30 September 2014

Dear Mr. Snowball,

Following is the College of Organisational Psychology’s submission to the AHMAC Review.

We hope the Review meets your requirements, but wanted to emphasise that Organisational Psychology as a profession has much to contribute to organisations in a highly competitive global environment.

We strongly believe in the potential value and uniqueness we can provide the Australian community, particularly organisations looking to be effective and efficient in a highly competitive world environment.

Our greatest challenge however is that the current requirements make it increasingly difficult for us to maintain our professional, and therefore the body of knowledge and capability that we are able to develop in our young professionals.

Psychology is a diverse profession, and our unique contribution to it we feel would be at risk without taking into account the specific environment in which we operate in.

We are not asking to be exempt from professional development and professional standards, but rather to be evaluated against standards that make sense in terms of the environment in which our members work, and standards which make sense in terms of maintaining the contribution that our profession makes to the overall Australian community.

We have detailed our concerns in the attached submission and we would be available to meet to discuss these in greater detail.

Please feel free to contact us any time to discuss any of the specifics of our submission, and we hope you look upon it favourably and understand the predicament in which we find ourselves.

Kind Regards,
Peter Zarris

National Chair, College of Organisational Psychology
College of Organisational Psychologists

SUBMISSION

TO

THE AHMAC\(^{1}\) REVIEW
(the ‘Snowball Review’)

OF

THE NATIONAL REGISTRATION AND ACCREDITATION SCHEME (NRAS)
30 September 2014

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\(^{1}\) Australian Health Ministers Advisory Council, comprising the heads of State, Territory and Commonwealth departments of health and the CEO of the New Zealand counterpart.
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EXECUTIVE SUMMARY

Now is a time of increasing globalisation of and innovation in manufacturing, commerce, finance, education and other sectors and industries in Australia, requiring sophisticated understanding of socio-technical, socio-economic and political systems, effective leadership and forward-looking managerial decision-making to ensure optimum development and use of “human capital” and other resources, in different cultural and organisational contexts and industries with high degrees of volatility. Industrial and organisational psychologists are amongst those who make major contributions in these areas, providing valuable and valued services not only in the private sector but also in the non-health areas of the public sector (education, justice, the military, air, sea and road accident investigation and prevention, the Family Court, etc.). These services are “non-health” in that they have different goals from improving an individual’s mental health, especially

• improving organisational productivity and effectiveness,
• managing social, organisational, group and individual change more effectively,
• advising on organisational redesign and restructuring for greater adaptability to external factors,
• improving job, equipment and procedures design and redesign to incorporate better the “human factors” involved and new technologies,
• providing evidence-based leadership effectiveness training,
• improving personnel training system features more generally in pursuit of optimum levels of skilled performance by staff in dynamic contexts,
• ensuring better personnel selection through psychometric testing and other evidence-based selection methods,
• more effective conflict resolution, and so on.

They also have different clienteles – often the “client” is legally an artificial body (including schools and courts as well as businesses), represented by business executives, government leaders, judges, principals and others - none weak in social or organisational power or “vulnerable” in other ways, with service delivery being typically “on site” rather than in a medical clinic. These differences have important implications for policies such as about duty of care, the balance of power in complaints-making, and the scope and content of relevant professional standards, training and CPD.

But the NRAS, in whose regulatory ambit industrial and organisational psychologists were included without the modifications they sought, is a scheme designed only for the regulation of the health professions and health services in the health sector and health industry, in a more economical and effective way than the previous separate registration systems, which were also health-focused.
That has been only a limited success with much improvement required. However it is not “fit for purpose” for psychology as a whole, which as indicated spans much more than the health sector.

Damage is occurring in various ways that in concert with chronic and worsening university underfunding and associated major cost increases for trainee psychologists is badly affecting our diverse profession:

- closure of popular and needed organisational psychology (and some other) accredited Masters programs that had led to registration, frustrating large numbers of intending students and dramatically reducing the output of trainees and research from the higher education bodies for our areas of psychological practice,
- unnecessary “clinicalisation” of the “beyond health” areas’ standards, with dramatic increases in the duration and costs of training for those specialisms,
- narrowed supervision requirements, shrinking the number of available supervisors and placement opportunities unnecessarily by imposing “clinical” criteria,
- thus further eroding our areas of specialist workforce development and training,

all leading to:

- impeded competition especially by truncating the future range of available services;
- added red tape and costs arising from a too-heavy regulatory footprint;
- but at the same time neglect of the rather different service and regulatory needs of the business, government and other communities (the “non-health publics”) currently using our forms of psychological services.

In effect the title “psychologist” has been commandeered by the health sector: it cannot be used unless the psychologist, in essence a “scientist-practitioner”, accedes to being classed instead as a “health professional”, and accepts a narrow “one size fits all”, “clinical” regulatory template suited primarily to health sector individualised mental health services. *Its diversity, which should be celebrated, protected and actively encouraged, is instead being seriously eroded.*

We have workable proposals about solutions for these significant problems especially for the publics and sectors beyond “health”.

*(End of Executive Summary)*
Introduction

1 Nature of Submission

This Submission evaluates aspects of the National Registration and Accreditation Scheme (NRAS) relevant to the profession of psychology, for the national-level review of the NRAS being carried out by Mr Kim Snowball, ex-Director-General of Western Australia’s Dept of Health. His review is reportedly being overseen by a panel of three health department heads comprising the Secretary Australian Government Dept of Health (presumably Mr David Learmonth, currently Acting Secretary), Dr Mary Foley, Director General, Ministry of Health, NSW and Mr Pradeep Philip, CEO, Department of Health, Victoria. These panellists being current members of the Australian Health Ministers Advisory Council (AHMAC), we refer to the review as the AHMAC (or alternatively the Snowball) Review.

It has been difficult for us to retain confidence in the submission-making and advocacy processes regarding the introduction and operation of the NRAS, as little real progress seems to have been achieved to solve key problems for our profession. On the positive side, many calls have been made for submissions on important features. But insufficient responsiveness from the NRAS bodies especially the Australian Health Practitioners Registration Authority (AHPRA) and the Psychology Board of Australia (PsyBA) to submissions has been a major perennial problem. That has been so despite:

- the 2009 Senate Inquiry into the NRAS (to which the College made a detailed submission and joined in an APS team making an oral presentation) specifically recognised and noted in its report that organisational psychology was experiencing problems which needed attention. The Senate Inquiry wrote “Evidence from psychology associations indicated that that profession is unique to the extent that it might be considered to have health and non-health streams; and that the NRAS as proposed needs to better accommodate these different streams in the design of its accreditation, registration and complaints processes.”
- the Western Australian Parliament’s Inquiry Report No 52: “Report On The Health Practitioner Regulation National Law (WA) Bill 2010” observed “5.57 The long title of the Bill states that this is an Act to ‘provide for a national registration and accreditations scheme for health practitioners’. This description may not cover some branches of the psychology profession.” (The College made a submission to this Inquiry.)

