

Committee Secretary □  
Senate Standing Committees on Community Affairs □  
PO Box 6100 □ Parliament House □  
Canberra ACT 2600 □ Australia

**Re: (e) (ii): workforce qualifications and training of psychologists**

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**Summary:**

- a. There is no vocation of ‘Psychologist’. The distinction between ‘generalists’ and ‘clinical’ psychologists is an artefact arising out of all psychologists, regardless of background experiences, training and places of work, being originally and currently registered under State, Territory and now Commonwealth Health Acts, as if they were a single vocation.
- b. The practice (testing and treatment skills modalities) of a ‘clinical psychologist’, as currently defined, cannot be significantly differentiated from experienced hospital psychologists, experienced private practitioners and from the other defined practitioner ‘specialities’ in Psychology.
- c. Psychologists, ‘generalist’, ‘clinical’ and other ‘specialties’, have inadequate training, experience, skills and knowledge due to the absence of a basic general vocationally oriented practitioner course of training, and the physical limits imposed by a two year training practitioner course incorporating a research thesis.
- d. The profession, by disowning its own history and composition, has created both internecine conflict and public confusion.
- e. The subsidising of fees through Medicare to ‘Registered Psychologists’ was a foreseeable mistake, due to the reasons outlined in points ‘a’ to ‘d’ above; and budgetary blow-outs predictable. The subsidising has created a new industry of ‘private practice’, with all components of the profession - Universities, practitioners and Professional Bodies - arguing the right to maintain an income in this new industry.
- f. Suggestions are made as to interim options in defining those able to provide health practitioner services, and for defining suitable practitioners in the future.

## History

The registration of Psychologists is a relatively new phenomenon: for example, the ACT Psychologists Registration Board was formed in 1996. Prior to this, any individual in the ACT could legally describe themselves as a psychologist and practice 'psychology'.

Originally, the majority of psychologists were in the Government employment sector, and titled by their place of work: Clinical Psychologists were those employed and working in Hospitals, which underlines the origin of the term 'clinical' – "by the bedside". Others were Army Psychologists, Vocational Guidance, Educational, Counselling, Organisational or Occupational Psychologists, depending on the workplace. Those in private practice were called Private Practitioners, and were a significant minority.

The largest professional body representing those who have studied Psychology is the Australian Psychological Society (APS). Originally it was comprised of a single membership of those interested in the field. In the 1960's it separated its members into two groups: one working in the academic, science and research field, the other in practitioner areas<sup>1</sup>. In the 1970s, the latter group was further separated between Counselling and Clinical Boards.

This early fractionalisation of the Practitioner group laid the seed for current problems within the profession. Counselling is a form of treatment in its own right, but also represented psychologists located in University Counselling Centres, School Counsellors and other counselling and treatment centres: that is, it was both a description of a therapeutic process and a place of work. Many of the then counselling treatments, especially Rogerian, Gestalt<sup>2</sup>, Hypnotic and encounter group therapies were also procedures used by those psychologists working in Hospitals – Clinical Psychologists.

This was the first dilution of the Clinical Psychologist identity: the division between Counselling and Clinical Psychologists within the APS Practitioner group took away any claim to unique treatment modalities belonging solely to the expertise of the Clinical Psychologist. The confusion thus began between the identity of a profession based upon their place of work with the inherent procedures they were engaged in, and the identity of a profession based upon some other set of criterion unrelated to the origins of that profession.

In essence, 'clinical' refers to a process, the clinical application of assessment and treatment of patients, and is not actually a 'title'.

The APS then began to form more 'specialist' Boards within the practitioner group, and with each Board further diluted the nature, identity and role of the Clinical Psychologist.

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<sup>1</sup> The American experience is salutary: its largest body of psychologists, the American Psychological Association (APA) saw a group split from it, around 20 years ago. The latter group, originally called the American Psychological Society (APS) and now the Association for Psychological Science (APS), comprises the University academic, research and experimentalist groups who had come to believe the APA was dominated by practitioners. The American experience suggests that one or more of the 'APS colleges', at some stage in the evolution of the profession in Australia, will secede from the academically dominated APS to become an independent professional body. Ironically, a reversal of the American experience.

