ShrinkRAP

Newsletter of the New Zealand College of Clinical Psychologists
THE SPECIALIST ORGANISATION FOR CLINICAL PSYCHOLOGISTS

ISSN 1174-4251 (Print)
ISSN 1175-3110 (Online)

Ko Takurua kei runga, ko Puanga kei runga. He Taonga te Makariri.
'Tis Sirius on high, 'tis Rigel on high. There is value from being exposed to the cold

NZCCP Membership News
At the National Executive meetings since the ShrinkRAP Autumn 2016 edition was published, we would like to welcome the following people in the following categories:

Full Members of the College:
Averil Abbott, Auckland
Cherie Benns, Christchurch
Kelly Birkett, Christchurch
Elle Black, Auckland
Hannah Blakely, Christchurch
Lauren Callow, Wairarapa
Rosemary Carson, Christchurch
Allanah Casey, Wellington
Maria Chalmers, Nelson
Jacqueline Chari, Auckland
Sophie Dickson, Wellington
Kathryn Dorgan, Auckland
Christina Faalago-Lilo, Auckland
Virginia Farnsworth-Grodd, Auckland
Jodi Field, Palmerston North
Marjolijn Guicherit, Auckland
Eve Hermansson-Webb, Auckland
Stephanie Kennerley, Auckland
Jaimee Kleinbichler, Christchurch
Anna Miller, Auckland
Jessica Morten, Wellington
Rewa Murphy, Wellington
Phoebe Naismith-Thomass, Wellington
Helen Rowse, Wellington
Vineetha Uthamaputhiran
Susan Yates, Auckland

As a Full Member, each may now use the acronym MNZCCP.

Associate Members of the College:
Aleisha Atkin, Wellington
Anna Campbell, Dunedin
Milesa Cepe, Christchurch
Mary Clark, Wellington
Nicola Crook, Wellington
Wendy Cuthbert, Wellington
Amanda Drewer, Hamilton
Amber Fletcher, Tauranga
Alexandra (Timi) Horne
Vandana Kapur, Christchurch
Charlotte Levings, Auckland
Joanna Lothian, Christchurch
Shekinah Manning-Jones, Wellington
Amy Montagu, Auckland
Aimee Peacock, Dunedin
Aisling Sheehan, Christchurch
Esther Vierck, Christchurch

The National Executive wishes to congratulate these people on attaining their new membership status.

Our new members might like to know of a few of the many resources, which members find particularly useful, as follows.

Access to excellent Indemnity Insurance with the Medical Protection Society, which provides inexpensive professional indemnity including access to legal advice and representation in the event of a hearing. The Medical Protection Society also facilitates a free EAP style counselling service for members who may be having difficulties or issues in their personal or professional lives, that can't be addressed during supervision

sessions. MPS can be contacted on 0800 22 55 677. (If you are not already a member of MPS you can download the MPS membership application form here.)

Access to the EBSCO Publishing online Psychology Research Database which is available free to all College members. This provides unlimited remote access to their Core Psychology Research Package containing Psychology & Behavioral Sciences Collection, MEDLINE with Full Text, and Mental Measurements Yearbooks with Tests in Print.

As a member of NZCCP you can register as a user of the website at this link or you can click on the following link: http://www.nzccp.co.nz/profile/register ; and while there if you want your private practice details published please add as many details as you wish to include in the "Professional Details" field. Once you have been authorised as a College member you will have full access to the EBSCO journal database and, if appropriate, your private practice details will be published in the "find a clinical psychologist" resource for the public.

For more information about these and other resources available to College members please go to **http://www.nzccp.co.nz/membership/**

Membership renewals
These are now overdue. If you haven't done so already please go to http://www.nzccp.co.nz/membership/nzccpmps-membership-subscription-renewal/ to renew your membership now.

Journal NZCCP
The themes for the next Journal NZCCP issues are:
Culture, published December 2016, deadline 30 September 2015
Trauma, published June 2017, deadline 30 March, 2017
Leadership, published December 2017, deadline 30 September 2017

If you have (or know of someone else who has) an interest in any of the above themes and

- could write an article, or
- do a literature search, or
- if you could review a conference or workshop you've attended, or
- review a book or article you've read, or
- if you are aware of some good online assessment measures or apps, please contact Caroline at office@nzccp.co.nz.

If there is a book you want to read and are interested in reviewing it, Journal book review editor, Dr Charlene Rapsey (charlrapsey@gmail.com), may be able to get you a free review copy.

Please don't forget that we are always keen to receive and publish letters to the editor, and encourage all students to submit articles, case studies, book reviews, commentaries on a set of abstracts, reviews of conferences or workshops and students whose submissions are published are paid $100.

We look forward to seeing your wonderful submissions (which can be submitted online here: http://www.nzccp.co.nz/about-the-college/publications-and-resources/journal-nzccp-article-submission/)!

Members in Leadership roles
As part of our Strategic Plan and focussing on supporting our membership, one of the areas of focus is to **build the leadership capability of our members**.

As part of this interviews with NZCCP members who have moved into leadership roles will be regularly published in ShrinkRAP, as a way of sharing information about pathways into leadership. In this issue we are delighted to include insights from ***Rob Devereux.***

1) What leadership roles do you currently hold?

I am currently employed as the Principal Psychologist for the Department of Corrections Dunedin Psychologists' Office. I am currently responsible for leading and managing 13 staff members, 11 of whom are psychologists (or intern psychologists). The Dunedin Psychologists' Office provides Correctional psychological services across South Canterbury, Otago, Southland and Central Otago. Two of our psychologists are based permanently in Invercargill (and as a result are largely managed remotely) while all of our other staff currently operate out of Dunedin.

