NEW ZEALAND PSYCHOLOGISTS BOARD

PSYCHOLOGISTS BOARD

Review of Scopes of Practice 2008:

7. Complete group responses

Stakeholder Groups

***This document has been adjusted to protect the anonymity of those submitters who prefer their organisation's submission to remain confidential to the Board.**

Gp1: DHB1.
Gp2: Professional advisors for DHBs. The NZ DHB Psychology Leadership Council consists of the Professional Leaders and Psychology Advisors of New Zealand DHBs, and therefore is both involved in the selection and employment of psychologists to health services and the maintenance of professional standards of psychologists.
Gp3: Dept of Corrections Psychological Service
Gp4: New Zealand Psychological Society – Institute of Clinical Psychology committee
Gp5: Professional organisation 1
Gp6: Canterbury NZCCP
Gp7: DHB 2
Gp8: NZ Psych Society
Gp9: NZCCP
Gp10: Institute of Educational and Developmental Psychologists, a professional subgroup within the New Zealand Psychological Society
Gp11: DHB 3
Gp12: *Child and Family Psychology Programme, Canterbury University*
Gp13: Employer/Contractor 1
Gp14: DHB 4.
Gp15: DHB 5
Gp16: Regulatory Authority 1
Gp17: Regulatory Authority 2
Gp18: University academic 1: "I make this submission as a psychologist (graduating in 1970); as a university academic who has contributed to both basic and applied science in Psychology; as a defacto employer of Psychologists (in my role as a University Head of Department); and as a member of the New Zealand Psychological Society holding office on the Executive of the Society".
Gp19: I am a General Practitioner in Christchurch. I am also the Clinical Leader in Mental Health for Pegasus Health.
Gp20: DHB 6
Gp21: DHB 7
Gp22: Medical Council of NZ
Gp23: Employer/ contractor 2
Gp24: DHBNZ Allied Health Workforce Strategy Group
Gp25: Institute of Community Psychology Aotearoa
Gp26: Submitter forwarded a detailed list of criteria for assessing Educational Psychology qualifications. Submission is noted but not included in the collated responses as it is tangential in content.
Gp27: Advisor 1
Gp28: Advisor 2

The responses were regrouped:
DHB Psychologists, GPs 1, 2, 7, 11, 14, 15, 20, 21
Other employers/contractors: GPs 3, 13, 23, 27, 28
Professional Psychology groups: GPs 4, 5, 6, 8, 9, 10, 25
Other regulatory authorities: GPs 16, 17, 22
Academics: GPs 12, 18, 26
Other: PHO GP19; DHBNZ Workforce Group GP 24

Question 3.3(a): Do the existing vocational scope titles make a useful distinction for the interested public and thereby improve public safety?

DHB Psychologists responses:

Gp1: No. The scopes are not specific enough to guarantee public safety. Justification for this standpoint has already been made above:
• That the scope title communicates little information and therefore does not protect the public. The higher the degree of specificity of title, the greater the distinction members of the public are required to make. That is, the title is only useful if the target audience knows what it means.
• That scope titles may mislead the public who assume all those with a particular scope title have the same specialist knowledge. Psychologists within a vocational scope vary considerably in their specialist skills and experience, and sometimes also qualifications. For example, clinical scope includes specialty areas such as (but not limited to) child and family; adult mental health; Corrections; forensic; young people; neuropsychology; pain management; and sexual therapy, all of which require distinct fields of knowledge and skill. Practitioners with the same scope title do not necessarily represent the same skills.
• That the title is redundant as both prior to and since the introduction of scopes the Board and the client have relied on the individual practitioner to state whether or not they deem themselves competent to practise in a particular area.
• That it adds further confusion to the public who cannot make a distinction between counsellors, psychotherapists, psychiatrists and psychologists, let alone "Psychologist" and "Clinical Psychologist" or "Educational Psychologist".

Gp2: Yes the vocational scopes are important. Psychology is a broad discipline with many different sub-disciplines, so members of the public can receive little guidance from the title Registered Psychologist alone as to which psychologists will be appropriate to address their needs. The existing vocational scopes assist members of the public in making an informed choice and identifying psychologists who have appropriate competencies to work on particular issues and within particular settings. Referrers also need this type of information to be able to make safe and optimal referrals. Although some psychologists with significant relevant skills do not attain a vocational scope, in general it is indicative of a level of training, qualification and practical experience that is a meaningful and useful indicator for the public. The fact that there is a perceived difficulty for the public in differentiating between psychologists, psychiatrists and other mental health professionals emphasizes the importance of assisting members of the public to make an informed choice.
The vocational scopes of practice also greatly assist DHBs to protect the public by giving an additional check in the case of overseas job applicants that their qualifications do meet equivalence. With its developing database of the level of many qualifications from around the world, it is possible for the Psychologists Board to undertake this task consistently and efficiently. It would be difficult, if not impossible, for each potential employer to provide this level of checking for each applicant.

Gp7: The existing scopes of practice have a degree of recognition both nationally and at an international level and provide a basis for choice and informed consent to the public. They assist to engender a degree of public confidence in the profession, and as an employer, the scopes (particularly the Clinical Scope) are a helpful guideline from which to assume a base level of qualification and competence from which practitioners can develop their specialist skills for working in the public health sector. Essentially these factors translate into public safety.

Gp14: Yes. The capacity to do this is a major improvement on the old legislation. This was one of the recommendations made by the Psychologists Board Consultative Committee in 1993 and the reasons given then still apply. "The interests of consumers are not safeguarded by the Act's general registration provisions when there is a need to identify an appropriately qualified and experienced specialist. There are no real constraints on a person claiming specialist skills when they have not received the required training or supervision" (p8).

Gp15: Yes. The basic Psychologist Scope does not discriminate between branches of psychology. The qualifications and experience for those qualifying for entry into the Psychologist's Scope is too broad. For instance Organisational Psychologists and Community Psychologists qualify for the Psychologist Scope but do not qualify for the Clinical Scope. The potential for confusion therefore risk to the public is arguably higher for psychologists than other health professionals as not all psychologists are "health practitioners" but may be registered. I doubt that the public are fully aware of this. In addition, those employing psychologists are not always aware of the differences between branches of psychology. We have to remember that Psychologists are independent practitioners who sit behind closed doors with their clients. We need to afford these clients the protection that titles afford. In addition, if the Board mandates a scope they need to approve the programme of training for that scope.

Gp20: Currently scopes reflect differences in training. It is important that these differences are recognisable given that the public have the right to know this thereby being protected from practitioners misrepresenting their skills.

Gp21: We believe the existing scopes make a useful distinction for the public, which we believe will in the long term enhance public safety. The current system of having vocational scopes is in general consistent with structures in other countries where specialist areas of practice are delineated. Almost every country has some sort of mechanism for identifying the subgroup of psychologists qualified to work in specific areas (e.g. to treat clinical conditions).

We believe there would be more ambiguity and uncertainty for the public if the Psychologists Board reverts to a position of only having one scope. All psychologists do not have the same training, skills or competencies and therefore all psychologists cannot be expected to practice competently in all areas of psychology. The public need a way of identifying which practitioners have the competencies associated with particular scopes so they can make more informed choices. This is particularly true where the public are seeking to select practitioners with the competencies to deliver psychological treatments for significant mental health issues. At the time when clients need to make such distinctions they are typically most vulnerable and need clear guidelines.
The fact that the public have difficulty distinguishing between psychologists, psychiatrists and counsellors is not a good reason to remove vocational scopes. Instead it indicates that a critical issue for the profession (and the Psychologists Board) is to provide additional (ongoing) education of public and stakeholders about what they can expect of psychologists in the different scopes.
Further work may need to be done within the profession to develop consensus on what the scopes mean and how to best apply them. This does not mean the enterprise should be abandoned.

Other employers /contractors

Gp3: To a limited degree because they at least provide a vehicle for members of the public, including bodies that are seeking specialist knowledge, consultation or advice, to obtain some core, albeit superficial, information about where that knowledge may best be obtained. Further, the fact that there are vocational scopes at all indicates to the public that they should ask questions about competence and scope, and limits of skills and knowledge.

Gp13: [Organisation] considers the existing scopes do allow the public and purchasers to identify appropriate psychologists for their need. The scopes also facilitate further enquiry as to the specialist skills involved with performing that particular clinical function.

Gp23: Yes, but not essential.

Gp27: No, over 877 hold the 'Clinical Scope' but this tells the public and purchasers like [organisation] nothing about their area of expertise, particularly with regard to competency as a [specialist skill]. [Organisation] purchase [specialist] services in quite large quantities, and pay well for these services. The standard of work received varies immensely, and client's futures with rehabilitation are often greatly affected.

Gp28: They do not delineate applied psychology areas beyond clinical and educational therefore in the current state they are inadequate.

Professional Psychology Groups

Gp4: The existing vocational scope of "Clinical Psychologist" provides a useful distinction for assisting the public (which includes the general public, related providers of health, disability and other services, educators etc) in selecting services, in particular health services.
We disagree that the title "communicates little information". Further, by providing a title a reader has the opportunity to inquire further if need be and gain relevant information.
It is appropriate for the public to know that all practitioners with this scope can provide a service based on sound clinical knowledge and skills and it is then for the practitioner to state any special interests they may or may not have; this is also seen in other health fields. It is (as it would be for any profession) preposterous to consider all will have the same skill set, however common foundations are shared and will shape practitioners' service provision.
The field of clinical psychology has existed for one hundred years, whereas some other similar specialties are more recent developments. Throughout this time practitioners of clinical psychology have made significant contributions to health and mental health (including from within subspecialties). The title is recognised and shares commonalities internationally.
We would argue that the scope provides for public protection; it clearly defines an area of practice which though broad is applied and clinical; there must be clear qualifications for entry to allow the public to be assured of the competence of practitioners. We do not believe the scope of clinical psychology unnecessarily restricts an area of practice; we consider that if restrictions have occurred then it is as a consequence of the 'settling-in' period of these first years under the HPCA Act.

Gp5: They do not delineate applied psychology areas beyond clinical and educational therefore in the current state they are inadequate

Gp8: The existing vocational scopes do not mark out distinct areas of practice or specialized knowledge in ways that assist members of the public to make appropriate decisions about who is the appropriate health practitioner. Qualifiers such as "advanced knowledge", "comprehensive knowledge" imply a comparison that those lacking knowledge of psychology are poorly equipped to make. The existence of vocational scopes encourages the public to think by way of medical specialties and expect all those practising in the scope to have comparable skills and knowledge, which simply is not true for or analogous with professional psychology.

Gp9: Yes, but we are concerned that they are not functioning in the way the legislation intended.

Yes – perhaps. This does depend on the knowledge of the public, we are not sure that the public in general are clear about the differences between professional groups (psychologists, psychiatrists, psychotherapists), let alone fine distinctions within these groups. However, certain groups or sectors (referring GP doctors, government agencies and departments) are aware of the distinctions and use them in deciding what sort of psychologist is needed for particular tasks or roles.
We are concerned about the stand the Psychologists Registration Board has taken, that is, that protection of title is not intended to restrict practice, that practice is not restricted by scope but by competence and that only title use is restricted by scope. This seems counter to the intent of the legislation and is not the approach that other registration authorities have taken with respect to scopes of practice. The Ministry of Health's recent paper on the review of HPCA ("Identification of issues and solutions") talks about the intent of scopes of practice – "the purpose of registration and APCs is to provide the public with an assurance that a practitioner is competent by certifying that the practitioner meets the requirements to work within a specified scope of practice". Our reading of this is that practitioners should not undertake work described within a scope of practice without actually holding that scope.
The development and use of vocational titles is an issue that has been discussed by psychologists for many years, with some of this summarised by the Psychologists Board Consultative Committee in 1993. The conclusions they reached about specialist titles and the reasons given then still apply. "The interests of consumers are not safeguarded by the Act's general registration provisions when there is a need to identify an appropriately qualified and experienced specialist. There are no real constraints on a person claiming specialist skills when they have not received the required training or supervision" (p8).

Gp10: We fully agree with the NZPS response to this question.

Academics

GP 12 Several questions need to be considered in answering this question.
Firstly is the question does having vocational scopes signify anything important about the psychologist with that scope. We believe the answer to the question is yes. It signifies that: the psychologist has undergone a selection/screening process; he/she has studied a specific and broad curriculum; he/she has learnt practical skills under supervision; he or she has spent time learning about ethics and self-reflective practice; and that he or she has had pre-internship practical experience and has undergone a formal examination process. There is little doubt that public safety is enhanced by this as it is impossible to fit all of that into a programme shorter than 2-3 years.
The second question is, what is the Board's role? In our opinion, the Board needs to take a wider view than simply accrediting for minimum standards. The Board's decisions will have considerable influence on the development of our profession with direct implications for public safety. Lack of access to well-trained psychologists is an issue of safety too. Should the Board dispense with vocational scopes the pressure on Universities to offer Vocational level training will decrease too.
It is exceptionally difficult to establish a new training programme. Such programmes are expensive and cross-subsidised by undergraduate and 4th year enrolments. In the current climate, Universities take a dim view of this. There is pressure on programmes, by the Universities, to increase research (and earn PBRF income) at the expense of practical and curriculum training in the 5th year. Because of this, programmes are forced to either add additional time (we have increased our 5th year programme to 15 months) or cut back 5th year practical and curriculum. If the Board dispenses with vocational scopes it is likely that new courses will have no leverage with Universities to continue these 5th year practical and curriculum programmes.
In addition, the position of New Zealand graduates overseas needs to be considered. What would be the implications of dispensing with the vocational scopes for our graduates in Australia, especially given the Medicare funding for clinical psychologists?

The third question is: How best should the Board exercise this role? Neither qualifications alone, nor experience alone is sufficient. The board needs to establish a minimum number of internationally recognised vocational scopes and also provide pathways into them for innovative new courses with different emphases.
In the case of the Child and Family Psychology Programme, graduates have 3 years of dedicated curriculum; they are selected on academic, personal and skills criteria; they have a term of psychometrics labs; they have intensive training in interventions; they have 3 placements in their 5th year –with written case-reports; they have 5 video assessments over 5th and 6th years; they write conceptually challenging assignments in both these years; they submit an 8 case portfolio during their internship and undergo an externally examined oral.
Currently these graduates receive simply a general scope.
We have discussed with the Board applying for both a Clinical and an Educational scope for this programme and are developing the programme to facilitate this. In order to develop the programme as an inter-sectoral programme it is now being jointly taught across Health Sciences and the School of Educational Studies and Human Development. The masters degree is being restructured but a new name for the degree has not yet been decided. This needs to be done in consultation with a number of groups, not least the Board as we cannot use the words "Clinical" or "Educational" unless the programme has been accredited under these scopes.
There is a literature addressing the need for clinical child psychology programmes to be developed with slightly different models from existing clinical programmes. There has been criticism of the tendency for such programmes to be "tacked on" to existing programmes. The use of other names for these programmes is also prevalent but we would have named our programme differently had the HPCA Act been in force when it was established. "What is in a name?" in this context is an important question.

How to establish different pathways in is the final question. The Australian College of Clinical Psychologists allows entry to graduates with a combination of alternative qualifications and appropriate supervised experience. We believe both are needed.

Other Regulatory Authorities

Gp16: Professional Ethics of a health provider is required to protect the public safety. A title may mean different things to the general public than an informed health professional.

Gp17: The distinction evident in the vocational scopes relate to the domain of knowledge. It is not clear how these differ from the general psychologist scope, other than being specialist versions of the former.

Question 3.3(b): Does it matter that practitioners with the same vocational scope may vary considerably in their knowledge and skills?

DHB Psychologists

Gp1: Yes it matters only, and only if, public safety is the main criteria:
That scope titles may mislead the public who assume all those with a particular scope title have the same specialist knowledge. Psychologists within a vocational scope vary considerably in their specialist skills and experience, and sometimes also qualifications. For example, clinical scope includes specialty areas such as (but not limited to) child and family; adult mental health; Corrections; forensic; young people; neuropsychology; pain management; and sexual therapy, all of which require distinct fields of knowledge and skill. Practitioners with the same scope title do not necessarily represent the same skills.

Gp2: It would be almost impossible to define any vocational group that did not vary in their knowledge, skills and experience. The purpose of the scope is to signal attainment of a core level of advanced training and qualification within a discipline or area of psychological activity. Further development of skills both generic and specialised, should occur throughout the psychologists professional life within a particular scope. Therefore, specialisation beyond, and building on, the core body of skills and knowledge can and should occur within a scope of practice. Defining vocational scopes on the basis of a specific qualification (or overseas equivalent) allows for accurate definition of the scope despite the range of experience.

