

No Worries, Mate: A Forensic Psychiatry Sabbatical in New Zealand

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Sabbaticals were initially intended to take place one year of every seven and to provide an opportunity for study or travel. Psychiatrists rarely take sabbaticals, but they can be of tremendous value in widening professional and personal horizons. It is not merely the psychiatrist taking the sabbatical who reaps the benefits, but also the home institution and patients. Sabbatical-takers have an opportunity to learn across cultures, to experience a new system of medical care, and to develop a less provincial view of their work and indeed their place in the world. A sabbatical can be a time of substantial accomplishments, such as writing or reorganizing programs. In this article, the benefits of a forensic psychiatry sabbatical experience in New Zealand are described.

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For six years sow your fields, and for six years prune your vineyards and gather their crops. But in the seventh year the land is to have a Sabbath of rest, a Sabbath to the Lord. Do not sow your fields or prune your vineyards.—Leviticus 25:3–4 (Ref. 1)

Similar to the revitalization of the fields every seven years ordered in the Bible, sabbaticals were meant to be taken every seven years, to revitalize oneself. The logic was that if the field was left unplanted every seventh year, the crops would be sustained because the fertility of the soil would be renewed; otherwise, the yields would gradually decline. In American academia, sabbaticals have been a tradition since the 1880s.^{2,3} However, they are rarely taken by eligible physicians; one study found that less than one-sixth of eligible faculty at 19 medical schools had taken sabbaticals.⁴

The sabbatical can be a time to explore the field of forensic psychiatry in a foreign location and to learn more about oneself as well. Exposure to the practice of psychiatry and forensics in a different nation, with its differences in sociopolitical context, health care system, and lifestyle, can lead psychiatrists to step

outside of a potentially ethnocentric way of conceptualizing patients and evaluatees. It is a chance to broaden perspective and to enhance and creatively reflect on one's practice. It can provide research and writing opportunities and chances to forge international collaborations.

The benefits of the sabbatical may be difficult to measure objectively, as they often involve quality of life. Nevertheless, one study in which interviews were conducted with 70 medical school faculty members from seven institutions who had taken sabbaticals, as well as 15 who were eligible but did not take one, indicated that sabbaticals often have positive outcomes.⁴ Four-fifths viewed their experiences favorably and three-quarters reported a substantial accomplishment related to it, such as publishing papers or books or revamping teaching programs.

Researchers studied the effects of sabbatical leave for 129 university faculty members (and matched controls) in four nations, using questionnaires that addressed resource change and well-being. The authors found that taking a sabbatical leave decreased stress and burnout. The sabbatical-taking faculty experienced increased well-being and a gain in resources during the leave,⁵ including knowledge, professional advancement, independence, a sense of control, improved conditions of employment (e.g., coworker support), increased energy, and time.⁵

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Articles extolling the virtues of sabbaticals have been written in various disciplines, including family medicine and general practice,⁶⁻⁸ psychiatry,^{3,9} cardiology,¹⁰ anesthesiology,¹¹ surgery,^{12,13} and health care administration.¹⁴ Publications have discussed sabbaticals on various continents, including opportunities available in the United States.^{15,16} This article will focus on my forensic psychiatry sabbatical. It is my intention to describe some benefits of this gratifying experience, to help others in our field who are considering a sabbatical.

New Zealand by Way of Cleveland

I had always wanted to practice overseas in another culture, but thought that it would be impossible with a young family. However, when we became close friends with a family from Israel who were in Cleveland on sabbatical, we discovered that a sabbatical year, even with children, was not out of reach. Multiple family discussions were sparked about the potential benefits and difficulties of spending a year overseas and where we would want to go. In speaking with various mentors, I received (initially guarded) encouragement. Although others in my family are skilled in foreign languages, I am not, and thus my location possibilities were more limited than they might be for others. There has been a need for psychiatrists in New Zealand and Australia, and we considered both of these while learning more about their cultures. I initially considered locums agencies, but mentors encouraged me to liaise specifically with those groups that I would be interested in working with and learning from. At the American Academy of Psychiatry and the Law Annual Meeting in 2007, I met with Dr. Sandy Simpson, an invited luncheon speaker, who was a leader in New Zealand forensic psychiatry. Dr. Simpson prefaced his luncheon remarks with a traditional Maori introduction, then focused on the responses to cultural differences among forensic patients in this unique nation.¹⁷

After visiting both Australia and New Zealand while pondering the sabbatical idea, I became enamored with New Zealand's island nation and its cultures and intrigued by its mental health system. This small country had a self-supported national health system, and leaders had thought carefully about costs and prevention. I continued discussions with Dr. Simpson, who would eventually hire me for the year. Subsequently, my family set off on an adventure of a lifetime, and I found myself, an American forensic

psychiatrist from Cleveland, at the Mason Clinic in Auckland, New Zealand.

The Practicalities

Planning the sabbatical is critical to a successful experience.⁴ In the aforementioned interview study of medical school faculty, those who did not take sabbaticals described their reasons, including concern that their clinical areas would be adversely affected, that their academic advancement would be hindered, or that family or financial reasons would prevent their taking a leave.⁴ However, these concerns are not insurmountable and can be addressed through good planning and communication. Although many of us feel indispensable to our job or our academic institutions, we should all remember that no one is really indispensable. With some planning and communication, colleagues can and will absorb one's duties, including patient care, during a year-long absence.

