PSYCHOLOGY PRIVATE AUSTRALIA Inc.

THE FEDERATION OF ORGANISATIONS OF PRIVATELY PRACTISING PSYCHOLOGISTS OF AUSTRALIA

CONSTITUENT BODIES

Association of Private Practising Psychologists (NT)
Association of Private Practising Psychologists (QLD)
Australian College of Private Consulting Psychologists (NSW)
Psychology Private Tasmania
Psychologists in Clinical Private Practice (A.C.T.) Inc.
Australian College of Psychologists in Clinical Private Practice (VIC)
Institute of Private Practising Psychologists (SA)

RESPONSE TO NATIONAL PSYCHOLOGY BOARD PAPER

I. Identification Statement

Psychology Private Australia Inc (PPAI) is the umbrella federation of the above constituent associations of private practising psychologists in clinical practice. The emphasis throughout this submission therefore will be on issues that are relevant to the private practice of psychology.

II. Contents of This Submission

III. Specialist Registration

Concern for and Concerns of the General Public

We acknowledge and applaud the Board's concern that the general public must be able to choose the psychologist who is most appropriately trained and experienced to meet their particular needs.

The circumstances whereby a member of the public would be making this choice would be in the arena of private practice and not for example in a hospital, doctor's surgery, academic institution, sports academy, or any other place where the nature of the workplace denotes the type of psychologist working there. It is in the area of private practice that members of the public self-refer to a psychologist or seek referral through their general practitioner.

Therefore, when considering specialist designations/titles (in medicine specialist designations carry restrictions) as descriptors of psychology practice, it is necessary to understand the nature of private practice, both in the cities and in regional areas, and the ramifications of the Board's decisions.

People consult private psychologists for a variety of reasons. Full time private practising psychologists often are unable to confine their practice to one particular specialty area. They will have a number of patients who present with mental health disorders (many of these now covered by Medicare). They see people who are distressed due to relationship difficulties and are seeking counselling. They may be consulted for assessments in relation to forensic issues, or insurance claims. They may be asked to provide a report on an existing patient for a court hearing. They may see people who are stressed due to workplace issues and whose presenting conditions could range from mild distress to anxiety, depression or adjustment disorder with severe PTSD symptoms. A child may be presenting with behaviour problems – such a case needs very careful assessment to find the reasons for the behaviour, perhaps due to one or more of a number of factors, including learning difficulties, bullying, parental discord and abuse. This is a small sample of a private practising psychologist's typical work load.

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In cities where there are larger numbers of practising psychologists and more people seeking to access psychological help, there tend to be more practitioners specialising in type of patient intake. In smaller towns and regional areas it is not possible to so specialise.

'Specialists' and 'Specialist' Titles

The 'specialist' titles as set out in the National Psychology Board proposal paper appear to be potentially restrictive and not in the best interests of either the psychologist or the patient. Moreover, in the context of a National Registration Authority for all 'brands' of health practitioners, the use of the term ***specialist*** for any psychologist is specious, hollow and a joke. The possession of a higher degree really says nothing about the actual professional competence of a practising psychologist – particularly one in private practice. **It is recommended** that (i) the National Board abandon its attempt to accommodate some registered Western Australian psychologists by perpetuating an anomaly of registration in the Australian scene, and (ii) direct its energies into introducing some realistic descriptor mechanism (such as was adopted by the Queensland Board in 2002) for accommodating any psychologist who works mainly in one of the specialty branches of psychological practice and can palpably demonstrate this. [The anomaly exists in that requirements for specialist registration in medicine in the Western Australian legislation bear no resemblance to legislative requirements for registration of psychologists.]

Should the National Board doubt the advisability of abandoning the designation ***specialist*** it should consider issues such as are implicit in the following. (i) Is it proposed that the so called 'specialist clinical psychologists' will restrict their practice to people with mental health disorders as recognised by the Better Access Medicare scheme? (ii) Will the 'specialist' clinical neuropsychologist, 'specialist forensic psychologist, 'specialist' health psychologist or the 'specialist' counselling psychologist be restricted to receiving patients/clients only in any one of these areas? (iii) How is it possible to be a competent practising psychologist and not have expertise in most or all of these areas? (iv) Why are educational and developmental lumped together? How could one possibly be a practising specialist developmental psychologist and not be a clinical psychologist? (v) Why is there not a 'specialist child psychologist'? (vi) Why is there not a 'specialist' private practitioner? (vii) Why are the so called specialty areas mirroring the sub-sections of one particular professional organisation which has historically not been able to recognise private practice psychology as a serious, vitally important 'specialty' or College?

