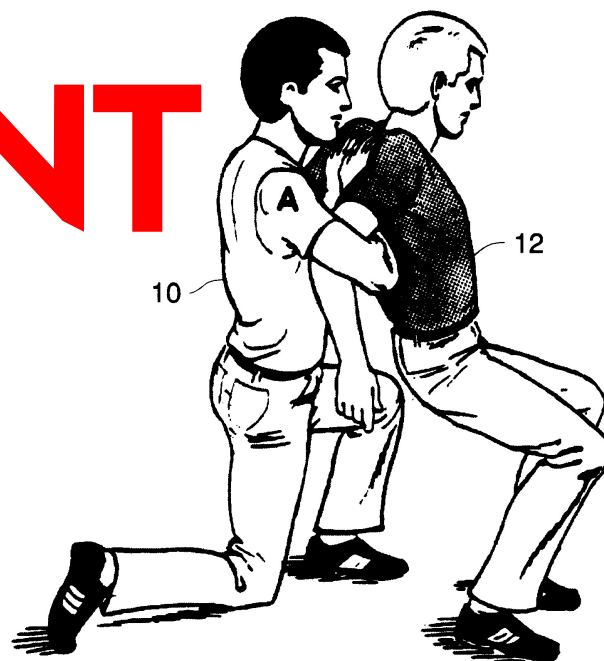


PATIENT RESTRAINT

DAMAGING TO THE THERAPEUTIC ALLIANCE



Despite our objections and communication with the DHB about why we object, in December 2016 Canterbury District Health Board confirmed they require psychologists to perform patient restraints. This escalated concerns to an employment relations dispute as a result. On 7 April 2017 we will meet with Canterbury DHB in mediation to discuss whether DHBs can indeed require psychologists to perform physical restraint of patients.

As of this month Auckland DHB has indicated their intent to require psychologists to perform patient restraint. We have written to them for clarification, but are aware other DHBs may seek to follow suit.

We are concerned over the approach taken by DHBs on this issue. Good faith requires employers to consult with employees and their union - to discuss issues, consider objections and engage meaningfully with a view to identifying constructive solutions that work for both parties.

The less than ideal process surrounding this

change to our duties has not given us the opportunity to explain why psychologists should not be required to take part in patient restraints. We are opposed to psychologists doing restraint because:

- It creates a serious risk of physical or psychological injury to us. Many psychologists don't have the physical attributes for restraint.
- Restraint techniques involve the use of intentionally inflicted pain - a violation of our Code of Ethics.
- Restraint damages or destroys the therapeutic alliance - restrained patients report feelings of fear, anger and distrust towards staff restraining them.
- Restraining a patient compromises our ability to maintain impartiality when writing court reports as expert witnesses about them.

We have also written to the Psychologists' Board asking for them to consider the risk this creates to our members practice and are awaiting a reply.

SUPERVISION

Directors of Allied Health and Psychology Professional Leaders at all fifteen MECA DHBs have been sent a copy of the data from our audit of supervision and a letter asking for them review and give thought to how they improve the quality of supervision at their DHB.

We have also asked for information about the number of psychologists who are getting supervision external to their DHB and external to their team or service, so we can

see to what extent dual relationships are being adequately addressed.

Eighteen of our members had specifically mentioned problems around accessing supervision for senior or specialist psychologists. We have asked the DHBs to consider how they can better support the supervision arrangements for these psychologists. When we have formal responses back from DHBs, we will feed these back to members.



PROFESSIONAL DEVELOPMENT FAQ

Are professional development funds based on FTE status?

Only if you work in private practice or secondary employment. If you are less than 1.0 FTE with the DHB and work in secondary employment or private practice then you will receive a pro-rated amount of the \$2500 entitlement. If you work less than 1.0 FTE and do not work in secondary employment or private practice you are entitled to the full amount.

Can my employer withhold my access to professional development to make me do something like SPEC training?

No, entitlement to CPD and other DHB training are separate issues.

Do I accumulate CPD money on parental leave?

Yes, you are still employed by the DHB when on parental leave and you still need to continue doing developing your professional skills.

Can I use CPD funds for books/journals?

Yes.

Do I have to book travel/accomodation through the DHB?

If your employer has a preferred travel supplier but you can find a cheaper alternative to make your CPD money go further then it is not reasonable for the employer to require you to book through their travel agent.