Principal Psychologists in Corrections are generally involved in wider leadership roles in addition to leading and managing their own teams. For example, I am actively involved in various Departmental forums or working groups at both a district, regional, and national level.

2) How did you end up as a leader, what path took you that way?

Prior to taking on my current role in 2014, I had worked full time as a clinical psychologist for 18 years. Sixteen of these 18 years had been working with the Department of Corrections. In 2000 I took on a permanent role running a sole positon satellite office for the Dunedin Psychologists' Office in Invercargill. I think that the isolation and associated high level of independence of this position helped to foster a skill set that promoted movement towards wanting to take on leadership positions. Outside of work I was involved with community organisations and helped organise a large number of weekend events. At work I was a PSA delegate for a long period of time and was involved in numerous rounds of national contract bargaining. I volunteered for a variety of tasks and opportunities and completed the Department's Future Leaders (now Emerging Leaders) Programme. I took on responsibilities including volunteering for Acting Principal Psychologist positions and in the months leading up to getting my current position I had accepted a four month secondment to an Acting Principal Psychologist's position in Rimutaka Prison (Wellington region).

3) What extra training did you undertake, if any? What was it like "learning the ropes"?

I had undertaken the Department of Corrections Future Leaders Programme some years earlier to starting my current role. However, it would be fair to say that most of "learning the ropes" has been on the job. When asking other Principal Psychologists how long it had taken them to learn and become comfortable in their roles, most indicated at least a one to two year period. From experience, I think this was a fair estimate.

There are always challenges with starting out in leadership roles when everyone knows that you are just starting out and are inexperienced as a manager. The challenges can become amplified when you start to shake things up and make changes to the way things have previously been done. These situations can be challenging to everyone and can, at times, cause distress. However, these situations also generally provide opportunities for teams to question how things have previously been done and to grow and develop new ways of working together.

The key things that I have learnt along the way is to use the mentoring, advice and support of colleagues that have either had (or are currently having) the same experiences and challenges. The other key challenge has been learning to manage operating in environments of constant change. In the brief period of time I have been in this positon, we have encountered significant changes to our operating environment. For example, we have undergone a Departmental restructure, government has passed significant new legislation which has had a direct impact on the work that our psychologists undertake, and there is a constant desire for new innovation and undertakings (which creates both opportunities and challenges).

4) If you have had any "failures" along the way, how have you dealt with these and what did you learn from them?

Managing staff always brings its own challenges and there are always situations that, when reflected on, you realise could always have been handled in a different and/or potentially better way. The key thing I have learnt is to reflect on these situations and to take key learnings from them. I cannot emphasise enough the need to consult with others (e.g. more experienced senior colleagues, supervisor, manager, HR, National Office etc.) when unsure of the best way to progress a challenging situation and to actively accept the support that others can offer during these times.

Other key learnings have included knowing when and what to delegate and learning how to best prioritise tasks and demands. When I first entered this role I ended up working some really long hours, trying to do everything at once. I have had to learn to accept that it's not always possible to do everything, especially during times of high stress and challenge!

5) Who supported or encouraged you as you entered leadership roles?

I have been lucky to have had the support of my partner who (albeit somewhat reluctantly) agreed to relocate to Dunedin so that I could pursue my current role. I have also had great support from within the Department both at a local, regional and national level. In particular, the other Southern Regional Principal Psychologists' have been a constant source of support and inspiration.

6) What advice do you have for clinical psychologists considering moving into leadership roles?

While I am extremely supportive of psychologists' making this move, I think that it is important that is that people are doing it for the right reasons and that they are also aware of what aspects of their previous roles they will be giving up.

I think that psychologists thinking of moving into a leadership roles need to reflect on why they wanting to make the move and why do they think that moving into a leadership role is the right fit for them.

For example, movement into leadership roles may not suit someone who still wants to retain a lot of direct clinical client contact. Additionally, I think it is important to question how comfortable you are with taking on the responsibility of leading, guiding, managing and developing other people and their careers.

However, if someone is in a position where they are comfortable leaving the frontline world of client contact and are excited by the challenge of leading others (and don't mind the inevitable paperwork and stress that goes with these roles), then I think moving into a leadership and management role is an excellent idea. I certainly believe that psychologists have a large number of transferable skills that can assist with the transition to leadership and management roles.

7) What do you see as important skills/competencies of leaders?

There are a lot of ways of looking at and answering this type of question. Obviously, being organised and having effective and efficient systems is essential to surviving in any busy and demanding roles. However, in my opinion, leaders need to be able to help motivate, guide, develop and shape others' behaviour, attitudes, competency and practice. Leaders need to be able to see the bigger picture and to think strategically. They need to recognise talent and provide opportunities for staff to develop and to be stretched. They also need to know when to provide additional support to staff and when to simply get out of the way and let staff get on with it! I believe that good leaders demonstrate commitment, integrity and respect when dealing with staff. They create an environment and atmosphere where staff can thrive and feel valued for their work and where they understand that their contributions matter. This is especially important in workplaces where the work is tough and the demands are high.

Additionally, I think that one of the most important things for a leader/manager to do is to spend time and attention to developing the right team who radiate the 'right values'. A team with unified staff who embody a professional and responsible attitude are extremely valuable to a productive, efficient and happy office environment.

8) If yours is a management role, to what extent does it require leadership skills or tasks?

I view leadership is an integral part of my current management role – but leadership is not something that can be done in isolation. The development of a senior staff "leadership team" who also embody a sense of leadership, commitment and authority within the team is an extremely important aspect to running a happy, functional, supportive and efficient team. I could not do most of what I do in my current role if it was not for my senior leadership team and the roles and responsibilities that they shoulder on a daily basis. ☺

Member's letter to the Minister of Health

Wellington member, Annemette Sorensen, has sent the following letter to the Minister of Health. This will also be tabled at the next Psychology Workforce Taskforce meeting on 23 August.

