Accreditation Systems Review

Response to Discussion Paper

1 May 2017
# Contents

1. Introduction ........................................................................................................................ 3
2. Background: Psychology Education within the National Registration and Accreditation Scheme .............................................................................................................. 6
3. Executive Summary ............................................................................................................. 9
4. Commentary on Issues and Responses to Questions ...................................................... 11
   4.1. Improving Efficiency ............................................................................................... 11
   4.2. Relevance & Responsiveness .................................................................................. 16
   4.3. Producing the Future Health Workforce ................................................................. 20
5. Conclusion ......................................................................................................................... 29

Appendices: .................................................................................................................................. 30
   Appendix 1: Pathways to becoming a Registered Psychologist ................................................. 31
   Appendix 2: Numbers of programs in each category accredited by APAC .................................. 32
   Appendix 3: Example of IPE Framework: Griffith University (extract only) ......................... 33
1. Introduction

The Australian Psychology Accreditation Council (APAC) welcomes the opportunity to respond to the Discussion Paper, dated February 2017, which forms part of the independent review of accreditation systems within the National Registration and Accreditation Scheme (NRAS).

We welcome also the Review’s concern to look beyond superficial assessments of costs, to the foundations of the system and the possible tensions and shortcomings therein. We commend its focus on innovation and improvements that may be made that are in keeping with contemporary thinking in accreditation.

In this submission we endeavor to provide constructive responses to the key questions asked, relating to governance, accountability and efficiency and the capacity of the scheme to support the future health care needs of the community.

Our submission follows the structure of the Discussion Paper. We provide for each of the three sections a general response highlighting aspects of the scheme particularly of concern in psychology accreditation, followed by our responses to the questions posed.

Our over-riding concern, in keeping with the basic tenet of the NRAS, is to maintain the highest quality of education of psychology professionals, and thereby to contribute to the scheme’s primary objective, the protection of the public.

About APAC

APAC’s mission

APAC’s mission is to protect the public by conducting accreditation activities that ensure graduates of accredited programs receive a high quality education and are well equipped to employ their psychological knowledge and skills in the community. This includes, where relevant, being sufficiently qualified and competent to meet the registration requirements of the Psychology Board of Australia.

APAC is a not-for-profit Company Limited by Guarantee, governed by a board of 12 Directors. APAC’s work is undertaken by 5 EFT staff reporting to the CEO, and a core team of 12 specially trained assessors, with additional assessors drawn from a pool as needed.

APAC was formed in 2005, primarily for the purpose of setting national standards for the education and training of psychologists and to accredit programs of study which meet those standards. Prior to this the functions now undertaken by APAC were performed by the Australian Psychological Society. In 2008, under arrangements set down in the Health Practitioner Regulation National Law, the Australian Health Workforce Ministerial Council assigned to APAC the accreditation functions for the psychology profession under the National Registration and Accreditation Scheme for the

1 In addition, at present the Australian Psychological Society (APS) assists with accreditation of (specialised) Areas of Practice, using APS College standards; this arrangement will change once new standards are adopted.
Health Professions. In May 2014 APAC was re-assigned the accreditation function until June 2018, (now extended to June 2019).

APAC accredits more than 400 programs of study across 41 higher education providers, and maintains an accreditation archive containing records dating as far back as 1971.

APAC’s three Members are: the Australian Psychological Society Ltd (APS), Heads of Departments and Schools of Psychology Inc. (HODSPA), and Ms Kaye Frankcom, a member nominated by the Psychology Board of Australia (PsyBA).

If a matter requires the agreement of Members, the APAC Constitution (‘the Constitution’) requires that this agreement be unanimous. One matter in the Constitution which requires the agreement of the members is the appointment or dismissal of the CEO, and the CEO’s remuneration and duties.

Each of the three members nominates 4 Directors. The Constitution requires that three of the four nominees be ‘Psychology Directors’, meaning a registered psychologist or person eligible for general registration, or a psychology academic, and one be a Community Director: a lawyer (nominated by the PsyBA member), an accountant (APS) and a person with higher education expertise (HODSPA).

The Board Officers are elected every two years by the Directors. There is a Chair and two Deputy Chairs. The Constitution requires that each of the officers be the nominee directors of different members.

APAC’s current activities include:

- Developing accreditation standards for the education and training of psychologists, for approval by the Psychology Board of Australia;
- Assessing higher education providers and the programs of study they offer to determine whether they meet the approved accreditation standards;
- Monitoring accredited education providers and their programs of study to ensure they continue to meet the approved Accreditation Standards;
- Supporting higher education providers in developing and maintaining high quality programs of education and training in psychology;
- Advising and consulting to a range of stakeholders including the Psychology Board of Australia, governments, education providers and professional bodies, on matters of education and training relevant to the psychology profession and discipline.

Preliminary work has been undertaken on:

- Assessing accrediting and examining authorities in other countries to determine if graduates of the authorities’ examinations or accredited programs of study have the knowledge, skills and professional attributes necessary to practise the profession in Australia.

APAC does not currently undertake some functions:

- Unlike most of the other Accreditation Councils, APAC does not assess overseas trained applicants for registration. The Psychology Board of Australia undertakes this function.
- Unlike a number of other Accreditation Councils, APAC does not accredit intern years. The Psychology Board of Australia oversees the certification of supervisors of interns, and sets a curriculum for the internship year/s.
Unlike the Australian Pharmacy Council, the only one of the Accreditation Councils (Councils) to conduct an examination after the intern year, APAC does not conduct such an examination. The Psychology Board of Australia conducts an examination for those who have taken the internship pathway to registration (see Appendix 1), in conjunction with its examination for overseas applicants. The examination curriculum is set by the Psychology Board of Australia, independently of competency standards linked to the Accreditation Standards developed by APAC.
2. Background: Psychology Education within the National Registration and Accreditation Scheme

The position of psychology education and the registration of psychologists is in many ways anomalous within the NRAS scheme. These anomalies are outlined below.

Health professional training for psychologist registration purposes begins at postgraduate level.

An undergraduate psychology degree does not necessarily lead to a career as a registered psychologist. Many thousands of students enroll in undergraduate psychology degrees or sequences within an arts degree or science degree, for example, but approximately 90% will not undertake postgraduate pathways leading to registration. This is not considered to be a cause for concern, as the undergraduate qualification is excellent grounding for many non-health professions, as well as the core discipline foundation for professional practice in psychology.

Some higher education providers (Providers) consider that APAC shouldn’t accredit undergraduate programs, but it is difficult to see how it would be possible not to accredit them, given the need to ensure the postgraduate programs leading to professional practice accept only those undergraduates who have a high level of understanding of the science underpinning the therapeutic practice of psychology.

Some psychologists and psychology academics, on the other hand, complain that APAC’s accreditation only concerns itself with the aspects of undergraduate education that are relevant to later studies in psychology as a health profession; they believe that the accreditation standards should encompass quality indicators relating to a generalist psychology education2.

There is no provision for student registration in the NRAS scheme

This relates to the undergraduate intake situation described above. Unlike the other professions, there is no provision for student registration in the national scheme. This is because there is no client contact at undergraduate level, the curriculum for which focuses on the science of the human mind and human behaviour, not therapeutic practice based on that science.

Students first encounter clients when they undertake the clinical placement component of a two year postgraduate program, when they enter a two year internship, or when they undertake a 5th year plus a one year internship. At this point, they are registered as provisional registrants in the scheme.

‘Psychologist’ is a protected title under the scheme.

This relates also to the undergraduate intake situation described above. Of the many thousands of students who pursue long-term studies in psychology, many may have intended to become health professionals but changed their minds, many may have intended to become health professionals but failed to gain entry to postgraduate training, many more may never have intended to become health professionals.

