APEX
PSYCHOLOGISTS
Newsletter
August 2018

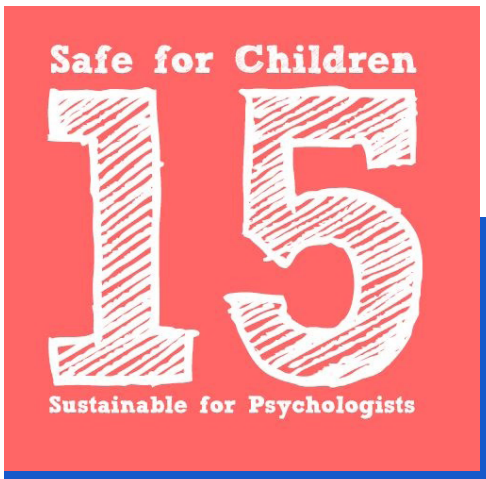
PSYCHOLOGISTS STRIKE FOR SAFE CASELOADS

APEX members working as psychologists at the Ministry of Education began partial strike action on Tuesday 24 July that will continue for five weeks.

Bargaining between APEX, the Ministry and education union NZEI made significant progress in improving the contract for the psychologists, speech language therapists, early intervention teachers and other field staff.

But negotiations did not result in a commitment from the Ministry to bring in a safe caseload of severe and challenging behaviour referrals for psychologists working in Learning Support. So on 23 July, we gave the Secretary for Education notice that all APEX members working as psychologists in Learning Support will not accept any further referrals of severe and challenging behaviour cases if to do so would take them above, or keep them above, a caseload of 15 severe and challenging behaviour cases (this limit being pro-rated for FTE).

Severe and challenging behaviour referrals to Learning Support are children with high needs and require intensive intervention. For example these are children that are sleeping rough, biting other children, lighting fires at school, bringing knives, alcohol or drugs to school, self-harming or repeatedly running away.



We explained to the Ministry that when our caseloads got above 15, we were unable to work in a pro-active way. Unsafe caseloads means working re-actively, only seeing children in crisis, and not having a chance to work with teachers and parents collaboratively.

Safe caseloads allows us to ensure we get safety plans in place and have regular contact with the supporting adults to help deal with trauma and work through any behavioural issues. It gives us time to write applications for additional support such as Oranga Tamariki funding for a teacher aide, mental health support and actually deal with the root causes of a child's behaviour.

Since we began industrial action psychologists at the Ministry have begun reducing their caseloads to a safe level. One delegate wrote, "In general, the strike is going pretty good. No one has been given any new cases and there is a lot of conversations happening around the office in regards to it."

Another delegate emailed this feedback from one of our members, "This member thought this strike action is a good strategy, as she was able to say to her manager today that she was at capacity and would not be picking any more cases, her manager took her seriously."

Bargaining between the Ministry and APEX is continuing. Sometimes nothing changes unless we change it ourselves.

MoE Psychologists: In their own words

"Pressure is being placed on service managers and staff to reduce waitlists by making initial contact (a phone call) with families but this still requires them to wait for service. This does not seem ethical to me for anyone involved."

"Can we have guidelines around acceptable caseloads nationally?"

"I am concerned with the size of our caseloads. Non psychologist managers are deciding our work and responding to "squeaky wheels" by demanding instant assessments and plans for schools that complain – without regard for existing caseloads or issues of parity with other similar schools."

"Psychologists who have left have not been replaced in some offices, leading to large caseloads, waiting lists and stress."

"We are asked to take on delivery of programs (IYT, IYP, etc) without reduction in caseload or recognition of extra hours."

"No clarification of expected caseload. It would be great if someone could make a call on what the expected number of severe behaviour cases is for a full time psychologist. At the moment we are all asked to make judgment calls about whether we are able to pick up more cases. Management pressure to reduce waitlists by picking up cases means that we are all working over capacity, but there is no guideline that we can refer to to support us in saying "no"."

"There is constant pressure to pick up cases, currently my caseload is very very full, because we have a behavior waitlist. Instead of hiring more people, they just insist we work "differently" essentially putting the pressure (and blame) at our feet for not doing an "efficient" enough job. Also if we "pick up" cases, they go onto our caseload but we may not be able to get to that case because we are so full, and so it becomes a hidden waitlist."

THRIVE: NEW YORK'S NEW MENTAL HEALTH PLAN

For the last three years New York City has been working to adopt a new model of mental health care.

The plan – known as ThriveNYC – was created and has been led from the top of City Hall by the First Lady of New York City, Chirlane McCray. In an interview on Thrive's new model of care by Russell Brand in his podcast Under the Skin , Chirlane McCray said;

> "Thrive NYC is a city-wide programme to change the culture around mental health and to bring new solutions, make solutions accessible to people where they live, where they learn, where they worship, where they go to school. We want to make sure there is just one door for people to go through to get help. It shouldn't be so hard."