Gp7: It does not matter that practitioners with the same vocational scope vary considerably in their knowledge and skills. This will be an inevitable consequence of sub-specialisation.
GP 14 This is inevitable, but if the scopes are properly conceived and written they should reflect a core set of skills that are different from those in another scope.

Gp15: Clinical training (if we consider the clinical scope of practice) is a necessary foundation for more specific specialist clinical psychology skills in most of the areas you mention. We would expect people working in forensic, adult, child and adolescent services to have the same base skills upon which they build their specialist skills. The health areas you mention you could argue that health or clinical psychologists could work in these areas. I would argue that this distinction should be made.

Gp20: The variety in knowledge & skill is a natural outcome of the breadth of services provided by practitioners under the various scopes. What is important is that the training routes for each scope provide basic core competencies that define and group professional under each scope.

Gp21: Some degree of variability is probably inevitable. We believe that it is more problematic if there is only one generic scope for all. The variability in skills between practitioners within a specific vocational scope is likely to be less than that currently existing across the whole “general” psychologist’s scope. If there was only one scope for all psychologists there would be significant variation in skills and knowledge in that scope. Having specific vocational scopes (with competencies attached to them) gives the public more assurance practitioners within a particular vocational scope will have will have a consistent level of training.
The public will need a higher level of discriminative ability to choose between practitioners if there is only one psychology scope.

Other employer/contractors

Gp3: An acceptable level of variation should depend on the skills in question: for example counselling could be expected to vary considerably simply because of the amount of experience since registration no matter which scope the practitioners are registered under. However, where the skills in question are actually a specialist sub-group (e.g. Neuropsychological assessment skills, or forensic recidivism risk assessments), one should expect less variation and more consistency of practice across practitioners.

Gp13: It is highly desirable and expected that all practitioners within a scope have a basic accepted level of specialist training and experience in that area and are up to date as judged by their continuing education, exposure to current literature, clinical practice and supervision. Thus we would not expect a vocational scope to be defined where this basic level of knowledge and skills varied.
Within that specialist vocational scope it is always expected that there will be a range of skill and expertise over and above this basic level. This may relate to special areas of research, further study or practice
Gp23: No, it is good for them to have a common qualification and a range of knowledge and skills depending on experience.
Gp27: Yes. There should be a 'benchmark' above which there can be some room for variation. With regard to neuropsychology, there is no benchmark and just about any psychologist can call themselves a neuropsychologist. This is misleading for the public, who generally assume that there is some sort of higher qualification attached to the label.

Gp28: Require same level of underlying psychological knowledge/framework on which different specialist applied psychology is based

Professional Psychology Groups

Gp4: Practitioners within the vocational scope of clinical psychologist must not have 'considerable' variance in the foundation knowledge and skills associated with clinical psychology. If a considerable variance has occurred in the transition to being under the HPCA Act legislation then this must be corrected. It is also essential that any practitioners' competence remain pinned to foundation knowledge and skills. It is understandable (and desirable) that within clinical psychology there are subspecialties. Underlying this is the practitioner's duty to inform where their knowledge and skills lie when entering into professional relationships.

Gp5: There will be based on applied psychology training the same level of underlying psychological knowledge/framework on which different specialist applied psychology is based. It is also normal for practitioners to vary and specialise in different areas over and above basic training, it would be curious if they did not?

Gp8: The difficulty referred to in 3.3(a) is compounded as practitioners within a particular vocational scope "may vary considerably in their knowledge and skills". We recommend that the specialist groups be encouraged, in consultation with the Board, to develop widely comprehensible statements of skills and services that practitioners can provide to assist members of the public seeking services. Associated with those statements should be guidelines to assist practitioners to assess and develop their competence to offer such services.

Gp9: No, as long as the core skills necessary are well defined.

Gp10: We fully agree with and wish to highlight the NZPS response to this question.

Academics

Gp12: Within the vocational scopes, not really. No programme can teach everything and graduates will reflect the strengths of their teachers. There is no function that is the sole domain of any scope or needs to be restricted within clinical, educational, health psychology and the like. Traditionally psychologists of all "flavours" have taken on varied roles. Safety needs to be maintained by ensuring that people practice within their areas of competence-determined by study and supervision. Psychologists should be able to monitor this themselves through self-reflective practice and in supervision.

Other Regulatory Authorities

Gp16: The [Regulatory Authority 1] Scopes committee feels that this will always be the case to a degree.

Gp17: A vocational scope should be set with a clear minimum standard for entry into the scope. Assuming this minimum level has been achieved, it is not for a regulatory authority to be concerned with variance in the scope.

Question 3.3(c): **What risks or advantages may exist for the Board to rely on practitioners to declare their own competence without specifying vocational scope specialist knowledge?**

DHB Psychologists

Gp1: Advantages: We as psychologists are ultimately responsible anyway for our practice and public safety. As stated above, the scope is not specific enough to provide safety. Does the Board want to be held responsible for public safety in terms of scopes?

Gp2: Psychologists may be tempted to work outside their area of competency for reasons such as financial gain, increased access to work, or because of lack of awareness of the limits of their own competence. Psychologists working beyond their area of competence is one of the more frequent causes of complaints against psychologists

and one of the most frequent finding in complaints proceedings. Therefore, there is a significant risk of psychologists working beyond their own competencies. Lack of vocational scopes of practice may increase this risk. No clear advantages, beyond an administrative simplification, were identified for removing the vocational scopes.

Gp7: While it is expected that all psychologists should be able to "declare their own competence" and limitations in their practice, the public is better served by the additional layer of protection offered by the Psychologists Board that clarifies required competence and regulates areas of practice (i.e some provision of scopes of practice). Otherwise the most salient risk for the public is the potential to be treated inappropriately or ineffectively by a practitioner who is unaware of gaps in their practice.

Gp14: We don't see any advantages to this but many risks. Practitioners may not be aware of their own level of competency, may wish to overstate in order to make themselves available to do work which they are poorly equipped to do.

Gp15: I think this would not be wise. In my experience many psychologists tend to either over rate or under rate their competence. Gender, nationality, personality factors may play a role. Over the years we have had people applying for positions for which they are clearly not suitable. This is less likely now if we specify the Clinical Scope. We have a process for credentialing which includes the presentation of a paper-case. In other DHBs where there is no clinical leadership, managers may rely on less data than we do to make decisions. I have seen people look excellent on paper and even on interview only to do very poorly when discussing specific clinical questions. ..

Gp20: Reliance on a model based on trust and good faith is vulnerable to exploitation. Checks and balances via well defined scopes of practice delineates baseline levels of expertise & allows for accountability to the public & also protection for the practitioner

Gp21: It is a risk to the profession and the Psychologists Board to assume that all practitioners will adequately recognise the boundaries of their competence and declare it. The history of complaints to the Board will no doubt show that some complaints have arisen where practitioners work outside of their areas of competence. This poses potentially both a credibility and financial risk to the Psychologists Board.

Other employers/contractors

Gp3: The main advantage of relying on practitioner's self report is that it would be easier to administer and less costly. However, one major risk is that the public's ability to rely on the Board's definition of a particular scope could be compromised by practitioners who over-estimate their skills or knowledge, particularly where such an overestimation results in risk to the public (e.g. as in cases where psychologists have presented themselves as expert witnesses when they did not have the skills to objectively measure recidivism risk for offending).

Gp13: From the perspective of an organisation which purchases services for clients (in addition to clients identifying and seeking assistance for themselves) practitioner declaration may not be adequate

1. self perception of competence may not reflect true competence
2. there may be barriers to declaring "yes I am out of date"
3. qualifications and institutions vary in their quality, meaning the practitioner may not have a realistic idea of their own competency
4. A system which relies on peer corroboration of competency may place an onerous burden on colleagues.
5. Rarely professionals have asserted they have qualifications which they are later found not to hold.

Gp23: Risk- relies on individuals appropriately recognising and acknowledging their areas of competence. Advantages- reduces administration and vests trust and responsibility with the practitioner.

Gp27: Risk - Practitioners may say they have specialist knowledge, when in fact they do not, obvious risk to the public, costly to purchasers like [organisation], promotes unfavourable opinion in a discipline which sometimes struggles to be taken seriously in some sectors of the medical profession.
Advantage - Easier for the board

Gp28: Inappropriate self appraisals and lack of clarity for the public.

Professional Psychology Groups

Gp4: The risk associated with relying on practitioners to declare their own competence is a sudden and rapid deterioration in the competence of psychologists practicing in clinical fields. Poor or even bad practice would impact on public health, potentially undermine an excellent profession and also lead to an increase in complaints and complaint processing at Board and H&D commissioner level. The 'benchmark' is currently attained via clinical training programmes. The HPCA Act then provides mechanisms for ensuring a practitioner's ongoing competence. The transition period to the new system of registration appears to have been less than optimal. However, there is now the opportunity for the Board to be more clear about who falls within the clinical scope rather than to abolish it. Were there no clinical scope the ultimate question would be: "who will provide the ways and means for practitioners to meet minimum standards (within clinical fields)'?

Anecdotal information from supervisors is that often psychologists who have had some experience in a clinical field will initially think they are well qualified. However, once in a training programme they quickly recognise what they don't know, or, for example, if not in a programme, they value the input from experienced (clinically trained) supervisors when faced with work-place dilemmas.
It is not in the best interest of the public to have a 'high trust' model. Likewise it is not in the interest of the profession to have to rely on a high-cost model to ensure on-going competence. Clear training programmes with adequate standards provide a basis for practitioners to acquire the necessary knowledge and skill sets.

Gp5: Inappropriate self appraisals and lack of clarity for the public, potentially a lack of realistic appraisal in different contexts.

Gp8: It is our contention that the vocational scopes do not offer significant advantages for the Board who still have to rely on practitioners declaring their own competence within what are recognized to be broad areas of specialization. The Board already recognizes that clinical psychologists "vary considerably in their specialist skills and experience" (p.3). To address that diversity utilizing scopes of practice would require an ever-growing number of scopes that would struggle to meet the Board's criteria.

- Be necessary for public protection
- Define an area of practice which (sic) is different from other scopes of practice"
- Must not unnecessarily restrict an area of practice.

The intent of the HPCA Act will be better served by enhancing practitioners' ability to accurately assess their competence and undertake the necessary continuing professional development to maintain and develop their competence. Audits undertaken in conjunction with the CPD are much more likely to identify and manage risks than are vocational scopes.

Gp9: No advantages seen for this.

Gp10: We fully agree with the NZPS response to this question.

Academics

Gp12:
Advantages: simplicity, room to acknowledge psychologist's growth.
Disadvantages: the very psychologists who need restrictions will be those who take advantage of the system.

Other Regulatory Authorities

Gp16: Health professional ethics should guide a practitioner to work in an area of competence. Regulatory authorities and HDC etc have accessible and well publicised complaints procedure for the public.. Knowledge of referrers to services is important.

Gp17: Advantages: low administration cost, professional accountability
Disadvantages: Limited self perception of poor performers; financial advantage will reduce practitioners' objectivity.

Question 3.3(d): Do you know of any examples where the safety of the public has been at risk due to misuse of scope title? If so, please supply a brief outline.

DHB Psychologists

Gp1: No, and equally we have not seen that the public safety has been enhanced by scopes, e.g. despite a psychologist having a scope, he still practiced questionably, and even got awarded a scope despite past complaints.

Gp2: There is less of a risk of misusing the title of scope of practice than of psychologists working outside their area of competence without the guidance which may be provided for both them and the public by the vocational scope of practice. It is quite likely that the public will assume competence if no further title is provided.
Some examples of psychologists misrepresenting their scope were reported by members of the NZDHBPLC. A typical example was a psychologist not correcting the information when introduced in a public setting with an incorrect scope of practice.

Gp14: We are not aware of any cases where people have claimed a title they are not entitled to. We are however aware of psychologists who are not clinically qualified and who do not hold a clinical scope of practice who offer clinical psychology services. Listings in the Yellow Pages make confusing reading.

Gp15: Do you mean people who have done so fraudulently? I am not aware of people who have done this.

However, people do apply for positions when they clearly do not have the qualifications or the experience. We are able to discriminate because we have processes to do this. However, I am not sure that either unsuspecting employers or the public are able to.
I think it is possible to misuse the general Psychologist Scope, where people are able to say they are registered but may not have the clinical skills to do the job (see 1). We usually require a professional qualification at this DHB. This qualification maybe in Neuropsychology, or Health but most would require a Clinical Psychologist. We have had Educational Psychologists in CAMHS. Where there have been exceptions only the Advisor makes that exception but still within a credentialing process.

Gp20: We are aware of instances that members of the public have assumed that a registered psychologist is equivalent to a clinical psychologist with regard to mental health assessment skills.

Gp21: We are not aware of any specific examples where public safety has been put at risk. We would argue that this suggests the current system is working.

Other employers/ contractors

Gp3: Although no direct misuse of a vocational scope has come to our attention (e.g. someone presenting themselves as a Clinical Psychologist when in fact they are registered under the General scope), there have been instances of psychologists misrepresenting their level of skill within the Clinical Psychology scope. These instances have included reports making statements about recidivism risk (e.g. "100% certain that ……..will not offend again") for an offender with a long history of offending, assessed by experts as high risk for recidivism, and another practitioner appearing in court as an expert witness when not having the skills to objectively assess recidivism risk. Both examples clearly could have put the public at risk.

Gp13: [Organisation] is aware of a few situations where counselling services have been provided under regulations yet the clinical standard of these services has fallen short of what is expected and appropriate for the clients concerned.

Gp23: No

Gp27: I know that the public are regularly put at risk by practitioners who do not know enough about neuropsychological assessment carrying out these assessments, coming to erroneous conclusions and making inappropriate recommendations, which are then carried out by therapists and case managers who have used the report as a guide, in good faith and with trust that the assessor is competent. The result is lack of faith in all neuropsychologists, inappropriate rehabilitation interventions and unnecessary expense and most unfortunately, delay in recovery for the poor clients.

Gp28: Clinical psychology scope has been interpreted as a professional title that identifies with specialist therapeutic training when in reality 'therapeutic training' may be minimal

Professional Psychology groups

Gp4: Anecdotally members report instances where members of the public have received and acted on information from practitioners they thought were clinical psychologists (it was 'implied' by the practitioner) which was not helpful.
Gp5: Clinical psychology scope has been interpreted as a professional title that identifies with specialist therapeutic training when in reality 'therapeutic training' (psychotherapy) may be minimal, no specific examples are used just a general observation based on client report

Gp9: No

Gp10: We have anecdotal evidence that in response to the shortage of educational and developmental psychologists (see NZPS submission paragraph 3.5a), some government agencies are employing staff who do not come under the HPCA to perform identical tasks and provide identical services(to Psychologists who do come under the Act) and thus fulfil their contractual obligations. In the circumstance of a shortage of registered practitioners then, the public is not protected by the fact of registration (unless government agencies are compelled to employ only registered practitioners), the public are at no less of a risk.

Academics

Gp12: Yes, we do. The public has been denied access to a graduate trained in child and family psychology, and with post-registration CAMHS experience; who applied for a position in a youth specialist service and was refused an interview on the basis of her non-clinical qualification. Our understanding is that unfilled positions remain. This is a matter of public safety given that there is a shortage of psychologists and positions are remaining unfilled. Would our graduates having a clinical scope have avoided this problem? We don't know, but possibly not. The restriction here appeared to be related to qualification specifically, not scope, but we are not sure.

Regulatory Authorities

Gp16: No

Gp17: No

Question 3.4(a): Do you consider that there is a high degree of overlap between scopes and if so, does it matter?

DHB Psychologists

Gp1: It seems when psychologists are asked, they often are not able to clearly define different domains beyond broad descriptors like 'educational' or 'clinical'. How is the public supposed to know the difference when psychologists struggle with this? Yes it does matter. It raises an important issue: Psychology is not that differentiated as medicine, and specialisations are not so far apart as surgery is from paediatrics. It is not clear whether the medical model of specialisation applies that well to psychology. With the scopes there is an assumption that the domains of the scopes vary so widely, yet some just don't, i.e. similar techniques, similar practices just slightly re-dressed are being applied to different areas. There is a high degree of overlap of applications and skills. Maybe one domain has a few assessment tools that are different, but is that enough to establish a whole different scope? Different scopes share most of their training. Qualification pathways are not distinct enough to deserve a different scope. Different specialisation yes, different scope is questionable. The distinction between scopes is exaggerated and misleading.