Annemette's letter emphasises the importance of funding for psychologists and psychological services and notes that research shows how effective it is when targeted well.

The NZCCP Executive welcomes more information from members from around the

country to add to this data so as to more effectively support the Ministry of Health's planning around increased provision of psychological services into primary care.

Dear Minister,

- ***Funding cuts to mental health/psychotherapy in PHO settings***
- ***Disparity in psychotherapy provision across different mental health settings***

I am a clinical psychologist in private practice. I see adolescent and adult clients who struggle with a variety of mental disorders and distress, ranging from mild to severe. I am writing this letter to express my bewilderment and concern about the ongoing funding cuts to the provision of mental health/psychology/psychotherapy services through the PHO organizations, as well as the disparity in funding for psychotherapy in different settings that provide mental health treatment, and to ask that these matters be addressed.

I have taken referrals from two PHOs in the Wellington region over the past nine years, and from a third PHO for the last couple of years. Initially clients were referred for six therapy sessions; such a 'package of care' (POC) could be supplemented with a second POC when required. Thus a client with moderate to severe mental health issues could access up to 12 therapy sessions. This is supported by research that suggests that between 10-20 therapy sessions provide significant mental health improvement for most people[1]. Over recent years, however, these sessions have been progressively reduced. Current practice is now that one PHO will only approve 4 therapy sessions, another PHO will approve 5 therapy sessions, and the third will approve 6 therapy sessions. Initially all PHOs were flexible with approving a second POC if recommended and requested by the treatment provider; as of now, two of these PHOs have become entirely inflexible in this regard, and I fear the third one will become so as well. They are all citing that they have experienced significant funding cuts, especially over the past 12-24 months. This is of great concern from an ethical point of view. Four to six therapy sessions for major mental health issues (anxiety and depressive disorders, trauma disorders, obsessive-compulsive disorders, impulse control disorders, etc.) is - to use a medical comparison - like putting a band-aid on a broken arm.

Six, and sometimes even just five or four, therapy sessions may be adequate for a client who suffers from anxiety or depression at a milder level, and who is generally a well-functioning trusting individual with the capacity to reflect psychologically and coherently. It is absolutely not enough for a client with moderate to severe mental health difficulties. Part of their unwellness very often relates to issues of mistrust. Even an otherwise well-functioning individual requires a couple of sessions to develop a trusting connection with a psychotherapy provider; it goes without saying that those who suffer severely (often on a background of neglect, abuse, mistreatment), require at least 4-5 sessions just to develop a sufficient level of trust that will enable them to open up about the issues that drive their symptoms. Many are often not ready to open up about a significant trauma until, say, session 10. As it is the unresolved trauma that leads to mental health symptoms, it is obviously vital that it gets addressed.

Thus it is a fact that even 12 therapy sessions are not enough to get the desired results for traumatized individuals. But I accept that there may be a limit to public funding (but why funding for physical health treatment is so much greater than mental health, and specifically psychotherapy, treatment, I don't understand but that is another issue). But a lot can be achieved with 7-12 therapy sessions for a majority of people.

If the reason for the funding cuts were because other and better services were put in place elsewhere, then that can only be applauded. However, I have not seen or heard anything that would suggest that to be the case. I hear daily from colleagues, clients, friends, and friends of friends, that referrals to DHB mental health services primarily consist of medication treatment and a push for early discharge, and that clients have to access psychotherapy privately. Yet, psychotherapy is consistently the treatment that most clients are seeking[2], and what the research shows as being highly, and often most, effective[3].

ACC funds therapy for people who have suffered from sexual abuse/assaults. What is really positive is that ACC seems to have ample funds to do so. Thus a client does not

have to make do with 4-6 therapy sessions; there are funds to provide for psychotherapy until clients have achieved wellness again. This is as it should be. But what about the clients who suffer from severe anxiety, depression and trauma for reasons other than sexual abuse/assaults? Why are they not entitled to the same level of treatment?

In summary, I am drawing your attention to the issue of significant differences in funding of psychotherapy between ACC and PHOs, and specifically the funding cuts to PHOs over the past couple of years. To repeat: PHOs vary from one another with regards to the now very few sessions they fund for clients; ACC provides ready access to psychotherapy for sensitive claims clients for as long as is required for the client to improve, while mental health services don't (there are significant waiting lists for very few in-house psychologists in, for example adult community mental health teams). Why is the provision of psychotherapy for mental health issues not being provided in an integrated, equivalent and consistent manner across these three settings (PHO, ACC, mental health services)? And what justification is there for reducing psychotherapy to 4-6 sessions for clients, who, in many cases, have very significant mental health issues, including suicidality?

Finally, I want to make it very clear that I am not dependent on referrals from the above agencies. In fact I have chosen to discontinue or to take minimal referrals from the agencies due to concerns I have outlined above. I get more private referrals than I can accommodate. I am writing this to express my concern about access to reasonable packages of psychotherapy for the groups in our society who don't have the means to pay for such (the young, the unemployed, the low-income families who are struggling to pay day-to-day bills). I ask that the matter be given urgent priority.

I look forward to your response.

Summary of the Psychology Profession Advisory 24 May 2016

Representatives of the New Zealand Psychologists Board, the New Zealand College of Clinical Psychologists, the New Zealand Psychological Society, the DHB Professional Leaders, university Heads of Department, and training Programme Leaders attended this half-day meeting in Wellington.

