A submission in response to the Consultation Paper, August 2014 for the Review of the National Registration and Accreditation Scheme for health professions.

On behalf of the Australian Psychological Society’s College of Health Psychologists, I am forwarding you the following responses to the questions posed as part of the review of the National Registration and Accreditation Scheme for health Professionals.

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

The College has two concerns regarding the introduction of a reconstituted AHWAC to undertake independent reporting on the National Scheme. First, given the objective of AHWAC, it is likely to prioritise workforce issues over protection of the public. While Australia is facing health workforce challenges, it is critical that workforce matters do not impact on public safety through a reduction in standards. Secondly, there would be a duplication of reporting of the National Scheme, given that AHPRA is governed by an Agency Management Committee that reports to and advises AHMAC.

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

Our understanding is that Australian Health Workforce Advisory Council main function was to understand and manage workforce issues. In particular meeting workforce needs. As such the council was not equipped to understand and manage cross-professional issues. This would seem to be better managed by a council that involved representatives from peak professional associations.

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.
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.

There is a significant risk that a single Health Professions Board will lose its responsiveness to the needs of individual professions and their members. Already I have heard reports from psychologists of a diminished responsiveness in the move from state based to a national based registration board. A further amalgamation is likely to only exacerbate this experience. As such, of the two options our preference would be for the option set out in Question 4.

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

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

We are concerned that a reconstituted AHWAC would prioritise workforce needs and so be a possible threat to training standards with a focus on filling positions rather than on quality assurance. It is also unclear how AHWAC could provide expert advice on threshold measures for entry to the National Scheme based on their previous functions.

9. What changes are required to improve the existing complaints and notifications system under the National Scheme?
10. Should the co-regulatory approach in Queensland, where complaints are managed by an independent commissioner, be adopted across all States and Territories?
11. Should there be a single entry point for complaints and notifications in each State and Territory?
12. Should performance measures and prescribed timeframes for dealing with complaints and notifications be adopted nationally?
13. Is there sufficient transparency for the public and for We about the process and outcomes of disciplinary processes? If not, how can this be improved?
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?

We believe that a central national for registering complaints is very beneficial to clients. A single entry point will maximise the ease and simplicity for clients to make complaints. In addition it addresses the issue of equality in that all Australian having the same right to complain and having the same processes of complaint irrespective of the state you live in. The complaints and notifications systems in Australia have become increasingly complex especially with the various different mechanisms now in place in for example, Queensland and New South Wales. One of the objectives of the National scheme was to ensure consistency across jurisdictions with respect to how complaints and notifications are managed.

However, we also believe that complaints should then be heard at the lowest level possible. This could be at a state level for larger states and a combination of several states and territories for the smaller states/territories. This will maximise the responsiveness of the committee that hears the complaints. Co-regulation is likely to make the process more complex for clients and more expensive for psychologists to fund.

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

If the practitioner is working full time then a period of approximately 2 years may be sufficient time to demonstrate a change in conduct, and so have any adverse findings removed against their name. If the individual is working part time then we suggest a period of 3 years.
16. Are the legislative provisions on advertising working effectively or do they require change?
The current legislation on advertising should be updated to keep abreast of the moving world of social media – especially sites like Facebook and LinkedIn. A psychologist should not be held responsible for what clients write about them on social media sites provided they have no involvement in the construction in the testimonial. My understanding is that this has been a significant issue for medical practitioners and that AHPRA has struggled to respond to their concerns because the legislation is not sufficiently clear.

Testimonials can have a powerful effect on the success of marketing, however there are significant ethical issues associated with soliciting testimonials from current or recent clients due to power imbalances and possible coercion (e.g. offering payment or discount for future services in return for favourable testimonials). As such it may be simplest to continue a ban on the solicitation of testimonials, but make it explicit that practitioners have no responsibility over unsolicited testimonials. In addition, we believe that solicited testimonials from colleagues and mentors are fine, and in line with international standards.

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

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?

We support the introduction of a National Code of Conduct for unregistered health practitioners. Public safety and quality of service is critical in this expanding area of service provision. We also support a mechanism that will allow an appropriate body to take responsibility for investigations and sanctions against unregistered health practitioners.

