The Australian Clinical Psychology Association (ACPA) thanks the Independent Commissioner for the detailed and thoughtfully developed consultation paper for the review of the National Registration and Accreditation Scheme (NRAS) for health professions, and for this opportunity to comment and participate in the process of consultation. ACPA represents those clinical psychologists that meet the standard for endorsement in clinical psychology established by the Psychology Board of Australia (PsyBA).

**Protection of public safety**

The importance and value of the NRAS and PsyBA cannot be underestimated in ensuring the protection of public safety. As per the Commissioner’s report, psychology is one of the five of the 14 regulated health professions that contributes to 95% of all complaints, indicating a high risk of harm to the public. Of those professions that exclude surgery and the prescribing of medication, psychology has the highest level of complaints. Psychology also has the highest level of mandatory reporting from within the profession itself (Bismark, Spittal, Pluekhahan & Studdert, 2014).

Preliminary data from tribunal findings that relate to the most serious complaints indicates that the pattern of notifications corresponds to the qualifications of psychologists (ACPA Research Committee, 2014, in analysis). While psychologists with all levels of training are represented at tribunals for boundary violations, qualified clinical psychologists have not come before tribunals for incompetence. The vast majority of psychologists found to be incompetent by tribunals are psychologists without accredited post-graduate qualifications in clinical psychology, and, in Victoria, counselling psychologists. This is despite the fact that clinical psychologists make up the largest Area of Practice Endorsement (AoPE) and would be expected to provide treatment for those with more serious mental health problems, where the potential for harm would be expected to be greatest. There are recent coroners’ findings in New South Wales where psychologists without accredited professional qualifications in any area of professional psychology treating serious mental health disorders have undertaken poor assessments or made incorrect diagnoses, leading to patient deaths.

The PsyBA was formed at a critical time in the history of psychology in Australia as standards of training were being undermined and were falling further behind the rest of the world. The implementation of the NRAS provided a floor to the dropping standards. The introduction of a National Examination further ensures that those trained via the unaccredited route of supervision are adequately prepared for basic psychology practice. This is to be applauded. As the Commissioner recognizes, consumers must “be confident the nation’s health professionals are properly trained and qualified to treat them” (2014, p. 5).

However, the issue of qualifications and standards in psychology still remains highly problematic. In 2006 when the Medicare Scheme was extended to psychologists, the Government wished to differentiate between practitioners and offer greater independence of practice and responsibility for more serious patient presentations to those psychologists with advanced training in mental health, and to provide a higher Medicare rebate in recognition of this. Accordingly they offered the higher rebate for services delivered by clinical psychologists, that is, those who specialise in the assessment,
diagnosis, formulation, treatment and evaluation of treatment outcomes for mental health problems.

The primary national body representing psychologists at that time, the Australian Psychological Society (APS), was given authority to determine which psychologists would be eligible to be recognised as ‘clinical psychologists’, which they determined were those who met entry criteria for their College of Clinical Psychologists. At the time the College entry requirement had been a four year undergraduate degree in the science of psychology, plus a minimum two year Master’s degree in clinical psychology, plus a year of supervised practice. However, once awarded authority to determine clinical psychology status, the APS executive removed the ability of the College to admit members on the basis of qualifications and established a ‘Medicare Assessment Team’, which then developed ‘Individual Bridging Plans’ for other psychologists to gain entry to the College via an ‘alternate route’ – one which no longer required accredited post-graduate qualifications in clinical psychology.

This move divided the profession, with many clinical psychologists leaving the APS, and other psychologists joining in order to take advantage of the new classifications for Medicare rebates; but more importantly it led to a complete incapacity for referrers to identify those clinical psychologists with advanced accredited postgraduate training in order to refer their patients with more severe, and/or chronic, or comorbid mental health problems. This also removed the capacity for the public to make informed decisions regarding their treating practitioner. Those psychologists who applied to the APS for entry to the College, but failed to meet the lowered standard, felt they were treated unfairly, while those who had undertaken accredited postgraduate qualifications in clinical psychology feared that the undermining of professional standards placed the public at risk. It was out of this concern that ACPA emerged to represent qualified clinical psychologists.

With the introduction of the NRAS, those determined to be members of the APS College of Clinical Psychologists were grandfathered into endorsement as clinical psychologists with the PsyBA. In subsequently addressing this issue, the PsyBA stated:

The Board proposes to not recognise individualised non-accredited bridging courses. The Board’s view is these do not provide the sustained education, training and supervision that characterises the integrated experience in a specific postgraduate degree plus supervision program required for endorsement. (2010, p. 2).