Having specific objectives for the sabbatical is paramount. For example, one might seek to learn new techniques, write articles, complete research, study a novel part of the field, or gain experience that will allow modification of one's career on return.¹⁰ Personal contacts among those with similar clinical and research interests, as well as mentors and colleagues, can help in finding an appropriate position. The location of the sabbatical should be related to its goals,¹⁰ and judicious selection of a location is essential in gaining exposure to new ideas. From this perspective, sabbaticals have been conceptualized as a form of continuing medical education,¹⁸ and international exposure should actually assist in academic advancement.

Nuts and Bolts

Once you have committed yourself and your family to taking a sabbatical year, it's time to address nuts and bolts. Key considerations include family matters (children's age and schooling, spouse's position, and extended family), current position and the position one would pursue, licensing and visa, and financial matters, including salary and taxes, insurance, and property matters.^{8,15} One's family should be included in the discussion rather than overlooked or considered an impediment. Their expectations and experience will help define the success or failure of the experience. Practical challenges may be less com-

plicated for someone without family obligations, and some psychiatrists with children have pursued sabbaticals after their children have left home. Nevertheless, good planning and communication can make the sabbatical a good experience for all, rather than a seeming burden on one's family. Regarding positions for one's partner, often employers will assist in job searches, as they are keen to recruit psychiatrists. Or a partner may wish to spend the year obtaining additional training or following other pursuits. In addition to advice from future colleagues about schools and neighborhoods, we found that much could be learned about both via the Internet. We needed to visit in person before signing a lease, but, while still in Cleveland, we found the house online that we wanted to rent, near schools, work, and the beach. The children researched cultural and recreational opportunities online, and thus our first adventure would be Zorb-ing (rolling downhill in a human-sized hamster ball).

From the time of deciding to pursue the sabbatical (which was made subsequent to family discussions) to starting work overseas, less than a year of planning and paperwork was needed. American Board of Psychiatry and Neurology (ABPN) certification translated to New Zealand certification, but licensing and work visa paperwork took time. During that time, we met with the children's schools to plan a year's absence with a smooth return. The planning included deciding what high school courses should be pursued and finding out whether the Preliminary Scholastic Aptitude Tests (PSATs) could be taken overseas. School years in the southern hemisphere are from February through December, presenting another hurdle. Regarding work positions at home, with the support of mentors, discussions were held with my various supervisors and chair about plans for the sabbatical and for my return. I also discussed with colleagues how my various roles could be filled temporarily. Throughout the year, I planned to remain in touch with colleagues at Case and to continue to supervise research and writing projects.

What I Found When I Got There: New Zealand and Mental Health

New Zealand is an archipelago in the south Pacific about 900 miles east of Australia. New Zealanders are often referred to internationally, and often refer to themselves, as Kiwis, a reference to the flightless national bird. Polynesians, who became known as

Maoris, came in the 1000s, followed by Europeans in the 1600s,¹⁹ and others more recently. The English translation for Maori is the word normal; those of European descent are known as *pakeha*.

New Zealand has in recent history embraced its Maori heritage,¹⁹ in contrast with the United States and the Native Americans and Australia's experience with its aboriginal people. Kiwis of all extractions use Maori words in their everyday vocabulary. A critical concept is *whanau* (pronounced fah-now), which means one's extended family and support network. *Whanau ora* is a broader concept including interpersonal dependency and inclusiveness.

Currently, the nation's population is over 4 million people (and over 40 million sheep). The largest city is Auckland, the City of Sails, with a population of 1.5 million and more sailboats *per capita* than any other city on earth. The city has dozens of beaches, and ferries are a routine part of many people's commute. Shops often close at 6 p.m., a social convention that reflects a different work-home-family balance than ours. The population of New Zealand is 15 percent Maori and 7 percent Pacific Islander; however, forensic patients have a significant over-representation among minority ethnicities. Research indicates differences in diagnosis, phenomenology, and treatment experiences between Maori and *pakeha*.²⁰ The nation has a shortage of psychiatrists, and there has been an attempt to increase minority representation in the field.

New Zealand has a national health care system, and it is estimated that 17 percent of persons receive mental health care through their general practitioner (GP) or social services and that the 3 percent with greatest need (severe mental illness) receive care in the public mental health system. New Zealand is not a rich nation, but, along with Sweden and Canada, it is a top spender on mental health, at 10 percent of the health budget.²¹ New Zealanders have also been pioneers in the recovery movement. Progressive services throughout the country include early psychosis intervention, maternal mental health, and refugees-as-survivors services, in addition to specific cultural services.

