The New Zealand Psychological Society

*Te Rōpu Matai Hinengaro o Aotearoa*

20 December 2007

**Submission to the Ministry of Health by the Executive Committee of the NZ Psychological Society on behalf of the Society in relation to the review of the operation of the Health Practitioners Competence Assurance Act (HPCAA) 2003.**

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The New Zealand Psychological Society is the premier association for professional psychologists in New Zealand. We have previously advised the Ministry of our intent to contribute to this review of the HPCAA.

One of the Society's Objects is:

> **To promote high standards of ethical and professional service and practice on the part of psychologists.**

In pursuit of that object the Society has committed significant resources to supporting members and enabling their continued professional development as we believe that the public is safest when practitioners can access quality professional development opportunities and enjoy the support and learning that collegiality provides.

To assist psychologists to inform their practice and ensure they continue to develop and enhance their competence in culturally appropriate ways, the Society has just published a substantial practice handbook (*Professional Practice of Psychology in Aotearoa New Zealand*, Evans, Rucklidge & O'Driscoll, 2007). Like the HPCAA and the Code of Ethics that provides the framework for the handbook, the Society presumes that practitioners who are skilled, ethically aware, culturally competent and responsive to guidance from their discipline provide the best protection of the health and safety of members of the public.

We are addressing five issues in relation to the operation of the HPCAA in this submission as outlined below:

1. *The HPCAA is focused primarily on the individual practitioner and, consequently, systemic failures are routinely ignored in reviews of competence, disciplinary and notification procedures.*
   [Questions: 1, 2, 17, 19, 32]

2. *The use of an inappropriately vague term 'psychosocial intervention' in sections of the HPCAA where a more precise and clearly understood term is appropriate.*
[Questions: 6, 7, 44]

3. *The impact of the Scopes of Practice and identified competencies on enlisting, training and employment of the health workforce.*
[Questions: 8, 10, 11]

4. *The effect and effectiveness of early stages in the disciplinary procedures.*
[Questions: 16, 27]

5. *The undesired side-effect of the Trans Tasman Mutual Recognition Act (TTMRA) on the protection of the health and safety of members of the public.*
[Question 45]

Our comments are organised within the format provided by the Ministry.

**1. Is the Act achieving its purpose? Please explain.**

The Society is in complete agreement that the health and safety of members of the public should be protected. We also agree that ensuring the competence and fitness of practitioners to practise are essential to achieving that objective. However the HPCAA, in focusing on the individual practitioner, fails to address systemic issues that often undermine the competence and fitness of the practitioner putting the health and safety of members of the public at risk. It is our contention that professional leadership and development activities are most likely to follow from strong (professional) supervision and peer review systems that complement and enable appropriate individually responsible practitioners.

Most psychologists who work in the public sector and in other large organisations like district health boards (DHBs) are responsible to generic managers who often lack relevant practice and disciplinary knowledge. Managers and often the policy advisors to the organisation attend primarily to contractual outputs and outcomes rather than providing or even recognising the importance of professional leadership. Such structures provide strong administrative leadership but display a limited ability to recognise professional issues and often show little concern to ensure the maintenance of a community of practice within which the professional development of employed practitioners is effected and valued. Performance appraisals are typically concerned with achieved contractual outputs rather than the quality of casework. Where professional issues, particularly complaints, are raised the priority of the organisation appears to be self-protection and, consequently, the individual practitioner their competence, fitness, and what they did or did not do become the problem to be managed. Rarely explored or responded to are the contextual and systems issues that may have contributed to the complaint.

A particularly egregious example of this inability to address serious professional issues concerns the inability of a health practitioner whose research is not deemed to be "health and disability research" to have any proposal for that research reviewed unless they are affiliated to a university. That was confirmed by Therese Egan, Manager Strategic Policy on Ethics and Innovation, Ministry of Health (14 May 2007) who said: "Research conducted by health practitioners that is considered to be education research would not generally be considered by HDECs". Psychologists like other health professionals are expected to undertake evidence based practice. Yet the lack of access to ethical review for research other than that deemed to be 'health and disability research' will mean that assessment instruments, assessment procedures, and interventions developed overseas cannot be safely tested and adapted for local conditions. It also means that modifications of psychological assessments and

interventions developed in particular local circumstances cannot be assessed for wider use or necessary modification. At the same time those clients who contributed to the local development, because it may not be evaluated, cannot assist the development of more effective, evidence based psychological practice. For practitioners that creates a double jeopardy: they could face a complaint for practising without or beyond a relevant evidence base and, were they to attempt to address that evidential lack, could face a complaint for undertaking research that had not received ethical approval.

