**Submission**

**by Kaylene Akins**

**Psychologist in Private Practice**

**to the**

**Psychology Board of Australia**

**on**

**Public Consultation on Area of**

**practice endorsement registration standards**

4th December 2018

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**Submission by Kaylene Akins - Psychologist in Private Practice on the Public Consultation on revised area of practice endorsement registration standards.**

I would like to submit my feedback on the above registration standard that has been put forward and appreciate the opportunity to do so. As I understand this consultation process is to: **1)** provide stakeholders with an opportunity to consider whether implementation of the proposed AoPE standard could have any impact on us or the broader regulatory environment, now or in the future; **2)** identify any existing or potential operational, workforce or legal impacts or barriers to adopting and implementing the proposed AoPE standard; **3).** Provide stakeholders with an opportunity to suggest improvements to the proposed AoPE standard that will provide for increased public protection and directly contribute to achievements of the objectives of the National Law; **4)** provide stakeholders with an opportunity to suggest improvements to the presentation of information in the proposed AoPE standard, and **5)** meet the consultation requirements of the National Law.

1. **Which Option do you prefer – Option 1 – Status quo or Option 2 (proposed standard)**

My submission is unfortunately in disagreement with **both** options 1 and option 2 that has been presented by the board. I need to dispute the presumed legitimacy of the AoPE (Area's of Professional Endorsement) of any Psychologist due to the differentiating of professional expertise through various competencies identified as being the gold stars of our profession. It does not, in my opinion, adhere tothose who would currently meet AoPE. Psychologists work in so many different areas of studies that endorsement titles do not depict and therefore the endorsement does not represent professional competencies and is misleading to consumers. An example of this is where an experienced psychologist who has studied a Masters (not an approved APAC course) and holds years of experience in applied psychology would arguably have equivalent competencies to any psychologist with endorsement.

The AoPE, it would appear, is being referenced as being an attempt by the PBA to introduce specialities in our profession and no AoPE is based on demonstrated competencies. I have cited in my readings that the Tuning EuroPsy document (Lund et al, 2014, at [www.efpa.eu/download/ff50966dba871e96230fdf9542586e4d](http://www.efpa.eu/download/ff50966dba871e96230fdf9542586e4d) makes evident that competencies in psychology are obtained not at university, but in the actual applied psychology job role. Additionally, 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) Furthermore, research that is available from education and learning shows that on-the-job training accounts for 70% of how adults learn. Formal learning through courses and degrees comprises 10% with the remaining 20% coming from supervision, feedback and reflection.

The area of AoPE that is being used is, in my opinion, flawed as most of those who have endorsement through being a member of the APS colleges obtained their memberships regardless of their training background or level of education early in the history of the APS by having an interest in the college. In fact, I was led to believe that after completing my registration I could have applied to become a member of the counselling college and the clinical college with my background and interest in complex clinical work and counselling. However, as it had taken me so many years to achieve full membership of the APS (something I felt at the time quite proud of achieving), I considered the cost of joining colleges on top of my APS membership, was not going to add anything more to my work, so I chose instead to put my efforts/and finances into learning as much evidence based training as I could and undertake supervision that could then be applied to help my client groups. Little did I know that not joining a college could have such profound implications as it is now having where my years of professional experience, ongoing professional development and supervision; being a supervisor for registration and general psychologist registration was to become devalued. Additionally, it is putting my clients at risk of not being able to access my services if I'm restricted in my practice.

It is important to note that the majority of psychologists’ work within their ethical and professional limits and that the Department of Health has no large-scale evidence distinguishing the outcomes of different types of psychologists concluding that psychologists are adding value to consumers in perception and in tangible outcomes (Pirkis, Harris, Hall & Flanou, 2011). Furthermore, Australian Psychologists including 4+2 and masters graduates, have been found to achieve client outcomes which are impressive and up to the best international standards (Pirkis et al. 2011).