2 In the Intergovernmental Agreement (IGA) which established the NRAS, an independent review of the Scheme was to be carried out under the auspices of the Australian Health Workforce Ministerial Council (henceforth “the Ministerial Council” or AHWMC) after the first three years of operation of the NRAS, i.e. after 1 July 2013 or (arguably) after 18 October 2013, the third anniversary of Western Australia’s belated joining in the NRAS. The term “independent” appears not to have been defined. Nor has the notion of “oversight” by an AHMAC panel been explained or foreshadowed in either the IGA or pre-implementation consultation papers, so far as we can establish.
Unfortunately no action has been taken on these important (to us) parliamentary-level recommendations. No avenue is available in the NRAS system for complaint about this inaction.

This AHMAC (Snowball) Review of the NRAS is particularly important in providing an opportunity for a coordinated and comprehensive national review of a complex regulatory system in which we hope the special problems of psychologists working outside the health sector and health industry such as industrial and organisational psychologists, and delivering very important “non-health” services, may at last be widely recognised and effective action taken.

We stress that in our various assessments there is no intention to denigrate “health” services (including “clinical”, using this term broadly) or other areas of psychology or other professions such as psychiatry, mental health nursing and social work which provide mental health services. We respect them as colleagues, and their work as very significant. Nor do we wish to stand in the way of important reforms to health care delivery. Of particular relevance for psychologists, the need for improvements in mental health services, in funding but also in staffing numbers, competencies and facilities to allow for much greater availability of expert service providers across the broad range of mental health conditions, is now (we hope) widely acknowledged, but governmental actions have yet to satisfy this need, especially in the public health systems where unfortunately psychological therapies are generally still not readily available.

However it is the inadequacy of regulatory recognition of the other (“beyond health”) areas of the profession and the substantial negative consequences flowing from it (for the whole of the profession and the significant “publics” using our diverse range of services) which concern us greatly and motivate us to seek changes. These other “publics” are not the same as the “public” that receives health services, and their regulatory needs are somewhat different. Ultimately the “clinical” areas of professional work will also be damaged by diminution of the diversity of our profession, the loss of the important contributions made to the profession’s overall knowledge base and skills by the very innovative non-health areas, and other negative developments.

This unintended but real reduction in “intellectual capital” and relevant services should (we consider) be viewed with some alarm by governments, private sector leaders and other stakeholders.

2 COMPLEXITY OF THE NRAS

The NRAS is a complicated, wide-ranging system with many (in our view too many) participants and units of administration (especially at government level), involving a raft of important issues. It embraces not only registration (involving the setting of entry standards for general registration and separate and more specialised entry standards for use in approving specialist “practice area endorsements”) but also course accreditation,
workforce planning and the handling of complaints and notifications. The devil is generally more in the detail than in the formal objectives of the NRAS, but many observers may stop at the latter, assuming wrongly that the detail merely follows from and implements the objectives.

In particular a widespread misperception of psychology needs challenging – that it is only an “allied health profession” that is focused on mental ill-health and abnormal behaviour. Psychology’s many other foci, on various aspects of normal human behaviour, and its multi-level explanatory concepts (group/team, family, organisation, industry, local community and global communities as well as the individual), research findings and evidence-based interventions, are not widely understood, including by regulators.

Specialisms such as industrial and organisational psychology are not “health” psychology merely applied in different settings, but regulators in the health sector generally seem to assume that to be the case. These misperceptions and false assumptions need to be changed as they impact very negatively on the regulation of our profession and its various clienteles, especially outside the health sector and health industry, in the many other sectors and industries in which psychologists play a valuable role including important specialised research, but in which the NRAS bodies seem uninterested.

They have had a real dilemma, in that while they had sought successfully (since 1995 in Victoria) to acquire responsibility for regulating all of the psychology profession including its non-health areas of practice, that responsibility immediately proved thorny. One major reason may have been the lack of legal clarity about the restrictive scope of the National Law Act’s objectives, and of the legislation empowering the Health Care Complaints Commissioners, confining regulatory action to regulating and planning for the health professions and processing complaints about health services (conventionally defined as being of “individual health benefit”). Thus regulating and planning for non-health areas, relevant to government and private sector service delivery, and processing complaints (notifications) about non-health psychological services may be considered by some regulators to be ultra vires or at least a politically unacceptable intrusion into other Ministers’ areas of responsibility. Another reason for inaction may have been the great diversity of psychology, involving types of services and fields of application well beyond the experience of regulators with backgrounds in health systems.

3 THE DIFFICULTY OF THE NRAS ESTABLISHMENT TASK

In making our evaluations, some positive and some negative, of various features of the NRAS, we are acutely aware of the size, complexity and difficulty of the task, politically (especially in the COAG context which operates by consensus rather than majority vote) as well as legislatively, administratively and legally, of building and managing a new (to Australia) federated regulatory scheme (rather than a single national one) with associated infrastructure, covering (now) 14 very different professions and over half a million registrants, across six States and two Territories. (Where we use the term “national scheme”, it is with the caveat above that it is really a “federated” scheme, not “national”.)
One particular factor affecting the development of the NRAS has been the apparent reluctance of jurisdictions to relinquish power in some matters, understandable because a jurisdiction’s parliament may lose real oversight of health service regulation despite being held publicly (and constitutionally) accountable for health service provision. But the multiple lines of reporting, accountability and review inherent in a “federated” approach have the potential for unintended outcomes of diffusion of responsibility and confusion if not also tensions and conflicts of views and expectations among jurisdictions.

Some “trade-offs” were evidently reached in COAG to achieve consensus that in a genuinely national scheme may not have been needed and which in our assessment have at times proven to be problematic. This has been particularly so in the complaints and broader disciplinary arena, where in effect local jurisdictional arrangements and associated health-related acts of parliament and regulations were retained, but also in regard to more ‘micro’ matters such as the uneven composition of the Psychology Board of Australia (PsyBA) and its regional groups (explained later). These COAG-level decisions and constraints may not be subjected to this Review’s close examination but should (we consider) still be taken into account as relevant background in evaluating the progress (at times lack of progress) made with regard to implementation of the NRAS.

Put more generally, the Snowball Review should (we urge) look ‘upwards’ (above AHMAC) as well as ‘sideways’ (to bodies at the same level as AHMAC), as well as self-examining the contributions of AHMAC itself, and ‘downwards’ (to bodies below AHMAC in the NRAS hierarchy especially the various registration boards and accrediting bodies) – that is, a systemic 360-degree perspective. If independence of the review is to be meaningful, and if the whole system is to be understood and modified appropriately, we respectfully suggest that this unhindered “helicopter vision” must be allowed to the Reviewer - the capacity for evaluation of the contributions of those at the top of the implementation hierarchy as well as those further down, in a thoroughly systemic, holistic way.