<sup>2</sup> Many of the current 'evidence based' treatments are re-badged 1960s procedures. For example, 'schema therapy' makes use of Gestalt techniques.

The current practitioner Boards/Colleges are Neuropsychology, Counselling, Health, Community, Forensic, Sport, Organisational, Educational and Clinical.

The original designation of a Clinical Psychologist as someone who worked in a Hospital with patients, and assessed and treated patients, lost its identity with each new Board, for each new 'speciality' took away some core component of skill and professional practice defining a Clinical Psychologist.

Parallel with this rise in Boards/Colleges, was the rise in University Masters courses to promote the new Board/College titles. There are neither Masters courses nor Colleges of Paediatric and Geriatric populations, both being subsumed among any and all of the aforementioned Colleges.

Thus, the psychology student can now become a specialist psychologist – Neuropsychologist, Forensic etc – without having general Clinical Psychology training. General clinical training is not a prerequisite for advanced or specialised clinical practice (in neuropsychology, forensic psychology and so on).

In 1980 a non APS group, the independent Australian College of Clinical Psychologists (ACCP), was formed some 16 years prior to the APS College of Clinical Psychologists. The ACCP introduced annual compulsory membership requirements of a peer reviewed case presentation, 35 hours continuing education and membership necessitated at least 6 hours of patient contact weekly (to ensure active clinicians were members). In 1984 the ACCP held the 1st Australian Clinical Psychology Conference at the Woden Hospital, in Canberra, and subsequently the 2<sup>nd</sup>, 3<sup>rd</sup> and 4<sup>th</sup>. In 1996 it convened and held the 1<sup>st</sup> National Congress of Private Practising Psychologist's Organisations. In the subsequent years, the College decided to admit any Psychologist practising with patients, not just Hospital based clinicians. In 2011 it dropped the term 'Clinical' from its title, fearing legal action from the Psychology Board of Australia, which had claimed the title for APS College membership.

### **Current**

There is currently no unique role, experience, training or skills defining the clinical psychologist: testing of cognitions, emotional states and personality is part of neuropsychology, forensic, health, educational, community and 'generalist' psychologists; treatments are part of counselling, neuropsychological, health, sport, forensic and 'generalist' psychologists.

Clinical Psychologists are not now designated by their Hospital workplace, but by admission to the APS College of Clinical Psychologists via a two or three year University training program including a substantial research component.

Graduates and their lecturers in Clinical psychology are very unlikely to have worked full time in a hospital for similar periods to nurses, physiotherapists and medical practitioners. Their experience of serious clinical psychopathology is limited. They may have more or less experience in treatment and testing than any of the other practitioner APS Colleges.

The amount and type of hospital experience undertaken by Clinical Psychologists is an empirical question and can be answered by seeking data on the number of full time hours worked by lecturers and students in Hospitals, with patients.

It can be argued that the term ‘clinical’ no longer refers to Hospital training and experience, that community and University clinics and private practice settings are sufficiently ‘clinical’ for training purposes. This is a reasonable argument for training purposes, but the term ‘Clinical Psychologist’ should then not be given to these Psychologists. If a Clinical Psychologist is not Hospital trained and experienced, then it loses its unique descriptive meaning.

In summary, the Clinical Psychologist was a title ascribed to a place and type of work, but now refers to the title of a two years Masters Degree; the defining characteristics of the Clinical Psychologist has been diluted, eroded and subsumed within each new University Masters course allied with an APS College, and will continue to do so with each new speciality (e.g. Paediatric and Geropsychology).

A ‘Clinical Psychologist’ appears to be whatever it is that is left once all the other health practitioner groups have been defined.

### **Registration**

There is no vocation of ‘Psychologist’. The distinction between ‘generalists’ and ‘clinical’ psychologists is an artefact arising out of the fact that all psychologists, regardless of background experiences and places of work, were originally registered under State, Territory and now Commonwealth Health Acts.

As Registration of Psychologists in each State and Territory health portfolios was introduced, individuals were also able to obtain Registration via those States and Territories with the weakest criteria for Registration, such as the Northern Territory.

Once obtained through the Northern Territory, Mutual Recognition Acts allowed that individual to be Registered in any other State or Territory.