Accordingly, the APS’s ‘alternate route’ to clinical psychology endorsement has now been closed, however, it did create a legacy in which more than half of the currently PsyBA endorsed clinical psychologists in Australia have not undertaken accredited training in clinical psychology. These clinical psychologists do not meet the minimum requirements for endorsement in clinical psychology established by the PsyBA. This leaves Australians unknowingly paying for higher level services by unqualified members of the profession, and referrers unable to identify those clinical psychologists who have been trained to meet the needs of those members of the public suffering more severe, comorbid, and chronic mental disorders.

It is important to note that the PsyBA has acted in fairness within its transition arrangements. This has largely deflected further divisions and the weakening of the profession, leading to a reduction of
psychological services to the public, as occurred, for example, in Cyprus in 2004 when the standard of practice for psychology was raised to a Master’s level (American Psychological Association, 2007). This is despite some complaints from psychologists without accredited professional training, particularly those without clinical psychology qualifications wishing for recognition as clinical psychologists, and those who represent them, such as the APS.

Properly regulated Areas of Practice Endorsements are critical for the protection of public safety and the proper governance of the profession, particularly in clinical psychology where the risks are high due to the level of complexity and vulnerability of those seeking services. While the PsyBA has established “the minimum standard for safe practice” by clinical psychologists, there is no current mechanism for recognition of those who meet this minimum standard. One mechanism that would enable identification of qualified clinical psychologists is specialist recognition. Consistent with terminology that is well recognized within the public sphere, recognition of qualified clinical psychologists as specialists will be necessary to ensure an informed public and referrers.

Given this recent history of the profession and the high level of risk of harm by psychologists to the public, the NRAS and PsyBA itself has been of critical importance. Protection of the public is paramount in the delivery of health services for our most vulnerable people with mental health problems. In the opinion of ACPA, as outlined above, we do not consider that the public is as yet fully protected or informed with regard to seeking services from clinical psychologists, and we ask that serious consideration be given to creating specialist title for those with accredited postgraduate training in clinical psychology.

Development of a flexible, responsive and sustainable workforce

Australia already allows the least amount and lowest level of training in the professional practice of psychology in the developed world. However, post-graduate professional training in psychology is currently under serious threat as it is deemed economically unsustainable. Despite having and no shortage of psychologists (ANZSCO, 2723, 2014; Grenyer, 2013), and in fact the largest psychology workforce amongst equivalent developed nations (Hyde, 2014), the bulk of Australia’s psychology workforce is currently the most poorly trained and will therefore be unable to adequately meet the mental health needs of the nation going forward.

Clear differentiation of qualified from unqualified clinical psychologists via specialist recognition of those with qualifications (as determined necessary for safe clinical psychology practice by the PsyBA) would enhance the flexibility, responsiveness and sustainability of the psychology workforce, while providing clarity of qualifications.

A tiered approach to registration, based on qualifications, allows for an appropriate triaged model of care to service the needs and demands of the community and enhance the practice of the profession. The full range of mental health disorders will best be managed by targeted interventions by the most appropriately qualified psychology practitioners for the specific condition and by cross-referrals between tiers, as patient needs change. For example, qualified clinical psychologists can be referred those with more moderate-severe, complex, chronic and comorbid conditions which require higher levels of training for adequate treatment, while endorsed but
unqualified clinical psychologists can be referred those requiring more flexible and higher level services than those provided by generalist psychologists who are trained to provide the more limited ‘Focused Psychological Strategies’ under Medicare, suitable for more mild – moderate mental health problems.

**Facilitation of workforce mobility**

While the NRAS has facilitated national mobility via a unified national system of registration, international mobility, particularly with other developed English speaking countries, remains very distant and apparently unattainable. Seventy percent of Australian psychologists would not be sufficiently qualified to practice as a psychologist in any other English-speaking developed country. In most of the developed English-speaking world a Doctoral degree for the practice of psychology is required (Hunt and Hyde, 2013). In Western Europe a Master’s degree plus a year of supervised practice is the minimum standard for practice as a psychologist.

The minimum standard for all Areas of Practice Endorsement established by the PsyBA is a Master’s degree plus a period of supervised practice, to bring post-graduate training to four years. In comparison, the minimum standard for generalist psychologist training in Australia is a four year undergraduate degree plus two years of unaccredited supervised practice. This is the least amount and lowest standard of training in the developed world. It is akin to jurisdictions such as Bangladesh.