We are heartened by the Consultation Paper just circulated by the Snowball Review project team, in which:
(a) some such self-examination is proposed (e.g. of the unheralded closure of the independent Australian Health Workforce Ministers Advisory Council, whose potential we suggest was never fully realised); and
(b) the questions raised are reasonably comprehensive and systemic (albeit not covering some of our major concerns about the NRAS).

In evaluation work it is of course easy to be wise in retrospect. Our evaluations have been tempered by this awareness, but we nonetheless wish to ‘learn the lessons’ arising from the NRAS experience so that future development of the Scheme avoids and where possible redresses some of the serious problems encountered thus far. This is important if only because the NRAS may be expanded in coverage to include some other professions. Issues such as the legality of NRAS coverage of those professions which do not deliver
“health services” as conventionally defined (explained above) might again be raised as serious impediments, as they have repeatedly been for psychology. The Snowball Review will hopefully indicate appropriate action to clarify the legal situation adequately and acceptably to the affected professions.

We should also say that as “scientist-practitioners” our expectations of and our general approach to the Review are scientific rather than political: where possible we seek good data and objective evaluations of those data, not political outcomes. The Review will, we hope, share our aspiration to “follow where the data lead” and accept perhaps at times uncomfortable conclusions if they are properly based evidentially. However we note that many elements of evaluations are prospective in character, not just retrospective, and/or that good data may not exist on some important issues.

It is not our view at this time (based on the evidence available thus far) that the NRAS’s defects are such that it should be closed down, a view expressed by at least one other body, or that psychologists should withdraw from the Scheme, as some of our members have urged. However the same evidence shows that serious damage is now being done to our profession which cannot be ignored. Urgent if comparatively minor changes to the NRAS are, we consider, essential for the public good as well as the very survival of important parts of the psychology profession and the achievement of COAG’s objectives and assurances.

Through this submission we hope that the problems facing our diverse profession, and industrial and organisational psychology in particular, are recognised and suitable actions identified.

4 ACKNOWLEDGEMENTS

The College appreciates the very considerable effort and goodwill that has already been put into the task of building the NRAS by many people - at parliamentary, governmental, Ministerial, and public service levels, as well as the professional registration boards, the professional associations such as the Australian Psychological Society (APS), individual registrants and other contributors, including the large number of submissions made in response to various Consultation Papers. We have drawn on many of these publications and submissions including as important background for our College’s own comprehensive review of the NRAS, carried out by a longstanding and specialised working party between mid-2012 and December 2013 and since updated.

In none of our review commentaries here do we wish to criticise any individual contributors (including public servants) and stakeholders, all of whom have no doubt acted in the best interests of their constituents or in the dutiful performance of their roles as they have seen them from time to time. Nor do we wish to imply that their contributions have been narrowly self-centred. To the contrary, we have been heartened by the degree of altruism and mutual regard that they have typically demonstrated, reflected particularly in the large number of submissions and the cooperative
relationships among the professions and other stakeholders that have characterised the NRAS developmental process.

In preparing this Submission, we have also had the benefit of two Senate inquiries, a Western Australian parliamentary inquiry, a Victorian Legislative Council inquiry, and a Productivity Commission inquiry into aspects of the NRAS. They have influenced our perspectives and we are grateful for them. Our drafters have also discussed aspects of the NRAS with the relevant unions (such as the National Tertiary Education (NTEU) in higher education and in other sectors), to whom we also give thanks.

5: FOCUS OF AND EMPHASES IN THIS SUBMISSION

5.1 GENERAL:

Since the reviewer and the panel members have long been involved in the health sector and committed to reforms therein including the planning for and ultimate establishment of the NRAS (some of which they have helped lead), we here:
(a) deal only briefly with the history of the development of the NRAS, the goals of COAG in establishing it, the import and guiding role of the Intergovernmental Agreement (IGA), the content of the National Law Act 2009 and jurisdictional versions of that Law, and details of the complex administrative structure of the NRAS, and instead:
(b) emphasise and describe how a considerable number of psychologists work outside the health sector, providing services that are not classifiable as “health” and are not directed at vulnerable individuals with mental health issues,
(c) show how those “non-health” (or “beyond health”) services involve multi-level concepts and forms of analysis (teams, groups including families, organisations, communities, industries and global environments and forces), and professional actions and interactions with other professions quite different from those typically associated with the “individual” level of health service (a key issue for the training of industrial and organisational psychologists in particular),
(d) explain how these differences have serious ramifications for how the regulatory task should be undertaken, which differences, in our view, have not been adequately comprehended for regulatory purposes, and
(e) indicate our positive and negative experiences with the NRAS in order to assist in the search for improvements.

Our comments are focused on the profession of psychology although they may at times be applicable to the thirteen other professions regulated under the NRAS. We have also distinguished between the profession of psychology and the science (“the discipline”) of psychology. Whether the NRAS was intended to cover the latter is unclear, an important threshold issue for the Reviewer to explore. The Psychology Board of Australia requires academic psychologists to register (if they wish to use the title “psychologist”), which would suggest that the science itself is to be regulated albeit indirectly (not only by registration of academics but also by specifications about academic and “on the job”
training set by the Psychology Board of Australia and achieved in part through the contentious National Psychology Examination and in part through the Australian Psychology Accreditation Council’s specifications about syllabus content and staffing of accredited higher education programs in psychology).

However we have focused on industrial and organisational psychological practice, considering that the APS as a whole (our parent body) should make any detailed submission as to the science or the profession at large. *Although at times we have been obliged to refer to the science, we consider that it should not be regulated under the NRAS. Scientific disciplines underlying other professions (e.g. anatomy, physiology, biology) and the staff teaching and researching in those fields are not regulated.*

We also examine the very important issue of workforce planning. Health Workforce Australia’s developing role in health workforce planning (after only a couple of years of operation) was becoming very important, and its funding was considerable (around $250M annually). Its closure and the transfer of its functions (but presumably not all of its funding since this closure was reportedly in part a Federal Budget savings measure) to the Commonwealth Dept of Health are in our view important issues for the workforce planning operations of the NRAS and should be considered in the Snowball Review (as Mr Snowball has indicated will be done, at least in some respects).

How the latter Department should and might integrate its workforce planning work with that of NRAS bodies and the various professions is a very important question. Whether it is empowered and able to carry out workforce data-gathering and -planning for industrial and organisational psychologists or for employers of non-health psychologists outside the health sector/industry is part of this question. As a key instance, the role of Commonwealth and jurisdictional departments other than health (e.g. Defence, Education) in such workforce needs assessment must be contemplated and respected, due to their having their own “capability assessment and planning” responsibilities and staffing needs that are most unlikely to be met by health-related workforce planning. The role of the private sector has also to be considered if it is not to be damaged by loss and non-replacement of valuable specialist psychologist workforces.