Gp2: Different scopes may have some overlap in areas of practice but may be differentiated by bringing different skill sets and knowledge to that area of practice.
Yes, there is some overlap, between the scopes, but there are also considerable areas of difference. Perhaps more importantly, in general there is a large difference between the vocational scope of practice and the Psychologist scope of practice. The previous "Option B." and Supervision 2000 pathways to registration by supervision were not developed or expected to provide equivalence to integrated post-graduate professional training programs and qualifications. The way of limiting the overlap between the Scopes of Practice is potentially to have a few more scopes rather than less scopes.

Gp7: There is considerable overlap between the scopes of practice which does not appear to be a problem.

Gp14: Yes there are some overlaps, but the parts that do not overlap are those that are the most important.

Gp15: The domains as currently defined are very general; the difference is in the knowledge and skill. There is also an issue of who or what area the knowledge and skill is applied to. A higher standard of knowledge and skills required for the Clinical Scope (see below) if you apply it to clinical work. There are also significant additions testing, formulation, diagnosis etc.
Presenting problems do not arrive in neat packages but I am not sure how this adds to the argument that vocational scopes are divisive. One of the issues is the ability to do an individualised formulation from which to draw to design an intervention rather than a cook book approach. Formulation skills come late in clinical training and I am not sure how people who do not have that training acquire this skill. I think that people underestimate the complexity of issues found within populations such as that we serve.
Yes. There is overlap, but there are also additions. The Clinical Scope requires a higher standard than the Psychologist Scope. For example "framing measuring and planning" in the Psychologist Scope does not include formulation, diagnosis, behavioural analysis, cognitive assessments etc. Although formulation may be implied I suggest that this is much looser than the standard required for clinical psychologists. However, it does not include the other two.

Gp20: At entry level there is an overlap in that "Psychologist" scope is also expected under "Clinical" and "Educational". However the more "specialised" scopes represent advanced knowledge training & skills that are distinct from one another and have generally been rigorously evaluated. Qualification in one scope is not interchangeable with another.

Gp21: There is inevitably some degree of overlap between scopes because there is a core scientific knowledge common to the profession. However, there are specialist areas of knowledge and skills that not all psychologists are trained in. Therefore there is a fundamental need for different scopes. Until there is one consistent level of training and education required for registration as a psychologist, there must be a way to distinguish between those who have obtained registration via a Masters/ PhD and a period of supervision, versus those who have undertaken a specific post graduate professional training programme (e.g. clinical, educational or child and family). These two different routes to registration do not provide the same level of training, knowledge or supervised practice.
As long as this difference in levels of training exists in the pathways to registration, there needs to be a way of identifying the difference, such as through differing scopes. This allows for more clarity and accountability to the

public. It more clearly allows practitioners to identify to the public the level of training and competencies they have.

Other employers/contractors

Gp3: There does appear to be considerable overlap between the scopes (e.g. all scopes require counselling skills, ability to identify where cross-cultural needs may arise etc), however, there are critical areas for the existing vocational scopes where expert training and knowledge is essential, and where there is less overlap, and where someone trying to practice without the knowledge or skills could pose a risk to the public. For example, the Clinical Psychology scope requires that the practitioner be trained in diagnoses of mental disorders. There are also current areas of practice where the same risks are apparent even for those registered under the same scope. For example, those registered as Clinical Psychologists may not be trained sufficiently well to safely undertake neuropsychological or forensic recidivism risk assessments.

Gp13: Overlap does matter. Effective scopes will have a minimum of overlap.
As a general principle for scopes of practice, the objective is to only define such a scope where necessary. As a test of necessity if there is a large overlap with another scope, the need should be questioned
Too much overlap can be confusing for the public and create an unnecessary level of bureaucracy.

Gp23: Moderate degree of overlap but do not consider that this matters as the current vocational scopes are defined by their qualifications which separate them from the general scope.

Gp27: Not sure

Gp28: There should be a high degree of overlap as all applied psychology specialisms are based on a framework of psychology. No it does not matter that there is a basic underlying level of training the specialist applied focus of psychology is the issue not the underlying psychology framework.

Professional Psychology Groups

Gp4: It is understandable that there can be a degree of overlap between scopes. We do not consider that there is automatically an overlap and where there is one it is definitely not a 'high' overlap.
The introductory statement for 3.4 contains a number of observations that must be briefly challenged. The first is the perception of 'high' overlap. Second is that fragmentation and division occurs as a result of scopes – these occurred well before scopes were ever even considered! Thirdly, that because something is not a neat package it does not benefit from a specialized 'unpacker'. Lastly, some practitioners move between areas of knowledge; however many move within and deeper within an area.

Gp5: There should be a high degree of overlap as all applied psychology specialisms are based on a framework of psychology. No it does not matter that there is a basic underlying level of training the specialist applied focus of psychology is the issue not the underlying psychology framework.

Gp8: While it is obvious that the Educational and Clinical scopes do define areas of practice that are different it is also clear that practitioners will often provide very similar services. We consider that actual overlap matters a great deal. First, as the Board has recognized, the initial establishment of the two vocational scopes means they are privileged as other specializations within psychological practice must differentiate themselves from these two broad vocational scopes that do not appear to meet a strict 'different areas of practice' test. Further, the overlap, in practice weakens the contribution of the scopes to assessment, whether by the responsible authority or members of the public, of a practitioner's competence.

Gp9: There are some inevitable overlaps, but many areas of distinct knowledge and application, these are the crucial distinctions and do not overlap. The draft Clinical Scope definitions were more tightly defined and should be revisited.

Gp10: We fully agree with the NZPS response to this question.

Academics

Gp12: Yes there is. It does not matter from a public safety point of view so long as the level of training and self-reflection is high. It does matter from a development of the profession and international recognition point of view (see 3.3a above).

Other regulatory authorities

Gp16: Hard for the public to understand where scopes overlap. Too many scopes are unhelpful.
GP 17 There seems to be considerable overlap with the differences relating to knowledge domain. However the requirement for a specialist diploma suggests that there is considerable difference in the two scopes. No difference however in other dimensions i.e. application, communication etc.

Question 3.5(a): Do you agree with the existing policies about qualification pathways to the vocational scopes? What, if any, changes would you like to see?

DHB Psychologists

Gp1: No, the 'grand-parenting' clause should be open-ended so that psychologists with a general scope trained before 2006 (e.g. some NZ psychologists who have gone overseas and returned) have an opportunity to access 'clinical' scope in order not to be disadvantaged, as DHBs clearly advertise for psychologists with clinical scope. Currently, since the 'grand-parenting' clause is closed, the concern is that the only path to the 'clinical' scope is through an university training, an academic route, which does not reflect clinical expertise.

Gp2: Yes. As is the case with all other medical and allied health disciplines, the only appropriate path should be through a recognized qualification involving an integrated academic and practical programme of study. This should be applied to New Zealand-trained psychologists.
There is a potential for a specific training course and subsequent evaluation process for people who come from overseas with a strong vocationally relevant qualification (for example, it meets the practicum requirements of the Scopes) about which there is uncertainty as to whether it meets the standard for entry into a vocational scope, leading to the vocational scope being declined. The purpose of entry to this training programme would be to allow the opportunity for evaluation of equivalency and to assist the person with adapting to the New Zealand environment. It would be very helpful for the Board to explore with the universities the possibilities of providing "bridging" courses to address this need.

Gp7: We will comment on the Clinical Scope only here. The existing qualifications and overseas equivalence are appropriate for access into the Clinical Scope of Practice. From an employers perspective it would be helpful if the Psychologist Board standard for measuring overseas equivalence for access to the Clinical Scope was appropriately robust. Also it would be helpful if the Board prescribed a robust practice-based pathway to achieve access into the Clinical Scope. The latter could be in addition to a qualification based pathway.

Gp14: For clinical psychologists trained in NZ the only appropriate path to qualification currently available is a Postgraduate Diploma in Clinical Psychology combining academic theory, research and clinical practicum. While this may well change in the future, the current scope definition should be written to match the current situation and could be amended at some point in the future if other courses became available. We do not understand why the Psychologists Board continues to raise the issue of "alternative paths to qualification". The other Registration Authorities are able to work with determining a standard of qualification and do not allow entry into the profession for NZ trained health practitioners other than through the stipulated courses.

Gp15: I think that there should be a minimum qualification set and this is unavoidable for a discipline such as ours.

Gp20: Current provisions for consistency within each professional scope allow, again, for protection of public and for practitioners there is accountability, and importantly, provides transparency in what a professional may be qualified to offer. We believe this training needs to be post-graduate, and thus support existing policies.

Gp21: We agree with the existing qualifications and pathways to the different vocational scopes as they specify the need for a specific postgraduate training and specialisation. If any change is to be made, we believe it should be the development of additional specialist scopes linked to specific competencies and qualifications (e.g. Health, Child and Family, Forensic, Neuropsychology, etc).

Other employers/ contractors

Gp3: The two vocational scopes coincide with two post graduate diploma (PGDip) qualifications offered traditionally by New Zealand universities. Some applicants who have trained overseas are able to establish equivalence of qualifications and therefore qualify for the scope (but some others are not).
The "grand-parenting" clause expired on 31 March 2006 which means that without the relevant post graduate diploma there is no other pathway to registration in the vocational scope for New Zealand applicants. This creates difficulty for those who consider themselves to be practising safely within that knowledge domain but are excluded from an income stream enabled by holding the scope.
We submit that we agree in that those practicing under a specialty scope should be able to demonstrate that they have been trained or are qualified to meet the core skill requirements of that scope. However, the blocking of entry into the scopes post the expiry of the grand-parenting provisions is in our view too restrictive. Not all psychologists were fully aware of the potential implications prior to the expiry of this provision, and they may be seen to be disadvantaged. Also, there are practitioners in a number of fields who are certainly acquiring and further developing specialist abilities who, in the current situation, would be excluded from entry into the existing scope. The Board may well consider that opening up the earlier provision, or creating a further pathway into the existing scopes to have some merit.

Gp13: [Organisation] would not like to comment on the existing pathways to vocational scope but notes the general principles of fair and defensible pathways:

1. Pathways are seen as accurately reflecting the skills and training needed for work in this specialised area.
2. The pathways are clear and agreed on in consultation with the sector and leaders in the field and firmly based on empirical evidence.
3. In an emerging specialist area, the validity of routes other than formal qualification are given due consideration.
4. In an emerging area of specialty, that there is an opportunity for cases to be individually considered.
5. Pathways that depend on qualifications are structured in ways that allow the institution and course qualities to be considered.
6. Where overseas qualifications are considered, the board has the opportunity to corroborate and investigate the quality of the qualification and experience.

Gp23: Yes, strongly agree with existing policies and believe that scopes should be defined by a relevant qualification.

Gp27: I do agree with existing policies, except to say that hindsight is a great thing, and there are now some people who did not apply for a scope under the grand-parenting clause, because they did not fully appreciate the long term implications. Here I am referring to the fact that they were not aware that [Organisation] would not purchase their services if they did not apply to a scope. Now that the picture is clearer, re-opening the grand-parenting clause for a very short period (e.g. one month) would be helpful.

Gp28: Yes specialist vocational routes are important but there are also internationally recognised 'independent routes' that are possible (see BPS independent route for Chartering in counselling psychology)

Professional Psychology groups

Gp4: The current policies on qualification pathways to vocational scopes provide one strong pathway for ensuring those entering the profession are knowledgeable and well trained. The absence of other robust accredited pathways is unfortunate and we consider the Board, Ministry of Health, Ministry of Education, Tertiary providers and professional bodies must work together to find ways for experienced 'general' psychologists to be able to increase their knowledge and skills to the same level attained through post-graduate study as this would benefit the public and assist all stakeholders.
It would be wrong to consider the current qualification and training as purely academic. Post graduate training in clinical psychology at the tertiary level in Aotearoa/New Zealand includes a large amount of skill training even before the practitioner is employed into their supervised internship year.

Gp5: Yes specialist vocational routes are important but there are also internationally recognised 'independent routes' that are possible (see BPS independent route for Chartering in counselling psychology)

Gp8: The New Zealand Psychological Society has long considered that there need to be alternative pathways to professional recognition for practitioners who enhance their knowledge and skill base. The absence of such pathways creates a disincentive to continued development of professional competencies. Currently only supervision for registration is available, to some would-be practitioners and then only for registration under the General' scope. Comprehensive continuing professional development offered by accredited organizations within a CCP framework would offer an alternative were it not blocked by the current qualifications-based, vocational scopes. With the continued scaling down of the last PGDip Educational Psychology programme that block could mean no future registrations in the Educational Psychologist scope.

Gp9: NZCCP holds the view that completion of one of the Postgraduate clinical psychology courses is the only valid entry into the clinical scope for people training in New Zealand. While it is necessary to make provision for people who train overseas there is no need to make such provision for NZ trained practitioners.

Gp10: We fully agree with the NZPS response to this question.

Academics

Gp12: It is too soon to answer this question as the accreditation process for new qualifications such as Child and Family Psychology has not yet occurred. Pathways into the vocational scopes have not been delineated. If they are flexible enough to add qualifications to a scope then we agree. If they are not then no, we do not agree. The public will be denied access to graduates from programmes with different and more contemporary emphases. University staff will not be game to take on their Universities re provision of innovative training programmes (see 3.3a above). If the clinical programme at a University is at capacity there needs to be an innovative approach in order to harvest other niches for placements which are the bottle-neck in training programmes. If these innovative programmes cannot be included within the clinical scope, (if this is appropriate), these programmes, regardless of how well they train, are by definition second-class programmes and their graduates will be blocked from income streams. As a consequence, new programmes will not be established and the public and the profession will be disadvantaged.

Regulatory Authorities

Gp16: This is for the profession to decide.

Gp17: Section 13 (b) stipulates "the qualifications may not necessarily restrict .." removal of grand-parenting or any other mechanism for recognising prior knowledge leaves the authority open to challenge.

Question 3.5(b): Is it feasible to establish a vocational scope without an established New Zealand qualification pathway?

DHB Psychologists

Gp1: No, rather let those with different overseas scopes find points of equivalence with NZ scopes and if necessary with further supervision and training achieve NZ scopes that have NZ qualification pathways.

Gp2: It would seem to be difficult to have a scope that is not matched by a New Zealand –based training programme. However, it may make sense to develop a scope if a New Zealand-based training is at an advanced stage of development, as is likely the case for the Counselling Psychology scope.

Gp7: In the absence of qualification then this would be possible if there was a well prescribed practice based pathway, or set of competencies, that a practitioner could work towards under supervision (and possibly further examination).

Gp14: No and this seems counter to the legislation. For people who have trained overseas there is provision for registration under the Psychologist scope of practice. It should be acknowledged that different countries have different ways of doing this – NZ Psychologists expect that if they travel to work overseas there are likely to be differences in registration requirements and procedures and that they may have to do additional work in order to meet overseas requirements.

Gp15: No. It is interesting that this is established but there isn't one for Health Psychology where there is training available.

Gp20: No, it will be impossible to establish rigorous & consistent requirements about skills sets, core competencies etc without a transparent national qualification framework

Gp21: Although it would be preferable to have an established qualification pathway before a vocational scope is established, we believe that it would be possible to establish a vocational scope without a current NZ qualification pathway. If there are appropriate postgraduate training pathways overseas that fit with the scope (e.g., as is the case with counselling psychology), then this would enable overseas clinicians to gain recognition of their specific training when gaining registration here. It would also provide much needed impetus for NZ Universities to develop additional NZ postgraduate professional training programmes.

Other employers/contractors

Gp3: For a scope to exist in NZ there should be a NZ based, or at least NZ recognised, qualification pathway that sets and maintains standards for that scope (as currently happens via the University training courses for both the Clinical and Educational Psychologists scopes). Under these scopes those coming from other countries can of course get registered under these scopes if the qualification pathway they have taken is recognised by the Registrations Board as being equivalent to the NZ standards. The creation of an additional scope should, first and foremost, relate to (a) there being a body of skills which can be identified as reasonably falling under that scope and (b) the need for such skills to be recognised by a scope in order for the protection of the public. An example of this is clearly a "forensic" or "criminal justice" sphere of practice which draws upon skills, only some of which will normally fall within the clinical scope, and many of which are particular to the area of forensic practice. While such a qualification exists overseas, there is currently no such qualification in New Zealand. However, it would still be possible using different accreditation procedures to create such a scope, and additionally the creation of such additional scopes would provide a strong inducement to tertiary institutions to develop courses and post graduate qualifications which were consistent with such additional scopes of practice.
Rather than establish a vocational scope in NZ for which there is no qualification pathway, the requirement should be for such a pathway to be established and recognised in NZ if the specialist skills are required here.
GP 13 We would see this as very much a professional matter for the board however in general, where an emerging field has limited opportunity for formal qualification or where the courses have not been benchmarked against existing international standards , the board could examine other types of experience such as overseas qualifications, clinical experience, supervised work and research to facilitate entry to the scope.

