UNSW Medicine & Health, Discipline of Psychiatry and Mental Health, The Department of Developmental Disability Neuropsychiatry 3DN

Submission to The Psychology Board of Australia:

Public Consultation – Updating the competencies for general registration

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About Us

The Department of Developmental Disability Neuropsychiatry (3DN) UNSW Sydney is pleased to have the opportunity to make this submission to The Psychology Board of Australia (hereafter "the Board") in regards to the competencies for general registration of psychologists (hereafter "the Competencies"). 3DN is led by Professor Julian Trollor and is part of the Discipline of Psychiatry and Mental Health within UNSW Medicine & Health. This submission is co-authored by Dr Samuel Arnold, lecturer and registered psychologist, former convenor and treasurer and current committee member of the Australian Psychological Society (APS) Interest Group on the Psychology of Intellectual Disability and Autism. 3DN champions the right of people with an intellectual or developmental disability, including autistic people, to the same level of health and mental health care as the rest of the population. We promote a standard of excellence in clinical practice, research, workforce development, education, and policy in the field of intellectual and developmental disability mental health.

3DN previously coordinated the Australian Longitudinal Study of Autism in Adulthood (ALSAA; Arnold et al., 2019) and associated studies, which was funded largely by the Australian Government through the Cooperative Research Centre for Living with Autism (Autism CRC). Importantly, the ALSAA profiled the situation of Australian autistic adults, with outputs identifying the underemployment and underutilisation of autistic adults in the Australian workforce, barriers to healthcare and to adult diagnosis, off label psychotropic prescribing, high rates of loneliness, suicidality, mental illness and comparatively poorer quality of life among other findings. The 3DN departmental submission to the *Senate Select Committee on Autism* enquiry drew heavily on ALSAA findings. As well as being called to give evidence, this submission to the Senate Select Committee was cited 90 times in the final report. The committee findings led to federal budget allocation and on-going work towards developing the first *National Autism Strategy*, key priorities including improving health services for autistic people, service integration and coordination.

3DN has a significant background in research and advocacy regarding intellectual disability. Of potentially particular interest to the Board, 3DN has previously developed an *Intellectual Disability Mental Health Core Competency Framework*, including a manual and toolkit for mental health professionals (see https://www.3dn.unsw.edu.au/IDMH-CORE-COMPETENCY-FRAMEWORK). These competencies were developed following comprehensive national consultation processes and have been positively evaluated (Eagleson et al., 2022). More recently, 3DN has supported the drafting of core capabilities in intellectual disability health with the Commonwealth Department of Health, as well as supporting the development of a *National Roadmap for Improving the Health of People with Intellectual Disability* (https://www.health.gov.au/resources/publications/national-roadmap-for-improving-the-health-of-people-with-intellectual-disability). We commend these national efforts to the Board and believe they would be of assistance in developing specific competencies for psychologists.

Note on Terminology

The language preferences of people on the autism spectrum vary, but many adults prefer identity first language (Autism CRC, 2017; Kenny et al., 2016). In response to this, the use of various terms such as "autistic person" or "autistic people", or where more appropriate "on the autism spectrum" are used throughout this submission, except in specific reference to autism diagnosis.

The Consultation

We are pleased the Board is reviewing the competencies for psychologists for general registration, and would like to provide the following submission. We are focussed on two questions posed by the Board:

"11. The Draft professional competencies for psychologists include an expanded core competency on working with people from diverse groups, including demonstrating cultural responsiveness (updated Competency 8).

Is there any content that needs to be clarified, added, amended or removed? Please provide details."

And:

"12: The Draft professional competencies for psychologists outline eight updated core competencies:

Competency 1: Applies scientific knowledge of psychology to inform safe and effective practice
Competency 2: Practices ethically and professionally
Competency 3: Exercises professional self-reflection and deliberate practice
Competency 4: Conducts psychological assessments
Competency 5: Conducts psychological interventions
Competency 6: Communicates and relates to others effectively and appropriately
Competency 7: Demonstrates a health equity and human rights approach when working with Aboriginal and Torres Strait Islander Peoples, families and communities
Competency 8: Demonstrates a health equity and human rights approach when working with people from diverse groups.

Do you suggest any changes to the eight core competencies and their descriptors? What would you like to see changed?"

Systematic Neglect and The Need for Specific Descriptors Regarding People with Intellectual or Developmental Disabilities (including autism)

The current *Australian Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (2020) gave an interim finding that "there has been, and continues to be, systemic neglect of people with cognitive disability in the Australian health system" (p. 27). Although there is brief mention of "disability, cognitive capacity" within the draft Competency 8, we would like to provide evidence that more specific focus and attention is needed, given the scale of need and level of skill required to provide psychological services to people with intellectual or developmental disabilities. We are hopeful that the Board does not perpetuate this current "systematic neglect" by having insufficient attention given people with intellectual or developmental disabilities within the competencies.

