

Institute of Clinical Psychology
New Zealand Psychological Society
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The Institute of Clinical Psychology (ICP), a member group of the New Zealand Psychological Society, promotes the highest standards of clinical psychological knowledge and practice within Aotearoa/New Zealand in the interests of the public and the profession, and with a commitment to biculturalism and cultural diversity. There are currently over 100 full members of ICP who must be psychologists registered within the Clinical Scope of practice. The Institute of Clinical Psychology has its own management committee which has prepared the following document for the purposes of the Ministry of Health's review of the Health Practitioners Competence Assurance Act 2003 (HPCA Act 2003).

Comment will follow the format suggested by the Ministry:

1. Is the Act achieving its purpose? Please explain.
The Act is having an impact on the registration of psychologists, in particular identifying those with the required qualifications and supervised training to be registered in the clinical and educational scopes of practice. The Act also is one mechanism of deterring unqualified individuals from operating under the titles psychologist, clinical psychologist, or educational psychologist. But the writers would suggest that there is insufficient evidence to definitively say that the Act is achieving its primary purpose of protecting the health and safety of members of the public.
2. What evidence supports your answer?
 - i) Three years is a short period of time to measure changes in data related to the health and safety of the members of the public.
 - ii) Psychologists were registered prior to the passing of the Act. In recent years, other changes in processes affecting psychological practice e.g. in the Family Court, are potentially confounding variables if considering changes in reporting data since the inception of the Act
3. What, if any, comments do you have on the adequacy of evidence available about the success of the Act and any changes needed – including, for example, any reporting requirements that might ensure more open access to evidence that the Act is being effective.
Pre and post Act data needs to be more easily accessible. The Ministry's framework for evaluating the impact of the Act needs to be explicit, transparent and communicated to members of the health professions.
4. Are the provisions in section 7 of the Act operating in a way that ensures that non-qualified persons do not claim or imply to be qualified practitioners and what, if any,

changes do you recommend (note that issues around enforcing breaches are dealt with in the section titled 'Enforcement of the Act' which is set out below)?

There are instances where non-qualified people continue to misrepresent their qualifications. We understand that the Board is addressing this issue to the best of its ability – e.g. notifying 'Yellow Pages' publishers of their responsibility when listing practitioners either individually or through group practice advertisements. New clients also report believing that they were previously seeing a (registered) psychologist. The writers believe more attention must be given to this part of the Act (beyond Board level) and greater protection afforded to the public.

5. Are the provisions in section 8 operating effectively and what, if any, changes would you recommend?

The provisions of s8 are not operating effectively and indeed there is a great deal of confusion regarding the relationship between vocational scopes of practice and competence to practice in specific areas. This is particularly so for the generic psychologist scope of practice and the Clinical Psychology vocational scope of practice. The NZ Psychologist Board recently published a clarification regarding the application of scopes of practice to employment matters, namely *"The Board wishes to remind organisations and employers that the prescribed scopes of practice do not 'fence off' any exclusive territory (other than the use of the title). Any psychologist can perform any activity – as long as they are competent to do so, or are doing so under appropriate supervision (for example when training in a new area of practice). A vocational scope simply provides the practitioner with the right to use the title, and thereby clearly and simply signal to the public (or an employer) their competence in that scope. In short, practise is not restricted by scope, but by competence. Title use is restricted by scope."* Yet this seems in notable contradiction to s8 and appears to reduce the scopes of practice within psychology to simple means to denote title use rather than communicate competence due to specific qualifications and training. ICP understands that the skills and knowledge of Psychologists can have relevance in clinical settings however these Psychologists have not had specialist training. ICP is concerned that the public may overestimate the knowledge and skill levels of these Psychologists when seeking assistance with clinical matters.

6. 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?

The restricted activity of relevance to our profession is that pertaining to "performing a psychosocial intervention with an expectation of treating a serious mental illness without the approval of a registered health practitioner". ICP asserts that psychological interventions can cause serious harm when done improperly and that the Act must provide a mechanism for ensuring public safety in this regard. We recommend that the Ministry reinvestigates how the public can be protected in this area and that provision is made in this regard in the Act.