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 can see only disadvantages. I would like to respectfully give you an example of my situation. I am a psychologist with 30 years of membership of the APS and have recently joined the AAPi. I'm experienced and in my latter career stage and hold a Masters. I have practiced in numerous ‘areas’ or settings including clinical, counselling and educational throughout my career; primarily in Private Practice providing clinical and counselling services for the last 19 years full time; and prior to this part time while working for a non-government agency full time. I'm a 4+2 pathway registered Psychologist and proud to call myself this. I completed a Bachelor Social Science (with a double major in Psychology and Welfare) and then a Post Graduate Diploma in Counselling (which had a research paper as part of the course) and then the required hours of supervised practice. I also have a Masters in Applied Science (Psychology of Coaching) and am a founding member of the International Society of Coaching Psychology (ISCP). I've been in Private Practice for 27 years and could not continue to maintain an income in private practice if my skills were sub-standard. I chose the pathway of 4+2 for, several reasons but the primary one was that it gave me the option of continuing to apply the science of psychology in a situational learning environment; doing the hands-on, face-to-face work with complex and challenging cases. I found that adding to my qualifications by taking training courses offered by other professionals and institutions gave me the opportunity to learn so much more than a university alone could. It is well documented that situational learning is shown to be a critical component of education and training for improving practice skills across all areas of health and allied health training. Moreover, the 4+2 gave me an opportunity to use applied skills in well-being to enhance my client’s capabilities to not just focus on the pathology of mental health, but to explore pathways for building my client’s ability to identify their strengths and set realistic goals to improve their functioning. This enabled me to apply clinical assessment and therapeutic counselling , family therapy and therapeutic techniques to support and manage clients needing direct psychological help for a variety of presentations including complex presentation of mental and physical health issues including: depression, anxiety, panic disorders, grief, ADHD, CD, ODD, PTSD, borderline personality disorder, bipolar disorder, ASD, disorders of the self, and other complex family therapy and system issues of family breakdown, including: domestic violence, alcohol and other drugs, attachment and bonding issues, traumatic stress, sexual abuse, psycho-social factors including homelessness, financial difficulties, unemployment, educational breakdown and difficulties, imprisonment, physical health issues, disenfranchised and suicidal clients. This involved clinical assessments and psychometric testing along with report writing, crisis management, child protection, case management, staff and team development, program planning and development; budgeting and management of government funding, recruitment employment and training; working with doctors, schools, department of community services, police, juvenile detention staff and court systems.

In private practice as a psychologist I have provided services to clients, through Mental Health Care Plans, Better Outcomes in Mental Health, Suicide Prevention, Peri-natal work, NDIS, Aged Care, Victims Services, Work Cover, MVA, Veteran Affairs, EAP and Coaching Services to Mental Health clients; and those wanting to improve their lives to prevent Mental Health issues and take a proactive approach to better health and well-being: a goal directed solution focused approach looking at the clients within a systemic contextual model using evidence based treatments I've completed training in and been applying for years in my practice.

I've provided training and supervision to colleagues; supervised 4+2 and 5+1 provisionally registered Psychologists for registration and when psychologist who have worked for me have applied for university for their Clinical Masters programmes, I've provided references for them which has seen them all being accepted. Furthermore, I have clinical Psychologist’s with doctorates who seek out my services for my experience in the field; something I am proud of but have never felt the need to boast about as I've just got on with doing the job I'm trained to do and be there for my clients, colleagues and the public who are in need of psychological support services.

In 2004 I completed a Master's in Applied Psychology (Psychology of Coaching) through University of Sydney. This applied positive psychology framework has further added to my clinical practice, as it assists clients to identify strengths, set goals, and move from positions of major mental health issues and psycho-social stressors to a place where they feel empowered to make changes to set goals to find meaning and purpose in their lives - an important process in the treatment of clinical clients and the prevention of mental health problems. This is one of the reasons that the AoPE would seem so absurd and has no scientific evidence base in relation to the 9 areas of endorsement listed, as it limits the professional competencies held by so many applied psychologists.

As professionals we have ongoing Professional Development and supervision for learning and quality assurance for our clients and to look after ourselves. But we are being devalued. To suggest that Psychologists without AoPE have less intellectual rigour is insulting to psychologists without ‘so called’ endorsement. Furthermore, we are expected to keep up with our professional development for registration purpose in relation to our duty of care for public safety, but we are not being given credit to say we can work with our years of experience; as being capable of providing services to more complex clients (my bread and butter) unless we are endorsed. As a Psychologist I estimate I have completed approximately 39,000 hours of face to face psychotherapeutic practice in psychological treatment and counselling alone and Continuing Professional Development and supervision on top of this and I've had no reprimands or conditions ever placed on me.

The notion that competent, experienced post graduate qualified psychologists like me have to undergo another year of study or bridging program and 2 years of supervision in order to become eligible for an AoPE is quite frankly devaluing and disrespectful and demonstrates major flaws in the current AoPE framework and any proposal for future development as it stands now.

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 or content from the standard that is set out in the proposed AoPE guidelines.**

I'm disappointed by a system that has the potential to restrict, ruin and destroy access to services for so many clients with a variety of complex mental health presentation by the implied restriction this AoPE could place on my professional practice and other like me. Furthermore, my professional reputation that I've worked so hard to build up over 27 years, could be majorly affected because as a Psychologist I'm not considered to be good enough because I'm not endorsed and the misleading promotion that is occurring by professional bodies that purports that only Clinical Psychologists can treat complex clients, is considered by many as misleading the health system and consumers.