The Commonwealth Dept of Health could hardly be expected to carry out such multi-sector assessments and planning. *But given that the NRAS has been given statutory responsibility for the regulation of all parts of the psychology profession, it would fail its statutory obligations if it ignored those “non-health” workforce matters.* Consultation at least with the affected parts of our profession is sorely needed here, as is the involvement of other bodies such as the ABS, business groups and appropriate representatives of all three levels of government, through at least some survey-based research into their workforce needs.

### 5.2 PROTECTING THE PUBLIC AND DEVELOPING THE PROFESSION

We offer our assessments, critiques, and recommendations for change constructively, in pursuit of the same broad goal that has driven the development of the NRAS so far – *the*
optimal protection of the various “publics” receiving professional services. These “publics” include but are broader than vulnerable persons receiving help with mental health issues.

However we are also guided by other professional values and goals, beyond the regulatory concern for “safe” services –

- the state of our very diverse profession, its continuing viability and capacity to flourish,
- the welfare of and opportunities for its students (which have received very little attention thus far in the development and appraisal of the NRAS),
- enduring respect for our professional ethics, and
- related matters.

6 BASELINES FOR ASSESSING THE NRAS

We believe that the main baseline for assessing better protection of the public is not “no protection” or “poor protection” previously. The previous jurisdictional systems (long established in all jurisdictions at least for psychology), were broadly functioning well and economically despite some operational shortcomings from time to time. Administrative costs were far below that of the NRAS especially AHPRA, largely due to much lower salaries paid to jurisdictional registrars and their comparatively small numbers of support staff. Course accreditation was carried out relatively inexpensively by a joint APS-Council of Psychology Registration Boards group, to which many psychology academics contributed their expertise and time in an effectively pro bono way. And self-regulation, through the APS, was effective and efficient in regard to the ongoing development of the profession. However the Society lacked the legal powers to prosecute unqualified, incompetent or otherwise delinquent psychological service providers, and for this and other reasons supported the building of a national registration scheme for psychology with those legal powers.

In contrast the need for a single national system covering many (initially 10) professions was expressed by governments and their supporting public servants largely in terms of legislative and administrative convenience, rather than evidence-based defects in the protection of the public.\(^3\) This has resulted in an absence of specific and agreed targets for improvement in the protection of the public, based on good data useful for evaluation of regulatory impact and progress. Retrospective data-collection is difficult and patchy. We consider this an avoidable and serious defect in the design of the NRAS, if one that unfortunately participants cannot now alter “down the track” for the currently-covered professions. However it should (we suggest) be avoided where any new professions are to be incorporated into the NRAS: collection of good baseline data should be part of the requisite Regulatory Impact Assessment.

\(^3\) The concept of a “health professions template” to cover various professions under a single act was (contentiously) introduced into the NRAS (notably driven by Victorian health public servants who had promoted this template to make changes to the Victorian regulatory legislation in 1995). It lies at the heart of the coverage problems for psychologists.
The other expected benefits for professionals and their clients were originally stated in terms of:

- greater practitioner mobility (mainly through a single national register for each profession),
- less red tape including for complaints by aggrieved clients, and
- clearer and more enforceable entry standards that prevented inadequately trained persons from entering a particular designated profession and ensured that those registered were able to provide safe services.

Some commentators have observed, and we would not disagree, that these quite valid goals did not require a national system of regulation. Cooperation among the jurisdictional bodies would arguably have been enough, coupled with reliance on the professional associations for the setting of adequate entry and specialist standards. There must be broader outcomes and benefits if the creation and maintenance of a “national” scheme are to be justified.

Review of the NRAS should (we suggest) ask as principal questions:

(i) “How (if at all) has the national scheme improved on the previous jurisdictional systems?”, and

(ii) “If it has not, where has it fallen down and what can be done to achieve the desired improvements?”, and

(iii) “Has the NRAS’s development been more efficient legislatively than would have been the case had the jurisdictional registration systems been retained?”

Of course there are many important subsidiary questions to ask and issues to raise. These are outlined later in our Submission, especially Section 2 “Parameters for evaluation of the NRAS”. Most but by no means all of them have been raised in the Snowball Review Consultation Paper.

On behalf of the College, I commend our Submission to Mr Kim Snowball and the three health department CEOs who are overseeing the AHMAC (Snowball) Review of the NRAS.

Signed: ………………………………

Peter Zarris,
Chair College of Organisational Psychologists. 30 September 2014.
SECTION 1

1.1 OVERVIEW OF THE COLLEGE’S REVIEW OF THE NRAS

(i) General Assessment of the NRAS:

The College assesses the NRAS at this stage in its development as very patchy, with some good parts such as the development of a data-clean and relatively up-to-date register of current practitioners in 14 professions across the 8 jurisdictions. Such registers, coupled with removal of specific additional fees for cross-jurisdictional registration, have allowed and may even have encouraged greater practitioner mobility across jurisdictions. (There is however no substantial evidence on this point and data available pre-NRAS about cross-border practice were very sparse and patchy.)

But many other parts need urgent revision if:

(a) the psychology profession and the various “publics” using its “human productivity and effectiveness focused” services (including and especially those delivered outside the health sector, in business, commerce, education, defence, justice, manufacturing, etc.) are not to continue to be damaged by a largely unforeseen confluence of forces, some internal to the NRAS and some external, the damage including but being much broader than

- course closures reducing the flow of needed graduates and frustrating large numbers of intending students,
- reduced competition in ‘service diversity’ terms and
- an impaired, less diverse and broadly less competent future professional workforce due to narrower training and Continuing Professional Development specifications, and

(b) psychologists, their clients and students are not to continue to be exposed to more and more regulation and “red tape” and much higher training and regulatory costs.

(ii) Design of the NRAS

The NRAS has been designed and operated solely for the health sector/health industry, and for stable domestic conditions (including political power-sharing among the States and Territories), with complex and mechanistic structures and interrelationships that are low in adaptive capacity and lack effective integrating mechanisms and processes. It was not designed for coverage of services provided in the many other sectors and industries in which psychologists deliver services. Indeed its legislative objectives would (we consider) constrain its expansion to those other industries and sectors, and to professional services that are not clearly “individual health care” in their intent. Psychology has been
recognised (e.g. 2011 Senate Inquiry and the Western Australian Parliament’s inquiry in 2010) to be a unique profession among those being regulated under the NRAS, spanning sectors and industries other than health, and involving much more than “individual mental health” services. Such “beyond health” services include enhancement of productivity and effectiveness of organisations and their people, collectively (in groups and teams) as well as individually, as part of dynamic “socio-technical” systems involving complex interactions between people and technology and operating in volatile (often global) environments. They are not “clinical” services merely applied in a different context. But these critical differences are not recognised in the design or operation of the NRAS.

