, building on the long "going downhill period" when distress was intensifying. Crisis assessment led two-thirds of the participants to an acute inpatient stay (many of them under compulsion), while the rest went directly to a variety of community mental health services.

- Acute inpatient units were described as unpleasant, frightening and not recovery-oriented. Several participants reported sexual harassment, physical violence, and/or sexual abuse in the units. Stays in

the acute unit were often long, there was little for people to occupy themselves with, and access to the outdoors was restrictive. Conditions in the units and practices, such as seclusion, had the potential to re-traumatise young adults who had already experienced abuse. No psychological help was available, despite young adults saying they would have liked to be able to talk to professionals about their distress.

- Alternatives to acute services, such as home-based treatment, were highly regarded by those few who had access to them.

- Post-acute services were often where recovery started to happen. Generic community mental health teams were often reported on as providing indifferent services, but many of the more specialised services, such as early intervention services and programmes with therapeutic, artistic, cultural and recreational activities, were seen as beneficial. In particular, a holistic, intensive psychotherapy programme was seen as outstanding.

- Specialised services and programmes would have been more helpful if they had been directly accessed from primary care and counselling services, averting the need for crisis and hospitalisation.

- Overall, participants wanted programmes with a holistic, rather than a solely medical focus, and they wanted access to psychological help, which was often not available in non-acute services, as well as acute services. They also preferred interacting with their age-peers in services.

- Recovery journeys were described in the report as movements towards the realisation of hopes and dreams. Participants were divided into three groups, in terms of their recovery stories. Those who were "*living well*" told stories that reflected a fundamental sense of "being in" and engaging with their communities. Those who were "*moving forward*" into recovery had some positive elements to their stories, but also

reported insufficient support for their mental health issues. Participants who were "*surviving day to day*" had some way to go in connecting hopes and dreams to concrete plans. Most lacked social, cultural and material support, and their days were often isolated, unstructured and felt meaningless. They were not receiving effective, comprehensive or recovery based mental health services.

- Recovery stories illustrated the intelligence, creativity and determination that young adults in all three groups brought to bear on grappling with severe mental health problems. They had progressed in understanding how their lives had brought them to this moment, and they were trying to harness what services could offer to help them move forward. They were very clear about what helped and what hindered. Participants tended to speak with a united voice about the importance of having someone to talk to, safety, respect, hope, friendship, work and careers, family support, meaning and purpose in life, independent housing, community participation, and the provision of holistic, recovery-oriented treatments and supports.

- A striking finding was that the mental health services had an overwhelming impact on participants' experience of mental health problems. At their best, they could powerfully ignite recovery, and at their worst they could significantly jeopardise it.

Research as a Journey

As well as describing participants' journeys, the Young Adult project was a journey for the researchers. This journey could variously be described as a research journey, a professional journey, a cultural journey and a personal journey. The stories we were told were often painful, disturbing and graphic. They were often profoundly moving and had a profound powerful impact on interviewers and even on the transcribers. It was important for us to support each other on this journey – and we did, through keeping in touch and sharing our experiences.

Research protocols do not usually contain requirements around researcher support and debriefing, but they certainly should.

This paper now concludes with commentary from one of the participants in the study, giving another perspective on the journey.

A Young Adult Perspective on the Research: Shona Clarke's Commentary

As a participant in this study, it feels quite powerful seeing that what other people are saying is similar to my experiences. I've had a number of beliefs from my personal journey through child and adolescent, and then later, adult services. It's good and bad to know that what I've been saying is reflected by other young people.

My own story starts when I was 14 and was extremely depressed and hurting myself. I didn't get help until I was 17. I believe that if I'd had help sooner, I wouldn't have had the trauma of the following years of psych units and residential houses. Anyways, obviously it has a happy ending – I'm still around and I've got a great job.

I'm working for the Werry Centre for Child and Adolescent Mental Health Workforce Development as the Project Leader for the Youth Consumer Advisor Project. I'm ultimately trying to improve youth consumer participation in NZ so that young people can say stuff they like or don't like. Young people having a say about services means they are better targeted to young people, and hopefully less people will have horrible unhelpful experiences.

I've said for a while that young adults can be a forgotten group. It seems weird, as this age group has such high suicide rate sand it is also the age group that mental health issues arise. In 2003, females 15-24 and males 25-44 had the highest age specific suicide rates. They don't fit into youth services and they don't fit in with adults – so they get placed wherever, and find that there just aren't the resources for them. Hilary and Heather's research seems to point to the fact that effective early intervention is essential. Too many young people aren't getting early and good enough treatment. So why is this?

Access is obviously the first part of the problem. Early intervention is great, but if the only way is through acute inpatient units, then it kind of defeats the purpose. And if your first experience of mental health services is being

locked up after being dragged to an inpatient unit by the police, you have to wonder how much stuff like this is contributing to mental distress rather than helping to alleviate it. Young people can especially benefit from early intervention, and then less money needs to be spent on adult services.

As I said before, I do believe that if I'd had good help earlier, I may not have had to continue using services for as long as I did. I could have completely sidestepped using adult services which is a whole other ball game to child and adolescent ones. My problem, was when I talked to the school guidance counsellor I said I didn't want my parents to know, so no external help. That was seen as reasonable, so for the next 3 years I continued to kind of cry out for help in a way until one day I just couldn't cope anymore.

So, other barriers? Does it mean I'm really crazy if I go there? …Other people might find out. Another barrier – not knowing who to go to or what to say or how to ask for help. Not all school guidance counsellors are that approachable. And if you're not at school – then where do you go?

The second part is finding "treatment" that is effective. Finding good help can be hard. If a young person's first contact with a mental health service is with someone who isn't youth friendly and isn't respectful and will not listen to what they say – this isn't going to be the most beneficial method of helping young people. I remember thinking some of the young people I knew were more helpful than the staff in the inpatient unit.

So anyways, for me it all comes back to effective youth consumer participation.

There are loads of documents and reports I could mention about why youth consumer participation is necessary. The Mental Health Standards, the youth development strategy, the United Nations convention of the children…But mostly it's necessary as I've read through the giant pile of articles on my desk, from around the world on how beneficial it is to both services and young people.

If services can encourage this and actually listen to what young people are saying, one day services will be reflective of their clients needs. Then maybe…I'll be put out of a job. Either that or I'll get to old to be a youth consumer advisor.

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Notes

[1] This paper was authored by Hilary Lapsley and Heather Barnett except for the section where Shona Clarke has been identified as the author.

[2] We use the terms *severe mental health problems*, *disabling mental health problems*, and at times *mental health crisis*, to refer to the experience of those who have been judged to have a severe "mental illness" and therefore meet the criteria to access mental health services. This usage reflect the preferences of the young adult service users we consulted, most of whom disliked the term "mental illness".

[3] Statistical data for this introduction was provided by the New Zealand Health Information Service (NZHIS) for 2005

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What can self-help support groups offer young people who experience mental health issues?

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Youth mental health is regarded as both a national and international priority. However, in this epoch of limited public funds, how can the array of support options be widened for young people with mental health issues? An option that does not drain the public purse might be community-based Self-Help Support Groups (SHSGs) – non-profit support groups that are run by and for people who come together on the basis of a shared experience. However, while existing research highlights the potential benefits of group involvement for adult group participants, do these groups offer any benefit to young people? This question is explored through findings from a study in which 53 young people who experienced mental health issues and have been involved in a SHSG to address these issues, were consulted. The young people were asked about those experiences that led to group involvement; their experiences with the group; and advice they could offer about who is likely to benefit from group involvement. Their contributions collectively offer insight into the potential value of these groups, as well as their shortcomings. The research findings also offer valuable direction to improve current social policy in youth mental healthcare.

Youth mental health constitutes both a national and international priority. The World Health Organization (WHO) advises that, "Contrary to popular belief, mental and behavioural disorders are common during… adolescence. [However] Inadequate attention is paid to this area of mental health" (WHO, 2001). A recent American report states that one in ten young people experiences a mental health issue that is severe enough to cause some level of impairment (U.S. Department of Health and Human Services, 1993). However, fewer than one in five receives the treatment they require.

The situation in Australia is comparable. Twenty-seven percent of those aged 18 to 24 years have a mental disorder in any one given year (ABS, 1998), while 20 percent of those aged 12 to 16 years have a mental health problem (Moon et al., 1999). Furthermore, problems of psychological development and emotional and behavioural problems are most prevalent among those under 17 years (ABS, 2004).

Substance use issues among young adults are also concerning (Toumbourou et al., 2005). Recent Australian reports suggest that more than forty per cent of those aged 14 years and over consume alcohol on a weekly basis (AIHW, 2005), and approximately one-third of surveyed teens have, at some time, used an illegal drug (AIHW, 2002). While unsafe substance use among young people in itself constitutes serious concern, a wealth of literature highlights a strong interrelationship between substance use and mental illness in this demographic (Lewinsohn, Rohde, & Seeley, 1995).

The mental and behavioural disorders of childhood and adolescence are very costly to society in both human (Daniel & Cornwall, 1993) and financial terms (Access Economics, 2002). Australian social policy has attempted to improve the current situation by (partially) directing political agendas toward youth mental health issues (Moon et al., 1999; NSW State Government, 2002). These efforts collectively recognise the urgent need to formalise protocols that ensure the early identification and treatment of youth mental health issues; they also acknowledge the importance of ongoing support for young people. Despite such interest, there is still room for much improvement in youth mental healthcare.

An option that may serve to improve youth mental health, and not drain the public purse might be community-based Self-Help Support Groups (SHSGs).

Self-Help Support Groups

The SHSG may be understood as:
a nonprofit support group run by and for people

who join together on the basis of common experience to help one another. It is not professionally run, although professionals are frequently found in supportive ancillary roles (Madara, 1999).

According to Riessman (1997), ten principles encapsulate the inherent value of the SHSG. Firstly, group participants are *socially homogenous* – they share similar experiences and thus have unique insight into each other's situation. Secondly, the groups offer opportunities for *self-determination* and different forms of *participation* – it is the group participants who drive group activities. Third is the *helper therapy principle*, whereby the best way to be helped, is by giving help. The fourth principle recognises the group participant as both *consumer* and *prosumer* (Toffler, 1980) – while he/she might *receive* the support of fellow group participants at one point in time, it is probable that he/she will reciprocate such support at another point in time. The fifth principle highlights the *capacity building* focus of the SHSG – in contrast to conventional medical models that focus on pathology, SHSGs are developed on the inner strengths and qualities of group participants. Sixth is the *non-commodification* of support, whereby support is gratis and reciprocal rather than attached to market forces. Further to this is the *social* nature of the support, which constitutes the seventh principle. The eighth principle pertains to the *self-help ethos*. According to Riessman (1997), this is commonly characterised by anti-dependency, anti-elitism, anti-bureaucracy, the sharing of community, informality, anti-addiction, a spiritual bias as well as participatory democracy. The ninth principle is that of the *self-help solution*. The support afforded by SHSGs does not come from expert knowledge; it is indigenous and born from experiential wisdom. It is therefore likely to hold pragmatic value for group participants.

In turn, the extended supportive networks found in SHSGs make human services more manageable; this is of particular benefit in light of limited government funds directed toward mental health services. Recent estimates suggest that, although mental illness is the leading cause of disability, Australia spends less than seven percent of the health budget on mental health – this is well down on comparable amounts spent by Organisation for Economic Cooperation and Development (OECD) countries (SANE Australia, 2002). The final principle highlights the notion of *internality*; SHSGs share an internal focus rather than relying on external interventions (Riessman, 1997).

Self-Help Support Groups, particularly those that meet around mental health issues, appear to be growing in popularity. Although there is limited information about the number of Australians accessing these groups, there is some information about particular SHSG organisations, like Alcoholics Anonymous (AA) – a 12 Step fellowship for those who identify as alcoholic, offering them support through its "well-developed ideologies and methods for dealing with their… problems" (Levy, 2000). A recent survey on group membership estimated that between 15,000 and 18,000 Australians were part of AA (AA World Services, 2002). Similar figures come from GROW – a group for those with mental illness. In the year 2000, it was estimated that some 10,000 people had direct contact with one of the 325 GROW groups in Australia (GROW, 2000). However, collated information from a range of SHSGs is lacking.

Benefits of Group Participation

While group participants may *vote with their feet* on the perceived effectiveness of SHSGs, a growing body of international literature also attests to their value. Research concerning adult participation identifies several benefits.

Self-Help Support Groups are said to offer an *environmental antidote* to the social isolation often experienced by those with mental health issues (Davidson et al., 1999). They facilitate the development of support networks (Humphreys, Finney, & Moos, 1994) and a sense of belonging (Noordsy, Schwab, Fox, & Drake, 1996).

The networks developed by adults within SHSGs are deemed beneficial to mental health, for social support acts as a buffer to stress and is thus implicated in the promotion of health (Thoits, 1985). The support offered by SHSGs can be both emotional (through affirmation and encouragement) as well as practical (aiding with daily affairs) (Cheung & Sun, 2001). Yet, of particular benefit is the long-term nature of this support (Kam-Shing, 1998), and the fact that it

can be tapped into when it is most needed – at times of personal hardship (Noordsy et al., 1996).

Adult group participants have been found to experience behavioural, cognitive and spiritual change (Humphreys, 1997; Kyrouz & Humphreys, 2000). Within the group, participants are exposed to others with similar issues. This can normalise the experience, which may be particularly important for those who experience the effects of stigma. Personal issues once considered shameful are transformed into a *qualification* for group membership. Further to this, fellow group participants, particularly those who have experienced greater personal growth, also make for positive role models (Adamsen & Rasmussen, 2001).

Research also suggests that group participants learn new information, and hear an array of opinion (Young & Williams, 1987). This can improve self-understanding (Reddin & Sonn, 2003), particularly in relation to the predicament that brought them to the group (for instance, possible external manifestations and/or causes). This serves as a *cognitive antidote* to personal issues (Davidson et al., 1999). In learning new information, group participants become aware of suitable coping strategies and treatments that might be of benefit (Galanter, 1988). They also have a forum in which to discuss fears and concerns about treatments they are ambivalent about (Felix-Ortiz de la Garza & Sorensen, 1995). The information shared in SHSGs holds particular relevance for group participants, as much of it is born from the experiential knowledge of fellow participants who are *in the same boat* (Borkman, 1999). They are able to compare their personal situation and monitor any progress.

The inherent processes of SHSGs can give rise to many personal benefits for group participants. They can develop greater communicative skills (Finn & Bishop, 2001), experience an improved ability to control undesirable behaviours (McCown & Chamberlain, 2000), and/or adapt to the issue that initially brought them to the group (Roberts, 1989). Mental health benefits also abound, for group participants are thought to

experience a greater sense of hope (Cheung & Sun, 2001; Davidson et al., 1999), improved self-image and personal identity (Reddin & Sonn, 2003), and enhanced self-esteem (Young, 1991). This is supported by research demonstrating relationships between group involvement and reduced psychiatric symptomatology (Galanter, 1988; Rappaport & Seidman, 1986), reduced hospitalisation rates (Kennedy, 1989; Kurtz, 1988), a reduced reliance on medication and human services (Finn & Bishop, 2001; Raiff, 1984; Young, 1991), and a reduction in the financial cost attributed to the use of these services (Humphreys, 1998).

This body of literature suggests that for many people with mental health issues, SHSGs are important source of support (Kyrouz & Humphreys, 2000). However, an extensive review of existing literature only located relatively few articles that specifically examined young people's involvement in face-to-face SHSGs. Lack of academic interest in young group participants means that we have little understanding of whether the aforementioned benefits apply to young people.

The existing research on young people in SHSGs has focused solely on 12 Step fellowships. Collectively, these studies suggest that young people can potentially benefit from group involvement. They cite prolonged periods of sobriety (Alford, Koehler, & Leonard, 1991; Kelly, Myers, & Brown, 2000), enhanced self-esteem (Hughes, 1977), and the development of support networks (Margolis, Kilpatrick, & Mooney, 2000).

However, these studies are limited in a number of ways. Firstly, they refer only to 12 Step fellowships, particularly those that meet around substance use issues, neglecting other group types. Perhaps this is because 12 Step fellowships are greater in number (relative to other group types) and are commonly recommended to young people in the course of treatment for these issues (Bukstein, 1995). Secondly, the focus of past research has largely been on therapeutic gain. *Benefit* of group involvement is mostly synonymous with *improved outcomes on substance use* – that is, either complete abstinence (Hsieh, Hoffman, &

Hollister, 1998) or reduced substance use (Brown, 1993; Kelly et al., 2000). Thirdly, none of the previous studies were conducted in Australia, with most coming from the United States of America (USA). Collectively, these limitations mean there is still much to learn about young people's involvement in these fellowships and other SHSGs. We know very little about the range of experiences among young people who attend SHSGs, particularly those with mental health issues other than substance use. We know even less about the possible benefits beyond mere therapeutic gain.

This ignorance was a primary driving force behind the current study in which the possible benefits associated with SHSGs were explored from the perspective of young people who experience mental health issues.

Method

Recruitment

Given the lack of a comprehensive database on SHSGs in New South Wales, Australia (the location of the present study), many and varied organisations were contacted to locate appropriate groups, including parent bodies of SHSGs, government and non-government agencies, educational institutions and other relevant bodies. Groups that met around mental health issues were contacted and visited, when appropriate. This served to ensure that the groups were actually SHSGs, both from the understanding of the researcher and the group. Through networking widely, young participants of these groups were invited to contribute to the study. This also led to a process of snowball sampling (Minichiello, Aroni, Timewell, & Alexander, 1995), which ceased following data saturation (Marshall, 1996). For this reason, there is no claim that the research participants in this study constitute a representative sample.

Research Participants

The cohort comprised 53 young people aged between 15 and 31 years (mean = 24.79 years, median = 25 years), with slightly more males (52.83%). Although the young people represented a number of cultural backgrounds, all participants, except two, identified as Australian. The remaining two were from New Zealand and the USA.

Although the cohort was comprised of young people who had experienced mental health issues, these could be categorised further using the self-definitions of the research participants. They could be classified as having primarily experienced (in order of frequency) a diagnosable mental illness (43.40%), substance use issues which includes alcoholism and drug addiction (30.19%), issues related to sexual identity (20.75%), or emotional health issues (5.66%). It is worth noting that these were self-determined identities and not imposed by the researcher or a mental health service provider for the purpose of the study. However, it is probable that human service providers were initially responsible for most of these descriptors.

The research participants collectively represented 17 distinct SHSGs. At the request of some research participants, the identity of these groups is not disclosed. Suffice to say, all groups brought together people who shared similar experiences and were run by and for their participants. Payment of fees to verify membership was not required, nor did the groups have a predetermined life span.

Despite these similarities, there was much structural diversity among the groups. Some were relatively semi-structured, providing the group with the flexibility required to meet the changing needs of both the group and its participants. During the meetings, participants would typically share personal experiences. They would discuss the shared attributes, as well as the struggles, the victories and of particular importance, the strategies that were most useful to achieve those victories. Discussion and the provision of feedback were also part of this process.

Other groups adhered to a 12 Step program to promote recovery among participants. More specifically, the program provided instruction for a manageable lifestyle, particularly for those who experience addiction to alcohol or other substances, or those living with a person who experiences such an addiction. The seemingly rigid format of the meetings allowed participants to become familiar with accepted protocols and procedures quickly and easily.

On average, the research participants were involved with their respective groups for 2.31

years (median = 18 months). Participants were able to offer a guesstimate of their group attendance levels. On average, they attended 7.4 meetings of their primary group per month (median = one). This frequency is inflated by the number of different 12 Step fellowship meetings that met weekly. This enabled some research participants to attend several 12 Step fellowship meetings each week.

