Practising psychology during the COVID-19 pandemic: Frequently Asked Questions

Psychologists seeking advice about how to continue working have posed different scenarios posed to the Board, Professional Associations, the Ministry of Health and MBIE and have received advice that is not always entirely consistent. "Essential" health services are determined by the MoH and MBIE, who do not necessarily have expert knowledge of psychological practice. Because of this, the Psychological Society, College of Clinical Psychologists and the Psychologists Board have formed a working group to consider questions arising from psychologists about working within level 4 restrictions, aiming to reduce the confusion that will ensue if multiple different sources of opinion predominate.

The advice we offer here is informed by our years of experience, understanding of the Code of Ethics, knowledge of extant literature on what is evidence-based best practice, and our commitment to support our professional colleagues to provide high quality professional psychology service to their clients. We aim to support the successful implementation of measures to slow the spread of the virus. It is intended to help apply and interpret generic COVID-19 policies for the particular issues facing psychology practice.

In the FAQ, dates are included to show the date the response was posted.

If you have questions about practising psychology during Level 4 restrictions, please email your questions to Covid19@nzpb.org.nz, and we will respond as quickly as possible.

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Level 3 Face-to-Face Client Contacts Register

7/05/2020

Q: Can you please clarify the process of how the MoH will use the information we supply to the Board if we are seeing clients during Level 3 face to face. The reason provided was this would help with contact tracing if the client did not know the name of the clinician. But if we are not providing names of our clients, how can this information be used for that purpose ? Does this mean that the MoH would approach each clinician who practiced in a particular geographical area, and asked if we had been the relevant clinical for a particular client? Or would we be asked by MoH to provide a list of client names at some later point in time, to the MoH.

A: The establishment of a "register" of events recording when and where face to face consultations took place has been a response to the Ministry of Health request to do this to assist the teams doing contact tracing. While the Ministry has not provided details of their processes, we carefully considered the request and agreed on the understanding that the register would only be accessed if needed for tracing of specific contacts. Either the Board could be asked to contact practitioners who registered a client contact in a particular area at or around a particular date, and facilitate connection to the Ministry's contact tracing team. Or, that specific information may be provide directly to the Ministry, for the sole purpose of assisting with contact tracing. There is no intention to share the entire register in its entirety, nor for it to be used for any other purpose. When the data is no longer relevant for Covid 19 tracing purposes, it will be deleted.

Alert level 3

30/04/2020

New Ministry of Health advice about Level 3 mental health service delivery

Q: *New advice has come out from the MoH about the mental health workforce. This seems to be more restrictive than earlier statements about Level 3. Which should I pay attention to?*

A: The government has been working under pressure, and where policy statements have been found to lack clarity or certainty, attempts have been made to provide more clarity. As a result of feedback about statements to the effect that said "some face to face appointments may be provided" by mental health workers in the community, a new statement has now clarified the rules for mental health services at level 3.

These now state that although **some community DHB mental health services, such as urgent/crisis mental health services are continuing with face-to-face appointments as normal, non-DHB providers should only see patients face-to-face for urgent care only**.

They have gone on to define clearly what "urgent care" means for community allied health services:

Urgent care means

- a condition which is life or limb threatening OR
- treatment required to maintain the basic necessities of life OR
- treatment that cannot be delayed or carried out remotely without risk of significant harm or permanent and/or significant disability.

You must also check that the care cannot be delivered by:

- a service which is currently operating
- health professionals that are already in contact with the patient.

28/04/2020

Q: *Just wondered if we could be given some sort of ETA of guidance for opening requirements/ expectations under L3/L2. This is particularly pertinent for those who conduct direct standardised tests as part of a prolonged face to face contact - often with children / special needs folk.*

A: We had posted an interim response about level 3 on 17/4, and this has now been updated with the following advice, which has come from our discussions with the Ministry of Health.

During the Alert Level 4 period the Board, the College and the Society have emphasised that face-to-face contacts should only occur if there is a clear rationale in acute or urgent circumstances, and where physical distancing and preventative hygiene or protective measures can be put in place. In summary, at Level 4 there is a high bar for face-to-face contacts. At Level 3, these expectations will not change.

On Friday 17 April the Ministry of Health's Chief Allied Health, Scientific and Technical Officer Martin Chadwick confirmed that face-to-face contacts must not become the norm at Alert Level 3 on Tuesday April 28.

Martin has emphasised that virtual contacts should continue whenever possible, with face-to-face contacts reserved for:
- acute or urgent circumstances only, and then
- only when virtual or phone contact has been properly considered, and
- appropriate physical distance is maintained, PPE (if indicated) is used and thorough hygiene practices can be put in place, and
- neither you nor your client have underlying vulnerabilities, and
- a register of all face-to face contacts is maintained, for use for contact tracing if required.

This means that psychometric testing done face-to-face of the sort you describe will have to wait until we reach level 2.

Many psychologists will have clients with ongoing (or new) heightened levels of distress who are of concern. Where possible completing robust risk assessments by phone or videoconference is recommended, as is linking with other sources of support for the

client. You will then need to exercise your best professional judgement when making decisions about whether the threshold for an acute or urgent care need has been reached, taking into account all the circumstances, including information about what Alert Level 3 involves.

We know that this is not the advice many psychologists will have been hoping for. We can only assure you it is not given lightly or without being sensitive to the potential impact on some psychologists or their clients. There will be clients who you know would strongly prefer face-to-face appointments, or for whom Zoom and similar means is simply not manageable. For some in the profession, getting back to business as usual comes with a financial imperative too. The financial impacts of COVID-19 are very real for some members of the profession and their families.