**Facilitation of high-quality education and training**

There are serious difficulties in the facilitation of high-quality education and training in psychology in Australia. A reduction in the number of universities able to offer Doctoral degrees in psychology practice, to meet international standards in equivalent countries, such as the United Kingdom, Ireland, United States of America and Canada, or to match requirements for clinical psychology in New Zealand, has recently emerged. The new requirements of the Australian Qualifications Framework (AQF) for universities now defines Doctoral training as requiring research at a Doctor of Philosophy (PhD) level, thereby making professional Doctoral degrees overly costly and therefore unfeasible.

Postgraduate training of psychologists at Master’s level is also unsustainable as the cost to universities for each student trained is $8,500, due to the intensity of practical application of training required (Voudouris & Mrowinski, 2010). These costs are currently cross subsidized from undergraduate revenue.
Furthermore, state-based public health facilities are moving to include post-graduate professional psychology students in a planned program of cost recovery for field placement supervision, which creates further risks to the future of professional training. This is despite the fact that postgraduate professional psychology trainees enter field placements work-ready, due to intensive prior training received in university psychology clinics. Should fees be introduced for placements, accredited professional training in psychology would become unviable. This issue may be assisted with the awarding of Limited Registration to postgraduate students undertaking supervised training, as opposed to Provisional Registration, as is currently the case.

It is imperative that the NRAS play a strong role in ensuring training and registration of practitioners to international comparative standards, even if for the higher qualified subset of the profession, in order to ensure acceptable quality of care to the Australian public and the capacity of the profession to be developed and sustained.

**Facilitation of assessment of overseas-trained health practitioners**

The duplication involved in the assessment of psychology qualifications for Visa applications, which falls under the auspices of the APS, and approval of these qualifications by the accrediting body for psychology, the Australian Psychology Accreditation Council (APAC), delays applications, adds to costs, and disadvantages overseas-trained practitioners who generally bring higher qualifications than locally trained psychologists. Standards in other developed English speaking countries and Europe are higher than those in Australia. The merger of these two application processes under the accreditation authority, APAC, is essential to ensure standards and facilitate these assessments.

**Promotion of access to health services**

Access to quality clinical psychology services is being severely restricted by State/Federal cost-shifting as State facilities refer patients with all levels of severity of mental health problems to Federally funded schemes and introduce case management models of care in State facilities. This is a poor utilization of highly qualified mental health professionals, such as clinical psychologists. The diminution of State services reduces access to effective mental health services for the most vulnerable people in our society with the most severe, chronic, comorbid and complex mental health problems.
Responses to questions posed by the Commissioner

1. Should the Australian Health Workforce Advisory Council be reconstituted to provide independent reporting on the operation of the National Scheme?

Independent review of the operation of the National Scheme is necessary on a regular basis; however, the re-constitution of the Australian Health Workforce Advisory Council (AHWAC) to provide ongoing reporting adds to the cost burden of the Scheme and provides another layer of potential conflict in the interests of Federal, State and Territory Ministers and the health professions. The independence of any body that is constituted to review the National Scheme must be assured to adequately weigh tensions between standards of education and training, protection of the public, and workforce needs. If reconstituted to undertake this function, AHWAC cannot have responsibility for workforce size and shortages.

A case has not been made for the reconstitution of AHWAC to undertake this function. The reasons for the previous demise of this body are not given. Should AHWAC be reconstituted, the terms of reference and key performance indicators would need to be clearly identified and published for consultation before a decision can be made as to its value relative to the costs and potential difficulties that are likely to emerge. A case would need to be made as to why other current bodies, such as the Health Ministers Advisory Council (AHMAC) in conjunction with the Agency Management Committee, cannot review the scheme.

However, if AHWAC, or any other body, were granted the authority to integrate health services across State/Territory and Federal funding parameters to ensure continuity and integration of care for the public accessing health services, then such a body would be invaluable. Responsibilities of State/Territory and Federally funded programs need to be clear to prevent cost shifting to the detriment of patients. Health care needs to be integrated, adequate and efficient, with the best utilisation of different levels of training of all health professionals to obtain value for the monies spent.

2. Should the Health Workforce Advisory Council be the vehicle through which any unresolved cross professional issues are addressed?

A case would need to be made as to why the Agency Management Committee cannot undertake this task, as the overseer of the Scheme, before adding another layer of complexity and potential friction to the mix.