MERIT PROGRESSION

In April 2016 APEX carried out a survey of members on DHB MECA merit progression: about 100 psychologists responded. The results highlight that although many members find the task of approaching merit progression difficult, of those that apply - the vast majority are successful. 51% of eligible members had not applied for merit progression. Of the members who did not

apply, 31% had been told not to bother while 68% said the process was too onerous. Interestingly 88% of those who applied for merit progression said their applications were successful. If you are thinking of making an application for merit progression, have a thorough read of clause 9.3 of the DHB MECA and consider using the following template letter for merit progressions.

To: Manager

Copied to: • Professional Leader Psychology • Practice Supervisor Psychology

I would like to apply for merit progression according to the DHB/APEX criteria, as of today's date.

Thank you for considering these activities in my capacity as a part time employee. I have referenced with footnotes the accompanying evidence and these are attached to this correspondence for your review.

Areas of practice put forward and related evidence:

1. Clinical work at the level expected of a senior practitioner

With regard to my Annual Performance Review – my initial objectives were outlined upon starting at this DHB, but these have never been reviewed.

Given the absence of any current performance objectives, I wish to proceed with my merit step progression application in the absence of an Annual Performance Review, and suggest that this need for a review should be waived, as specified in the MECA (***** or alternatively** will actively participate in a timely review, but wish to have my application reviewed as at today's application date and may ask that this requirement is waived if we are unable to proceed in a timely manner).

Clinical work undertaken

Specialist assessment and treatment service **and more....**

Assessment: I have advanced knowledge of **and more...**

I have extensive experience **and more...**

Formulation: I provide psychologically driven and creative formulations for clients **and more...**

2. Clinical Supervision

I have a longstanding and regular supervision arrangement with

o Supervision of clinical psychologist for

o Supervision of clinical psychologist for

o Supervision of clinical psychologist for

(Or given my role I wish to have this requirement waived as it is not appropriate)

3. Optional Task #1 –

For example “Has had a substantial role in one or more service development initiatives that is regarded as important for the service since last progression.”

Details here

4. Optional Task #2 –

For example “Has had a major role in the development of one or more significant programmes (e.g. a new clinical initiative) since last progression.”

Details here

5. Optional Task #3

For example “Is recognised as a consultant to other staff with complex difficulties on an on-going basis”

Details here

Supporting evidence attached, and labelled

CONTACT APEX
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09 526 0280 | APEX.ORG.NZ

"NEW TECHNOLOGY WILL CHALLENGE OUR PRACTICE"

Adrian Tyghe is an APEX delegate working in ICAMHS at Waikato DHB.

How did you end up at a DHB and how do you find working there?

I became a psychologist in 1989 and spent twenty years in private practice and community work before coming to the DHB. Working at ICAMHS is challenging, there are many processes, procedures and policies that need to be taken into account in one's practise. The best part of working in the DHB is working with other psychologists and being able to share resources and knowledge. Other psychologists come from different viewpoints that enriches your own. The camaraderie and the collaboration working with others is very beneficial compared to the isolation of private practice.

How can DHBs support psychologists?

It is about the balance of what is needed in the organisation and the needs of the clients and the professionals. Hopefully these can be dovetailed and the interests of the client can be in the forefront. Sometimes the balance shifts and we need to provide a clinical perspective.

How have you seen the practice of psychology change over the years?

My sense is that the funding is becoming more and more critical to our practice. The constraints that the lack of funding has on the practice means a continual adjustment in what is regarded as optimal. We find ourselves compromising and adjusting on an ongoing basis because resources are kept constant while demand increases. People stretch further and further to cover over this

gap but at some point this will become untenable.

One recent example is SmartHealth a new initiative being put forward where doctors will be offering some sessions through teleconferencing. If we were to adopt this for therapy, careful consideration will need to be made.

What are the risks of video therapy?

We might become a virtual person to them and our youth spend enough time in the glass box where they insulate themselves from the real world. They don't get the real experience of being in a room with someone who is listening and available and is staying with them as they go through something that is painful.

Our practice might become more detached. Sometimes it is what is in the background that is critical to understand. How do we deal with family issues? Particularly in child and adolescent settings family issues are prominent. How can these issues be seen when one is doing a video call with a client. It is seen as an advance as technology becomes more accessible and therefore we reach more people but it comes with risks. New proposals around technology will become a challenge to the way we practice.

What do you enjoy in your spare time?

Trail walking, movie festivals and I love food – exploring different foods in Auckland.