**2. What evidence supports your answer?**

The above statement is based on comments from Society members who regularly communicate their experiences and concerns to the Executive of the Society.

**5. Are the provisions in section 9 and the current list of restricted activities operating effectively and what, if any, changes, amendments or additions would you recommend?**

We are concerned about the use of the phrase 'psychosocial intervention' in specifying one restricted activity:

> *Performing a psychosocial intervention with the expectation of treating a serious mental illness without the approval of a registered health practitioner.*

The phrase may be found in the writings of a variety of health professions being used to assert that people should be recognised as both social and individual beings. Apart from that common factor the phrase lacks a developed theoretical base on which to ground evidence based practice as when the Aotearoa New Zealand Association of Social Workers (ANZASW) relied on a general dictionary (*Concise Oxford*) in defining psychosocial as: "of or involving the influence of social factors or human interactive behaviour". We are aware that the Ministry has frequently used the phrase when describing contributions and roles of various professions in health settings. For example "crisis intervention" by social workers is defined as "identifying and dealing with psychosocial problems that arise as a result of, or that are contributing to, the crisis of illness, treatment and hospitalisation".

It is our contention that the purpose of the HPCAA requires the Ministry to employ terms that are informed by significant bodies of evidence and theory. Use of such terms is consistent with the purpose of the HPCAA because they provide the clarity and precision needed for the registration authorities to be able to specify and monitor the required competencies, scopes of practice, accreditation of training providers, competence reviews, and disciplinary procedures. We recommend that the phrase 'psychosocial intervention' be replaced by the more appropriate phrase 'psychological intervention' in the Restricted Activity.

7. **Is the Ministry approach to enforcement of the Act in keeping with the purpose of the Act and what, if any, changes would you recommend?**

Earlier this year the Ministry sought views on their proposal that the Minister should revoke the restricted activity *Performing a psychosocial intervention with the expectation of treating a serious mental illness without the approval of a registered health practitioner.* That proposal would have exposed vulnerable members of the public to unnecessary risks for at least two years and we advised that the proposed action violated the purpose of the HPCAA and should be unacceptable.

As that proposal sought to address an apparently unforeseen consequence of the Ministry commitment to the phrase 'psychosocial intervention' that the Ministry preferred to the more apt 'psychological intervention' we recommend that the Ministry reflect critically on that commitment. We find it intolerable that the Ministry should

seek to rectify a problem with the wording or operation of the HPCAA by withdrawing the protection of the Act from any members of the public.

Further, in relation to this review we are very concerned that the Ministry has not sought evidence and opinions on whether or not the HPCAA encourages the development, dissemination and widespread adoption of the cultural competencies needed to ensure the health and safety of all members of the public. In particular we would have expected the Ministry to be concerned about the extent to which the HPCAA supports the Maori Health Strategy, the Mental Health Strategy, and the Pacific Health Strategy.

8. **Are scopes of practice achieving their intent? Please explain.**

For practising psychologists core competencies are specified for the General or Foundation scope of practice with additional competencies specified for Vocational scopes; currently, Clinical and Educational. The scopes specify minimum requirements for practice at an entry level to guide intending practitioners, assessment of qualifications for registration, competency reviews, and the registration authority's accreditation of tertiary training providers. Workforce planners have identified critical shortages among the professional health workforce, including psychologists, and the published scopes appear to be having unanticipated effects on the recruitment and retention of practitioners in these areas.
In the Society's view there are not fundamental problems with the foundation, Psychologist Scope of Practice - as it applies to health practitioners. The development of the specialist, vocational scopes of practice, is however, in our view having some unfortunate and distorting effects on the professional field of psychology.

This arises, in part, because of the historical development of professional registration for psychologists in Aotearoa/New Zealand. The original Psychologists Act 1981 both recognised existing professional training programmes, and guided the development of new training programmes. The net effect is that tertiary education institutions (initially only universities) offering pathways to professional registration offered programmes in a range of specialist areas - clinical, educational, community, industrial/ organizational. As new programmes developed, in Child and Family Psychology, and Health Psychology for instance, they were modelled on the existing training programmes. So long as professional registration was concerned only with core competencies required by all psychologist practitioners interacting with the public, then new specialist areas are accommodated in the registration regime with little difficulty.

In the transition to the new HPCAA system, however, two profound problems have been encountered. The first is that not all the existing professional specialities were, or are, indubitably, health practices.
The "health practice" status of clinical and health psychology is not arguable, but the appropriateness of calling industrial/organizational psychologists "health practitioners" is highly debatable, and if educational psychologists are health practitioners, why are teachers also not so classified? The effect of the HPCAA is to create a Procrustean bed onto which all professional psychology must be forced, no matter how inappropriate. Second, for reasons that are not clear, the Board chose to add only two specialist scopes of practice - clinical and educational - but to ignore the existence of the additional, well-established professional specialities. This essentially left a large body of established professional practitioners and their related training programmes out in the cold.