Cultural Competence (*Updates re each organisation's cultural competence activities)*
A brief update was provided on the Board's establishment of two "Cultural Advice Reference Groups" It was noted that more nominees are required for the Maori group.
The Society noted that each chapter of the Professional Practice book, which will be launched at their annual conference in Wellington on the 2nd of September, has a strong cultural component.

The HoDs reported that:
- The NZQA are looking at changes to provide NCEA credits for psychology in secondary schools. This would likely make such courses more popular for students.
- The government has announced an increase to health research funding, and psychologists should consider applying for some of it. Partnerships between universities and DHBs might be particularly effective.

The DHB Professional Leaders reported that:
- They met 2 weeks ago.
- Presentations were made by Malcolm Stewart (on organisational change) and Tina Earl (updated on Te Pou Stepped care toolkit progress).
- Primary care funding is variable, and early intervention requires training, time, and supervision. There is a high dropout rate without adequate support.
- There has been a lot of concern/discussion around the use of electronic records and issues of confidentiality and storage of psychological data.
- ACC sensitive claims contracts have been taken up by some DHBs, but have not proven as lucrative as anticipated and implementation has had its challenges.
- There was discussion re models of care, CAPA, and single points of entry.
- The Ministry of Health has published a Practise Note for ASD Assessments but has provided no funding for further training.
- There has been a substantial recent increase in numbers of referrals of transgender clients, with limited expertise around the country of this specialist area.

The Board reported*:*
Family Court issues/meetings – A very helpful meeting with the Principal Family Court Judge (Lawrence Ryan), lawyers for the indemnity insurance schemes, and Family

Court Report Writer representatives was held on April 26th. Solid progress was made on an agreement for the managing complaints where the related case is still active in the court. Subsequent discussions have resulted in new legal advice being obtained, stating that the Board is able to withhold some information (where there are good reasons to) from complainants. This will largely eliminate the related obstacle practitioner's faced in putting forth a full defence to a complaint. The advice will be published soon (including on the Board's website).

Neuropsychology scope consultation (Round 2) – Having decided after the first round of consultation that a scope of practice for neuropsychology should be established, the Board will consider approving a second consultation document for publication later this week. The document will outline a number of proposals for the scope, including: a description, a title, the qualifications required for registration, the core competencies, and a process for managing grand-parenting applications.

Best Practice Guideline development – The next draft of the "Coping with a Client's Suicide" guideline (which is really more of a "resource document than a best practice guideline) will be considered by the Board this week. We will then seek the input of a Coroner, and the resource should be ready for wider consultation in late August. The "Informed Consent" guideline is also being reviewed in light of recent feedback from Family Court Report Writers. The Board will consider at their meeting this week what areas of practice should be prioritised for future guideline development, and would welcome any suggestions or recommendations.

International Project on Competence in Psychology – The IPCP Working Group has recently published the final *International Declaration on Core Competences in Professional Psychology*.
The Declaration has been sent to the broader project Reference Group, and to the two supporting organisations (IAAP and IUPsyS). A final report is now being prepared and it is expected that a website will be established (likely under IAAP auspices) to promote the declaration. Indications are that the IUPsyS and IAAP will both formally adopt (or endorse) the Declaration at their meetings in Yokohama in July.

Unexpected increase in number of HPDT referrals – It was noted that there have already been more charges (3) referred to the HPDT in the first two months of the financial year than were budgeted for the entire year. This may pose a financial risk, and could lead to an extraordinary disciplinary levy if the hearings prove costly or if there are more cases referred later in the year.

MoU with the Psychology Board of Australia renewed – The Board recently renewed its (2012) MoU with the PsyBA for a further three years (2019).

The next PPAF meeting will be held on 23 August 2016.

Summary of the Psychology Workforce Group (PWG) meeting 24 May 2016

Representation on PWG

Anne Goodhead has decided that she will no longer routinely attend these meetings.

Internships

- HWNZ psychology internships have been clearly ring fenced.
- There was discussion about various models of funding psychology internships. Development of a national training model would be very complicated, given the different requirements of the students, clinical programmes and variations across the DHB employers compared to other groups such as medical students. There is minimal funding allocated at present compared to other groups, and any changes will take time.
- Focus on encouraging DHBs to recognize the value of interns as the future psychology health workforce.
- We are also looking to link with government key initiatives that need psychologists, as this generates a resource pathway.

Future of Psychology Initiative-website/Facebook page
This has been actioned with the development of an identical FPI web page on each of the NZCCP and NZPsS websites that includes, as a starting point, the content of the pamphlet that Malcolm produced.

Psychology Workforce Taskforce Group (PWTG)

Pithy statements

- Workforce members are developing brief summary statements of what psychology brings to the health workforce, and the values of the various speciality professions. These have been completed for clinical and educational psychology, and will be done for health, counselling, neuropsychology and Corrections for the next meeting. These will provide clear statements about the profession of psychology as a flexible and effective resource, and the information will be formatted and cross referenced so that they can be used widely.
- It was suggested that focus groups such as service users and managers / DAHs/ planning and funding be utilised to provide feedback.
- This is an opportunity to clearly highlight the psychology profession and what we can offer. Providing concise information about the different types of psychologists and scopes will provide clarity.
- Use of vignettes was suggested to highlight the effectiveness of psychological treatments and the benefits to consumers of effective treatment. Using case studies of psychologists in clinical leadership roles was another idea.
- Primary care is an important area to target, as a current national health focus. Tina Earl from Te Pou will be invited to contribute to this as it fits with the work she has been doing on Stepped Care.