This situation continues with the Registration of every type of ‘psychologist’, health focused or not, under the Commonwealth Health Acts.

It is clear that a University graduate in ‘clinical psychology’ is more experienced in treatment and assessment than an Organisational, Industrial, Community, Educational or Sports psychologist, and those academic and research psychologists registered under State and Territory Health Acts during the ‘sunset clause’ periods. It is not clear that a university graduate in ‘clinical psychology’ is better trained and experienced than a university graduate in Health, Counselling, Forensic or Neuropsychology; and even less clear that any of these two year University graduate ‘specialities’ are more proficient than practitioners with decades or more of patient contact and a clear history of continual professional body<sup>3</sup> training outside the academic system (and prior to the academic system providing such training).

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<sup>3</sup> For example, intensive workshop training in treatment and assessment from any peak professional body - the Australian Pain Society, the Society of Personality Assessment, The National Academy of Neuropsychology, ACCP and so forth; or full professional training in specific techniques such as the two year training in Hypnosis from the Australian Society of Hypnosis, or Psychoanalytic training from the Australian Psychoanalytic Society.

The consequence is that the term ‘generalist psychologist’ represents a very large variety of individuals: the term ‘generalist’ does not mean a psychologist who has no experience or skills in the treatment and assessment of patients, nor is it a designation of a homogeneous group of health practitioners with less treatment or clinical experience.

### **Training**

Psychology began as a branch of Mental Philosophy: the first Professor of Psychology at Sydney University came from its Philosophy Department. It was initially a three year BA, then in the 1960s, a fourth year Honours year was added. Those graduates from this era who went to work in Hospitals were designated Clinical Psychologists. This group are now designated ‘generalists’ under the present guidelines.

1. Clinical Psychology is unlike any other Health practitioner professions<sup>4</sup> in that it is the only practitioner health profession in which:
  - a. The Profession does not train, guide and control the profession: the Universities and their academics do.
  - b. There is no basic (undergraduate) practitioner vocational training course aimed at producing a Health Professional.
  - c. A Clinical Psychologist practitioner can be produced with just two years of formal academic lectures, placements, and a substantial research thesis component.
  - d. A student can specialise in a clinical field (Neuropsychology, Forensic Psychology) prior to or never being a generalist clinician.
  - e. A Clinical Psychologist, student or teacher, may never have seen a patient in a Hospital.
  
2. All health professions, save Psychology, have a basic undergraduate vocational training, with an undisputed uniform base of knowledge<sup>5</sup>, aimed at producing a health practitioner: usually of four to five years training duration. The (non Psychologist) health practitioner graduate will then proceed to post graduate specialisation, after generalist training.
  - a. Psychologists undertake a four year undergraduate (academic/research) science programme, with a substantial research thesis component, which trains a student to undertake PhD research work.
  - b. Psychologists then undertake a two year Masters or three years PhD program, which involves lectures, placements and a research thesis at the appropriate (Masters or Doctoral) level. This two or three year academic/practicum placement/research program enables the student to be called a ‘Specialist’: Clinical Psychologist, Neuropsychologist, Forensic Psychologist, Counselling Psychologist, Community Psychologist, Health Psychologist, Sports Psychologist, Organisational Psychologist, Educational Psychologist.<sup>6</sup>

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<sup>4</sup> Such as Medicine, Nursing, Physiotherapy, Social Work, Optometrists, Pharmacists, Speech Therapists, and Occupational Therapists.

<sup>5</sup> Such as anatomy, physiology and biochemistry. Clinical psychology has no undisputed core knowledge base; for example one only needs to look at the variety of theories of personality, the absence of any theory of personality in the main diagnostic manual (DSM IV) section on Personality Disorder, the changing conceptual formulation of Personality Disorder for the DSM 5, and the lack of validity (but not reliability) of DSM psychiatric categories.