I'm committed to my career as a psychologist and have a practice building that meets all Government standards for disabilities and parking (which took me years to achieve). The clinical practice is open 5-day a week and every second Saturday to support the demands for clinical mental health services. I employ both administration staff and Psychologists, and despite regular advertising, suitably qualified Psychologists are not coming forward to meet the demand as I have the referrals coming in that I'm just not able to take on. Moreover, demographically and socio-economically this region has the second highest reported domestic violence cases in the state, suicide rates are growing and there is a high need for services provided by psychologists. But if restricted in our practice, this will not only affect consumers and bank up other already overburdened health systems, but also place people at risk of not having their mental health needs met.

I've completed years of professional training and applied psychological work, and now those who have (in many cases) never completed face-to-face psychological work with complex clients on a daily basis and only completed the university training or been accepted as endorsed because of the APS College memberships will be deemed to be more professionally competent and superior and this is just untrue.

In my professional opinion our competencies are also measured by our clients who are reporting positive outcomes and feed this back to their doctors. These doctors need to be respected for being the gatekeepers in deciding who they will refer to, as they see and hear the results from their patients. Therefore, differentiating professional expertise through various competencies has the potential to mislead and confuse the public and add further stress on a system already under stress because of a lack of access to professional psychologists that will come about if AoPE goes ahead.

Another concern is that Clinical and other endorsed Psychologists not long out of university are going to be taking on the most complex clients without necessarily having commensurate experience. I question how this has the public safety as the most important thing. They are also being paid the higher Medicare rebate because of the clinical title (under the two-tier system) an inequality for registered psychologists with extensive experience and a disadvantage to consumer groups who are not able to access a higher rebate.

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

The premise in which the AoPE divides Psychologist in Australia by competencies is flawed and, unworkable. If this AoPE registration standard that the board proposes occurs, it is expected to create great division in a profession that is already in deep crisis on so many levels. There has been the promotion of so called 'Bridging Courses' for Psychologists to gain an AoPE and only then upon completion of such a programme the psychologist can then return to do exactly the same work they may have been doing for years even decades. In my case for example, in my latter years of my career and with a busy private practice; I could not reduce my workload and income as a single person and continue to meet my financial obligations as well as pay the cost of the courses and supervision that is required. Furthermore, to what value would this add to my clients and career at this stage of my life in my 60's.

There are numerous allied health and medical colleagues who report that they see no value within the profession of having AoPE as it is confusing, limiting and implies some form of expertise within an area of psychology that does not represent or transpire in the work provided by a psychologist. An example of this only occurred this week when a client of mine presented at the local hospital and was assessed by the Mental Health team on a weekend. She was told to see me for a report for Centrelink - and when she advised I was not a Clinical Psychologist they told her this was not true, and even though she reiterated this, she indicated she was not believed. While I have never misrepresented myself in any way - based on the number of years I have been working as a Psychologist doing clinical work with good standing in the community and health profession, it is a common misperception that I am indeed a Clinical Psychologist (as I do clinical work) and I'm forced to correct people and attempt to explain the difference on numerous occasions. Furthermore, it should be noted that since Centrelink will only take a Clinical Psychologist or Psychiatrist report as valid to determine a client's mental health diagnosis and condition - clients who are financially disadvantaged and the most vulnerable in our community are being placed under even further psychological and financial stress in trying to access and pay for such reports. It is these financially disadvantaged clients that are generally being seen under ATAPS-BOMH services for counselling and need, but are unable to, access services for reports. This is made even more difficult because we are more isolated as a regional coastal area and services are geographically more difficult to access, psychiatrists do not bulk-bill and few clinical psychologists do such reports or have long waiting lists. Furthermore, these clients having developed a trusting therapeutic relationship with a psychologist, feel overwhelmed having to go and see another psychologist with clinical endorsement for such a report.

There is another major concern relating to this AoPE that has the potential to affect Mental Health consumers and professionals alike as well as the entire system. I'd like to give you an example of a referral made to me. Dr. X has referred a patient with depression and anxiety. In completing a clinical assessment and obtaining their history, background and completing a Genogram, the client shares that they been the victim of sexual and physical abuse in their childhood; have domestic violence occurring, they present with depression and anxiety; they have major sleep problems and have difficulties functioning in their day to day and have suicidal ideations. This is not an uncommon presentation and the client has not shared all of this with their doctor. The client has trusted that they are now in a safe place with someone who is going to be able to help them psychologically by listening with empathy and understanding as they share their story; whilst assisting them to understand and learn how to manage their symptoms and support them to apply psychological treatment strategies and skills to improve their functioning in consultation with the treating doctor develop a treatment plan. Based on the proposal that only psychologists with AoPE are going to be able to work with more complex and chronic presentations, how will a non-endorsed psychologist ethically manage this situation? Will we then be saying to this type of client: "I'm sorry but I'm not endorsed to be able to treat you. You will need to be referred to a clinical or endorsed psychologist and I will need to refer you back to your doctor."? How is this in the best interest of the client, the public or the entire health system that is already in peak demand and under resourced? This type of client is at least 95% of the client group that I work with daily.