Even from just a health sector perspective, as a regulatory “system” the NRAS has seriously problematic structural complexities, unclear role relationships, overlapping boundaries among units, and decision-making rigidities. These mean a glacial rate of policy development and legislative and policy change that will predictably ensure that guidelines and standards are outdated by the time they are completed and published, and that their review and improvement will always be tardy.

(iii) Specific negative consequences:

More specifically, for the psychology profession the implementation of the NRAS, especially trying to force all of our diverse profession into a “health profession” regulatory mould, is having and will continue to have serious unintended negative consequences:

- imposing regulatory demands that are causing service restrictions and collectively beginning to reduce competition and drive up the costs of entry of recent graduates into the profession (developments which may be considered serious by governments, the National Competition Commission and the Productivity Commission whose aims in reforming the health sector included improving competition among health service deliverers and facilitating entry into the professions),
- reducing career and training opportunities for, and otherwise unfairly discriminating against, those practitioners and trainees who work in sectors and industries other than “health”, with serious personal costs and negative workforce and service delivery impacts. Trainees wishing to enter the “beyond health” areas of psychology are being forced to follow an unnecessary and costly “health psychology” training track before they can begin training in their “beyond health” area of specialisation. These outcomes are contrary to the explicit objectives of the Scheme including fairness and equitable treatment of registrants, and facilitating – but not dictating - continuous improvement in professional training, and thus should be taken very seriously.

It is regulatory nonsense, and damaging to our clients, to force organisational psychologists to go in the direction of one-on-one personal mental health services tied to
local mental health frameworks such as the “National Practice Standards for the Mental Health Workforce (2002).” Unfortunately the NRAS, through AHPRA and the Psychology Board of Australia (PsyBA), is requiring this highly undesirable shift.

The diversity of the psychology profession should be celebrated and protected but is in fact being eroded. To elaborate briefly, the NRAS has been more narrowly applied than psychologists were assured in the early consultation processes would be the case. This defect, coupled with external negative developments especially university funding cuts over many years, is already beginning to have severe negative impacts on the diverse character of the psychology workforce and the flow of trainees.

- Loss of some university programs for psychology training (especially in industrial and organisational psychology, reducing the availability of training places in Victoria by two-thirds with the closure of the Monash and Melbourne industrial and organisational psychology (IOP) Masters programs, and in South Australia by about half through the loss of the University of SA’s IOP Masters program) and frustrating large numbers of intending students is mainly due to a mix of NRAS-related and external factors.
- The former include inflexible and too-“clinical” supervision requirements on supervisors and about supervision of trainees that are reducing placement opportunities (by ruling some placements out as insufficiently “clinical” and disqualifying and/or discouraging some perfectly suitable supervisors because they are considered not to have enough “clinical” experience to satisfy the registration board’s clinically biased expectations). Thus training throughput is reduced, trainees experience serious bottlenecks in the availability of placements (if they can even find a place in a suitable course), and training costs are significantly increased quite unnecessarily.
- These impacts are potentially very detrimental for the host of employers which currently use and depend on the wide range of psychological services for purposes such as:
  - productivity improvement,
  - performance enhancement,
  - strategic planning and organisational adaptation to global and other sources of uncertainty and volatility,
  - the design of contemporary work systems (including job design) and equipment (many of which are now global as in Boeing’s multi-country aircraft manufacture) from a “human capital” perspective,
  - enhancement of group and team functioning through more effective leadership and team activities (including job design),
  - better personnel selection and training.

- Not only private sector organisations’ specialised psychological services are endangered. Many government bodies at all levels, and the military, schools and

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4 The Heads of Departments and Schools of Psychology (HODSPA) have objected strongly to this attempted imposition of mental health standards on university programs.

5 Notably in the special meeting between APS representatives and the NRAS Implementation Team led by Dr Louise Morauta before the legislation was drafted. We were assured that the breadth and diversity of the profession would be protected, not diminished.
the justice system as well as “not-for-profits”, are also at risk in terms of this diminished flow of appropriately trained psychologists. Psychologists trained to deliver individual mental health services cannot substitute for psychologists specifically trained and experienced in industrial and organisational psychology or in the various other fields of psychology beyond “health”.

- The policies of the Psychology Board of Australia (PsyBA) especially the high clinical content of its National Psychology Examination are also very detrimental for trainees as well as registered psychologists working outside the health services industry and health sector. In particular they are discriminating unfairly against students who wish to enter those fields of practice, requiring them to be partially trained as “clinicians” working with individuals’ mental health issues before they can embark on their specialised training in their real interest areas which are non-“personal health” areas of practice. This unfair and unnecessary discrimination substantially prolongs the time and increases the costs of training and delays trainees’ entry into the workforce. Some trainees have even been forced to forego stable and well-remunerated employment in a non-clinical area of practice in order to undertake a clinical type of placement, with lower or sometimes no remuneration, and with severe disruption of the trainee’s employment and career.

- These factors will severely inhibit competition as the full range of psychological services and employment opportunities are diminished in order to fit into a narrow “personal health services” regulatory and training mould. Diversity of services is already being lost, contrary to earlier assurances of protection given by those driving the NRAS’s development.

- They are also now leaving clients of psychologists who receive psychological services that are not definable as “personal health services” with no discernible avenue of complaint about unprofessional conduct (except in the small number of jurisdictions where complaints need not be limited to “services intended to be for personal health benefit”). This is so because of the legislative limitations on types of complaints that can be assessed by the Health Care Complaints Commissioners who are expected to play a central role in the NRAS disciplinary system.

- These discriminatory policies are largely operationalised by the very “clinically”-oriented National Psychology Examination and placement and internship requirements of a “clinical” kind but also by changes to syllabuses for accredited courses. They present serious barriers to entry into the various fields of the profession not just for Australian trainees but also for overseas-trained applicants. And locally they inhibit “return to practice” of some practitioners such as those on extended parental leave or who have been working in profession-related but “non-clinical” roles.

### 1.2 RECOMMENDED ACTIONS

Five steps in particular would provide a process to begin to address most of our concerns about adverse impacts on our part of the profession.

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*See statement by Heads of Departments and Schools of Psychology (HODSPA) in Attachment H protesting about such interference.*
First, the wording and objectives of the National Law Act 2009 should (we commend) be broadened to read “health and cognate professions” and “health and cognate services”. The definition of “practice” should also be modified similarly. (See our later specific Recommendations.) These changes would help solve the legal and policy “coverage” problems regarding psychological services that are not “health-related”. They would signify and confirm that the NRAS has regulatory responsibilities for psychological services that are not in essence “health services” but that rely on a cognate conceptual and methodological scientific base that is much broader than just mental ill-health and “abnormal psychology”. Such an extension may also help with the regulation of additional professions, some of which may also offer “non-health” services.