Two problems have followed from this. First, within the profession, there are now two "elite" groups, who can register both in the generic Psychologist Scope, and also in one or other of the two specialist scopes. Given the competitive nature of the world in which professionals work, this 'distinction' can create competitive and anticompetitive

behaviour that has little to do with protection of the public and much to do with patch protection/challenge by particular specialist groups.
Second, from the employer perspective, specialist scopes of practice may be used in employee selection, as a kind of screening device, that may exclude perfectly competent professionals from gaining employment in a particular setting even though their training and skills are highly appropriate to the particular job. For instance, some District Health Boards will not hire registered psychologists qualified with the Postgraduate Diploma in Child & Family Psychology as psychologists, because they do not have the additional clinical scope of practice, even though it is possible that the Child & Family qualified person may actually be a better match to the job description than a person with the clinical psychology qualification.

The distorting effects of the specialist scopes of practice will continue until either (a) all the distinctive professional training pathways are recognised with their own specialist scope (and then, what of the generic scope?); or (b) the specialist scopes are revoked, and only the Psychologist Scope is retained; or (c) the scopes are retained but are redefined in such a way as to allow for the consideration of alternate pathways for eligibility without threatening the current high standards that eligibility currently requires. It should be noted that even an expanded list of scopes of practice would do little to protect the public over and above the protection offered by generic registration. There are simply so many diverse, specialist niches in psychology that any moderate, finite number of specialist scopes will not much assist members of the public in selecting the most competent practitioner for their particular needs. Members of the public still have to ask about qualifications and experience, and make an informed choice of the practitioners available to them.

**10. Is the process for developing scopes of practice operating well (eg, are there suitable mechanisms for ensuring scopes of practice reflect service need) and what, if any, changes would you recommend?**

Service needs must inform the planning of training programmes and assessments of the necessary capacity. Those needs should also be an integral part of all reviews of service provision and quality. However health practitioners who are committed to providing safe, effective assessments, interventions and evaluations rely on the developed wisdom of their profession. Increasingly that wisdom is guided by evidence of what is and is not appropriate and effective and that has been recognised in developing the psychology scopes of practice.

**11. Do prescribed qualifications reflect scopes of practice? Please explain with reference to particular scopes of practice and considering whether a) the levels of qualification are too low or too high when considering their purpose of assuring public safety, and b) whether they meet the requirements of section 13.**

Under the Psychologists Act 1981 the registration authority was not required to develop scopes of practice but the Act specified a lower level of qualifications for registrants. Experience from that time consistently showed that an undergraduate degree, with or without honours, failed to provide the necessary levels of knowledge and skill to enable practitioners to adequately investigate, describe, explain, predict and modify clients' behaviour, cognition and affect. Consequently there is strong professional support for the currently prescribed qualifications. That consensus was reflected in the collegial process that gave rise to the current scopes of practice although there remain significant concerns about the role of vocational scopes and their details.

**16. What would be the gains or problems associated with requiring all authorities to institute recertification programmes?**

The Society believes that all registered psychologists need to ensure that they are engaged in continuing professional development (CPD) for the maintenance of professional standards. We see CPD as fostering peer engagement, support, and life long learning. Recertification programmes need to focus on core competencies, be well organised, and properly administered to ensure that compliance requirements are reasonable and practicable for busy health professionals.

**17. Registration authorities have to judge when a practitioner 'may pose a risk of harm to the public' and trigger notification: is this working effectively and what, if any, suggestions do you have to improve effectiveness?**

Our perception is that the registration authorities may be too passive in this respect. In its Annual Report (2007) the Psychologists Board reported some findings from their record of complaints against psychologists since 2001. Of the 55 registered psychologists subject to a complaint in the past year 34% were more than 50 years old, 18% were in their 40s. Consequently the majority (54%) had been practising for 20-24 years. These data are consistent with the perception that older (experienced) private practitioners who are professionally isolated are significantly more likely to 'pose a risk of harm to the public'. The registration authorities need to be pro-active with respect to such identified 'at risk' populations making use, in the first instance, of competence reviews, and supervision requirements.

We are also concerned about the apparent lack of concern shown by registration authorities for the professional leadership and support available in public service and other large organisations as outlined in response to Question 1. There we identified circumstances in which a health practitioner may be more professionally isolated than those in private practice and, more alarmingly, those individuals will include numbers of recently registered practitioners who need and should be able to access significant professional guidance and support as they seek to enhance their competencies.