Gp23: No we are not supportive of this option.

Gp27: Yes. With regard to a neuropsychology scope, I suggest firstly including those overseas qualifications which provide specialist postgraduate training in neuropsychology such as the Doctor of Neuropsychology degree from Melbourne University. As most people in NZ will not have this, I suggest opening the scope with a grandparent clause which includes people who have been working appropriately as neuropsychologists in NZ for the past five years. After that, individuals should have the Clinical Diploma, then work while being supervised by someone who already holds the specialist scope for a period of two years full time equivalent. This could be stipulated by the number of assessments completed and could be spread out over as many years as was necessary. It would be preferable to have formal training programmes set up in NZ, but perhaps having a scope would encourage this? To my knowledge, the Massey programme may not be sufficient, and further experience would probably be necessary.
There should be some onus on supervisors to prove that they have undertaken sufficient professional development each year

Gp28: Yes. See previous comment re 'independent route' already an established training route in the UK. This information is misleading as there is a training route at AUT for counselling psychology but it is understood that the psychology board has failed to give the course accreditation. There are also internationally recognised applied psychologists who cannot work within their applied psychology specialism due to a lack of Scope of practice

Professional Psychology Groups

Gp4: Currently the only criteria available for entry to the Clinical Psychologist and Educational Psychologist scopes are based on historically strong post-graduate curricula. In clinical psychology the tertiary institutes continue to provide graduates of high quality who have studied within the Aotearoa/New Zealand context.
The pertinent question is what needs to occur for a practitioner to enter a vocational scope where they are unable to enter into post graduate study in New Zealand yet have a knowledge base and battery of skills which could enable them to be eligible for entry into a scope.
Were there to be no established New Zealand qualification pathway there would need to be very specific criteria governing what other (overseas) qualification pathways, together with additional New Zealand training, would be adequate for a person to enter any given scope.
Of critical importance is that the criteria for all scopes are at a similar level so that the public is assured of the level of competence when they are seeing a practitioner registered in a specific scope.

Gp5: Yes. See previous comment re 'independent route' already an established training route in the UK. This information is misleading as there is a training route at AUT for counselling psychology but it is understood that the psychology board has failed to give the course accreditation.
There are also internationally recognised applied psychologists who cannot work within their applied psychology specialism due to a lack of Scope of practice

Gp8: As noted immediately above closure of the only PGDip Educational Psychology would threaten the credibility of the vocational scope. Once 'grand-parenting' is closed there would be no way for practitioners, even if they have developed the requisite skills and knowledge, to be recognized as practicing within the scope. If, in response to such needs or the wish to recognize practitioners who have worked to develop and maintain specialized skills and knowledge, a non-qualifications based pathway, like supervision for registration, were to be developed we consider that the development would be best linked to ongoing assessment of competency associated with the CCP.

Gp9: No. A relevant qualification should be part of the definition of the scope.

Gp10: We fully agree with the NZPS response to this question.

Academics

Gp12: No, unless it is established to recognise overseas qualifications. The Board has decided that qualifications should be the criterion for scopes. There is a risk that there will be a disorganised demand for scopes which simply recognise a psychologist's experience. However, there should also be other pathways in to scopes which recognise appropriate relevant other qualifications (such as a relevant PhD or other specialist training e.g. neuropsychology) and experience–as for example the practice of the Australian Clinical College. Should the Board decide that an area of experience is sufficient for a scope then the length of experience criterion should be considerably longer than a training programme (e.g. 5 years) or there will be less pressure on Universities to provide higher training.

Other Regulatory Authorities

Gp17: If there is a clear need, why are there no providers in NZ for the qualification?

Question 3.5(c): What alternative criteria for vocational scope qualification, if any, would you regard as practical?

DHB Psychologists

Gp1: As these scopes are not truly reflective of psychological practices but rather reflect positions of employment, it is possibly more helpful to focus on specialisation backed by experience, training and supervision rather than scopes.

Gp2: None. In particular, time working in an area is not a sufficient criteria. Additional time working in an area does not necessarily lead to improved expertise or practice, particularly if this work is done without formalised ongoing learning objectives and without adequate professional development oversight.

Gp14: For the clinical scope there are problems with anything other than PGDipClinPsych / D Psych for those who train in NZ. Equivalence of overseas training can be established in relation to this. Overseas applicants may need additional supervision to enable them to work safely in the NZ context.

Gp15: The issue is whether this is practical and /or appropriate. We are a large DHB and I do not think we can provide the training necessary to produce scientist-practitioners with the skills we need on our own without a significant input of resources. However, I would suggest that there are some people that the Board may identify as very near the requirements and require specific input to get them to a standard. This top up training should be provided to a standard set by the Board.

Gp20: We believe a post-graduate diploma seems the only realistic and transparent way this can be applied to ensure academic excellence, theoretical knowledge, research skills, in addition to practical supervised internships

Gp21: We do not believe that there are any acceptable alternative criteria or pathways into the vocational scopes. We believe that a professional postgraduate specialist training and qualification is the way forward for psychology in NZ. The tertiary institutions/universities that provide psychology courses need to be encouraged to explore options for improving access to specialist professional training courses, e.g., part-time University training programmes and increasing student intakes.

Other employers/contractors

Gp3: If the decision is made to retain scopes, there needs to be more specificity for what type of skills could constitute a reason for having a vocational scope, probably best achieved by differentiation between skills that are particular to, or the central skills area of a specific specialty group or scope of practice, and those skills which one would expect to occur across several scopes for ethical practice to occur. This would mean that any criteria for a vocational scope should rest on whether the specialist skills are particular to the suggested scope, and where those practicing in that area without the specialist skills would put the public at risk. In contrast, skills such as counselling or some level of assessment of cross cultural needs, should not be particular to one scope of practice in the way that neuropsychological or forensic assessment skills would be. For example, sound counselling skills and cultural needs assessment skills should be expected for ethical practice across the vocational scopes of practice. This implies that vocational scope qualifications should require a recognised training or degree programme that a practitioner by obtaining the degree etc can demonstrate they have acquired the skills and knowledge in the specialty area. "Recognised Training" could well include work based accredited training sanctioned by the Board of a certain duration and specificity, and this could be monitored and quality assured by a scope "council" who could examine the candidates for that scope with respect to their training, experience, and practice before such a scope were accorded to them.

Gp27: I think qualifications, experience, and good supervision are essential, as outlined above. Can't think of any other way a psychologist can be competent. Psychologists must have client contact to maintain their practical skills.

Gp28: In line with international psychology institutions recognising a psychologist only after a three year PGDip course rather than allowing individuals to call themselves psychologists after a basic degree.

Professional psychology groups

Gp4: Alternative criteria might be by way of the completion of relevant (accredited) academic papers at post graduate level e.g. through short courses, together with relevant (accredited) skill training and (accredited) supervision. During this process the applicant's knowledge and skill base would be critically appraised.

Gp5: In line with international psychology institutions recognising a psychologist only after a three year PGDip course rather than allowing individuals to call themselves psychologists after a basic degree.

Gp8: In responding to 3.3(b) we argued that groups of specialist practitioners should, in consultation with the Board, seek to develop clear statements of the services (skills and knowledge) they are able to offer. Development of

such statements could provide a basis for identifying other practitioners who have maintained, or developed the competence to provide such services. Should the Board maintain vocational scopes that test could offer an alternative pathway into such specialist registration. However, we consider such processes would be more effective if incorporated within the continuing professional development of practitioners registered under a single 'General' scope.

Gp9: None for people training in New Zealand

Gp10: We fully agree with the NZPS response to this question.

Academics

Gp12: The Board could either follow the practice of the Australian College or you could work with the Colleges or divisions here to mount entry exams for graduate psychologists without the conventional qualification. These exams would need to be flexible enough to respond to the needs of those with sub-speciality training such as child and family or health.

Other Regulatory Authorities

Gp17: None

Question 3.5(d): Can this learning by pathways other than qualifications be taken into account in determining scope title? Do you consider it sufficient to establish eligibility for practising safely in an area/vocational scope title?

DHB Psychologists

Gp1: If eligibility is the question here, then there is no perfect system, but an accredited educational system, as well experience and supervision can go a long way and cover most of the ground for eligibility. Considering we do not consider the scopes sufficient for public safety, eligibility could be achieved through specialisation rather than scopes either through an university pathway or through other paths.

Gp2: A specific qualification leading to a vocational scope provides a more integrated training than can generally be achieved with alternative approaches such as supervision for registration or similar alternative paths. While some other practitioners may achieve very high levels of ability through these paths, it is by no means guaranteed. Similarly, lengthy experience in an area does not necessarily guarantee the development of high levels of expertise. Therefore, we believe that acceptable advanced qualifications in the specific field of the scope should be a requirement for achieving the vocational scope. "Grandfathering" arrangements have lead to variation in the application of these criteria. However, in the future a more consistent application would be very beneficial for achieving the aims of registration.

Gp14: No

Gp15: No this is too loose. I do advocate a professional training programme rather than an adhoc group of events. Learning also involves learning to be a professional. Learning by experience suggests that someone is on the end of the learning while they are doing it. In the areas we work that is risky.

Gp20: The training, academic rigor & postgraduate study provided in a university offering qualification is vital to ensure all members of a scope have the same core competencies and skills, which can then be extended and complemented by lifelong learning via supervision, experience and additional training.

Gp21: We disagree with the introductory statement to this question. A focus on qualifications does not necessarily ignore learning by supervision, experience or other training. The specialist post graduate professional training programmes in NZ (e.g. clinical and educational) integrate academic knowledge, supervised practical experience and examinations of competence. The internships in such programmes are typically supervised by clinicians registered in that specific scope. Scopes cannot be based solely on the familiarity with the literature. They must be based on achieving standardised knowledge and demonstrated competence via qualifications which integrate academic knowledge, supervision and practical experience. These qualifications are provided by the post graduate professional training programmes.

Other employers/contractors

Gp3: Although a recognised academic training or degree course might be preferable, it could be possible for practitioners to demonstrate competence in a specialty area without qualifications such as a specialty university degree, but there would need to be some specification of what is required to demonstrate competence: for example, the production of training workshop attendance as well as examples of specialist practice work that

does show safe practice and competence in the specialty area. The Department of Corrections is an example of where a competency based training programme for psychologists produces specialists that have been required to both undertake training and demonstrate competence. However, trying to do this under the auspices of the board could prove to be too costly.
While many successful applicants for positions within Corrections Psychological Services hold a post-graduate diploma in clinical psychology, they are relatively poorly equipped to undertake the specialist work involved in professional practice with offenders. This includes specialist risk assessment, including risk of violent and sexual offending, expertise in the assessment of psychopathy, and the provision of treatment to resistant (often oppositional) clients who are severely personality disordered. Also, the application of psychological knowledge and expertise within the wider correctional setting is not something which is taught in any local universities, yet is invaluable within the Service. Additionally, staff need to have sufficient knowledge to function as witnesses in Court or before the Parole Board, and withstand often vigorous cross-examination.
Many of the assessment procedures which are employed require comprehensive training and monitored practice and these are not part of any university training in this country.
Corrections Psychological Services is currently in the process of overhauling its own internal training and will shortly be implementing a strategic training framework which will enable us to better monitor the development of staffs' professional abilities in this specialist area. Additionally, such a framework, along with the current proposal to accredit the Psychological Service as a provider of training towards registration, could form the basis for the development of a specialist forensics/criminal justice scope.

Gp23: No, we recognise that learning and supervision is essentially for on-going professional development and competence but consider it is difficult as a basis of a vocational scope.

Gp27: Provided supervisors are appropriately qualified and adhering to requirements regarding professional development.

Gp28: Yes see previous comments re independent route training in the BPS for CounPsy.

Professional Psychology Groups

Gp4: There should be no other pathways other than those that are rigorous, accredited and ensure that all entrants to any scope are of a similar competence.

Gp5: Yes see previous comments re independent route training in the BPS for CounPsy, there is an international precedent set for this and the grand-parenting route allows such a process

Gp8: The HPCA Act presumes that practitioners must undertake ongoing professional development to maintain their ability to practise safely. It would seem that presumption conflicts with qualifications-based vocational scopes. We have already argued that such scopes, because the qualification is required, cannot recognize a practitioner's development of competence to practice within that scope. At the same time groups of practitioners registered in a vocational scope are actively supporting well organized continuing professional development, recognizing that competence is not established forever by one's qualifications. We have argued consistently that better, clearer, more comprehensible, statements of service provision and the requisite skills and knowledge better meets the purpose of the HPCA Act, the needs of members of the public, and the interests of the profession.

Gp9: No

Gp10: We fully agree with the NZPS response to this question.

Academics

Gp12: (see 3.5c) The Board could either follow the practice of the Australian College or you could work with the Colleges or divisions here to mount entry exams for graduate psychologists without the conventional qualification. These exams would need to be flexible enough to respond to the needs of those with sub-speciality training such as child and family or health.

Other Regulatory Authorities

Gp16: This is a professional question for psychologists.

Gp17: No- other mechanisms are not robust enough to safeguard a scope of practice. However, this is only relevant if the need for a scope of practice has been established ,i.e. in terms of public safety.

Question 3.6(a): Is the distinction between "Psychologist" and vocational scopes also necessary for safe practice?

DHB Psychologists

Gp1: No, as argued above. One point is that in terms of ethical considerations, which are one of the highest risks for public safety, such ethical considerations are mostly similar to all scopes, and would be covered by the scope 'psychologist'. Other reasons already mentioned above also apply here:
• That the scope title communicates little information and therefore does not protect the public. The higher the degree of specificity of title, the greater the distinction members of the public are required to make. That is, the title is only useful if the target audience knows what it means.
• That scope titles may mislead the public who assume all those with a particular scope title have the same specialist knowledge. Psychologists within a vocational scope vary considerably in their specialist skills and experience, and sometimes also qualifications. For example, clinical scope includes specialty areas such as (but not limited to) child and family; adult mental health; Corrections; forensic; young people; neuropsychology; pain management; and sexual therapy, all of which require distinct fields of knowledge and skill. Practitioners with the same scope title do not necessarily represent the same skills.
• That the title is redundant as both prior to and since the introduction of scopes the Board and the client have relied on the individual practitioner to state whether or not they deem themselves competent to practise in a particular area.
• That it adds further confusion to the public who cannot make a distinction between counsellors, psychotherapists, psychiatrists and psychologists, let alone "Psychologist" and "Clinical Psychologist" or "Educational Psychologist".

Gp2: It will not in all cases be necessary for safe practice but will on the whole promote safer practice.

Gp7: There will be an inevitable overlap between the skills of those with general registration and those with specific scopes of practice. To this extent there will be client populations who could be safely served appropriately by both. However, the scope distinction, while not absolutely necessary in all cases, is a useful guideline, for reasons outlined above, to better ensure appropriate match between the clients' needs and the skill sets offered by those with specialist scopes of practice.
At an organisational level, the assurance that employees have a good general grounding, and qualifications that allow them to function and develop competently as a "Clinical Psychologist", makes it easier to allocate clinical case loads.
Employees who have not received thorough clinical training and function within narrow frames of competence (e.g. those without training in psychometric testing or with narrow therapeutic preference), can be difficult to utilise within the organisation and pose risks to the public, the individual practitioner, and the organisation, if they feel pressured (or submit to inevitable pressure) to function beyond a limited level of competence. Further, if they remain safely, or for too long, in a narrow fame of practice without firm commitment to extend themselves to meet the client and the organisations needs, then they bring the profession into disrepute.

Gp14: Yes

Gp15: Yes this does need some clarification.

Gp20: Yes. The public has a right to know that there are differences in levels of training & scopes of practice & this needs to be reflected in the titles, e.g., we know that a clinical psychologist has undergone training in mental health assessment, diagnosis and intervention within the framework of a scientist practitioner model.

Gp21: Yes - The distinction between Psychologist and vocational scopes is necessary for safe practice. Without this distinction, the task of determining competency lies with the individual practitioner and with the public. The public are being asked to determine competence without any information on which to base this judgement. I think it is appropriate that there is an external agency to determine and publish competencies (i.e. the Psychologists Board). As noted previously, it should not be assumed or taken for granted that all practitioners are able/willing to identify the boundaries of their competence and remain within them.
Having guidelines about different scopes provides;

1. The public a greater assurance that there is a standardised level of competence in particular specialist areas.
2. The public with a clearer way of identifying practitioners with the appropriate competencies for them and consequently better access to appropriately skilled practitioners.
3. An easier pathway for education of the public about differing competencies and areas if practice within the profession.