Second, more representative registration boards for psychology (national and jurisdictional) should be appointed at the next opportunity (national in 2015/16) using the processes outlined in the British Nolan Rules in place of jurisdictional health departments nominating appointees so that their policies and practices are better founded conceptually and pragmatically, and better grounded in a diversity of professional experience across the full range of sectors and industries, not principally in health services provided in the health sector/industry. This broadening would finally deliver the assured profession-wide representation that was promised in the pre-NRAS consultations, and remove the very limiting and inflexible jurisdictional representation criterion employed despite the Senate Community Issues Committee Inquiry into the proposed NRAS legislation being assured in 2008 that an open advertisement and merit-based appointment process would be used. The composition of the Australian Psychology Accreditation Council (APAC) should also be similarly broadened.

A third action step could be to have differentiations within the register of psychologists to provide for the regulatory and workforce needs of the health sector in a way that would not treat all psychologists as if they were all health service providers in that sector. This however could be damaging to the profession if implemented insensitively and rigidly, without knowledge of the complexities of issues involved and potential misconceptions, such as that psychologists not on a health register were somehow poorly qualified and “second grade”. Consultation with APS Colleges would be essential.

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7 Explained later in this Review Paper, but essentially an open advertisement process of clearly-delineated positions, without quotas such as the jurisdictional quotas currently used in the NRAS.

8 Oral assurances were given by Dr Mourata (chair of the Implementation Team) in a special meeting in Canberra with psychology representatives in 2008, before the introduction of the National Law Act 2009, that the psychology registration board’s composition would be large enough and its other provisions would be such as to allow profession-wide representation. But the first appointees to the Psychology Board of Australia (PsyBA) were jurisdictional representatives, one member from each jurisdiction, and because they were nominated by the jurisdictional health departments’ heads, were predominantly drawn from the “health” areas of psychology. Almost all PsyBA members have been reappointed for the period 2013/2015. Organisational psychology has no representation at all on the Q’ld and NSW boards including the NSW Psychology Council and the NSW Board of PsyBA (two different groups), and only one member of PsyBA has qualifications in organisational psychology. (Our detailed analysis of all psychology boards’ membership is available on request.) We also note the following assurance given by Dr Morauta to the Senate Community Issues Committee regarding the role of the professional associations: “I think it is mainly in the process by which they (registration board members) are appointed. The national board process is set down in the legislation. There has to be a public advertisement—there was for the agency management committee—and the process is that either people can express an interest on their own behalf or they can be nominated by other people or by groups. So that would be the role in arriving at the practitioner members, and the community members would be that any organisation in the country would be able to nominate people that wish to.”
The fourth action step is closer and better-targeted consultation by PsyBA with the APS and its Colleges on specific matters such as its current policies and its strategic plans. The 2011 Senate Inquiry into AHPRA recommended establishing “professional consultative groups” as a source of information and advice to AHPRA. This kind of mechanism for psychology is commended to the Reviewer as a desirable bridge not only between the professional association and AHPRA, but also between the professional association (the APS and its Colleges) and PsyBA.

This step could help extend and deepen the registration board’s understanding of the many sectors and industries in which psychologists function and the different kinds of services that they provide. Such issues as the very different placements required by trainee organisational psychologists could be addressed through this consultation process. (For example, given the increasing globalisation of manufacturing, finance and commerce, more placements ought, arguably, take place in overseas contexts – e.g. Asia, India, the USA, the UK, etc. Some European universities already send post-graduate organisational psychology students to Australia on placements, with whom reciprocal arrangements could presumably be made given a more sympathetic PsyBA.)

This would also be an early step in trying to encourage a transition by PsyBA from a “top-down command and control” approach to its regulatory duties, to more of a “collaborative, partnership” approach (on which we elaborate later in this Submission).

It would allow for and hopefully encourage debate about contemporary developments that are re-shaping and often shaking higher education institutions, such as COURSEERA, an international MOOC (“massive open online course”) which (for example) the University of Melbourne has recently joined. Such innovations in delivery of quality courses (even if not currently accredited) are significant for Continuing Professional Development (CPD) and other purposes.

The fifth action step is making strong representations to the Australian Government about university fees, as this is the major single impediment to our professional training effort and production of suitably trained graduates to provide the full range of psychological services. Accredited post-graduate (Masters) programs in psychology are not generally FEE-HELP supported. This means that the completion of professional training (after the undergraduate and Honours years) via the “6 year” and “5+1 year” routes would cost the trainee well in excess of $44,000 (possibly double that in a new fully deregulated environment). When that amount is added to the costs of already-completed undergraduate and Honours courses (likely to be around $42,000 for a Science

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8 “ 6.23 To improve consultation with professional organisations, including provider organisations, the committee considers that AHPRA should establish professional consultative groups. Such a mechanism would improve communications between AHPRA and professional organisations and help to quickly identify shortcomings in AHPRA processes.
Recommendation 7
6.24 The committee recommends that AHPRA, as a matter of urgency, establish consultative groups with professional organisations and health providers.” (Extract from Senate Inquiry 2011 Report.)

10 For example, Deakin University’s Master of Psychology (Industrial and Organisational) full fee for each of its two years of study was $22010 in 2013. Its annual fee under FEE-HELP (Commonwealth Supported Places) was $5870. A Doctoral coursework program such as at Griffiths University costs almost $64000 full-fee.
3-year degree and $45,000 for a three-year Arts degree plus at least $5870 for the requisite fourth/Honours year), a debt upwards of $92,000 is predicted to arise for completion of the full 6 years of professional training. This prediction does not take into account the substantial compounding effects of debt over the 6 years. This amount would be a mix of FEE-HELP and full-fee debt. The former would attract the Commonwealth bond rate of interest (reportedly 4% in 2013), and the latter would presumably be a bank loan (or loans) on which a higher level of interest would no doubt be charged. Given the importance of professional training, extension of FEE-HELP (Commonwealth Supported Places) to post-graduate students in accredited psychology Masters and doctoral programs would in our view be the very least the Federal Government could do. Without such support, there is a very real prospect of serious and rapid diminution in student numbers, and thus of future cohorts of professional workforces, at least in industrial and organisational psychology and predictably in other areas of psychology and other professions too. Retention of the CPI as the basis for calculating interest on FEE-HELP debt instead of the much higher Commonwealth bond rate would be another welcome step.

An associated problem is that the public universities, largely due to chronically shrinking federal funding, are very focused on income from research grants, and over recent years have hired new academic staff with PhDs and strong research performance records able to compete for ARC and NHMRC grants. Such staff typically have limited professional experience and must perforce be or become more oriented towards research than professional training (a trend exacerbated by insecure forms of employment). It may be necessary, not only in psychology training, for governments to contemplate the establishment of a different form of higher education institution dedicated to professional training, in whose programs research training plays a less central part, and is of an ‘applied’ kind of higher relevance to professional practice (such as policy or program evaluation). Such programs in industrial and organisational psychology, with their supportive role in regard to economic growth and business innovation and adaptation to global and local pressures, might well be of interest to the private higher education institutions which the current Federal Government has indicated it wishes to promote and support. Alternatively or additionally, within the current university system, the offering of industrial and organisational psychology programs may be enthusiastically undertaken by some of the business schools, if APAC’s specifications were broadened to allow for the location of business-relevant psychology programs in those schools (currently in effect proscribed).