---

2 The APAC Board understands the reasoning behind this view, but in response has noted that APAC’s funding at present is only for the purposes of the NRAS.
This leads to a situation whereby those who have pursued a research or teaching career may not be able to use the title ‘Psychologist’. Conversely, one area of psychology practice, Organizational Psychology, where the title is considered especially important, is a recognised area of practice in the scheme, albeit the practice is not generally ‘therapeutic’ in the same sense as for other psychologists and other health professionals registered in the scheme.

There is no provision for specialist registration in the national scheme.

However, APAC accredits programs in nine designated areas of practice\(^3\), which can lead to Area of Practice (AOP) Endorsement after the practitioner fulfils some other requirements. These areas are not ‘specialist’ services within the meaning of the National Law, but require the equivalent of at least one year of postgraduate level training. This is another point of difference with other professions, in relation to what might be designated an endorsed area of practice as opposed to a specialty.

**Accreditation under the scheme**

Because of the situation regarding undergraduate psychology studies, APAC accredits many more programs than any of the other Accreditation Councils, and assesses a higher number of Providers than any council other than the Australian Nursing & Midwifery Council. This causes significant anomalies when comparing costs of accreditation across the professions.

**APAC statistics**

Currently, **accreditation statistics** are as follows:

- **No of providers:** 41 (37 government-funded universities, 1 private university, 3 non-university private providers.)
- **No of programs\(^*\) accredited:**
  - Active: 606 programs across different campuses (461 individual programs). Discontinued: 155 programs are currently being taught out. See **Appendix 2**.

\(^*\)A **program** can be a **sequence** within an undergraduate degree, not necessarily a whole degree; the same **sequence** may be offered through many different degrees, sometimes located in different academic units within a provider. A sequence is not the equivalent of a ‘major’, rather it is a recognised set of units of study in psychology and a recognised order in which they must be taken.

**Generalist and AOP Pathway issues**

It is possible under the current standards, and common practice, for a student to complete generalist and AOP training as part of the same Masters or Doctorate qualification.

Under the current standards it is not possible for a psychologist to gain an AOP qualification without undergoing the whole two years of a masters course. Two year masters courses generally combine generalist and specialist training. There are a limited number of ‘bridging’ programs on offer, which would enable a generalist practitioner to acquire the equivalent of a one year AOP qualification, or an

---

\(^3\) Clinical Neuropsychology, Clinical Psychology, Community Psychology, Counselling Psychology, Educational & Developmental Psychology, Forensic Psychology, Health Psychology, Organisational Psychology, Sport & Exercise Psychology.

There is an imbalance in the number of courses offered in the different specialties: overwhelmingly, Providers offer Clinical AOP, as there is a high demand, partly because Medicare rebates are more favourable to Clinical Psychology services.
AOP endorsed practitioner to acquire the qualification for another AOP endorsement. The proposed new standards submitted to the Psychology Board in September 2016, awaiting approval, allow for one year ‘stand-alone’ AOP programs for registered psychologists.

Internship inconsistencies

APAC does not accredit either the 2 year or 1 year internship programs, which are intended to provide training equivalent to that provided in postgraduate programs offered by Providers, which programs include clinical placements. APAC’s standards and assessment processes apply only to the Provider programs. We believe this to be a significant anomaly.

Internships are overseen by the Psychology Board, which certifies supervisors, sets a curriculum, and administers an examination at the end of the internship.

The examination curriculum is set by the Psychology Board of Australia, independently of competency standards linked to the Accreditation Standards developed by APAC. This is an inconsistency vis a vis other professions’ accreditation standards, which we discuss in our commentary in Section 4 below.
3. Executive Summary

APAC welcomes the opportunity to comment on the many important issues raised by the Accreditation Systems Review Discussion Paper. Our response highlights in particular a number of concerns we have with the current operation of the scheme, albeit noting that the anomalies described in Section 2, above, may mean that APAC’s experience of the scheme is different from that of other professions.

That said, in common with the other accreditation councils, APAC believes strongly that the accreditation system is an essential part of the NRAS for the health professions. In our view there is a direct link between the accreditation of courses and the protection of the public. While there are a number of areas in which we believe improvements might be made which will give rise to efficiencies, and possible cost savings thereby, we caution that these efficiencies would be false if they were to compromise public safety. We note also that the accreditation arrangements, no less than registration and disciplinary arrangements, must be robust such that they have the respect of the profession, whether working with clients or teaching future practitioners.

In our comments in Section 4 we highlight the following key concerns.

Improving Efficiency

The proportional cost of accreditation within the scheme is comparatively low\(^4\). APAC’s fees and running costs are among the lowest of all the Accreditation Councils (‘the Councils’), so we do not see any prospects of saving costs without compromising the quality of our work.

APAC, along with a number of other councils, is moving to risk-based decision-making, with no particular expectation that this will reduce our costs, as opposed to increasing our effectiveness.

We caution that any move to a risk-based system requires considerable discussion: clearly, ‘risk-based’ means different things to different parties. APAC certainly does not see that health professional accreditation could move to an open-ended system such as that adopted by TEQSA\(^5\): the purpose of regulating the higher risk health professions is to protect the public. APAC is of the view that the public would not be happy if ‘right touch, light touch’ were to be interpreted as ‘set and forget until something bad happens’.

Relevance and responsiveness

APAC supports a move to outcomes-based accreditation, and has recently developed standards that move towards this approach. We also welcome alignment between the professions of accreditation standards frameworks and principles. We are of the view that there is room for all the registered professions to develop standards using high level domains common to all, as has been done by a number of Councils in recent years, including APAC. However, the competencies associated with the standards must be developed by the relevant professions, in order to maintain currency and credibility.

---

\(^4\) Less than 6% of the cost of the total NRAS scheme. See Accreditation Councils Forum, Accreditation Liaison Group, Cost of Accreditation in the National Registration and Accreditation Scheme, November 2016.

We comment on the notion of ‘work-readiness’ and caution against any assumption that an accredited course, perhaps followed by an examination, would produce ‘work ready’ graduates. We note that the highest quality program, with the best teaching available, can only produce registrants who are ‘ready to start’ work. Thereafter they require oversight by an employer and ongoing education in the work setting. In our view, any high-risk profession requires supervised practice for a period, before and/or after graduation.

**Producing the Future Health Workforce**

We note the NRAS objective in relation to workforce.

The mode by which workforce flexibility might be achieved through accreditation has not yet been described, to our knowledge. We assert that accreditation follows from education, not the other way around. We support the notion that accreditation should not create barriers to innovative teaching and learning, indeed should encourage this, and our proposed new standards are designed on this basis. On the other hand, this would not of itself lead to new kinds of health worker or ‘inter-disciplinary practice’. Accreditation is at the end of a regulatory process relating to workforce reform, it is not the instigator.

This final section of our submission discusses at length the problems we see in the current governance structure of the scheme, whereby accreditation appears to be the ‘poor relation’ to registration. We are firmly of the view that governance structure and policies and processes relating to accreditation need to be addressed, whether within AHPRA or as part of a separate body.

We are also of the view that the relevant professions, including teaching and research staff, are the most significant players in the accreditation process – there cannot be ‘one size fits all’ if the objective of safeguarding the public is to be achieved. Consumers of health services are very important in the NRAS, and could well be part of the governance of accreditation as a whole or the governance of accrediting authorities, but the accreditation processes themselves require professional expertise, in the profession, in teaching and in accreditation methodology.

All our comments are based on our view that accreditation of health professional education plays a significant role in protecting the public.
4. Commentary on Issues and Responses to Questions

4.1. Improving Efficiency

APAC welcomes any moves to improve efficiency, as long as this is linked with effectiveness.

We believe that the Review process will provide a useful comparison of costs structures, but note that costing work undertaken by the Accreditation Councils’ Forum (the Forum) Accreditation Liaison Group\(^6\) demonstrates the problems associated with comparing organisations with diverse functions, methodologies and funding sources.

