Commentary on *Lobbying for endorsement of Community Psychology in Australia*

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In their interesting and highly reflective article, my Aussie colleagues have nicely encapsulated some of the dilemmas and challenges which also face community psychologists on this side of the ditch. (For readers unfamiliar with downunder colloquialisms and/or geography, the "ditch" is the 2,000 kilometre-wide Tasman Sea which separates the east coast of Australia from the west coast of Aotearoa/New Zealand[16].) Like our cousins, we have often suffered from low visibility, we have had to fight for recognition, and we have had to resist hegemonic models of what constitutes psychology. Like them, it has often been our political nous, our networking and our advocacy skills which have carried the day.

Commentators were asked, could the struggle described by Lynne Cohen and her colleagues happen here? The short answer is yes. In some ways, it already has, although because of some contextual differences, we chose to pursue a different direction as I will explain below.

The statutory arrangements which regulate psychology in Aotearoa/New Zealand underwent a radical change in 2003 with the enactment of the Health Practitioners Competence Assurance Act. This established a common framework for the regulation of a wide range of health professions from psychologists, to doctors, nurses, dentists, mid-wives and physiotherapists, each with its own board to oversee it. The purpose of the legislation is "to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions" (s.3). One important mechanism is control over the use professional titles. Under the Act, it is an offence to hold oneself out to be a "health professional" unless one is registered with the relevant board (s.7.1). This means that however we might self-identify, we cannot call ourselves psychologists unless we are registered.

As Cohen and her colleagues note, there are some differences between Australia and Aotearoa/New Zealand in the way sub-disciplines are regulated. Here we have what is effectively a two-tier system comprising of a general scope (termed "Psychologist") and "vocational" scopes. Originally, two vocational scopes were established: "Clinical Psychologist" and "Educational Psychologist." Recently, a third scope, "Counselling Psychologist," was approved. Thus community psychologists are registered in the "psychologist" scope, along with organisational psychologists, health psychologists, sports psychologists, correctional psychologists and others.

It is important to appreciate that scopes of practice do not prescribe what one can and cannot do within a particular scope, at least not in any meaningful way. The definitive differences between scopes are the qualifications needed to enter them. That is, scopes limit the use of certain titles by linking them to prescribed qualifications rather than limit areas of practice per se.[17] This is hardly surprising: how could one write a definition of, say, clinical psychology, without calling on concepts common in other sub-disciplines (e.g. assessment, intervention).

The fragmentation of psychology

During the latter part of the last decade, community psychologists discussed but rejected the idea of seeking approval for a vocational scope for community psychology. Given the objective of the legislation, we would need to show that a community psychology scope was required to protect the health and safety of the public. While our work rarely poses imminent risks to identifiable individuals, we reasoned that it often carried significant risks for communities and societies. However, we quickly concluded that the effort and cost of administering a vocational scope for such a small number of community psychologists was probably unsustainable. Moreover, it did not seem

[16] The name "New Zealand" (after the Dutch province of Zeeland) was adopted by early colonists. "Aotearoa" reflects the earlier tradition of indigenous Māori. Increasingly, both terms are being used to signal the bi-cultural foundation of the modern nation state.

[17] The definitions have very similar wording appearing in all three vocational scopes and, to a lesser degree, in the general scope. See http://www.psychologistsboard.org.nz/scopes-of-practice2

to make much sense to divide psychologists into a series of guilds. Interdisciplinarity is a strong feature of community psychology. It would seem counter-productive to create a guild which excluded critical psychologists, kaupapa Maori psychologists[18], cross-cultural psychologists and applied social psychologists – or forced them to accept our nomenclature. Neither would it help build links with, for example, progressive clinical and organisational psychologists who are often important allies.[19] In fact, the further fragmentation of professional psychology into numerous guilds is probably in nobody's interest. Cohen et al's reference to Victoria abandoning specialist registration during the 1990s is instructive here.

In my view, the availability of a generic Psychologist has been an advantage to community psychology in Aotearoa/New Zealand. The battle for statutory recognition described by Lynne Cohen and her colleagues has not been necessary. Instead, there have been different sorts of battles. Principal among these is challenging the clinic-centric thinking which dominates Board decision making. This is almost inevitable given the numerical dominance of clinical psychologists within the profession and among psychologist members of the Board. It is also closely related to the construction of psychology as a health profession.

Community psychologists as health professionals

There is some ambivalence among community psychologists about being positioned as health professionals. While many of us consider ourselves to be in the business of health, broadly defined, we do not feel comfortable with the dominant construction of "health professional": the assumed rational, dispassionate and objective expert who classifies and treats individuals experiencing ill-health. We feel uncomfortable with the medicalization of poverty, stigma and oppression. We do not see ourselves as treating individual clients. If there is a client, it is more likely to be a community, an organisation or a society than an individual. And the desired solutions to the challenges they face are unlikely to be therapy but conscientization, liberation and progressive economic, social and cultural policies.