COAG and all federal and jurisdictional Ministers should (we consider) be alerted to the problems outlined above, especially the negative workforce effects which will affect government departments at all levels as well as the private sector if not solved. However the Australian Health Workforce Ministerial Council should (we consider) be asked also to play a key role in supporting these representations. Given the 2014 federal budget, even the extension of FEE-HELP (Commonwealth Supported) Places to students in accredited professional Masters and doctoral coursework programs (rather than full-fee regimes) would need powerful representation to the Federal Government and to COAG. The Reviewer would presumably be the appropriate person to make such representation.
to the Health Ministers, and to draw to the Federal Government’s attention our suggestions about more professionally-focused higher education units.

A number of other action steps are outlined in our full set of Recommendations. They are all non-trivial. Such actions as changing the funding model employed by AHPRA, discouraging its continued “regulatory creep” and other expansionist trends, ending PsyBA’s refusal to register students as students (rather than provisional psychologists and charging them full registration fees) and immediately broadening placement requirements for interns and registrars beyond the “clinical” may well be considered by many psychologists to be at least as important as the five steps listed above. The submission by the Organisational Psychology Program Coordinators to the Australian Psychology Accreditation Council (available on the Council’s website) makes powerful representations about the ill-effects of too-narrow supervision and supervisor requirements and other accreditation matters which we strongly support and which we commend to the Reviewer and the AHMAC oversight panel.

1.3 SUPPORTING COMMENTARY

In reviewing the NRAS at this time, it is important to distinguish among: goals (how the NRAS was intended to function); current reality; and apparent trends. In our judgment there are significant and worrying gaps and ‘disconnects’ between goals and current reality, and some adverse trends, as we outline later in this Submission.

1.3.1 THE NRAS AS A WHOLE

The NRAS as a whole is over-populated with well over 150 regulatory agencies, public service units of administration and other bodies, in complex, ill-defined and poorly integrated interrelationships. We refer more to the administrative superstructure above the professions’ registration boards and subsidiary groups than to the latter. This complexity will predictably increase with the transfer of important workforce planning functions from HWA to the Commonwealth Dept of Health.

This superstructure needs

- streamlining, simplification, and slimming down in functional, staffing and cost terms, but also greater integration (by using more effective integrating processes, not installing yet another structural unit), and
- a paradigm shift from a “command and control” mindset to a “collaborative partnership” one. The former generates higher staffing and compliance costs, with more associated red tape, discourages the involvement of professionals in their own regulation, and fails to draw on their expertise and pro bono effort in
overcoming problems in safe service delivery and in carrying out expert assessments for course accreditation purposes.

A much smaller and less expensive “regulatory footprint” is needed, based on 21st Century, not 20th Century, administrative and regulatory thinking, as recently urged for all Victorian public service operations in a discussion paper issued jointly by the Victorian Department of Premier and Cabinet and Melbourne University’s School of Government. (Full details given later and in Appendix Q.)

The NRAS also has some inconsistent and at times dysfunctional jurisdictional differences. As a major instance, the withdrawal of Queensland from the complaints/notification system11, coupled with the NSW decision at the outset (circa 2008) to retain its own disciplinary system, and Western Australia’s only partial and more cautious involvement in the NRAS, dilutes further the notion of an integrated national system, leaving the NRAS’s “common” complaints/notifications system limited to Victoria, South Australia, Tasmania, the ACT and the Northern Territory. Such jurisdictional divergences from a common approach further complicate the disciplinary system.

Also the Queensland Health Ombudsman Act 2013 extends the scope of the Queensland disciplinary system to cover unregistered providers of health services unambiguously, an extension (valuable, we believe) that one would think should be applied in all jurisdictions if the National Law Act 2009 is defective in this respect. The Queensland authorities assess it to be defective, but the Victorian Dept of Health – which has provided and continues to provide staff to work with other jurisdictional and national health department staff on developing the NRAS - appears to consider that the National Law Act 2009 already contains adequate powers. Such divergent administrative views are likely to complicate further policy development in this area. Properly managed, they may stimulate valuable discourse, but if not may lead to policy delays if not paralysis, or troubling inconsistency.

Further complexities and problems will predictably arise from this jurisdictional separation (if there is not collective adoption) that would make a seamless national system virtually impossible to develop further and maintain. Such defects could well degrade the protections available to the various publics using our diverse professional services and the safeguards for professionals, especially but not only for the psychology profession.

It also makes real (rather than notional) portability of practitioners and service delivery across jurisdictions more unlikely, even with the completion of the various professions’ national registers that has been one of the achievements of the NRAS so far.

This unilateral rather than joint action is surprising and disappointing in a national scheme intended to be more efficient legislatively than the previous separate

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11 As outlined in the Health Ombudsman Bill 2013, currently (August) before the Queensland Parliament’s Health and Community Services Committee. (Available on the Q’d Govt website and/or the Law Institute website austlii)
jurisdictional systems especially by the collective adoption of legislative and other improvements. The IGA provisions for collective adoption of legislation require Ministerial Council approval of the proposed Queensland legislation (Queensland being the “lead” jurisdiction for NRAS legislative changes) and an agreed timetable, which is then to be passed through the Queensland Parliament, a process that, so far as we know, has not occurred regarding the Queensland Health Ombudsman Act.\textsuperscript{12}

\textit{COAG should be urged to ensure that the Ministerial Council approval process for collective adoption outlined above and footnoted is followed in regard to the Queensland legislation, including proper Regulatory Impact Assessment and consultation with the regulated professions.}

1.3.2 THE FUNDING MODEL

The funding model employed for the “administrative” and “disciplinary” parts of the NRAS is considered inappropriate and indeed contrary to the objectives of the National Law Act 2009. Further, the proposed transfer of a significant quantum of NRAS funds as part of the withdrawal of Queensland from the NRAS “common” disciplinary system\textsuperscript{13} will shrink the current funding base, already reduced by the non-involvement of NSW from what was originally anticipated, and predictably reduce further the economies of scale and cross-jurisdictional consistencies potentially achievable from a genuinely national system. We examine funding issues in more detail later in this Submission and make a set of interrelated recommendations in our Recommendation 4.

