Thank you for the opportunity to respond to the Consultation Paper. As one of the APS Colleges and the only professional organization representing Clinical Neuropsychologists in Australia, with the historical role of accrediting training programs in Clinical Neuropsychology, we will restrict our comments specifically to the guidelines leading to Specialised Area of Practice in Clinical Neuropsychology.

1. Is there anything that is missing from the components of the proposed Accreditation Standards for Psychology Programs?

While the overt intention to provide greater flexibility in the Guidelines is potentially beneficial, there is a risk that flexibility, if not accompanied by effective monitoring of standards will lead to a reduction in standards. Inevitably, there will be a continuation of the strong cost pressures to reduce training content, coverage and monitoring. Without clear mechanisms for accreditation of training courses in Clinical Neuropsychology, there will be an inevitable drift to lower standards.

The Guidelines emphasize strongly the ‘what’ of competencies (but see caveats below) but are light on the “how” of establishing and monitoring competencies. While successful completion of a course leading to Specialised Area of Practice in Clinical Neuropsychology requires ‘supervision’ by a supervisor holding the relevant area of practice endorsement (p. 18), there is no requirement in the Guidelines that overall competence is monitored or established by an appropriately qualified Clinical Neuropsychologist.

Of equal concern is the absence of reference to the APS College of Clinical Neuropsychologists (CCN) or any other professional organization representing competence in Clinical Neuropsychology in Australia (currently there is no organization other than CCN) having any role in monitoring or maintenance of standards under the Guidelines. In other words, it is the explicit intention of the Guidelines to seek to establish competence in Specialised Area of Practice in Clinical Neuropsychology without any formal reference to a representative body of those registered Psychologists in Australia.

Of course, this proposal only formalizes a trend that has been in place for some years, and has resulted in accreditations processes over recent years, for courses leading to endorsement in Clinical Neuropsychology being conducted without formal reference to the CCN. This is a situation that is unacceptable to the College, and we question the basis on which APAC asserts competence to accredit endorsement or Specialised Area of Practice in Clinical Neuropsychology without formal reference to the College?

The specific guidelines for Specialised Area of Practice in Clinical Neuropsychology (Section 4.1) represents a truncated version of the CCN course-approval guidelines which used to be the basis for
course accreditation and omits many essential competencies. In addition the specific guidelines in Section 4.1 include a heavy emphasis on conditions arising from ‘neuropathology.’ This emphasis reflects an out-dated model of neuropsychological practice and does not do justice to the wide variety of patients who seeks services from Clinical Neuropsychologists in the public and private sector. To give just one example, mild traumatic brain injury (TBI), constituting approximately 80-90% of all TBIs, commonly produces symptoms of ‘post-concussional syndrome’ which may develop, if not managed appropriately, into a significant psychological condition including potential for symptom exaggeration. It is generally assumed that there is no neuropathology associated with the majority of patients suffering mild TBI. There is no requirement in the guidelines that this condition to be covered.

There is no mention of the specifics of a host of other conditions that Clinical Neuropsychologists address, only some of which address known pathologies, including the myriad developmental brain disorders, TBI, substance misuse, psychosis, and other Axis 1 disorders comorbid to common neuropsychological conditions, dementias, cognitive and behavioural manifestations of systemic/medical illness (e.g. liver disease, kidney disease, chronic respiratory illness etc) and the multitude of medical illness that affect cognitive and broader psychosocial function. While it might be imagined that knowledge of some or all of these disorder would be covered under the general terminology of Section 4.1, the ‘flexibility’ in the Guidelines raises the possibility that none are specifically required. In the absence of detailed explicit competency criteria in the Guidelines, it is hard to image how competence in these core areas of neuropsychological practice will be established. It is difficult to avoid the conclusion that the Guidelines, if adopted, will lead to a loss of competence in the Clinical Neuropsychology workforce in Australia, over time.

International best practice involves establishing competency by examination and scrutiny of work competency adjudicated by a panel of peers who have satisfied the peer-reviewed standard, e.g., BPS Division of Neuropsychology; American Board of Professional Neuropsychology. Currently, APAC accreditation processes only include a single endorsed neuropsychologist, selected by APAC, not the CCN.

Knowledge of psychopharmacology including common psychotropic medications was not listed under the competencies for Clinical Neuropsychology. We believe this is an essential competency for neuropsychologists.

A general concern with the Guidelines relates to the lack of specification regarding “sufficient” training. In the absence of clear specification of sufficiency, it is easy to imagine much confusion amongst training providers and much variation in standards. Similarly, “APAC requires regular benchmarking and reviews of each of the programs where the scope and outcomes are clearly identified” (p. 38) but the detail and processes of the benchmarking are not described. In the case of Specialised Area of Practice in Clinical Neuropsychology we request the APS CCN be involved in the benchmarking, and would have no confidence in accreditation processes that did not include colleagues nominated by the CCN.

