

PSYCHOLOGISTS

Newsletter

April 2019

NEW GRADUATES REPORT PIECEMEAL **CLINICAL** **EDUCATION** IN DHBs

In response to the proposal at MECA bargaining by DHBs for a stepped CPD allowance from \$1500 to \$3500 depending on years post-graduation, many new graduate psychologists wrote to us – providing a stark picture of how little clinical education is being provided internally within DHBs.

As one psychologist reported to us, “In-house DHB CPD has been pretty piecemeal and variable.”

At MECA bargaining in March the DHBs’ representatives had argued for early career psychologists to have more of their CPD needs met internally. One DHB representative said, “For the really early career psychologists in a general sense they require consolidation of skills they’ve learnt at university or internship. Often training requirements are either free or very local.”

DHB representatives also stated at the negotiation table, “Because of the way the training programmes operate there is a gap in the base expectation of skills of new grads. Different type of training is required in first years of practice – which is more about consolidation of skills. Skills that should be available locally as they are basic sorts of skills.”

But the information from psychologists in their first three years of post-graduate practice is that very little formal clinical education is being provided internally, including on core parts of a psychologists practice, such as advanced therapy and assessment skills. The in-house training that is provided is often at a basic level, that does not extend

the knowledge and skills graduate psychologists enter employment with.

This feedback came from graduate psychologists across the country, from both North and South Islands and from metropolitan and rural DHBs.

As one new graduate psychologist noted to us of what sort of curriculum a post-graduate training programme would entail, “I needed more therapy training and also more differential diagnosis training specific to the target



population at that point, not refreshers from an advanced course I had just finished. Advanced CBT, advanced ACT, family therapy training, countertransference, narrative therapy techniques, art therapy techniques, open dialogue, cognitive analytic therapy, a repertoire of ways to do things - this is what I needed and have sought overseas.”

DHBs contain scores of senior and consultant psychologists with knowledge of the advanced therapy, assessment and other skills that a post-graduate training curriculum would include. Implementing the curriculum would require co-ordination between DHB psychology leadership to develop the teaching material and service managers to allow release of psychologists to attend training sessions.

“LITTLE TO NO INHOUSE TRAINING”

New graduates on DHB Clinical Education

“I am a psychologist and am just beginning my third year of practice. There are no in-house trainings that support the development of a psychologist’s therapy skills or more advanced skills in assessment and formulation.”

“There has been no formal inhouse CPD provided which is directly and specifically relevant to my role as a psychologist.”

“Whilst most Psychologists here readily provide trainings within the DHB, they are usually to non-psychology staff and at a basic level. I myself attend these trainings where possible as a ‘refresher course’ to compliment what I have recently learnt through my study. Topics typically cover basic behavioural strategies for managing anxiety or depression or risk management. However, these trainings would not suffice in order to maintain or improve my competence in providing therapy to people with moderate to severe complex presentations.”

“Regarding in house DHB CPD this has been pretty piecemeal and variable. I have attended several introductory workshops in house on Family therapy, which was more the theory and model with some role plays to get people interested in applying for further training. This was great and informative but did not lead the way to being able to provide this as a service.”

“The in-house training provided is very basic information about topics like self-harm, substance use, sensory modulation, certain psychometrics, developmental histories...all things a new grad clin psych has just spent many years studying at a far greater detail than these trainings provide. We need training that will extend from where we have left off.”

“Over the last two years I have been to some great inhouse trainings including supervision workshops, introduction to Te Reo, a workshop on the Treaty of Waitangi, and Trauma Informed Care. These were all very helpful and I got a lot out of them.”

“I am in a provincial DHB and there was little to no inhouse training. The psychologists as a group tried to organise education sessions but this was limited as often there was insufficient time to prepare presentations due to workload.”

“In my 14-months at DHB there has been two in-house training opportunities of CPD level for psychologists.”

“Interpersonal therapy could probably be taught in-house, but I’m not aware of anyone who could teach ACT or Schema therapy in-house - perhaps there are trainers in other DHBs and we could all attend such a workshop.”

“I would be very reluctant to rely on the DHB for inhouse professional development. This is because the learning modules that are compulsory within the DHB, which I have attended so far, have been at such a low level of quality that I didn’t learn anything from them. For example, on Tuesday I attended an all-day orientation which included a half an hour presentation on how to make a phone call.”