A recent debate concerning the standards for the accreditation of training programmes exemplifies the need to be vigilant regarding the clinic-centric thinking of the Board. Originally it was proposed that training programmes would be required to ensure that interns had an on-site supervisor who was a registered psychologist. This may well make sense for clinical psychology interns who are working in clinics providing services to individual clients who may be at imminent risk to themselves or others. It does not make sense for community psychology interns whose work rarely poses an imminent risk to identifiable individuals. Moreover, community psychology interns often work in settings in which they are the only psychologist. Indeed, for some interns there is no site as such. While it is obviously important that interns are supported and supervised, for community psychology interns, this generally needs to be a responsibility shared between university and other supervisors or mentors external to the setting. After some debate, a guideline was developed that better reflected the diverse realities of internships outside the clinical psychology norm.

We are not the only sub-discipline to chafe against the positioning of psychology within this hegemonic version of health practitioner. Like community psychologists, organisational psychologists tend to find the clinical-centric policies and practices of the Board onerous and not particularly relevant to their work. The same is true for many academic and research psychologists but in addition, many of them cannot legally use the term psychologist because they do not hold one of the professional qualifications accredited by the Board.

Community psychologists as psychologists

As Lynne Cohen and her colleagues note, Australian community psychologists have much in

[18] Kaupapa Maori Psychology is a term often used to describe a psychology based on Maori world views. See Levy, M., Nikora, L.W., Master-Awatere, B., Rua, M.R., & Waitoki, W. (2008). Claiming Spaces: Proceedings of the 2007 National Maori and Pacific Psychologies Symposium, 2-24 November, Hamilton. Hamilton: Maori and Psychology Research Unit.

[19] Good examples within a New Zealand context are (a) John Read, clinical psychologist who has exposed the role of poverty and abuse in the development of psychosis and (b) Stuart Carr, an organisational psychologist whose work addresses poverty on a global scale. See for example

(a) Read, J. (2010). Can poverty drive you mad? 'Schizophrenia', socio-economic status and the case for primary prevention. *New Zealand Journal of Psychology39*: 7-19

(b) Carr, S.C. & Bandawe, C.R. (2011). Psychology applied to poverty. In Martin, P.R. et al. (Eds). *International Association of Applied Psychology Handbook of Applied Psychology*, 639-662. Wiley-Blackwell.

common with other people outside the psychology tent: among them, community development workers, social planners, indigenous health workers and political activists. The same can be said of community psychologists in Aotearoa/New Zealand, although here the list might be extended to include policy analysts, health promotion workers and evaluation researchers. In fact, many people who have been trained in community psychology identify with psychology to only a limited extent. This is reflected in at least two ways. Firstly, very few of them carry community psychologist as a job title. Secondly, it is reflected in membership of professional organisations. For example, while exact numbers are not available, it is almost as easy to find a community psychologist at a meeting of the Aotearoa/New Zealand Evaluation Association as it is at a meeting of the New Zealand Psychological Society. Because the Psychologists Board maintains a public register, it is possible to calculate the number of registered psychologists who have a professional qualification in community psychology. In New Zealand, that means a post-graduate diploma in community psychology from the University of Waikato, the only accredited professional training programme in community psychology in the country. When I checked the register a couple of years ago, I found only 18 of our graduates listed as having a current practising certificate. At that time, there were approximately 90 graduates of our programme. That is, 4 out of every 5 graduates (approximately) do not hold a current practising certificate. And, as previously mentioned, they cannot legally call themselves a psychologist.[20]

Does this matter? Possibly not. There are many settings and roles in which the values, skills and knowledge of community psychology can be put to good effect. If our graduates had been restricted to those roles which accord with the dominant conceptualisation of "psychologist" they would have had made a much reduced contribution to community wellbeing and social justice. On the other hand, because so many of them fly under the official psychology radar, so to speak, it can be argued that they have had a smaller impact on the wider discipline of psychology than might otherwise have been the case.

The future

It would be nice to conclude this commentary with some sound advice about how to avoid the sort of marginalisation that community psychologists in Australia had to resist. If the experience thus far in Aotearoa/New Zealand has anything to offer it is the value of promoting a broad conception of professional psychology. Imperfect though it is, the availability of the general Psychologist scope has been beneficial to community psychology. However, as our history shows, this is not necessarily to liking of some of our siblings. Whether one attributes it to professional snobbery or a concern to protect vulnerable members of the public, it is quite likely that we will see a continued growth in the number of sub-disciplines seeking their own vocational scope.

I suspect that we will continue to fight battles for recognition and voice. It could hardly be otherwise. A field which prides itself on having a social conscience and a commitment to social justice will never be warmly welcomed into the ranks of professional elites. Nevertheless, there probably is value in fighting for our right to be at the table. At the table, we can engage our colleagues in conversation, even if sometimes we will need to pound the table to be heard. The trick is to never forget why we are there. It is merely a means to an end. To forget that, to become comfortable diners, will make us just another elitist guild, more problem than solution.

[20] More correctly, they cannot hold themselves out to be *practising* psychology. One can be on the register without holding a practising certificate. Such a person can call her- or himself a psychologist but cannot "practise".