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?

No comment. We have insufficient information about Ministry's approach to enforcement of the Act.

8. Are scopes of practice achieving their intent? Please explain.
ICP is of the opinion that the scope of practice "Clinical Psychologist" is a very important scope to have defined for reasons of public safety and information. As such one purpose is achieved, that being the delineation of Clinical Psychologists and their specialist area in psychological practice.
However in other respects it has been only partly successful. It is the scope aspired to by many psychologists and, as outlined in Q.5, there appears to be confusion about what skills and knowledge are adequate for Psychologists to work in the clinical field and what are the minimum requirements to then move into the scope of Clinical Psychology. The public must be able to understand these differences when considering which practitioner they will choose when seeking assistance with clinical matters. This is particularly important when serious mental health issues need addressing (here serious mental health refers to conditions that pose significant risk to the health and wellbeing of the individual concerned or to other individuals).
9. What, if any, comments do you have on the operation of the powers that registration authorities hold to allow conditions or authorisations on individuals' scopes of practice? Similar to that already mentioned, there appears to be, at times, differences of opinion between the Authority and psychologists about what skills and knowledge are adequate for Psychologists to work in the clinical field and what are the minimum requirements to then move into the scope of Clinical Psychology. We recognise it must not be an easy task for the Authority to 'draw the line' but respectfully suggest there needs to be more debate with the profession on how entry to the Clinical Scope is achieved.
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?
ICP is of the opinion that the risk is that too many scopes could be developed and that the public would not necessarily benefit from this. We believe it might be helpful to discuss with psychologists whether there should be other 'critical' criteria considered e.g. number of likely registrants, before a new scope is proposed.
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.
The qualifications listed for entry to the Clinical Psychologist Scope reflect the level required for assuring public safety. Clear, agreed guidelines need to exist on how else a person might obtain registration in the Clinical Scope. Of concern, however, is that there is the possibility that some subgroups with far less uniformity of qualification and training will also develop scopes e.g. the proposed counselling psychology scope of practice. The risk exists that an impression of uniformity in practitioner knowledge and skill levels is implied (between groups) once any subgroup receives a 'scope' title even though the qualification and training is possibly of a lesser quality.

12. With regard to their purpose of assuring the competence of registered professionals, how well are the current recertification regimes working (where possible refer to particular professions)?
No comment
13. What changes, if any, are needed to improve the evidence available to answer the previous question?
No comment
14. Where recertification arrangements are in place, what issues arise and what changes, if any, would you suggest (eg, in respect of the nature of the programmes, the level of compliance, monitoring practitioners' compliance, the costs and other impacts on practitioners employers etc)?
No comment
15. Where recertification programmes have not been introduced how do the authorities assure competence, and are there ways that these processes could be improved?
ICP has given feedback on the proposed competency assurance programme currently under consideration. We currently have no experience with recertification processes.
16. What would be the gains or problems associated with requiring all authorities to institute recertification programmes?
The risks associated with low-trust and arduous processes are that professionals leave the profession. Anecdotally there are reports that this is occurring in Occupational Therapy as a result of their competence programme.
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?
On the information available, this appears to be occurring safely.
18. Is it appropriate that authorities must notify a particular set of agencies: what changes, if any, are needed?
This currently seems appropriate.
19. 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?
No other times seem necessary
20. Is voluntary reporting by practitioners of possibly unfit practitioners working, on what do you base this opinion, and, in the light of experience, what are your views on making it a requirement to report concerns about a possibly unfit practitioner?
There appears, at times, to be some indecision on reporting of practitioners and whose responsibility this is. It appears that some view the process as negative and not in the best interests of the practitioner or the reporter. We would suggest that there needs to be more education on this particular section of the Act.
21. Is compulsory reporting by employers of possibly unfit practitioners working, on what do you base this opinion?
Unknown