Workforce data collection

The current psychology workforce data is being summarised. The response rate was 43% but this still provided important current information on various areas, including interns and placements. The Werry Centre has done a stocktake of the Child & Adolescent workforce to add to the picture. The aim is to combine this information with other available information such as that held by the Board to develop a good model of psychology workforce dynamics that can be used to assist future workforce planning.
Demographic information confirmed that males and Maori /Pasifika are under-represented in some of the workforce.

The Psychologists Board is discussing with HWNZ the revival of an annual workforce survey as part of APC renewal.

Tasks from the PWTG

1. Explore the medical student model used in the DHBs and will also talk to the RMA coordinators and to Tony Crane at HWNZ to get more information.
2. Investigate the centralised internships/registrar systems for psychology trainees used in US and Canada.
3. Finalise and circulate the summary of the current psychology workforce survey data for comment.
4. Draft a report that summarises the outcomes of the Key Informant project to gather information about current and projected workforce gaps.
5. Review the tools for psychological therapies and stepped care model on Te Pou website and approach Tina Earl at Te Pou to get a brief summary of relevant information.

Māori and Pasifika Workforce Issues

- Le Va has managed to secure some extra funding for psychology positions from the Pacific provider arm.
- Moana Waitoki and Luke Rowe are organising a hui in Palmerston North for Māori psychologists.
- The first full-time Māori staff member has been appointed to the clinical staff at Auckland University.
- VuW has introduced scholarships from the inequity fund to go towards fees for Māori and Pasifika students. In addition, VuW is providing greater support for the bicultural components of the programme(s) and is also working towards fostering Māori and Pasifika undergraduate students. Of note 4 of 11 in this year's intake into the VuW clinical programme are Māori and Pasifika.
- Denise noted that there 14 funded Pasifika psychology students.

Other business

- A query was raised about **e-therapy** and it was noted that there are guidelines for this on the Psychologists Board's website.

- The review of **Voluntary Bonding** was discussed briefly and it was agreed that submissions should be made focussing on the hard-to-staff work areas such as Corrections.

Next meeting: Tuesday 23 August 2016.

ACC/NZCCP/NZPsS liaison meeting, 7 June, 2016

Issues for Discussion

1. ACC policy for cover of Suicide
2. Funding for/ Access to DBT through DHB Mental Health Services
3. Increasing access of sensitive claims services to Asian persons
4. Clinical Psychology students working on ACC contracts

ACC Policy for Cover of Suicide

Summary of legislation

- Cover accepted for physical injuries caused by wilfully self-inflicted injuries. If no physical injuries then cover declined.
- Entitlements such as weekly compensation usually not payable
- Entitlements apply if the person likely did not have the cognitive capacity to form intention to harm self.
- Entitlements may also be payable if the wilfully self-inflicted injury or suicide arose from a mental injury which ACC has covered or would have covered in the case of sensitive claims.

What needs to be considered under cognitive capacity?

- Nature and extent of mental health problems
- Were they receiving Compulsory treatment under the Mental Health Act?
- Was there temporary cognitive incapacity via significant drug and/or alcohol ingestion – inability to form a clear intention to harm themselves?
- Client age

Discussion for funding for/access to DBT through DHB Mental Health Services

Several DHB's are in the process of contracting with ACC and this is a means by which ACC clients can access DBT. ACC recognises the need to be flexible when contracting with DHB's in order to accommodate the existing DHB processes.

Increasing access of sensitive claims services to Asian persons

It was noted that there is not a lot of understanding in Asian community about the services ACC offer and the uptake of Asian people low especially with regard to the Integrated Services for Sensitive Claims (ISSC) service.

The ACC Asian Advisors have commented that there is significant under-reporting among the Asian community with regard to both sexual and family violence often associated with shame and guilt. There are cultural values associated with disclosure and a lack of acknowledgement among the Asian community as to the extent of family and sexual violence. The ACC Asian advisors are active in working with Asian clients and often play a crucial role in this population accessing services. Sometimes the services offered by ACC are difficult for clients of Asian background to access due to family and community pressure not to disclose and language barriers. ACC, through the cultural advisors and Injury Prevention are trying to work more closely with the Asian community.

Clinical Psychology students working on ACC contracts

There is now the capacity for ACC suppliers to take on clinical psychology students to work under the following contracts

- Neuropsychological Assessment Services
- Psychological Services
- Concussion Services
- Pain Management Psychological Services

Please contact ACC for more information about the conditions under which this can occur and the process of application

NZCCP/NZPsS Member Issues

Clients with active physical injury and sensitive claims: An issue was raised about the difficulties with these claims being separately managed by different parts of ACC.

There are historical reasons for doing so with the main reason for this separation being to restrict the number of people looking at a client's sensitive claim information. This was in response to clients being concerned about the number of people who might have access to their sensitive claims information. As with every solution, there are also downsides and it is acknowledged that this separation of claims and the management of them can lead to fragmentation and less than optimal

service. This issue has recently been raised in the Clinical Governance Committee and is currently being debated. The BAPs have access to both the sensitive and physical injury claims and are often consulted to look at both claims together to ensure that a client's assessment and rehabilitation is considered with respect to both the physical and sensitive claims.

Concerns were expressed regarding the slowness of responses from Service Coordinators, their level of experience and knowledge, provision of the correct documentation for assessments, and difficulties with accessing clients' medical records.

The concerns outlined in points have been repeatedly raised in ACC/NZCCP/NZPsS meetings and have been conveyed to the Sensitive Claims Unit. A recent review of the Sensitive Claims Unit has been undertaken by an external research company and ACC's clinical reviewers have been around the country interviewing suppliers. This has led to a wealth of information and the concerns mentioned above have been verified. The reports have been sent to management who will provide a response and ultimately an action plan. In the interim, there is very little to report except that we hope to discuss the findings in the next ACC/NZPsS/NZCCP meeting.