The previous NRAS Review (the Snowball Review)\(^7\) proffered a financial analysis that was not robust. APAC and others criticised this analysis at the time\(^8\):

\[ \text{Comment on Table 5: Total accreditation costs by profession} \]

The report has calculated the cost per accredited program in the same manner for all councils and this is incorrect for psychology. APAC charges cycle accreditation fees by the type of program, i.e., a psychology sequence, or professional stream, and not by individual degree title. For example, an education provider may have 5 bachelor degrees with a psychology sequence embedded; assessment of the sequence is charged once, not 5 times.

Correction;

Column - Number of accredited programs;
552 is the number of degree titles APAC accredited
195 is the number of sequences and professional streams APAC accredited

Column - Correct cost per accredited program;
$4,214 not $1,574 (total spent on accreditation $821,808 / number of sequences 195)

This analysis highlights the anomalous nature of APAC accreditation within the scheme, as described in Section 2, above.

By comparison with other Councils our costs are very low, and the fees charged to Providers are not high in comparison with many other councils. This is not to imply other Councils are over charging; APAC’s payments to assessors, for example, have historically been quite low. On the other hand, assessment teams travel from all around Australia, and our travel costs are very high.

The composition of APAC’s accreditation assessment teams varies depending on the size and complexity of each particular assessment. These range from smaller assessments (for example a minor change to an already accredited program) to very large assessments (e.g. a de novo assessment of a new provider and its programs, including multiple campuses, some of which may be located offshore). Assessment teams thus range in size from 1 to 4 or more people, and depend on the number and variety of types of programs for which accreditation is sought, the nature of any site visits required, the type of assessment, and other factors.

\[ Op \ cit. \]
\[ Snowball K, \ Independent Review of the National Registration & Accreditation Scheme, Report, December 2014, released August 2015. \]
\[ APAC \ Communiqué \ released in response to Snowball Review, August 2015. \]
APAC’s workload varies considerably from one year to the next. This is partly because education providers and the programs of study they offer are accredited on a five year cycle, with the scheduling of programs and providers across any given five year cycle not being evenly distributed for historical reasons. Thus, in some years, a high number of providers and programs fall due for a scheduled assessment, whereas in other years a low number fall due. There are also unscheduled assessments which are triggered by changes to programs, changes to providers, audits and assessments related to the tracking of progress in meeting conditions imposed. For the same reason, income generated from accreditation fees paid by education providers can vary appreciably from one year to the next.

APAC would not have a problem with implementing a longer cycle – perhaps seven years – but would oppose an ‘open-ended’ system, on the basis it would inevitably lead to a deterioration in quality, the effects of which might not show up until some years after graduates leave and begin practice.

While we would welcome improvements to efficiency that might be gained from, for example, collaborative processes, we would be extremely concerned if quality were to be compromised, noting always that there is a direct link between accreditation and the protection of the public.

**Issues Raised and Responses to Questions**

**Accreditation standards**

While it would be simplistic in the extreme to assume that making everything the same would lead to cost savings or cost efficiencies, APAC recognises that there is considerable room for standardised processes and joint activities. The benefit would be in cost savings and also in the value that would derive from Councils’ methodologies being the same or similar, (and based on best practice) in the event of challenges from aggrieved providers, or queries from government.

We note that the Councils’ Forum has endeavoured to move towards commonality but has been hampered by a lack of resources.

1. **What would be the benefits and costs of greater consistency and commonality in the development and application of accreditation standards?**

    First, we note that not only is there a distinction between the development of standards, their content and their application, but the development of standards also entails an approval process, and the application of standards has a number of different dimensions, only some of which could usefully be standardized.

    In relation to the **content of standards**, we comment under Section 4.2, below. Clearly, were there to be some commonality in content, there would be cost efficiencies. Initially, however, there would be costs entailed in achieving the commonality. We highlight that APAC’s proposed new standards (once approved) are modelled, at ‘Domain’ level, on those developed by the Australian Dental Council and adopted by other Councils.
The development of standards at Domain Level needs to capture what is essential to ensure graduates achieve the competencies required for professional practice (the proposed new APAC standards do this). The differences in each profession are then able to be captured by the graduate competencies developed by each profession, and key profession-specific requirements, for example in teaching and learning methodologies, assessment methodologies, work placements etc., can be captured in an Evidence Guide.

In relation to the approval of standards, we welcome the Discussion Paper’s recognition that a review of standards is extremely taxing on time and financial resources. We note that AHPRA’s Guidelines are sparse and appear to be open to differing interpretation by different parties. We are aware that Councils have had very different experiences in endeavoring to get standards approved by the relevant registration boards. See also our comments under Section 4.3, below.

In relation to assessment processes, as noted above, and in our comments in Section 4.2, below, despite some aspects of commonality, the different requirements relating to different professions would prevent there being substantial commonality in the assessment of, in particular, teaching to and achievement of profession-specific competencies. Most of the professions within the scheme are very different, in training and practice, and there is a real danger in underestimating the expertise associated with practising and teaching the profession.

However, at a more superficial, albeit important level: from the providers’ point of view administrative processes and associated documentation could usefully be standardised, e.g. assessment and decision-making processes, appeal processes, site visit format, application forms, format of reports etc. This would make it easier for providers to re-use material, to deal with reports and to prepare for multiple visits from different accrediting authorities. As suggested above, the set-up costs might be considerable, but ongoing costs for providers ought to be less because of more streamlined processes.

2. Should accreditation authorities be required to incorporate the decisions of TEQSA/ASQA assessments and accreditations of education providers as part of their own reviews?

Professional accreditation standards presuppose accreditation of the educational institution by TEQSA/ASQA. If an institution does not have such accreditation, professional accreditation is pointless.

Educational quality assurance (by TEQSA) and health professional quality assurance (by APAC) play complementary but different roles in an effective quality assurance system. Both are important for ensuring the quality of graduates.

In an effective quality assurance system both the educational and the professional quality assurance agencies should take into account the decisions of each other.

While individual Councils are able to enter into formal or informal arrangements for the exchange of information, in APAC’s view NRAS would be greatly improved if the relationship between the relevant two quality assurance agencies were to be created formally. The impediment to such an arrangement currently is the somewhat ambiguous standing of accreditation and accreditation processes within the NRAS scheme. See our comments under Section 4.3, below.
3. What are the relative benefits and costs associated with adopting more open-ended and risk-managed accreditation cycles?

In principle, risk-based accreditation combined with robust reporting and monitoring processes is acceptable. The key is achieving robustness.

The wording of this question implies that risk-based accreditation necessarily entails open-ended cycles. This doesn’t follow. Clearly, any move to risk-based accreditation requires a thorough examination of what is meant by ‘risk-based’. Good practice would imply that the focus of accreditation should be on new courses, new providers and new approaches to achieving outcomes, along with paying due attention to ‘red flags’. Any move to ‘open-endedness’ would seem incompatible with the scheme’s primary objective of protecting the public. In this respect, the NRAS accreditation model must differ from that of TEQSA.

APAC is currently reviewing its processes, with an initial objective of moving to risk-based decision-making, and potentially then moving to risk-based assessment processes. We are indebted to the Australian Dental Council and the Australian Nursing & Midwifery Council for sharing their learnings from such moves, and would as a matter of course endeavor to adopt processes which are followed by other Councils, in keeping with our view that common processes should be followed where possible.

The key challenge would be not to compromise quality, which certainly would be the case if cycles were to be open-ended. In a risk-managed system, closer scrutiny is required in the case of, for example, new providers or new programs, but also in the case of a ‘red flag’. It would be extremely remiss of the accreditation system if it were to wait for ‘red flags’ from whistleblowers and student complainants, or for data gathered over a period of years from disciplinary processes. Regular site visits, along with ongoing desktop monitoring can uncover the red flag issues before they get as far as the flag-pole.

APAC’s current accreditation cycle is five (5) years. We are open to moving to a longer cycle, but would consider 10 years to be too long, and we oppose open-ended, ongoing accreditation, in the interests of protecting the public.