**18. At what times, if any, other than when there is a concern of a risk of harm to the public, should a registration authority exercise its power to review the competence of a health practitioner?**

In response to question 17 we identified two different populations of health practitioners who may be at risk of threatening the health or safety of members of the public. It is our view that it is indefensible to do nothing until there is a complaint as that would be using members of the public as an early warning device. Waiting for and only acting on a complaint also risks losing the practitioner's skills, experience, and knowledge at a time when our health services are experiencing serious shortages of appropriately skilled practitioners. While we would not wish to protect the career of a health professional who posed a serious risk to the health and safety of members of the public we believe that registration authorities must accept the need to shepherd and develop the practitioners whom they regulate. Competence reviews must be seen as offering an effective intervention with at risk health practitioners especially those who are professionally isolated by circumstances beyond their control.

**27. Are PCCs being used by the registration authorities you are familiar with, how often and for what reasons?**

Where a complaint against a registered psychologist is referred back to the board by the HDC the Psychologists Board may decide to establish a PCC and currently does so for 39% of those complaints (2007 Annual Report, pp12-13). Only the registration authority has access to more detailed information about the operation of PCCs and we

would hope that the Board has been undertaking evaluations of the effectiveness of PCCs and the impact on members of the PCC and those involved in the process. We sought responses from members of the Society who had been involved in or with a PCC but received no comments. We interpret this to mean that the processes are tolerated by those involved.

**32. Is there a need for the HPDT to have the capacity to deal with multi-practitioner/ team-based disciplinary matters and, if so, how should this be organised?**

Multi-practitioner teams and team-based disciplinary matters both raise serious questions about the adequacy of the individual-centred approach of the HPCAA as currently operating. The establishment, operational maintenance, and discipline of such teams reflect the priorities of the organisation in which they are established. In some instances those priorities allow for strong professional support of team members who are enabled to contribute to the work from that secure professional foundation. In other instances the organisation's priorities, for whatever reason, do not respect team members' needs for such professional support, effectively isolating the individual practitioners and so putting them at risk of complaint or disciplinary action. If the HPDT were to be given "capacity to deal with multi-practitioner/team-based disciplinary matters" it would be essential for the Tribunal to be able to address the systemic failures that underlie or contribute to the matters coming before it.

36. **Are the provisions for adding new professions or health services working and what, if any, changes would you make?**

An important thread in our submission has been the necessity of recognising the importance of the disciplinary foundations of each health profession. That body of theory and knowledge on which safe, effective practice is based must be acknowledged for each profession. The creation of blended registration authorities has the potential to undervalue and distort the disciplinary foundations of the health professions to be blended. While we recognise that there may be strong, possibly compelling, arguments favouring a blended authority in particular circumstances we do not believe that 'blended authorities' should be the norm for additional professions.

44. **What changes, if any, do you recommend to specific wording in the Act in order to clarify or address technical issues not otherwise covered already?**

As already argued [Qns 6, 7], we recommend that the phrase 'psychological intervention' replace the current inadequately specified 'psychosocial intervention' in the Restricted Activity (Section 9). The Restricted Activity would then be *Performing a psychological intervention with an expectation of treating a serious mental illness without the approval of a registered health practitioner."*

**45. What, if any, other matters are you aware of in respect of the operation of the Act and what changes do you recommend?**

The Psychologists Board has regularly reported to the Minister concerns about the misuse of the Trans Tasman Mutual Recognition Act (TTMRA) that enables applicants (for registration as a health practitioner) to circumvent the legitimate registration requirements put in place to protect the health and safety of the public. In its 2007 Annual Report the Psychologists Board (p. 11) noted that such misuse was increasing. Psychologists who are either not eligible for or whose application for registration has been rejected by the Board can currently obtain registration in an Australian jurisdiction with a lower threshold for registration without leaving New Zealand. Once registered in one TTMRA jurisdiction the practitioner can use that

registration as the basis for an application in another jurisdiction such as New Zealand. We support the Board's efforts to seek changes to the TTMRA so that it is mandatory for an applicant to have worked as a registered health practitioner in one TTMRA jurisdiction before being able to use that registration as the basis for an application to another jurisdiction under the TTMRA. We strongly recommend that the Ministry support the Psychologists Board in these efforts.

## References


Evans, I., Rucklidge, J. & O'Driscoll, M. (2007). *Professional practice of psychology in Aotearoa New Zealand*. Wellington: New Zealand Psychological Society.

New Zealand Psychologists Board (2007). *Annual report to the Minister of Health for the year 1 April 2006 to 31 March 2007.* Wellington: NZ Psychologists Board.