However, we urge you to take heed of the advice from the Ministry of Health, in the hopes that usual care and business as usual can resume quickly and smoothly, without any upsurge in COVID-19 infections or prolonged disruption**.**

20/04/2020

Q*: Can you please clarify whether psychologists can meet face to face with clients when the country is in Level 3?*

A: During the Alert Level 4 period the Board, the College and the Society have emphasised that face-to-face contacts should only occur if there is a clear rationale in acute or urgent circumstances, and where physical distancing and preventative hygiene or protective measures can be put in place. In summary, at Level 4 there is a high bar for face-to-face contacts. At Level 3, these expectations will not change.

Last Friday 17 April the Ministry of Health's Chief Allied Health, Scientific and Technical Officer Martin Chadwick confirmed that face-to-face contacts must <u>not</u> become the norm at Alert Level 3. The Ministry expects to issue clearer advice for health practitioners, including allied health practitioners, before New Zealand moves to Alert Level 3 on Tuesday 28 April. We will ensure you receive that advice as soon as it becomes available.

Until then, Martin emphasised that virtual contacts should continue whenever possible, with face-to-face contacts reserved for:

- acute or urgent circumstances only, and then
- only when virtual or phone contact has been properly considered, and
- appropriate physical distance is maintained, PPE (if indicated) is used and thorough hygiene practices can be put in place, and
- neither you nor your client have underlying vulnerabilities, and
- a register of all face-to face contacts is maintained, for use for contact tracing if required.

The Board, NZCCP and the Psychological Society are working hard to help the profession have access to the best telepsychology guidance available. Please check our websites from time to time for the latest updates, and keep each other informed of useful guidelines, tools

and resources and online training. There is also information on PPE for community care providers, that the Ministry advises will be appropriate for those in private practice. Some major employers will also be developing policies and decision guidelines for their staff.

Many of you have clients with ongoing (or new) heightened levels of distress who you are concerned about. Where possible completing robust risk assessments by phone or videoconference is recommended, as is linking with other sources of support for the client. You will then need to exercise your best professional judgement when making decisions about whether the threshold for an acute or urgent care need has been reached, taking into account all the circumstances, including information about what Alert Level 3 involves.

We know that this is not the advice many of you will have been hoping for. We can only assure you it is not given lightly or without being sensitive to the potential impact on some psychologists or their clients. There will be clients who you know would strongly prefer face-to-face appointments, or for whom Zoom and similar means is simply not manageable.

For some in the profession, getting back to business as usual comes with a financial imperative too. The financial impacts of COVID-19 are very real for some members of the profession and their families.

However, we urge you to take heed of the advice from the Ministry of Health, in the hopes that usual care and business as usual can resume quickly and smoothly, without any upsurge in COVID-19 infections or prolonged disruption.

17/04/20 (please note the more recent response above, dated 20/4/20, on Level 3)

***Q**: Following Jacinda Adern's address today, recommending that businesses start planning forward for a possible move to Alert 3, and to consider together how to provide the safest business practice, my question is whether the government has provided the NZ Psychologists Board with specific feedback regarding whether face to face work, such as that required for psychoeducational assessments, would be permissible under Alert 3, or whether it is anticipated that we would need to wait until we are safely in Alert 2.*

I have read recommendations provided by Pearsons Group in Australia and also by other colleagues, psychologists, who until recently were continuing to administer psychoeducational assessments in Australia, such as using gloves, providing clients with a pointer, rather than touching equipment, and so on. From experience, many of my younger, impulsive clients find it hard to follow instructions, and sensory seeking clients will not be able to avoid "touching" equipment or keeping gloves on. Conversely, there are a number of high school students, who require a psychoeducational assessment to access Special Assessment Conditions for upcoming NCEA examinations, who may be adversely affected if they were not able access this service.

If the Board has been advised that administering psychoeducational assessments will be permissible under Alert 3, what changes to practice are recommended by the Board to

ensure the ongoing health of psychologists and clients? I have considered a few and would be happy to share my ideas, if wanted.

A: [As at 16 April] The Government has not provided the Psychologists Board with specific feedback regarding whether face-to-face work is permissible under Level 3. It is unlikely to be seen as a priority for the Ministry of Health to provide such feedback to psychologists (and it may not be possible for them to do so given the variety of settings psychologists work in), but as a profession of competent and effective professionals who are quite capable of understanding the principles needed to control the disease, we believe it is possible to work this out for ourselves. More guidance may be forthcoming in the next few days. The COVID-19 Level 3 has the single-word descriptor of "Restrict." [1]On the way into the crisis the short descriptor for Level 3 was "Heightened risk that the disease is not contained.
After the peak the single-word descriptor for Level 3 will still be "Restrict" and the short descriptor will be something like "Heightened risk of the disease becoming uncontained again". Given this context, great care will still need to be taken by everyone, including psychologists.

Some of the measures that are specified for Level 3 and are relevant to determining what psychological practice will be appropriate are: "Alternative ways of working required and some non-essential businesses closed," "non-face-to-face primary care consultations," and "non-acute (elective) services and procedures in hospitals deferred and healthcare staff reprioritised."

The situation is fluid, and more detailed information may emerge as we get closer to moving to Level 3, but if one translates the degree of care that health professionals are expected to take in the Level 3 measures listed above to psychological practice, it is our opinion that psychologists should not be expecting to move to face-to-face practice again in Level 3. It is likely to be Level 2 before we can really start face to face consultations and assessments again.