Training and readiness of assessment panels

4. What changes could be made to current accreditation processes (such as selection, training, composition and remuneration of assessment teams) to increase efficiency, consistency and inter-professional collaboration?

Inter-professional collaboration is not an appropriate goal for accreditation. Insofar as different professions share common resources (e.g., simulation laboratories, hospital placements) these could and should be assessed through collaboration of the relevant accreditation authorities, but much of what is assessed by the Councils is profession-specific.

That said, it would be useful to run some common assessor training programs, in that assessment teams need to be formally trained as assessors (against external standards) and for assessors to have an understanding of the HESF (Higher Education Standards Framework) and TEQSA requirements.

Peer review during site visits could also be considered, and it is an excellent learning experience for staff or assessors to shadow another Council’s assessment team.
As noted above, APAC relies on dedicated professionals to undertake assessment work at a relatively low rate of remuneration. Moves to commonality would imply commonality of fees and honoraria.

5. Should the assessment teams include a broader range of stakeholders, such as consumers?

This proposal is of great concern to APAC, as it seems to imply that professional expertise in practice, teaching and research in the relevant profession is of little value. While we understand the motivation for the suggestion, an unqualified health consumer, no matter how well-intentioned, does not have the expertise required to add value to a site assessment.

In any case, arguably, the ‘consumers’ of APAC’s services are students. Every site visit conducted includes gaining confidential feedback from students on their experiences, and therefore, by implication, on the effectiveness of APAC’s work.

APAC would be comfortable including appropriate consumer representation at board level or potentially at Accreditation Committee level, but cannot see a benefit in including consumers on assessment teams.

Sources of accreditation authority income

6. What should be the key principles for setting fees and levies for funding accreditation functions, including how the respective share of income provided from registrants and education providers should be determined?

The basis should be that those who receive a benefit should pay. The beneficiaries of accreditation are (a) the public (b) practitioners, and (c) the education provider.

Of these, the public receives the greatest benefit but pays nothing directly, given the Councils are allocated a portion of registrants’ fees. A contribution by state and territory governments on behalf of the public would seem appropriate. Of the remaining two, given there is no reason to favour one over the other, a 50-50 division would seem fair.

This is another area where attempts to standardise, as proposed by the Snowball Review, could be simplistic, as different Councils have different approaches to assessment, for valid reasons.

On the other hand, standardised principles for allocating funds would assist, as each Registration Board seems to have total discretion to decide how much to provide, and for what purpose.

We note that AHPRA’s response to the Snowball Review’s concern about pricing was to add a new term to our most recent Annual Funding Agreement, that fees charged to providers could not increase by more than CPI. Setting aside the implications of the Agreement making requirements relating to Councils’ commercial arrangements with third parties, this edict unfairly disadvantaged those Councils, like APAC, whose fees have historically been quite low. The fees we currently charge providers do not cover the direct costs of site visits and administrative costs, and we are currently using reserves to cover the considerable cost of developing new standards.

7. Should fees charged for the assessment of overseas qualified practitioners and assessment of offshore competent authorities be used to cross-subsidise accreditation functions for on shore programs?
Based on the above principle, the overseas qualified practitioner gains no direct benefit from accreditation of onshore programs (over and above the benefit of any practitioner). It could be argued, therefore, that they should only pay for the benefit they directly receive.

On the other hand, APAC does not currently undertake this work, and, we are mindful that small enterprises like ours owe it to our stakeholders to run as efficiently as possible; it would be retrograde to demand excessively rigid funding compliance activities in a small office where all staff are trained to be able to cover all functions.

4.2. Relevance & Responsiveness

APAC welcomes the Review’s examination of possible impediments to swift responses to innovation.

However, while we accept that the process of accrediting a new program may take some time, as always we feel a responsibility to ensure that quality is not compromised in the interests of speedy turnarounds. In any case, the process of developing and offering a new course begins with Provider requirements at Academic Board level, after which the formal process of accreditation assessment commences.

We are of the view that APAC’s processes are reasonably quick, and we certainly don’t take an overly long time in accrediting a sequence that is the same or similar to other sequences offered by the same provider. As is appropriate, we take considerable care with new providers and new programs: paradoxically, while we wish to encourage innovation, (our proposed new standards, awaiting approval, are designed to allow providers greater freedom to innovate) an unusually innovative program would inevitably come under greater scrutiny, as is consistent with a risk-based approach.

Our main concern in relation to potential delays is that, unlike the model used by a number of other Councils, APAC’s proposed new standards are written, at the Psychology Board’s request, so as not to refer to external instruments.

Comparable standards such as those of the Dental Council, the Optometry Council and the Pharmacy Council refer to Graduate Competencies that have been developed by professional bodies, thereby allowing simple changes to be made to course content should the competencies be changed, to allow for, for example, a wider scope of practice, or removal of a discredited mode of practice. APAC’s proposed new standards reference graduate competencies, developed by APAC in consultation with the profession, with both to be approved by the PsyBA as part of the Standards, at PsyBA’s request. Even a minor change to the competencies will therefore have to go back to the PsyBA for approval before being advised to providers. This is one of the anomalous situations in the scheme, whereby harmonised processes and protocols would benefit all parties.

Input and outcome based accreditation standards

8. Should accreditation standards only be expressed in outcome-based terms or are there circumstances where input or process standards are warranted?

Our focus in our proposed new standards has moved from an inputs-based approach to primarily an outcomes-based approach, albeit supported by a number of key inputs which have been retained at the request of stakeholders. We expect that this change will allow for more flexibility in

---

9 On average APAC takes 5 months from receipt of application to accredit a new program, and 2 months to accredit an additional degree title.
the ways providers may choose to structure programs, and allow for innovative and effective approaches to learning and teaching.

APAC’s expectation is that after a period of familiarisation for stakeholders we may see fewer inputs in future revisions of the standards.

That said, it is not possible to phrase all standards in terms of outcomes so a mix of the two will always result. Good quality assurance standards will be a mix of outcomes, outputs and inputs. If only outcomes are used, the outputs and inputs must in any case be elaborated in an Evidence Guide.

9. Are changes required to current assessment processes to meet outcome-based standards?

Assessors will need training to move from assessing inputs to assessing outcomes.

Providers will need training to enable them to best demonstrate achievement of the required outcomes, as the focus of the assessments would shift to ‘end results’.

Assessments of students undertaken by the Providers would likely move towards a greater emphasis on practical demonstration by students of competencies, for example through Objective Structured Clinical Examinations (OSCE).

Health program development and timeliness of assessment

10. Should there be a common approach to the development of professional competency frameworks and to the inclusion of consumers and possibly others in that development?

A common approach would be optimal, in the sense described above: ideally, competencies sit outside the Domain Level Standards and associated criteria: i.e. in the relevant Domain, an essential criterion relates to achievement of the competencies. If the competencies are linked to, but not part of the Standards, they may be amended as needed in response to changes in professional practice.

A common template would be useful for greater acceptance by stakeholders. There is likely to be some commonality in competencies across professions and there would be benefits in consistency in the expression of these to support inter-disciplinary practice. This would help build up knowledge, experience, and inter-professional collaboration across different accreditation authorities, thereby avoiding unnecessary duplication of effort. However, differences also need to be accepted.

Including consumers and others could be useful for accountability purposes and consumers could contribute to common public interest elements such as diversity, patient-centred care, and so on, but, as noted above, it would not be possible for them to contribute more because they would lack the required skills and insights relating to the teaching of the relevant profession.

A consumer advisory body might appropriately be given a role in an enhanced accreditation governance structure within the NRAS scheme.
11. What are the risks and benefits of developing accreditation standards that have common health profession elements/domains, overlaid with profession-specific requirements?

Common accreditation standards are not problematic if comprehensive graduate competencies for the profession co-exist (rather than ‘overlaying’) and the profession-specific inputs and outputs are detailed in an Evidence Guide.