22. Are the interests of the public and of practitioners being balanced when dealing with the risk of harm from practitioners who are deemed to fail to meet required standards of competence? Please explain.
Unknown
23. In practice, do competence and recertification programmes differ, are both sets of provisions needed or should changes be made?
These processes differ and any change to current provisions would need wide debate within the professions.
24. Should any other parties be obliged to inform the registrar of a practitioner's inability to perform their required functions because of a mental or physical condition?
There appears to be no need to broaden the current group
25. Are the interests of the public and of practitioners being balanced when dealing with fitness to practise issues? Please explain.
This seems to be occurring
26. Are protected QAAs operating in areas you are familiar with: are they valuable, are there any problems, are the reporting requirements appropriate, should there be any changes to the QAA arrangements, should QAAs continue? Please explain.
Quality Assurance Activities appear to be providing one valuable way for enabling quality improvement
27. Are PCCs being used by the registration authorities you are familiar with, how often and for what reasons?
Professional Conduct Committees are being used by the Authority though the frequency is unknown
28. To what extent is the suspension of an annual practising certificate and referral of a practitioner to the HPDT effective in protecting the public?
This step is especially effective when the psychologist is employed by a public service. However, it is questionable how effective it is for a person in private practice
29. What, if any, additional steps should be taken into account when determining to suspend an annual practising certificate?
No other steps seem necessary
30. What, if any, benefits or problems have arisen from having a single tribunal for all regulated professions and what, if any, changes would you recommend?
Unknown
31. Is the current membership structure of the HPDT operating and are there any changes you would recommend (for example, the mix, the selection and appointment processes, training of members)?
Unknown
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?
Unknown

33. Are the current arrangements for financing and supporting the HPDT, appropriate and what, if any, changes would you recommend (including the costs of taking cases to the tribunal and sustaining the operation of the tribunal)?
Unknown
34. Are the appeal provisions operating well and what, if any, changes would you recommend?
Unknown
35. How do you think the current number and mix of professions and authorities is operating and what, if any, changes do you think should be made?
The current mix appears to be working
36. Are the provisions for adding new professions or health services working and what, if any, changes would you make?
Smaller professions are at risk of being influenced by small groups within the profession to the detriment of the greater good. The Ministry has a responsibility to ensure this does not happen when appointing Boards. An example of this might be the recently formed Psychotherapy Board where most members appear to have a strong psychoanalytic/psychodynamic view of psychotherapy and where regulation of the profession may lead to diminishment of other empirically validated models of psychotherapy.
The place clinical psychologists hold in the delivery of psychotherapy has not been adequately addressed (there are probably more clinical psychologists delivering psychotherapy than there are psychotherapists).
37. Are the current membership and appointment provisions working (eg, is the size and mix right, are people with the best skills being appointed, should the power to hold elections be retained and/or used, are lay and professional members appropriately trained and supported) and what changes, if any, would you recommend?
See 36 above. The power to hold elections should be retained and used expeditiously.
38. What deletions, amendments or additions, if any, do you recommend to the list of functions – and why?
None
39. How well are authorities carrying out their functions and what changes, if any, do you recommend?
The Psychologists' Board appears to be doing this well.
40. Are there any specific legislative requirements that regulatory authorities are currently subject to that they should not be? Please explain.
The current provisions seem adequate
41. Are there any specific legislative requirements that regulatory authorities should be subject to that they are currently not? Please explain.
Unknown
42. To what extent are the current powers of the Minister of Health appropriate to the purpose and effectiveness of the Act and what changes, if any, do you recommend?
No comment

43. What changes, if any, do you recommend to matters covered by the provisions of Part 7 of the Act?
No comment
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?
No comment
45. What, if any, other matters are you aware of in respect of the operation of the Act and what changes do you recommend?
Reciprocal arrangements with other authorities need clear and binding agreements that ensure the integrity of the Act. The most pertinent example of this for psychologists is the trans-Tasman relationship where legislation has allowed under-qualified (by NZ standards) Australian psychologists to receive registration in New Zealand and has also allowed some New Zealand psychologists to successfully apply in Australia for registration without even residing or practising there. They have then been able to require the NZ Psychologists Board to register them to practise in New Zealand where, based on their New Zealand qualifications they were unable to gain registration. We encourage the Ministry to assist the Board to address any such anomalies.

Thank you for the opportunity to respond to this review

John Thorburn,

Chair

Institute of Clinical Psychology