We concur with the question-asker that there would be many situations in which trying to proceed with personal protective devices and other safety barriers may make assessment less valid and possibly make therapy less effective. In specific instances where speed of response is an issue, such as the difficulty for students requiring assessments for NCEA, there is a good case for direct representations to the relevant Ministry to signal the need for modification of usual requirements if disruptions due to COVID 19 interfere with usual processes.

In summary, we are not going back to "business as usual" any time soon. It is likely that even at lower COVID19 alert levels, until a vaccine has been developed and widely utilised there will still be a need to maintain physical distance and carefully consider our approaches to maintaining hygiene. So, it is really helpful for you to start thinking now about how you can

[1] The single word descriptor for Level 4 was "Eliminate" and the short descriptor was "Likely that the disease is not contained")

resolve the challenges in the area in which you practise psychology. Sharing your ideas with your colleagues may help test out how reasonable your solutions are. Looking for resources on websites for your particular specialty area is a really helpful step forward.

It has been clear in the correspondence that we have had since Level 4 began, that the vast majority of psychologists are thoughtful, intelligent and socially responsible, and are making huge efforts to contribute to the process of containing and eliminating the spread of the disease. As the restrictions ease, it is important that we keep up those efforts.

28/04/2020

***Q**: Thank you for your careful consideration of the questions of psychologists during the COVID-19 restrictions. It is amazing how complex it is to set clear guidelines about safe behaviour in these times of change and I value your guidance.*

I work as a Clinical Psychologist providing inpatient health psychology services as well as outpatient clinics. My outpatient work is now being done remotely, as per recommendations.

However, I would advocate that there is a role for inpatient face to face clinical work to continue - as long as it meets the criteria set out by Martin Chadwick. i.e. that

- *acute or urgent circumstances only, and then*
- *only when virtual or phone contact has been properly considered, and*
- *appropriate physical distance is maintained, PPE (if indicated) is used and thorough hygiene practices can be put in place, and*
- *neither you nor your client have underlying vulnerabilities, and*
- *a register of all face-to face contacts is maintained, for use for contact tracing if required*

These conditions are generally met in a hospital setting, except that the patients will have clinical conditions that may need to be considered.

At present, our inpatient population are highly vulnerable. There is anxiety about coming to hospital and this means that often their clinical condition is more serious, and the patient is distressed about being in hospital. There have been higher numbers of early discharges or discharges against medical advice. The patients are not allowed to have family visitors and isolation can contribute to difficulty tolerating treatment regimes.

Psychological input address patient distress, factors that may impact on ability to complete treatment as recommended, and distress associated with COVID-19 restrictions.

In the FAQ p13 under Essential Services, you state that face to face contact should only occur in "life or death" circumstances. This has been taken as guidance that there should not be any psychology service provided for medical inpatients under Level 3.

Can you please consider the disparity between the recommendations?

I would argue that where the criteria set by Martin Chadwick are met, then it is reasonable to provide psychological input, with the expectation that any face to face contact should be carefully considered to ensure the patient's best interests are primary.

A: The advice from MBIE and MoH has gradually been refined over the last month as issues with its implementation have been identified and the threat has stabilised.

In Level 3, we think the best current advice we have available is that from Martin Chadwick, which would allow inpatient contact for acute or urgent circumstances with distancing and PPE and hygiene measures:

“virtual contacts should continue whenever possible, with face-to-face contacts reserved for:

• acute or urgent circumstances only, and then

• only when virtual or phone contact has been properly considered, and

• appropriate physical distance is maintained, PPE (if indicated) is used and thorough hygiene practices can be put in place, and

• neither you nor your client have underlying vulnerabilities, and

• a register of all face-to face contacts is maintained, for use for contact tracing if required.
“

The wording that Martin has used for Level 3 , “acute or urgent” is less restrictive than MBIE/MoH advice given earlier in the Level 4 lockdown. It is not surprising that service managers have struggled with advice that has changed over time, but we agree with you that that where the criteria outlined by Martin Chadwick form a solid basis for a clinical decision about when it is reasonable to provide psychological input, with the expectation that any face to face contact should be considered carefully, and carefully implemented to ensure the patient's best interests are primary.

Neuropsychology

28/4/2020

Q *I'm just seeking clarity regarding the capacity to perform neuropsychological assessments during level 3, where a robust comprehensive assessment cannot be performed via telehealth.*

I could not find any clarity on this from the ACC website or otherwise since the level 3 guideline announcements from the government.

Thank you for your time and I appreciate a rapid response so I can inform my clients scheduled and reschedule as required.

A In line with our advice from Martin Chadwick at the MoH, which is outlined elsewhere in this Q&A, I think you will need to wait until level 2 before undertaking neuropsychological assessments. I appreciate there is a conflicting advice around, even emanating from different government agencies, so we have sought to work closely with the Ministry of Health when considering these issues and are trying to ensure our advice is as authoritative

as possible, so our practise stays as closely aligned as possible to the purpose of the Covid19 restrictions..

27/3/2020

Q: *I see ACC say neuropsychological services can now be provided on Telehealth. My understanding is we cannot undertake testing over the internet and I have had a number of enquires. Can you comment please?*

A: (We are seeking expert opinion on this issue, including consulting NZSIGN on the evidence for virtual forms of testing, aim for reply Friday 3 April. Please consider carefully what is the evidence that neuropsych assessment can be carried out by virtual tests?).