APAC’s view is that along with other ideas about standardisation, the apparent simplicity of the solution might be belied by the realities of trying to achieve commonality.

Undoubtedly, the profession-specific competencies would have to be developed by the profession, and adopted by the relevant Council. Common Domain Level standards could be developed by another agency, but would still need criteria specific to the professions.

We are not sure whether there is a sizeable element of any set of standards that is common to all health professions.

However, if this were achievable it would make accreditation processes marginally more simple for the providers.

We note that assessment of the common elements would still need to be in the hands of the relevant Council. Successful coordination between Councils would likely be difficult, and add to delays.

12. What changes in the accreditation system could improve the timeliness and responsiveness of processes to ensure education programs are delivering graduates who have the knowledge, clinical skills and professional attributes required of the current and future workforce?

As noted above, the time lag experienced by APAC and others in gaining approval by the relevant Boards and AHPRA is a very good argument in favour of competencies being linked to but not part of the standards. The flexibility to keep the professions’ graduate competencies current is important.

In addition, further flexibility is enabled with the inclusion of specific inputs and outputs in an Evidence Guide, which may also be amended as needed.

Inter-professional education, learning and practice

13. How best could inter-professional education and the promotion of inter-disciplinary practice be expressed in accreditation standards that would reflect the priority accorded to them?

APAC is a signatory to the Forum’s position statement on inter-professional education (IPE). APAC, in its current standards and its proposed new standards, promotes the expectation that psychologists demonstrate understanding of the practice and roles of other professions and the capacity to report to other professionals and to work collaboratively. Although psychology programs are not located exclusively within health faculties - and many psychology graduates ultimately work alongside other professions such as law, business, science - being able to work collaboratively with other professions is an important competency for all psychology graduates to have.

---

10 APAC, Accreditation Standards for Psychology Programs, 2010.
Many universities where psychology is located in health faculties have begun to provide explicit inter-professional education opportunities that include both simulation as well as opportunities to work with and reflect on inter-professional practice while on placement. An example of a structured IPE program is included at Appendix 3, where inter-professional education at Griffith University is embedded in a 3-phase framework for graduates from all health disciplines.

A criterion in the standards, common to all professions, requiring inter-professional education to be part of all programs of study, would be acceptable to APAC.

Inter-disciplinary practice, however, is a separate matter. Scope of practice is determined and regulated by bodies other than universities and accreditation councils.

Clinical experience and student placements

14. How could the embedding of healthcare priorities within curricula and clinical experiences be improved, while retaining outcome-based standards?

These could effectively be embedded, on consensus between the profession, providers, and registration boards.

A criterion in the standards, common to all professions, requiring attention to current agreed healthcare priorities\(^{11}\) to be part of all programs of study, would suffice.

15. How best could contemporary education practices (such as simulation-based education and training) be incorporated into the curricula and clinical experience?

Accreditation standards should not stand in the way of such developments especially if they offer training experiences equivalent to more traditional methods.

A criterion in the standards, common to all professions, requiring this to be part of all programs of study, would suffice. APAC is concerned not to be overly prescriptive: providers are in most cases full of innovative ideas, others lack the incentives and/or resources to be innovative.

The delivery of work-ready graduates

16. Is there a defensible rationale for a period of supervised practice as a pre-condition of general registration in some professions and not others?

Psychology is a high-risk profession, i.e. as for medicine, dentistry, pharmacy, and nursing, there is a high incidence of notifications from clients/patients. This necessitates the highest levels of diligence in all aspects of the selection, training, assessment and supervision of potential practitioners.

A considerable amount of supervised practice is essential before general registration for any high-risk profession.

\(^{11}\) This assumes a governance structure whereby the Councils might agree these priorities with appropriate health professional and consumer groups.
17. How should work readiness be defined, and the delineation between registration requirements and employer training, development and induction responsibilities be structured?

Work readiness needs to be defined to enable a sensible approach to supervised practice. Formal education can only take graduates to ‘the starting gate’, that is, graduates are ready to start work in their profession/occupation/field, a concept which we believe is different from that of being ‘work ready’. Once a graduate starts work, the responsibility for building competence lies with the individual and employer.

National examinations

18. Does a robust accreditation process negate the need for further national assessment to gain general registration? Alternatively, does a national assessment process allow for a more streamlined accreditation process?

In principle, APAC has no issue with a national examination, as long as it is not considered to be a substitute for accreditation.

An exam may be a valid way of assessing some outcomes, but is of limited value to accreditation and therefore of limited interest to an accreditation agency.

An exam at the point of applying for registration uniformly tests knowledge however acquired, e.g. through an accredited program, work experience, cramming from sample exams, etc. Such an exam can be an outcome measure of accreditation; it is not, however, a substitute for accreditation. Accreditation is the quality assurance of the provider and the program to ensure in a more direct way that students have the best opportunity of achieving the graduate competencies (not just knowledge) and assuring public safety during the study period and on entry to workforce (as well as receiving an appropriate student experience which is a consumer protection matter).

If the exam content is matched to the graduate competencies (which it should be) then the exam is one measure of the outcomes of accredited providers and programs.

APAC believes that were there to be such an examination it should be overseen by the Providers. Currently, the PsyBA oversees psychology internships and then examines interns along with overseas applicants.

Ideally, and in keeping with the processes of the Pharmacy Council, APAC should accredit internships, given they are intended to be equivalent to postgraduate courses or part thereof.

4.3. Producing the Future Health Workforce

This part of the Discussion Paper contains our insights into current flaws in the governance of accreditation within the national scheme.

The proposals made in the Discussion Paper about governance of accreditation go to a fundamental problem with the scheme’s operation in relation to accreditation. There is an inherent disparity between the registration function (i.e. setting minimum standards to protect the public) and the accreditation function (i.e. ensuring a well-trained workforce that can safely deliver quality services) of the National Boards. These functions serve two different purposes and would possibly be more effectively carried out by two separate entities, or two discrete divisions within AHPRA.
APAC’s response is necessarily informed by our own experience, nevertheless an objective look at the way accreditation is approached reveals a number of flaws that inevitably will impede effective accreditation processes and timely responses to changes in education or professional practice. This in turn affects accreditation’s role in protecting the public.

This is not to criticise the parties involved, merely to point out that in a scheme that purports to regulate registration and accreditation, accreditation has played second fiddle, with the registration boards left to their own devices in interpreting their role in relation to approving funding for the Councils, approving courses and approving standards. The last has caused most concern to APAC in recent years, but funding principles and course approval processes would also benefit from the kind of standardisation discussed in Section 4.1, above.

We recognise that some of the problems derive from the scheme’s quite proper concern to allow the registration boards to function relatively autonomously. However, in achieving this end, it appears that AHPRA has been set up, at least in relation to accreditation, so as to allow for too much diversity in the way the registration boards perform their accreditation functions. The Discussion Paper also makes the valid point that the expertise required to undertake disciplinary and registration functions is very different from that required to make effective judgements about educational standards.

However, while we understand the thinking behind linking governance to perceived inadequate progress towards workforce reform, we suggest that considerably more thought needs to go into how workforce reform occurs and why. As we note below, accreditation comes at the end of a significant change to scope of practice, or new kind of health worker; it is not the instigator.

**APAC’s Accreditation Standards**

APAC has had an especially difficult time achieving approval from the PsyBA for a proposed new set of standards that is based on models developed by the Australian Dental Council (ADC), the Australian Pharmacy Council (APC) and the Optometry Council of Australia & New Zealand (OCANZ), and subsequently approved by their respective Boards. The model incorporates contemporary approaches to accreditation, notably a focus on outcomes rather than inputs.

The lack of direction or guidelines for boards concerning the approval of accreditation standards creates considerable variability across boards and, in the case of Psychology, considerable uncertainty and delay has resulted.