Other employer/contractors

Gp3: If it is accepted that the vocational scopes provide registration for minimum levels of specialist skills that are a core of that scope, then the distinction is necessary to protect the public, in that the distinction should prevent those who may have minimum requirements to register as a psychologist (that is having acquired basic

psychological assessment and counselling skills), from practicing in the specialist area without obtaining qualifications in the specialty in question. The current clinical scope does not, however, protect the public when issues of practice within the criminal justice area are considered. The Service has a number of examples of poor practice and appalling examples of advice given to Courts and Parole Boards by practitioners, some of whom are registered under a general scope and some who are registered under the clinical scope. It is evident from perusal of much of the material which is tendered in this domain that such practitioners are working in an area in which they do not even have a superficial knowledge, and the problem is compounded by a lack of knowledge among the audiences for these reports. Additionally, sometimes practitioners will provide "treatment" to quite dangerous offenders who will then regard themselves as "cured" and refuse to engage in intervention programmes which are more genuinely tailored to reducing their future risk to the community.

Gp13: We understand that the activities of a clinical or educational psychologist require particular skills, experience and qualification which are not to be found in the general training of a registered psychologist.
There may be other areas of practice which may also have quite defined requirements in terms of expertise without which the practice is not safe. We therefore regard safe practice as enhanced in these identified areas by the scope status.

Gp23: Yes

Gp27: Yes

Gp28: Yes. In NZ anyone with a psychology degree can call themselves a psychologist, it is very misleading

Professional Psychology Groups

Gp4: The client of a practitioner belonging to a specialist scope should expect in general a more specialized level of service which allows for more security and 'peace of mind' over any services delivered to them. This is also what is expected in other health professions. For example, a general practitioner may be able to capably perform minor surgery; however it is reasonable to expect a qualified surgeon to do a better (and safer) job.

Gp5: Yes. In NZ anyone with a psychology degree can call themselves a psychologist, it is very misleading

Gp8: Our argument is that regular self-reviews and audits of competence offer much stronger guarantees of safe practice than registration in vocational scopes. The qualifications and competencies required for the Psychologist Scope and the qualifications on which it is grounded provide a good platform for safe, constantly evolving practice informed by evidence and the collective wisdom of the profession.

Gp9: Yes

Gp10: We fully agree with the NZPS response to this question.

Academics

Gp12: In the previous section, the Board has stated it considers the criteria for Psychologist scope sufficient for safety purposes. Given that, this question is redundant. There are however, some related questions which can be usefully asked:
Do we agree that these criteria are sufficient? This has been covered under 3.3a above- if Vocational scopes represent a higher level of training then there is an issue of public safety. The issue is not so much that a general scope psychologist will not practice safely, the issue is that the Board needs to encourage psychologists to reach for higher qualifications and standards of practice.
Is there a benefit to the public in making the distinction? If it leads to better training programmes the public will benefit in the long-term. Related to this is the question of what is required for a vocational scope. The Universities, by putting pressure on to increase research, are providing pressures to eliminate practical training in the 5th year. The Health Psychology programme has had to keep their 5th year practical training outside of their degree, as there is no room for it. We have had to increase the 5th year by 3 months to incorporate the previous summer and ensure students are well enough advanced with their research to cope with the training programme. Educational Psychology at Massey has increased the thesis and has dropped their selection into the 5th year. My reading of the proposal is that they are dropping their practical training in that year too.
Our programme which has extensive practical work including training in interviewing and report writing, psychometrics laboratories, practical interventions training, Family Court involvement, 5 video assessments and a dedicated curriculum taught over 3 post-graduate years and has been described as a clinical programme in a review, has not, as yet, received a vocational scope although accreditation was pending, prior to the scopes review.

Regulatory Authorities

Gp16: Public safety should rest with all registered practitioners within a profession. Vocational scopes do not greatly improve public safety.

Question 3.6(b): Do you agree the prescribed qualifications for the vocational scopes are reasonable, or do you consider the prescribed qualifications to be unreasonably restrictive?

DHB Psychologists

Gp1: Yes, certain level of prescribed qualifications are necessary to establish knowledge, skill and practice, but to what degree? There are too many overlaps, pseudo-differences, as well as transference of skills to different areas, that we are wary of too much prescription. For example, in Germany the prescribed qualification to work with children and youth is lengthy and expensive. An unforeseen consequence has been that now there are fewer psychologists who work with children, and the waiting lists are long. Imagine CAMHS services in NZ being that specific with scopes, it will be the children and families that will suffer. Ironically, public safety is put at risk through absence of available treatment modalities.

Gp2: The prescribed qualifications are reasonable as a minimum.

Gp7: The prescribed qualifications for the vocational scopes are entirely reasonable and appropriate.

Gp14: Reasonable and necessary.

Gp15: Yes they are the basic professional qualification, a basic building block. This is something we can have some confidence in when employing people. I can't say that I would have confidence in any other avenues suggested to date. We need confidence in the process of assessing competence.
There are obviously not the vocational scopes currently for all the psychologists we may employ. We employ Health Psychologists and Neuropsychologists in particular. We have also employed others under the Psychologists Scope. However, it would be helpful if we knew that the Board had approved a particular domain of practice for a professional qualification.

Gp20: We see these as both reasonable & necessary to ensure consistency of skills & protection of public from misrepresentation or malpractice arising from a practitioner (e.g., Psychologist scope) offering services for which they are not qualified or competent.

Gp21: As noted in the above responses / answers, we do not believe that the qualifications are restrictive. They are potentially open to all persons to undertake, in that anyone can do the prerequisite courses and then apply for a position on a course that would provide a qualification leading to eligibility for a vocational scope. We believe that the current prescribed qualifications for the vocational scopes are appropriate and should not be changed.

Other employers/contractors

Gp3: The prescribed qualifications for the current vocational scopes are reasonable, in that they specify what qualification is necessary in order to demonstrate the skills required to practice within the scopes, if the purpose of a vocational scope is to protect the public by restricting practice under the scope to those who can demonstrate a minimum level of competence in the specialty area. However, having said that prescribed qualifications are necessary, this should not necessarily in all cases lead to the exclusion of other pathways to achieve such a scope. As has already been commented, there are people who can practice within both the educational and clinical domains who may not in every case have post graduate qualifications associated with such practice.

Gp13: We would regard this as a professional matter for the board but the current scopes have not appeared restrictive

Gp23: We agree that the current qualifications are reasonable.

Gp27: I think they are reasonable.

Gp28: Yes reasonable (if more scopes recognised in line with international categories pertinent for NZ)

Professional Psychology Groups

Gp4: The current prescribed qualifications are very reasonable and ensure there are competent practitioners entering the work force. What is unreasonable is that there are no other robust means for attaining any prescribed scope. The consequence is that, for some, entry to a scope may appear restrictive

Gp5: Yes reasonable (if more scopes recognised in line with international categories pertinent for NZ) as a starting point as purchasers become more knowledgeable then they will differentiate psychologists out on experience. They need to know in the first instance that they have a well qualified psychologist.

Gp8: In the absence of clearly specified pathways for psychologists who lack the formal qualifications but have undertaken appropriate supervised practice and suitable workshops or other forms of professional development to gain registration in a vocational scope those scopes are unduly restrictive. The scopes specify minimum requirements for practice at an entry level whether 'Psychologist' or vocational, to guide intending practitioners, assessment of qualifications for registration, competency reviews, and the responsible authority's accreditation of tertiary training providers. Workforce planners have identified critical shortages among the professional health workforce, including psychologists, and the published scopes appear to be having unanticipated, and undesirable, effects on the recruitment and retention of practitioners in these areas. This arises, in part, because of the historical development of professional registration for psychologists in Aotearoa/New Zealand. The original Psychologists Act 1981 recognised existing professional training programmes and thereby guided development of new training programmes. Consequently, tertiary education institutions (initially only universities) offered programmes in a range of specialist areas - clinical, educational, community, industrial /organizational. As new programmes developed, in Child and Family Psychology, and Health Psychology for instance, they were modelled on the existing training programmes. So long as professional registration was concerned only with core competencies required by all psychologist practitioners interacting with the public, then new specialist areas were accommodated in the registration regime with little difficulty. HPCAA identified all practising psychologists as 'health practitioners' although not all the existing professional specialities were, or are health practices and that difficulty has been compounded by the definition of only two vocational scopes. Two problems have followed from this. First, within the profession, there are now two "elite" groups, who can register both in the Psychologist Scope, and also in one or other of the two specialist scopes. Given the competitive nature of the world in which professionals work, this 'distinction' can create competitive and anticompetitive behaviour that has little to do with protection of the public and much to do with patch protection/challenge by particular specialist groups. Second, as acknowledged in the consultation paper, specialist scopes of practice may be used in employee selection as a kind of screening device, that may exclude perfectly competent professionals from gaining employment in a particular setting even though their training and skills are highly appropriate to the particular job. For instance, some District Health Boards will not hire registered psychologists qualified with the Postgraduate Diploma in Child & Family Psychology as psychologists, because they do not have the additional clinical scope of practice, even though it is possible that the Child & Family qualified person may actually be a better match to the job description than a person with the clinical psychology qualification.

Gp9: Both reasonable and necessary - the combination of academic theoretical knowledge and supervised practice is required, with both having examination processes to ensure that standards have been achieved .

Gp10: We fully agree with the NZPS response to this question.

Academics

Gp12: As indicated above, it is too soon to tell. We were to be accredited under both vocational scopes. If that happens then the qualifications are not too restrictive. If it does not then they are. The Board needs to decide how programmes such as ours will get an appropriate scope- e.g. will they support the programme to change its name so it does meet the criteria?

Question 3.6(c): Do the scopes introduce more benefits than the costs and disadvantages imposed?

DHB Psychologists

Gp1: They provide less real benefits, and provide more costs and bureaucratic demands, which of course may be an advantage to certain organisations if such costs financially benefit certain organisations. This happened in the beginning phases of such discussions in South Africa, where some institutions (a group of people) wanted to financially benefit from the costs that fell to the psychologists through prescribed qualifications.

Gp2: We believe that the vocational scopes do provide more benefits than any costs or disadvantages that they incur. It is our opinion that maintenance of vocational scopes is likely to add little to the overall administration cost of registration. No other costs to the Board or the public have been identified.

Gp7: Yes. The benefits of maintaining scopes outweigh the costs.

Gp14: We hope so.

Gp15: Yes. We are operating in the context of a shortage. The answer to this is train more offer appropriate training rather than having people we cannot have confidence in. Again I stress that psychologists are independent practitioners. I think there is an argument for second tier registration but there would be a need to be clear about whether or not they have equal skills and knowledge as those who have been appropriately trained.

Gp20: The public has the right to enhanced safety. The negative consequences are not major and easily justified on the basis of protection of the public.

Gp21: We believe that there are more benefits than costs to having the different scopes in place.
Key benefits are;

1. Improved clarity and uniformity in standards of practice.
2. Increased differentiation of the profession for the public, which enables the consumers of psychological services to make better informed choices about who they require.
3. It enhances public safety via transparency of competencies. Having clearly defined scopes avoids the "Caveat Emptor" situation (i.e. buyer beware).
4. Improved clarity for employers when employing clinicians for specific psychology roles.
5. We do not know of any specific evidence that the hypothesised costs described above have actually occurred, or that if there are increased administrative costs, that this outweighs the benefits.

Other employers/contractors

Gp3: While the current system does provide some protection for the public by the introduction of vocational scopes, there may well be some people who have been grand-parented into these scopes who are deficient in terms of the training and supervised experience, and there are some practitioners who, albeit having a post graduate diploma, still ply their wares in areas of clinical work in which they have no experience, training, or supervision. Additionally, by closing off alternative pathways into these scopes, there is a risk that some potentially competent and able practitioners may be excluded from some areas of work. For that reason, there is still merit in maintaining alternative pathways. Additionally, as has already been noted, the clinical scope is indeed vary broad and there is no guarantee that those who are practising within that general rubric have the skills and expertise necessary to undertake some specialist functions.

Gp13: The indirect cost to the public would be substantially higher than the board assessment of scopes, if every employer/contractor in NZ were faced with having to independently structure contracts to get the exact set of skills to meet the need and then sift through applicants using a variety of mechanisms.
Each employer /institution would have to have it's own process to :

1. assess qualifications
2. monitor registration and up to date training & research
3. monitor supervision
4. monitor serious transgressions e.g. criminal charges etc.

Additional legal and bureaucratic costs would be incurred without guarantee that the resultant contracting decisions would be consistent across the sector

Gp23: We consider the current situation is beneficial, but if there is an increase in scopes consider it is unlikely that there would be enough benefits to offset the costs.

Gp27: Yes, protection of the public is extremely important. Another advantage is enhancing the perception / reputation of practitioners by helping to ensure all practitioners are competent and safe.

Gp28: Yes it provides clarity and protection for the profession and the public as well as clarity for purchasers/employers of psychologists

Professional Psychology Groups

Gp4: The current specialized scopes allow for members of the public to be more assured of the service they are receiving from their chosen provider. The current specialized scopes set a clear standard above (and in the case of trainees below) any currently stated for the general scope.
As raised previously, additional costs could easily occur were these scopes not in place. These would likely quickly outweigh the costs associated with having a broader range of scopes that are capable of capturing specialized practice. This does not mean automatically that there must be a plethora of scopes

Gp5: Yes it provides clarity and protection for the profession and the public as well as clarity for purchasers/employers of psychologists

Gp8: In the Society's view there are not fundamental problems with the foundation, Psychologist Scope of Practice - as it applies to health practitioners. The development of the specialist, vocational scopes of practice, is however, in our view having some unfortunate and distorting effects on the professional field of psychology. We can see that there are benefits for practitioners registered in a vocational scope but doubt whether this translates into benefits for their clients that would be more easily and effectively achieved through regular self and other assessments of competency, well organised and accessible CCP, and regular access to professional conferences and other fora. Throughout this submission we have pointed out that even an expanded list of scopes of practice would provide the public with little more protection than is offered by generic registration. There are so many diverse, specialist niches in psychology that any finite number of specialist scopes will do little to assist members of the public in selecting the most competent practitioner for their particular needs. The safety of the public would better served

by helping the profession produce clearer ways to describe services although members of the public still have to ask about qualifications and experience to make an informed choice of the practitioners available to them.

Gp9: Yes.

Gp10: We fully agree with the NZPS response to this question and for the reasons given, do not think that separate scopes in Psychology enhance the safety of the public.

Academics

Gp12: The costs to individual psychologists are not unreasonable. The Universities now have accepted the cost involved in accreditation.

Question 3.7(a): Do you perceive restrictions imposed by having vocational scopes? If yes, is this a cause for concern?

DHB Psychologists

Gp1: Yes, this 'silo thinking' leads to less creative and scientific research in the overlapping areas. Interdisciplinary thinking suffers. We already have the odd circumstance in NZ where sexual abuse issues of one person are treated by an ACC therapist, but other co-morbid mental health issues of the same person are sought to be treated by a DHB. This is a good example of a silo situation, which is based on astounding ignorance and bad practice, esp. if the diagnosis for the person is BPD. The concern is that the scopes and related qualifications restrict psychologists. It encourages psychologists to learn more and more about less and less, whereas the clients of DHBs generally have complex needs, which often demands knowledge and skills across specialities. For example, NZ trained clinical psychologists often have very limited understanding of developmental factors. So, vocational scopes could be understood as restrictive and in fact a greater risk for public safety. Also, from anecdotal evidence, Switzerland, which has more generic scopes than Germany, has stopped the flood of German psychologists to Switzerland, because in Switzerland there is more scope to practice more freely and with fewer restrictions. One German psychologist noted that the Swiss counterpart had more freedom and resourcefulness in their application of therapeutic innovations compared to German psychologists.

Gp2: It is the point of scopes to protect the public through restricting practice to competent, adequately trained psychologists. Any system which seeks to protect the public by setting minimum standards of practice will restrict some people from being able to work freely in that area. Achieving the right balance is always difficult in this type of situation, but we believe that the vocational scopes significantly assist in maintaining the appropriate balance at this time.

Gp7: Yes there are restrictions imposed by the vocational scopes and this would appear to be appropriate.

Gp14: Some restrictions are necessary – surely that is the point of this ?

Gp15: It's about having confidence in a practitioner to do the job we require. We want confidence in the people we employ to carry out their duties ethically, competently and safely. I think vocational scopes give this confidence.

Gp20: It is important that people without sufficient training & expertise are restricted in practice.