7/04/2020

There have been several later queries about tele/remote/virtual processes for conducting neuropsychological assessments (TeleNP), and these are raised below, some abridged for clarity and brevity. The questions overlap to some extent therefore please read all of the responses below to see the collaborative hub's comprehensive thinking.

Q1: *I see ACC say neuropsychological services can now be provided on Telehealth. My understanding is we cannot undertake testing over the internet and I have had a number if enquires. Can you comment please?"*

Q2: *I am concerned at the prospect of conducting neuropsychological assessments remotely, particularly when there is not much evidence that such assessments can be thorough, valid, or ensure test integrity. From some statements online I am getting the sense that there is enthusiasm for or urgency in conducting assessments over the internet, but it is clear the evidence is not there to support complex neurocognitive assessments in the majority of clients under the present conditions.*

Q3: *I am writing with some concerns about neuropsychological practice in the current covid-19 situation. There is discussion in the neuropsychology field of some clinicians starting to complete neuropsychological assessments using psychometric measures via telehealth processes, as we are unable to see clients face-to-face during the current situation. I find this quite concerning, and I know I am not alone.*

One area that sets neuropsychology apart is that we are able to use objective psychometric measures to assess our clients, including performance validity. Based on the results we get, we make recommendations that have implications for the client's well-being, rehabilitation, and financial compensation. There are several issues in conducting this work via telehealth, and I am concerned that these issues are not being fully recognised. Doing this work unsafely can have a detrimental impact on our clients' future. Aside from our clients, we need to consider test security and integrity. There is at least one test publisher (Pearsons) who is in the process of providing some tests via electronic means during this covid-19 time, but this will still be limited, not least by the lack of clinician experience and supervision in administering tests in this telehealth manner.

In the last few days, we have been able to view two webinars on the topic of completing neuropsychological assessments via telehealth (TeleNP). One by the Australian Psychological Society (APS), and the other by the International Neuropsychological Society (INS). There are also various documents out there (link from INS website).

In order for you to fully understand my comments you will need to view both webinars yourselves, but they do raise some interesting issues that lead me to be concerned that rushing into this is not advisable, and that we (i.e., neuropsychologists) need some guidance from the Board.

If you are interested and have not already seen them, the INS webinar is shorter, and it appears that they have been doing TeleNP for longer than the group in Australia. However, both raise similar points: That 'at home' assessments have not been validated as yet. Rather, TeleNP has been completed between clinics (to reach more remote areas) with a technician/assistant in place at the remote setting to help out at that end. This is of course not possible in the current lockdown situation. They do not recommend the home-to-home model of TeleNP.

The TeleNP processes used to date have involved a small range of conditions (e.g., stroke, dementia), and therefore have not been validated with other conditions such as traumatic brain injury, ADHD, etc.

They recommend against doing assessments with clients who have significant impairments.

Methods to assess performance validity via telehealth are lacking, to say the least, as more statistically robust measures are not able to be used.

They emphasised (more so in the INS webinar) that attending the webinar/s is insufficient training to do TeleNP.

That it takes time and a lot of supervision to learn to do TeleNP competently. To the best of my knowledge (and that of those I have spoken to) there are no neuropsychologists in NZ who can provide the supervision necessary for this to be introduced as regular practice at this stage. The presenters of the APS webinar mentioned they would look into supporting us, but that this would take time to arrange and get to the point that would be able to be practically applied. They also mentioned that they are aware that those of us in NZ are not currently in a situation (lockdown, lack of access to clinics, lack of supervision) to do TeleNP.

That the client needs (including urgency, suitability for telehealth) should be prioritised, not clinician financial concerns. Specifically, the INS seminar stated that: "It is strongly recommended that Direct-to-Home TeleNP service provision is considered based solely on the urgent clinical need of the patient, as opposed to the financial concerns of the provider or logistics of clinic". I get the impression that financial issues may be a driving force behind some pushing TeleNP.

In the course of my discussions with others about this topic, I have noticed that those of us with significant reservations tend to be more experienced clinicians. I do worry that, for those less experienced clinicians pushing for this to go ahead quickly and without sound guidelines in place, it is a case of 'you don't know what you don't know'. In turn, this is putting clients at risk of not getting a fair assessment, and the clinicians putting themselves at risk of practising outside the scope of their expertise.

Some have expressed concerns that neuropsychology will become obsolete if we don't make these changes and start practicing TeleNP immediately. I am not against TeleNP

as a whole, but my experience and the information contained in the webinars and readings I have done advise that we need to do our due diligence in setting this up, otherwise we risk doing more damage to neuropsychology and the wider psychology profession as a whole (and most importantly the clients themselves) if we rush into unsafe practices. As a result, this is becoming an urgent matter that needs your guidance please.

I expect that in time our testing processes will adapt and we will be using more electronic means to conduct assessments (perhaps in the near future as the impact of the virus continues in some aspects) but for now, in my view, there needs to be recognition that we are not in situation at this time whereby we can do so safely, for our clients, or ourselves.

Response to the TeleNP Questions

A: Telehealth as a method for delivering neuropsychological services (TeleNP) is an emerging area with some evidence of its effectiveness, but there are unresolved questions about its application and validity. Reliable and valid neuropsychological assessment relies not only upon integrity of psychometric tests, but also upon effective engagement of the client through establishing a working alliance, synthesising test results with observations of behaviour and affective responses, collateral information from whanau and other sources. Each of these is significantly more challenging in a telehealth environment. Many aspects of neuropsychological tests are culture-bound and may discriminate against Māori clients, or those from cultures other than that in which the test originated. That discrimination may be compounded by an electronic assessment format.