Furthermore, I have grave concerns in relation to our professional indemnity insurance and question if it will be able to protect us. For example, if the AoPE was to go ahead and a complaint was lodged by a client against an experienced psychologist who does not hold an area of endorsement, would the insurance cover us?

Another concern is that there are many colleagues with extensive experience who are feeling undervalued for the work they do and disillusioned by what is occurring in our profession, and are talking about even leaving the profession or changing careers; which has the real potential to contribute to a major workforce shortage as we lose really talented and previously dedicated psychologists and put further pressure on a mental health system that is currently in crisis within our country.

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

The improvement would be to abolish this AoPE framework as the prospect of having to undergo another year of study, or some form of bridging program in order to be eligible for AoPE is absurd. The notion of engaging in further university studies in order to become competent in jobs which I/others have been capably performing for many years is quite frankly insulting. Furthermore, the notion of restricting mine and other's ability to practice after having met all professional requirements for (in my case 30 years) and potentially cause damage to our livelihoods is ethically preposterous. This process needs to respect and legitimise the history of Psychology practice in Australia has been made up of expertise in many areas, including lecturing, clinical practice and other areas of expertise and competencies, developed through a range of pathways and it is unethical and unscientific with no supporting - evidence that Masters or Doctoral level studies result in competencies in the workplace which are associated with better outcomes for clients. There is no scientific evidence to support that just because someone has a Clinical Masters that the client outcomes will be improved and that they are a more competent and effective psychologists.

The entire AoPE framework is in my opinion filled with major flaws, inconsistencies, and historic wrongs. This is evidenced in the automatic endorsement of APS members who belong to colleges, and at the outset of the PBA and endorsement, and various training options and hence in my opinion renders the entire AoPE framework as illegitimate to applied psychologists and misleading to the public and therefore questions who is really placing the public at risk through such a framework. I would recommend removal of the board and a more equitable representation of all registered psychologists be voted in, where a new constitution is written to reflect the scientific evidence of our profession.

On a personal level I'd like to add that being a 4+2 pathway Psychologist gave me the opportunity to pursue registration while working and raising 3 children as a sole parent. I enrolled as a mature aged student and put myself through University doing distant education as a single parent and have been the only income earner in my career becoming fully registered in 1996. I also at that time had the responsibility of being a mother of teenage children, something that required my commitment both personally and financially and for this reason I chose to not go on and do a Clinical Masters, as a colleague of mine did when I finished my Post Graduate qualification. Then a few years later it became more challenging to obtain a University placement in a Clinical Masters as they became competitive and limited and chose instead to do a master’s in applied science (Psychology of Coaching). This combined with my clinical and counselling experience and diverse background in Family and Couples Therapy and working with complex clients has contributed to my success as a Psychologist in Private Practice as I'm well respected within my professional and local community. Also working in a regional coastal area, with so many complex presentations I needed to draw on many areas of experience and competencies. If this AoPE comes about it will bring with it unnecessary restriction on consumer choices as neither I nor other psychologists will be able to afford bridging courses or the additional supervision costs and we will be forced to leave the profession. The impact on our community and clients will be major as they will be only able to access psychological services from specialist endorsed psychologist who make up a minority and who are in some cases less experienced. It will also mean that there will be even larger waiting lists which will put a massive strain on a health system already in crisis.

In summary I appeal to the board to completely revise this proposed framework and rectify the wrongs, looking at the notion that Clinical Psychologist and those endorsed Psychologist are more competent and safer for the public than those Psychologists who work in so many other areas of psychological practice and play major roles as respected and competent professionals in our country. Furthermore, the notion that those who automatically became endorsed after being members of the APS colleges does not reflect competencies nor outcomes to consumers and does not necessarily equate to safety of the public as there is currently no details, that I’m aware of, that provides research to say that public safety is increased by being an endorsed clinical/or other psychologist.

In conclusion I can see this proposal of AoPE in general creating a rift within our profession and appears to be referenced as an attempt by the PBA to introduce specialities in our profession and no AoPE is based on demonstrated competencies. It is unfortunate that those who are being given the responsibility to run psychology in this country appear to have not taken the time to look at the evidence or even outcomes of therapeutic relationships, and other relevant scientific evidence in making such policy decisions. This is particularly alarming when it affects access for consumers to mental health, and well-being services along with an entire professions standing in this country. I call for unity where we are all equally valued for our years of experience and competencies and until scientific evidence can unequivocally demonstrate that there is a difference in outcomes for consumers by being an endorsed psychologist, that all psychologists be allowed to work towards a common goal of meeting the demands of a health care system in crisis and not be expected to undertake further onerous studies that is likely to see so many excellent professionals leaving the industry.

Yours Sincerely,



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