'Specialist' Titles and Procedures for Standard Development Elements

The National Board proposal to introduce specialist titles into the practice of psychology does not meet the requirements of the legislation in that restrictions on the practice of the health profession of psychology are not necessary and do not ensure that psychological services are provided safely to the public.

In fact, they are arbitrary, based on recently available accredited post graduate university programmes and the membership requirements of sub-sections of one particular professional organisation to the exclusion of all other professional organizations. Such a basis may well convey a false belief about professional competence; and they therefore are actually potentially detrimental to the practising psychology profession and a danger to the general public.

Further, in developing the proposal, the most relevant groups, i.e. the private practitioner groups, were not involved in any discussion.

The actual nature and realities of full time, established, serious, real world private practice has been ignored in this effort to try to marry the interests of suppliers of accredited academic courses plus the professional organisation that has historically accredited these courses, with the sudden and belated interest in private practice occasioned by the introduction of the Better Access Medicare scheme.

The Process of Using and the Use of Private Practising Psychologists
People visit psychologists with a variety of presenting problems or symptoms. In Australia, over the last thirty years or more they have done so without doctor's referrals, and sometimes with doctor's referrals. This is still the case, particularly with those who have private health care. They most often do not present with a ready-made diagnosis. The private practitioner has been, and often still is, **in a primary care position** and has the responsibility to carefully assess and diagnose and treat accordingly.

It is the opinion of members of PPAI that any psychologist in private clinical practice where people can self-refer must have clinical skills, must know how to take a clinical history, must know how to assess patients/clients, must make differential diagnoses, and must be able to decide whether there is a need to encourage the patient to also consult a medical practitioner or psychiatrist. There is also a need for the psychologist to have knowledge of and experience in the use of a variety of therapies and the ability to choose the best, most appropriate therapy for the particular patient and the particular presenting problem or set of problems.

Even where a patient has been referred by their GP, there is still the need for a careful and detailed clinical history and diagnostic formulation and an understanding of the process by which the patient's presenting problem or crisis developed.

The Designations 'Specialists' and 'Clinical Psychologists'
By their initial training and their wealth of clinical experience diagnosing and successfully treating a wide variety of patients with a wide variety of presenting problems/symptoms/mental health disorders, experienced psychologists in clinical private practice ***are*** 'clinical psychologists'. They are not without specialist qualifications and they have multiple specialist experience. To restrict a psychologist, as a 'specialist' to a particular area of psychology practice imposes an impossible and unworkable impediment to safe and successful assessment and treatment in private practice; and to require a practitioner to style himself/herself by way of multiple 'specialist' categories is a fallacy – the psychologist so styled, becomes a *generalist.*
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The decision for purposes of the Better Access Medicare scheme, to arbitrarily define a 'clinical psychologist' as a psychologist who had a relatively recently available clinical Master's degree, which is the eligibility criterion to join the 'clinical' subsection of one professional organisation (excluding all others) was a travesty of categorisation.

It has divided the profession with hostility and acrimony over issues of anti-competitive discrimination, unethical bias and conflict of interest. However those who suffer most from the outcome of this decision are the patients who choose to consult more experienced and trusted 'generalist' psychologists but will have to pay more in the gap fee than those who consult less experienced 'clinical' psychologists. (The Australian Psychological Society recommends to **all its member psychologists** working privately, the charging of the same fee).

Further, if the older, experienced, so called 'generalist' psychologists (ridiculous as a differentiating title) obey the dictates of the Better Access 'focussed therapy' rules, they risk unethical practice by not using the therapeutic intervention which is best for the patient. By dint of their knowledge and experience and years of practice they know they ethically must use the appropriate therapies for each patient's unique needs and therefore cannot abide by the arbitrarily misguided Better Access rules. The majority of experienced private practitioners have not accepted this limitation on their work.