Thrive's guiding principles are:

1. **Change the Culture:** ThriveNYC is changing the culture by challenging the stigma that prevents too many New Yorkers from seeking care and by encouraging every New Yorker to be part of the solution.
2. **Act Early:** The City is investing in prevention and early intervention for all New Yorkers, with a special focus on our youngest citizens. In order to safeguard our children's future, we must act early and make sure they get the mental health support they need, as soon as they need it.
3. **Close Treatment Gaps:** This includes significant investments in new models to reach the seriously mentally ill, and tailoring treatment to individuals, greatly increasing the likelihood that individuals remain in care, whether in their homes or in our hospitals, jails, or senior centers.

4. **Partner with Communities:** New Yorkers are more likely to access behavioral health counseling in places they already go to receive care and feel connected to their community. Community-based organizations, houses of worship, and senior centers are just a few settings that foster this dynamic.
5. **Use Data Better:** ThriveNYC is testing new and innovative models that have either never been tried before or not implemented at this scale. It is driving the use of best practices through data collection, surveys and ongoing evaluations of initiatives.
6. **Strengthen Government's Ability to Lead:** To ensure effective and efficient communication among all partners involved in this work, ThriveNYC is breaking down silos between city agencies, community- and faith-based organizations, and immigrant communities as well as academic and research institutions.

Launched in November 2015 to a city of over 8 million people, Thrive has been recognised as a successful public health approach to mental health. In its first two years Thrive reported the following progress:


Chirlane McCray

- Training nearly 37,000 people in Mental Health First Aid at free trainings;
- Placing victim advocates in all police stations;
- Creating an Early Childhood Mental Health Training and Technical Assistance Centre and reaching 17,000 pre-school children with a programme on coping skills and emotional resilience;
- An educational card game called "Fun with Feelings" distributed to 68,000 families;
- Placed 100 School Mental Health Consultants to provide additional mental health supports to all schools without existing mental health services;
- Expanded support for families living in homeless shelters;
- Placed social workers in all homeless shelters for families with children;
- Screened 24,436 pregnant women for maternal depression and to connect them to essential services and treatments;
- Set up a one-call, one-click connection to counselling – NYC Well – available in 200 languages, 24 hours a day.

In one year NYC Well received 250,000 calls, texts, and chats;

- Graduating 300 peer support specialists to invigorate the workforce;
- Engaging with 2,000 military veterans each year through things like creative writing, arts, music and theatre programmes;
- Reached 5000 runaway and homeless youth with mental health professionals;
- New staff hired to work with victims of domestic violence, elder abuse and sex trafficking;
- Ramping up mental health services in 25 centres for the elderly.
- Training staff in community organisations in mental health interventions.
- Religious leaders across the city each spring for the past two years devote part of their weekend service to taking about mental health and addiction issues;
- Setting up a Mental Health Innovation Lab to support programmes and a Mental Health Council with cross-government representation.
- Training 6,674 police officers in crisis intervention training, a nationally recognised model that teaches officers how to better identify the signs of mental health conditions, how to deescalate encounters with people with behavioural health conditions and how to divert these individuals away from arrest when appropriate.

As McCray said in her interview about the principles behind Thrive:

> "The need is there. You cannot deny the pain of the people. ... We believe in change. Change is possible. We believe we can make change. People do have power. Most people shrink away from the power that they have and don't take away from the tools that they have... I don't think of myself as an idealist, I think of myself as a realist. I am not going to create heaven on earth but I know I can transform some people. I know I can make more services available through Thrive. If I inspire people, those people may go and inspire other people. This is how you create movements, and we all have that power.
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> It's all treatable, it is part of the human condition. There is a great need, a great hunger for this information, for understanding. Because it is at the root of so many people's problems. Not being able to have a healthy relationship, not being able to work, not being able to go to or finish school. What can you do? If you don't have your mental health, what do you have?"

Listen to the interview with Chirlane McCray here:

DIVISIONAL NEWS

Divisional Secretary Elected

Annmaree Kingi, consultant clinical psychologist at Canterbury DHB, was elected unopposed as Divisional Secretary on 22 June 2018. Annmaree joins Rajan Gupta, consultant clinical psychologist at Waitemata DHB, on the divisional executive.

In APEX, each profession has their own division – so each profession bargains autonomously. The divisional executive advises the union's national secretary on matters affecting psychologists. Divisional officers also play a key role guiding and leading collective bargaining, representing members with other organisations in the sector, and developing and shaping the aims of the division.

Meeting the Mental Health Inquiry

APEX delegates from Canterbury, Counties Manukau, Auckland and Waitemata DHBs met with the Mental Health Inquiry on the evening of Wednesday 20 June. The Inquiry was represented at the meeting by Professor Ron Paterson, Dr Barbara Disley and Dean Rangihuna. The inquiry members thanked us for our submission and said the presentation of it made it easy and enjoyable to read. Our delegates talked about the importance of the work we do, but tried to illustrate the worrying levels of burnout, stress and staff turnover in the sector.