In the light of this diversity, caution is warranted when conclusions are drawn across groups.

Research Method

Adapted from the research efforts of Gray and colleagues (1997), a semi-structured, open-ended interview schedule was designed to explore the experiences of young people with mental health issues in SHSGs. The schedule facilitated an exploration of life circumstances prior to group involvement; experiences with and perceptions of the group; impact of group involvement on the young person; and any advice about who is likely to benefit from group involvement. However, it is the purpose of the present paper to explore what SHSG offered these young people.

Each interview was recorded on audiotape and, on average, lasted two hours. Transcriptions were prepared almost immediately after each interview and returned to the research participants for clarification and/or revision. This immediacy also enhanced personal reflexive practices (Hutchby & Wooffitt, 1998), as subsequent interviews could be informed by the information gained (Bolam, Gleeson, & Murphy, 2003). For instance, initial interviews demonstrated the need for clarity when exploring first impressions of the SHSG – some young people had many attempts to engage with a SHSG, corresponding to their phase of recovery; thus, they had many and varied first impressions.

The interview material was then examined for emerging themes. Given the exploratory nature of the study, this examination was conducted through an interpretive paradigm (Denzin & Lincoln, 1994; Flick, 1998), which uncovered interpretations of the social world within a contextual framework involving the research participants and the researcher (Crotty, 1998).

The analytical process of the study involved coding the interview transcripts, whereby items and themes of interest were grouped. Three questions guided this process:

"What is of interest here?"

"Why is this of interest?"

"Why am I interested in this?" (Richards & Bazeley, 2001).

Thus, the coding was both a descriptive and an interpretive process (Buston, 1997) influenced by theoretical preconceptions that were continually revised (Kelle, 1997). Responses to these three questions were documented in a journal, giving rise to new questions and the creation of new codes.

Research Findings

As the following section demonstrates, the SHSGs were of particular value to the young people interviewed. The groups offered them *support*, *opportunities to learn*, *hope*, *an extended social network*, as well as *connectedness* with people they could identify with. The presentation of research findings commences with an examination of why the young people joined a SHSG.

Why did the Young People join a Self-Help Support Group?

The research participants joined their respective groups because *something* was missing from their lives. Many seemed dissatisfied with their current situation and wanted something different. Yet, for the most part, they were unable to change their situation. Some had sought the support of family members, peers and/or mental health professionals. Unfortunately though, most of these sources were deemed unhelpful. This is exemplified by the following two excerpts:

My house was just immaculately clean like it was kept really clean cause I… put out a lot of my manic episodes out on the house; so I'd scrub the walls, clean the kitchen you know, would be immaculate and everything was just perfect in my house and my friends would come over and go, "I can't believe you're saying you know, your life is so bad when you know, you're obviously doing something; your house is totally clean!"

I went to a psych for like eighteen months and he put me on all this different medication; diagnosed me with five mental illnesses all at you know, different times… I just felt like a guinea pig with the psychs.

Thus, the research participants essentially joined their groups seeking *change*. Many spoke of change at a personal level and at a social level. They wanted to be able to exercise agency and manage their lives more effectively; they also wanted to improve their social networks and their relationships with others. Yet, these two reasons were not mutually exclusive, but often interrelated.

The need for personal change was highlighted by those with serious mental health issues. These research participants seemed to have reached a state of desperation. They were unsatisfied with the dire situation they were in, for what they had was inadequate. This was particularly the case among those with substance use issues. The negative effects of alcoholism and/or addiction on these individuals were significant, giving rise to a sense of desperation. As stated by one research participant, "I was really desperate; that was what there was."

It thus appears that serious mental impairment often motivated the research participants to seek help through involvement in a SHSG. However, when mental health was not seriously impaired, different reasons gave rise to group involvement, like the need for change at a social level.

Change at a social level was predominately highlighted by those who described generally better functioning. These research participants wanted to connect with people they shared similarities with and could relate to in a meaningful way, because existing relationships were sometimes described as shallow. One research participant commented:

There was a kind of superficial support which is good but… not anything terribly meaningful, so [the group]… has been an opportunity to get a lot more meaningful kind of support and a lot more… reliable

[support] cause you know the group's here every week.

The added benefit of this was the opportunity to compare personal experiences. Another research participant explained:

I guess one of the things I wanted to establish in my own thinking was how… my illness was compared to other people… But, you know, I hadn't really met anyone else.

What did the Groups offer the Young People?
Overall, the research participants spoke of the *support* they received through group involvement. They suggested that group participants offered emotional support through expressions of concern, compassion and sympathy. Support was also evidenced through the group atmosphere. It was regarded as supportive in meeting psychological or emotional needs. One research participant suggested, "It's a very relieving atmosphere… Every week I was supported, basically."

The SHSGs also offered *opportunities to learn* about a range of matters that were of personal interest to the research participants. This includes mental health issues and available human services. One research participant stated:

They had someone by the name of Professor [name of doctor] come in, and it has been useful having him you know, his sharing [of] information about treatment strategies and hope for people, and have… the opportunity to express their concerns or their doubts and their fears or uncertainties about the treatment.

Not only did this save them time and effort in researching available options, but it rekindled lost faith in the medical paradigm. Another participant affirmed this sentiment:

People that have sort of better relationships, like doctors that are

more involved and more able to you know, really see what the issues are with the individual you know, and concentrate on that; like that sort of gives you some idea that…there are doctors out there that are willing to do that, and it's just a matter of sort of finding them, and so that's also useful, sort of makes you not give up hope on all doctors anyway you know, find ones that can actually help you.

Some of the advice received through the group context was of particular benefit because it was practical. Further to this, the advice and information offered by the fellow group participants was perceived as more credible and genuine, for it was born from personal experience:

It's been good just having that contact with positive people, like the people who… are able to give you that kind of… peer-based support, advice, and information about recovery.

The SHSGs also offered the research participants a sense of *connectedness* with others. They were able to develop friendships with fellow group participants. This widened their support network, offered a sense of belonging and reduced their sense of isolation: "It can be really good for self-esteem… because… you get to meet people and make friends and feel part of a community and feel… part of a network."

Not only did the groups offer the opportunity to connect with others, it also offered them the opportunity to connect with people they could *identify* with: "They know exactly… what you mean… there's no real sort of substitute for that." The ability to relate to the mental health experiences of others allowed the research participants to feel understood – this was an important feature of the group experience:

When you're not doing well, it's, you know, good… to sort of… meet

people that are… also not doing okay… you sort of have that sense of… "You're not the only person"… You realise that it's like an illness and… you feel better about the whole thing.

In light of these research findings, it appears that the SHSGs offered the research participants a number of benefits. Further to this, the groups filled the void in their lives that was the initial impetus for group involvement.

Discussion

Given the prevalence and seriousness of youth mental health issues, and the increasing economic costs associated with youth mental healthcare, this paper explored what SHSGs might have to offer young people who experience mental health issues. This was achieved through semi-structured, open-ended interviews with 53 young people, all of whom experienced such issues and have participated in a SHSG that met around mental health concerns.

A thorough analysis of the research material suggests that the research participants came to their respective groups seeking *change*. Those who experienced relatively poor well-being sought recovery, while those who were better functioning wanted to expand their social networks. A number of research participants spoke of personal efforts to incite this change; these include seeking the support of family members, peers and/or mental health professionals. However, these attempts did not seem to fill the void in the lives of the young people and in fact propelled greater interest in alternative supports, including SHSGs.

Collectively, the research participants advised that the SHSGs offered a number of benefits. Of particular importance was the provision of *support*. The research participants alluded to emotional support, which fellow group participants demonstrated through empathy and friendship. Further to this, the support was expressed through advice that was of great practical value. The groups offered many opportunities to *learn* about mental health issues, services and professionals within the mental health sector, as well as contemporary treatment options. While the

availability of such information was advantageous in itself, it also offered *hope* to those whose views about the mental health sector had been tainted.

The SHSGs were also an opportunity to expand social networks, particularly with people who were *in the same boat* (Borkman, 1999). The research participants spoke of *connectedness* with people they could identify with. This ability to relate to the personal experiences of others not only helped the research participants feel understood, it also added value to the information and advice they received. This is because much of it was born from experiential wisdom, rather than academic discourse.

These findings are reminiscent of existing research efforts in the area of SHSGs. The literature suggests that these groups have the potential to offer support that is both emotional and pragmatic (Cheung & Sun, 2001; Kam-Shing, 1998; Noordsy et al., 1996). Self-Help Support Groups also have the potential to facilitate support networks (Humphreys et al., 1994; Rappaport et al., 1985) and a sense of belonging (Noordsy et al., 1996; Young & Williams, 1987). In effect, the groups are said to offer an *environmental antidote* to the social isolation often experienced by those with mental health issues (Davidson et al., 1999).

This research is limited by its exploratory nature. Firstly, there is no claim that the young people form a representative sample. Secondly, qualitative research is limited by time, context and the nature of individual perspectives. Thirdly, the findings reflect the interaction between the researcher and the young people. They also reflect the researcher's interpretation of these interactions, and are thus influenced by the lenses the researcher brings to the project; the construction of themes from the interview material may therefore not adequately encapsulate the perceptions voiced by the young people. Fourthly, given the epistemological dilemma associated with interpretive methodologies, the present findings, which were the result of a cross-sectional design, have a limited lifespan.

Nevertheless, the findings to emerge from this project offer pertinent insights to those interested in youth mental healthcare –

particularly the providers of youth and community services. The findings suggest that SHSGs – a relatively inexpensive community-based resource, can be of benefit to young people with mental health issues, offering them a degree of respite.

Human service providers need to acknowledge the positive contribution SHSGs can make to the well-being of young people who might otherwise remain disengaged from traditional approaches. These service providers can demonstrate their support for these groups, search out and network with existing groups in the local area, and advise their clients of their availability. They may also encourage and support the establishment of new groups located in places that might be more accessible to young people. Such a holistic approach, which complements conventional treatment with community-based support, increases the likelihood that positive mental health is sustainable in the long-term. Not only is this good news for young people with mental health issues, but also for their families and for human service providers who may struggle with limited resources.

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Walking together:
Facilitating participation of disabled people on voluntary committees

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This paper focuses on issues relating to empowerment, decision-making and citizen participation of disabled people in organisations such as self-help groups, and is based on my personal experience. I am a community psychologist and president of a disability self help group. There is rarely any competition for places on the management committees of self help groups and often these groups operate with vacancies. Many committees for groups based on a specific diagnosis have an imbalance of members in favour of the parents of affected children. Parents can be great advocates for their children but they can also be misguided due to their own prejudices concerning disability. This paper applies aspects of the contextual-behavioral model of empowerment to the disability organisation I am a member of. I discuss the underpinning belief systems of organisations 'for' disabled people' and 'organisations 'of' disabled people. The distinction between empowering and empowered organisations is also considered in terms of creating representative and collaborative committees. The paper provides a starting point for development of strategies that could be used to increase citizen participation of disabled people on voluntary committees.

My interest in the management of voluntary organisations has developed from the perspective of an insider on a number of committees for voluntary organisations including a professional association, a local community action group, and a disability self-help group. Like all voluntary organisations, these three groups rely on the efforts of members to function. Gann (1996) suggests that there is rarely any competition for places on management committees and this has been demonstrated in the committees I have been part of.

This paper focuses on empowerment and citizen participation of disabled people in disability organisations. The problem concerns the lack of adequate representation of disabled people on committees of organisations that purport to represent them. This can have the effect of further contributing to disabled people's oppression in society. Community psychology provides an ideal forum for research into this issue as it uses an ecological perspective incorporating individual, group and environmental factors. Before dealing with the nature of disability organisations a brief explanation of disability terminology and two models of disability are provided as the nexus between disability studies and community psychology.

Terminology and Models of Disability

For the purposes of this paper I will be using the term *disabled people* rather than *people with a disability*. There are two reasons for this choice. First, disability is seen as part of the individual's social identity. O'Toole (1996) believes it reflects "membership in a defined social and cultural community that has its own norms, humour, history, and culture" (p.35). Waxman (1996) uses the term to denote prideful identity rather than downplaying the influence disability has on the lives of people with impairments. Secondly, the use of people first then language implies that the disability is an inherent part of the individual. Disabled people prefer to distinguish between their impairment and the disabling effects of society. In other words, disabled people do not *have* the disability but rather it is something that is *done* to them by a society that fails to take their needs into consideration (Swain, French & Cameron, 2003).

Individual models of disability view disability as stemming from functional limitations assumed to have arisen from the impairment and which require individual treatment (Oliver, 1996). Disability is viewed as a personal tragedy that happens at random to unfortunate individuals and disabled people are viewed as "victims". The

social model believes that disability stems from external social and physical barriers and society's failure to take account of the needs of people with impairments. Disability is not random but imposed on top of impairment (Oliver, 1996) in other words it is a form of social oppression. The solution involves removing the barriers e.g. provision of an accessible environment and educating the community so that they come to view disability in terms of social justice.

Self-Help Groups

The term self-help group refers to groups that are formed and run by members as opposed to support groups that may be run by professionals (Borkman, 1991). Levy (2000) says that self-help groups differ from other social support systems because: members share the same problem, they relate as peers within the group, individuals act as provider and recipient of support, they are intentional groups, they are guided by ideology, and they are autonomous. The last point has implications in terms of the management of self-help groups as their success depends upon how well they mobilise the members to participate at various levels of commitment. Involvement on a management committee usually indicates a high level of commitment.

Disability Organisations and their Management

Disability organisations can be distinguished in terms of whether they are *for* disabled people or *of* disabled people (Macfarlane, 1996). Organisations *for* disabled people are organised and controlled by non-disabled people or a mixture of disabled and non-disabled people. Organisations *of* disabled people are organised and controlled by disabled people. Most of the groups concerned with disability in Australia are organisations *for* disabled people. They are organised along diagnostic labels, are named after the disability they represent and are medically oriented. The aims of these groups reflect an individual model of disability promoting awareness of the effects of the condition and emphasising need in order to raise money mostly for medical research. Attention to individual support can get lost amid these other activities. There are a few organisations *of* disabled people in

Australia. One such group, People with Disability Australia Inc., is not based on a single medical diagnosis but has members with a wide range of impairments. The organisation adheres to a social model of disability and accordingly emphasises social justice and environmental change rather than the search for a cure. The group provides opportunities for citizen participation and empowerment of disabled people by having a policy that allows only disabled people to be full members, to serve on the committee, and to vote at general meetings.

A survey of voluntary disability organisations in a county of Wales found that 81% of these organisations held personal tragedy views of disability consistent with an individual model of disability (Drake, 1994). Although the majority of respondents viewed favourably the idea that disabled people in their organisation should have roles of influence, authority and control, very few of these organisations actually put this into practice. Forty-seven percent of organisations had no disabled people on their management committee and only 15% had disabled people filling all positions on their management committee. Drake concluded that disabled people remain subordinated and powerless in agencies and that agencies continue to reflect a medical model of disability creating dependency and oppression.

Drake (1996) conducted follow-up qualitative interviews with disabled and non disabled members of organisations from his earlier study and found that they had differing ideas concerning the objectives of the groups they belonged to. Disabled members of the organisations were interested in lobbying, campaigning and empowerment. Non disabled members believed their organisation's role was to serve other groups, to support parents and carers, and what the author describes as "a disembodied concept: 'The Need'" (p.10).

Although the organisations that Drake investigated were not all self-help groups, the findings are important for two reasons. First, they provide evidence of poor representation by disabled people on committees of disability organisations and secondly, they suggest that there are philosophical differences in the views of disabled and non disabled members of committees in terms of the goals of these

organisations. It is important to act to redress these issues and ensure that disabled people gain some control in the organisations that purport to represent their interests. One way of doing this is to increase participation levels of disabled people on committees of self-help groups. This corresponds with a number of values of community psychology: individual wellness, sense of community, social justice, collaboration and community strengths, respect for diversity, empowerment and citizen participation (Dalton, Elias, & Wandersman, 2001).

The self-help group that is the subject of this paper represents the interests of families affected by a particular genetic condition. It was formed over 20 years ago when a non-affected member of a family placed a notice in a popular women's magazine seeking contact with others with an interest in the condition. He was overwhelmed by the response and the group was founded not long after. The group was incorporated in 1991 and part of this process involved the drafting of objectives and a constitution. These documents were developed by the parents of children affected by the condition and reflected the parents' desire for research to find a cure for the condition. Incorporation is beneficial to groups as it limits the liability of members, however, it carries with it a number of statutory requirements including the formation of a committee and the holding of regular committee meetings. The role of the committee is to manage the group and make decisions concerning resource allocation and program development.

When I joined the committee there was only one other member with the condition. The following year I was the only affected member. The participation of affected members on the committee reached a peak of five out of seven in 1999 but I am now the sole surviving affected committee member. The other members of the committee are either parents or grandparents of affected children. The rest of the paper will discuss factors that have contributed to a poor representation of disabled people on the committee using a contextual-behavioural model of empowerment.

The Contextual-Behavioral Model of Empowerment Applied to a Self-Help Group

It is important to take an ecological approach when considering the barriers to disabled people becoming citizen participants in disability organisations, because participation is dependent upon factors at multiple levels of analyses. The contextual-behavioral model of empowerment (Fawcett et al., 1994) suggests that empowerment is a function of the interaction between individual or group factors, and environmental factors. At the individual or group level, capacity is viewed as a function of competence and experience, and physical and biological capacity. Environmental factors include stressors and barriers, and support and resources. I will draw upon some of the elements of this model to suggest reasons why disabled people are under-represented on the committee to which I belong.

Knowledge, critical awareness and skills are aspects of competence and experience that can empower a disabled person. Consistent with many members of disability self-help groups based on diagnosis, the members of my group tend to view disability from an individual model perspective. This means that they believe disability should be dealt with at an individual level rather than through collective social action. Many affected adults in the organisation have lower than average levels of education and believe they lack the skills required for a position on the management committee. They believe that non-disabled members are more qualified to make decisions. Unfortunately, several affected committee members have found the task difficult. The increasing complexity of legislative requirements for running incorporated associations has led to disabled members retiring from the committee. The extent of their difficulty was demonstrated by the fact that when I was first elected as President of the association there was a tendency for members of the committee (both disabled and non disabled) to defer to me rather than initiate ideas. This posed a dilemma for me as a community psychologist. I was, of course "one of them", but as an academic, I was also viewed as an expert on matters relating to disability. We now have an active and skilled committee but it is made up of non-disabled family members including a lawyer and an accountant - very useful skills for dealing with the complexity of managing an organisation

in the 21st century.

Other aspects relevant to competence and experience in the model are one's history of empowerment as well as values and beliefs. Many of the members who attend support meetings have little experience of empowerment as they have internalised negative messages from others in the community throughout their lives. These members relate stories of difficulties at school and having been told throughout their lives that they are lazy or "dumb". This has contributed to low self-esteem and lack of psychological empowerment. Many tend to passively accept their lives and believe they have little influence over what happens to them.

Barriers based on individual and collective beliefs and values have considerable potential to limit our opportunity to coopt skilled disabled people onto the committee. Those who join the association and attend meetings are not necessarily representative of everyone who has the condition. There are various reasons why affected individuals may decide not to join or not to attend meetings. Some may not know of its existence while others may not experience any major difficulty and therefore see no reason to join. Others may be reluctant to join because they fear being outed or stigmatised if they are associated with the condition and the organisation. We have also been told by people who have joined the organisation that doctors have suggested joining but warned them not to go to meetings as they could find it confronting to meet people who are more seriously affected than they or their children are.