We are aware that any policy relevant to an area of practice where there is rapid change may quickly become outdated, and we will continue to monitor developments, and incorporate new evidence that arises. This answer will separately address neuropsychological assessment and other neuropsychological services.

Tele-Neuropsychological Assessment

To undertake neuropsychological assessments remotely with effectiveness requires not only competencies in neuropsychological assessment but also development of competencies in delivering tests remotely via a telehealth format. Additionally, skills in using Telehealth methods for other aspects common to any effective consultation are required. ACC has accepted the use of telehealth for some neuropsychological services and in the current Covid 19 situation this may be important. However, we recommend that remote neuropsychological assessment only be undertaken during the period in which face to face consultations are precluded and beyond if:

- There is an **urgent clinical need for the client** that requires this TeleNP assessment to be undertaken during the Level 4 restrictions, (i.e. the client's need for assessment is so acute and time-sensitive it cannot wait for COVID19 restrictions to end) **and**
- The psychologist undertaking the assessment is competent to undertake remote neuropsychological assessment on the basis of training and/or experience in undertaking remote clinical assessments, **and**

- The psychologist undertakes available training before undertaking TeleNP, and engages in peer supervision that monitors the competence of their remote delivery of neuropsychological assessment.

If these conditions are not met, then it is strongly recommended that the psychologist does not undertake remote assessment during this time.

- The long waiting lists for neuropsychological assessments in much of the country suggest that it may be hard to argue that most cases can be considered as in acute need. However, there are some assessments (for example early identification of TBI following concussion) where it may be clinically important to assess early. There are also aspects or parts of an assessment that are less problematic to undertake by remote methods, such as conducting interviews to engage the client, provide education and support, obtain a clear history from the client and collateral history from whanau or others.

Financial concerns of the provider or logistics of the clinic does not excuse psychologists from their ethical and legal requirements, including those to ensure test security and delivery of testing that is competent and delivers results that can be relied on.

Other Neuropsychological Services by Telehealth

Several other neuropsychological services can be safely delivered via telehealth, including feedback on assessment results, many psychological components of rehabilitation programmes, and therapy with people with neuropsychological difficulties. As with all other telepsychology services, informed consent to use telehealth processes should be clearly established with clients prior to service delivery.

"Essential Services?"

7/04/20

Q: *We have a private practice centre with a number of psychologists. We have all been working from home.*

Now that we have been deemed an essential service the issue of whether we could see clients in need face to face in our rooms. I understand that we are encouraged to work from home but there have been some significant challenges for some psychologists to do this.

If a psychologist would want to use the rooms for Tele health sessions without face to face, is this permissible if another psychologist is in the building again following the prescribed Ministry of Health protocols?

A: Although psychologists are part of the workforce designated as 'essential' we still need to restrict our activities to essential tasks, this is not 'business as usual'. We still need to stay at home, avoid any contact with people outside our 'bubble' unless it is essential to do so. We

can and should continue to offer what services we can remotely, although this can be challenging for all involved.

Understanding what an essential service is, is only partly about the profession of the person - it is significantly about where they work and the specific tasks they are undertaking.

While mental health workers are considered essential workers, psychologists should consider face-to-face contact with people outside their "bubble" only if:

1. In case of face-to-face contact with other staff: Their workplace and the nature of their work requires them to be present at that site or
2. In the case of face-to-face contact with clients, it is a matter of life and death.

In any other situation, you should be staying in your "bubble" and at your home location.

Please keep in mind that if you decide to go to your office, even if not seeing clients, you are exposed to the possibility of contracting the virus from other people who might be using, or have used, the building, and you then run the risk of transmitting the virus to others in your "bubble". This is a risk even with careful attention to hygiene. This is why going to your office even to work alone is contrary to and not in the spirit of the Level 4 "Lockdown" provisions.

25/3/2020

Q: *The service I manage is considered an essential service and we want our psychologists to come to work as we consider them essential employees. How do we know what is "essential" for Level 4.*

A: The MoH and MBIE are the organisations determining what is considered "essential". MBIE's contact details are 0508 377 388 or essential@mbie.govt.nz. It may also be helpful to discuss this with the psychologists as face to face contact is not recommended if they are able to do their work remotely.

1/4/2020

Q: *Can you let me know if psychologists are considered essential workers as I need to purchase computer hardware to facilitate my working from home. The online supplier I spoke to said that they are only open for online provisions to essential workers so unless I have a letter of confirmation I am not able to purchase the monitor.*

A: We suggest drawing the online supplier's attention to the Ministry of Health's website list of "essential workers"- this list includes mental health workers which covers psychologists.

https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-current-situation/covid-19-essential-services-health-and-disability-system

Students Using Zoom Recording for Training Purposes

30/04/20

Q *Psychology students, interns and other clinicians commonly use the recording of sessions for supervision and exam purposes. During COVID-19 times sessions are usually via Zoom, which has a recording function. It is my understanding that the MoH does not allow the use of the Cloud for the storage of personal information. I would like to hear your view on the recordings of Zoom sessions, with Zoom a Cloud based platform. Similarly, when working from home students commonly use their own devices. Would it be appropriate to use a personal device for the recording of Zoom sessions? Any tips of how this can be done safely are welcome.*

A: It is dependent on context as to whether the storage of video data (rather than textual/numerical data) for student training/assessment purposes (rather than health information purposes) on the Cloud would be acceptable, but such recordings require a high degree of security.