3. Should a single Health Professions Australia Board be established to manage the regulatory functions that oversee the nine low regulatory workload professions? Estimated cost saving $11m per annum

It is appropriate that high risk professions, such as Psychology, are excluded from this merger due to the far greater regulatory workload and complexity of this profession. However, a single Health Professions Australia Board to manage the regulatory functions that oversee low regulatory
workload professions, with an estimated saving of $11m per annum is an excellent proposal. The exclusion of the Chiropractic profession from this Board needs to be considered as the number of notifications per thousand practitioners is high and equates to other professions that incur higher costs, despite the low number of practitioners in this profession. Of key relevance is the potential harm to public posed by Chiropractic health professionals. If the risks of harm are serious, these professionals need to be more carefully regulated and their registration fees need to reflect the costs of the regulatory workload required for the public safety.

4. **Alternatively, should the nine National Boards overseeing the low regulatory workload professions be required to share regulatory functions of notifications and registration through a single service?** Estimated cost saving $7.4m pa.

While ACPA supports Option 1 (as above) in amalgamating the regulatory functions that oversee the nine low regulatory workload professions into a single Health Professions Australia Board, it might be wise to take a step-wise approach towards achieving this goal. The nine National Boards may initially be required to share regulatory functions of notifications and registration through a single service as a step towards full consolidation of all functions of the regulatory process under a single Board. This would enable the costs of establishment of a single Board to be spread, and allow for due consideration before moving forward to a single Health Professions Australia Board to avert any unintended consequences that may become apparent in this first step.

5. **Should the savings achieved through shared regulation under options 1 or 2 be returned to registrants through lower fees?**

Savings achieved through shared regulatory functions should indeed be returned to registrants through lower fees for these professions.

6. **Should future proposals for professions to be included in the National Scheme continue to require achievement of a threshold based on risk to the public and an associated cost benefit analysis?**

A threshold based on risk to the public and an associated cost benefit analysis is essential for future proposals for professions to be included in the National Scheme. The primary role of the National Scheme is the protection of public safety in the delivery of health services. Due to the costs involved in regulation, this primary role needs to define membership, not any other driving force for professional recognition.

7. **Should the National Law be amended to recognise those professions that provide adequate public protection through other regulatory means?**

The National Law needs to ensure that all professions that pose risk to the public are adequately regulated and that this regulation is efficient and properly accountable. Regulatory processes need to be regularly reviewed for all professions that pose risk to the public to ensure the mechanisms operate efficiently and serve the public interest. If this can be undertaken in cases where professions have a relatively low risk profile and other regulatory means are adequate, regular audits of the
regulatory processes may be adequate. However, where there is high or serious public risk, the current standard regulatory functions need to apply.

8. **Should a reconstituted Australian Health Workforce Advisory Council be the vehicle to provide expert advice on threshold measures for entry to the National Scheme to the Health Workforce Ministerial Council?**

A case would need to be made as to why the Agency Management Committee cannot undertake this task, as the overseer of the Scheme, before adding another layer of complexity and potential conflicts to the mix in reconstituting the Australian Health Workforce Advisory Council.

9. **What changes are required to improve the existing complaints and notifications system under the National Scheme?**

The commissioner has listed the difficulties inherent in the current management of the Scheme in terms of the concerns raised about the management of notifications. AHPRA’s management is cumbersome and non-transparent. A State and Territory-based co-regulatory system with a single point of entry and oversight of the ongoing process of management, such as that in Queensland, would be an ideal way to address these difficulties.

10. **Should the co-regulatory approach in Queensland, where complaints are managed by an independent commissioner, be adopted across all States and Territories?**

The co-regulatory approach to managing complaints by a single independent commissioner, as operating in Queensland, would bring efficiencies and streamline processes and is recommended. This system needs to be extended to all States and Territories other than NSW, where effective co-regulatory functions currently operate. The relative advantages of the NSW and Queensland co-regulatory systems need to be identified and amalgamated.

11. **Should there be a single entry point for complaints and notifications in each State and Territory?**

This would be ideal. It would certainly lead to greater efficiencies and allow follow-up to ensure all aspects of the complaints process meets the standards set.

12. **Should performance measures and prescribed timeframes for dealing with complaints and notifications be adopted nationally?**

National performance measures and prescribed timeframes for dealing with complaints and notifications are essential for equality and fairness. National measures and prescribed timeframes for dealing with complaints and notifications are necessary.
13. *Is there sufficient transparency for the public and for notifiers about the process and outcomes of disciplinary processes? If not, how can this be improved?*

Not currently. Notifiers are not made aware of the process and outcomes of decisions, or the reasons behind the findings. Should a single independent commissioner be appointed for each State and Territory a process of oversight by the commissioner would enable greater transparency for the public and notifiers.