The unique structure of psychology training has led the PsyBA to develop a curriculum for training during postgraduate internships. This has created the situation in which the PsyBA seeks to direct APAC to reflect this curriculum and the final examination based on the same content, in the standards and competencies developed by APAC.

In contrast, other Boards and Councils maintain a clear separation of accreditation and registration functions. For example, as noted above, the APC’s internship accreditation and examination are part of the APC’s remit, and the internship standard and the examination content are based on the competencies developed by the Pharmaceutical Society and linked to the Undergraduate Degree Standard.
In 2014 the new APAC Board instigated a period of intensive development of new standards, based on the successful model first implemented by the Australian Dental Council (ADC) and subsequently adopted by other councils (An earlier attempt to revise the APAC standards was abandoned following significant governance and management changes at APAC in 2014). These standards were submitted to the PsyBA for approval in September 2016, and at time of writing approval still has not been granted.

Of concern, as we have already noted, is that the successful model on which the APAC standards is based has been modified, at the request of the PsyBA, so that the graduate competencies are considered to be part of the Standard itself, therefore requiring approval by the PsyBA. This has the undesirable consequence that it will prevent APAC from responding in a timely manner to changes in professional practice, as might be reflected in a change to commonly accepted competency sets: any amendments will require formal approval by the PsyBA.

This is not to criticise the PsyBA’s approach to the broadly expressed requirement for them to approve standards, merely to point out that others have interpreted the requirement differently.

Clearly, a better model is needed, based on a shared understanding of the Boards’ role vis a vis accreditation.

Possible models would be:

(1) Registration Board commissions and sets specifications for standards and pays Accreditation Council/other to develop to those specifications; or

(2) Accreditation Authority (AHPRA or new) commissions standards and retains accreditation councils to accredit against them; or

(3) Existing process but with clear and detailed guidelines as to what is required, how the standards are to be judged and by whom, with consistency across the professions, with the accreditation function governed by a new authority or new division within AHPRA12; or

(4) Standards set by the appointed council and automatically adopted after assessment against requirements set by Accreditation Authority (AHPRA or new), with the Registration Board adding specific requirements for registration as a second set of criteria for the provider to take into account if relevant.

Of these models, APAC prefers (3) or (4). (1) is clearly contrary to the legislation’s intent in relation to independence of the two functions, but in APAC’s case, would have saved a good deal of time and money13.

Independence of accreditation and registration

19. Do National Boards as currently constituted have appropriate knowledge, skills and incentives to determine accreditation standards and programs of study which best address the workforce needs of a rapidly evolving health system?

---

12 Noting the importance of allowing for suitable timelines for transition to a new model.
13 APAC’s estimate of the cost of developing and submitting the Standards (version commenced in late 2014), not including voluntary labour and not including editorial and print, is: $240,000+.
Based on APAC’s experience, the national Registration Board is not constituted to enable informed approval of accreditation standards. The Board members have been chosen for their expertise in disciplinary and registration functions. Approval of accreditation determinations and accreditation standards, even were they to be governed by better guidelines as described above, are awkward additions to the Board’s other duties.

The reference to workforce needs in this context signals an issue with the legislation governing the NRAS scheme, whereby workforce solutions are assumed to flow naturally out of the existence of (more or less) nationally consistent arrangements for registration and accreditation. While taking the point made in the Discussion Paper that the Boards might be risk-averse, APAC does not support the implied criticism in this comment. The Boards should be risk-averse in all their functions: their primary objective is to protect the public.

The point that is missed in the Discussion Paper is that neither the registration boards nor the accreditation councils lead on workforce reform. Their processes follow the reform. The best recent example of this is that of the Aboriginal Health Worker: this new type of health worker developed in response to a perceived need, new courses were developed and funded, and the accreditation and registration functions followed.

While APAC has had issues in relation to the PsyBA’s approval of its standards, our concern is not with the members of the PsyBA, but with the broadness of the guidelines with which the parties are working. The PsyBA’s request to embed the graduate competencies within the Standard, for example, may be an indication that its members are risk-averse, but at present there are no rules or protocols relating to the status of various external instruments referred to in Standards.

20. Would greater independence of accreditation authorities, in the development and approval of accreditation standards and/or approval of programs of study and providers, improve alignment of education and training with evolving needs of health consumers?

APAC believes that greater independence would improve this alignment. Accreditation authorities are the acknowledged expert on education in the relevant professional field. In order to maintain this expertise they maintain close ties with education providers. Therefore, moves by providers to respond to demand for new kinds of health worker or new approaches to achieving professional competencies are able to be discussed at an early stage. There is a history of collaboration between the accrediting authority and the providers, as a matter of course; providers invariably approach the accrediting authority at an early stage of developing a new course or new approach, and the final product being a result of this consultation. The registration boards, on the other hand, must maintain a suitable distance, and might well be reluctant to approve seemingly radical concepts. As noted above, their expertise is of necessity focused on registration and discipline issues, not innovations in education.

In our view, the models canvassed above, whereby the accreditation authorities’ expertise is recognized, within a system of governance and monitoring by a separately structured or separately constituted body, would lead to a more productive relationship between registration boards and accrediting authorities.

The current model has had the effect of reducing APAC to an arm of the Psychology Board, rather than an independent authority. Again, APAC believes this is more a systemic issue than an intentional impingement on our independence.
Governance of accreditation authorities

21. Is there adequate community representation in key accreditation decisions?

At appropriate times, APAC consults with consumers. For example, in the 2016 public consultation on proposed new standards, consumer health organisations were invited to submit feedback, as were a number of government departments which provide services to consumers.

Any accreditation assessment entails extensive discussions with students, the direct consumers of our services, and with employers of graduates.

APAC does not support the addition of consumer representatives on assessment teams. We are open to having consumer representatives on the APAC Board, noting that the inclusion of students on the APAC board may be a useful addition.

22. What changes are required to current governance arrangements to allow accreditation authorities to source professional expertise without creating real or perceived conflicts of interest?

All of APAC’s Directors are nominees of its members, but we have not had a concern that these directors see their role as representing the interests of the stakeholder group which appointed them to the Board. Notwithstanding, as a matter of good governance we are finalising with the appointing bodies a Nominee Director policy.

Three of the nominee directors are non-psychology members, coming from the law, accountancy and higher education respectively.

APAC sees no issue with nominee directors, noting that the existence of nominees does not preclude the application of a directors skills’ matrix in the process of selecting directors.

23. In the case of councils, what governance arrangements are necessary to allow them to separate accreditation activities from their commercial and other obligations as legally constituted companies?

At present, accreditation activities are based on contractual arrangements with AHPRA with recognition of the registration board’s role. The terms of this agreement and the need to provide program budgets and report against them should be sufficient to effectively keep separate AHPRA funded activities.

Role of accreditation authorities

24. Is the standard clause in AHPRA funding agreements with accreditation councils sufficient to ensure that the delivery of accreditation functions is aligned with, and is adequately responding to, the objectives of the NRAS?

APAC has had no problems with the clause, and there have not been any recent instances where our compliance, reported through half-yearly reports against the agreed Quality Framework, has been questioned.
What other governance models might be considered?

25. What is the optimal governance model for carrying out the accreditation functions provided in the National Law while progressing cross-profession development, education and accreditation consistency and efficiency? Possible options include:

- Expanding the remit of the AHPRA Agency Management Committee to encompass policy direction on, and approval of, accreditation standards;
- Establishing a single accreditation authority to provide policy direction on, and approval of, accreditation standards.

APAC favours much greater attention to the accreditation function within NRAS. We have no particular preference for either of the above, as long as a new approach addresses problems we see with the current model.

Our experience with the PsyBA in relation to our development of new standards indicates that something is amiss. The roles, duties, and relationships between registration boards and accreditation councils needs addressing. At one level, both are viewed as ‘independent’ agencies by NRAS. In practice, at least some of the Councils seem to be beholden to the Boards.