Although MoH policies about Cloud Computing changed in 2017 to become slightly more accepting, they still require a substantial formal risk assessment process prior to use of Cloud storage of health information. The DHBs and some other larger organisations will have done this kind of assessment so if you work in such an organisation ask your IT services. Smaller organisations or individual practitioners, it may find it hard to do any meaningful kind of risk assessment.

Zoom does allow you to record to your own device rather than the Cloud, (choose “record on own device on the record button, Alt R shortcut), so you can record sessions without needing to store it on the Cloud. This is a reasonable option for students whether they work for a large organisation or not. You should ensure that you gain explicit consent from your client for the recording and storage.

Using a personal device may pose less risk if careful precautions are taken. If you are using a personal device to store recorded consultations, we strongly recommend ensuring your antivirus software is up to date, keeping all data files in a location or format that needs a password to open, and ensuring that all records are deleted as soon as they are transferred to the employer or are no longer needed for the purpose of the recording. You should not use a personal device if the device is shared, e.g., a computer that is accessed by others in your household. Any paper notes you write should be kept in a locked filing cabinet or similar secure location while at your home.

Zoom Privacy

7/04/20

Q: *I have been reading in the press articles expressing concern regarding the privacy of Zoom software. Many of the psychologists at our DHB are using the free Zoom software, from their own devices, in order to conduct assessment and therapy with clients during the COVID 19 situation whilst working from home. We are aware of the need for consent etc as per the various guidelines re teletherapy. Should we as a profession however be continuing to use this software or are their special safeguards we should be taking?*

A: As a first step, if you work for an organisation, it would be wise to refer to the IT department of that organisation to ensure that your practise is consistent with their IT policies and cybersecurity protocols.

We are aware of the press regarding the privacy of Zoom software. It is probably not possible for psychologists to routinely obtain access to software that offers absolute security, just the same as it is probably not possible to absolutely ensure that no-one is listening through your office door, or has a listening device in your office, or is listening from outside your office window. We need to take the best measures we reasonably and practically can to ensure client safety. That includes checking available information and instructions from the software platform company or suppliers, and regularly installing any security enhancements or updates made available for them. At present we believe that Zoom can offer an acceptable degree of security, if the psychologist takes the following steps to elevate the security level when using it:

- **Use a "Generate Automatically" meeting link rather than your "Personal Meeting ID".** This means that a new link is established for each meeting you set up so someone who has connected with you on Zoom before can't use that link again and try and "piggyback" on your current meeting. The choice between "Generate Automatically" or "Personal Meeting ID" link is provided on the Meeting Scheduling page.
- **Add a Password.** This will also help prevent any unwanted guests at your meeting. The choice of using a password, and the ability to choose that password is also on the Meeting Scheduling page.
- **Use the Waiting Room function.** This prevents guests from entering the meeting without the host (person who set up the meeting) from being aware of their presence. The host is notified of the presence of a new guest in the waiting room and has the choice to admit them to the meeting or not. This function is chosen during the meeting creation by opening the Advanced Options tab at the bottom of the Meeting Scheduling page, checking the 'Enable waiting room' setting, and then clicking on the 'Save' button.
- **Lock the Meeting when all intended guests are present.** This stops anyone else from joining the meeting. This is done by clicking on the 'Manage Participants' button on the Zoom toolbar, selecting 'More' at the bottom of the Participants panel, then selecting the 'Lock Meeting' option.

Virtual vs face to face?

7/04/20

Q: *Can you please consider whether the use of Telehealth is deemed to be appropriate for aassessments and diagnosis of mental injury from sexual abuse trauma, given the complexity and the use of psychometrics*

A: It is difficult to see circumstances in which this type of issue would be of such urgency that is could not wait until Level 4 restrictions are lifted. Psychologists need to ensure that their assessments are comprehensive and valid, and that they put ethical considerations over that of the administrative and financial issues.

24/3/2020

Q: *We are an essential service. We need our psychologists because some of our clients become dysregulated and suicidal, and the psychologist can help de-escalate the situation. Can we make them come into work?*

A: If any clinician is required to conduct a face-to-face consultation in a crisis situation where there is no alternative, they should have the means to maintain physical distance, and use (and be trained to use properly) PPE equipment.

24/3/2020

Q: *I want to provide telepsychology services. What does the Board recommend that I do when providing this?*

A: The following guideline from the Board may be helpful when considering offering telepsychology. The link is below:
http://www.psychologistsboard.org.nz/cms_show_download.php?id=244

The NZCCP and the NZ Psychological Society also have a number of resources available which may help with this – the links are below

https://nzccp.co.nz/about-the-college/news/nzccp-covid-19-virus-response/

https://www.psychology.org.nz/community-resources/covid-19-resources/

As always, the Board's expectation is that psychologists are working within their scope of practice and adhering to the Code of Ethics and the HPCA Act.

Consent issues

27/3/2020

Q. *Hi, I am a psychologist working for the XXXXXX. We have a written consent form where we visit clients and talk through the consent process before all parties sign a consent form. At present my work is being done on the phone from home and I already have written consent for almost everyone. However, I have a new client and have not been able to visit. Can I set up a video meeting with the clients and can we agree verbally to me carrying out the work? Can the clients also verbally consent to me talking to specified professionals when working on the case? Also, how would I record this? Perhaps I could use the consent form, sign it and post this to the client with a return address? I would have to use my home address as we do not have anyone to receive mail from my workplace. Please let me know your thoughts.*

A: The Psychologists Code of Ethics and H&DC Code of Consumer Rights stress that we have to obtain consent, but do not require it is in writing. Under the current (and other) circumstances we believe it is fine to have verbal consent as long as it is documented carefully, and recommend you also document the reason why verbal consent is recorded rather than written consent. Once things return to 'normal' the service user could be re-consented if relevant.
If you have concerns about the acceptability of this strategy to your employer, you should talk it through with your manager in the first instance.