<sup>6</sup> The profession has chosen to not provide practitioner Masters degrees in Paediatric Psychology

- c. Every 'specialist' APS college is intimately tied to a University Masters degree course.
  - d. Unlike all other Health Practitioners, Psychologists become 'specialists' before they are generalists.
  - e. Recently, additional follow up experiential components have been added to the Masters degree, but the student is by then called a Clinical psychologist and this work experience is rarely within a hospital for 'Clinical Psychologists', for example, it can be in a Private Practice setting.
3. The Profession does not train Psychologists. All other health practitioner professions, such as medicine, physiotherapy, nursing, occupational therapy, optometrists, social work, train their profession. They all train students to be a doctor, physiotherapist, nurse, OT, optometrist and social worker. And they do it from day one with a dedicated course.
- a. Psychologists are trained, even at the post graduate level, by the University. Many Professorial heads of Psychology departments are not legally registered, and hence cannot call themselves Psychologists, nor are many of the undergraduate lecturers.
  - b. It is the profession of Medicine, or the profession of Nursing, Physiotherapy, Social Work, who train their future profession: the profession of clinical practitioners has never done this in Psychology: all training emanates out of the research cauldron of the University.

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or Geropsychology, but creating other Specialist titles in areas where greatest financial remuneration is obtained, as distinct from greatest social need. It can be argued that some 'Clinical Psychologists' or some Neuropsychologists will further 'specialise' in child or geriatric areas: this underlines one argument of this paper: that 'specialisation' prior to generalisation creates a false profession.

## **Clinical and generalists: an empirical question**

Whether a patient is better assessed and treated by a 'Clinical Psychologist' or a psychologist with clinical experience is an empirical question. To my knowledge, no significant 'on the ground' empirical evidence has been provided by the profession to settle this. All assertions that one group is better than another are mainly aimed at ensuring an adequate income for the professional, and not at whether a patient is receiving the best treatment. It is a 'pigs in the trough' phenomenon. It is likely that the majority of submissions to this enquiry, from all sides, will be primarily aimed at maintaining an income stream for the psychologist, and only secondarily at best patient care.

University employees need to protect their income and consumer base by asserting their training is best, whilst graduates from these programs need to assert they require more income due to the greater expense they have invested, and 'generalists' will assert that they have been practising and training outside the academic sphere for many years, and have the right of prior occupation to their share. This 'substantial private practice income is my right' phenomenon is a newly created vocation for psychologists, put in place by the lobbying of the profession and the Federal Government subsidy scheme.

One source of indirect evidence of training competency is from two State and Territory Registration Boards surveys. The pathways to Registration, after the 'sunset clause' time period ended, was via an Internship or Masters degree. The former were psychologist working 'on the job' under private supervision, the latter University students under academic supervision.

In April 1997 the NSW Board undertook a project to investigate the Supervision process. The research found that the University Masters programmes were excessively costly and students may not have satisfactory "real world experience"; at the same time there was a lack of quality control over private supervisors, placements, content and fees charged for the Intern pathway.

In the 2004 the WA Board presented to the Council of Chairs of the State and Territory Registration Boards, their survey findings that 'consumers' preferred the internship with full time work in the field as their optimal training. The Council of Boards rejected this conclusion not by looking at the survey data, but on assuming the questions had been incorrectly worded to get this result.

The Senate should obtain copies of these surveys as part of their objective data collecting.

The empirical question of who delivers competent professionally acceptable treatment and assessment can be settled by objectively and publicly assessing generalist and clinical psychologists with similar patient groups, in vivo. Argument, appeals to authority, CV presentations, publications, reference to experience in the field, marketing and spin are no substitute for having psychologists see live patients in clinical conditions of practice, and be evaluated.

Although I have worked as psychologist for over 40 years, I am a 'generalist' psychologist under the current definitions, and am ineligible to use the title 'clinical'. It is quite possible that I am less competent than those with a two year Masters degree and two years follow

up experience, but it is also possible I am not<sup>7</sup>: I just don't know, nor do the Senators without the assertions being tested. I propose the following empirical tests:

1. That my expertise as a clinician be evaluated against a strong contingent of practitioners who claim that only those trained in the University stream are eligible for the title 'Clinical Psychologist'.
2. To ensure a strong contingent I propose the evaluation include, in addition to myself as a 'generalist', the following Medicare and APS approved Clinical Psychologist Supervisors:
  - a. The professor in charge of the ANU Clinical training program.
  - b. The professor in charge of the University of Canberra Clinical Training program.
  - c. The Senior Psychologist in ACT Health.
  - d. Members of the APS Medicare assessment team.
  - e. An APS Clinical College member of the Psychologists Registration Board.
  - f. And randomly selected graduates of the ANU and UC Clinical masters programs.
3. The evaluation consist of:
  - a. Each of us psychologists being given 8 - 10 treatment patient referrals to see on a single day from all wards, Units and specialist programs of the Canberra and Calvary Hospitals, as would occur in a normal days clinical practice; with appropriate follow up sessions as required.
  - b. Each psychologist conduct five full psychometric evaluations, from Neurology/neurosurgery, Rehabilitation, Psychiatry, Clinics (such as Pain Clinics), and can include child or geriatric patients, to be fully completed over four days.
  - c. Present a patient/s illustrative of a complex, unusual, or important clinical condition at a Grand Round.
  - d. Examination of the last 100, or a random selection of 100, clinical assessments and clinical reports from each of the above individuals (including myself).
  - e. The test library of each of the practitioners, or the University training facility they are attached to, be audited and each practitioner examined in the administration of standard psychometric instruments and interpretation.
4. The evaluating body should include experienced psychologists, specialists from the area of referral (Psychiatrist, Neurologist, Pain Specialist etc) and the results of the empirical evaluation be made public.

The above empirical evaluation can be modified or changed in the detail, but any watering down will de-emphasise the serious purpose of such an evaluation: whether the profession of Clinical Psychology, as it is now constituted, is adequate to meet the needs of patients.

Currently, the Government has appointed the APS (Medicare Assessment Team) to assess the suitability of a 'generalist' psychologist for 'eligibility' for membership of the APS

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<sup>7</sup> And it is equally possible that neither group, generalist nor clinical, can lay claim to being more proficient than the other, as both are found wanting.



College of Clinical Psychologists, and hence as a 'Clinical Psychologist' under the Medicare scheme. This then allows that psychologist to attract the higher Medicare subsidy.

The Psychologists Board of Australia has also nominated the APS Medicare Assessment team as the vehicle for transitioning psychologists to clinical status, though closing this avenue in September 2010.

In principle this is a sound procedure, but in practice it falters. Aside from the conflict of interest between the examining (APS), training (University), licensing (the Registration Board) bodies being inter-connected, there is no transparency to the procedure.

I have no data on how many 'generalist' psychologists have been accepted, rejected or offered a bridging plan by the APS. The bridging plan is a set of study and supervision requirements the 'generalist' must satisfy prior to gaining 'eligibility' status to the APS College and Medicare (one and the same). I have no information on the criteria or reasons why one bridging plan imposes one set of requirements on an individual, and a different set on another.

In my own case, I have never met and do not know those examining my clinical expertise. I have not been allowed the opportunity to examine my examiners as to their clinical competence, nor have they directly examined mine.

The bridging plan given to me, includes three semester units at a University Masters Clinical Course (the connection with the training body): having done two of these Units, I have my lecture notes as evidence<sup>8</sup> that the APS Clinical College criteria means I have to de-skill and substantially lower my standards of clinical practice.

The Plan also requires I lower my research level by submitting a 5,000 word research proposal despite my recent (and current - 2011) PhD student status with three Supervisors, presenting a 40 page PhD research proposal to the University of Western Australia, being rigorously examined and questioned on the details by the UWA Human Ethics Committee (passed), summarising the research proposal to 15 pages for the UWA Post Graduate Committee (passed), presenting the proposal over one hour at ECU for a viva examination (passed) and presenting the proposal, with questions, to peers and colleagues at my faculty, the UWA School of Psychiatry and Clinical Neuroscience.

The research involves the administration of psychological tests – neuropsychological, psychopathology/personality and symptom validity tests – along with biomarkers. It is on a clinical psychological topic and uses clinical patients as subjects, and involves clinical protocols.

Despite asking for and not receiving (to date) an explanation as to the reason I am still required to give a separate, lower level research proposal on a topic different to my PhD, the APS insists that this be done. I am aware of those on bridging plans, who are not undertaking examinable research, who do not have to submit a research proposal.

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<sup>8</sup> This is not due to poor lecturing, but to the impossibility of imparting sufficient knowledge and experience in a semester Unit covering complex psychopathology treatments and assessments.

