Re: Psychology Board of Australia Consultation Paper

Note: Please see the end of this submission for information on my background.

I support the establishment of a National Board and National registration.
I also support the National Board's proposal for standards regarding Criminal History, English Language Skills, recency of practice and Professional Indemnity Insurance
However, I have a number of concerns about the proposals, as follows:

1. Professional Development (PD)

I support the need for continuing professional development but I oppose the proposed prescriptive system, particularly in relation to prescribed hours for one-to-one supervision because:

1.1 The proposed system is different from that of the APS - if that means running two systems at once, the administrative cost individually (time, hassle) and with the Board/APS is ridiculous. Apart from it being a personal pain-in-the-proverbial, I object to registration and membership fees going to pay for redundant systems.

1.2 The proposed PD system appears to be annual – this is a problem for rural practitioners. Good quality PD activities are somewhat sporadic in rural areas, so we either need more time for them to occur or we need to have more time to be able to afford and arrange to attend PD programs in city centres. A biannual system allows flexibility which is important in practitioners choosing PD activities that will be useful to them, rather than just attending PD activities to accrue points– that is a waste on everybody's part.

1.3 Prescribed one-one supervision / peer discussion will add to practitioner time and cost, which is already an issue with existing APS PD requirements, especially for those who are not working full-time. Trying to get 2 busy professionals who also have lives outside of work together on a regular basis is difficult, particularly in rural areas. Another problem is how the supervision will be proven/assessed and who will be accepted supervisors / discussion participants - are we to be subject to yet more paperwork and reporting requirements? And does a clinical psychologist have to have supervision with another clin psych? Will it be informal discussion (as currently implied in the document) or will there be MORE forms to complete? Running my practice involves more than enough paperwork already!

1.4 Where is the equity of PD requirements across professions (are all other health professionals *required* to have 10 hours individual supervision / peer discussion every year, as well as their other PD once they have completed their supervision requirements for registration?

1.5 This prescription will also be a problem for Clinical Psychologists like myself, who live in rural areas – numbers of Clinical Psychologists with comparable experience are very limited. Coordinating face-to-face time is also an issue. Whilst your document says "The Board is sympathetic to alternative modes of delivery in regional and remote areas.", I question how this will work. Telephone consultation may be appropriate but email certainly would not, due to confidentiality issues when using the internet. Skype would be a problem for the same reason. Telephone conferencing could add to costs for rural practitioners.

1.6 An experienced, skilled and competent clinician knows when they need assistance and will contact a peer to discuss their issues accordingly. I question what evidence exists for the statement in your discussion paper that "…..supervision is critical to safe and effective psychology practice *throughout a professional career*." How much research has been done on supervision with skilled and experienced clinicians, to determine whether compulsory supervision (as opposed to self-sought supervision or peer discussion on an as-needed basis) makes any difference at all? I understand that experience does not necessarily result in skill (see below), however, I do not believe that introducing compulsory supervision later in a person's career will address the problem – it will simply add cost and time to all practitioners, whether they need a formal supervision / discussion process or not.

1.7 The focus of supervision requirements is at the wrong level. I have supervised clinical practice in working environments and in two university clinics where post-grad students had their first practical placements. All sessions were videotaped. There was a clear difference between what students thought they had done in a session (ie their description) and what they had actually done. This was, with very rare exception, a perceptual / clinical judgement error rather than a deliberate intent to mislead the supervisor. However, it highlighted the questionable value of supervision in which practitioners with limited knowledge, experience or insight discuss what they have done and are planning to do in their work with clients - some of the students had been working as registered psychologists for many years under the 4+2 system and if it wasn't for the videotaping plus myself in the supervisory position being assertive and persistent with issues I identified, those practitioners would have continued without change in practices that could be damaging to clients . If the Board is serious about protecting the public, the quality of supervision needs to be addressed at the academic and immediately-post qualification supervision level, not later in people's careers. The reality of students on placement outside the university is that supervision is generally very limited, simply because of a lack of time on behalf of the supervisor and it is relatively rare for sessions to be taped. Also, typically, student placements occur in government or government-funded organisations, which limits their experience. My experience with clinical supervision in universities has seen sub-standard supervision by people who have very limited clinical experience, especially experience outside a university environment (although there are also some very good superivosrs). And, typically, students may be given feedback but it is very rare for them to fail or be required to extend their placement in order to show they meet good practice criteria (something I have done on several occasions) – therefore, students are going on to outside placements and leaving university with deficits in skills or approach that are not corrected later because they are not always evident from self-report.

1.8 I would draw your attention to extracts from your summary of the NZPB program, which treats their psychologists as professionals:

"..Psychologists at different stages of their career have quite different professional development needs. Maintaining competence is a process that continues over the entire course of a career, adapting to changes in practice environments, professional domains and consumer needs.

…Flexibility in maintaining competence: There is no one best way to maintain competence. The range of activities selected will vary according to individual learning style, identified needs,

timing, availability, and context. Other life experiences may also contribute to professional competence.