Conflicting Employer Expectations

30/03/20

Q: *I work for a DHB mental health service and believe I can provide adequate services from home via videoconference, which I am willing to do. MBIE website says I should be providing virtual services wherever possible. However, my employer insists that I come in to the office and work by phone from there. So, I am doing therapy over the phone, but we have face to face team meetings and people have shared offices. I don't understand how this is maintaining our "bubble" particularly when therapy over the phone could be done at home. Please can you advise?*

A: The Board agrees with the MBIE/MoH advice, which is intended to slow the spread of disease by helping maintain physical difference from others outside your own “bubble”. The Ministries involved are working at speed under difficult circumstances. Many Psychologists are mental health workers and many of them work in services that have been deemed essential, while others don't. Some of their tasks can be done from home, others may not be able to be, depending on setting.

The Board believes that the Ministry’s advice is that any mental health workers, including psychologists, whose job role does not specifically require them to be present on the worksite should be working remotely and staying in their "bubble". However, DHBs ***may***

have reasonable grounds for deciding to require work from their premises, based on their weighing of risks such as breaches of confidentiality, and the need for maintaining electronic records. We believe that the best approach would be for the psychologists in a particular DHB where this was a problem to take it up with their GM of Mental Health (or another appropriate manager). We believe that ***if*** other obstacles such as confidentiality and record keeping can be overcome, there is evidence that remote therapy can be appropriate and effective, so psychologists could use this evidence (see links above) that working remotely is a reasonable path of action.

Q *My company wants me to do Initial Assessments through ONLY a phone call. I do not see this as safe practice. I insist on a visual video aid (Skype etc.). I view this as a risk for me and the client. Your guidance is appreciated.*

A: Please see the reply immediately above. Psychologists are well placed to help service managers to understand and interpret the MBIE/MoH information, but to do so they need to use their skills in communication to determine what the issues are that have precluded an obvious solution like using videoconference. An agency providing essential services may have a range of concerns such as privacy, confidentiality, record keeping that are legitimate, and psychologists may be able to help them find solutions without a "standoff".

Student Issues

17/04/2020

Q*: I am in my internship year completing the requirements to register as a psychologist. The Ministry of Health has just put out a policy that means I am not considered an essential member of an essential service. Because my placement has been cancelled, I will not be able to complete 1500 hours of supervised practical experience by the time I register. Will I be able to register as a psychologist at the end of my degree?*

A: Because protection of the public is the Board's primary concern, it must be confident that new graduate psychologists are appropriately safe and competent to practice. However, it is talking with Directors of courses leading to registration and exploring ways to work flexibly in the current circumstances. It will avoid any unnecessary barriers to final registration. We expect have a clearer sense of the extent of impact on student placements over the next week or so, and the situation will be reviewed during the next meeting of the Board 22-23 April meeting

International Student Support

17/04/2020

***Q**: I am the head of a University Counselling Service. With the current Covid-19 situation, there are many overseas students who have been unable to come to NZ to study the courses they have enrolled in. The University is working remotely with most of these students. In the event that some of these students need mental health support I am wondering if the Board has any recommended approaches to the problem of working across international borders, through remote services? I realise that this is a legal and ethical issue and is covered in your Telepsychology competency document.*

I look forward to hearing from you.

A: Under their Covid-19 study arrangements all NZ Universities will have recommendations for such situations worked out. So, first thing to do is refer to the University's own guidelines.

The Board's policy on New Zealand registered psychologists working in cyberspace is spelt out in its policy on telehealth, available on the Board's website, and has not changed because of COVID19.

Ethically, any New Zealand registered psychologist who wishes to work via the internet should register in any jurisdiction from which they recruit clients. If you enter the state or country via technology, you may be deemed to be practising in that country. Psychologists who are registered in New Zealand who practise with clients online are advised to ensure they research the legal and regulatory obligations of that geographical location prior to accepting clients from that location.

Although it is likely that the HPCA Act can only be applied to protect the "public" (persons) in New Zealand, under sections 7 and 8 of the HPCA Act if a practitioner is based in New Zealand and claims to be a psychologist able and entitled to practise in New Zealand (notwithstanding that their proposed clientele may be based overseas) then this may be sufficient to support charges under the Act (unless the practitioner has expressly stated that the offer of service is not available to New Zealand residents or citizens and does not intentionally handle any offer or provide any service within this country).

Therefore, all psychologists who practise via the internet in other countries should ensure that they hold a current annual practising certificate and meet New Zealand requirements to maintain competence. They should also ensure they meet whatever obligations arise in the country in which they practise (i.e. where their online clients are based).

Use of personal devices

17/04/2020

***Q**: I was wondering if you would be able to let me know if there is any guidance or the group's position on psychologists being instructed by their employer to use their own personal devices (mobile phones/laptops etc) to contact clients and write notes from home (which are usually handwritten in paper files which are located in the office)?*

I am specifically interested in the use of clinician's personal devices and the ethical/privacy aspects of this as opposed to it being a general teleworking query.