Gp21: The operational policy on scopes has not included any restriction on practise imposed on those without a particular scope. Any restrictions arise from the limits of a practitioner's competence.
However, we also think it is appropriate that practitioners be restricted in practicing in certain areas if they do not have the identified competencies for the area. In the medical profession there are various vocational scopes of practice which do restrict practice due to the need for specialist competencies and safety reasons. The public (and Ministry of Health) would not tolerate doctors without specialist training working in specialist areas – (e.g. a General Practitioner cannot practice as a neurosurgeon). The same rationale should be applied in psychology.
Re Q 3.7a, No. It does not restrict people from offering services providing they have the competencies to do so. Importantly the benefit is that having vocational scopes does empower the public t be able to make wiser/better informed choices about the type of psychologist best suited to deal with their concerns.

Other employers/contractors

Gp3: There are restrictions imposed by having a vocational scope, and some of those restrictions may be unjustified. Conversely, as already noted, the scopes of practice do not necessarily prevent people with that scope operating in areas which are clearly outside of their expertise.

Gp23: Some restrictions will exist, but we consider they are reasonable for the current scopes. If there become many more scopes this may become concerning.

Gp27: No. A line in the sand should be drawn somewhere. Those who have been practising safely for many years in a particular area should be allowed into that scope under a grand-parenting clause, and subsequent practitioners in training should be given clear direction as to the requirements of each scope.

Gp28: By maintaining the current position there is a 'patch protection' mentality, unless there is an expansion to include internationally recognised specialisms the restrictions of scopes continues.
An alternative is to protect the title of 'registered psychologist' to those with a 3 year PGDip, but purchaser's would still benefit from some ability to differentiate between applied psychology specialisms.

Gp13: This would be a concern where the scope was not sufficiently justified by the clinical expertise required for the tasks. As long as the scopes are carefully considered this should not unfairly restrict practitioners.
The question which needs to be addressed in leading up to the scope decision is : Do the tasks undertaken in this domain require skills and training not assessed or taught in the basic qualification?
If the answer is yes, then the next question is: are these skills and training common to all psychologists or only assessed and taught in specialist areas. If the latter is the case, then the scope is justified

Professional psychology groups

Gp4: We believe the public has the right to be assured of an expected level competence of any health practitioner. The most common argument is that employers are using 'scope' to assist in selection processes thus 'restricting' the employment of others. This has been especially raised in the health environment where the need for a practitioner with the Clinical Psychology scope is being challenged from some quarters. It must be noted that for decades before the current legislation the majority of Employment Agreements specified that registered psychologists employed into the health environment were to have a post graduate diploma in clinical psychology (or equivalent). That is, this is not a new phenomenon. What is new is that health providers have recognised the need for more practitioners in this area and that other agencies such as the Ministry of Health and Ministry of Education have been unable to quickly find solutions that benefit professionals and the public.
In other words, it is not the scope that imposes the restriction, it is the lack of processes and, for example funding, which restricts practitioner numbers from attaining appropriate further education.

Gp5: By maintaining the current position there is a 'patch protection' mentality, unless there is an expansion to include internationally recognised specialisms the restrictions of scopes continues. An alternative is to protect the title of 'registered psychologist' to those with a 3 year PGDip, but purchaser's would still benefit from some ability to differentiate between applied psychology specialisms.

Gp8: As the consultation paper notes there is anecdotal evidence of employers and contractors using vocational scopes in selection processes. That certainly imposes unneeded and unhelpful restrictions. We have also argued that, as the vocational scopes require specific formal qualifications they restrict practitioners' ability to benefit from efforts to extend their areas of competence. Such restrictions introduce unwanted constraints on efforts to ensure that New Zealand has adequate numbers of well qualified health professionals whose practices are safe and effective.

Gp9: Restrictions are inherent in vocational scopes, they are meaningless without them. It is more a cause for concern that the board has downplayed this aspect and promoted the scopes as restricting title only.

Gp10: We fully agree with the NZPS response to this question and refer the Board to our response to Question 3.3d.

Academics

Gp12: How could restrictions possibly be imposed? Traditionally all kinds of activities have been undertaken by psychologists regardless of scope. Clinical psychologists from courses with minimal Family Court, child psychotherapy or intellectual disability content have worked in these areas; Educational psychologists have traditionally been strong in family systems work because of the models they are familiar with; they did Family Court work when many clinical psychologists would not touch it. Educational psychologist's experience and assessment of autism is the most thorough we have come across; internationally there is a burgeoning literature on role of educational psychologists in mental health in schools. These initiatives make restriction of diagnosis meaningless. The competence of any individual graduate psychologist is a reflection of their training programme and workplace policies in their experiential settings. Our students in Ministry of Education settings act like clinical psychologists in some settings and are forbidden to make written diagnoses and work with families in others (these students therefore get these experiences in other settings). These restrictions reflect management policy and are driven by financial considerations, not competence.
There is no reason to restrict practice to vocational scopes. But there is reason to have these scopes, as they will increase pressure on training providers and on individuals towards excellence. There is also reason to create pathways into them for new programmes and experienced psychologists with general scopes, again to provide an incentive for excellence.

Other regulatory authorities

Gp16: Yes for the reasons above such as creating boundaries, disputes, fragmentation and "silo thinking".

Question 3.7(b) – for registered practitioners: Are you in the position of being either promoted or demoted linked to a vocational scope?

DHB Psychologists

Gp1: No, but I am supervising a NZ trained psychologist of general scope, who is very clinically skilled, who through no fault of their own missed out on the grandfathering clause (return from overseas after March 2006), and will in the future be disadvantaged as DHBs generally require the clinical scope. This psychologist is currently working in a position that could fall within the clinical scope, and although the person is currently not disadvantaged, s/he will be as soon as they seek further advancement or other employment as a psychologist.

Gp2: The career path and career advancement is primarily determined through the Annual Performance Appraisal and related processes. It is typically related to achieving a satisfactory level of performance and in many DHBs related to achieving particular agreed-on goals. No reference to scope of practice is made in these processes in any of the DHBs we are aware of.

Gp14: No. Promotion / attainment of career path is determined by demonstrated achievement of a range of competencies determined by the organisation. This is determined through a performance appraisal process, no reference to scope of practice is made. Scope of practice does determine use of title.

Gp15: had for example a Health Psychologist working in diabetes we would not consider them appropriate to work in adult mental health. If someone applied that had a track record in mental health we would consider them. However, I would be mindful that we would need to be more thorough in assessing them.

Gp21: This issue has not typically arisen for our psychologists. All have the same level of qualification and a vocational scope. We have always employed people based on their clinical competencies as demonstrated by their having successfully undertaken a clinically relevant professional training programme. We believe it provides at least some assurance that a person has an appropriate level of competence.

Other employers/contractors

Gp23: No

Gp27: No

Professional Psychology Groups

Gp9: No, this is not what scopes of practice are about.

Academics

Gp12: Our graduates are. They are being blocked from very suitable positions on the basis of their qualification.

Question 3.7(c) – for respondents representing organisations: Do you employ or issue contracts through a decision-making process partially or wholly based on vocational scope?

DHB Psychologists

Gp1: We have been directly involved in the employment of psychologists in two DHBs and both emphasised the necessity for clinical scope as a necessary requirement. (Highly clinically skilled psychologists of the general scope need not apply.)

Gp2: Scopes of practice are used as part of the selection process in DHBs but are not the entire basis on which decisions are made. The primary approach that is used is to match the qualifications with the needs of the position. For example, for the majority of jobs in mental health services, the Clinical vocational scope of practice signifies a level of training in mental health that is particularly relevant for these positions. Alternatively, for positions in many physical health services, a health psychologist with the Psychologist Scope of Practice may be most appropriate. For some other positions, other psychologists registered under the Psychologists scope may be most appropriate due to their qualifications and experience and are employed.

Gp7: Yes. Amongst other factors, recruitment decisions are informed by the scopes of practice, in combination with qualifications and experience of the applicant.

Gp14: Holding a vocational scope will determine the title a psychologist may use. Holding a clinical scope of practice is necessary, but not sufficient, for employment as a clinical psychologist at Capital Coast DHB, but there are other psychology positions where a clinical scope is not necessary. Employment decisions are made on the candidate's suitability to the position – initial shortlisting decisions are made based on academic qualification and experience relevant to the particular position being recruited to.

Gp15: Yes we do. We have positions for Clinical Psychologists and we have positions for other types of psychologists. It is based upon our requirements for the position.

Gp21: We have historically always based an employment decision making process on whether a person has undertaken a specific professional training programme to provide some assurance that psychologists being employed have relatively similar levels/standards of knowledge, supervised experience and competencies. More recently since the scopes of practice were introduced with the HPCA Act, the fact that the qualifications we seek have (conveniently) aligned with particular scopes has helped simplify our process. However it has not changed the qualification standard we base our decisions on.
In reality having vocational scopes has probably not changed employment decision making processes much across the country, nor added any more restriction to practice than the situation under the old Psychologists Act. Like our organisation, many other employers and contractors of psychologist's services have always made their decisions based on whether a psychologist has qualifications that clearly identified the specialist skills and competencies they were looking for. For example, many DHBs have always when possible, preferred to hire people with a professional post graduate qualification in psychology (or overseas equivalent), as opposed to those without.

Other employers/contractors

Gp3: No psychologist employed by the Department of Corrections, Community Probation and Psychological Services is promoted or demoted based on the scope they are registered under. In fact all psychologists have the opportunity to progress in competence and remuneration within the same employment position based on competency demonstration. Further, all psychologists, no matter which scope they are registered under, may apply for and be appointed to higher earning specialty and management roles. However, to the extent that psychologists are required to identify their scope when providing, for example, reports to the Parole Board or the Courts, the addition of "clinical" or the lack of that nomenclature may connote something which is erroneous if, for example, a very experienced psychologists registered under the general scope is providing sentencing advice, such advice may rest on a much firmer foundation than a relatively junior psychologist who can attach the word "clinical" to their scope when providing similar advice.

Gp 13: "[Organisation] provides cover for a range of health conditions under the [legislation] Act . Once a person has cover, they have entitlement to treatment which is necessary and appropriate in relation to schedule 1 of that Act.

[Organisation] has several relationships with psychologists for the purchasing of services

1. Under the regulations of the [legislation] [the organisation] can pay for counselling by a psychologist. If the person has an accepted mental health condition which requires treatment clients can access psychologists as counsellors under these regulations which attract a fee defined in the … Act .This is not restrictive although the set fee is less than contracts for services below.

2. [Organisation] contracts specifically for the services of "clinical psychologists" under the [name] contract . This service specifies assessment , formulation, and treatment. Clinical scope was identified as most likely to offer the degree of clinical expertise necessary for this service which is in place for clients with often difficult mental health issues . The scope here means that [organisation] does not need to "vet" providers as all clinical psychologists would be considered as having the necessary skills. [Organisation] weighed up the risk of excluding some providers against the need for the clinical domain of skills. This contract is appropriately restrictive in our view.

3. [Organisation] contracts specifically for psychologists with an interest in [disorder] under the [name]_contract . [Organisation] has specified clinical psychologists and other psychologists who have demonstrated a specific interest and competence in this area. These services are intended to assess and provide interventions for injured persons with [disorder], recognising that psychological and social features affect disability in this area. In contracting with providers [Organisation] has to take an active role in determining whether a self – assessed expertise and interest in psychological [disorder] management meets [organisation's] assessment of the qualifications of the applicant. This is clearly not restrictive for psychologists but places a burden on [Organisation] to understand the skills and training pertinent to the task and make judgements. [Organisation] needs to employ or consult with psychologists to make these decisions.

4. [Organisation] contracts specifically for psychologists to undertake [disorder] assessments. In the first contract schedule, the psychologist was not defined in terms of scope. In the second and later schedule the clinical scope was

identified as being most likely to incorporate the required level of expertise to make this service safe. However those who already had a contract(without such a scope) were not excluded.

We currently have both clinical scope and other psychologists holding this contract. [Organisation] is currently reviewing what type of scope or qualification is appropriate for this contract. This is one clear instance of where a scope which defines [specific] assessment and treatment skills would be very helpful and safer yet not more restrictive than the existing scopes.

The absence of such a scope leads [organisation] to consider clinical scope as a proxy for [specific] assessment skills which is less accurate than the board could manage with a defined scope."

Gp23: No

Gp27: No, but I would if there was a [specialist area] scope, because I have recommended assessors who told me they were competent, and after receiving their reports, it has become obvious that they are not.

Gp28: Speaking in my role of [Advisor] there is a restriction currently within the contracts that excludes referral to appropriately trained providers because they do not hold recognised 'scopes of practice'

Professional Psychology Groups

Gp9: No. Eligibility for membership of NZCCP is determined by academic qualifications not by scope of practice.

Academics

Gp12: N/A to us but it is interesting to note that employers may be blocking appointments on the basis of qualifications. Does scope over-ride this?

Other Regulatory Authorities

Gp16: No

Question 3.7(d) – for all respondents: Should the Board be concerned about these apparent restrictions on some psychologists?

DHB Psychologists

Gp1: If the Board is concerned about the employment opportunities of and the career pathways for psychologists, then yes. Also, it needs to warn psychologists both in NZ and overseas applicants for registration that psychologist with a general scope can or will be disadvantaged when working at DHBs.

Gp2: The primary purpose of the HPCA and registration is to ensure that the public are protected and have the opportunity to receive the most appropriate and effective care. While no such system can be perfect, it is necessary for the registration system to ensure that it is sufficiently rigorous as to identify people less adequately qualified to provide particular services, and make it possible for the public to recognize this also. It is not primarily a means of ensuring income or access to all types of work for all psychologists. The board should be concerned about protection of the public rather than protection of the income stream of particular psychologists. To protect the public, some restriction of practitioners is important. It behoves the Board to make clear that the operation of Scopes is for protection of the public rather than unnecessary restriction of practitioners.

Gp14: No. The Act is for the protection of the public, not about enhancing income or perceived employment prospects for psychologists.

Gp15: I would say that most of the people complaining are those who have been excluded because they do not have the requisite training. The Board may need to consider that the exclusion has been appropriate. We recently interviewed someone who had been buoyed by the position taken by the Board that employment should not be based upon Scope. We advertised for a Clinical Psychologist. He contacted the Clinical Director and Manager of the Service and quoted the Board. The person was an Educational Psychologist who indicated years of clinical experience. He appeared to have some good clinical experience so we duly interviewed him. None of the panel thought him appropriate and he was not employed. He did not demonstrate the clinical skills required for the position. Although only an n of one, it is a salutary reminder that people may hold themselves out to be more than they are. Although I do not think this person was dishonest he did not know what he did not know. Some people

do report experience they clearly have not had and there is not always robust ways of checking this out. The Scope is a does provide some protection

Gp20: Employers as well as the public have a right to expect a certain level of competence & experience & access to a system that transparently communicates this & easily identifies those able to provide various services. There was a well publicised opportunity for practitioners to take advantage of the grand-parenting options which needed to have an end-point.

Gp21: We do not believe that anyone is being unfairly restricted. Psychologist's who do not have the appropriate competencies to register in a particular scope should not be allowed to claim competence in that area. Any individual has the ability to apply to do a course of study that would lead to registration in a vocational scope. A psychologist, who has a particular skill, but not the full competency, is not prevented from exercising that skill.

Other employers/contractors

Gp3: Corrections operates its own competency-based system which in a sense acts as a quality assurance process as far as expertise and professional practice is concerned. However, beyond Corrections, and particularly in the area of private contracting, there are examples of people who have clearly misused the impression which is created by a "clinical" scope and this is a cause for concern. This is particularly the case when there are other potential providers of services who may be precluded by virtue of their scope.

Gp13: Scopes should be brought into the profession to restrict the performance of certain subsets of activity to persons with those skills. The question that requires further exploration is how those skills can be obtained and recognised.

Gp23: We do not consider that the Board should be concerned if the restrictions meet the aims of public of public safety and are based on principles of fairness.

Gp28: Yes very, particularly in light of the fact that there are insufficient numbers of appropriately qualified psychologists to provide services to the NZ public and aggressive recruiting exists to attract psychologists to work in NZ

Professional Psychology Groups

Gp4: As stated previously in 3.7 (a) a person's qualification has served as a benchmark for employment into the health service for decades, it is not a new phenomenon. It would be interesting to ascertain whether there are proportionately more psychologists who do not have appropriate post-graduate qualifications currently working in health fields than there were prior to the new HPCA legislation. We would challenge the perception that a scope is the sole criterion used for candidate selection. In relation to the second point, the Board should be concerned that it has allowed anomalies to occur where those with similar qualifications and experience have been treated differently. We do not see this as an argument for or against the concept of scopes of practice.

Gp5: Yes very, particularly in light of the fact that there are insufficient numbers of appropriately qualified psychologists to provide services to the NZ public and aggressive recruiting exists to attract psychologists to work in NZ. There are highly competent and qualified psychologists in NZ who cannot practice

Gp8: It should be crystal clear that we consider the Board should be concerned about the restrictions and distortions created by the vocational scopes and the history of their creation.

