

COMMENTS ON HEALTH PRACTITIONERS COMPETENCE ASSURANCE ACT 2003

RESPONSE FROM ODHB CLINICAL PSYCHOLOGISTS' GROUP

This response is not going to respond to every question set by the review group, but is going to discuss a few main issues. We understand that feedback from individual registered practitioners may be sought in the future, and at that time those individuals may respond with more detail.

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

The stated purpose (section 3) of the Health Practitioners Competence Assurance Act 2003 (the Act) is:

- (1) *The principal purpose of this Act is to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions.*
- (2) *This Act seeks to attain its principal purpose by providing, among other things,—*
 - (a) *For a consistent accountability regime for all health professions; and*
 - (b) *For the determination for each health practitioner of the scope of practice within which he or she is competent to practise; and*
 - (c) *For systems to ensure that no health practitioner practises in that capacity outside his or her scope of practice; and*
 - (d) *For power to restrict specified activities to particular classes of health practitioner to protect members of the public from the risk of serious or permanent harm; and*
 - (e) *For certain protections for health practitioners who take part in protected quality assurance activities; and*
 - (f) *For additional health professions to become subject to this Act.*

Our opinion is that as the provisions stated in subsection 2 have mostly been put in place, the principal purpose of the Act is more able to be met than it was prior to the commencement of the Act.

2. What evidence supports your answer?

The evidence exists in the processes set in place by each authority in order to meet the provisions in subsection 2. While risk of harm to members of the public by health practitioners cannot be eliminated, the processes have enabled a degree of clarity in so far as establishing scopes of practice and restricted activities, of ensuring initial and ongoing competence of practitioners, and for providing consistent processes regarding concerns about competency or regarding complaints.

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.

No comment

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)?

We do not have anecdotal or factual evidence about the efficacy of this section. We note, however, that the fine of \$10,000 for breaching this section of the act comes only after a summary conviction, and this amount may be perceived by some who are implying they are health practitioners without the registration or qualifications for registration, as being trivial enough to ignore.

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

We do not have anecdotal or factual evidence about the efficacy of this section. Further comments regarding scopes of practice are below.

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?

We have been concerned at the proposed changes to the list of restricted activities, specifically in relation to the provision of psychosocial interventions with the aim of treating a major mental disorder without the supervision of a registered health practitioner. Exactly what this restricted activity entails requires consideration outside of the scope of this review.

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.

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

In general, the scopes of practice appear to be achieving their intent, however, we hold concerns about the psychology scopes. Most (over 60%) registered psychologists work outside of the health services. The training and skill base amongst the registered psychologists is markedly disparate. We are particularly concerned about mooted proposals to include other practitioner groups under the psychologist profession.

The protection of the public can best be achieved by having a robust registration and identification system. There could be an increased number of scopes of practice within the psychologist profession. These scopes should be clearly linked with prescribed training and the acquisition of specific skills. We also believe that the authority for psychology could provide specific education to the public regarding skills and expertise held within the scopes of practice, so that the public can become as aware about who to go to for what psychological issue as they currently appear to be regarding medical issues.

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?

This power appears to work to protect the public. We have no anecdotal or factual evidence to indicate that these have been working poorly.

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?

As stated above, there needs to be more work on scopes of practice in the psychology profession so that the public can best be protected.

- 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.**

In regard to the Clinical scope of practice under registration as a psychologist, we believe that the qualifications should indicate an "overseas equivalent" to the University based Postgraduate Diploma in Clinical Psychology, rather than just "equivalent". In our opinion, training within New Zealand for a Clinical scope of practice needs to be through a University programme as it is the level of academic, scientific, and practical rigour developed through the University that can lead to practitioners who are best able to work towards ongoing safety of the public with whom they have professional contact. There should be no exceptions to this with New Zealand training.

There are concerns that under the Trans-Tasman Mutual Recognition Act 1997 some psychologists who do not meet criteria for registration in New Zealand move to Australia for a short time, become registered there (some states have lower standards of competence and training than in New Zealand) and then those practitioners return to New Zealand and get registration here. In order to enable the safety of the public to be maintained, it is suggested that an initial period of intensive supervision for those overseas practitioners whose initial registration requirements are not as robust as those in New Zealand, may be beneficial.

- 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)?**

In regard to the psychology profession, there needs to be significantly more work in relation to ongoing competence reviews. We understand the Board is continuing to work on this.