Who are the Real Clinical Specialists?

It takes years of clinical practice to become a really good therapist, to understand individual patients' needs, to be able to build rapport with a diverse range of people, to select the intervention technique appropriate to each patient, and to be able to deliver successful therapeutic outcomes over a relatively brief period of intervention time – a necessity where in the years without Medicare, the number of sessions was limited by financial considerations.

It is the experience of those psychologists who have successfully maintained a clinical private practice for many years, that patients self-refer on the recommendation of a friend or relative, or neighbour, or work colleague who themselves had benefited from therapy with the psychologist or knew someone who had benefited. Also, doctors refer patients to psychologists for the same reasons.

The criteria suggested by the National Psychology Board for conferring specialist status appears to be a plan for the future as accredited post graduate courses become available. **The National Board,** if it persist with the nonsense of some psychologists being *specialists,* must take into account the real specialists – those whom the description in the first paragraph of this section fits. Existing psychologists who were trained as clinical psychologists in the courses that were available at the time of their training, who worked as clinical psychologists following graduation and who have been practising as clinical psychologists for many years cannot be excluded simply because there are now different course structures and, in Western Australia, differential registration possibilities and requirements. *Any changes to the status of psychologists must include a grandfathering provision for those older experienced psychologists.*

The 2002 regulation of the Queensland Psychology Board allowing the use of descriptor titles was very helpful, and would be a useful tool for grandfathering criteria. However, it could be considered discriminatory, if not fraudulent, to have trained and registered psychologists under one set of State conditions and legislation grandfathered in, and not grandfather in all such from all States under new legislative arrangements.

A Snapshot of Very Experienced Private Practising Psychologists

Psychology is the only profession (or trade) where long term experience does not count. Yet if one asks a member of the public would they choose to seek psychological help from a newly graduated psychologist with a particular university degree or a psychologist with clinical training who has been in practice for more than twenty years, the choice is invariably for the latter.

It was the entrepreneur private practising psychologists who over many years built the reputation of Psychology as a profession proficient in delivering primary care in the mental health arena, and created the trust of the general public and the demand for private health fund rebates, and ultimately Medicare rebates for patients accessing psychologists. In fact, when the Better Access scheme was announced, a delegation from Psychology Private was informed by the then Parliamentary

Secretary for Health that it was the intention of the then government for the rebates to be given to patients of the private practitioners who had been available and successfully treating patients for many years without the benefit of Medicare rebates.

IV. CPD and Supervision

General Issues

It would appear that the unfortunate dichotomy in the profession due to decisions by Public Service advisors to the Health Minister to arbitrarily entitle one group to be referred to as 'clinical' psychologists and another as 'general' or 'focussed' psychologists as a convenient method to determine specialists versus general practitioners, is now being taken up by the National Psychology Board. The distinction is not based on professional competence or expertise and does not represent a real professional boundary between generalists and specialists.

A genuine concern about the welfare of the general public would recognize the indivisibility of psychological problems and the impracticality of pretending that psychologists in clinical private practice can offer different levels of intervention simply because some by accident of history belonged to a particular section of one professional association and those who did not.

Psychologists in private practice, whether arbitrarily designated as 'clinical' or 'general' have a requirement and a necessity to maintain competence by the very nature of their work with persons who suffer dysfunction at levels of severity that cannot be conveniently graded or distinguished as might be the case with physical illness. Furthermore the general public (and most medical practitioners) do not distinguish between these two professional groups when they seek help.

It would appear that the National Psychologist Board's plan for Supervision and CPD are predicated on this unfortunate dichotomy.

A proposal to require different levels of CPD and different levels of supervision based on 'specialist' and 'general' categories of psychologist is alarming. Is this a plan to attempt to train a superior group of psychologists and maintain their superiority OR a plan to train mediocre psychologists and keep them mediocre? Either way it is unacceptable to divide the profession. All psychologists should have the same CPD requirements and should be able to access the supervisors who are most suitable for the requirements of their professional practice. The subject matter and depth of professional responsibility for both groups of psychologists is identical.

