16 June 2006

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Sector Policy
Ministry of Health
PO Box 5013
WELLINGTON

Dear Ryan,

NZCCP Submission

Response to the consultation request on the form of regulation of Psychotherapy under the Health Practitioners Competence Assurance Act 2003

The following submission reflects the position of the New Zealand College of Clinical Psychologists. We support the provision of a "Stand Alone" authority for psychotherapists and do not support the proposal of a "Blended Authority" combining psychotherapists and psychologists.

We have considered the questions posed by the Ministry:

1. **Which would provide better protection for the public, a stand alone or blended authority, and what would be the impact on the public in regards to safety and treatment outcomes?**

A blended authority would exacerbate the current confusion that exists between the respective roles of psychologists and psychotherapists. These two groups share similar names but are fundamentally different in philosophy, training and the principles that underlie their work.

2. **Are there any other reasons that it would be in the public interest to have a stand alone or blended authority? If there is potential for a blended authority ….**

None of the existing authorities would seem to be a good match for incorporating psychotherapists. If counselors are to be regulated then they could be considered as a reasonable partner for a blended authority with psychotherapists.

If a blended authority is imposed then using a sub-board approach, such as that used with the Dental Council, would be preferred.

There is minimal overlap or commonality in qualifications or competencies between psychotherapists and psychologists. Psychologists have as minimum qualification a Masters level degree and have completed independent research. Psychologists who register in the "Psychology" scope and work in areas such as Industrial and Organisational, or Sports Psychology, or those who register in the vocational scope as educational psychologists work in quite different areas from psychotherapists and have little in common with them.

The role and qualifications of clinical psychologists should be given special attention in this discussion as they work in the area most closely related to that of psychotherapists, and this is where current confusion in the eyes of the public is strong. Both groups do deliver therapy, but the basis for this and the philosophy behind it is quite different. This is clear from the very different training requirements.

Qualification as a clinical psychologist requires a minimum of six years university study, completing a Masters or Doctoral degree in Psychology **plus** a Postgraduate Diploma in Clinical Psychology **plus** an internship involving 1500 hours of supervised practice. Some of the courses are moving towards the standard qualification being a Doctorate of Psychology (Psy D) with at least seven years of university study. The base psychology training firmly establishes psychologists as scientist-practitioners, with a sophisticated understanding of behavioural principles.

There is not sufficient overlap between scopes of practice to warrant a blended authority. Clinical psychologists are able to make formal mental health diagnoses using recognised classification systems such as DSM or ICD. (Their psychiatry colleagues are the only other mental health discipline able to complete this task). Psychotherapists do not make such diagnoses.

Psychologists are able to use a range of restricted tests, (psychometric and neuropsychological assessment tools) to make formal assessments of such things as intelligence, cognitive function and personality, and aspects of clinical presentation such as depression or anxiety disorders. Psychotherapists are not able to take on these roles or tasks.

Tasks undertaken by clinical psychologists include psychological assessment, conceptualisation and formulation; functional analysis of behaviour; provision of psychological therapies and psychotherapies; psychological interventions, often with complex problems, utilising specific evidence-based therapy modalities including cognitive

behaviour therapies, for individuals, families and groups and at times community level interventions; and the development and evaluation of new methods of psychological intervention. The only task amongst these that applies to psychotherapists is the provision of psychotherapy.

Clinical psychologists are able to take on formal roles under the Mental Health Act, Responsible Clinician, Director of Area Mental Health Service, Duly Authorised Officers. Psychotherapists are not able to take on these roles or tasks.

Clinical psychologists have privilege in a court setting and act as specialist assessors and expert witness in court as defined by legislation such as the Evidence Amendment Act, the Criminal Procedures (Mentally Impaired Persons) Act and the Intellectual Disability (Compulsory Care and Treatment) Act. The courts may order assessments by health assessors – defined as a practising psychiatrist or psychologist – on insanity and fitness to stand trial. Psychotherapists are not able to take on these roles or tasks.

3. **To what extent do the members of the existing regulated and the profession to be regulated, work together? If not, is it in the public interest that they work together more effectively ?**

- While many psychologists and psychotherapists share a similar client group, so do other occupational groups such as psychiatrists, nurses, occupational therapists, social workers and counselors. These clinicians may work as sole practitioners or, in many cases, as members of a multidisciplinary team, each contributing to a package of care. While there may be some areas of overlap, each role has a unique contribution.

Yours sincerely

Nigel Fairley
PRESIDENT