Thank you all very much for your patience while the Sensitive Claims Unit is working through these difficulties. Some of the problems which have arisen are due to the much higher than expected number of claims since the Integrated Services for Sensitive Claims contract was introduced in November 2014.

I have an issue about updated the well-being plan. It is paid by .5 hours however it is not realistic to write an updated, meaningful report in such a short time

We acknowledge this and some communications were sent out recently to suppliers that a new wellbeing plan needs to be submitted every 12 months to ACC and we will pay up to 2 hours for each of those plans. An update to a Wellbeing plan is required only if there are minor changes to the original plan at some stage throughout the 12 month period.

<u>Who owns reports written for ACC after an assessment has been completed and accepted by ACC?</u>

ACC owns the report. Copies of reports are not routinely sent out to clients and providers – rather this is done on a case by case basis taking safety into consideration and client privacy. ACC is currently looking at ways by which client permission can be secured at the time of the assessment for the lead provider to receive a copy of the assessment report when it is completed in those cases where the lead provider is not the assessor. Clients can request their reports but there will still be a safety/risk assessment to ensure that the client accesses the report contents in a way that does not compromise their safety.

<u>DNA's for Integrated Services for Sensitive Claims (ISSC) Getting Started</u>

This was a discussion point at the original Supplier Training back in October 2014. With the up to 2 hours for Getting Started, there is always a "risk" that a client will attend the first hour, and then plan to come back for the second hour to lodge the form. If the client does not attend and there is no engagement form lodged, then there is no ability for a provider to invoice for a DNA as there is no claim. A claim (engagement form) can only be lodged with the explicit consent of the client. It is important to ensure that as a Supplier / Provider appropriate steps are in place to ensure that clients are reminded of their upcoming appointments.

<u>Is it possible for psychologists to receive a copy of the Branch Advisory Psychologist Comments?</u>

The Branch Advisory Psychologists are looking at ways by which they can directly and routinely send Branch Advisory Psychology comments to the assessors. Currently, due to privacy policy, the comments needs to be sent out in a WinZip file format which can result in up to four weeks delay in sending out the comments. The use of Email toolkit potentially gets around these problems and the Branch Advisory Psychology team is looking at ways by which this technology can be used in the near future. It is most likely that in the future that there will be the opportunity to send out the Branch Advisory Psychology comments in a routine and timely manner and we will provide updates regarding this.

ACC Sensitive Claims Advisory Group (SCAG) meeting, 2 June Wellington

Update on Sensitive Claims Unit, how is the ISSC going, and chance to meet the Staff

The ISSC is a tailored service that was developed in collaboration with victims, professionals, sector and ACC staff. Designed to meet requirements of clients to have access to the service with no barriers and provide pre cover assessment without having to go through specific channels.

- Claims that come into the unit are reviewed through the Triage and Allocations team. Approximately 30% of claims are coming through as an ACC45 (lodged by Doctors or the DHB's). (5-10% closed following initial communication and or multiple attempts to call as the client does not wish to engage in the service) and 70% are engagement forms. The client can come back into the service at any point and reopen their claim if they wish to engage – information on accessing the service (www.findsupport) at a later stage when the client is ready is provided by mail with the letter closing the claim.
- Adverts and cards with information on the ISSC are being rolled out to GP's in a new initiative. This includes the findsupport details on GP wall planners (approximately 10,000) across the country, and also a re-print of the original client centred brochure, a translated version into Te Reo, and a wallet sized card with contact details for young people.
- Category alongside our Clinical Services Directorate are holding a breakfast session on demystifying mental injury at the two forums in June (Rotorua) and August (Christchurch) which gives an overview of all our mental injury services, and clarifies the ISSC service and how clients can access via their GP's.
- Acknowledgement of the service provided by Service Coordinators in SCU over the last 18months has been absolutely amazing
- Child and adolescent claims are managed a bit differently to the adult claims, and that is around the increased risk associated with these claims, that there are often more parties (Schools, CYFS etc.) involved with the claims and therefore these are allocated immediately to a Service Coordinator to be managed in one of the two C & A teams in the Unit.
- All claims that are lodged are reviewed / triaged for a number of risk factors, assistance from ACC requirements, and then are allocated to a Service Co-ordinator once ACC receives the Early Planning report.
- Query by an attendee as to whether ethnicity is considered during the allocation process as they were unclear as to when the client can advise of cultural needs. ACC advises that ethnicity is not looked at when it comes to judging the priority or allocation of a claim. However, ACC will consider the request by a client for a "particular" Service Co-ordination initial engagement is currently the first opportunity for the client to state this and can also be addressed at any point of the claim. Information on these services is also available on the Find Support website
- Action: Bev will put together an information sheet to provide clarification to providers about the difference between cultural advice vs. cultural supervision
- SCU are proactively working to keep our clients informed during the process and keep the communication as open as possible. However, sometimes there are delays in being able to contact the client, as they often do not answer their phones during the day, and ACC's privacy process with leaving voicemails on phones also impacts on this... As a workable solution to this Service Coordinators also wills often text the client before calling in order to make them aware / prepare them for the call – the contact preference / contact issues is a great thing to indicate as early as possible on the engagement form.

Action: Tracey to send out comms on the "free text" box on the engagement form to prompt / trigger providers to share engagement options with clients in the next fortnightly communications to all ISSC Suppliers and Providers

- Continuity sessions is a hot topic, some frustration was raised about

"constantly" having to request 4 sessions, and if calls / emails are not returned it makes it very hard and time consuming. Agreed that in the future when claim volumes have stabilised, it would be ideal to have Service Coordinators proactively contacting and informing providers to let them know where sessions / notes are at but each claim does vary in terms of timeframe and the Service Coordinator are often waiting on essential information from Practitioners.