14. *Should there be more flexible powers for National Boards to adopt alternative dispute resolution, for instance to settle matters by consent between the Board, the practitioner and the notifier?*

Absolutely! Flexibility in the approach to resolution of disputes ensures a less adversarial approach. However, care needs to be taken to ensure that these methods are not applied when serious risk to the public is in evidence.

15. *At what point should an adverse finding and the associated intervention recorded against a practitioner be removed?*

Adverse findings and associated interventions recorded against a practitioner should be removed once the conditions have been met, and there are no further restrictions on the practitioner’s practice. Confidential historical records must be kept in AHPRA and applied in situations where a practitioner has further complaints made against them, until the practitioner leaves the profession.

16. *Are the legislative provisions on advertising working effectively or do they require change?*

Legislative provisions on advertising are generally working efficiently, but require emendation to provide greater clarity on the use of testimonials when public comment is permissible, such as on social media sites (Option2). The use of testimonials in advertising by practitioners themselves needs to remain restricted in order to protect the public from undue influence.

17. *How should the National Scheme respond to differences in States and Territories in protected practices?*

Differences in States and Territories in protected practices cause confusion for the health professions and the public. The National Scheme needs to evaluate outcomes and safety of the public in jurisdictions with different protected practices to determine how best to serve the public and to move towards unity and agreement.
18. In the context of the expected introduction of a National Code of Conduct for unregistered health practitioners, are other mechanisms or provisions in the National Law required to effectively protect the public from demonstrated harm?

This work is to be commended. The protection of the public needs to extend beyond the currently regulated professions to all health care providers, particularly to those that do not hold accredited training and education standards. It is frequently at the hands of untrained and unqualified practitioners that serious risks to the public emerge. Mechanisms for public protection for unregulated practitioners are not always available in all States and Territories, and where they are the processes and methods are not clear and transparent, so are often not utilised.

The National Law needs to provide mechanisms of complaints and notifications that are straightforward with appropriate outcomes. It may be that the co-regulatory systems of all health complaints and notifications handling via the ombudsman for each State and Territory could be expanded to bring all those who deliver health services under their auspices.

19. Should the mandatory notification provisions be revised to reflect the exemptions included in the Western Australian and Queensland legislation covering health practitioners under active treatment?

No. If treating practitioners are not required to make mandatory notifications of serious breaches of professional conduct and/or impairment, the NRAS essentially hands the task of regulation over to the treating practitioners. Treating practitioners may not have access to a range of other information that regulatory authorities would hold, such as past complaints, history of impairment etc. Furthermore, mandatory reporting enables National Boards to put in place other supports or supervision that are beyond the capacity of a treating practitioner. There needs to be a process whereby a treating practitioner can submit, within their notification, that they believe the impairment is being well managed, and in some circumstances the regulator may then decide to take no further action.

20. To what extent are National Boards and Accrediting Authorities meeting the statutory objectives and guiding principles of the National Law, particularly with respect to facilitating access to services, the development of a flexible, responsive and sustainable health workforce, and innovation in education and service delivery?

It is difficult to meet the health needs of Australians when models of health care and funding lack integration and are based on cost shifting and avoidance of responsibilities between State/Territory and Federal Governments. The development of a flexible, responsive and sustainable health workforce is difficult in an environment where the shifting sands of funding drive services, rather than patient needs. It is difficult for Boards to prepare a workforce to meet the health needs of the population when the focus remains on funding the least expensive alternatives at the expense of expertise.
21. Should the proposed reconstituted AHWAC carry responsibility for informing regulators about health workforce reform priorities and key health service access gaps?

It is essential that a body is constituted to oversight the health system; in particular, cost-shifting between Federal and State/Territory funding schemes, that reduces the efficacy of treatment by dividing responsibilities and off-setting these against budgets, rather than placing the needs of the patient at the centre and ensuring an integrated care model that adequately meets needs. The current funding models place members of the public at serious risk of harm as treatments offered are inadequate, poorly tailored to need and lack coordination. For example, in mental health State/Territory services are being disseminated as more severe and chronically ill patients are shifted to short-term private care under federally funded schemes that are inadequate to meet their needs. A different model of cost sharing and responsibility is required for more vulnerable patients to benefit from health care services and receive sufficient care. If the public can be served by AHWAC in this manner, the outcomes would be greatly improved and the public better served. However, this should then preclude AHWAC from undertaking oversight of the National Scheme as it would no longer be an independent body, but would hold a potentially opposing agenda to the National Scheme in the establishment of standards and regulation of the health professions.