WHAT’S COMING UP

DHB MECA BARGAINING: Next negotiation postponed to 3 May. DHBs requested bargaining be delayed. DHBs told us they needed time to get their funding arrangements in place before coming back to negotiations to offer us salary increases in line with other groups. Negotiations for APEX MECAs covering medical physicists, radiographers, radiation therapists have also been delayed for the same reason.

MINISTRY OF EDUCATION: Joint Working Group meeting dates agreed for 10 May, 7 June and 1 July. Terms of reference are signed, and Kirsty Ferguson has been appointed as the external facilitator of the working group for the parties that will look at:

- Identification of appropriate workloads
- Workforce capability and development.
- Improving retention of specialist staff
- Safety and quality of practice

The [terms of reference are available on the Psychologists’ Division page](#) of the APEX website.

“SUPERVISORS ARE NOT REMUNERATED FOR ADDITIONAL WORKLOAD”

MINISTERIAL ADVICE ON BARRIERS TO PSYCHOLOGISTS’ TRAINING

A 2018 Ministerial briefing paper from the Office of the Director of Mental Health to the Minister of Health, Dr David Clark, sets out the key barriers in the pathways for psychology and, in particular, clinical psychology training.

The paper states, “Each university clinical psychology programme generally offers ten new places per year. Places are limited for two reasons; difficulties attracting appropriate levels of funding for the programme, and difficulties finding appropriate internship placements for participants (which is a necessary component of the programme).”

The advice notes that psychology programmes are not “cost effective” for universities, who are reluctant to increase the number of places offered.

And “internships rely on the professional good will of local senior clinical psychologists, who are appropriately qualified to provide such supervision, agreeing to take on an intern. Supervisors are not remunerated for the additional

workload that this creates, and may not consistently offer placements.”

Although Health Workforce New Zealand funded internships increased from 8 to 12 in 2018, the lack of internship positions is a problem. Disappointingly, the advice suggests some in the Ministry would like DHBs to employ interns on a lower salary than the MECA allows.

The advice does suggest additional psychology places could be filled via existing demand if financial barriers for universities and difficulties arranging internships and placements were resolved. But all parts of the pipeline are leaking and need repair. Making sure supervisors receive consideration for the work they do supervising interns and placements is absolutely vital to the security of the pipeline and remains a live issue in MECA bargaining.

The briefing paper was requested under the Official Information Act, and you can view a copy of the paper on the [APEX Psychologists’ Division page here](#).

DARK REFLECTIONS ON NEUROPSYCH CLINIC

Writing under the pseudonym A.K. Benjamin, a British neuropsychologist has published a collection of anonymised and fictionalised case studies in an NHS clinical neurology department that offer a sometimes cynical, sometimes touching view of the relationship between brain injury, patient, professional and institution.

Some observations reflect universal challenges of the profession. In one chapter, Benjamin writes of trying to do therapy in a sweltering hot clinic room with loud swearing coming through the flimsy wall from the Tourette’s clinic next door.

In another chapter written about a woman being considering for epilepsy surgery Benjamin wrangles with the methodology of an MDT “The drive towards medical specialisation has meant we can only make certain decisions by combining expertise. We assume consensus can be routinely achieved without acknowledging certain threats; intolerance of uncertainty, confirmation biases, inter-professional power imbalances, interpersonal differences specific to the group.... At one meeting I used to attend at a hospital in the Midlands, I could set my watch by the fluctuating blood sugar levels of the massive surgeon as they spiked and then crashed following his ingestion of a large Danish.”

Throughout the book there is a seam of tension between the author and his ethics, and the ethics of hospital management.

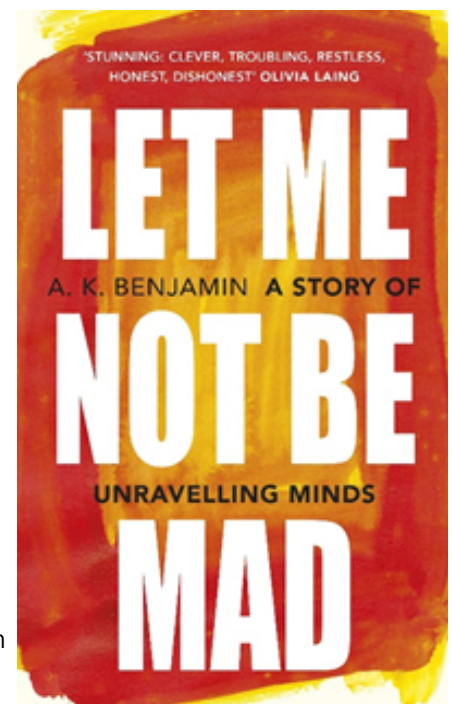
Benjamin’s personal life becomes more difficult by the middle