I am aware of a psychologist who has worked full time in a Psychiatric Hospital for 15 years, as the principle psychologist, requiring further training in the their Bridging plan in psychotropic medications (as I also have been directed), whilst a psychologist with no Psychiatric Hospital experience has not.

There are numerous other issues with the Bridging plans, but these personal experiences suffice to illustrate the principle that in practice, as opposed to ‘spin’ on paper, lowering of standards is required to be admitted to the APS College of Clinical Psychologists, and there appears to a lack of consistency, or at least transparency, as to the reasons for one psychologist being directed to obtain further qualifications in one area, and others not.

### **Private Practice**

Private practice as a psychologist, in the 50s, 60s, 70s and early 80s was very difficult: they were very few in number<sup>9</sup>; did not have the privilege of a State Registration body representing their profession; GP’s and the public did not have the concept of referring to a psychologist; and when they did they expected the same fee subsidisation as Psychiatrists received; and the rest of the profession of psychologists at that time tended to look askance at the private practitioner.

This last state of affairs can be directly attributed to the university training which fostered a critical attitude toward the status of tests and therapy. Few psychological tests were then available and aside from Wolpe’s (a psychiatrist) new behaviour therapy and Skinnerian token economies (and some reinforcement regimes), nothing else of scientific practical value was available from academia and the Universities.

The university at the time encouraged a highly critical approach to the veracity of tests and techniques: “further research was required” was the catch cry at the end of each honours paper. The clinical component of the profession was located in a few hospital posts and they tended to look down (as they had been taught) at psychologists trying to put primitive techniques into practice and charging money for it.

The large majority of psychologists were salaried.

Early private generalist practitioners not only had to fight the vagaries of their unsubsidised financial situation in an unequal market of Psychiatrists, but also the uninformed prejudice of their clinical and academic colleagues.

Private Practice now dominates the psychological practitioner service scene: this new component of the profession was artificially created on the 9th October 2006, and is dependent upon Government subsidies. Those who initially pioneered the private practice arena have been deliberately discarded. Eliminating the pioneering efforts of these early private practitioners and then denying and dismissing those efforts, also eliminates history from the identity of both clinical psychologists and those now in private practice.

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<sup>9</sup> In 1988, there were six full time private practitioners in the ACT, of which only two conducted a general testing and treatment practice: the other four offering counselling and treatment. There are now well over two hundred private practice Psychologists and psychology services listed in the Canberra Yellow pages under ‘Psychologists’.

The skill and experiential contribution to younger practitioners from those with lengthy experiences in private practise is now actively dismissed by the profession. This ensures the absence of a collegiate culture in the profession.

Since the Medicare subsidy, psychology in the private sphere has become an industry in its own right, independent of patient care. The issues are not about the profession of 'clinical psychology', but the Industry of Private Practice. There is a drive for profit and the maintenance of a private practice income, a drive for the monopoly of service providers and the eliminating of competition, and the maximising of the consumer base. The profession has replaced salaried senior, experienced Hospital based Clinicians with Private Practise oriented two-year University trained practitioners.

The old models of patient care can also be fiscally prudent whilst involving best practice standards: the Government and the profession can establish more salaried positions in out patient and community health settings. That is, for considerably less cost than the present scheme, by providing an appropriate salary to experienced clinical practitioners, one commensurate with other professional/managerial levels of income, and ensuring the stability of the position by not making it a short term contractual arrangement, and providing sufficient funds for the proper equipment required for assessments, then the needs of the community could be met through the public system: more cheaply, and equitably.

Appropriately paid senior and experienced practitioners in the public system, with their students, eliminates the problems with restrictions on the number of treatment sessions, decisions about taking on difficult patients, allows the free choice of appropriate treatment and assessment, and not unimportantly, causes a profound reduction in the non useful administrative cost in selecting, maintaining, monitoring and paying the Medicare 'registered psychologists'. This would also eliminate the embarrassing and humiliating set of actions among the profession as they all fight to push the snout into the Medicare trough.

Those wishing to pursue private practice, after a period of training and delivering services through the public health facilities, can do so by demonstrating they offer an equivalent or higher quality of service than their salaried colleagues.