A: It may be within your rights as an employee to refuse to do this, but given the state of emergency, you may see this as part of your responsibilities to your clients. You still need to ensure confidentiality for your clients. You should also consider your own right to privacy and it is advised you ensure your personal contact details are not routinely displayed for a client to view. That is, consider making your mobile number 'private' and do not send emails from a personal email account.

We are aware that some employers are installing client software like CITRIX on personal computers to give staff access to the clients' records, and this probably poses less risk than ad-hoc solutions. We strongly recommend taking extra precautions by ensuring your antivirus software is up to date, keeping all notes in a location or format that needs a password to open, and ensuring that all notes are deleted as soon as they are transferred to the employer. Using a personal device is not recommended if the device is shared, e.g., a computer that is accessed by others in your household. Any paper notes you write should be kept in a locked filing cabinet or similar secure location while at your home.

Videoconference issues

17/04/2020

***Q** I'm working from home during the covid-19 lockdown, my question is, can the NZPB provide some guidance around what online chat platforms are sufficiently secure to use with whaiora? I am checking in with my whaiora on a weekly basis via telephone during the lock down. However, my phone reception at home isn't great, and particularly with one whanau I have real trouble hearing/communicating with them via phone. They would naturally prefer to talk via an internet chat platform, such as skype. However, I have very little computer or IT knowledge and I'm unsure which option would be best and how to best protect their confidentiality whilst I do so. I would really appreciate some practical advice on which options are considered acceptable by NZPB.*

A: Our advisory group is not highly expert on technology either, but we have had a fairly steep learning curve, and you may have seen our response to other questions about using

ZOOM privacy on the Boards COVID19 FAQ webpage. There can be security issues with all videoconference software including Skype. Zoom seems to have become the most popular and if you follow the advice we have put up, it seems to be secure. Most of the problems seem to come from failure to be careful with meeting IDs and passwords for meetings, so if you avoid those you should be OK.

Virtual vs face to face for ACC Sensitive Claims Assessments

7/04/20

Q: *Can you please consider whether the use of Telehealth is deemed to be appropriate for aassessments and diagnosis of mental injury from sexual abuse trauma, given the complexity and the use of psychometrics*

A: It is difficult to see circumstances in which this type of issue would be of such urgency that is could not wait until Level 4 restrictions are lifted. Psychologists need to ensure that their assessments are comprehensive and valid, and that they put ethical considerations over that of the administrative and financial issues.

17/04/2020

Q*: My question relates to doing supported assessments for ACC via zoom. This involves a thorough assessment of history of sexual abuse as well as a generally standard clinical interview and the administration of some basic and small psychometrics.*

I have postponed all assessments that clients have identified significant risk concerns, or if the counsellor themselves has also (the counsellor is often the lead provider), these are not my own clients, rather clients of other providers who require assessments. The zoom appointments would be the first time of meeting these clients.

I had believed that where it was established that distress could be managed and the client had supports, including access to counselling etc that these assessments can continue when managed as above (screening out for this likely to experience significant distress), discussing consent and limitations, ability to stop process at any point, discussing topics to be discussed before starting the assessment and giving client opportunity to discuss this with their lead provider before asking them to let me know if they give verbal consent (I have moved away from the video and turned off my sound/removed head phones for a few minutes).

I recently saw something on the NZCCP private practitioner's fb page that suggested another psychologist had been advised doing these assessments at all and I wanted to check the standpoint on these and my approach. I have done two assessments using this process and they appear to have gone okay, with multiple checks with both client and counsellor and leaving the assessment with the two of them still present to allow for after assessment debriefing also without myself present after reviewing skills and strategies/supports if required for the client as a result of the assessment.

I do not have any other assessments like this scheduled under level four, however if level four is to continue or I am to find myself working in an ongoing way from home I would appreciate your guidance as to this process and recommendations for moving forward? On a more personal note, these assessments form over half of my usual work and I am interested to know also, if it is recommended, they do not proceed, as then I will also need to seek alternate employment.

A: Our initial response when we were first asked about sensitive claims work was to share our doubts that a video-conferenced psychologist could safely establish rapport and form a working alliance with enough trust to enable a thorough and comprehensive assessment in such a complex area. In an area where distress is common, and confidentiality is vital, it may be difficult to safely use a video-conferenced consultation.

Those concerns remain but is also clear that there is a rapid cultural change happening throughout society in the way video-consultations/ telehealth are being seen, and practitioners of all sorts are using them for all sorts of purposes. And clients in their day to day lives are widely adopting videoconference by skype or zoom just to keep in touch with friends and whanau during the lockdown.

So, our advice today is probably less black-and-white than just a couple of weeks ago. Determining the extent of mental injury attributable to abuse and trauma is an area fraught with challenges when the client is seen kanohi ki te kanohi, and more complex again when there is no direct face to face contact. The key issues that psychologists need to assure themselves of is whether or not, with this client and these issues at this time, they can reliably, validly and safely undertake this assessment. We also recommend that practitioners only undertake such assessments remotely at this stage if there are urgent clinical need that requires that the assessment be undertaken immediately, and if the practitioner feels sufficiently trained and experienced to undertake a distance assessment that will be of the same quality as an in-person assessment . If this is not the case, we recommend that the assessment be postponed, and the psychologists continue to develop their telepsychology skills with other existing clients until they do feel sufficiently skilled in the use of telehealth approaches to undertake such assessments effectively.

In our role as your colleagues we cannot rule this out, but we urge caution in proceeding.

This list will be regularly updated as we address new issues arising.