APAC’s preferred model would be:

A separate accreditation authority or separate accreditation division of AHPRA, responsible for setting policy and, most importantly, procedures that would be followed by all parties. While we recognise that the relevant registration board would have to assess accreditation standards in relation to acceptability for registration purposes, and possibly accreditation determinations, these processes would be better managed if there were specific guidelines setting the boundaries of the two roles, of Registration Board and Accrediting Authority.

Such guidelines could include:

- Standardised rules and processes,
- Standardised formats for reports,
- Standardised format for Accreditation Processes,
- Standardised protocols relating to the level and kind of input from Registration Boards,
- Standardised protocols relating to the interface between accreditation standards and registration standards.

26. How best in any governance model could recognition and accreditation of cross-professional competencies and roles be dealt with?

This is not an end in itself but forms part of an appropriate training pathway. In this regard, it is like any skill or knowledge set.

Cross-professional competencies, as we note above, would follow from market demand and/or political imperatives/incentives. Education pathways and curricula would follow, as appropriate. Accreditation and Registration would then follow in their turn. Better governance arrangements would be very welcome, for the reasons suggested above, but the current governance arrangements are not a significant impediment to workforce reform.

14 Noting however that AHPRA is already a very large bureaucracy, and mindful that it is entirely funded by registrants’ fees.
Some might see that boundaries between the professions are an impediment to workforce reform, but these boundaries and the regulation based on them are key aspects of protection of the public. It would be foolish to suppose that tweaking the governance of the national system would allow for significant and ongoing changes to scope of practice without involving any detriment to public safety.

We note the Forum has undertaken work on inter-professional education, and would assume that in any new structure, the Forum might usefully have a role as an advisory body.

Accountability and performance monitoring

27. What should be the standard quantitative and qualitative performance measures for the delivery of the accreditation functions across NRAS and who should be responsible for, firstly, reporting against these measures and, secondly, monitoring performance?

As noted above, APAC supports any model that facilitates the independence of accreditation functions. A separate authority or AHPRA division focused on accreditation would also entail monitoring and performance responsibility. Accreditation itself may be accredited, using national and international standards.

Setting health workforce reform priorities

28. What role should the Ministerial Council play in the formal consideration and adoption of proposed accreditation standards?

We note the potential political agendas that might be involved, and regard Ministerial Council involvement in the approval of standards as something that should be avoided. The scheme is supposed to be independent of government and is designed to protect the public.

The appropriate place for political activity in relation to changes to the health workforce is in public forums and in consultations with health consumers and health professionals, not within the forests and thickets of a regulatory system generally unknown to the public.

29. Is the requirement that the Ministerial Council may only issue directions under s11(3)(d) if it considers a proposed accreditation standard may have a substantive and negative impact on the recruitment or supply of health practitioners, too narrow to encompass all the National Law objectives and guiding principles, and if so, how should it be modified?

Arguably, this clause is already a bridge too far. If the acknowledged authority, the accreditation council, advises that an accreditation standard is the minimum required to assure quality, and the registration board advises that a registration standard is the minimum required to assure safety, a contrary Ministerial Council direction based on workforce supply issues might be seen as a poor bargain by health consumers.

30. How best can a national focus on advice and reform be provided, at least for the delivery of accreditation functions, that:

   a) As part of a broader workforce reform agenda, regularly addresses education, innovative workforce models, work redesign and training requirements?

---

15 See for example, JAS-ANZ, www.JAS-ANZ.org.au
b) Has regular arrangements for engagement with key stakeholders such as the regulators, educational institutions, professional bodies, consumers and relevant experts?

This question again goes to the issue of workforce reform, which certainly aligns more closely with the accreditation function under the current AHPRA model than with the registration function.

The functions described under (a) and (b) would likely require a new authority, which APAC would not oppose, but the danger we see implicit in this question is that yet again the accreditation function would be the poor relation, this time struggling for attention beside what appears to be a revamp of the former Health Workforce Agency.

Greater independence of accreditation councils would enable them to address these issues. At present, the series of checks and balances build in undue conservatism so that nothing really changes.

APAC agrees that Accreditation Councils should operate more independently, but for reasons described above rather than subscribing to the notion that accreditation could lead workforce change.

Good accreditation standards, including the proposed new APAC Accreditation Standards currently awaiting approval, are designed to encourage innovation in teaching and learning, certainly not to stifle it or create barriers. Workforce reform starts elsewhere, however.

Specific governance matters

The roles of specialist colleges and post-graduate medical councils

31. Do the multi-layered assignment arrangements involving the National Boards, specialist colleges and post-graduate medical councils provide mechanisms for sufficient scrutiny of the operations and performance of these functions?

APAC has no comment on this matter.

Assessment of overseas health practitioners

32. Are there any reasons why processes for having qualifications assessed for skilled migration visas cannot be aligned with those for registration that are conducted under NRAS?

Such assessment depends on (a) judgement of the quality of training, and (b) judgement of the practitioner’s skills (e.g., English language competency, cultural awareness). The former is properly within the remit of accreditation councils, the latter within the remit of the registration board. This suggests a 2-stage process: (a) approval of qualifications, and (b) assessment of skill level, by the corresponding agencies.

33. Is there is a defensible justification for the bodies who have been assigned responsibility for accreditation of Australian programs not being assigned the function to assess overseas trained practitioners?

No, APAC would welcome this role.
34. Should there be consistency across the National Boards in assessment pathways, assessment approaches and subsequent granting of registration status for overseas trained practitioners?

Yes, for the reasons stated in Section 2 and Section 4.1 re consistency of processes

35. Should there be a greater focus on assessment processes that lead to general registration for overseas trained practitioners without additional requirements such as supervised practice and how might this be achieved?

Supervised practice is extremely important, as many recent disciplinary cases show. A period of supervised practice enables a safety net assessment in case of errors in the original assessment or in case of fraud. The protection of the public is paramount.

Grievances and appeals

36. Does the AHPRA/HPACF guidance document on the management of accreditation-related complaints resolve the perceived need for an external grievance/appeal mechanism?

The guidance note is unclear in a number of respects, and in any case essentially relates to internal review processes.

37. If an external grievance appeal process is to be considered:

a) Is the National Health Practitioner Ombudsman the appropriate entity or are there alternatives?

b) Should the scope of complaints encompass all accreditation functions as defined under the National Law, as well as fees and charges?

In principle, APAC would have no problem with the role of the National Health Practitioner Ombudsman being expanded to cover complaints about any aspect of accreditation, but further detail would be required.
5. Conclusion

APAC thanks Professor Mike Woods and the Review Team for their work on the Review to date.

We reiterate our commitment to protecting the public through ensuring the high quality of our graduates.

We support any moves to ensure accreditation is accorded appropriate recognition and attention within the NRAS scheme.

We welcome any support for alignment of processes and protocols, but caution against adopting a ‘one size fits all’ approach. In particular, we note the importance of maintaining close involvement of the profession in setting standards and competencies relating to their own practice.

We support moves to risk-based accreditation but note the danger of assuming the TEQSA model would work with health professional training, and doubt this would be accepted by the professions or the public.

The NRAS scheme has as its primary objective the protection of the public. Accreditation is a small part of the scheme but plays a vital role in achieving this objective.
Appendices:
(1) Pathways to becoming a Registered Psychologist
(2) Numbers of programs in each category accredited by APAC
(3) Example of IPE Framework: Griffith University
Appendix 1: Pathways to becoming a Registered Psychologist

Undergraduate psychology sequence
- 3 year sequence OR
- 3 year bridging program (12-18 months)

Fourth year of psychology

Four year psychology sequence
- 4 year sequence OR
- 4 year bridging program (24-30 months)

Provisional Registration

4 + 2
- 2 years of supervised

5 + 1 Internship
- Fifth year of psychology
- 1 year of supervised practice

General Registration

5th and 6th (plus) years of psychology
- At least 2 years of study with one or more of the following areas of practice endorsement:
  - Clinical
  - Forensic
  - Ed. & Dev.
  - Counselling
  - Organisational
  - Community
  - Health
  - Sport
  - Clinical Neuro.