Gp9: No

Gp10: We fully agree with the NZPS response to this question and emphasise again, that the differences in the competencies between Psychologists who are Registered in one of the two main vocational scopes, is much less than the competencies that they share and can be less than the differences between Psychologists colleagues within the same scope. The difference between Psychologists having different scopes is likely to increase over their professional lifespan. This is in part a function of the diverse nature of professional psychological practice / client need, specialisation and continuing professional development (see again our response to Question 3.5a). There is then no point in having separate scopes.

Academics

Gp12: Yes it should. There are profound implications for the Board related to steps it might take. Psychology as a profession in New Zealand has come of age but is still fragmented. The Board has an important role to play in bringing the profession together and facilitating the development of the profession through new courses etc. Employers may be defining their psychologist positions through agreement with existing psychologists, rather than through scopes. Ideally, the Board would work with the College and the Psychological Society to agree on

pathways into College (as in Australia), divisions and vocational scopes. Agreement between these groups (led by the Board) would defuse the situation while retaining standards.

Other Regulatory Authorities

Gp16: N/A

Gp17: Only if the public risk element has not been established.

Question 3.7(e): What are the risks and advantages of vocational scope being used for selection purposes?

DHB Psychologists

Gp1: The risk is that the scope is not a reflection of specialist knowledge, skills and training, which given the degree of complex cases in DHBs, is necessary. In physical health, the vocational scopes are restrictive for psychologists, as different speciality areas affect clients across the lifespan. Thus the DHBs are vulnerable in loosing potentially skilled labour force of psychologists if the only scope that DHB use is 'clinical' scope. The emphasis for DHBs should be on good clinical care rather than legal risk aversion.

Gp2: Vocational scopes are not the sole instrument used to assist with selection process. Vocational scopes do indicate that the psychologist has been adjudged as having advanced training, and this does give some indication of a practitioner holding the skills necessary for some positions. Vocational scopes are particularly beneficial in assisting employers such as DHBs with confirming the type and equivalence of qualifications for people from outside New Zealand. It would lead to enormous duplication of effort and would be difficult, if not impossible, for each potential employer to provide this level of checking for each applicant. It would also lead to a greater deal of inconsistency which could be disadvantageous to people with more marginal qualifications and experience and their potential clients.

Gp7: From an employers point of view there are real advantages in maintaining the scopes of practice and utilising them for selection purposes. This can be particularly important for overseas applicants where it can be difficult for many employers to appreciate the equivalence of qualifications and understand the context of an applicant's professional experience. Provided that the Board has a robust and valid process for establishing 'equivalence' of qualifications and/or the experience required to receive NZ Registration as a Clinical Psychologist, then this would be a very helpful foundation from which to enter into the dialogue necessary to begin the recruitment process.

Gp14: Clinical Psychology positions in mental health services do require a specific set of skills and knowledge. Holding the clinical scope of practice is necessary but not sufficient for employment in these positions.

Gp15: It depends on the position. There are positions for which we require a Clinical Psychologist; therefore we use the scope as a screening. This has been very useful particularly with overseas candidates. Others we may appoint an overseas trained Neuropsychologist, or a Health Psychologist. In these cases we have to do more scrutiny ourselves. Not all DHBs will be in a position to do this. I would also consider the C&A programme Psychologists. My view is that I want people who have a professional qualification not just an academic one. Although there is a risk of exclusion in my opinion the exclusion is usually well founded. In my experience Clinical Psychologists suit a range of positions in what is the hard end of mental health in particular.

Gp20: Advantage: employer knows the baseline level of expertise that a person has.

Gp21: As noted in answers to previous questions, we do not base employment decisions primarily on scope of practice, but rather on whether a person has undertaken a recognised professional postgraduate training programme. The fact that these two things are now aligned has not changed my approach to recruitment. However, we do not believe there are significant risks using vocational scopes for selection purposes. It is that it is more likely this will provide employers greater clarity about the differing skills and competencies of psychologists, enhancing selection of appropriately skilled people for particular roles. Thus it is more likely to enhance public safety.

Other employers/contractors

Gp3: The main advantage is that where an employer or contractor is looking for specific skills then they will know that psychologists registered under a vocational scope have a minimum level of the skills they require (e.g. clinical skills under the clinical scope, for those being employed into the mental health area). One risk is that employers may over-estimate skill level if they base selection too much on vocational scope registration.

Gp13: See above. We feel there is always a risk where [organisation] is obliged to analyse the task area and determine qualifications and experience for a given domain of work. We believe the board is better placed to

critically examine domains of work and establish scopes where appropriate. We feel the public is best served by having active oversight of the scopes by the board. Where no scopes or other advice exist, there is a risk in agencies and organisations determining who is able to do the job.

- Agencies may rely on one particular psychologist for all advice on areas of expertise and inappropriately restrict or include practitioners in contracts.
- Agencies may not know how to judge competency
- Agencies may extrapolate from one domain to another without a clear understanding of the different skill sets involved

Agencies may not know how to evaluate the qualifications and experience of individual practitioners.

Gp23: An advantage is that employers can ensure competence and training in specialist areas. A disadvantage is that the selection pool will be decreased.

Gp27: Advantage is ensuring the person is competent in the area they say they are. Risk is that some who are competent but do not meet the criteria may miss out, but this could be overcome by the grand-parenting clause. Next time round, we will all have learnt a lesson from those who made the mistake of not applying under this clause when they could.

Gp28: They are already used with the problem that they currently exclude appropriately skilled applied psychologists from practice

Professional Psychology groups

Gp4: We believe this question is unnecessary and of little value. As noted previously, post graduate qualifications have often been used to assist with employment processes and would undoubtedly continue to with or without scopes. Employers and the public have a right to determine their processes for selecting practitioners. There are numerous examples where practitioners are chosen on their merits and not their scope.

Gp5: They are already used with the problem that they currently exclude appropriately skilled applied psychologists from practice

Gp8: There are only managerial advantages to using a vocational scope for selection purposes. The selectors can reduce the field of candidates very easily without having to consider the skills and experience each applicant offers and, if the job description is adroitly crafted can do so without any possibility of legal challenge.
The disadvantages are more significant. First, because of the diversity of practitioners within the vocational scopes there is a reasonable probability that such selection will not identify the best applicant for the position. Second, because experienced, competent practitioners lacking the formal qualification cannot access vocational registration the procedure limits the pool of capable applicants in a way that does little for the safety of the public.

Gp10: We fully agree with the NZPS response to this question

Academics

Gp12: Risks: good people being left outside, nowhere to go
Advantages: level of qualification kept high

Other Regulatory Authorities

Gp16: Risk: to disadvantage experience over more recent qualifications.
Advantage: raises standards and standardises scope

Gp17: The fact that there is still debate regarding continuing to select practitioners from one scope, even where practitioners from the vocational scope would be preferred, indicates that the public risk element is not clear.

Question 3.8(a): Should there be a mechanism to enable the members of the public and other psychologists to identify those with specialist cultural knowledge? If yes, what should be the criteria to determine such identification?

DHB Professionals

Gp1: As with any other specialisation, the criteria of cultural training and supervision, as well as experience would be necessary.

Gp2: Cultural competence should be an aspect of the practice of all psychologists irrespective of their scope of practice. The requirement for culturally competent practice is covered by the Code of Ethics and other practice standards such as the New Zealand Mental Health Standards. As it is a requirement of all psychologists, it should not need to be included as part of any of the scopes of practice. If it was the opinion of the Board that it did need to

be covered in the Scopes of Practice, including it in the Psychologists Scope of Practice and the Intern/Trainee's Scope of Practice would be sufficient to cover all psychologists. It is our opinion that this could be part of the psychologist's self-description rather than being defined as a scope of practice issue. This may change in the future if a specific training processes or programmes and qualifications were appropriately developed.

Gp14: Not sure

Gp15: I don't think that this is necessarily psychology specific and that specialist cultural knowledge may come from a range of people and disciplines. I do find it useful to be able to consult with people that understand both psychology and have the cultural knowledge. I do not think I am in a position to determine the criteria for such identification.

Gp20: Specialist cultural knowledge is analogous to other speciality advanced areas of expertise within each of the general scopes, (e.g., neuropsychology, forensic etc) and we don't believe we are yet at a stage where we are able to further define speciality areas within scopes. The Code of Ethics & core competencies provide for a minimum level of cultural knowledge for all practitioners within a scope.

Other employers/contractors

Gp3: Advertising specialist skills should remain the responsibility of individual psychologists, and obtaining suitable supervision from appropriate cultural advisors or psychologists should remain the professional responsibility of individual psychologists also, as is the case for other professional development and supervision requirements.. Perhaps if a register to simply impart information to people is seen as desirable, this may be more in keeping with professional organisations such as NZCCP or the NZ Psych Society.

Gp13: In general [organisation] supports all psychologists having safe practice across our community. We believe there is a grave risk in placing self determined cultural competence over clinical competence. However within the field of clinical psychology, if there is a mechanism or pathway for attaining cultural competence this may offer clients more choice. This probably does not need to be a separate scope indeed it may be to the detriment of psychology as whole to have culturally competent practitioners set aside. [Organisation] would suggest that this area is explored with extreme care and a sound clinical competency should be the minimum requirement for practice in all circumstances.

Gp21: Yes, there should a mechanism for this, but we believe this should be considered separately to this current debate about scopes. However, a specialist scope in this area could be developed, requiring an appropriate level of postgraduate training. It would need to be developed in partnership with appropriate cultural groups.

Gp23: No

Gp28: It is expected that all applied psychologists would be working from a culturally respectful perspective. Counselling psychology specifically is 'person centred'

Professional Psychology Groups

Gp4: Our experience is that service users usually ask service providers when they have needs in any area pertaining to a cultural issue. A competent practitioner will also be sensitive to appropriately inquiring of cultural needs.

Gp5: It is expected that all applied psychologists would be working from a culturally respectful perspective. Counselling psychology specifically is 'person centred', respectful of the client's context, system and meaning.

Gp8: Identification of psychologists having specialist cultural knowledge is closely akin to having the Board work with groups of practitioners to develop clear statements of the services they can offer so that members of the public and other lay people are better able to understand what is being offered. There are important differences with respect to cultural knowledge. First it is imperative that members of the culture, through the representatives they appoint, are the arbiters of whether any psychologist has specialist cultural knowledge, is using that knowledge appropriately, and could be trusted to mediate that knowledge to other practitioners. Second, members of the culture, again through representative they appoint, must be directly involved with all efforts to specify aspects of the culture in relation to safe practice.
The question refers to "psychologists …with specialist cultural knowledge" but it must be appreciated that in many cultures it is understood that knowledge exists in relationships and that people have to grow into knowledge and grow into authority to express and communicate that knowledge. That means it would be inappropriate for the Board or any group of psychologists to rely on a culturally grounded psychologist who is 'young' in their culture's understanding. There are culturally appropriate mechanisms for enabling such 'young' informants to grow into roles in the culture and psychologists should be both aware and supportive of such mechanisms. To do any less is to, yet again, colonise the culture for the convenience and profit of the dominant group.

Gp9: Assessing specialist cultural knowledge and the competence of the practitioner to work with different cultures is likely to be too difficult. It would be worthwhile having the capacity to identify and acknowledge practitioners

who are making the effort to develop knowledge and skills in working across cultures. Some way for practitioners who are making the effort to promote this, for example by completion of specific training, would be good.

Gp10: We fully agree with the NZPS response to this question.

Other Regulatory Authorities

Gp16: Cultural competence should be inherent in all registered psychologists. Individuals could advertise a special interest in specific cultures.

Gp17: A desirable mechanism- but not for regulatory authority. What about the funders?

Question 4(a): What is your preferred way forward?

DHB Psychologists

Gp1: Option E. When we have been involved in the employment of psychologists at DHBs, we have not used the scopes to determine public safety, but rather have used specialization, in other words option E, to determine public safety. Although intuitively CCP makes sense and most psychologists do indeed continue to advance their knowledge and skills, we need to be mindful that there is no real evidence from international studies that CCP does really enhance public safety, and it will mean more costs and bureaucratic demands, all things that eat into clinical time.

Gp2: Option B: Retaining Scopes and making them more meaningful. The experience to date has not been for the "proliferation" of scopes predicted in the warning in the "description" of Option A and B. A slow growth in the number of scopes could be helpful to clarify the focus of existing and new vocational scopes and to increase the public and referrers ability to match the psychologists' area of expertise with the needs of the client. It should be possible for the Board and the profession to work together achieve the number of vocational scopes that balances flexibility and maintenance of working within areas of competence. The meaningfulness of the Scopes could be further improved over time. We are strongly opposed to Options C, D, and E as we believe these do not protect the public.

Gp7: Preferred Option B for the way forward**.** At the same time ensuring any further proliferation of scopes is limited and therefore balanced against the need to have a flexible psychology workforce that is able to meet clinical demand and without unnecessary barriers against developing specialist areas of practice.

Gp11: As a group, we favour adoption of either Option A (retaining the status quo) or Option B (retaining the status quo and making them more meaningful), as outlined in the consultation paper. It is our view that the scopes of practice are necessary as they help broadly define a shared set of skills/abilities held by practitioners registered in each scope. With regard to the Clinical Scope, it is our view that practitioners in this scope have, as a basis for their practice, the skills and training in assessment, diagnosis, formulation, and treatment of psychological and psychiatric conditions. We believe that these skills are generally quite distinct from practitioners registered in the Educational Psychology scope. We regard registration in the Clinical scope as necessary but not sufficient evidence that a psychologist is able to work within a DHB Mental Health Service. As the Clinical scope only broadly defines a shared set of skills, it is usually necessary to ensure that psychologists applying for, or working in, specific areas of practice (e.g., child & adolescent mental health; forensics), have prior experience or specific skills in these areas. At present the scopes of practice themselves do not convey the specific prior experience or skill set each psychologist has, and consequently this information may not always be available to the general public. Therefore, any improvements to the current scopes of practice which more specifically defines skills held by practitioners working in different areas, would be welcomed as being in the best interests of public information and safety.

Gp14: Option B – This option is preferred, yes more meaningful would be useful. Don't agree with the final statement, this is not about people competing for work – it should be about protection of the public through limiting certain areas of work to those who are qualified to safely carry it out. Option D – No. Option E - No. This is not in the spirit of the Act. Not sure why this exercise is being done now given the review of the HPCA currently in progress.

Gp15: I prefer an option that retains vocational scopes and extends them. Option B. Ideally I think there should be as many as there are appropriate professional training programmes. I know this creates problems. So I would still go for broad areas. One way may be to consider some as restricted under a broader scope. For instance Child and family may be a restricted part of Clinical. Part of this for me is that I want some direction from the Board as to which psychologists are safe and competent to practice in which areas. I want to know that someone scrutinizes the training programmes. I want confidence in the professionals we employ to do what is difficult and challenging work.

Gp20: Option B. Needs to be a transparent, consistent, accessible process providing for accountability & allowing for education in the strengths/skills offered by each scope. Option B seems to offer the safest way to acknowledge skills, training & experience of practitioners, educate the public about how to be informed consumers of psychological services.

Gp21: We prefer Option B, but are open to option A as well. For all the reasons noted above in answer to the previous questions, we do not believe Options C, D or E are viable or in the best interest of public safety.

Other employers/contractors

Gp3: Option E: that is to retain the notion of competency practice which can be defined by a few core specialty skills and knowledge, but allowing for pathways into the competency to be somewhat more flexible than they have been. I suggest that the Board becomes more specific about which skills should be expected as competencies for safe and ethical practice across all or most domains of practice, whether psychologists have obtained specific qualifications in those areas or not. This list would include counselling skills, general psychological assessment skills (including ability to screen broadly for physical and mental health issues for which referrals should be made), cross cultural assessment skills, basic CBT intervention skills. This may help to restrict the number of proposed areas of practice.

Gp13: Option B

Gp23: Option C has clear disadvantages – it would be confusing for the public, costly and restrictive depending on qualifications for scopes. Option E has some benefits but would be costly in time and resources. Option B is the preferred option but only if there is not a proliferation of scopes – effectively this would dilute the general scope. Other wise Option D has disadvantages as restrictions on practice would not be imposed on those without scopes. The only restriction would be the practitioner's competence.

Gp27: Option B and include a Neuropsychology scope.

Gp28: To expand the Scopes to include internationally recognised applied psychology specialisms that are pertinent for NZ.

Professional Psychology Groups

Gp4: Ultimately we consider Option B the way forward. We challenge the thinking that scopes will 'proliferate'. We believe that a small range of scopes in specific areas, with emphasis on ensuring there is the same quality and quantity of training to achieve a similar competence, will enable the public to be assured that they can seek and use the services of a specialist when they so wish.