Barriers relating to physical and biological capacity include health, and type and degree of impairment. Although the social model of disability tends to minimise the effect of impairment on disability, this stance has been criticised by feminist scholars (Morris, 1991; Crow, 1996) who say that their impairments have very real effects on their lives. Many members of my organisation face significant health issues that diminish their capacity to regularly attend and participate in meetings. Members have retired from the committee because of difficulties related to pain and fatigue as well as multiple surgeries that have

necessitated time away from committee duties. Members of the organisation have a diversity of impairments affecting mobility, vision, hearing, and balance. A significant proportion of disabled members have learning difficulties including problems with literacy and higher executive functioning that can affect their ability to read and organise information. Issues surrounding body image and appearance are a concern for some due to the disfiguring effects the condition can have. Many members do not drive so travel to meetings can mean running the gauntlet of staring and insensitive comments from the public.

Environmental factors include stressors and barriers that occur at multiple levels. Although our meeting place is physically accessible, geography poses a significant challenge as members are spread throughout Australia reducing the opportunity for many to become committee members. At one time we were faced with a dilemma concerning whether the organisation should fund a committee person's taxi travel to and from meetings. We wanted this person on the committee as she represented the specific interests of an important membership group but it would have been a high expense for our limited budget. The problem was unsatisfactorily resolved when the committee member resigned due to ill health. Poverty potentially decreases participation for some members who face financial stress and may have less time and energy to devote to citizen participation. The social model of disability (Oliver, 1996) argues that environmental barriers both physical and social have a greater effect than impairment itself.

Fawcett et al. (1994) suggest that the environment can provide support and resources to optimise empowerment of disabled people. In terms of increasing the levels of participation of disabled members on the committee, we need to work towards being a more supportive organisation and providing more information about what is involved in committee membership. Some disabled members may need greater encouragement and prompting to join the committee. It is important that disabled members' family and peers are supportive of their involvement otherwise conflicts can arise (Kieffer, 1984). The current committee could provide positive role models and act as mentors to

assist more disabled members to learn the skills necessary to work on the committee. It is also important for the general membership to express their appreciation for the efforts of all the committee so that they may feel valued and their work is recognised.

At the moment I am the only member of the committee who has the condition the organisation represents. The parents and carers who are on the committee are competent and highly motivated but they tend to see disability from an individual perspective and most of their efforts are directed at programs for children. In order to represent the members and broaden our scope, we need affected adults on the committee. My organisation has strengths, but still has a distance to travel to become both an empowering organisation (fostering personal development in members) and an empowered organisation (contributing to social change).

This paper has focused on issues relating to empowerment and citizen participation of disabled people in disability organisations. It suggested that there is poor representation of disabled people on committees of disability organisations and that there are philosophical differences between disabled people and non-disabled people in terms of what they see as the objectives of their organisations. The paper applied aspects of the contextual-behavioral model of empowerment (Fawcett et al., 1994) to the organisation I am a member of. A full discussion of strategies that could be used to increase citizen participation of disabled people on committees is beyond the scope of the paper, but it provides a starting point for further work in this area. The first step for groups such as mine is to determine the extent to which impairment and environmental issues respectively affect participation of disabled members on their committees. These findings could then be used to carry out an action research project to try and increase citizen participation levels of disabled people on the committees of self-help groups.

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The Personal Support Programme: 'Where we walk the walk'

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The Personal Support Programme (PSP) is an Australian Government funded programme that is part of the Welfare to Work welfare reform process. The overall objective of the programme is "to enable people with multiple non-vocational barriers to achieve economic and/or social outcomes" (DEWRa, 2005). Here, economic outcome refers to either employment or education, whilst social participation refers to 'soft' outcomes such as a stronger support network, increased level of social activities, reduction in offending, and so forth. During their two-year journey on PSP, participants could expect to receive a variety of services from their PSP Providers, including assessment, counselling, referral to and coordination of appropriate services, advocacy on behalf of participants, and practical support. By means of an active case management approach, participants are assisted in overcoming identified barriers, with Case Coordinators facilitating the re-integration and re-engagement of participants with their community. Incorporating essential Community Psychology principles, the Personal Support Programme has shown itself effective in not only shaping but changing the lives of its vulnerable but remarkable participants. This paper aims to provide an overview of the programme's reported successes, whilst taking a critical look at the programme strengths and limitations.

The Personal Support Programme (PSP) is an Australian Government funded programme that commenced in July 2001 as part of the Australians Working Together welfare reform process. The programme is nationally administered by the Department of Employment and Workplace Relations (DEWR) and delivered by contracted private sector providers such as WorkDirections.

The overall objective of PSP is "to enable people with multiple non-vocational barriers to achieve economic and/or social outcomes" (DEWRa, 2005). These outcomes are expected to be matched to the abilities, capacities and circumstances of the individual participants (Perkins & Nelms, 2004). PSP therefore bridges the gap between crisis assistance and employment assistance programmes such as Job Network (JN) or Disability Employment Network (DEN).

Programme Overview

Participants are referred to PSP following individual psychological assessment by a Comprehensive Work Capacity Assessment (CWCA) Provider, known as a Job Capacity Assessor, as being unable to benefit from employment assistance programmes such as Job Network. During such assessment, barriers preventing participants from obtaining and or maintaining employment are identified. These barriers include, amongst others:

- Homelessness;
- Drug and alcohol dependence;
- Mental illness, including mood disorders, anxiety disorders, agoraphobia, panic attacks, personality disorders, anger management issues and stress;
- Social problems such as domestic violence, torture or trauma, gambling addictions and financial management problems;
- Physical or intellectual disability including organic mental disorders or acquired brain injury;
- Social isolation including alienation and poor communication and language skills. (DEWRb, 2005)

Perkins (2005) suggests caution with the use of the government prescribed term 'barrier' within the context of PSP. Perkins argues that whilst focusing on personal and familial barriers could have the potential to improve services and support for highly disadvantaged clients, there is

a clear danger that it could result in an "increased focus on a 'deficit' model of the unemployed and divert attention away from structural causes of disadvantage" (p. 3). Perkins does however suggest that recognising the broad range of obstacles PSP clients face could encourage the development of programmes such as PSP that can address needs outside the traditional vocational domain. This is supported by Danziger et al. (1999), who argue that determining the number and severity of barriers faced by an individual constitutes an effective method of determining the appropriate level of intervention.

Upon referral to the programme, participants are assigned a Case Coordinator. At this point, client and Case Coordinator commence the PSP journey together. The Case Coordinator, in consultation with the participant, develops an action plan for the individual participant based on the barriers identified. The aim of the action plan is to assist participants in overcoming the identified barriers, ultimately facilitating their increased economic and social participation (Perkins & Nelms, 2004). Here, economic participation refers to either employment or education, whilst social participation refers to 'soft' outcomes such as a stronger support network, increased level of social activities, reduction in offending, and so forth. During the two years that participants journey through PSP, participants are exempt from activity test requirements. PSP thus provides a 'time-out' from the pressures of looking for employment, allowing participants to focus instead on the barriers or obstacles preventing them from functioning optimally both socially and economically.

During the two years on PSP, participants could expect to receive a variety of services from their PSP Providers, being:

- Assessments: mental status assessment; barrier assessment; progress (Action Plan) review.
- Counselling and personal support: guidance, assistance, encouragement, building self-esteem and confidence.
- Referral to appropriate services, coordination of activities with other service providers, advocacy on behalf of participants.
- Practical support: to attend interviews/

appointments, to facilitate access to services and assistance.

Although they have a maximum of 104 weeks for participation on PSP, participants often overcome the barriers much sooner. Once the participant reaches a point of 'work readiness' the Case Coordinator discusses various options for moving into economic activity. These can include referral to:

- Intensive Support Customised Assistance (ISCA),
- Community Work Placement (CWP),
- Work for the Dole (WfD),
- Disability Employment Network (DEN),
- Vocational Rehabilitation Services (VRS).
- Following such referral, the PSP Case Coordinator continues to provide transition support in the form of dual servicing for a period of 26 weeks in order to ensure the smoothest possible transition as well as the sustainability of such transition into economic activity.

Case Studies

Having provided a brief overview of PSP, in the next section we look at two case studies of how the PSP journey has made a difference in the lives of two participants:

Case study 1

Anne* commenced PSP in February of 2003. Her identified barriers were: alcohol & drug dependency; depression; past abuse; involved in an armed kidnapping; panic disorder; anger management; psychotic episodes; post natal depression; suicidal ideation; lack of confidence and self-esteem.

Following the birth of twins, Anne had experienced Post Natal Depression which had developed into long-term chronic depression and recent suicide attempts. She had a large state debt and no licence. Her twin boys were removed by the Department of Community Services (DOCS) and were in care. All Anne's previous relationships were abusive and at times violent. Despite all this she presented as warm, open and keen to make positive changes.

Time with Anne was spent engaged in exploring her negative self-beliefs and providing practical strategies. A referral to Mental Health Services proved useful and she linked in with anxiety groups and on-going

counselling. She was supported in commencing a debt repayment scheme and eventually regained her licence. She reduced her substance use and ultimately abstained. The PSP Case Coordinator and the DOCS caseworker liaised in setting up access visits to the children and eventually sleepovers. She commenced and sustained a positive and healthy relationship with a supportive partner. Having reported to feel 'work ready', Anne was referred to ISCA and gained employment with the Post Office despite having been granted a Disability Services Pension. She has recently been told that her twin boys are to be returned to her full time care.

Case Study 2

Mark* commenced PSP in December 2003. His identified barriers stemmed from a violent and brutal childhood.

Once a seasonal worker and in his 40s, Mark was referred to PSP about two years ago. His childhood had caught up with him and although he tried to settle down in conventional accommodation it was not the right place for him. So he turned his back on society, took a few belongings and withdrew to live in a cave. There in the foothills of the Blue Mountains, with Park Rangers discreetly turning a blind eye, he survived on the bare minimum. Remarkably, he kept his appointments with WorkDirections, making the considerable trek on foot. After what seemed like slow progress, Mark finally took the step of moving into temporary accommodation. Further counselling and accommodation assistance saw him eventually able to transfer to a less intensive level of assistance. During the week he lives in a room at a hotel and goes to work. On the weekends he retreats back to the cave. He has saved quite a deal of money as a down payment on a place of his own.

* Pseudonyms used to protect the privacy of participants.

Programme Strengths

The success of PSP, and the provision of the services previously mentioned, is based on a strong case management focus employed by providers. PSP Providers employ discipline-specific qualified Case Coordinators such as registered psychologists, social workers, rehabilitation counsellors, and community mental health workers, who all operate from a case management approach. Orford (1992, in Cook, 2000) defines Community Psychology as understanding people within their social worlds and using such understanding to improve people's well-being. PSP at WorkDirections is also driven from this perspective with the aim of re-engaging and re-integrating participants with their community. WorkDirections addresses this process at various levels:

- facilitating re-engagement and re-integration with immediate and extended family (through counselling, personal development; and skills acquisition).
- facilitating re-engagement and re-integration with the individual's social network (through encouraging and facilitating new friendships; attendance of hobby groups/ learning groups/ support groups; sporting activities).
- facilitating re-engagement and re-integration within the vocational environment (through addressing vocational fears; identifying vocational skills and goals; compiling a vocational pathway; facilitating educational endeavours; and on-going work/live support once engaged in a vocation).

This is an on-going process of assisting clients to become part of a community (on both the micro and macro level) by building their capacity to take the step of re-engagement and finally successful re-integration. The ultimate aim is to build familiar and community support networks capable of providing a continued level of care and support once the client has completed PSP.

In October 2005, Perkins conducted a structured evaluation of the PSP. The aim of the study was to evaluate the extent to which the PSP is enabling people within multiple non-vocational barriers to achieve economic and/or social outcomes. This was done by surveying 134 PSP participants who had been on the programme between two and twelve months, across 12 metropolitan and non-metropolitan PSP providers in Victoria. Three client focus groups were also conducted with PSP participants who had been on the programme between two and twelve months. In addition to the client research, in-depth interviews were also carried out with Case Coordinators across 15 PSP Providers, as well as with PSP staff in Centrelink and the Department

of Family and Community Services who administered the programme before its migration to DEWR. Results from this study summarized the main strengths of the programme to include: the holistic nature of the model of assistance; strong partnerships with local agencies to provide a wide range of support services; a focus on addressing clients' underlying barriers; smaller case loads than in regular employment assistance, and more intensive case management; a recognition that some clients are unable to work or meet regular welfare-to-work requirements before addressing personal barriers; a strength-based approach; greater flexibility to meet clients' varied and complex needs; and finally a broad definition of outcomes extending beyond an employment focus.

In order to sustain the strengths as identified by Perkins (2005), WorkDirections approaches its delivery of PSP from a social justice perspective. Prilleltensky & Nelson (1997) define social justice as the "fair and equitable allocation of bargaining power, resources, and obligations in society" (p. 168), a concept which begs implementation right at an individual, community, and societal level. PSP provides the opportunity to incorporate social justice at both the individual and community level, with the aim of improving the quality of life of the clients. Just as Community Psychology concerns itself with "issues of social regulation and control" (Perkins, 2005), WorkDirections PSP concerns itself with enhancing the positive characteristics and coping abilities of relatively powerless social groups such as the minorities and the highly disadvantaged individuals constituting our client group.

Programme Limitations

Despite the successes achieved by the PSP and the inherent strengths of the programme as highlighted above, it is not without limitations. A major limitation is the lack of funding from the government for clients considered highly disadvantaged and thus the 'hardest to

help'. An example of this is the fact that funding remained unchanged with the recent commencement of the new 2006-2009 three-year contract. Providers are expected to deliver the same standard of service, and more, with funding amounts unchanged since 2003. Within the new contract, and in-line with the Welfare-to-Work Reforms, the Government is placing increased emphasis on the achievement of economic outcomes (i.e. some form of work or study) for clients. This is reflected in the addition of a fourth high performance indicator aimed at measuring the number of economic and social outcomes achieved by providers. Very often providers are also delivering services for which they are not being compensated. For example, when a client is referred to PSP the provider has six weeks to engage the client into the PSP.   Although providers differ in their approach to engaging clients, it generally consists of contacting the client either by phone or letter to arrange a commencement appointment. Should the client not attend the appointment, the client is again contacted and the process repeated. Very often providers do not receive up to date contact details via Centrelink, which is mostly due to the transient nature of many PSP clients, but also a delay in the interface between the Centrelink IT system and that of the provider. Although the provider spends a significant amount of time and energy on this attempt at engagement, no payment is received for such services should the client not physically sign-up.

Client groups that have been identified as particularly hard to engage have been identified as homeless clients with mental health issues, drug-using clients that are deeply ensconced in their subculture, men who have been in jail, younger clients in general and socially isolated clients (Perkins, 2005). Considering that such client groups make up a significant portion of PSP participants, more financial recognition for the effort in engaging these clients should be forthcoming.

Limited funding from government also implies limited discretionary funds available to assist clients. As PSP Providers employ discipline-specific Case Coordinators, not all Case Coordinators are in a position to provide

all services as required by clients. For example: should a client be in need of sexual abuse counselling, a specialist referral needs to be made at a financial cost. Most Providers have only between $50 to $100 per client per year available to secure such services for their clients (Perkins, 2005). This dilemma could possibly be overcome with the introduction of a 'Jobseeker Account' type fund as is used within the Job Network. Here, the Job Seeker Account consists of a national quarantined pool of funds that are used to meet expenses associated with a jobseeker's obtaining employment. Services to be paid for from the Jobseeker Account range from employment related training, to work clothing and equipment, through to employer wage subsidies. There is no overall cap on the cost of assistance to a Job Network jobseeker, however, it is expected to be commensurate with the jobseeker's level of disadvantage and duration of unemployment (DEWRc, 2005). Access to such an account for PSP clients, who are the most disadvantaged and have often been unemployed long-term, would go a long way in assisting clients with achieving both the social and economic outcomes listed as programme objectives for PSP clients.

As a government funded programme, PSP brings with it a significant amount of administration as stipulated by the DEWR as a means of ensure programme compliance. Administration relates to, amongst others, keeping hard copy client files, gathering evidence in support of outcomes achieved, coordinating referrals for clients, and maintaining an IT system. As a result, Case Coordinators spend roughly 50% of their time on administration and contractual requirements, time which could be better spent working directly with the client. This echoes research conducted by Marston and McDonald (2006) which reported on electronic survey results compiled by Jobs Australia and the Brotherhood of St. Laurence where 1114 Job Network case managers were asked two evaluative questions: What do you think would be the most effective way to improve the current

Job Network system? and Other comments you would like to make about the Job Network system?

The most consistent theme that arose was the "significant unhappiness with the high (from their perspective, excessive) administrative load prescribed by the contract requirements, its outcomes focus and the general operation of the system" (p. 7). A number of case managers claimed that they spent up to and in excess of 50% of their time managing administrative requirements. Many respondents claimed that the administrative overload was severely hindering their capacity to work with people to the level of intensity required to actually assist them in overcoming their barriers.

It is not surprising that Marston and McDonald's (2006) respondents regularly associated administrative load with escalating negative attitudes towards their jobs and feelings of burnout. This highlights the importance of conducting a review of how the PSP could be streamlined to ensure a more effective service delivery to more clients. At the PSP conference of the National Employment Services Association (NESA), held in November 2006, such streamlining of the internal programme process was highlighted as a DEWR priority for the next year. It is hoped that this process will come to fruition. The fact that the number of client places allocated to providers is capped (i.e. limited in terms of numbers) exacerbates the limitations already listed. Having capped places limits the number of clients that could be serviced whilst resulting in clients being placed on waiting lists during which period they receive limited or no support.

A real concern is the continued alterations made to PSP by DEWR, in an attempt to align it to the Welfare-to-Work reforms. There is a real danger that PSP will lose its effectiveness as a helping program due to increasing Job Network-type restrictions being placed on it. A prime example of the latter is the recent introduction of Participation Reporting by PSP Providers. DEWR justifies the introduction of Participation Reporting for PSP on the grounds that it is aimed at reducing the chance of PSP participants disengaging by ensuring that they

are re-engaged sooner, thus improving their chances of overcoming barriers and participating in mainstream employment. As of July 2006, PSP Providers are required to submit a Participation Report to Centrelink when clients fail to attend scheduled appointments with their PSP Provider or a Job Capacity Assessor, where the PSP Provider initiated the referral; where the client refuses to satisfactorily participate in PSP over a period of time; or where a client engages in serious misconduct. In such instances, the Case Coordinator has to make at least two attempts at contacting the client over two days. Should the Case Coordinator be successful in contacting the client, the reason for the missed appointment will be discussed. The Case Coordinator then has to decide whether the client has a 'reasonable excuse' for not attending, in which case the Case Coordinator does not have to submit a Participation Report. Should Case Coordinators be unable to contact a client or a reasonable excuse is not identified, they are compelled to submit a Participation Report. Should a client have three Participation Reports upheld by Centrelink within a 12 month period, they will have a mandatory 8-week non-payment period. Although the Government offers Financial Case Management services for clients undergoing a non-payment period, this assistance is very limited and will leave many PSP participants struggling to support themselves and their families during such periods.

At WorkDirections care is taken in making a decision to submit a Participation Report. The very nature of why clients are in PSP offers in itself a reasonable excuse for non-attendance at times. Case Coordinators also ensure that all avenues have been exhausted to make contact with clients following non-attendance. Clients are also well informed of the new expected compliance framework and possible consequences when they first commence PSP.

A further limitation is the fact that very often clients who are unsuited to PSP, for example due to the severity of symptoms, are referred to the programme solely on the basis that there is no other programme that is more suitable. As these clients are also unable to cope with Job Network or other programmes such as Disability Employment Network, PSP is the only remaining option for providing some level of support. However, this again has implications for the client's ability to comply with the programme requirements of attending monthly face-to-face appointments, with non-compliance possibly leading to providers having to submit a Participation Report on the client's pattern of attendance which could ultimately result in benefit penalties.