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?

In response to question 19, it is essential that practitioners are able to access health providers if they have a health issue, and the exemption in Qld and WA are very important in that they encourage health professionals to seek help, without fear of being reported under the mandatory notification regulation. Therefore the mandatory notification provisions should be revised to reflect the exemptions included in the Western Australian and Queensland legislation covering health practitioners under active treatment.

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?

Given the expected increase in lifestyle and behavioural medicine-related illnesses (chronic diseases such as diabetes, coronary heart disease) and the lack of psychological services for individuals with illness perceptions, behavioural habits and treatment adherence problems,
and the recent HWA *Psychology in Focus* report there is a developing shortage of psychologists in the workforce, the current access to service is not sufficient, flexible or providing an adequate behavioural psychology workforce. Under the National Law, the current regulation for entry to registration for psychologists is the completion of a 4-year APAC accredited program in Psychology followed by 2 years of either supervised practice or an APAC accredited Master degree. Notwithstanding the large number of students who successfully complete a major in psychology (APAC approved undergraduate program), the access to 4th year and Masters Programs is minimal. The way forward to ensure an adequate workforce of psychologists is to either:

- Increase the funding to psychology departments in university as a means of employing more staff and providing resources to train future psychologists
- Change the education model for psychology. (e.g., entry to professional psychology training after the completion of a 3 year accredited degree in psychology, which would be consistent with the recommendations from the AQF)

**21. Should a reconstituted AHWAC carry responsibility for informing regulators about health workforce reform priorities and key health service access gaps?**

While the provision of such information may be helpful for health profession regulators, a reconstituted AHWAC may not be necessary to provide such information. It is likely to be cheaper and more efficient to include such processes into existing government agencies rather than reconstituting an entire agency.

**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?**

The current accreditation Standards for Psychology do not include sufficient scope for encouraging multidisciplinary competencies to be developed. Furthermore, the prohibition of any cross-disciplinary supervision to be allowed is not consistent with more collaborative ways of working, nor changing models of care. Given as indicated above the increase in lifestyle related complex diseases and disorders, multi-professional practice (interprofessional practice) is necessary. Consistent with the International models such as the WHO *Framework for Action on Inter-professional Education and Collaborative Practice* is the most recent HWA (2013) report *Inter-professional Education: A National Audit*, which indicates that IPE in Australian universities “exists on the margins of the curriculum, minimally resourced and …frequently unsustainable…” (p10) and argues that IPE needs to be included in all accreditation standards and that a national approach to IPE is required.

In addition, and with an extension of the needs for a diverse psychology workforce as outlined in question 21, the uptake of training in interdisciplinary models of care would be best achieved when there is a tangible and salient need for such an approach. For example, the area of health psychology services for chronic disease management by its nature requires a collaborative approach with medical, nursing, dietetics, physiotherapy, and other allied health and social service professionals to achieve the best outcome and improvements for patients and the community. The need for such a collaborative approach might not seem as relevant to universities or students undertaking the currently dominant type of psychology training for severe mental illness (i.e., Clinical Psychology).
23. What relationship, if any, is required between regulators and educational institutions to ensure the minimum qualification for entry to professions remains available?

Clearly there needs to be very strong relationships between the regulators and the educational institutions to ensure the minimum entry to professions remain available. While some psychology education providers are resistant to changing standards for accreditation which may see additional applied psychology content required in an undergraduate degree as preparation for professional at a 4th and 5th year (AQF level 8 & 9), education providers need to recognise that psychology education and training is no longer consistent with international Standards for education and training in psychology (see for example, the EuroPsy, or the UK models of education and training). If the National Law were changed so that the regulations for entry to the profession were changed, accreditation standards would need to be revised, and then educational institutions would be required to make changes to their accredited programs to accommodate innovation in the education and training of psychologists.

While the objectives between regulators (i.e. protect public safety) and educators (i.e. provision of quality learning) are overlapping, there is also the potential for differing objectives and as such it would seem wisest to ensure some degree of separation in a co-equal relationship.

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

While the review provides limited information regarding the assessment of overseas practitioners, it would seem that the system appears to work well mostly at the moment.

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

Yes.

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?

Yours Sincerely,

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