Prevalence and Mental Health Burden in Intellectual Disability

Intellectual disability is defined as a development disorder with onset before 18 years of age, with reduced intellectual ability and significant impairment in areas adaptive behaviour. A person with intellectual

disability may have difficulty with thinking skills that impact planning, problem solving, abstract thinking and learning. They may also experience difficulties with communication, social skills, and independently managing daily activities. People with intellectual disability make up a significant portion of the Australian population. A study using registry data in Western Australia gives estimates of 17.0/1000 livebirths with intellectual disability (Bourke et al., 2016). Previously the Australian Institute of Health and Welfare (AIHW) estimated an Australian population prevalence of 1.86% for intellectual disability (Wen, 1997).

Unfortunately, people with intellectual disability experience grossly higher rates of mental health burden than their non-disabled peers. These rates are heightened due to compounding disadvantages across medical, social and psychological factors. Forthcoming research from our department, using large linked administrative datasets, and achieving an almost whole of NSW population ascertainment of people with intellectual disability, in comparison with matched controls, has identified a two to threefold period and annualised prevalence of psychiatric disorder and three to fourfold prevalence of serious mental illness. This strengthens a recent first ever meta-analysis (Mazza et al., 2020) highlighting the multi-fold increased prevalence of psychiatric disorder in intellectual disability .Earlier work from our department has identified that whilst only making up a smaller percentage of the general population, people with intellectual disability make up 6% of public mental health service users in NSW and 12% of the mental health budget spend (Srasuebkul et al., 2021). This excludes Medicare Benefit Schedule (MBS) funded services, where our department is working to update these indicators to include MBS and identify whole of government costs in the near future.

These disproportionate rates of mental illness and related costs to the Australian taxpayer are not simply the result of biological predisposition, research has identified barriers to preventative and primary mental health care, ineffectiveness of care and longer acute stays with poor transition to community services (Srasuebkul et al., 2021). Updating the competencies to include more attention to the needs of people with intellectual disability could provide some impetus to shift the current “systematic neglect”, reduce the barriers to engaging with suitably skilled psychologists and the too often ineffective care received by people with intellectual disability.

Prevalence and Mental Health Burden in Autism

Autism Spectrum Disorder (ASD) is defined as a developmental disorder characterised by impairments in social communication, and restricted or repetitive behaviours, interests, or activities. This heterogeneous and complex disorder impacts on daily functioning ranging from mild to profound (Williams et al., 2014). Over 60% of the people on the autism spectrum have a disability involving profound or severe restrictions in core activities of daily living (Australian Bureau of Statistics, 2016). A combination of developmental assessments and behavioural observations are used during the diagnostic process (Whitehouse et al., 2018).

According to data from 2015, approximately 1 in 150 Australians, or 0.7% of the population are estimated to be on the autism spectrum (AIHW, 2017). Over the past 70 years, the reported worldwide prevalence of autism has increased dramatically from 4 in 10,000 people to 1 in 100 people (Ward et al., 2016). Australian statistics reflect this rise, with a 79% increase in the number of children diagnosed with autism since 2009 (Autism in Australia, 2009). It is likely that improved clinician awareness, screening practices

and expanded diagnostic criteria are the chief drivers behind these significant shifts in prevalence (Hansen et al., 2015; King & Bearman, 2009; Ward et al., 2016). Given childhood rates of 1 in 54 recently reported in American studies (Maenner, 2020), and the fact that autism is a lifelong condition, we highlight to the Board it is likely that Australian data are underestimating the true population prevalence of autism.

International systematic reviews report autism prevalence among people with intellectual disability to fall between 8% and 30% in adult populations (Emerson & Baines, 2010), and between 4.5% and 25.1% in younger populations (Oeseburg et al., 2011). Factors such as severity of intellectual disability, sample selection and diagnostic criteria used in studies all contribute to this variance (Dunn et al., 2019). Prevalence of intellectual disability among autistic people falls between 15% and 84% (Emerson & Baines, 2010). Co-occurring prevalence rates have declined with expanded autism diagnostic criteria and the identification of more autistic people with less intense or constant support needs (Dunn et al., 2019).

Physical and mental health co-morbidities (Arnold et al., 2019), core adaptive functioning impairments and other vulnerabilities commonly occur in autistic populations (Henninger & Taylor, 2013). Very high rates of mental ill health have been reported (Kohane et al., 2012; Mannion & Leader, 2013). Depression and anxiety disorders are the most common conditions experienced. Whilst most research has focused on children and adolescents (Gillberg & Billstedt, 2000; Simonoff et al., 2008), very high rates of mental ill health are also observed in autistic adults internationally (Croen et al., 2015; Lever & Geurts, 2016) and in Australian adults on the autism spectrum (Cvejic et al., 2018; Hedley et al., 2018; Uljarević et al., 2019). A striking feature is the very high rates of suicidal ideation (Hedley et al., 2018) experienced by this group. While Australian data relating to suicide attempts is limited, a large 2015 US study comparing health of autistic adults with a non-autistic control group found a 5-fold risk of suicide attempts in the autistic group (Croen et al., 2015). There are significant implications of these complex presentations to the delivery of psychological services to this group.