of the book, and his work is troubling him more and more – “The follow-up clinic that afternoon had just finished. After Tracy, I had assessed a dropped baby, skateboard fall, and finally a road traffic accident in which the young TBI’s father and brother had both died... Unceasing suffering, death, despair compressed into less than two hours.”

By the end of the book, Benjamin is describing his own journey into madness – “They stopped my clinics, gave me pointless audits to complete, sent me on risk-management training, made me in charge of information governance which meant tidying the test cupboards.”

A wry and unsettled reflection of the psychology profession, *Let Me Not Be Mad* is a jagged, rough but optimistic collection of tales from a neuropsychologists’ clinic room.

AK Benjamin. *Let Me Not Be Mad: A Story of Unravelling Minds*; London, 2019.



STRESS/BURNOUT: “COMPASSION ONLY GETS YOU SO FAR”



Emma Edwards is a clinical psychologist and APEX delegate at Waitemata DHB

Where do you work and what do you do?

I'm a clinical psychologist at West Auckland Adult Mental Health Team. I work in the community, seeing adults 18 to 65 with a range of mental health difficulties. Common presentations are depression, anxiety, trauma, emotional dysregulation, suicidality and self-harm. I use a range of therapy in treatment – mostly dialectical behaviour therapy, acceptance and commitment therapy, cognitive analytic therapy, compassion focused therapy, and mindfulness.

Why did you decide to become a psychologist?

I've wanted to become a psychologist since I was a teenager, when a psychologist had a big impact on my life at an important time. I have a passion for working with individuals, working with them one on one therapeutically. And I have a passion for working with systems, hopefully helping make greater changes not just inside, but also outside the therapy room.

How have you found being an APEX delegate?

It's been really enjoyable to be in the role, which I have been in for the last eighteen months. It's rewarding and given me training and leadership skills I wouldn't otherwise be getting. I get to attend meetings and interact with management in a way I wouldn't otherwise do and represent my colleagues in those forums. One of the things that works well at Waitemata is the partnership between union delegates and management. I've had positive responses from management to issues I have raised as a

delegate, which I've found encouraging. We recently had success securing funding for DBT training. Psychologists were paying for this out of their CPD. It's now been approved that all staff doing DBT will have that training funded by the DHB. Our wonderful profession lead put many hours of hard work into sorting this out for us.

What other things have you done as delegate?

I've been able to be a part of and initiate projects. One came about after I raised an issue as a union delegate. There has been a project going for about a year now to gain funding from the DHB to do trauma-informed spaces in the waiting and therapy rooms. There have been delays getting all the funding needed, but we've been able to get some decals to improve our waiting room.

What are the challenges representing your colleagues?

One of the difficulties is asking for feedback but not getting any, so I'm not sure whether I'm representing my colleagues because I don't know what their views are. My main concern right now is around bargaining. If we don't hear from members, we don't know if we are representing them. As a big DHB we rely on email communication.

From about year 3 post-graduation psychologists start to leave DHBs en masse. Why is that and what can DHBs do to retain psychologists?

It's money, stress, and work-life balance. A lot of what we have put forward in our current MECA claims are our attempt to offer solutions to the current recruitment and retention problems. We are saying, if you pay us more, give us more flexibility in work hours, give us more leave to compensate for the stress and burnout of working with the top 3% complexity and high-risk clients, maybe we would be able to keep psychologists in the DHB. We are just not being compensated through pay, leave and CPD for the work we do. Why would you stay? You cannot sustain this work on values alone for years and years. We all came into the profession because we are passionate about it and we have compassion but that only gets you so far. People burn out; they have lives they need to prioritise as well.

What do you enjoy doing outside work?

Spending time with my family, my partner, my two dogs (rescue Staffordshire terriers) and my cat. Playing video games, going to the beach. Facetime with my nephew overseas. I do a lot of reading, mostly DBT and trauma books recently haha.