The proposed guidelines contain a minimum number of hours for placements, but not for coursework. Theoretically, this could mean that a program could include minimal or no coursework at all, and be an entirely on-the-job training in the context of placements. We believe that allowing for this possibility would be highly undesirable.

Regarding placements hours, we would advocate for the direct client contact requirement be removed, or the definition of direct client contact be substantially broadened (e.g., to include
providing secondary consultation to significant others involved with the client, collecting other information about the client, etc).

We would argue that exposure to a range of clients is more important than face to face hours, and align better with the new structure of the competencies. For example, Clinical Psychology and Clinical Neuropsychology trainees could be required to demonstrate involvement in both therapy/intervention and assessment activities during placement.

No minimum number of hours of supervision is specified. P.18 states ‘In each case, hours of supervised psychological practice must comply with the PsyBA’s general registration standard’. However, the PsyBA Registration Standard: General Registration does not specify the number of supervision hours required for a Masters or Doctorate training program, only for 4+2 and 5+1 psychologists. In this case, there is strong evidence that clinical supervision improves psychologist competence; therefore, we would advocate for a minimum of at least 1 hour of supervision (either individual or group) per 17.5 hours of practice, consistent with the requirements of other kinds of provisional psychologists.

2. Is the introduction to the Accreditation Standards for Psychology Programs contained in the Preamble and Application of the Standards sufficient to guide the use of the standards?

We would have found it helpful if the pre-amble had clearly listed the main changes from the previous set of standards. Also, it would have been useful to clarify that the new standards replace the previous College guidelines that were used for accreditation of specialist postgraduate programs leading to an area of practice endorsement, as well as the previous APAC standards.

3. Should the Graduate Competencies specify that one level must be completed before the next can be undertaken.

Yes. This will ensure that students do not continue in programs if they are not able to meet baseline competencies. It is not helpful for students to invest money and commitment to a program if they are unlikely to achieve a positive outcome. In addition, supervisors find it increasingly difficult to terminate a student who is not reaching competency level when the issue is being addressed in the final stages of training. Furthermore, resources invested by the HEP are considerable and need to be carefully invested in each student cohort.

If concerns are raised about a student’s competency-level, these should be dealt with near the beginning of professional training and not delayed. This could be achieved at the end of a first year of a two-year master’s training in a specialised area of practice and/or at the end of two years of doctoral-level training in a specialised area of practice.

4. Should APAC accredit the internship year following five years of academic work?

Yes. As APAC is assuming oversight of psychological practice for the protection of the public, it is necessary that any psychologist who is to be provided general registration by completing a year of professional practice should be required to have achieved certain competencies in applying psychological knowledge as proscribed by APAC. This would be (partially) achieved by APAC developing standards for the internship.

5. Are the Graduate Competencies listed under each level helpful and logical?

Graduate competencies were generally helpful and appropriate. However:
All competencies are now phrased as “apply advanced knowledge...” This seems a little broad and generic. Some competencies require other verbs such as “demonstrate”, “state”, “critically evaluate”.

6. Are the Graduate Competencies under each level grouped appropriately?
7. Is the information in the Evidence Guide helpful and logical?
8. Are there terms in the Accreditation Standards for Psychology Programs that have not been defined in the glossary and should be?

No additional comments on the above.

9. Are there any other issues?

Professional Competencies for specialised areas of practice have now been predicated on completing 1000 hrs of practical placement and 400 hours of direct client contact. This number of 400 hours is the traditional clinical psychology benchmark and is now to be imposed across specialisations. Previously CCN used completion of 50 cases (and competency) as the requirement for master’s level training in neuropsychology. The importance of the change is how direct client contact is determined. For clinical psychologists, it is usually considered as ‘face to face’. However, neuropsychologists operate differently to clinical psychologists in clinical practice. In neuropsychology a lot more time is spent in report writing (hours) and associated client-related tasks so this needs to be included within the hours of direct client contact.

Some rough workings suggest that to achieve 400 hours of face to face direct client contact within a Masters degree, in each of the three external 45 day placements there would need to be 135 direct client hours, or 3 hrs per day. The most common task for neuropsychology students on placements continues to be assessment. 3hrs of direct assessment on each and every day of placement may represent quite a heavy load for students and for supervisors to provide. In contrast, if the 3hrs represents/includes time spent on case preparations, report writing etc, 3hrs would be easily achieved. By comparison, if each of 50 neuropsychology cases typically involved only 2hrs of face-to-face assessment, this would result in only 100 hrs of direct client hours across the whole masters degree.

Therefore, there is a need to be some clarification of what can be included in direct client hours as clinical neuropsychology operates differently to clinical psychology.