Although PSP Case Coordinators at WorkDirections engage in continued cross-sectional dialogue with supporting agencies such as mental health, with the aim of building good working relationships and paving the way for increased client access and quality service delivery, it has been found that such integration is not mutual across agencies. What is needed is a coordinated effort in linking all the services required by clients, both community-based and otherwise, in order to ensure improved awareness of services, speedy access, efficient intervention and on-going psycho-education of clients and others to contribute towards positive prevention strategies.

Conclusion

This paper has provided some insight from the provider perspective into the person-centred and community-centered work conducted as part of the Personal Support Programme. Stories of empowerment such as Anne and Mark's provide clear evidence of the positive work being done within the programme. We have also identified a number of structural limitations that invite future research aimed at improving the effectiveness of the programme for clients, Government and providers alike. At WorkDirections we believe in the Personal Support Programme and the remarkable work done by our clients and Case Coordinators. However, without the participants there would be no PSP, so we thank participants such as Anne and Mark for allowing us into their lives and for journeying with us.

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Working in partnership with Indigenous communities: A pilot program

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In 2003 the Epilepsy Association and Carers NSW formed a partnership to develop and trial a model of service delivery on epilepsy and seizure management that was culturally appropriate for Aboriginal communities. This paper outlines the process involved in identifying and liaising with key stakeholders in local Aboriginal communities, and in designing and implementing the pilot program. It includes discussion on the evaluation and its implications for future development and sustaining relationships with the community.

The Epilepsy Association and Carers NSW Partnership

The Epilepsy Association is a national not for profit organisation supporting people with seizures. Epilepsy educators are health professionals, who support and educate people with epilepsy and their families, raise awareness and work with local community organisations and health workers. Education sessions are tailored to meet the needs of specific groups such as disability groups, schoolteachers, aged care workers, ambulance services and hospital staff in metropolitan, rural and remote areas throughout Australia.

Carers NSW is an association for relatives and friends who are caring for people with a disability, mental illness, chronic condition or who are frail aged. As the only statewide organisation that has all carers as its primary focus, it is committed to working with all carers, governments, business and the community to get a better deal for carers, and has become internationally recognised as a leader in innovative carer support.

Carers NSW employs an Aboriginal Carer Program Coordinator whose role is to develop pathways for Aboriginal and Torres Strait Islander Carers in NSW. The primary focus is to ensure culturally appropriate:

- education and training for carers, service providers and communities
- emotional support, counselling and individual advocacy for carers
- information, publications, resource development and delivery
- policy development, research and advocacy
- sector development and systemic change
- service innovation, development and evaluation

Project Background

To ensure access and equity in service delivery, the Epilepsy Association initiated a pilot program for epilepsy and seizure education in Aboriginal communities. This raised the questions - was there a need and, if so, is it identified by the Aboriginal community?

Carers NSW, via the Aboriginal Carer Program Coordinator, was willing to be involved in a joint project that could be seen as a bridge to address the health needs of the community in the specific area of epilepsy, involving health and community workers, people with epilepsy, their families and carers. The partnership allowed an Aboriginal perspective in the design, implementation and analysis of the workshop. It was also a unique opportunity to gain insights into aspects of Aboriginal culture from an inside perspective.

There is widespread recognition of the crisis in Aboriginal health. The NSW Chief Health Officer (2000) acknowledges that '"the association between socioeconomic status and health is well documented with lower socioeconomic status associated with poorer health." (p.107). Furthermore, the report takes pains to point out the marked variances in available data for Aboriginal and Torres Strait Islander peoples. "These differences may be explained by variations among surveys in the

sampling methods used, as well as differences in Aboriginal participation and self-identification" (p.114).

The incidence of epilepsy in the general population is approximately 1-2%, with a much higher percentage occurring in people with disabilities (roughly 30-50%). Given that the incidence of epilepsy existing in the Aboriginal community is at least of the same proportion as the rest of Australia, there is in addition a high probability of further increased incidence of reactive seizures due to lifestyle factors such as alcoholism, substance abuse and injury. (This was illustrated in the Birripi workshop where three of seven participants spoke of seizures they had experienced due to alcoholism in their youth. All were women who had stopped drinking when they had children.)

Cultural Appropriateness

The concept of cultural appropriateness is complex and refers to a range of factors.

- Culture arises through socialisation and learning; it is neither natural nor fixed.
- Culture entails multiple personal and social meanings, relationships, practices and values… In this sense, all our cultures have multiple layers, each layer in a complex and dynamic relation to the others. (Brosnan, Scheeres, & Slade, D. 2000, p.188).

This defines culture in a context that includes education and the learning process, the workplace and the people involved, as a dynamic and interactive process. In a real sense the facilitator is part of, not detached from the learning experience and the interplay between cultures, which allows for learning as a two way process. In addition, any organisation involved in Aboriginal health has to be aware that:

Aboriginal people have a holistic and social view of health encompassing the physical, emotional, cultural, and spiritual well-being of individuals and communities. A holistic approach to the delivery of services is essential to the improvement of Aboriginal health outcomes. [Furthermore] The practical exercise of self-determination is central to Aboriginal health. It underpins

cultural, community and individual wellbeing. Aboriginal self-determination and responsibility lies at the heart of Aboriginal community control in the provision of community-based health services." (Ensuring Progress in Aboriginal Health, A Policy for the NSW Health System, 1999, p.iii).

Cultural appropriateness from an Aboriginal perspective involves a community-based approach to learning that recognises the need to tailor educational programs to specific local needs (http://www.naccho.org.au/Paper1.html). "We have all said we are not the same, we are all Aboriginal people, but we are Koori, or whatever" (NACCHO Report p.13).

An example arose in our workshop in Kunnunurra when we asked the participants what they would do if the person having a seizure was a father-in-law, a sister-in-law, or someone who they could not have contact with. The women were adamant that they would assist because they were health workers. They openly admitted they would be punished by the elders, and that they would accept the punishment. The men on the other hand would not break the law.

Partnerships with Local Communities

The epilepsy workshops attempted to take variations between communities into account through a process of consultation for each workshop. A series of consultations were held with key stakeholders in the Aboriginal community and this became the basis on which partnerships were formed. The first step was to educate Aboriginal health workers and community workers, then in conjunction with local workers to hold focus groups to identify the needs of people with epilepsy, their families and carers.

Consultations were important in exploring the level of interest in, and the perceived need for an education workshop in epilepsy. Janeena Humphries, clinical coordinator of the Ord Valley Aboriginal Health Service, commented:

The consultation process with you and the group really decided it (the epilepsy workshop) as they were very keen to

learn about epilepsy, especially as all had seen seizures and were aware of it happening in the community.

The consultation process was informal and both personal and work related experiences were openly discussed. For instance, Marcia Greedon (OVAHS) said "When I used to see people taking a fit I only related it to alcohol" and "Aboriginal people see many fits in their own group and are used to it, but outside the group they leave them alone."

Initial agreement on the program content and general house keeping arrangements such as the flyer, logo, venue, equipment, refreshments and joint radio interviews were discussed. Issues identified during the consultation process also reflected individual community attitudes and needs. For example OVAHS staff requested that a section on shame and substance abuse be included in the program, while the Biripi Aboriginal Medical Services at Purfleet identified three priorities: education, accreditation and a survey of the incidence of epilepsy in the community for a needs assessment. In another example, OVAHS workers requested that a result of the workshop should be a joint development of an Aboriginal pamphlet on seizure management. According to Janeena Humphries, "Doing the pamphlet is part of the ownership, they contributed to it, they own it. I think that's very good and it's been helpful for us."

The Pilot Study

The model was trialled in metropolitan, rural and remote areas over an 18-month period. Those involved were:

- Birripi Aboriginal Corporation Medical Service, Taree, NSW
- Inner West Aboriginal Community Company, (IWACC), Marrickville, Sydney
- Department of Ageing Disability and Home Care (DADHC), Dubbo, NSW
- Ord Valley Aboriginal Health Service (OVAHS), Kununurra, WA
- Greater Murray Area Health Service (GMAHS) Wagga Wagga, NSW

Participants

Participants consisted of 64 health and community workers (14 male, 50 female) and some administrative workers.

Designing the Workshop Model

For each workshop key local workers were involved in the planning process, writing case studies, reviewing workshop content. Where this was not possible, consultation was conducted electronically and by phone.

The workshop content was in essence the same as all epilepsy education workshops. The program content consisted of a number of topics that were specific to epilepsy and epilepsy management. It included duty of care issues and documentation. Changes were made to make the process more specific and understandable to the target audience. This was done by taking into consideration factors such as language, cultural differences and other issues raised in the initial

PRE WORKSHOP SURVEY - COMBINED

WORKSHOP EVALUATION - COMBINED
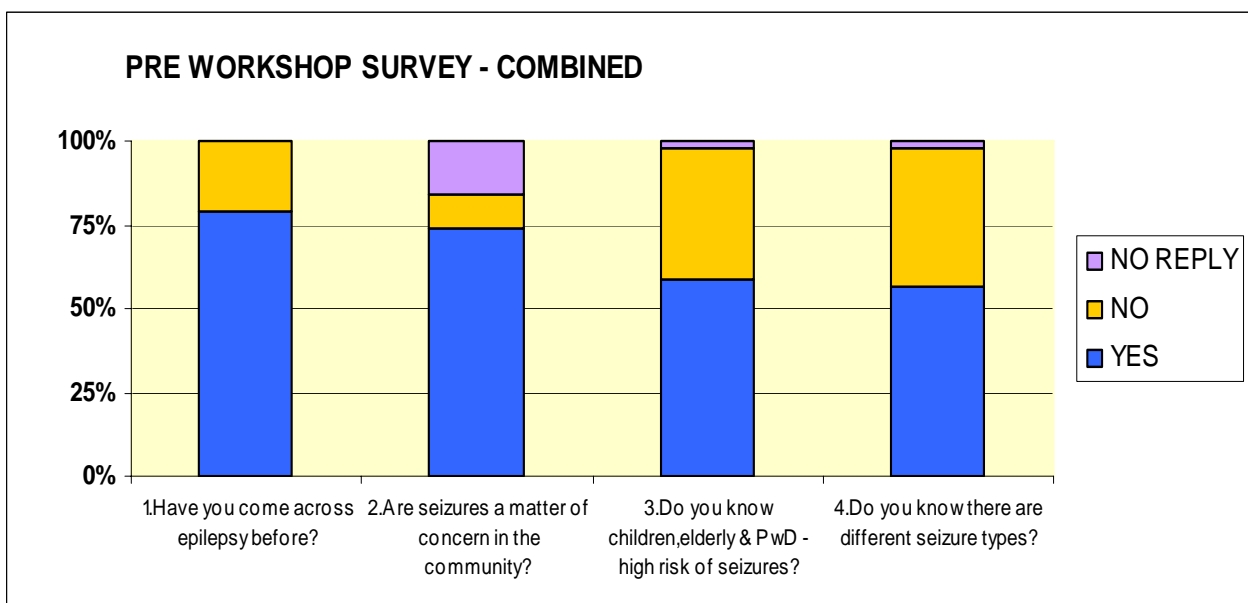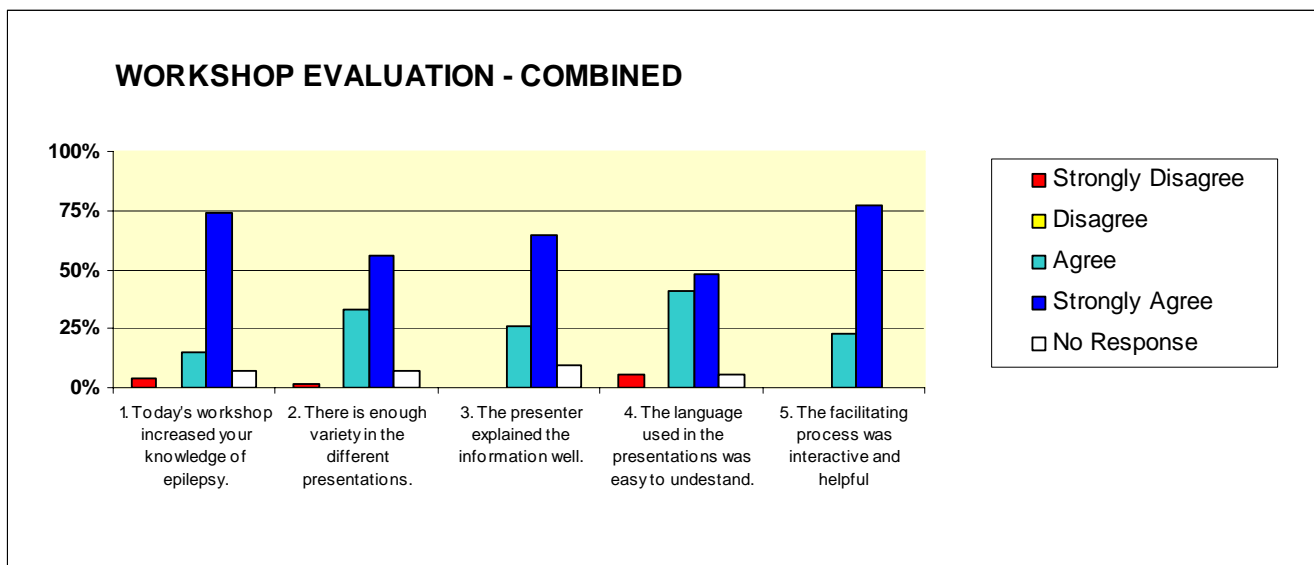
consultation with local community groups.

All workshops were co-facilitated with a local Aboriginal worker. The workshop was a day presentation that allowed time for participant interaction. The aim was to move away from a lecture-type method of education to participant experiential learning that utilised the existing experience and knowledge of the participants. Presentation was delivered in Power Point and included videos, work sheets and case studies. At the workshop participants were given a resource package and a content workbook outlining the program, the information covered in the talks, the work-sheets, contact information, carers information and the evaluation forms.

Pre-Workshop Survey

The purpose of this survey was to raise awareness and identify community interest in an epilepsy workshop. The survey was undertaken prior to the workshop, at Aboriginal interagency meetings or as part of the initial consultation process.

Of the 53 respondents approximately 80% had seen seizures and 75% thought it was of concern. The general level of knowledge about seizures was rated lower. The level of knowledge was clearer in participants' responses to an additional two questions not charted.

Question 5. *What would you do if you saw someone having a seizure?*

Here the first aid answers given were general such as keep them safe and remove dangerous objects. Only 2 people knew to time the seizure, and in 10 cases not allowing someone to swallow

their tongue was of concern. A number said they were unsure or left the question blank.

Question 6. *List any issues about epilepsy you want raised at this workshop.*

Topics people wanted included were: Shame, fear, safety, the importance of medications, drug and alcohol issues, substance abuse, first aid, mental health implications, follow-up for clients, children and epilepsy.

Evaluation of the Workshop and the Program

The evaluations included a workshop and program evaluation, and a pre and post education survey on epilepsy issues

1. Workshop Evaluation

Questions from this section of the evaluation form looked at the overall response to the workshop. The combined totals are shown in the following table

Comments

Overall, of the 54 respondents, increased knowledge and the facilitating process rated the highest in agreement, both at around 75%. Language and variety tended to be rated lower. Some reasons for the responses about language could be:

- where English is obviously a second language   as at OVAHS
- where the participants were community workers rather than health workers as at DADHC
- where the facilitator had more experience and changed medical terminology as in GMAHS presentation

Other factors that could explain perceptions

about variety are the amount of new information given in a short period of time, or that participants were tired.

2. Program Evaluation

In the program evaluation participants were asked how they rated individual topics. For example,

- The case studies discussed first aid for specific seizures and community attitudes to seizures.
- The duty of care content related to health workers attitudes and understanding.
- The video The Right Stuff included discussion on myths, not wanting to talk about seizures in the community and issues relating to shame and fear.

Overall there was a good response to the program content. This included discussion around cultural and social issues such as shame, stereotyping and substance abuse. Evelyn Wilson, a health worker at OVAHS for 8 years said after the workshop

> Ignorance is bad and now we can tell our people in the community that that person isn't funny in the head, we can show them what to do to help and explain things to them so that they understand.

3. Combined Education Pre- and Post-survey

This was designed to see if there was an improvement in the knowledge of epilepsy after the workshop. The same questions were given at the beginning and end of the workshop.

The results indicate a general improvement in knowledge about epilepsy following the workshops. However, the real value of the workshop was illustrated more by what participants said, how they interacted, questions and level of interest. For instance Aboriginal workers have requested workshops in other areas and have agreed to co-facilitate these workshops. These are now being planned in metropolitan and rural and remote areas. David Cox, the remote area coordinator, OVAHS, says

> …with the knowledge you give us we can help the community. I got a lot out of the workshop and would like to see more health workers educated.

People should know that epilepsy is not a mental disease. They should know what to do and not run away from them." (Marianne Skeen, health worker, OVAHS)
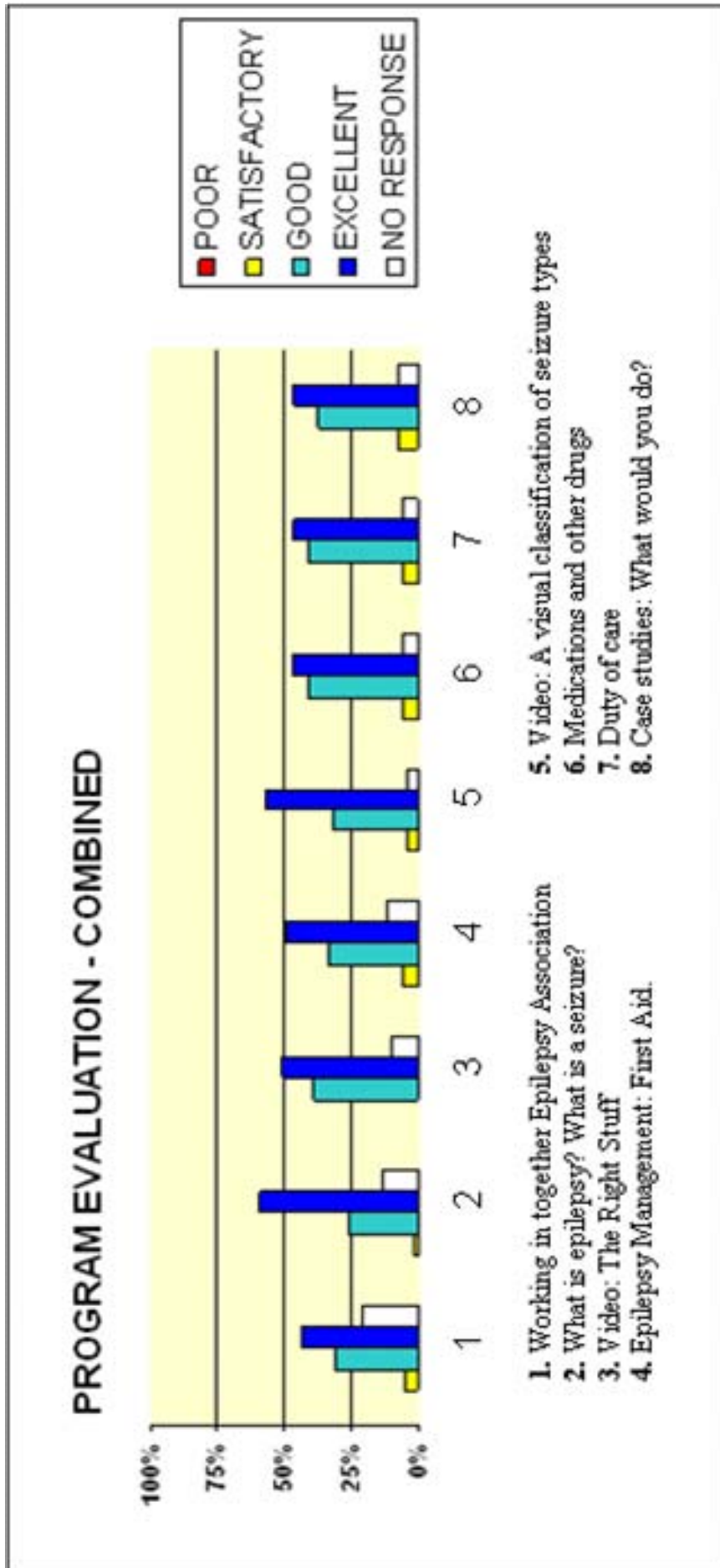
You have no idea how important it is to have a workshop. We get lots of glossy publications sent here but no real health educators teaching the health workers. It makes a big difference, as Aboriginal people need to see a face to get across the message. (Janeenna Humphries, OVAHS)

Learnings from the Pilot Program

Local Aboriginal workers were enthusiastic about participating in this project as workers and learners. Participants' enthusiasm to continue community education and expand the workshops in other communities indicated a clear need for culturally appropriate education and resources about epilepsy in Indigenous communities. It could be suggested that this success was in large part due to the extensive consultation partnerships that allowed for dialogue and communication at a grass root level. This consultation process enabled project workers to structure the program to include issues that directly affect families, carers, and people experiencing seizures. This process also provided mainstream organisatons (The Epilepsy Association and Carers NSW) the opportunity to learn about Aboriginal cultural and health issues that can only come experientially and on an individual basis.