The Need for Adaptations to Psychological Practice for People with Intellectual Disability

There is general recognition that people with intellectual disability need adaptations to practice to be able to effectively engage in psychological therapies (Dagnan et al., 2023; Man & Kangas, 2020). Limited cognitive ability, verbal communication skills, difficulty with abstract thinking, sensory processing and social skills difference can all impact on the ability to engage in typical therapy which is likely to be heavily verbal, involve complex abstract concepts and utilise social cues between the psychologist and client.

Too often there is limited availability of specialist expertise in intellectual disability (Weise & Trollor, 2018). This compounds the barriers faced by people with intellectual disability accessing psychological services, where practitioners are ethically required to only practice within their perceived areas of competence. However, specialisation is not required, simple adaptation is sufficient to enable people with intellectual disability to engage with e.g. Cognitive Behaviour Therapy (Dagnan et al., 2023), which is likely within the scope of competencies for a psychologist with general registration with sufficient formal training. A survey of 109 Australian psychologists (Man et al., 2017) highlights the current lack of formal training in intellectual disability, 85% of respondents indicating a need for training in this area. Giving more focus to intellectual disability in the competencies would go some way in driving change to fulfil this area of need.

The Needs for Adaptations to Psychological Practice for Autistic people

Autistic individuals have unique sensory, communication, and social processing differences that can impact how they experience and respond to traditional therapy techniques. For example, autistic individuals may struggle with eye contact, understanding of nonverbal cues, or may be overwhelmed by sensory input such as bright lights, loud noises, or certain textures. Although guidance for the delivery of psychological services to autistic people is dispersed (Petty et al., 2021), there is growing evidence that adaptations to therapy are needed and can be effective (Cooper et al., 2018; Spain et al., 2015). This is a rapidly growing and changing area, with neurodiversity-affirming approaches now being mentioned in the literature (e.g. Dawson et al., 2022), promoted by practitioners and the subject of emerging research and conference presentations. Importantly, autistic adults have reported the detrimental impacts and misdiagnosis experienced from engaging with practitioners who lacked appropriate autism knowledge (Arnold et al., 2023).

Our suggested change to the competency descriptors

We are pleased that the competencies drafted by the board include "Competency 8: Demonstrates a health equity and human rights approach when working with people from diverse groups". However, given the scale of need and systematic neglect outlined, we feel it is currently insufficient to simply describe in 8.1 "Works without discrimination and is inclusive, sensitive and respectful of all forms of individual diversity in clients…disability, cognitive capacity". It is also important to note that in 8.6 "Adapts psychological practice… needs of people with diverse social identity groups" that intellectual disability or autism are not simply social identity groups, they are complex disabilities where a depth of understanding is needed to provide effective psychological services that are beneficial and cause no harm to the client. The competencies as drafted will fail to achieve health equity for people with developmental disability. We are aware that many Australian universities undergraduate psychology courses still contain insufficient, limited and deficit focused education regarding autism and intellectual disability.

We suggest the following additional descriptor is added to competency 8:

> *Understands neurodiversity, strengths-based, trauma-informed and positive approaches to supporting people with developmental disability, and demonstrates the ability to adapt psychological practice and make reasonable adjustments for people with disability, including understanding of alternative and augmentative communication.*

In brief, we suggest the inclusion of specific concepts and practice models, whilst acknowledging this is a rapidly growing and changing area of practice, as without knowledge of these approaches, we fear a continuation of the circumstances where we have autistic research participants reporting misdiagnosis and harm arising from incompetent practitioners. These suggested practice models are frequently discussed within disability scholarship and practice, have growing evidence bases and we believe represent the current best practice in supporting people with developmental disability.

Neurodiversity:

Neurodiversity is a concept that emphasises the natural variation in human brains and minds. It recognises that individuals have unique neurological differences, which can manifest in a variety of ways, including differences in learning, communication, and behaviour. The concept of neurodiversity aims to shift the

focus from viewing neurological differences as deficits or disorders to recognizing them as natural variations that can bring strengths and abilities to individuals and society.
As a practice model, neurodiversity emphasizes the need to understand and accept individual differences and to create environments and support systems that accommodate diverse ways of thinking and being. This model recognizes that individuals with neurological differences may require different types of support and accommodations to thrive, and that there is no one-size-fits-all approach. Neurodiversity affirming positions neurological difference as potential strength rather than deficit and is aligned with social model approaches to disability.