We talked about the psychiatric model of care being outdated, and how Ministry of Health targets force children needing mental health care on internal waitlists, as some DHBs focus only on throughput and not outcomes. We also spoke of the need to fix the culture in District Health Boards, where some psychologists feel bullied or unvalued.

It was a good korero with the inquiry, and they indicated that many of the recommendations we made are being echoed around the country. We look forward to seeing their report to Government at the end of October.

Psychotherapists join APEX

Psychotherapists at Auckland and Waitemata DHBs have recently joined APEX, and there is a remit going to the APEX AGM for a psychotherapy division to be created within APEX. We are looking forward to negotiating collective agreements tailored to the needs of psychotherapists.

Delegate Interview

Iris S. Fontanilla

Where do you work and what do you do?

I am a full-time Health Psychologist at Auckland District Health Board. I work in the New Zealand Heart and Lung Transplant Service. More recently, I have started a new role as the resident Health Psychologist in the Cardiothoracic and Vascular Intensive Care Unit (CVICU) too.

I am part of a multi-disciplinary team (MDT), and my role in the team involves the provision of assessments and relevant, evidenced-based psychological therapies across the transplant patient's trajectory. It is a privilege "walking alongside" patients and their whānau throughout their transplant journey. We provide patient education support groups from the beginning and in the post-transplant period. I also provide training, support, and clinical supervision of other Psychologists and pre-intern Health Psychology students. I am an Honorary Clinical Lecturer in the Department of Psychological Medicine at the University of Auckland.

The CVICU role has a slightly different remit. I am only on duty 1 day a week and the role is varied. For example, my duties include direct patient clinical input when it is medically appropriate, consultation and advocacy for the patient and their whānau, participation at ward rounds, and being part of a substantial MDT. I also provide in-service training and support for CVICU staff on psychosocial issues, which can manifest in our patients in this critical care environment.

What type of staff training do you do?

My passion is in the area of resilience and preventing burnout in the workplace. During these staff training sessions, I impart knowledge of psychological tools, techniques, and strategies to cope in their rewarding but challenging work environment. I also provide training on communication and educating non-psychologists about pervasive psychological issues in patients' with physical health issue(s). In this regard, I try to convey the importance of a biopsychosocial approach.

How did you become a Health Psychologist?

It all started for me when I took a health psychology stage III paper and I happened to meet really supportive, enthusiastic lecturers and professors who really piqued my interest in helping people who have concomitant physical and psychological conditions. I liked the hospital work environment so it seemed a good fit.

After completing Master's thesis in Health Psychology, I was in the first cohort of the Post-Graduate Diploma in Health Psychology at the University of Auckland. This was my first foray in working in acute, hospital settings as an Intern.

Fast forward to the present time, I am now in my 12th year and counting at ADHB. I am fortunate to work alongside a very supportive, stable MDT that values the contribution of health psychology.

However, access to Health Psychologists remains an unmet need in DHBs: we are still few and far between on a national level. Ideally, we should be in most if not every physical health service across the board, because you do not need to have a mental health issue to be able to benefit from psychological expertise and input.

How have you found being an APEX delegate?

I reluctantly took the role, daunted by the fact that the APEX delegate position has been filled by Aaron O'Connell for quite some time. Aaron has been such a strong and supportive advocate for Psychologists in DHBs. Aaron was looking for people to share the role, some two years ago, and at the same time I also had a good colleague who also took the position. It felt like a supportive team of delegates to work together with.

If we do not have representation, we are not in any position to complain if things aren't going our way in terms of our MECA. So how can we then support each other, especially with some challenging times in the public health sector? We do have to exist, we do have to band together, because otherwise the future of psychology in Aotearoa New Zealand will remain stagnant. We need this forum to meet, discuss, and progress our profession.

As we count down towards MECA bargaining, what do you think we need to fix in the contract?

Salary. We need to offset the increased cost of living. CPD, too, is vitally important. It is great we have $2,500 dedicated to CPD but if you compare us to specialist clinicians, we still have a long way to go! Workforce is also an issue. We are really short on paid internships. We need dedicated funding to create more internships, to start providing the heath psychology services across all physical health conditions.

It would be wonderful to have protected research time. We are scientist-practitioners and a lot of research that happens tends to happen at one's own expense in the form of longer work hours and weekends. We are also one of the few specialised clinician groups who still do not have the opportunity to take sabbaticals after a long period of dedicated service.

Last but not least: we need a pathway to clinical leadership and management positions. We are implicitly leaders in many ways because we are trained to be able to manage difficult interactions, assist individuals and groups/team across systems, and manage conflict amongst.

What do you enjoy doing in your spare time?

I've got a "threenager" so there is no such thing as spare time! Haha! On a serious note, I love spending time with my daughter, my partner and extended family. I love reading whenever I can. I am also the Chairperson of the New Zealand Psychological Society's Institute of Health Psychology which can be busy at times but I find very rewarding. And did I mention, travelling, when I can…!