However, the program encountered some challenges that should be considered. First, preparation time was involved and lengthy and program organizers should be ready to use a flexible approach in the design and delivery of the project so that it accommodates for local needs. For some organizations, participation rates may not adequately offset the operating costs for the program that included staff time, travelling and accommodation and resource materials.

In addition, the conditions for health care workers and communities themselves should be considered. In situations where health workers were involved in clinics, a day was too long to

PROGRAM EVALUATION - COMBINED

Legend: POOR, SATISFACTORY, GOOD, EXCELLENT, NO RESPONSE

1. Working in together Epilepsy Association
2. What is epilepsy? What is a seizure?
3. Video: The Right Stuff
4. Epilepsy Management: First Aid.
5. Video: A visual classification of seizure types
6. Medications and other drugs
7. Duty of care
8. Case studies: What would you do?

EDUCATION SURVEY - COMBINED

spare for an epilepsy inservice; for many communities, epilepsy is only one of many health issues that need to be addressed.

Future Directions

In analysing the feedback it must be noted that the number of participants was relatively small. However it is useful in extrapolating trends that can be used to improve future workshops or be used as a basis for further research.

1. For a directed national service to be implemented that meets the needs of Aboriginal communities, Government funding is essential.

2. Working in partnership with other organisations and with local community workers and families is a slow process. This can only be sustained if structures are put in place that ensure resources are there to support and encourage the process.

3. There are mutual benefits from this process. Partnerships can be effective in combining skills and resources.

4. The consultation process provides an opportunity to move towards holistic community-based health services where Aboriginal communities are central in determining their health needs.

This paper is meant to open up future directions rather than in providing answers. Hopefully it is useful as a process for exploring trends that can assist organisations in consulting with Aboriginal communities.

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http://www.naccho.org.au for National Aboriginal Community Controlled Health Organisation (NACCHO)

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Knowing where you are walking:
Benefits and hazards of theoretical maps to guide practice

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This paper progresses the 2006 Trans-Tasman Conference theme by considering "do you know where you are walking?" and more importantly "do you know how to get there?". The community psychologist's aspirations for the "common good" anticipate outcomes such as social justice, sense of community and empowerment, and prescribe congruent values-based praxis to accomplish it. Such concepts and visions compel us to act for social change; they also enlighten the challenging decisions and processes we encounter in our personal every day walk of life. This journey can be complex as the "doing" of community psychology often involves an emotive personal as well as professional commitment, sometimes associated with a particular political agenda. This paper considers how mapping the psychological landscape of a community, along with its history and geography, can help guide the practitioner through difficult terrain. Some of the author's experiences are considered from theoretical perspectives including sense of community, community consultation processes, social ecology, community readiness and capacity building. These narratives illustrate how such theoretical maps can help the community psychologist to avoid walking in circles, down dead-end streets and up one-way streets while "walking the walk".

This paper progresses the theme of 2006 Trans-Tasman Conference in Community Psychology by considering "do you know where you are walking?" and, more importantly, "do you know how to get there?". The theme of this conference suggests that to identify as a community psychologist is to be on a journey, which unlike most travel these days, entails the slowest transport – walking. Walking is something that few of us do out of choice; we do it when we can't park any closer to the shops, when we try to keep fit or to relax. I think this metaphor was well chosen to describe the practise of our discipline and for this conference. Without being too analytical, there is meaning in positioning community psychology as "walking". With all the attention to sport in Australia, we could have chosen metaphors about "running the race", or "scoring the goal" rather than "walking the walk". However I doubt these would reflect our experiences of doing community psychology.

Having identified as a community psychologist for thirty years, I find I am still "walking the walk", even though a more energetic run through a community may be tempting at times. However I am still not fit enough to run up the hills. Nor am I confident to speed through intersections without stopping to ask residents for directions.

Indeed the complexities of evolving community research and theory, best practice methods and values based praxis are daunting. My students describe their reactions to current debates about the *raison d'etre* of community psychology, like being on a multi-lane roundabout where you are going in circles and too uncertain as to how to exit to actually engage with a community. They see signs that post warnings about the primacy of values and praxis, while other signs alert them to what Wandersman (2003) has called the science of community. My students suggest that it feels safer as a professional to stay on the roundabout and discuss the signs rather than to exit, walk into a community and engage.

As keepers of what Nelson and Prilleltensky call the "social conscience of psychology" (Nelson & Prilleltensky, 2005), community psychologists aspire to the "common good", committed to outcomes supporting social justice and empowerment, while engaging in congruent values-based praxis. This conscience compels us to act for social change, but it also impinges on the many decisions and confrontations we encounter in our personal "walk of life". Hence, this journey can be quite perilous from a personal as well as professional perspective. The "doing" of community psychology can involve an emotive personal as well as professional commitment, and at times can be associated with a deliberate political agenda.

Unfortunately as yet we have not developed a GPS device to help us navigate a way through the mazes of values, professional expectations, evidence-based practice demands and competing needs of multicultural community networks and agencies. In the absence of such an instrument we have to depend on our map reading skills to navigate the psychological landscapes of a community. However throughout this journey we also need to know where we are and where we are going at any point in time. This requires mapping also our personal journey through the communities we choose to visit.

In this paper I will attempt to make sense of my own journey as a community psychologist to illustrate this kind of mapping. The paper is not meant to be a review of best practice in our field. Such a review would conclude "You should have known better" or "I told you so". Rather I will talk about some of my experiences which were guided primarily by a commitment toward and values associated with building and sustaining community. Some of this will be presented through a sense of community lens, a concept that Sarason (1974) advocated as an overarching principle of the practice of community psychology, which is often sacrificed in the name of community development and change. However I will also consider a few theories that provided maps in the earlier days of community psychology, social ecology and community consultation theory, and more recently community readiness and capacity building.

Despite being guided by these maps, I sometimes found myself a little lost; walking in circles, heading down dead-end roads and up one-way streets. Sometimes these diversions occurred because of poor theoretical map reading skills, while other times they were due to having such a focus on the map that I missed the relevant signposts along the road. Still other times I was so personally engaged and led by *my* social justice issues, that I lost my professional compass. In these circumstances I could not orient my map to assist community members who were looking to me as a scout through difficult political inter-agency processes.

My journey begins with fisher folk on the island of Newfoundland, which sits in the icy Atlantic waters of Canada's northeast. It ends in the dusty paddocks of Southeast Queensland with a community of woolgrowers. My walks have taken me through several Canadian universities and mental health institutions, and community programs in Trinidad and Belize. It was, and is, driven by a passion for preventing the loss of community by people who have one, and the building of community by people who have been displaced.

Acknowledging the personal is political, and both are professional

In clinical and other individual oriented psychologies the practitioner is encouraged to be aware of one's own "unfinished business", so as not to project onto the client one's own personal issues. In community psychology it is imperative to own, and reconcile any differences in, one's personal, professional and political identities. The social conscience at the heart of community research and practice does not cope with cognitive boundaries separating the "me" from the "thee" (Buber, 1958).

I grew up in a small Canadian town in a bay on the west coast of Newfoundland in the 1960s. This was the era when the government of Newfoundland attempted to solve its resource distribution problems by determining some remote communities to have "No great future". The Newfoundland Resettlement and Centralization Programs were one of the largest government-directed mass relocation movements in Canadian history. From the early 1950s to the 1970s approximately 250 communities disappeared and 20,000 people were evacuated to Growth Centres where a better quality of life was assured. The process of resettlement diminished the well-being of individuals who were displaced from house and land that had been in their families for generations, and which had afforded them self sufficient living. Some government policies were particularly destructive to the social fabric of Newfoundland. For example, the expenses of any individual household wanting to relocate were not funded until all households in the village signed an agreement to move. This positioned neighbour against neighbour and family member against family member. It destroyed the sense of community in places where people had shared centuries of survival and celebration.

While my own community was not deemed "without future", members of my extended

family were displaced from inherited properties and independent livelihoods. I grew up with those who came to our community to resettle, but who seemed to me to never settle, despite better education, health care and housing. At age ten, I had a gut sense of what social injustice meant. I was aware of the disparate lifestyles of those who were displaced from the bays compared to those who had always been townies. I remember mothers and children visiting our house asking for food or clothing, as they had no recourse but to turn to strangers for survival. These experiences were significant in my identity formation as a psychologist. In Newfoundland today, family acquaintances whose ancestors knew self determination and self sufficiency against all odds now enter a third generation of life on the dole. During those adolescent years I was determined there had to be another way of meeting the needs of disadvantaged people without disempowering and displacing them, and without creating derision amongst those who were already oppressed.

I left my home province to attend a university where I was mentored by an assistant professor who had just graduated from Yale University. We read *Rules for Radicals* by Saul Alinsky and *Blaming the Victim* by William Ryan. It was an epiphany the day I soulfully knew that the cause of the depression suffered by so many displaced Newfoundlanders was not dysfunctional cognitions and behaviours. Rather it was the destruction of the ecology of their lives that now made survival of even the fittest somewhat doubtful. And I knew that individual therapy was not the solution to the island's despair. Hence I found my intellectual, professional and, in many ways, spiritual home in community psychology. The first paper I wrote as a fourth year student was an analysis of the sense of community in a rural town. That was 30 years ago and, as some of you know, I've been rewriting that paper on sense of community ever since.

Making a difference as psychologists with incomplete maps

For me, community psychology provided academic justification for my gut feelings that social justice was more than a political platform. However I was also aware that I was a PSYCHOLOGIST and that meant understanding things from a behaviour science framework. It meant that I had maps of theories and evidence based practice to understand how people behave as individuals and as collectives. I had a guide for how and why they go from point A to point B.

Psychologists usually describe and predict people's journeys of development and change in terms of behaviour, cognitions and affect. For example, we might plan a community intervention based on the theory that the cognitions and behaviours indicative of residents' sense of community will increase if we can facilitate more positive perceptions and experiences of belonging, identity and influence.

However, unlike geographical roadmaps, which usually tell us exactly what points on the map will lead us to precisely where we want to go, theoretical maps get us only within proximity of our destination. Just how close is indicated by what is called the explained variance which, if we are lucky, gets us 30% of the way there. The rest of the journey relies on intuitive hunches, bush-knowledge, and finding locals who know the territory beyond where the theoretical map ends.

In other words, our theoretical maps can guide us just so far. A recent special edition of the American Journal of Community Psychology (June, 2005) summarises the many reasons why there is such a gap between our science, practice and values. Suffice it to say that our tradition of relying on positivist science models and methods, which seek to explain human behaviour in terms of cause and effect or linear associations, has not been able to capture the complexities of diversity and contexts. Our intuition tells us that not everything in our human experience is ordered that way. So, while our models and theories can help guide us so far to our destination, there is still a considerable amount of unknown territory to navigate before we get there.

As I indicated earlier, I use various kinds of maps to guide me through my practice, which often has the destination of generating and sustaining sense of community. My experience suggests to me that unless people are connected to each other by more than just place and time, it is very difficult to work with the collective. In the absence of this connectedness and common identity, we end up working with a group of individuals, but not with the community. With a

sense of community, people can accomplish things that otherwise as individuals they would think impossible.

So let's look at how we map our walk through a community. I am going to pay particular attention to our choices of entry points and walking routes, how we might navigate a roundabout, or recognise dead end and one-way streets, the importance of knowing when to walk and when to run, and finally how to know when you have arrived using landmarks and significant sites – especially if you've never been there before.

Starting the journey: Using theory to determine strategic entry points

Much of my early career centred on the psychiatric deinstitutionalisation movement in Eastern Canada. My passion for this work was led not as much by my professional expertise as it was by my sensitivity to the oppression of displaced persons. I will use a few orientation points on my map to describe these experiences. I will start by making a case for mapping the possible entry points to community consultation. It is based on the premise that some points have more strategic advantage than others. Where and how we enter a project or program can influence our future access to other locations in the community that have strategic importance.

In my early career I entered three communities to facilitate procedures to enact new government policies. These were purported to end the practice of residential isolation of people with psychological disabilities from the general community. I entered each community by way of the psychiatric hospital. This immediately identified me as not being a member of the general community. I should not have been surprised by this as Sarason (1974) wrote about the deleterious effects of some institutions on the sense of community of its staff and residents, and the community at large. This is represented by the physical, psychological and sometimes economic separation between psychiatric institution and community.

At the time of doing this work Caplan's (1970) model was popular to describe different entry points for community consultation. These included working directly at "grassroots" with clients (client-centred consultation), with those who assist clients (consultee-centred

consultation), with the programs providing the services (program –centred administrative consultation), and with the consultee who is managing the program to improve its delivery (consultee-centred administrative consultation). Of all of these, community psychologists were encouraged to identify with the stigmatized groups and work in consultation with them for social change.

Complementing this model of practice were theories of people-in-context such as Bronfenbrenner's (1979) model of four levels of systems where each system offered different capacities for change. Bronfenbrenner's work alerted us to the reciprocal nature of influence within and between systems from family to institutions to the larger community. Rappaport (1977) also noted this in his early writings on community psychology practice where he warned that entering at an inappropriate level of a community can jeopardise a consultant's accurate determination of the primary causes of the problem.

By entering these communities via the psychiatric hospital, I had access to only particular destinations, such as licensed boarding homes, sheltered workshops and mental health street clinics. Settings such as apartments in safe residential neighbourhoods, recreation centres and local businesses could not be accessed. Furthermore, once on this street there were no U turns or exits to permit a change in direction, and worst of all, the street itself was a dead end. It did not provide me, or the disenfranchised community members, access to other avenues to different destinations.

Another experience of trying to sustain sense of community in the face of mental health programs involved a project in Labrador, a part of Canada's north with a significant Inuit population. This program sought to address an increasing rate of youth depression and suicide. Again I was drawn to this project because the aim was to prevent young people from being removed from their communities to receive treatment and residential schooling. We oriented the community toward an education model, rather than their relying only on services from visiting medical teams. The program was situated within schools to enhance the competencies of teachers, youth workers and parents to pick up

early signs of distress and determine its sources from a person-environment fit model. This would hopefully prevent serious distress in young people requiring their relocation. After our initial meeting with teachers in the first town, we were approached by a group of young people wanting to know why, if they were the reason for our visit, they were not given the opportunity to meet with us so that they could tell us what the adult community needed to know. Our best intentions here in terms of building a self reliant community network failed to consult the most vulnerable members of the community. In this instance I think we got the entry point right, but we didn't look at the map of the whole community before we chose our walking route. We omitted an important district, that inhabited by the young people themselves.

Where to next? Getting off the roundabout

This leads me to my next observation about using maps in practice. In our enthusiasm to make a start once we've entered a community, we often don't take the time to read the map and consider all possible roads that traverse a community. Sometimes we don't have a choice in the direction we take, especially when we enter via a time limited government program. However, how do we know which exit to take when we are on the roundabout? Staying on the roundabout too long is not recommended as the community will lose confidence in our ability to engage in a meaningful way. Similarly to wander around the streets without direction and no carefully considered route does not facilitate an action-oriented ethos.

The importance of orienting to where we are in a community, and choosing what districts and neighbourhoods to tour, is further underscored by the importance of congruency between the level of analysis and the source of the problem. In community psychology

This is an important issue, given a central tenet of community psychology theory, Lewin's (1951) point that Bf (P x E). Hence, our understanding of a community will be partly determined by the contexts we choose to visit. Furthermore, not all transactions between residents and their environments are visible from the "cook's tour".

adherence to a map of ecological theory and principles (Kelly, 1966) can assist us. Working from an ecological framework demands that we assess and intervene with consideration of:

- Interdependence, what affects one part of the community will eventually impact throughout its systems such that effects of any intervention will be felt outside of those areas initially targeted.
- Cycling of resources, where and how equitably resources are distributed throughout the community usually determines the sources of energy in that community.
- Adaptation, organisms that cannot adapt to an environment become extinct, therefore a community must provide resources to those who are in the process of adaptation to insure their survival.
- Succession, there are orderly, predictable changes in the development of community systems as they orient towards establishing stability while coping with changes imposed from outside, the natural direction in which a community might be heading must be considered in the planning of any intervention.

Taking this theory as a roadmap we quickly realise that we cannot be naive in focussing our energies and resources wherever there is least resistance or the most enthusiasm. As tempting as it is, we cannot always walk around hills, sometimes we must walk up and over them. We must be mindful of where there are inequities that prevent other people in the community from engaging, Positive and negative ripple effects of our consultation must be mapped as they are likely to occur across the community landscape.

My work in the deinstitutionalization movement provides further evidence of the relevance of an ecological map when consulting for change. In our attempt to prepare institutionalised residents to move into the city we facilitated new experiences that encouraged daily support, decision making (influence) and emotional connection through learning practical self care skills. A ripple effect was evident when they finally moved from the institution to their individual apartments. Their relational sense of community was so strong that its boundaries remained in tact in the new setting. Residents met

together to make meals, shop, socialise and go to work at sheltered workshops even though they lived blocks away from each other. The closed nature of their community served purposes of keeping themselves safe and connected, but unfortunately did not promote the inclusion of others, nor their inclination to join community outside of their own. It took some time before resources could be redistributed such that they could adapt to engage with the larger community. In time their natural progression to a stable day to day life including just each other, could accommodate the changes from outside that we initiated.

Nowhere was this ecological map more useful than when working in communities that were far removed from my cultural heritage and experience. In diverse settings, such as a residential school for children without parents in Trinidad, and a rural community mental health project in Belize, having basic principles to guide my understanding of people-in-context was essential. While observations of how powerlessness and oppression had similar political and economic systemic roots regardless of culture were disturbing, observations of the power of voice and human resilience were both humbling and exhilarating.