Strengths-based approaches:
Strengths-based approaches refer to psychological interventions that emphasise identifying and building upon an individual's existing strengths, talents, and resources, rather than focusing solely on their problems and weaknesses. Practitioners work collaboratively with the individual to identify their unique abilities and interests, and then use these strengths to build resilience, increase self-efficacy, and overcome obstacles. By fostering a positive and empowering relationship with the individual, strengths-based approaches promote a sense of hope, optimism, and motivation that can lead to improved well-being and a higher quality of life.

Trauma-informed approaches:
Trauma-informed approaches are a set of principles and practices designed to promote safety, trust, and empowerment in individuals who have experienced trauma. These approaches recognise that trauma can have a profound and long-lasting impact on an individual's psychological well-being, and that traditional approaches to therapy may not be effective for those who have experienced trauma. A trauma-informed approach involves creating a safe and supportive environment for clients, focusing on building a therapeutic alliance based on trust, collaboration, and respect. Practitioners using a trauma-informed approach also seek to understand the unique needs and experiences of their clients, including the impact of trauma on their lives. This approach emphasises the importance of empowering clients to take control of their own healing journey and providing them with the tools and resources they need to build resilience and recover from trauma.

Positive approaches: (including positive behaviour support and person-centred thinking)
Positive approaches refer to a set of principles and practices used to promote well-being, positive outcomes, and quality of life for individuals. Positive behaviour support is one example of positive approaches that involves identifying the underlying reasons for behaviours of concern (e.g., hurting self or others) and developing strategies to address these while promoting positive alternative behaviours and overall strategies to promote quality of life. Not to be confused with Carl Rogers person-centred therapy, person-centred thinking is another positive approach that emphasises valuing the person's perspective and placing them at the centre of their support planning and decision making. It provides a range of tools that also look to involve key people in operationalising support for the person and connecting the person with valued roles in the community. Positive approaches emphasise collaboration, respect, and empowerment, and aim to foster independence and self-determination in the provision of support. Practitioners using positive approaches work to create a supportive and inclusive environment that promotes social connections, positive outcomes, and overall well-being.

Reasonable adjustments:
Reasonable adjustments refer to modifications made to environments, assessments, interventions, or support services to accommodate the unique needs of individuals with disabilities. These modifications may include for example simplifying language and instructions, using visual aids, providing additional time or breaks during assessments, or using alternative assessment methods. Psychologists working with individuals with intellectual disabilities may also need to adapt their communication style and use alternative methods of communication, such as picture-based communication systems or sign language. Additionally, psychologists may need to work collaboratively with other professionals, such as speech therapists or occupational therapists, to provide a holistic approach to assessment and intervention. Reasonable adjustments are implemented to comply with anti-discrimination laws and disability rights legislation, to ensure that people with disabilities are not unfairly disadvantaged in accessing services or participating in society.

Alternative and Augmentative Communication:
Alternative and Augmentative Communication (AAC) refers to a range of methods and tools that are used to enhance or replace traditional forms of communication for individuals who have difficulty with verbal language. AAC includes a variety of techniques such as sign language, gestures, facial expressions, pictures, symbols, electronic devices, and computer-based systems that enable individuals with communication difficulties to express themselves and interact with others. AAC can be temporary or permanent and can be tailored to the individual's needs and abilities. AAC is particularly useful for individuals with developmental disabilities, as well as people with acquired disabilities, such as stroke or traumatic brain injury, who have difficulty with speech, language, or writing.

The time for change and benefit to psychology in Australia generally

With an approaching *National Autism Strategy* and existing *National Roadmap for Improving Health of People with Intellectual Disability* the time has come for increased recognition and attention to the needs of people with developmental disability to achieve health equity. The upcoming *APS 2023 Members Symposium* is focused on the members chosen topics of neurodiversity and trauma, highlighting the Australian psychological workforce's interest in these areas and acknowledgement of existing lack of training.

We would also briefly highlight the transferability of these approaches to improving psychological practice more broadly. For example, trauma-informed approaches are applicable to many clients who may be seeking treatment for a core issue that does not immediately appear as impacted by traumatic experiences. Positive behaviour support not only teaches an application of learning theory which is often a focus of first year psychology education, though is also core element to many childhood and educational practices. Strengths-based approaches are applicable to many models of mental health treatment, and aligned with the recovery movement and solution-focused therapies. Alternative and augmentative communication can also be useful again with children or people with acquired disability. Reasonable adjustment also applies to clients with psychosocial disability.

Closing

Thank you for the opportunity to respond to this consultation. We would be happy to provide more detailed or thorough responses or rationale if needed, and to engage with the Board to improve the competencies for the benefit of people with developmental disability, and the practice of psychology in Australia more broadly.

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