Gp5: The proposal is for either D or a further option, Option F which would be to expand the original Scopes to include internationally recognised applied psychology specialisms that are pertinent for NZ.

Gp8: Our submission favours abandoning vocational scopes. Of the two options, D & E the latter appears most likely to provide means for regular self- and other-assessment of competency in declared domains of practice. Linking such declarations to proposed CCP when applying for an APC adds significantly to the value, flexibility and effectiveness of such a self-monitoring regime. We prefer option E

Gp9: Discussion at PPAF and reconvene the working parties (Board, NZCCP, NZPsS, Universities)

Gp10: Option E: We strongly urge the Board to abandon vocational scopes because they do not protect the public and may inadvertently restrict their access to some valuable services.

Gp25: The Institute of Community Psychology Aotearoa has a strong preference for abandoning the vocational scopes. Of the two options which envisage this, we favour Option E. As you may know, we began work on an application for a vocational scope for community psychology. Out thinking at this time was that such a scope was needed for the protection of the public because the interventions of community psychologists can have significant impacts on large numbers of people. Poor community psychology practice can see whole communities disadvantaged by the implementation of unwise policies, the promulgation of unsound programmes, or conversely, by the unjustified withdrawal of sound policies and practices. However we have now stopped working on that application because it was difficult to see how defining a vocational scope was going to provide any more protection for the public than the general scope. It seemed to us that attempts to "carve up" the domain of psychology are inevitably doomed to failure because:
a) there are inevitably huge overlaps between scopes;
b) Scopes need to be written in such broad language that they impose few real limits on what psychologists actually do.
c) Because of these considerations, scopes in effect protect qualifications, not the public.
Defining multiple scopes has additional problems. That is, in our view, having multiple scopes
a) will be confusing to the public, and therefore, unlikely to provide greater protection than a general scope.

b) Runs the risk of locking psychology into a rigid system, slow to adapt to developments on psychological knowledge and practice.
c) Will be unnecessarily cumbersome for practitioners as their practice develops over their professional life-times.
d) Will be unduly expensive as each scope will need to be administered, reviewed and monitored somewhat separately from other scopes.
At the same time, the sort of declarations of competence envisaged in Option E will help users of psychological services choose (where they have a choice) who they hire, commission or consult, as the case may be. They will also provide some accountability to the wider profession as other psychologists could presumably take action of they thought someone was falsely representing themselves as competent in a particular area.

Academics

Gp12: Option A. This is our preferred option provided graduates of our programme can enter the existing vocational scopes which comprise a list of internationally recognised scopes (as noted before, Child and Family Psychology is not an internationally recognised scope). This option, if our graduates were not to get a clinical scope, would be detrimental to our programme. They may get a child and family scope but this would not overcome the problems being encountered in being locked out of some positions and income streams. Proliferation of scopes is a problem with streamlined pathways in to a few scopes solving this. The perception that some scopes represent lesser qualifications and access to income streams will still be a problem. The discussion paper seems to imply that other vocational scopes will have the same benefits as Clinical. This is not necessarily so.
Option B. This would be unworkable. See comments above. It would also be contrary to the type of training we are trying to create- i.e. training which ensures psychologists have all the tools needed to work with children and families.
Option C This would result in a greater proliferation of scopes and still would not solve the lesser qualification problem- just repackage it.
Option D This would create less pressure for higher level training. It would also result in the scopes not providing guidance for employers and agencies providing income streams. This role would be adopted by the more powerful and larger interest groups within the profession.
It would be detrimental to our graduates in not providing a means to recognise their level of training and the clinical –child nature of the programme.
Option E This suggestion has some merit but would not overcome the problem of influence on employers and agencies providing income streams by powerful and larger groups as outlined under Option D above. If our programme does not become accredited under a clinical scope then this is the option we would prefer.

Other regulatory authorities

Gp16: Option E

Gp17: Option B?

Q 4 b Other Comments or Suggestions

DHB Psychologists

Gp1: Is this country large enough, does it have such a huge number of psychologists that it can afford or need distinctions in scopes that mostly don't serve the function of public safety and therefore realistically provide little gain? We do not have enough psychologists to cover the financial costs for any further development and implementations of other scopes. This will lead to increased costs for psychologists, and in turn in certain cases, more costs for DHBs, whilst the scopes add little, if anything, to public safety.

Gp2: This is an important issue that needs careful consideration. Thank you for undertaking this consultation process. However, it concerned us that some of the introductory statements and the wording of some questions were presented in ways that were not neutral or objective, and in some cases pointed to a preferred outcome. We trust that the analysis of the results be undertaken from a more neutral stance so that the outcomes do reflect the feedback received.

Gp11: We believe that the adoption of either Option C or E as a way forward would be potentially confusing for the public, as it would require psychologists to register under a multitude of scopes or domains. Adoption of either Option C or E may also carry with it a significant increase in registration fees for psychologists. We do not support either Option C or E. We also do not support Option D as it essentially reverts to the situation that existed prior to the HPCA Act where a blanket term "psychologist" was applied to all registered practitioners. A single scope is so broad as to carry almost no helpful information for the public.
We would strongly support the New Zealand Psychologists Board and the professional organisations representing psychologists in New Zealand, to undertake an intensive public education program once the direction for scopes of practice is determined. In our experience, there exists a considerable knowledge deficit in the general public about the distinctions between different types of psychologists and different types of practitioners within the mental health field generally. We would like to see the Psychologists Board take the lead in an education program as we

believe this would serve to assist the general public to make an informed choice about who they seek assistance from, and thereby protect the public safety.
The HPCA Act appears to set out a pathway towards establishment of new scopes of practice. We are not aware of any evidence that this pathway is insufficient, and support the use of this pathway if the adoption of new scopes of practice are to be considered.
A number of our practitioners are aware of colleagues who have been trained overseas and found it difficult to register in the Clinical Scope of Practice, despite appearing to have the necessary skills and experience. We are aware that for other health care professions (e.g., medical practitioners), there are competency exams that practitioners trained overseas are required to pass before being registered in New Zealand. We wish the Board to consider adoption of a similar competency examination process for psychologists trained overseas, to enable registration in specific scopes of practice in New Zealand. These exams should not be available to New Zealand trained practitioners as there already exist established pathways for these clinicians to become registered in a scope of practice.
In reviewing the current consultation paper we noted that this review appeared to have arisen, at least in part, out of concerns from some practitioners that their income streams have been affected by the introduction of the HPCA Act. It is our view that any review of the Scopes of Practice should be undertaken out of concerns about the "health and safety of members of the public" (s3(1) HPCA Act 2003). The current consultation paper did not provide any evidence that public health and safety is of primary concern in this review. In addition, the consultation paper does not provide details about the number of practitioners who consider themselves to have been negatively affected by the HPCA Act Scopes of Practice, which raises further questions about the appropriateness of the current review (e.g., is this review in response to a minority of practitioners?).

Gp15: See above. This questionnaire seemed to be slanted towards abolishing vocational scopes. I think this would be disappointing a return to 1981.

Gp20: Clinical psychologists undergo specific post graduate training in mental health assessment and diagnosis. The public have a right to know that there are differences in basic training and expertise between psychologists. They also have the right to know for their own protection that the person providing them with an assessment and diagnosis has undergone the appropriate training.
The public needs to be educated about the differences between a registered psychologist (general scope) and a clinical psychologist because this is not currently clear to the lay-person, potentially putting them at risk for receiving services from a psychologist without appropriate specialist training in assessment.

Gp21: The concept of vocational scopes has not been in operation for long. From our perspective it does not appear that there have been any significant problems with it. As a consequence we do not believe it should be abandoned –"if it isn't broken, don't fix it". It is more appropriate to focus on the question of how the concept can be refined to ensure some of the perceived negatives can be addressed.

Other employers and contractors

Gp3: It should be apparent from the tone of this submission that the Psychological Services of the Department of Corrections has considerable concern about the practice of forensics/criminal justice psychology in New Zealand which is currently quite uncontrolled. We have numerous examples of people both with and without specialist scope (both clinical and educational) clearly practising way beyond their area of expertise and by naïve assessments which are provided to inform sentencing, or at times in relation to Parole Boards where releases are being considered, clearly endanger the public. Additionally, at times they are providing "treatment" which is known to be ineffective for the problem under consideration, and this may give rise to such individuals being resistant to other, and potentially effective, interventions in the future. This Service is concerned that an additional "forensics/criminal justice" scope be developed, if scopes are to be retained which could be monitored by sub-committee of the Board and which would give some assurance to the public that those involved in this type of work were operating under supervision and with a degree of training and experience which enabled them to carry out these functions. As Corrections is one of the larger employers of psychologists (approximately 110 at the time of writing) and there are others involved in the various forensic services around the country, there is a clearly identified group with a communality of functions which would support the development of such a scope.

Gp28: This review document is somewhat misleading as a number of academic applied psychology training courses exist yet the impression is given by the society that they do not.

Professional Psychology Groups

Gp4: Clinical psychology and clinical psychologists perform a valuable role in the health workforce. This is currently enabled though an initial intensive training at post graduate level, academic and practical, and then through clinical psychologists participating in continuing education.
It would be ill-conceived to diminish the role of clinical psychology based on other issues such as: how certain practitioners were grand-parented (or not) into the scope; that some psychologists are not employed into clinical positions; that there is (currently) no other way of acquiring or showing one's knowledge and skill to enter a scope; that the number of educational psychologists is diminishing; that there is a concern that there will be a

'proliferation' of scopes; that other areas may not actually meet requirements to establish a scope; that some psychologists who are in the 'general' scope think they are 'second class'; etc, etc.
Ultimately it is also for the public that psychologists become clinical psychologists. As a clinical psychologist they are more able to work with their client(s). We believe the public should remain informed and confident of the specialist service they receive and that having a clinical psychology scope is the best way for this to be achieved.

Gp5: This review document is somewhat misleading as a number of academic applied psychology training courses exist yet the impression is given by the society that they do not.

Academics

Gp12: We wish the Board all the best in making the very difficult decisions involved in this process.

Gp18: On 15 September 2003 I (University academic 1) made a previous submission to the Board on Scopes of Practice. Nothing that has happened in the following years has led me to change my general views expressed in that memo, and I attach (below) it to this Submission with a request that the two documents be read together. What follows should be taken largely as an extension of the ideas presented in that memo.
1. Note that in addition to the three areas of practice/scopes that my 15/09/03 memo identifies, I support the retention of Intern and Trainee scopes of practice, and would advocate for the extension of these to cover PhD students, under some specific conditions (see below).
2. To summarise my conclusions, I think that I favour Option E, so as to have one scope of practice for psychologists (post training), but with the three areas my earlier memo identifies as the domains within which psychologists might nominate themselves as qualified to practice. Unless one rigorously stays at a highly general level with scopes/domains, then the list of possible areas of competence could grow bewilderingly large, and would tax the comprehension of all but the most extraordinarily well-informed member of the public. Given that the public struggles to separate psychologists from psychiatrists, and counselling psychologists from clinical psychologists, I believe that a simple descriptive scheme such as the one that I have outlined is the best way of informing and protecting the public.
3. Further to point 4, the history of the past four years is that if one allows a few specialist scopes/domains then one, for reasons of equity and fairness, must allow many. The present system has notoriously (and quite undeservedly) privileged one group of psychologists, seriously disadvantaged many other perfectly competent psychologists, inhibited the development of services, restricted access by the public to needed psychological services (e.g., in child & family and health psychology), and has done nothing to assist us to meet the workforce needs for psychologists. The only way not to continue or repeat this mistake is either to retreat to a high level of generality, or permit a thousand flowers to bloom. The Board has to recognise that psychology is a heterogeneous discipline, profession, and occupation. For the purposes of protecting the public, fundamentally two conditions must be met: (a) practitioners having relevant learning that leads to familiarity with current literature on research-based best practice (as your Document notes, in 3.5(c)), and a commitment to putting that learning into practice; and (b) a common understanding of and commitment to a Code of Ethics. Beyond that all a registration authority can hope for is primum non nocere.
4. I have never been able to understand why, in principle, the period spent in supervision (two years fulltime equivalent) as a PhD student does not qualify a graduate holding a Masters qualification in Psychology from meeting the requirements of Registration. My supposition is that this says something about the intrinsic superiority of professional/occupational supervision over academic supervision. I also recognise that recognising the PhD as a pathway might well be contingent on academic programmes including in the PhD student's preparation appropriate training in ethics, bicultural issues, and the legal and professional context for psychology in New Zealand. While these are not currently common elements of the NZ PhD experience, they are not in principle difficult to incorporate into academic programmes (noting that extensive experience with ethical review of research is part of most PhD student's experience, and that that would be a foundation on which to base a wider consideration of ethics). If this pathway were available it would, of course, open the way for PhD's to be registered and recognised as fit to practice in the research/teaching domain/scope. Given that all registered psychologists understand the ethical constraint on practicing outside their areas of competence, this is not going to open the floodgates to graduates practicing in ways dangerous to the public. What it might do, if allied to some sensible developments permitting on-the-job training under supervision, is help us meet the workforce demands that otherwise mean that the numbers of registered psychologists will be static or decline, as the current workforce ages.
5. To further elaborate on point 6. As the Board well knows, there are now no pathways to registration (other than through a couple of public service schemes) except via the university diploma programmes. These programmes face considerable constraints. The clinical programmes are constrained by the difficulty of finding intern placements, and by the huge cost of in-house university clinics. These clinics, necessary though they may be viewed by many of us, are under constant threat from university administrations because of the cost relative to any revenue they bring in (that difference may be in the range of hundreds of thousands of dollars/annum). Similar though not perhaps such severe constraints affect I/O and other professional programmes. Since 2008 a new element has entered the equation, namely the new university funding system. University funding is now capped on a three-year basis, after negotiation between the university and the Tertiary Education Commission. Only if growth or decline in enrolments exceeds 3% will the funding be adjusted. Previously, if a psychology department or programme recruited more students, the university got additional funding (the "bums on seats model"), now it does not. It is now very difficult to get extra funding to expand programmes, so even if a university department

decided to try and meet workforce or community needs by expanding its registration-pathway programmes, it is difficult to see how the department would build its business case to the university to justify such a development, because there is no attributable revenue growth. The one area where there is the possibility of growth in revenue to sustain programme growth is in research degree completions (this is through the PBRF funding stream, not the student component funding), which is why growth in PhDs is still welcome. My recommendation is that the Board and university heads have further discussion on this because of the implications demographic changes and university funding policies for the supply of registered psychologists in the medium and longer-term.

Other –PHO Group

Gp19: I have been given a copy of your consultation paper and asked to comment. I am a General Practitioner in Christchurch. I am also the Clinical Leader in Mental Health for Pegasus Health. My comments are that the "general" scope of Psychologist does not confer any useful information to a referrer. The terms "intern" and "clinical" are slightly more useful to a referrer but not to a member of the public. In my role as a referrer it is complex to gauge quality and skill set that is going to be, or already is, being applied to a patient who is registered with a General Practitioner. The publication of a list that is constantly updated advising experience and skills and training undertaken would be very helpful.

Other –DHBNZ Workforce Group

Gp24: The Allied Health Workforce Strategy Group is part of DHB's collaborative Future Workforce Programme. The role of the Strategy Group is to undertake project activity and to support allied health workforce and network development. As a group with a keen interest in allied health workforce development, the Strategy Group offers the following comments to you for your consideration:

- We welcome all attempts to monitor the safety of the NZ public as they engage with the NZ health sector.
- In order to enable ongoing development of workforces that are flexible and responsive to health sector need it is the suggestion of the Strategy Group that scopes of practice should be kept broad and enabling.
- In our experience narrow scopes can be confining and often result in increased costs and compliance within the sector.

Other Regulatory Authority

Gp22: The Secretariat for the Medical Council of NZ submits:

- From the perspective of patient health and safety, the status quo does not appear to be an appropriate option. This is because the current scopes of practice provide inaccurate information to the public and organisational stakeholders about the training and expertise of registered psychologists in NZ.
- Psychologists who have done some specialisation should be able to identify themselves, but the Board has a responsibility to ensure that any psychologist who calls him or herself a specialist maintains his or her competence in the area of specialty. Of the options presented in section 4, we recommend Option B or Option E.
- The challenge with Option B is that deciding what is, and what is not vocational scope can be difficult, resource intensive and time consuming. I have attached a copy of the criteria the Medical Council uses in deciding whether or not to recognise a new vocational scope. We use a panel to conduct the assessments, and the process for accepting a new vocational scope generally takes over a year and can be quite controversial. Option E would be more straightforward to administer.