In the 1980s, prompted by high-profile violence and suicides by mentally ill persons, the government commissioned an inquiry into the mental health services, led by Judge Ken Mason. The Mason Inquiry established a model of forensic mental health care, considering the appropriate institutional locus for

forensic psychiatric services, and moved care for patients from prisons to hospitals.²²

The Forensic Psychiatry Experience in New Zealand

The Mason Clinic, created in response to the governmental inquiry, is the forensic hospital serving the Auckland region and has the largest forensic service in New Zealand. It sits at the bottom of a hill on the grounds of a former psychiatric hospital, the rest of which has been repurposed into a university, bustling with students. Forensic patients of ethnic minority descent are often plagued by poverty and alienation, and a disproportionate number have serious mental illness and offending histories.¹⁷ The clinic has sought to address cultural identity throughout the forensic psychiatry service. Its services have been recognized with an award for quality.²²

Mason has eight units, each named after native trees, and, except for the intellectual disability unit, patients move progressively through the units. A section purposely built by Maori for Maori patients offers critical cultural rituals of engagement and communal living.¹⁸ Recovery occurs in the context of identity and culture, and *whanau* are implicitly involved. Patients participate in occupational rehabilitation, development of independent living skills, and learning of *kapa haka* (Maori performing arts), and they reintegrate into the community in eye-opening ways. Traditional healing is considered complementary to forensic psychiatric treatment. Given a patient population with psychotic disorders and violent offenses, forensic treatment outcomes have been impressive, with a median length of stay of three years. A follow-up study found that, after 7.5 years, half of the discharged patients were employed and half were living independently, and, only 19 percent had been readmitted to the hospital.²³

Mason has over 400 staff (many of whom are of Maori or Pacific Islander extraction) and approximately 100 forensic patients. Mental health treatment teams include psychiatry, psychology, social work, nursing, and occupational therapy, as well as cultural advisers and *kaumatuas* (elders). Every patient has an identified key worker who is a treatment collaborator throughout the patient's recovery process. Trainees include medical students, house surgeons (similar to interns) on three-month rotations, registrars (similar to American residents, on half-year-long runs, getting to know fewer patients but

knowing them more intensively), and advanced trainees (for two-year forensic fellowships).

Colleagues considering sabbaticals have asked about the differences between American and New Zealand mental health law. The New Zealand Mental Health Act for commitment is similar to American civil commitment criteria, but it includes compulsory treatment for those who are involuntarily committed. Mental Health Review tribunals hear psychiatric testimony and, with the goal of therapeutic jurisprudence, determine whether patients are fit to be released from compulsory status.²⁴

As one concerned about practicing in a different legal system, I found that, in many areas of local forensic practice, American forensic skills translated well. Competency to stand trial (referred to as fitness to stand trial) standards were similar to those in U.S. law. Mental impairment may render a defendant unfit because of inability to understand the nature and consequences of the proceedings, conduct a defense, or instruct counsel. Insanity law (referred to as criminally responsible or not) was similar to the *M'Naughten* progeny, with moral wrongfulness made explicit. Mental illness or intellectual disability had to have rendered the defendant incapable of knowing that his act was morally wrong or of understanding the nature and quality of the act. Colleagues in New Zealand were welcoming and appeared as interested in learning about American forensic psychiatry practices as I was in learning about theirs.

Of particular note was New Zealand's infanticide law, which is unique throughout the world, in that it is partially excusatory of mentally unwell mothers who have killed their children up to 10 years of age.^{25,26} Women may be found guilty of infanticide, rather than murder or manslaughter, and incarcerated for up to 3 years or detained in a forensic hospital. As a scholar of filicide, I had learned about New Zealand's infanticide laws, but had not seen them in practice. Despite America's not having specific infanticide laws, I was led to further contemplation of the utility and appropriateness of such laws. The interested reader is referred to Friedman *et al.*,²⁶ wherein a New Zealand colleague and a Cleveland mentor and I discuss the subject.

Other aspects of practicing forensic psychiatry in New Zealand were fascinating and professionally gratifying, such as learning about different cultures and beliefs about mental health and balance, living in a nation where an American accent allowed different

transference, and discovering the differences in thinking in a place where there is a debate about whether police should be armed (contrasted with our Second Amendment). Interesting national murders and trials were discussed on all sorts of media during my sabbatical, including the case of a psychiatrist convicted of murder,²⁷ who, because of the smaller number of psychiatrists nationally, was known personally by many colleagues. Even the unit milieu was exciting and energizing: my forensic unit had a cat, and forensic patients approaching discharge readiness went on camping trips, routinely shopped and cooked for the unit, and took trips with cultural advisers for healing. This experience particularly helped refocus my thinking on our rehabilitation and reintegration goals for forensic patients in the United States.

Final Thoughts

When years of practice have led to apathy and disenchantment, “. . . some take to alcohol or love affairs, but a safer remedy is to take sabbatical leave.” (Ref. 8, p 644). If one is struck by the sameness of it all, a sabbatical can help prevent burnout. Sabbaticals can enhance not only the adventuring psychiatrist’s own practice, but our collective practice. On a personal level, I found New Zealand breathtaking. Regardless of where the sabbatical is taken, it should be considered an opportunity to learn and grow, to gain invaluable opportunities in cross-cultural forensic psychiatry and experience in another effective mental health care and legal system, and to meet and collaborate with brilliant new colleagues. If you go to New Zealand, you can do all of this within a kilometer of the beach. *Carpe diem.*

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