Hazards of theoretical maps

My work in deinstitutionalisation also taught me to be aware of the practice implications of using theories and models that were still hypothetical and incomplete. Sometimes the very theories and models promoted in academic discourse have little real world validation. Hence there can be liabilities in using one particular model of how a community works. Of special concern are models that have not been explored enough to accurately map roads that link their components. Hence you can be walking in a circle without knowing it until you find yourself back where you started. Sense of community is one example of this instance.

Sense of community is seldom represented in diagrammatic form. This is partly because relationships between its components are hypothetical, and all have not been mapped collectively. Sense of community is usually described as promoting an adaptive open system where experiences and perceptions of membership, support, influence and emotional connection contribute to it. However, in "walking the walk", in this instance orienting deinstitutionalization processes by facilitating these components of sense of community, I discovered how sense of community can create a closed system. I failed to notice that by focussing exclusively on these processes, I was passing by the road-signs indicating the access exits to the larger community. I did not know how closely the components were linked to each other and how the journey toward sense of community can become circular, closed and exclusive.

Observing community speed limits: When to walk and when to run

Once we find our way into the community and map a route for our destination, the next consideration is determining reasonable time-lines for our consultation. Again, this may not be negotiable if consultation contracts have a timetable for program delivery. In this instance having a map of the community's history of change, and current stage of readiness for further change, can be beneficial. A project that demonstrates this is currently ongoing with Natural Resource Management (NRM) groups within the Queensland Murray Darling Basin.

A National Action Plan for Salinity & Water Quality (NAP) promotes an innovative approach to devolving aspects of natural resource management to regional communities. In some communities this will mean residents' experiences of self management have come full circle, from a century ago where initial decisions about one's own property were made in situ, to decades of middle government management policies developed out of context of specific regions. Each community has a different history of cooperative and collective NRM experiences. Not all will have experienced success in building community confidence and competence. The NAP philosophy does not take this into account. It is built on several assumptions, including that 'regional communities' will have the capacity and motivation to take up the challenge of managing their own catchments and landscapes. Therefore, in order to meet the NAP agenda there will need to be development of the community's technical and human capacity to accomplish this, as well as networks and partnerships amongst the many levels of formal and informal organisations that have vested interest in processes and targets

of change.

When using an ecological framework to guide consultation in this area, it is certainly easier to explain the principles to groups of environmentally aware people, than to argue its relevance to groups of mental health professionals! However, even with the obvious utility of these principles to map our "walk" through the Murray Darling Basin, I have been unsure it would give direction to the most strategic entry points, or address sensitivities around different timetables for action, in the different communities concerned. Therefore, we sought to begin the consultation process using the "community readiness" approach of Edwards, Jumper-Thurman, Plested, Oetting and Swanson (2000) to map possible routes for our journey as well as to set a realistic timetable. This approach is supported by the assertion that NRM is intrinsically a social process (Vanclay, 1999).

Edwards et al. (2000) suggest that before implementing an intervention where success depends on the consensus within several sectors of a community, each sector needs to be at the same point of change. Organisations and sectors within a community are each at particular stages of readiness to deal with any given problem, and each will likely be at a different stage of readiness depending on the issue. These stages can be assessed and organisations and groups can be assisted to move to a common stage with appropriate facilitation and education. We have been mapping the location of each NRM sector within the nine possible stages of readiness. These stages range from issues not being recognised by the community sector, to awareness, and action for preplanning and initiation. We are finding that this mapping process results in an indication of how fast or how slowly we need to proceed before we can target actual community behavioural change related to NRM management. We hope this will provide some congruence between the processes required by any policy or program initiative and each community sector's state of readiness to engage in such processes. However, throughout this project one of our objectives is to provide a process that enables communities to do their own self assessment of community readiness for other NRM issues as they emerge. A 'community readiness self-assessment toolkit' has been developed on a website. This enables NRM groups to determine and strengthen their capacity for community building processes that will be necessary to initiate collective decisions and changes in NRM issues.

Appreciating the scenery: Community as geographical as well as social place

In many ways my involvement in NRM community issues has brought me back to my political and professional roots as a community psychologist, except that the question as to whether a community has any future is answered in terms of resources found in paddocks and rivers, rather than in oceans. I am learning a lot about sheep, timber and land-clearing rather than cod and overfishing.

It is also interesting to me that I have been brought back to issues of place, and the importance of place, or geographical context, in community consultation. While NRM is a social process, it is also a geographical process, situated some*where* as well as with some*one*. That place can have a significant impact on understanding the community in which resource management is at issue. In the context of the conference metaphor, not attending to place in one's consultation framework would be like having so much attention on a map that one forgets to take in the scenery. Hence one does not determine that where you are on the road coincides with where you think you are on the map.

The importance of place has become very evident to me in another NRM project where we are exploring the biodiversity, agri-biological, geological, economic and psychosocial characteristics of a southeast Queensland region. This area is one of the most successful wool growing regions in Australia. Despite challenges related to drought and land-clearing regulations, woolgrowers have built and maintained a cooperative that offers the highest quality product and maintains a consistent share of the marketplace. However, despite their resiliency over the past decade, commitment to the cooperative is under threat as more woolgrowers consider their future on the land to be unsustainable. I knew I was in familiar personal territory when one landowner said to me "our way of life is under threat and we may become refugees of the land…displaced persons". Where have I heard this before? - on the other side of the

globe, forty years ago.

We've used the Photovoice technique (Wang, Cash & Powers, 2000) to hear woolgrowers on matters of biodiversity and sustainable land management. Photovoice is a qualitative participatory research method which allowed us to elicit and document woolgrowers' thoughts and feelings about their paddocks, properties and sub-catchment. It was preferred over the use of surveys, interviews and focus groups because our participants got to set their own agenda. They chose what they wanted to talk about and to determine the relative importance of issues. With the use of photos that they chose to take, their narratives were constructed from their discourses, rather than from predetermined discourses of interviewer questions. Indeed we are finding the method supports one of our objectives to facilitate the voice of the woolgrowers in NRM policy making, an outcome noted recently by Foster-Fishman, Nowell, Deacon, Nievar and McCann (2005) in their use of Photovoice.

This has told us a lot about wool-growers' sense of place; their attachment, identity and dependence on their land. Their photos have in effect shown how woolgrowers see themselves as a link in the biodiversity chain that is necessary to sustain adaptation and growth of living organisms. In this project the psychology of place features significantly in mapping the ecology of the region. Literally grounding our theoretical notions as we walk the local landscape gives us a depth of understanding that discourses from questionnaires, interviews and focus groups could never provide. Indeed residents who had been surveyed extensively by other social science groups were very appreciative and responsive to our focus on place rather than their stress, coping and personality traits.

Another example of the importance of place comes from my involvement with youth services in my community. It took several years to get community consensus and resources for a permanent youth centre. Much time and discussion dealt with issues of management, security, insurance and governance. When it came to securing a site, matters of cost and keeping it out of the adult business sectors were the prime considerations. The centre has been operating for several years now, and has been a success in many ways. However, the

longstanding divide between aboriginal and non-aboriginal youth in this town remains a serious issue. "Never did set foot in that part of town and never will…don't belong there" stated an Aboriginal youth in response to a question as to why there weren't more Aboriginal young people at the centre. No one thought to construct a geographical map or historical map along with the financial, administrative, educational maps, etc.

There is a resurgence of interest in place as phenomena to study in psychology as well as other social sciences. This returns us to ideas of early theorists such as Barker (1968) who insisted on the importance of built and natural environmental contexts of behaviour, or behaviour settings. I think much of our reluctance to consider physical place in our models and theories has been because of the gear required to assess it. Video cameras and image processors were too heavy to carry on our "walk", compared to the paper and pencils required to assess other constructs. However, digital cameras and videos provide easy access to methods for recording place data that participants themselves choose. Stories of journeys also tend to be richer when told with visual images of where we've walked. Photos give immediacy and common understanding of our destinations and points along the way.

Are we there yet? Using theory to identify the destination

It seems absurd to say that a map is not of much use if you do not know where you are going. However, in our work we sometimes describe our destination in such vague terms that we may not actually recognise it when we reach it.

For example, if we are on a walk with a destination of Enhanced Community Capacity, how do we know when we've reached it? How do we know when it is time to disengage, other than when our contract runs out or we've "burned out"? Furthermore how can we be reflective practitioners if we have only fuzzy notions of the outcome on which we are asked to reflect? Can we justify our work only in terms of process, or are we responsible for the outcome also? And why do so many program evaluations have a lot to say about the values-laden process, but little about the anticipated

values-laden outcomes.

Even something as vague sounding as Community Capacity Building has theory that can help us identify our destination. Without researching current information on our destination before we start our walk, we may find ourselves looking for one landmark when in fact that landmark no longer exists. Without clear descriptions of where we are going we may pass by our destination without recognising it. Or, we may actually arrive at our destination, albeit in a different place than where we expected. This is especially important if we have not been there for a while, or for a long time. It is essential to use current maps.

Let's consider again Community Capacity. It has been defined as "The characteristics of a community that enable it to mobilize, identify and solve community problems" (Goodman et al. in Kegler, Norton, & Aronson, 2003). However many different landmarks identify it, including: mechanisms for community input and distribution of community power; skills and access to resources; sense of community and social capital; and a capacity for reflection and learning (Kegler, et al. 2003). Or if we consult a social ecology map (Kegler, et al, 2003), we might be looking for changes in individuals, changes in civic participation, organizational development, inter-organizational activity or community level changes. Indeed I can recall many occasions when a very tired community development team asked "Are we there yet?"

At Journey's End

David Chavis recently wrote on the SCRA electronic mailing list "The field of community psychology cannot survive without standing for more than just a set of values. We'll do best if we can develop a field that understands, knows how to study, and is able to develop community" (D. Chavis, personal communication, March 13, 2006)

This gives us much on which to reflect when reviewing our journey at the end of a project. Firstly we consider how well we've met the challenges of doing the science of community. Here we have to think realistically about how much we can carry in our methodological backpack while we are walking. Maybe a bigger backpack is necessary in order to go beyond conventional methods as Kelly (2002) suggests,

or to pursue what Tebes (2005) calls the parameters of "the truth". Secondly we consider how well we've met the challenges of social change. Here we need to consider who was walking with us. Did our community partners, government and non-government officials assist us in navigating political and economic territory, or did they add to our baggage. Furthermore, were we all using the same map?

I hope that whatever journey you have travelled has left you eagerly anticipating your next adventure. For, without that enduring passion to climb the next mountain, community psychology as we currently define it will not survive. With all the challenging roads rising up to meet us, this is not the time to contemplate walking, or even riding, off into the sunset.

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There is nothing so practical as …: Building myths in community psychology[1]

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Kurt Lewin's comment about the need to integrate psychological theory and practice famously has been mythologised in academic psychology in a distorted, self-serving form. Myths may serve to create a sense of collective identity, but in professional arenas myths can lead to distortions of the nature of theory and practice. We argue that some central tenets of community psychology have developed mythical status and, as such, perform social as well as conceptual functions. We argue that the unexamined status of these myths can lead to difficulties in praxis, the theory-practice interface. This has led to misunderstandings of people and community. For example, although community psychology was to be operationalised at broader levels (i.e., societal, community and organisational) as well as the individual, the prevailing zeitgeist of positivistic psychological thinking dominated actual practice and community psychology's myths have contributed to the failure to recognise the dominance of individualistic thinking, with little conceptualisation and operationalisation occurring beyond the individual level. This has led to poor implementation of the ecological approaches epitomised by contextualism.

A popular myth among academic psychologists that is reflected in the common assertion that Kurt Lewin had stated that "there is nothing so useful as a good theory" (e.g., Dalton, Elias & Wandersman, 2001, p. 5). What he was actually emphasising was a praxis model where theory and practice inform each other when he wrote:

> [Close cooperation between theoretical and applied psychology] can be accomplished ... if the theorist does not look toward applied problems with highbrow aversion or the fear of social problems, and if the applied psychologist realizes that there is nothing so practical as a good theory. (Lewin, 1951, p. 169)

The misquotation of Lewin reifies theory and is a hallmark of mainstream psychological myths as it fits the dominant worldviews that allows academics to see themselves primarily as 'thinkers' and not 'doers' (Sarason, 1981; Wicker, 1989). Similar myths within community psychology have emerged over time and they too have consequences, as we will explore. The creation of myths serves to helps collective identification with communities, both lay and academic. Myths, worldviews and community narratives are aspects of community that help in defining 'deep abiding truths' about the nature of people (Davis, 2005), social identity and providing a sense of belonging (Rappaport, 2000). In academic disciplines, these aspects can be seen as aspects of both the existing and the emerging paradigms in scientific revolutions (Kuhn, 1970). They provide disciplines with a sense of identity and a sense of community. If the worldviews, narratives and myths are left as unexamined, axiomatic assumptions about the nature of the world (Sarason, 1981), they can create distortions in the way we conceptualise issues and solutions (Becker, 2005; O'Neil, 2005). Sarason criticised academic psychologists for not recognising the "fact that psychologists are, no less than those they studied and about whom they theorised, were and are products of a socialization process from which they absorbed a particular view of people and society" (p. x). We suggest that critical examination of community psychologists' socialisation is essential and that faulty theorising occurs when a awareness of our disciplinary myths is not present in conceptualising praxis.

The myth of the pre-eminence of theory over praxis in mainstream psychology is reflected in the misquoting of Lewin. While it reassures academic psychologists on their role and in their science, it has led to many problems such as the crisis of relevance (Elms, 1975), methodological

crises (e.g., Orne, 1962; Rosenthal, 1966) and value laden research (e.g., Hayes, 2002; Sarason, 1981; Tuffin, 2005). We will address a few of the myths surrounding the emergence and development of community psychology and some unintended consequences. One concerns the development of the discipline and the second deals with how we operationalise our research and practice.

The Swampscott myths

The Swampscott conference has achieved mythical status. Duffy and Wong (2003) stated that:

> … very important to the history of community psychology was a conference held in Swampscott, Massachusetts, in May of 1965. This conference is usually cited as the official birth date of community psychology … This first conference was attended by clinical psychologists concerned with the inadequacies of their field and orientated to creating social and political change …. [and] agreed to move from treatment to prevention and to the inclusion of an ecological perspective (loosely, a person-environment fit) in their work. (p. 7)

The social ecological fit and the move to broader levels of interventions are some of the defining aspects of community psychology (Dalton et al., 2001; Duffy & Wong; Rappaport, 1977; Reiff, 1968), yet are these characteristics observed? Reviews of the literature assert that community psychology is still too individualistic (e.g., Lounsbury, Leader, Meares, & Cook, 1985; Martin, Lounsbury, & Davidson, 2004; Speer et al., 1992). Martin et al., reported that:

> A breakdown by dependent variable categories used in quantitative studies [in community psychology] showed that most (94%) were defined or operationalized at the individual level of analysis. Compared to the two previous reviews, this reflects a decrease in dependent variables assessed at a level of analysis above the individual, such as selected community, organizational, and person-environment constructs, such as crime, sense of

community, social change and spirituality… (p.169).

Why have the myths of an ecological perspective and intervention at non-individualistic levels been perpetuated, when the research output does not match the rhetoric? The failure to move to broader level interventions and away from individual conceptualisations could be due in part to a limitation in how the field conceptualises people and the nature of community; a complex issue that is at the heart of what community psychology should be about (Bishop, Johnson & Browne, 2006). While Dalton et al. (2001), for example, recognise the importance of understanding people in community, there is 'slippage' in the thinking. At the centre of this are alternative notions of people and community. In the first instance, people are viewed as separate from social contexts, as in traditional social psychology, which is defined in terms of examining the impacts social structures and systems have on 'individuals', (which Altman and Rogoff, 1983 referred to as interaction). The second views people not as separate from context, but in relational terms (Crossley, 1996) where people are aspects of the social context (which Altman and Roggoff referred to as transaction). While these differences may appear slight, they have important implications for our theorising and research.

There is confusion between the two approaches of viewing the individual as separate entities and that of seeing people as aspects of context, due to the broadly held myths about the individual that are held by community psychologists and the broader community. This can be seen in how community psychology textbooks deal with 'people'. For example, Dalton et al. (2001) refer to Bronfenbrenner's (1979) concepts of nested levels of society, pointing out that Bronfenbrenner used the analogy of the Russian dolls in which each doll fits inside of a slightly larger doll. This approach articulates the view that micro systems are subsumed by meso, exo and macro systems:

However, the nesting doll is incomplete: Not only is each individual nested within larger units, but individual life is *strongly influenced by* those layers of relationships and in turn *influences them* as well. (Dalton et al., p. 10, emphasis added)

While acknowledging the importance of relationships, as in a transactional approach, people are conceptualised as separate from each other, and from the levels of the social environment, as in the interactional approach. Dalton et al. go on to write "Our point is not that individually based research, testing, and psychotherapy are never useful, but that psychology relies heavily on such individualistic tools when others are also needed." (p. 33). Implicit in the previous comment is that individuals can be considered as separate from the broader systems. This reflects the common myth that community psychology is about the 'person in community', a concept that sees people and community as separate elements. This approach has utility in that it allows researchers to ask questions about how community and social factors affect individuals. It has the 'look and feel' of the familiar positivism that dominates mainstream psychological research.

When the considering the person in community, the research model becomes one of what Pepper (1942) called Organicism. In organicism, the entities are separate, but operate within a bounded environment, such as in systems theory. Organicism is based on what Pepper called the root metaphor of the 'harmonious unity' and does not challenge positivistic assumptions of universal truths. It has the look and feel of a contextual approach, yet retains some of the features of positivism in that causal inferences can be made. Research on sense of community and its relation to wellness in school communities, and the impact of organisation climate on workers are examples of how research is undertaken in organicism. Linney (2000), Shinn and Toohey (2003) and Tebes (2005), for example, argued for models based on this when trying to assess contexts. The approach has real appeal as it allows the use of sophisticated methods and statistics, such as structural equation modelling, giving the appearance of 'real science'. Even when non-quantitative methodologies are employed, there is still is the risk that organicism will be the underlying conceptual basis. The disadvantage is that much of the research may be meaningless as it fails to reflect the complexity of changing social contexts and to considered aspects outside

the bounded context, such a government policy and globalisation. For example, Thomas (2004) showed how notions of empowerment in organisations could not be meaningfully understood without understanding national and international change. She demonstrated how empowerment policies are set in changing social circumstances that reflect globalisation and increasingly conservative national and state policies.

Contextualism as the underpinning of community psychology

Pepper (1942, 1966) referred to another way in which community might be conceptualised, and that is contextualism. In contextualism the root metaphor is the 'act in context'. The post-modern contention of multiple realities is allowed. The notion of separate 'elements' disappears and people are considered as aspects of the context. Thus people are part of the context and not separate from it. This notion has considerable merit for community psychology. The ecological notion of action being understood in a blended micro, meso, exo and macro system is possible in contextualism. The core principles of respect for diversity, social justice, sense of community, wellness, citizen participation and community enhancement (rather than a deficit orientation) are understandable in contextualism. For example, Rappaport's (1981) exaltation for community psychology to adopt empowerment over prevention can be clearly understood in terms of contextualism versus organicism. Prevention has a deficit orientation and is targeted at reducing particular problems, such as anxiety and depression, through social intervention. Empowerment, like community enhancement, is diffuse. There are no simple identifiable outcomes. The emphasis in on the processes: on giving people the resources to employ in a manner of their choosing.

Understanding contextualism is difficult, as psychologists have been socialised in positivism. It requires a change in worldviews. Developmental psychologist Moore (2001) described this new way of conceptualising in discussing the nature-nurture issue. He made the point about the lack of separateness and the need to consider aspects of a greater whole. He wrote:

As traditionally conceived, "nature" is taken to refer to "human nature" and is imagined to reside within our bodies, to be that with which we are born, that exists independently of our experiences. In contrast, "nurture" is taken to arise outside our bodies; usually, "nurture" is understood to comprise our experience. But a little further reflection shows these conceptualizations to be problematic. While we are certainly nurtured by elements of an environment, our bodies (and minds!) are also shot through with nurture. Every breath we take, every meal we eat, every scene we see is assimilated into the very structures and functions of our bodies, literally becoming us….