…..Easy to follow, understand and economical: It is envisaged that the CCP can be readily integrated with regular workplace requirements and professional tasks and roles, rather than being extra/extraordinary. The self-reflective review should be tailored to individual needs to make it a useful and personally meaningful exercise. Recording of continuing competence activities should be clear but brief.

1.9 I agree that supervision OR peer consultation be encouraged (perhaps it could carry a higher points level than reading for example) but NOT prescribed. Practitioners should be free to choose the PD that is best for them at that stage in their career or the area in which they are working at that time.

2. Supervisor requirements

Whilst I agree with the principle, the practice is a problem and will result in the loss of many experienced and skilled supervisors (who are already at a premium anywhere, especially in rural areas). I have completed the QLD program. One issue is that there is no recognition of prior learning and experience. So even if you are a very well trained and experienced supervisor and manager, you still have to sit through the same 2 days (plus follow-up activities) as people with no training or experience. To add insult to injury, we then have to do a refresher, which so far has not been available in my rural area in the necessary time frame. And as someone who works part-time (for various reasons), 2 days at a course can result in the loss of the majority of my weekly income. I think there should be an RPL /assessment option. For me, the time and money involved in the current program is not worth it - which means that in a regional centre with a limited number of clinical psychs, a supervisor who used to run a clinic teaching psych post-grads clinical skills, who used to manage other psychologists in private and public settings and who has worked in corporate settings, will not be available. I'm not trying to make myself out to be special - I'm just mentioning this to provoke some thought about what increasing regulation is doing in terms of opportunities for individual psychologists to access supervision which is most relevant / useful to them.

3. Qualifications for registration

I agree that Masters level should be the minimum academic qualification (especially since these days, there appears to be virtually no practicum and psychometric testing experience in a four year degree). However, if a doctorate is to become the new standard, I think there need to be optional pathways for practitioners who are already experienced in the field – eg the final year of their doctorate could be on-the-job. Otherwise, only a certain demographic group will be able to afford the time and cost of a 3 to 5 year program on top of their four year graduate degree. This limits equity and I would expect a decrease in mature-age students (due to mortgage and work commitments), which will be of detriment to the profession. What evidence is there that an extra year of academic training (compared to the two year clinical masters) produces better clinicians?

3.1 Whichever pathway, I believe the old standard of two years post-qualification supervision, not one year, should be applied. What I've seen of the doctorate, even if it has longer placements, in no way prepares students for unsupervised practice after one year post-qualification. As indicated earlier in this submission, I have seen the importance of 'getting it right' with practitioners

before they get into external placements and into independent practice. Also as indicated above, I believe there should be some focus on supervision and performance management skills in academic practicum supervisors. I contend that students should have practical placement in university clinics *before* they get to post-grad level – I have seen students whose (serious) unsuitability for professional practice was not discovered until the first year of their masters degree, when they started their university placement. It is not fair to the student, or appropriate, for them to get so far in their studies before discovering they are not suited to practice in the field. These are students who do not meet minimum practice criteria even after many extra hours of support, feedback etc etc. Research skills do not necessarily make a good clinicians.

I'm sure I am not the only one who has seen practitioners from many fields who have completed the required qualifications, PD etc but are still dreadful, whilst others would be great even if they were totally unregulated there is a lot more to effective practice than academic knowledge and research skills.

4. Other issues

   4.1 If the Board is serious about protecting the public, they should be actively lobbying for the continued restriction of the use of psychometric testing to psychologists – I have seen enough inaccurate / inappropriate conclusions in testing reports from psychologists, let alone opening it up to others who don't have the level of professional training to evaluate test reliability, validity and what can (and cannot) be concluded form the results.

   4.2 Similarly, I believe hypnosis should remain in the realm of the psychologist and medical / dental practitioners for relevant use (as it is in some states) – hypnosis is a very powerful tool which should not be used to treat any disorder / problem that the practitioner is not qualified to treat in any other way.

5. It is ironic that an experienced, well-trained psychologist who meets criteria for specialist registration, would be required to undertake 10 hours supervision per year while people titled counsellor, community worker , support worker, case manager, life coach, or whatever other title has been thought up to avoid the restrictions of the title psychologist, use approaches that clearly involve psychological interventions and techniques, without any restrictions.

Background

I am a Clinical Psychologist (specialist title) who originally did a 4-year bachelor degree followed by 2 years of supervised practice to get generalist registration. After working in the field for 12 years, I returned to university to complete a Master of Clinical Psychology, followed by 2 years supervised practice for specialist registration. I have been working as a psychologist or clinical psychologist for over 20 years. I have supervised psychologists and other staff in the workplace (as their manager &/or clinical supervisor) and as Director of the ECU Psychology Clinic (where masters and doctoral students do their first clinical placement). I also was supervisor at JCU clinic. My experience encompasses public, private and tertiary education sectors. I have considerable performance management experience and industrial training in management / supervision.

Rosemary Crake