- ACC are looking to identify the external providers (GP's and DHB's) where there are extensive delays in the request for medical notes and actively work with them to increase their responsiveness. We can do this by utilising the Supplier Managers who hold relationships with the DHB's and GP's to be proactive in capturing these issues and reduce the delay for all involved.
- It is acknowledged that there are technical issues around the "Languages" feature on the Find Support Website.

Action: Selena to follow up with Barry directly re: what is not working with the language filter?

The issue of waitlists and capacity was also raised. This is further complicated by the fact that if a claim / engagement form is not lodged with ACC then we do not have any oversight of it and there is then potential for these clients to be missed. It would be beneficial to come up with some solutions and consistency on running the waitlists well. In response:

- ACC does help direct clients towards available providers. It does come down to how long the client is willing to wait. If it is known the wait will be long, we can have up to 5 or 6 agencies actively involved with the client.
- Initiative in the pipeline: ACC is currently looking into having a page on the "my ACC" page which will show supplier / provider capacity. Providers will essentially be responsible to update.
- Averaging 25-40 new named providers every 6 weeks and now have over 1200 named providers registered.
- ACC is actively engaging with all of professional bodies to not only look at mentoring and attending professional body work conferences but to look at how are we going to make it easier, help reduce some of the pains and really sell this as viable and important profession
- ACC is currently working on a strategy to engage with all of the tertiary providers to continue to build provider capacity and capability.
- At the August supplier trainings, the Branch Advisory Psychologists will do a session on waitlists, and how to actively manage any risks or support clients.
- Query as to whether ACC would have some capacity to fund suppliers to support clients to find alternative avenues when there is no space or capacity within their own service. However, was acknowledged that on the TOAH-NNEST website, is a list of agencies that are currently funded by MSD to provide this support before a claim is lodged with ACC.
- Rick Manley was recognised for his work with a case down in Christchurch and a really positive outcome for a number of young people and their families.
- Issues with the Supported assessment and the hold up from ACC's end when collecting / sending information to Assessors pre-assessment. Due to the time delay in rescheduling the appointment, assessments are being conducted with information only being received hours beforehand or without any basic information at all. Feedback acknowledged by ACC and advised that reporting on timeframes is currently being looked into and that assessors can also contact GP's directly if they have not received notes, to have a discussion prior to the assessments. Urgent requests of notes can be managed over the phone through the Service Coordinators.
- There is no "ideal case load" for a Service Coordinator as it comes down to capacity and complexity of claims. The focus is currently on workload as opposed to case load as each claim can vary significantly in needs.
- If there is an urgent or client related request and the Service Coordinator is unavailable, a "hunt" group has been set up and will look for another

available coordinator who sits within the same team. There is also a 0800 line to the Sensitive Claims Call centre (0800 735 566) and staff are being up skilled to help with claims related questions. Alternatively, the Sensitive Claims inbox – isscclaims@acc.co.nz is cleared daily. Feedback in relation to this is welcomed by ACC.

Concern was raised around multiple people possibly having access to a client's information within the Sensitive Claims Unit, and whether the need for disclosure of this to clients is appropriate or have them give consent for other team members within the Unit to view their information.
ACC's response: Only staff within the Unit have access to the client's information and unless a call or request is received, only the service co-coordinator managing the claim will be accessing the information, however if that staff member is not available and action might be required on a claim in their absence (i.e. Purchase order approval) then in order for that to be done, another service co-ordinator will action this request.

All claims for ACC staff are managed by a TPA (Third Party Administrator), so staff within SCU will not have access to other staff claims. We rely on providers when lodging the engagement form to be identifying this kind of information to ACC immediately to ensure the claim gets allocated to the correct place straight away.

Summary of decision of the Health Practitioners Disciplinary Tribunal for publication: Ms E – Psy15/336D

Charge
On 5 April 2016 the Health Practitioners Disciplinary Tribunal considered a charge of professional misconduct laid by the Director of Proceedings against Ms E a psychologist (the Psychologist)

The charge alleged that the Psychologist failed to set and/or maintain appropriate professional boundaries with a former patient and that the Psychologist engaged in sexual and/or intimate encounters with her former patient.

The hearing proceeded on the basis of an agreed summary of facts and the Psychologist accepted that her actions amounted to professional misconduct and warranted disciplinary sanction.

Finding
The Tribunal found that the charge was upheld and was a serious departure from professional standards, coupled with the Psychologist's dishonesty in attempting to cover her tracks and that the conduct constituted both malpractice and conduct likely to bring discredit to the psychologist's profession.

Penalty
The Psychologist, soon after the events in question, voluntarily relinquished her registration and the Tribunal noted that it was to her credit she recognised that her departure from the standards which the public and profession are entitled to expect of her were simply too significant for her to be able to contemplate retaining her registration.

The Tribunal stated that although it did not finally decide on this, had the Psychologist remained in practice there was a very real prospect that the Tribunal's penalty order would have included cancellation.

The Tribunal ordered that the Psychologist be censured and that she pay 30% of both the Tribunal and the Director of Proceedings' costs. Conditions were also imposed that are to be completed before the Psychologist applies for re-registration if she chooses to do so.

Permanent orders of suppression were granted for the name of the Psychologist and any information that may lead to her identification or that of her former patient.