General Registration
plus Area of Practice Endorsement
Appendix 2: Numbers of programs in each category accredited by APAC

Summary of APAC accredited programs 1 May 2017

1. The total excludes same title program offered at different campus within each Education provider

### Active programs

<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Count of Program Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 3 year</td>
<td>169</td>
</tr>
<tr>
<td>1 - 4 year</td>
<td>38</td>
</tr>
<tr>
<td>3 year bridging</td>
<td>10</td>
</tr>
<tr>
<td>4 year bridging</td>
<td>1</td>
</tr>
<tr>
<td>4th year</td>
<td>85</td>
</tr>
<tr>
<td>5 - 6 year</td>
<td>112</td>
</tr>
<tr>
<td>5 - 7 year</td>
<td>9</td>
</tr>
<tr>
<td>5 - 8 year</td>
<td>15</td>
</tr>
<tr>
<td>5th year</td>
<td>13</td>
</tr>
<tr>
<td>Post-masters bridging</td>
<td>9</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>461</strong></td>
</tr>
</tbody>
</table>

### Discontinued Programs (still being taught out)

<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Count of Program Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 3 year</td>
<td>59</td>
</tr>
<tr>
<td>1 - 4 year</td>
<td>12</td>
</tr>
<tr>
<td>3 year bridging</td>
<td>18</td>
</tr>
<tr>
<td>4th year</td>
<td>11</td>
</tr>
<tr>
<td>5 - 6 year</td>
<td>19</td>
</tr>
<tr>
<td>5 - 7 year</td>
<td>33</td>
</tr>
<tr>
<td>5th year</td>
<td>3</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>155</strong></td>
</tr>
</tbody>
</table>

**Total (Active +Discontinued) = 616**
2. The total includes same title program offered at different campus within each Education provider

### Active programs

<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Count of Program Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 3 year</td>
<td>233</td>
</tr>
<tr>
<td>1 - 4 year</td>
<td>62</td>
</tr>
<tr>
<td>3 year bridging</td>
<td>13</td>
</tr>
<tr>
<td>4 year bridging</td>
<td>3</td>
</tr>
<tr>
<td>4th year</td>
<td>120</td>
</tr>
<tr>
<td>5 - 6 year</td>
<td>124</td>
</tr>
<tr>
<td>5 - 7 year</td>
<td>9</td>
</tr>
<tr>
<td>5 - 8 year</td>
<td>18</td>
</tr>
<tr>
<td>5th year</td>
<td>15</td>
</tr>
<tr>
<td>Post-masters bridging</td>
<td>9</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>606</strong></td>
</tr>
</tbody>
</table>

### Discontinued Programs (still being taught out)

<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Count of Program Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 3 year</td>
<td>69</td>
</tr>
<tr>
<td>1 - 4 year</td>
<td>17</td>
</tr>
<tr>
<td>3 year bridging</td>
<td>22</td>
</tr>
<tr>
<td>4th year</td>
<td>11</td>
</tr>
<tr>
<td>5 - 6 year</td>
<td>19</td>
</tr>
<tr>
<td>5 - 7 year</td>
<td>36</td>
</tr>
<tr>
<td>5th year</td>
<td>3</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>177</strong></td>
</tr>
</tbody>
</table>

**Total (Active+ Discontinued) = 783**
Appendix 3: Example of IPE Framework: Griffith University
(extract only)

An implementation framework for interprofessional learning at Griffith Health 2011 – 2014
General schema

The Group recognises that 'one size does not fit all' in relation to interprofessional learning activities for professional programs. Clearly, the needs of students in different programs are somewhat distinct and a range of solutions will be required to ensure that they are all interprofessional practice-ready on graduation.

There will be circumstances where 'bilateral' (ie between students in just two programs) interprofessional learning activities will be appropriate and others where 'multilateral' activities (ie involving students in a wide range of programs simultaneously) will be required.

Ideally, a program to engender the values, understanding and skills that are necessary for effective interprofessional practice would occur at a point when students have already developed some sense of professional identity in relation to the profession in which they are training, but before they have been fully acculturated to existing practices and values within their profession that undermine optimal teamwork. In order to achieve this balance, the Group’s approach will include a matrix of different activities situated at different points in students' professional development. Each activity will be designed to be appropriate for their stage of development at that point.

The detailed content of these activities will accord with the proposed national curriculum framework for interprofessional education in the health professions that is currently under development through the project Curriculum Renewal for Interprofessional Education in Health, funded by the Australian Learning and Teaching Council. Health IDEAS is deeply involved in this project and will contribute significantly to the final form of the framework. For the present, a broad schema for interprofessional learning activities in Health Group professional programs is offered on the next page on the basis of the existing scholarly literature and of discussions at the recent Griffith symposium. Each core activity needs to be compulsory and appropriately assessed.

In addition to the 'core' activities outlined on the next page, the Group will continue to encourage and support the implementation of the excellent existing, elective, interprofessional learning activities developed by Schools, as well as other initiatives developed in the future, on a 'bilateral' or 'multilateral' basis, to enrich the learning experience of students.

All activities supported under this framework will be evaluated for their effectiveness in accord with the Educational principles elucidated in this document.
<table>
<thead>
<tr>
<th>Phase</th>
<th>Point In program</th>
<th>General description of activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>First year</td>
<td><strong>Introduction to the health professions</strong>&lt;br&gt;Activity aimed at providing an understanding of the history, theoretical underpinnings, roles and contributions of the major health professions, including participants’ own.&lt;br&gt;Ideally this would be undertaken through an interprofessional collaborative activity such as one or more problem-based learning cases. However, for larger programs it need not be undertaken interprofessionally (i.e. with students from other professions) but should at least involve academic input from multiple professions. As a minimum, it could take the form of interactive large group sessions involving guest speakers from multiple professions, supported by video resources where practitioners from the major health professions are interviewed and seen ‘in action’ in their professional roles. Students would be invited to ask guest speakers about their day to day roles. To improve interactivity, students might work through simple clinical scenarios and be invited to consider which professions might appropriately contribute at each point, and why.&lt;br&gt;This activity would need to be formally assessed in a way that is integrated with existing assessment for the relevant program.</td>
</tr>
<tr>
<td>II</td>
<td>Mid-program</td>
<td><strong>Simulated professional team experience</strong>&lt;br&gt;Activity aimed at providing students with a realistic experience of working in an interprofessional team but in a controlled and safe environment. This would involve creating interprofessional student teams who would work together on the assessment and management of simulated patients and clients (played by trained actors). Ideally student teams would be able to work together for a sufficient period to allow them to experience a range of team dynamics and interactions. This might be achieved by a single extended simulation (e.g. over a week) or through a series of regular simulated experiences over a longer time.&lt;br&gt;Scenarios for this activity would be crafted to enable students from each of the participating programs to draw upon - and demonstrate to their colleagues - the skills and understandings that are particular to their profession.</td>
</tr>
<tr>
<td>III</td>
<td>Final year</td>
<td><strong>Real service professional team experience</strong>&lt;br&gt;Activity aimed at providing students with a real life, work integrated, learning experience of practice in an interprofessional team, under supervision. This would involve working with senior students from other health professions in the direct assessment and provision of care to patients and clients. Students should, as far as possible, assess patients and clients themselves, then discuss and plan their care and support in interprofessional student teams, under the supervision of qualified practitioners, before personal involvement in the direct service provision.&lt;br&gt;This might take the form of placement in ‘student training wards’, as have been developed in Sweden, ‘student led clinics’ like those that have been trialed in North America and Rockhampton in Queensland or any of a range of other possible models or combinations of models.</td>
</tr>
</tbody>
</table>