The same story holds true for nature: we are certainly natural, but we are also completely embedded in nature. The sun, the trees, and the clouds that constitute our environment are no less part of nature than our genes, our eyes, and our sorrow. Even nurture is natural. This can hardly be denied: *we are shot through with nurture even as we are embedded in our nurturing environments, we are embedded in nature even as we are shot through with it* (p. 11).

Moore is describing a contextualist approach. Payne (1996) has pointed out that while contextualism has been recognised as being very important in developmental psychology, it is rarely, if ever, operationalised properly. Part of the problem involved in a contextual orientation is that we are imbued with positivistic thinking in which we see the world through what Pepper (1942) referred to as mechanism. Mechanistic (or positivistic) thinking emerged as part of the Renaissance and strengthened in the age of enlightenment. Hume's notion of 'cause and effect' is the hallmark of this orientation, which has saturated disciplinary and societal myths and grand narratives. While has been of great utility in the physical sciences, and 'hard' psychology, Moore is illustrating that we need to put aside simple, reductionistic thinking and embrace a post-modern approach in which social entities are seen as part of context (Burr, 2002; Gergen, 1992, 2002).

Returning to community psychology, the nature of people needs to be seen in terms of them being community and community being people. It requires critical examination of the powerful and prevailing myth of the independent

individual. It means recognising that people are not separate entities but have characteristics, ideologies, language and culture in common, while also having some characteristics that allow members of the community to differentiate between people. Even these characteristics that differentiate people are socially constructed. The myth that has been perpetuated in community psychology is that people are separate from each other and from the context. This myth allows the continuation of positivistic research in community psychology.

A contextual framework requires other research models (generally qualitative) based on vastly different conceptions of community. We need to adopt different notions of science, one in which tender minded approaches are integrated with tough minded (James, 1907); in which professional psychology is integrated into conceptual knowledge (Schön, 1983); a Model II way of thinking in which double-loop learning is dominant (Argyris & Schön, 1974); and a iterative-generative and reflective method of acquiring knowledge (Bishop, Sonn, Drew & Contos, 2002). The basis of all these approaches is recognising the importance of context, and that people and context are aspects of the same phenomena. It means dispelling the myths that individuals are separate entities and society is comprised of many individuals. We need to recognise that we are 'shot through with community', to use Moore's (2001) metaphor. This requires understanding that communities will differ and that the 'laws' of our community science will be developed through the experience of working with multiple communities. The irony here is that this approach puts people at 'centre stage', not as individuals, but as relationships (Crossley, 1996), transactions (Dewey & Bentley, 1949) in nested ecological levels (Bronfenbrenner (1979), as community (Bishop et al., 2006).

Knowledge claims need to be promoted as assertoric knowledge (Polkinghorne, 1983) using abductive reasoning (Peirce, 1955). This model recognises that knowledge is not separate from those who voice it, that multiple realities can exist (e.g., different cultures may have differing social realities). Abductive reasoning frees us from the 'rigours' of logical positivism, and involves speculation and intuition. It involves

making knowledge claims based on firm evidence and less firm evidence to produce speculations that need to be presented and debated. This model of knowledge recognises the importance of community understanding and endorsement of knowledge. It also recognises the importance of mutual support in communities and developing collaborative and shared knowledge rather that the more general competitive nature of science in psychology, and more broadly in science.

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Iatrogenisis, community psychology and natural resource management

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Reflections and learnings from our involvement in contextual analyses of large collaborative/participatory research and development programs within NRM are captured within this paper. The authors deconstruct community psychology's involvement in NRM with reference to a metaphorical understanding of the concept of iatrogenesis, a term used to refer to the unintended consequences of any form of intervention by health care professionals. Such a deconstruction creates an awareness of the lack of recognition of community psychology's involvement in the replication of systems of NRM which 'do no harm', rather than create structural change. Although new structural processes that take into account the issues raised within this paper are yet to be defined, concepts such as biopolitics and biogovernmentality, are considered as platforms for understanding how these processes may begin to be conceptualised, for the future of community psychology's role within NRM.

Iatrogenesis is a term that is used to describe the effects of a treatment or intervention by physicians or other medical professionals such as psychologists. Within this paper, we wish to highlight a number of reflections and learnings from working within natural resource management (NRM) over the past 4 years, through our involvement in the evaluation of large scale NRM programs and the first authors PhD these exploring contextual issues of the impacts of NRM R&D. This narrative of our involvement with NRM, told through 4 specific reflections and understood through the use of the metaphor of iatrogenesis, can be used as a cautionary tale for understanding unintended impacts of community psychological theory, research and practice, within NRM as well as other settings which focus on human physical/psychological health and environmental health.

The 'Nature' of NRM

Firstly, an understanding of the nature of NRM in Australia and internationally is needed. Policy makers have adopted processes whereby the impacts of people, both potential and realised on the environment, are managed through the process formally known as NRM (Synapse Consulting, 2000). This process has characterised the NRM policy arena since the 1980s (Bridger & Luloff, 1999). Research provision, on the other hand, has generally been characterised by linear models of technology transfer (Ruessll, Ison, Gamble & Williams, 1989, cited in Allen, Kilvington & Horn, 2002), in which science

professionals uncovered ultimate truths regarding land and water management and developed technologies and innovations (Ashby, 2003), and through an extension model were promoted to, and adopted by, 'community' (Ashby; van Kerkhoff, 2002).

The characteristics of many NRM setting has been one in which scientific or political professional groups involved in the policy, research and technology of land and water management have controlled definitions of problems within these systems. Historically, the features and problems of the environment are defined through disciplinary, professional and political definitions.[1] This has lead to a situation where environmental problems have been defined by the theoretical lens of the professional group looking at the issues, and by political groups who focus on specific environmental problems as it is a condition necessary for their political control. There are a number of diverse disciplines involved in producing problem definitions, and the solutions for, social and environmental problems. Despite these disciplinary boundaries, there is an emerging communality of defining NRM as a way of managing the environment and people in synergy, with an ultimate goal of focussing on the impacts of the interactions between humans and the environment. It is in this definition of NRM as a reciprocal impact of interaction and intervention, that the metaphor of iatrogenesis becomes useful, a point to which we will return

Participation and NRM

Participation, and other integrated and collaborative processes, have become 'buzz words' within research and policy settings of NRM. This recognition of the need to incorporate these strategies is underpinned by the awareness of the location of the social within environmental systems. Community psychology became involved in NRM at this level, and it is at this location in the system that we are potential able to create change. This awareness of the social in the environmental has emerged perhaps largely because of the perceived critical state of national and international environmental problems (e.g., Lanthier, Olivier & Eloy (trans.), 1999) and the perceived and real effects of problems such as salinity, poor quality and quantity of water resources, and the greenhouse effect, on human physical, and to a less recognised extent, psychological, health. The 'social', that is, individual and community/regional behaviour, has been seen also as fundamentally linked environmental problems, and therefore to the solution (Sampford, 2002).

Iatrogenesis: Understanding impacts

The third point hinges around the emergence of an essential paradox from the linking of the social to environmental issues[2].

The implications of these paradox are how, even when trying to create change within social systems, we often unintentionally through these 'change strategies' re-embed ourselves in these systems. It is this link between the social and the environmental that brings to awareness the significance of impacts of current systems of NRM, and it is this self-referential system of which community psychology is now a part. Community psychology sits 'naturally' within environmental management (e.g., see Browne, Bishop, Bellamy & Dzidic, 2004), but in a way that challenges both community psychology's and NRM's fundamental methodologies, philosophies and ontology.

A metaphorical understanding of clinical, cultural and social iatrogenesis aids in understanding the impacts of this paradox. For both community psychology and NRM. From a medical perspective iatrogenesis is an illness which would not have come about had medical treatment not been applied (Illich, 1975). Clinical

iatrogenesis can be defined as "all clinical conditions for which remedies, physicians or hospitals are the pathogens or 'sickening' agents" (Illich, 1975, p. 22). For example, if you take antibiotics, you generally alter your immune system and the presence of healthy bacteria, which makes you more susceptible to other infections.

Social iatrogenesis, from a medical perspective can be seen in the over-medicalisation within Western society (Illich, 1975). For example: "medical practice sponsors sickness by reinforcing a morbid society that not only industrially preserves its defectives, but also exponentially breeds demand for the patient role" (p. 26). Structural/Cultural iatrogenesis "is the ultimate backlash of hygienic progress and consists in the paralysis of healthy responses to suffering. It strikes when people accept health management designed on the engineering model, when they conspire in an attempt to produce something called 'better health' which inevitably results in the heteronomous, managed maintenance of life on high levels of sub-lethal illness" (p. 27). The cumulative effect, particularly of social and cultural iatrogenesis is that the unwanted effects of these treatments are generally attempted to be alleviated by new devices, approaches, and organisational arrangements. However, although conceived of as remedies these interventions, actually contribute further to the impact, as they themselves become the 'pathogenic' structure. Illich discussed this as a "self-reinforcing loop" (p. 28) and therefore can be related to the features of NRM as a paradoxical system, and community psychology's role within it..

Positive impacts of community psychology within NRM

The mutual recognition and involvement of community psychology in NRM provides many 'benefits' in terms of the conceptualisations of the notion of community, the introduction and elaboration on issues of social and human justice (in the context of environmental and political justice) particularly regarding Indigenous Australian perspectives, and the focus on discourse and community stories and narratives as a way of introducing these understandings to a domain that is largely characterised by scientists and policy makers whose default way of

understanding community is through 'science' rather than through 'story'. Through this different perspective, a new set of discourses is brought to the field of NRM. It is through our discipline of community psychology, in a way that complements other social sciences, that social justice, empowerment, and a recognition of the importance of multiple scaled projects (that is, a focus on broader macro level issues as well as micro level issues, e.g., Bronfenbrenner, 1979; Dalton, Elias & Wandersman, 2007), begins to shape NRM policy and research projects.

However, the domain of NRM itself, and community psychology's place within it, particularly considering the exponential popularity of participatory and collaborative processes within NRM research, policy and development, actually masks a number of iatrogenic impacts, both with Indigenous and non-Indigenous people involved with NRM within their regions and communities. The potential benefits we see from community psychology's involvement within NRM hides for example how our role within these settings can easily be positioned in such a way that maintains the political, social and professional systems that define the current 'state' of criticalness our environment, rather than truly reflecting on the impact of these 'interventions' for community.

Negative impacts of community psychology within NRM

Although community psychology positions itself to change systems (e.g., Dalton et al., 2007; Rappaport, 1977; Reiff, 1968) in not considering our unintended impacts within NRM, by focusing on the mandate of do no harm, we potentially can cause harm. Through our work within NRM, there are a number of examples of the potential negative impacts of NRM, and our role in the continuation of these impacts.

As discussed, the move to participatory and collaborative approaches within NRM, does provide positive opportunity for the building of capacity within the geographic regions, and through the recognition of the importance of social and community issues creates potential for empowerment of community through the adoption of the participatory processes that community psychologists generally advocate. However, the adoption of participatory and collaborative processes, as well as being spurred

on by the recognition of the 'social in environmental', has also occurred as a result of the national and international phenomenon of deregulation, decentralisation and devolution of responsibility for NRM, amongst other 'social' services to regional community levels (e.g., Abrahams, 2005; Herbert-Chesire, 2000; Smith, 2002).

Consider for a moment our involvement in an evaluation of a large NRM research project in this social and structural environment, and the types of iatrogenic impacts (clinical, cultural and social) that emerge from this setting. The evaluation was of a large collaborative NRM research program, which through scientific, *and* participatory and collaborative processes set out to be a research program that created biophysical and social baseline data to inform future development of the region. It incorporated both Indigenous and non-Indigenous community stakeholders in their research programs.

Due to the project prematurely being terminated, the framework for the evaluation of the NRM R&D changed from a formative evaluation design where 'learnings' were to be feed back into the project plans (Bellamy, 2002) to an 'impact' evaluation (Chess, 2000). Both within the original plans, and subsequently amplified in the final format of an impact evaluation, the nature of the evaluation was one of problematisation of issues, through the multidisciplinary frameworks of 'evaluation'. A difficulty that we struggled with was how to frame the evaluation in a way that did not reflect our 'scientific' background, and therefore re-embed the discussion of impact in terms of policy and science rather than the impact on the community. By framing the evaluation in terms of influencing the 'formation' of the project, or the 'impact' of the project, our role within the evaluation, and our impact therefore, was consistently reframed in terms of iatrogenic 'positive or negative' impacts of 'intervention' (both the intervention of the larger research project, and our individual roles as community psychologists within the evaluation).

Another example of forms of 'iatrogenesis' within this evaluation existed within our disciplinary philosophy of addressing issues of social justice and empowerment, and how easily it is to either neglectfully (by being unaware of

our positioning), or unintentionally (by thinking we are 'doing good') we can easily do harm, or replicate 'harmful' histories. Cascade iatrogensis is a series of increasingly more severe effects on the health of patients, caused by medical interventions which were applied to solve the previous one (Hofer & Haywood, 2002; Mold & Stein, 1986; Potts, et al., 1993). When applied to Indigenous involvement within NRM, cascade iatrogenesis highlights the significance of the true impact at clinical, cultural and social levels of working with Indigenous people in NRM settings as well as the impact that 'evaluation' through scientific frameworks can have.

A focus on multiple levels of impacts and the history of previous interventions in a region is necessary. For example, an Indigenous sub-program was created within the program that we evaluated. It was recognised that there was a limited amount of research done with or for Indigenous people with regards to NRM in the region. However, there was a lack of recognition of the significance of adopting research programs such as this given the tenuous nature of research involvement with Indigenous people of Australia Garvey, 2000), and policies and laws which have prohibited Aboriginal involvement with NRM e.g., issue of citizenship, the issue of sovereignty, native title etc. Although the Aboriginal program was a very successful program, and it was motivated be a desire to create change for Aboriginal people within the region, it was done with a lack of recognition of the potential for it just being another intervention adopted to solve Australia's history of oppression and persecution of Aboriginal people. Although there is not room to discuss this here, community psychology's ability to address the issue of impact at all of these levels, through a methodological and conceptual limitations, is tenuous itself at best. It is the recognition of the lack of methodological strategies which enable us to address the layers of historical and regional impact of these programs, and the cumulative 'community intervention' history, that is the location of our role in perpetuating oppressive and 'unintentionally' harmful iatrogenic practices.

Used as a metaphor iatrogenic processes can be found within NRM, and community psychology, and speak to the 'unintentional consequences' at many levels, of intervention

(both social and environmental) to ensure a sustainable and just future for our social and environmental world.

Ways forward: Iatrogenesis and biopolitics in NRM and community psychology?

The fourth and final point are ways that we can begin to understand the location and significance of these impacts through our involvements within these systems. How can we actually begin to understand these impacts as they are defined by the system? Does an understanding of our history of previous, current and cumulative impacts within this system then enable us to create movement for the emergence of new systems, which are as yet relatively undefined?

Understanding how the metaphor of iatrogenesis and history fits within NRM, and community psychology, leads to a discussion of biopolitics and biogovernmentality. In both iatrogenesis and biopolitics, a fundamental issue is the way in which social systems are created in a manner that governs and controls through individual behaviour, and the even for contextually embedded problems, the location of pathology, if often at the level of the individual. We have discussed that there is an increasingly common reconfiguration of environmental issues at the epicentre of human health, and vice versa. Such a location we would argue, potentially frames the 'environmental' as another condition for the continuation of the problematization and pathologization of health, through processes that appear changed, but actually are reconfigurations of similarly destructive processes, that continue to be framed as 'doing no harm'.

The notion of biopower is a form of scientific power that "works continuously, changing scales, areas of action, and instruments of government" (Biehl, 2005, p. 249) which is actually played out through the biological processes and actions of citizens. Throughout the history of environmentalism, populations of citizens were governed by 'scientific expertise' which was then linked to the community by extension programs that they then adopted 'on farm'. Participatory and collaborative approaches to NRM could be viewed as another form of regulation of the biological processes and governance of populations, as links are made through these processes between geographic and

regional communities, and individual citizens, to a responsibility to this country which is framed as 'dying from environmental diseases'. That is, by linking human, social, political, economic and environmental health through these 'new' processes, it creates new settings in which through emerging forms of power the governance of populations through individual citizens' relationship to the environment is achieved. These are processes that affect both Indigenous and non-Indigenous communities, but it is by locating history within this discussion that the true differentials of impacts for Indigenous and non-Indigenous communities is revealed.

Conclusions

The discussion of iatrogenesis can be used metaphorically to begin to understand community psychology's role in replicating a system of governing human behaviour through the management of our natural 'resources'. NRM is by its nature a complex setting characterised by multiple disciplines, professions and lay involvement and multiple geographic settings. It is our argument that by first recognising community psychology's involvement within this system that we can begin to understand our location for creating change.

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Notes

[1] Think for a moment of federal elections that have been won in Australia which have hinged on the interchangeable issues of health care, education, environment and border protection.

[2] This paradox is embedded in the organisational functioning of NRM projects, but it is also embedded in a larger paradox of participation, participatory democracy and neoliberalism as features of national and international policies. See Browne (2006) for more detail.

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The use of psychological theories of development and adjustment in the broader culture to support the political agenda: a critical view

Jenny Sharples
Wellness Promotion Unit, Victoria University

The main purpose of this paper is to explore the use to which concepts from lifespan development and adjustment are put within the broader culture; in particular, ways in which these concepts are used for political purposes. I wish to explore the use, or misuse, of psychological theory to support political agendas. In doing so I am drawing on the work of Caldicott, Watson and others who have explored a parallel issue: the use or misuse of language in political discourse, and on other voices that have critiqued the impact of Western popular culture on the practice of psychology. It is my contention that lifespan development and adjustment concepts have been misused in popular culture and the public sphere, to provide a pseudo-theoretical backing for the manipulation of public opinion, in American/Western and therefore to some extent global culture. Our profession needs to maintain an awareness of this trend and work to prevent its occurrence.

The main purpose of this paper is to explore the use to which concepts from lifespan development and adjustment are put within the broader culture; in particular, ways in which these concepts are used for political purposes. I wish to explore the use, or misuse, of psychological theory to support political agendas. In doing so I am drawing on the work of Caldicott, Watson and others who have explored a parallel issue: the use or misuse of language in political discourse, and on other voices that have critiqued the impact of Western popular culture on the practice of psychology. It is my contention that lifespan development and adjustment concepts have been misused in popular culture and the public sphere, to provide a pseudo-theoretical backing for the manipulation of public opinion, in American/Western and therefore to some extent global culture. Our profession needs to maintain an awareness of this trend and work to prevent its occurrence.

Australian peace activist and physician Helen Caldicott (2002) has focused on the use of language in the discourse of war and nuclear weapons. She has argued that using phrases such as 'collateral damage' and 'soft targets' to refer to killing other people in war serves to dehumanize the other, and to distance us from the emotion, and therefore the reality, of damage to the other person. Distancing from our emotions is an important part of the dehumanization of others. Using language to dampen and reduce painful and frightening emotions serves to anaesthetize the listener and decrease the likelihood of independent thinking and social action. Caldicott's aim in naming this process is to reinvigorate and re-empower the listener.