### **Conflicts of Interest**

It has been a significant pattern that Professorial heads of Psychology Departments have been Chairs of State, Territory and Commonwealth Registration Boards; that these individuals are members of the APS; and the APS has been a significant partner to all Boards in formulating policy.

An example of this conflict of interest creating the confusion over what a psychologist 'is', can be seen in the Code of Ethics for Australian Registered Psychologists cited by the Psychology Board of Australia (the Board): the APS Code of Ethics. The Board is a regulatory authority and the APS Code is now part of the Board's regulations.

The APS Code is an omnibus document, betraying its origins in Psychology as a University line of enquiry, not as a designated Health profession of clinicians. The APS code attempts to be a general code for every scientist, administrator, researcher, lecturer,

health and non-health related practitioner. It captures both the history and the dilemma now facing psychology as a Health Registered group.

There are many instances in the APS Code which either do not apply to clinicians, or cannot apply. I shall highlight only some:

1. The term 'patient' is never used in the document, as many Board Registered and APS member 'psychologists' have clients, subjects, customers, and students.
2. The term 'client' is used to cover the diverse functions of APS and Board Registered members who have to, by the definitions in the Code, then deliver a 'psychological service': this relates historically to the APS combining academics, teaching staff, researchers, experimentalists, administrators, organisational psychologists, private practitioners, sports, counselling, educational, forensic, neuropsychological, health, community and myriad others under one roof, and subsequently for the purposes of Registration, under a Health Act. The term 'client' is necessary to ensure that APS Members are covered by the Code of Ethics, not Psychologists working within a clinical health setting (as distinct from counselling, educational and organisational).
3. The APS Code is necessarily supplemented by and integral with, a separate number of Ethic Code Guidelines. These are not accessible from the Registration Board, being only available to APS members.
4. There is no explanation for the derivation of the three ethical 'principles' upon which the Code is based: no philosophical references are cited; there is neither scientific nor theoretical evidence provided for 'empirical' ethical statements made in the Code; and the term 'psychological service' used through-out the Ethics Code is tautological, as it refers to any service provided by any type of psychologist who is an APS member, including teaching, research and experimentalists. The term 'psychological service' does not specifically pertain to a clinical psychological service.

The Board has established and limited the specialist titles in psychology to those matching membership of the APS Colleges<sup>10</sup> and associated University Masters courses. One could argue that monopoly control of the profession has now been legally established by the Board, Universities, APS and the Federal Government. Given the history of predominantly Professorial (academic) incumbents on all Registration Boards as Chairs, and their membership of the APS, this can give the appearance of a conflict of interest.

The Senators may wish to look at separating the training and examination of health practitioners, and divesting monopoly control of the psychology profession whilst recommending improvements of clinical training standards.

## **Suggestions**

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<sup>10</sup> The APS Colleges have no legal status and are not independent bodies. They are component parts of the APS and can be called by any title, having been 'Boards' in the past.

1. Hospital trained and experienced clinicians, with eight or more years of full time psychiatric hospital work with patients, be offered a sunset provision for designation as a 'Clinical Psychologist'.
2. State and Territory Health employed Psychologists, in any form of Mental Health Clinics, with eight or more years of full time experience, be offered a sunset provision for designation as a 'Clinical Psychologist'.
3. Private Practitioners in a full time, demonstrably health related practice, of 10 or more years, be offered a sunset provision for designation as a 'Clinical Psychologist'.
4. That in future, Clinical Psychology be a 5 year vocational undergraduate practitioner training course, incorporating a research component, and be the basic requisite for any further specialisation to Neuropsychology, Forensic Psychology and the like.
5. That currently Medicare Registered psychologists in practice, not meeting the criteria in points 1 to 3 above, have a provisional status to keep practising whilst completing the requirements of point 4.
6. The examination and training bodies be separated: there be a national examination<sup>11</sup> for clinical licensure under the Registration Act, overseen by an Authority separate from the University training institutions, the professional bodies, and the Board, to eliminate conflicts of interests.
7. That Hospitals and State Health Departments make provision for Psychologists to be trained, paid and obtain experience within their clinical settings. This requires State and Commonwealth Hospitals and Health Centres to employ permanent full time clinicians, to enable a body of experience to be re-built in individuals so that adequate supervision and mentoring can take place.
8. That an increased number of senior psychologists, with extensive experience of Hospital based patients with psychopathology and general pathology, be permanently employed on appropriate salaries, in Hospital attached out-patient and Community Health clinics, with all the equipment professionally required, to provide free treatment and assessment services to those most in need. This model is fiscally more prudent than the current Private Practice subsidy program, allows for as many treatment sessions as is required without a budget overload, attracts those community members most in need, means those patients with irregular attendance habits due to their illnesses can also be accommodated, takes pressure off Crisis teams and can be administratively cheaper to manage than the present system.
9. Those patients in a defined 'rural' area, be given a higher rebate per session, regardless of the Psychologist's designation.