The Tribunal directed publication of its decision and a summary, subject to the suppression orders. The full decision of the Tribunal can be found on http://www.hpdt.org.nz/Default.aspx?Tabid=487

NZCCP

National Education Training Timetable

The NZ College of Clinical Psychologists aims to encourage and facilitate continuing education opportunities for members, by providing nationally coordinated events to a high standard. Our goal is to coordinate training opportunities between branches with the goal of facilitating training in all regions. Please consult the College website for further information and links (http://www.nzccp.co.nz/events/)

TRAINING TIMETABLE

NZCCP Events

LOCATION	MONTH	PRESENTER/ CONTENT
Christchurch	9 September	Martin Dorahy/ When mortification knocks: An exploration of shame and its relevance to distress and therapy
Dunedin	23 & 24 September	Sarah Calvert/ Attachment Across the Lifespan: Theory, Practice & Application
Auckland	10 & 11 October	Dr Eric Morris/Acceptance and Commitment Therapy: ACT for recovery and psychosis

Other Events

LOCATION	MONTH	PRESENTER/ CONTENT
Nelson	August/March 2017	Alan Fruzzetti/DBT Intensive Training
Auckland	6-7 September	International Asian and Ethnic Minority Health and Wellbeing Conference
Palmerston North	15 September	Perinatal Anxiety & Depression seminar
Auckland	15-16 September	Tony Attwood & Michelle Garnett/Master Class: Children and Adolescents with ASD
Auckland	17 September	Professor Tony Attwood/Emotion Management with Children and Teens with ASD
Wellington	31 October-1 November	AnzaCBT Annual Conference and Workshop
Auckland	27-28 October	Trish Purnell-Webb/Gottman Level 1 Clinical Training
Auckland	3-5 November	Trish Purnell-Webb/Gottman Level 2 Clinical Training
Wellington	4-5 November	Family Therapy Training in EFFT – with Gail Palmer (Canada) & Jim Furrow (US)
Hamilton	14-16 November	Dr Robert brockman/ Level 2 Schema Therapy Workshop
Wellington	24-26 November	Psychosocial Oncology New Zealand 2016 conference
Nelson	2-4 March 2017	Annual Scientific Meeting of the New Zealand Pain Society

PRIVATE PRACTICE OPPORTUNITY

Looking for a lifestyle change?

Do you want an EXCITING new position? Private clinical psychology practices in the SUNSHINE COAST and BRISBANE want you in 2017!

Anxiety House is a unique private psychology practice that provides treatment for people aged 6-65 years who suffer from a wide range of anxiety disorders. To be eligible, you will hold a NZ Post Graduate Diploma or Doctorate in Clinical Psychology (or overseas equivalent) and Registration in the Clinical Scope of Practice.

Our head office is located in Brisbane but we will have an additional clinic in the Sunshine Coast FEBUARY 2017. We need psychologists for both the Brisbane and the Sunshine Coast clinics in 2017:

Position 1: Full time Child clinical psychologist - days and times are flexible

Position 2: Full time Adult clinical psychologist - days and times are flexible

NEW GRADUATES and experienced psychologists welcome!

We can offer

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- Competitive remuneration
- Professional Development days.
- An amazing team of experienced psychologists to work with.
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Apply Now!

If you are interested, we would love to hear from you. Enquiries should be directed to Kym Geier, Practice Manager on email manager@anxietyhouse.com.au

Leah is a Sydney-based doctoral-level clinical psychologist with 20 years of clinical and teaching expertise in CBT and traumatology

November 2016 Trauma Education

presented by Dr Leah Giarratano

Two highly regarded CPD activities for all mental health professionals: 14 hours for each activity

These workshops are endorsed by the, AASW, ACA and ACMHN

Clinical skills for treating posttraumatic stress disorder (Treating PTSD)

This two-day (8:30am-4:30pm) program presents a highly practical and interactive workshop (case-based) for treating traumatised clients; the content is applicable to both adult and adolescent populations. The techniques are cognitive behavioural, evidence-based, and will be immediately useful and effective for your clinical practice. The emphasis is upon imparting immediately practical skills and up-to-date research in this area.

3-4 November 2016, Sydney CBD **17-18 November 2016, Melbourne CBD**

Clinical skills for treating complex trauma (Treating Complex Trauma)

This two-day (8:30am-4:30pm) program focuses upon phase-based treatment for adult survivors of child abuse and neglect. In order to attend, participants must have first completed the 'Treating PTSD' program. The workshop completes Leah's four-day trauma-focused training. The content is applicable to both adult and adolescent populations. The program incorporates practical, current experiential techniques showing promising results with this population; techniques are drawn from EFTT, Metacognitive Therapy, Schema Therapy, attachment pathology treatment, ACT, CBT, and DBT.

10-11 November 2016, Sydney CBD **24-25 November 2016, Melbourne CBD**

Program Fee for each activity is in Australian Dollars (AUD)

$550 AUD (when you email this form to pay for an Australian workshop with a Visa or Master card)

Please note this reduced price only applies if you live and work in New Zealand and travel to Sydney or Melbourne

Program fee includes written materials, lunches, morning and afternoon teas on each workshop day

Please direct your enquiries to Joshua George on: **mail@talominbooks.com**

For more details about these offerings and books by Leah Giarratano refer to www.talominbooks.com

2016 Trauma Education Registration Form for NZCCP

Please circle the workshop/s you wish to attend above and return a scanned copy of this completed page

Name:		
Address:		
Phone:	Email (*essential*):	
Mobile:	Special dietary requirements:	
Method of payment (circle one)	Visa MasterCard	
Name of cardholder:		Expiry Date:
Card Number:		Card Verification Number:
Signature of card holder:		Debit amount in Australian Dollars: $

Credit card payment is preferred. Simply complete the information above, scan and email this page mail@talominbooks.com

A receipt will be emailed to you upon processing. Note: Attendee withdrawals and transfers attract a processing fee of $55 AUD.

No withdrawals are permitted in the seven days prior to the workshop; however positions are transferable to anyone you nominate