This process of manipulation of language occurs in many other spheres of life, not only in relation to war. Another well known Australian, Don Watson (2006), has coined the phrase 'weasel words' to describe the way language becomes a tool for maintaining power rather than a means of communication or expression. Watson gives as an example Prime Minister Howard's distinction between "core" and "non-core promises". Through such obfuscation language is manipulated, and the meaning of a simple word 'promise' is made unintelligible by adding 'core', the end result being that the promise may be evaded. Watson gives other examples of what he calls corporate speak such as 'downsizing', a word used as a euphemism for sacking people. This manoeuvre is akin to those described by Caldicott, where the listener is distanced from the emotion and so from the reality of the other person. Watson argues that 'corporate speak' cannot carry an emotion and as such provides a pathway for dehumanising the worker who must listen to it and often reproduce it. The spread of such language to the wider community impoverishes the language in general and renders us all less emotionally articulate. Watson's work draws on a long history of such criticism, as his publicity declares: "Oppressive

language does more than represent violence; it is violence; does more than represent the limits of knowledge; it limits knowledge" (Toni Morrison, Nobel Lecture, 1993). I might add to this that dehumanised language does emotional violence both to the individual and to the culture. How much worse then when the language used is from psychology, so that instead of enriching our culture and enhancing development, our work instead becomes a servant of the powerful.

This debate on the reduction of emotion in language as a means of manipulating opinion and outcome has also had some airing in the field of psychology. Bruno Bettelheim (1983) and others who knew the culture of Freud's Vienna and the German language, have pointed to the mistranslation of Freud's work and ideas. Bettelheim argues that the mistranslation of Freud's work into English was done in a way that systematically reduced the feelings evoked in Freud's original German. For example, Freud writes in German of 'das psychologische elend der masse'. Bettelheim translates this as 'the psychological misery of the masses'. The translation of this phrase in the standard edition of Freud's work is "the psychological poverty of groups". Bettelheim argues that 'groups' is a mistranslation of 'masse', and points out that the German word 'elend' means misery or wretchedness, and that the word for poverty is "armut" not "elend". "A word that evokes a strong emotional response, as does 'misery' or 'wretchedness', has been replaced with a different word (poverty) that is likely to be considered as referring to an objective fact" (p. 81). He argues that the translation reduces the emotion from the English text, in order to support the idea of psychoanalysis as an objective science and medical specialty in the United States. It is interesting to note Bettelheim's point that Freud did not take action against what he considered mistranslation of his work and ideas into English. Before Hitler came to power, Europe was the centre of psychoanalysis. Freud did not foresee the primacy of the English language in the global culture, and did not expect that the United States would become prominent in the field.

Psychological concepts and theories have influenced popular culture across this century. However, what is less evident is the interactive nature of this process. We may ask to what extent

has psychology contributed to the understanding of ourselves and the human condition, through the move of psychological concepts from our discipline to popular culture, and to what extent has popular culture impacted on thinking in the discipline? Not only has language been used to distance us from our emotions, but psychological theory has been employed by those in power to support the values of Western popular culture and the needs of the Western economic system of capitalism.

Our profession is embedded in a global culture that has been rapidly gaining ascendance in recent times. Bettelheim (1982) reports Freud as being "dismayed by what he recognized as the prevalence of a shallow optimism in the United States" (p.80) and by that culture's difficulty with the wider range of human experience, including so called negative emotions. Freud suggested that such a culture could lead to the "psychological misery of the masses". This is an interesting point given the rise of depression in our Western materially privileged society. Such 'shallow optimism' has been credited with the development of positive thinking and the positive psychology movement in general (Held, 2002). There are many voices now in the field of psychology arguing against the positive psychology movement, pointing out that the idea that so called 'negative emotions' should be treated, reduced or removed, is likely to diminish mental health rather than improve it (Held, 2004; Solomon & Stone, 2002; McWilliams, 2005). Furthermore, the very idea that 'negative emotions' are not healthy psychologically serves to discount the voices of those angered by their experience of the social context, and to disregard the role of emotions such as anger as catalysts for social activism.

Psychotherapists have argued that their profession is under attack from cultural pressure to diagnose and treat, rather than develop understanding and hold to values that often conflict with or challenge Western culture's "materialism, consumerism, appeals to vanity and greed, distain of dependency and vulnerability, and abetment of narcissistic entitlement" (McWilliams, 2005, p. 139). McWilliams asks: "is psychotherapy the servant of popular culture or its participant observer and critic?" (p. 139). We should ask the same

question of psychology.

The sub-discipline of community psychology has worked to reintroduce the notions of values and social context to the mainstream of the profession. My purpose here is to further this work by naming the ways in which psychological concepts are misused in the broader culture and in the service of manipulation of public opinion. This paper considers two examples; the popular cultural idea of 'moving on', and the use in the 2006 US Presidential State of the Union address of the concept of addiction: 'addiction to oil'.

'Moving on' has been presented in popular culture as a healthy psychological action. We could consider, from a professional point of view, in what circumstances this could be true. One might employ this concept working with a person with obsessive compulsive disorder, or someone stuck in ruminative grief. We could let go, leave behind, or 'move on' from a neurotic symptom. I cannot comment on the origin of this term, since there is little to indicate its genesis, whether it is born from psychology or from popular culture. I have found one reference to 'moving on' as a term in the literature in an article on transformation and construction of alternative emotional schemas: "it is time to leave the maladaptive state and move on" (Greenberg & Watson, 2006, p. 281).

However, the idea of 'moving on' has been used in popular culture to represent an aspect of healthy emotional development across the lifespan. For example, 'moving on' has been presented as a way of dealing with difficulty in relationships. A non-violent relationship difficulty calls for understanding which will not be attained simply by 'moving on' through leaving that relationship. More than one client consulting me as a psychologist over a non-violent relationship problem has said "I suppose you think I should leave (the relationship)". While this may well be a projection of their own desire to leave onto me, it may also reflect a mainstream popular cultural discourse, that one can solve a relationship problem by leaving the relationship and beginning another where there will be no history (or baggage). McWilliams (2005) cites the idea that 'the cure for a bad relationship is separation' as one of her 18 messages from US culture that therapists should regard with skepticism. She argues that:

…the most compelling rebuttal to these omnipresent secular themes may be not religious or moralistic but empirical; namely, the lack of evidence that living by these precepts increases well-being (cf. Lane, 2000). Most clinicians can attest that there is massive evidence for the converse, for the considerable satisfactions that ensue when people acknowledge limitation, respect their interdependency, grieve over inevitable disappointments, and tame their sense of entitlement. (p. 142)

The use of concepts such as 'moving on' in this way leads more to a prescriptive approach to development than to a deepening of understanding.

The idea of 'moving on' suggests not taking responsibility for the relationship breakdown, thereby misdirecting responsibility away from the self. In contrast, psychological theory would more likely support the contention that adult development is about building on experience, not about an ahistorical 'move on'. We might move closer, move toward, move through, or move forward, all of which may signify some building on experience. 'Moving on' applies more adequately to finishing something in a timely way, such as graduating from a course or a school, or leaving a job or a workplace. If we are always positive, ahistorical and prepared to 'move on' when the going gets tough, then social action grown from outrage, anger, and dissent is less likely.

Furthermore, 'moving on' implies that there is 'somewhere else' to go, suggesting a lack of consequence for negligent and despoiling use of relationship. In the age of science, popular culture has misused recent scientific 'successes' to reify science and inflame our grandiosity, purporting that through science we will be able to fix or even improve on that which we destroy. The environmental movement has pointed out the fallacy of this framework in relation to the earth; science cannot reproduce fresh air and clean water after we ruin the atmosphere. I would like to remind us of the same the point when considering the psychology of relationship. 'Moving on' suggests leaving without

responsibility and implies ending without grief. Grief may be to our times what sexuality was to Freud's Victorian times, the suppressed experience. To grieve well we must be able to honour a range of experiences of the lost relationship, not just the positive aspects. If we always 'move on' we cannot see the patterns of our behaviour from which we may learn and grow. Promoting such an ahistorical stance as emotional health will likely result in an emotional dumbing down, and a tendency to repeat the same problems in different spheres. I was jolted into writing this paper by a carton drawn by Michael Leunig cartoon depicting a victim of the Iraq war with bandaged leg and arm stumps being advised: "You really, REALLY, should just get over it and move on...".

Another example of the recent misuse of psychological theory in public discourse can be found in the 2006 United States State of the Union address (Bush, 2006). Offering a framework that seems implicitly to be supported by the discipline of psychology, US President Bush described (North) America as 'addicted' to oil. While all of us in the West benefit from the spoils of our oil-based economy, an economy we know to be unsustainable, the idea that the problem is fuelled (sic!) by individual greed attributes the cause to individual pathology and thereby does not name a problem caused by social policy. Bush may well have used the addiction metaphor to co-opt the environmental vote, since the green movement has been using this metaphor for some time. However, although it has its uses metaphorically, namely that each of us must be aware of our contribution to wider social and environmental problems, the concept of addiction serves to misdirect responsibility for the problem from the wider system and global capital players to the individual person. It is akin to treating gamblers as they exit the casino, the very casino they have been lured into by its developers, while a busload of new potential problem gamblers alights outside.

The concept of addiction may be used as shorthand in popular culture for 'it is your individual personal fault'. Those who pay for the treatment, the taxpayers, will not be those who profit from the running of the casino. The problem will be seen to be owned by those individuals who cannot control themselves. We are asked to take responsibility at an individual level for social policy such as the pursuit of oil, driven by the oil companies' profit motive. Furthermore, we all know with what lack of humanity addicts can expect to be treated. Will this reference to addiction become shorthand for the need for the pain associated with a cure? If we really were to take this metaphor, we might ask: What pain is being medicated by such an addiction, emptiness?

What conclusions can be drawn from these examples? First, psychology must struggle for meaningful use of psychological terms and concepts in the wider social discourse. Second, we must reinvigorate the language of psychology to include feelings and to acknowledge the importance of emotional life. Third, we must draw the connection between language, feelings and action, including social action.

Rather than seeking to reduce 'negative feelings' we must seek their meaning, including their social meaning. The local supermarket cannot look up a food type on the computer database to tell me if they have it, but they can look up a brand. On the one hand I should not be surprised that supermarkets sell brands and not food; on the other hand my surprise and anger may also be important social comments in refusing to accept the implications of food branding. Our culture is struggling with understanding and placing our feelings in every walk of life. It seems wellbeing involves the return of the feelings to many areas of life. The list may include the role of emotions in physical and mental health, education, parenting, management, intelligence, and relationship - to which I would add social action. I object to psychological concepts such as addiction being used to manipulate public opinion. The term 'addiction' is meant to convey the idea of a biopsychosocial problem, not an individualizing of social policy. This objection might be an important social comment for our profession.

It is in the end the marketplace economy we work in, where all is for sale and profit, so that arts, education, health, knowledge, and therapy are commodified (Neville, 1992). Watson's (2003) ironic Friends, Romans and Customers,

can easily be applied to our discipline. In our own discipline we may need to ask: do we sell psychological techniques or offer thinking space and frameworks for living and growing? The removal of emotion from our language and therefore from our lives, also results in the removal of meaning. Removing meaning, history and the physical body are first steps in justifying aggression and dehumanising the victim. How can we resist the sound bite culture and reclaim meaning in the theory and concepts we offer society? How can we counter psychological concepts turned into sound grabs for the purpose of manipulation of public opinion?

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APS College of Community Psychologists

Annual Report to Members 2005-2006

National Committee 2005-6

Name	Position
Heather Gridley	Chairperson (to December 2006)
Meg Smith	Secretary & NSW Section Chair
Lynne Cohen	Treasurer & Journal Editor
Catherine D'Arcy	Membership Secretary & Vic Section Chair
Grace Pretty	Program accreditation & Qld Representative
Diane Clark	Professional development
Dawn Darlaston-Jones	WA Section Chair
Carol Tutchener	Student Representative (Vic)
Anne Sibbel	Student Representative (WA)

This is my last report as Chair of the College of Community Psychologists. I have accepted a half-time position in the APS National Office, as Manager (Public Interest), a newly created position covering what was formerly the Directorate of Social Issues. Associate Professor Grace Pretty from the University of Southern Queensland was elected Chair at the recent AGM on December 7th, which is great news for the College.

The National Committee managed several tasks in the past year, including the revision of college competencies and the completion by Catherine D'Arcy of a resource package to assist applicants for college membership. We also managed to keep our bank balance in the black despite some scary interim figures around the time of the Trans-Tasman Conference.

The production of two issues of the College journal *Network* was a significant achievement, thanks to editors Lynne Cohen, Dawn Darlaston-Jones, Tao Jordan and Anne Sibbel, and special issue editors Colleen Turner and Chris Sonn (on teaching and practice issues in Indigenous psychology). The journal was renamed *The Australian Community Psychologist (ACP)* and is now available online via the College website.

The College hosted the 10th Trans-Tasman Conference in Community Psychology, in Sydney April 20-23rd 2006. Several outstanding keynote speakers drew on the theme *Less talkin', more walkin'*, and participants rated the conference highly for its inclusiveness as well as the standard of presentations. A number of the papers presented at the Conference make up this special Proceedings issue of *ACP*.

An APS Directorate of Social Issues paper on *Psychological sense of community and its relevance to well-being and everyday life in Australia* was completed by Grace Pretty, Brian Bishop, Adrian Fisher and Chris Sonn, and is finally accessible on the College website. The College was very well represented at the APS/NZPsS Conference in Auckland, and also at the first International Conference in Community Psychology in Puerto Rico in June.

Membership numbers have remained low but relatively stable over the past twelve months. It is always a challenge to provide adequate professional development opportunities for a small, scattered and disparate membership. PD activities have been organised mainly in Perth and Melbourne, where there are active sections of

the College. Members are reminded that the Community College trusts its members to assess and manage their own PD needs, so we rarely challenge individual claims for specialist points, although random audits continue to occur via National Office, so it is wise to keep all supporting documentation. Members who lack a filing gene, or who don't need to maintain an identity as specialist Community Psychologists can also have opt for Affiliate Membership of the College, which is essentially an Interest Group level that does not require the completion of PD. The key message is that wherever you are, and whatever you're doing now, we do want you to stay within the College.

Foundation College member Brian Bishop was elected to APS fellowship in 2005, as was Goff Barrett-Lennard in 2006. Craig Wallace and Briony Kercheval shared the Victorian Section award for the outstanding postgraduate student in Community Psychology in 2005. The 2005 Robin Winkler Prize was awarded to Ann Dadich for her doctoral research project on self-help groups for young people with mental health problems. The 2006 recipients were the ERIS team – Eleanor Wertheim, Ann Sanson, Margot Trinder and Elisabeth Freeman, whose paper on the project Enhancing Relationships in Schools appeared in the August issue of this journal.

Plans for 2006-7 will focus on securing a publisher for the college journal, becoming more financially viable, and increasing membership take-up by students, graduates and others. We also expect to continue the College's contribution to APS policy and public profile on matters relating to community well-being and social justice – Psychology in the Public Interest!

Heather Gridley –
Chairperson (till December 2006)

Preparation, Submission and Publication of Manuscripts

The Australian Community Psychologist publishes work that is of relevance to community psychologists and others interested in the field. Research reports should be methodologically sound. Theoretical or area review papers are welcomed, as are letters, brief reports and papers by newer contributors to the discipline. Contributions towards the four sections of the journal are sought.

The Australian Community Psychologist is published twice per year. Usually, the first issue is a themed issue, and the second is a general issue.

Articles
Contributions that are state of the art reviews of professional and applied areas and reviews and essays on matters of general relevance to community psychologists. They are between 4,000 and 10,000 words, including all tables, figures and references.

Research Reports
This section is for the publication of empirical research reports relevant to community psychologists. They are between 4,000 and 10,000 words, including all tables, figures and references.

Practice Issues
This section publishes individual manuscripts and collections of manuscripts which address matters of general, professional and public relevance, techniques and approaches in psychological practice, professional development issues, and professional and public policy issues.

Book Reviews
The journal publishes book reviews of up to 1,000 words. Books reviewed relate directly to the major areas of practice in community psychology.

Review and Publication of Manuscripts
The acceptable word processing programme format is Microsoft Word. All manuscripts are to be submitted electronically to the:
> Editor
> Dawn Darlaston-Jones
> Email: ddarlaston-jones@nd.edu.au

If authors experience any difficulty with electronic submission, hard copy materials together with a disc copy should be sent to:
Dr Dawn Darlaston-Jones
School of Arts & Sciences
University of Notre Dame
PO Box 1225
FREMANTLE WA 6160
Australia

All contributions, including book reviews are handled by an appropriately qualified Associate Editor and all contributions are blind-reviewed.

Articles submitted for review must be original works and may not be under consideration elsewhere.

All manuscripts for consideration for publication in *The Australian Community Psychologist* must be formatted according to the instructions for authors below.

Instructions for Authors
The following constitutes advice to contributors that is relevant generally to all journal sections.

Every submission must include:
1. A cover letter stating the section of the journal to which the author(s) wish to submit the article.
2. The complete manuscript including title page, abstract, text, tables, acknowledgements, references and illustrations.
Written permission from the publisher (copyright holder) to reproduce any previously published tables, illustrations or photographs.

Manuscripts should be arranged as follows:
> Title page
> Abstract and keywords
> Text
> Acknowledgements
> Disclosures if required

References
Short biography of author/s
Address for correspondence from readers
(e.g., an email address)

Tables and figures should be placed in the correct position within the body of the text.

Number pages consecutively, beginning with the Title page as page 1.

Sections of the Manuscript

Title Page should contain:

Title: Should be short and informative. Recommended length is between 10 and 12 words.

Running Head: Short title with a maximum of 50 characters

Author: This should include the author's name in the preferred form of given name, family name.

Institution and Affiliations: This identifies the location where the author(s) undertook the investigation.

Corresponding Author: Provide the name, exact postal address with post code, telephone number, fax number and email address of the author to whom communications and requests for reprints should be sent.

Specific Formatting Requirements

Paper Size, Margins, Alignment
A4 page, ALL margins 2.5cm.

Spacing
All text double spacing, left aligned (not justified) unless otherwise specified.

Font & Size
Times New Roman, 12pt unless otherwise specified.

Paper Title
14pt, bold, centred, sentence case.
Place one line after the paper title.

Abstract and Keywords
12pt, italics, left aligned.
Place one blank line before and after the abstract.
The abstract must be no more than 200 words.
Place up to 6 (six) keywords.

Normal Text
12pt, Times New Roman double line-spacing, left aligned (not justified)
Do not leave line spaces between paragraphs but indent the first line of each paragraph.

Long Quotes (roughly, quotes of 30 words or more)
12pt, italics, indented 1 cm left and right

1st Level Heading
Sentence case, bold, centred, not italics.

1st Level of Subheading
12pt, italics, sentence case, left aligned.
Leave one line space before this level of subheading.
Do not number subheadings.

2nd Level of Subheading
12pt, italics, sentence case, left aligned. Text should continue on the same line.
Leave one line space before this level of subheading.

Tables, Figures, and Diagrams
Captions in 12pt and typed below the figure, as required by Publication Manual of the American Psychological Association Fifth Edition. These should be black and white and inserted in the correct place within the body of the text. Do not allow a figure or table to be split over two pages or to be separated from its label or caption. Diagrams, illustrations, graphs, etc, must be 'screen readable'. This means fully legible and readable on screen when displayed at widths that ideally do not exceed about 750 pixels and certainly should not exceed 1000 pixels.

Page Numbers
Insert page numbers at the top of the page, right aligned, beginning with the title page.

Footnotes
Avoid using footnotes.

References and Citations
Use the Publication Manual of the American Psychological Association Fifth Edition citation and reference style. List references under the 1st level subheading,

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