**Public Consultation**

**Area of Practice Endorsements Registration Standard**

Thank you for the opportunity to comment on the Psychology Board of Australia’s public consultation on the ‘Area of Practice Endorsements Registration’.

Below are my answers to the five questions contained in the ‘General questions for consideration’.

Before I answer these questions, I will summarise my personal situation:

I have been a registered psychologist since 1994. I have worked in a number of areas including the last 12 years in forensic psychology. I have presented papers to various local state and national conferences and lectured at university. I am currently in private practice.

1. Which option do you prefer – the status quo or option 2 (proposed standard).

I prefer neither and believe that the available accepted evidence clearly indicates a different model should be used.

Even the Tuning EuroPsy document (Lund et al, 2014, available at [www.efpa.eu/download/ff50966dba871e96230fdf9542586e4d](http://www.efpa.eu/download/ff50966dba871e96230fdf9542586e4d)) indicates that competencies in psychology are obtained not at university, but in the applied psychology job role. There is no evidence that Masters or Doctoral level studies result in competencies in the workplace which are associated with better outcomes for clients (Pirkis et al., 2011; Anderson 2016). Unless such evidence can be demonstrated, it is illegitimate to state that this form of training results in competencies that lead to superior client outcomes. The premise fails to account for other factors related to outcomes e.g., the therapeutic alliance, problem solving ability, The majority of practising psychologists in Australia score as Intuitive Feelers (NF’s) on Jungian concepts. They demonstrate great skill and a sense of timing regarding people’s feelings – some people will never achieve this no matter how much university training they receive. Clinical on the job training not to mention the multiple other pathways of academic learning add to the complex soup that makes up competency. Australian psychologists as a cohort, including both 4+2 and masters graduates, have been found to achieve client outcomes which are impressive and up to best international standards (Pirkis et al 2011). Thus, the framework upon which the AoPE is based is opinion of those making the policy decisions: it implies that those psychologists with endorsements have a higher level of competence than those without endorsements. There is no empirical evidence to support this view- it is a view of policy makers.

When AoPEs were introduced most APS college members (members due to having an interest, not a qualification) obtained automatic endorsements, regardless of their training background or level of education. Therefore, to state that all psychologists endorsed as Clinical Psychologists have superior competencies is untruthful. It is an inconsistent process that a registered psychologist simply having an area of interest and choosing to be a member of the Clinical College (of which there are multiple areas) of the APS, could suddenly make one qualified to be endorsed as a specialist when AoPE were introduced. Some of these members have a 3 year undergraduate degree only. That many long-term applied psychologists chose to not be members of the Clinical College meant that they were excluded from this automatic endorsement. This means that 50% of those endorsed do not hold the requisite qualification.

I believe the process of ‘grandfathering’ non-APS college members is also corrupted by APS interests and biases. Some high-ranking members of the APS and PBA were awarded multiple areas of endorsement, despite primarily having academic careers. This underscores the flaws in the framework of AoPE. For example, some members of the PBA have a range of AoPEs, such as clinical, forensic, counselling, health, and community, etc. The hours/years do not add up: psychologists who have spent most of their career in academia could not possibly have achieved such broad levels of competence in these AoPE’s. It appears that such individuals were given automatic multiple endorsements simply because they were members of multiple colleges of the APS. Yet there are many thousands of ‘generalist’ psychologists who will never be eligible for any endorsements, even though they have many years of actual competencies, and many who also have Masters or PhDs in counselling, education etc. that are not recognised as reimbursable by Medicare.

1. What are the advantages and disadvantages of moving from the current AoPE standard (supported by the current AoPE guidelines) to the proposed AoPE standard (supported by the proposed AoPE guidelines)?

I see only disadvantages.

The prospect of many competent, experienced, post graduate qualified practitioners like me having to undergo another year of study, or some other form of bridging program and 2 years supervision in order to become eligible for AoPE is ludicrous, and underscores flaws in the current AoPE framework as well as the proposals for further development. There is no reason that psychologists like me should have to engage in further university studies in order to become “competent” in our job that we have been capably performing in for many years.

1. Is the content and structure of the proposed standard helpful, clear, relevant and workable?

The premise upon which the AoPE distinguishes psychologists in Australia and various competencies is flawed and makes the proposal unworkable.

I am 53 years old with over 25 years experience as a registered psychologist. It is unaffordable and impractical for me to undergo such a bridging program. It has provoked untold unnecessary anxiety and fracturing in our profession. Again, there seem to be one set of rules for PBA making policy decisions, while the rest of us are urged to engage in the scientist-practitioner model. All I see is division when we should be working together for our profession.

1. Is there any content that needs to be added to, deleted from, or changed in the proposed standard?

A complete revision of the entire AoPE framework is required.

As it stands, the framework is corrupted. Our profession requires that we conduct evidence-based practice, making decisions on data rather than opinion. Therefore the AoPE framework needs to do the same. No amount of revisions will alter the basic problems which are perceived as being at the heart of AoPE.

There needs to be an acceptance that there is no evidence that a Clinical Masters improves client outcomes, a cultural shift to accept that choosing to study a Clinical Masters does not mean I automatically become a more effective psychologist.

I recommend removal of the entire Board and re-writing of the constitution to ensure proportional representation between both types of registered psychologists. The way the Board is currently structured in Divisions simply encourages divisiveness rather than a unified body looking after all our needs. At a recent APS dinner an APS board member was heard to say that her belief that Clinical Psychologists fundamentally differ in their assessment, diagnosis and treatment of clients goes back to 30 years ago when she did her training. Here we have important policy decisions being made based on personal experience and opinion rather than empirical data.

I recommend that if AoPE does remain in some form (this should only be an if and only be based on evidence), that there be a ‘grandfathering’ process so that a 4+2 graduate with years of practical experience should be accepted as being competent. There is no reason such an individual should be required to undertake a bridging program when they already possess ample competency.

Another option to a bridging program should be an evidenced based exam or assessment process. This would be much more cost and time effective and would provide an opportunity to demonstrate competencies objectively (although this is already available through studies of equivalence). However, grandfathered psychologists by virtue of being a member of the Clinical College in 2010 should also have to undergo such competency assessments.

I cannot see why 2 years of registrar supervision would be needed when we have already undertaken supervision. In addition, it is a requirement of maintaining registration that we undertake regular peer supervision.

1. Are there other specific impacts (positive or negative) arising from the proposed AoPE standard that need to be considered? This may include impacts from the proposed removal of content from the standard that is set out in the proposed AoPE guidelines.

A bridging requirement would result in unnecessary restriction of consumer choice, as neither I nor many thousands of psychologists will be able to afford the money or time to undertake a bridging program and supervision, so a career change will be necessary. The impact on our community will be untold: that the majority of clients will only be able to access “specialist endorsed” psychologists that make up a minority, means wait lists for them will be even more strained.

We are already starting to see the deleterious effects of such a division: the NDIS now has guidelines that only a Clinical Psychologist can assess and diagnose ASD. As very few Clinical Psychologists work in the disability sector seeking a diagnosis will be nigh impossible for clients.

In summary the Board’s proposed changes will result in unnecessary restriction of consumer choice, restriction of trade practice, and is going to cause much more damage than good.

Starting from scratch rather than a revision is necessary.

Yours sincerely

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**References:**

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