Difficulties are likely to arise as gaps in services are identified and professionals without adequate training to meet the service needs are deployed to work beyond their scope of expertise; thereby placing the public at risk. The body constituted to oversee this function needs to work closely with regulators to resolve such difficulties, not over-ride standards of training and education to increase workforce size and address needs via lower educational and training of health professionals. This is a false economy and solution as efficiencies obtained by adequately trained health professionals are not acknowledged.

22. To what extent are Accrediting Authorities accommodating multidisciplinary education and training environments with coordinated accreditation processes or considering future health practitioner skills and competencies to address changes in technology, models of care and changing health needs?

Psychology competencies include inter-disciplinary communication skills, but there is little integration of services between the profession and the private and public sectors that would enhance a multidisciplinary approach to education and training. Structural changes to the models of health care delivery are essential to lead these developments. Health services delivered by the States/Territories and Federal Governments need to be integrated to enhance patient centred care and a multidisciplinary approach to health care.

23. What relationship, if any, is required between regulators and educational institutions to ensure the minimum qualification for entry to professions remains available?

Regulators and educational institutions need to be mutually involved in accreditation processes and interface on requirements at this level to ensure balance between minimum qualifications for entry
to the health professions and safe, effective, adequate and sustainable training of health professionals.

24. How effective are the current processes with respect to assessment and supervision of overseas trained practitioners?

In psychology the dual system of Visa application and assessment of qualifications lengthens the process of assessment of overseas practitioners and amplifies costs. Both of these functions need to be integrated under the auspices of the accreditation body for psychology, APAC.

25. Should the appointment of Chairperson of a National Board be on the basis of merit?

No. It is essential that the Chairperson of each National Board is a member of the profession the Board represents. Health professionals look to the Chair of their National Board to provide leadership and regulation of the profession. A non-professional in this role is unlikely to understand the application of professional practice for the profession represented, or the nuances of differences between different segments of the profession, leading to conflicts and a lack of confidence in the Chair and the Board. This would undermine the standing of the NRAS and the professions themselves.

26. Is there an effective division of roles and functions between National Boards and accrediting authorities to meet the objectives of the National Law? If not, what changes are required?

Yes, there is now sufficient division of roles and functions between the PsyBA and the Australian Psychology Accreditation Council (APAC).

27. Is there sufficient oversight for decisions made by accrediting authorities? If not, what changes are required?

The PsyBA has needed to undertake an enormous task in resolving difficulties with the accreditation process in psychology, and has achieved a great deal. However, there is still much to be done in this area.

The history of accreditation of the psychology profession is outlined by the APAC:

Since the early 1970’s the discipline and profession of psychology in Australia has had a national accreditation process in place for higher education courses. This process was managed by a professional association (the Australian Psychological Society, hereafter APS) and although the accreditation system was not originally intended to be used for the purpose of assessing eligibility for registration as a psychologist, registration boards noted and mostly respected the accreditation status it granted. By 2002, however, concern was growing about inconsistencies between decisions made by the APS concerning the accreditation status of courses and decisions made by State and Territory registration boards regarding which degrees were acceptable qualifications for the purpose of registration. In 2005 this concern led the Council of
Psychologists Registration Boards Australasia (CPRB) and the APS to jointly establish a national accreditation body, the Australian Psychology Accreditation Council Limited (APAC). (2010, p.2).

However, with the introduction of the NRAS and the demise of the Council of Psychologists Registration Boards Australasia (CPRB), the APS reconstituted APAC as the single member. This has taken some time to rectify and a re-constituted APAC is now commencing to operate.

However, during the period that the APS was in primary control of APAC new standards of training were developed that were entirely unsatisfactory in ensuring the protection of the public. The PsyBA has returned these standards for review by the newly reconstituted APAC. If satisfactory standards of training cannot be adequately developed by the current Board of APAC, the PsyBA will need to remove the accreditation authority from APAC and devolve this to a PsyBA Committee. Currently the PsyBA is overseeing this process and has the trust of the profession as a whole.

28. **The Review seeks comment on the proposed amendments to the National Law.**

It is clear that the regulatory laws around health professionals in different States and Territories and the Commonwealth are complex, at times contradictory and frequently overlapping. The proposed changes bring greater clarity and update current structures. Any streamlining of these processes is helpful.
References