In relation to establishing initial competence, as long as the registrant is presenting a NZ Postgraduate Diploma in Clinical Psychology or overseas equivalent, then their initial competence will have been established through those programmes.

- 13. What changes, if any, are needed to improve the evidence available to answer the previous question?**

Completion of the work undertaken by the Board to establish ongoing competence programmes.

- 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)?**

A concern regarding recertification programmes is the compliance cost, both in terms of time and money. Many employers do not provide sufficient funds or allocation of time to enable completion of recertification programmes. The provision of professional development funds to ensure that each health practitioner maintains and improves competence over time will be expensive, and could end up being prohibitively so for some employers.

- 15. Where recertification programmes have not been introduced how do the authorities assure competence, and are there ways that these processes could be improved?**

Flexibility of recertification programmes is necessary. They should be easily understood, that is clear in purpose and content; not be overly time consuming; able to be achieved without requiring significant on-going expense by the practitioner; and be meaningful in terms of improving protection of the public.

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

Gains would clearly be a greater confidence that the health practitioners are indeed competent and can help to protect the public. Problems are those as stated above.

- 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?**

In our experience this appears to be working well.

- 18. Is it appropriate that authorities must notify a particular set of agencies: what changes, if any, are needed?**

The agencies noted within section 35 of the Act appear to be appropriate agencies to inform.

- 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?**

Given the principle purpose of the Act, risk of harm to the public should be the only time to review the competence of the health practitioner. To do otherwise could set up an authority that seems to be punitive or “big brother” like.

- 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?**

Individual practitioners may provide specific details in their own submissions if and when requested at a later date. It does not seem appropriate to provide such information in a joint submission.

- 21. Is compulsory reporting by employers of possibly unfit practitioners working, on what do you base this opinion?**

Individual practitioners may provide specific details in their own submissions if and when requested at a later date. It does not seem appropriate to provide such information in a joint submission.

- 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.**

Individual practitioners may provide specific details in their own submissions if and when requested at a later date. It does not seem appropriate to provide such information in a joint submission.

23. In practice, do competence and recertification programmes differ, are both sets of provisions needed or should changes be made?

These appear to be markedly different. The “recertification” programmes would, it is assumed, start with an expected base of competence, with aspirational goals developed for the future so that the health practitioner’s contact with the public can be more effective and efficient in the future. The “competence” programmes would occur after concerns had been raised and it had been established that the practitioner needed to develop skills to ensure basic safety to the public.

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?

If such a condition had clearly been established that the public was unsafe if the practitioner continued to practice, and the practitioner did indeed do so, then the registrar should be informed. Without ongoing practice, and clear risk of harm to the public, this should not be necessary.

25. Are the interests of the public and of practitioners being balanced when dealing with fitness to practise issues? Please explain.

Individual practitioners may provide specific details in their own submissions if and when requested at a later date. It does not seem appropriate to provide such information in a joint submission.

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.

No comment.

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

No comment.

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 would appear to be effective in protecting the public.

29. What, if any, additional steps should be taken into account when determining to suspend an annual practising certificate?

No comment.

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?

Consistency of response by the authority members is assumed. This can only be beneficial for the public and for health practitioners.

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)?

No comment.

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?

While this would appear to be sensible, the need for each practitioner's practice to be reviewed individually, even in relation to "team" competence would help to ensure that those health practitioners who are competent are not "tarred by the same brush" as those in the team whose competence may be in question.

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)?

No comment.

34. Are the appeal provisions operating well and what, if any, changes would you recommend?

No comment.

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 number and mix of professions and authorities appears to be satisfactory.

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

No comment.

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?

No comment.

38. What deletions, amendments or additions, if any, do you recommend to the list of functions – and why?

No comment.

39. How well are authorities carrying out their functions and what changes, if any, do you recommend?

The Psychologists' Board appears to be some way behind other professional bodies, such as nurses, in regards to on-going competence programmes and so on. This may well be related to economies of scale, and complexities within the psychology profession (i.e. as stated above, over 60% of registered psychologists are not health practitioners), however, it would be beneficial to have these matters completed within a short time frame.

40. Are there any specific legislative requirements that regulatory authorities are currently subject to that they should not be? Please explain.

No comment.

41. Are there any specific legislative requirements that regulatory authorities should be subject to that they are currently not? Please explain.

No comment.

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?

No comment.