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<sup>11</sup> This has been the established model in the United States for many years. The national (all States) licensing exam is the Examination of Professional Practice in Psychology. This proposal for a national exam in Australia was rejected several times by the Council of Chairs of the State and Territory Registration Boards.

10. Rural Psychologists have a dedicated Rural training facility, making use of current distance education technology, current Rural Health training services, and subsidised regular and obligatory training/educational workshops in central towns.
11. Rural Psychologists have subsidised psychometric test equipment purchase (via higher tax relief).

## **Thomas Alfred Sutton**

- 1. Chair ACT Psychologists Registration Board 2001 – Sept 2004**
- 2. Member ACT Psychologists Registration Board 1998 – Sept 2004**
- 3. Registered Psychologist in ACT (ACT PSY 6), National Registration:  
PSY0001394740**
- 4. National President Australian College of Clinical Psychologists 1980 – 2004**
- 5. Research PhD candidate at School of Psychiatry & Clinical Neurosciences,  
University of West Australia; and The Sir James McCusker Alzheimer's Disease  
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1969 Honours Psychology, UNSW: research thesis – thinking style of murderers, Long Bay Prison.

1970 Mental Survey Tester, NSW Dept. of Education.

1971 to 1988 Clinical Psychologist - Concord Repatriation Hospital (Psychiatric and General wards), Broughton Hall Psychiatric Hospital, Callan Park Psychiatric Hospital (along with Canterbury and Western Suburbs General Hospitals), Kalparrin Community Health Centre, Woden Valley Hospital (Psychiatric and General Wards).

1988 - present: Private Practice

1998 - 2004 Member ACT Psychologists Registration Board

2001- 2004 Chair ACT Psychologists Registration Board

Convenor: 1984 - 1<sup>st</sup> Australian Clinical Psychology Conference

1996 – 1<sup>st</sup> National Congress of the Federation Or Private Practising

Psychologists' Organisations

1971 - present: Nurse & Psychiatric Registrar lecturing: Canterbury Hospital, Concord Hospital, Broughton Hall Psychiatric Callan Park Psychiatric Hospital, Woden Valley Hospital, Royal Canberra Hospital. Lecturing and supervision of Intern & postgraduate psychology students from University of Sydney, University of NSW, ANU, University of Canberra, Wollongong University, NZ Registration Board, ACT & NSW Registration Boards.

Major areas of teaching - neuropsychology, hypnosis, pain and general clinical psychometric assessment & treatments. Workshop presentations - hypnosis, neuropsychological assessment, psychodynamic oriented psychotherapy, differential psychiatric diagnostic testing, symptom validity testing, forensic assessments, stress management, hypnosis, assessment, PAI, & treatment of chronic pain. Postgraduate theses assessor for ANU, University of Canberra - neuropsychology, pain management.

Consultant to AFP Hostage Negotiation teams (1984 - 87). Witness hypnosis consultant to AFP & NSW Police. Adviser to ACT Government on Health (1989-90). Independent Rehabilitation Provider. Member ACT Adoption Review Committee.

PhD research on APOE4 allele, beta amyloid, other biomarkers and radiological tests, and cognitive function in brain disease and traumatic injury: School of Psychiatry & Clinical Neurosciences, University of West Australia. Supervisor Prof. Ralph Martins.

Australian Army Psychology Corps (Res) 1967 – 1986.

Full Member:

Association of Psychological Science - APS

Australian College of Clinical Psychologists (Fellow) - ACCP

Society for Personality Assessment – SPA

Society for a Scientific Clinical Psychology - SSCP