Private practitioners and CPD – Some Facts

Every privately practising psychologist is an entrepreneur. If she/he fails to provide an effective service, the business will fail. Those psychologists who have been in practice for many years have had to keep their knowledge base up-to-date and their skills honed. Only by adequate CPD and by professional and business net-working could these two 'necessities' be achieved.

The private practitioner is not working with a team and backup as is the case with psychologists working in a hospital, public clinic, Education Dept. etcetera. Private practitioners have to build their own multi-disciplinary network. Their CPD may involve attending seminars, reading material or holding case discussions with professionals other than psychologists e.g psychiatrists, paediatricians, developmental physiotherapists, audiologists, speech therapists, etcetera. They have

to take sole responsibility to provide the best possible, ethical and appropriate service with care and respect. All of this is relevant to CPD.

The only compulsion to engage in CPD that private psychologists have had, is an inner drive to strive for excellence of delivery of service and for maximum benefits to flow to their clients/patients from the service provided.

CPD for Two Categories of Private Psychologists
Psychologists in private practice do fall into two categories: (1) those who have recently moved into private practice, lured there by the assured income that comes from the Medicare 'Better Access' scheme, and (2) those who put their professional competence on the line and for many years before 1 November 2006, provided an effective and efficient fee-charging service. It is **this categorisation** that should provide the grounds for differential 'programmes' of CPD and of supervision.

The National Board should consult experienced private practitioners on their CPD activities in the past and on the essential nature of CPD activities that are needed to maintain and increase competence in service delivery. The Board should also examine the need for training of 'newly-arriveds' in the private practice environment, as well as the need of CPD for them.

Whilst there are two categories to be considered for CPD offerings and activities, account must be taken of the fact that every practice is unique and different. It is difficult therefore for a central authority to provide for hundreds of unique needs.

The Need for a CPD Accrediting Authority
The National Board as the central authority should establish itself (not delegate the function in any way) as the CPD-accrediting authority and consider every application from every private psychology source for CPD recognition of an activity. (It should also, from the beginning of its operations, establish its own national section for accrediting academic psychologist training courses and accrediting supervisors for on-the-job training of conditionally/provisionally registered psychologists.

Any attempt at division of CPD into specialist-area requirements for accreditation would unnecessarily complicate the recording and monitoring procedures that the National Board should have in position by 1 July 2010. Of course, should the National Board decide to abandon, at least for some years, the enshrining of *specialists* in its registration procedures and processes, specialist-area requirements per se could not exist.

V. Psychologist Training

Undergraduate Training
The policy adopted by the course-accrediting authority of the past years has been disastrous both in respect of (1) the opinions held by employers of the usefulness of psychologists as against social workers coming off course into employment, and (2) the inadequacy felt by new graduates entering employment as how to go about <u>being</u> a psychologist practitioner. This needs to be remedied from the outset of the National Board's operations by pressuring teaching organisations to introduce an adequate compulsory 'applied' as against an advanced 'research methods' component of a four-year undergraduate course.

Recognition of Equality of Alternative Pathways

There is failure to recognize on the part of the National Board in their paper that neither the academic nor the on-the-job pathway to full registration has been shown to produce more effective psychologist practitioners than the other. If the National Board controls the accreditation of professional supervisors, it is possible, even perhaps likely, that the 2-year supervision pathway with its longer and much greater 'hands-on' work period and one-to-one supervision will produce more effective practitioners at the date of full registration than the 1-year supervision pathway. The Board has neither research nor anecdotal reason for setting a time limit on the continuation of the 2-year supervision pathway to full registration. The National Board should endorse for indefinite use, both pathways.

Given the current 'non-applied' undergraduate courses in Psychology, an academic post-graduate applied degree with one year experience is not enough for private practice. There should be a requirement for 5 years post-graduate practice experience before entering private practice; or there should be more applied psychology over a longer period than a 2 year master's degree with university clinic experience that is patchy and practical placement experience that is dependant on the skills of a workplace supervisor who is not always as reliable as a supervisor who uses a standardized programme.

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