1.4 MAJOR CONCLUSIONS AND RECOMMENDATIONS FROM OUR REVIEW:

1.4.1 General:

\textbf{Generally,} we consider that a shift is required:

(a) from the current “top-down” and essentially adversarial model of health reform (with associated demotivating attitudes and expectations, high compliance costs and red tape) where change is to be imposed on the professions and in psychology also on the

\textsuperscript{12} The IGA reads “13.3 If the changes agreed at 13.2 require legislative amendment, the State of Queensland will:
(a) submit to its Parliament a bill in a form agreed by the Ministerial Council which has the effect of amending the legislation in the manner agreed; and
(b) take all reasonable steps to secure the passage of the bill and bring it into force in accordance with a timetable agreed by the Ministerial Council.

13.4 If the amendment is passed through the Queensland Parliament, legislation of the States of New South Wales, Victoria, South Australia and Tasmania and the Australian Capital Territory and the Northern Territory will incorporate the changes by applying the amendment as a law of those jurisdictions. In the State of Western Australia, agreed amendments to the legislation will be carried out via changes to the corresponding Western Australian legislation. The State of Western Australia will use its best endeavours to secure the passage of any agreed amendments and bring them into force to ensure ongoing consistency with the national scheme.”

\textsuperscript{13} In fact we doubt whether the NRAS disciplinary system was ever genuinely “common”.

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underlying scientific discipline\textsuperscript{14}, to a more fully collaborative “partnership” model where joint change objectives can be identified, agreed and pursued, and where the full diversity of the psychology profession is recognised, respected and indeed celebrated (rather than psychology being treated inaccurately as only an “allied health profession” in a health industry/sector). (We say this despite some recent signs that such a shift might be beginning to take place at AHPRA level. It needs to be strongly encouraged. However we have seen no sign of it occurring with the key jurisdictional public service staff involved in the design and ongoing restructuring of the NRAS. The Victorian Dept of Health’s submission to the Victorian Parliament’s 2013/14 Inquiry into AHPRA is the starkest instance of such an adversarial view of the professions being regulated, leading that Dept to recommend “corporatisation” of AHPRA, with even less involvement by the regulated in their regulation than is now the case. For example it wrote: “There is an extensive body of literature on professions that suggests the drive towards increasing specialisation is monopolistic in nature. The professions and sub-groups within professions are motivated to draw a boundary around their work in order to create a ‘market shelter’, that is, to carve out an exclusive scope of professional practice to protect their members from competition from other professions or sub-groups within professions (Freidson 2001). Such processes often lead to conflicts over turf both between and within professions. Arguments about turf protection are often presented as bids to protect patient safety and service quality.” See Appendix M for more detail.)

(b) from an associated large regulatory footprint with intrusion into, and PsyBA’s attempted micro-management of, professional matters that have generated considerable angst within the profession, duplication, red tape, inefficiencies, legal questions, and unaffordable monetary and other costs, to a small regulatory footprint that is structurally lean, low-cost and focused on safe services and associated core tasks particularly setting entry-level standards and delineating and evaluating unsafe practices.

c) from an over-inclusive and unworkable claim to be able to regulate any and all activities that may have unintended personal and collective health outcomes\textsuperscript{15}, to a focus on proffered services that are presented to the public as having individual/personal health benefit intentions and goals using evidence-based intervention methods. Many activities and services may have intended or unintended health outcomes, but are not regulatable under the NRAS – acts of parliament and regulations (e.g. about OHS practices), government budgets, managerial decisions, school staff’s teaching methods and career advice to students, and marriage and other interpersonal relationships. Legally these are not covered by the NRAS legislation. Nor, logically, should they be. Yet this over-inclusive claim has been used to attempt to answer this College’s questions as to the legal coverage of non-health services under the preceding Victorian legislation and the later National Law Act 2009.

(d) from a “stability orientation” (valuing conformity to a prescribed stable set of ways of doing things) to a “built to change” one (where there is strong built-in capacity for ongoing adaptation to changing circumstances, new evidence and information, and shifts

\textsuperscript{14} Initiated by working groups in the National Competition Commission and later the Productivity Commission in their reports on health sector reforms in the 1990s, and apparently adopted broadly in the health bureaucracies in the design of the NRAS.

\textsuperscript{15} Such as and especially the assertion by some VDH staff that any services or other activities which affect health are regulatable under the NRAS.
in client needs and forms of psychological services and their modes of delivery such as where they are Internet-based or involve multi-country operations). 16

Regulation does not create the changes in point (d) above but, if it is to be and to remain relevant and effective, and if it is not to stultify innovation and adaptive capacity, it must be able to identify, understand, acknowledge and respond to them.

This “built to change” approach does not deny the importance of some forms of stability of regulatory policies and standards over the short and medium term so that there is certainty in the regulated professions and the user publics about those matters. Nor does it deny a significant role for safeguards against abuses of regulatory flexibility. But it is to argue against structural and process rigidities, perpetuation of inappropriate or outdated perceptions, policies and standards, and absence of mechanisms for rapid change when the circumstances require.

We support the general thrust of Lateral Economics’ arguments that regulation generally in Australia has yet to move beyond a “Taylorist” approach to a “post-Taylorist” one. They wrote:

“In important respects, the transformation from Taylorism has yet to be fully made in the area of regulation. Policies are decided upon, with or without appropriate consultation, and then, in being promulgated, receive the imprimatur of the sovereign. Though the purpose of the regulation can be of some significance when lawyers are interpreting the meaning of the regulation, what is generally required from subjects of the regulation is compliance with its specific commands, not with their purposes. Indeed, there is no requirement on regulators to specify the purpose of their regulation, and those purposes may not even be clear. The Robens report on occupational health and safety regulation in the UK in the early seventies was a watershed in regulation. It ‘blew the whistle’ on regulatory ‘Taylorism’. Robens argued that occupational health and safety regulation had become a mass of technical rules for workers to follow and inspectors to enforce that were so complex and ad hoc that they were often worse than useless. They could not be taken in and understood by workers and they undermined responsibility for safety throughout firms by inviting the impression that safety was imposed from outside the workplace. Robens proposed the first attempt to move beyond what we are calling here ‘regulatory Taylorism’. Firms were to be given general duties of care for their employees’ occupational health and safety and they would discharge them by collaborating with their workforce in developing, documenting, implementing and improving auditable safety management systems. The new style of regulation seeks to use its power of command in a way that is more analogous to good management – it seeks to encourage excellence at the same time as putting a floor, below which performance shall not fall. It seeks to draw out the expertise of the regulated in improving outcomes. And, at least in intention, it takes those it regulates as being in charge of complex adaptive systems which may change over time.” (See Appendix T.)

We consider that there continues to be a real and urgent need to modify the NRAS and broaden its empowering legislation if it is to encompass more clearly and bring within the scope of the NRAS those many and varied psychological services which go beyond “health care intended for individual clients’ personal health benefit”. Unless the

National Law Act 2009 is suitably modified, organisational psychology services, at least those focused on goals other than individual health benefits, will remain – at least in our view of the legal situation - outside the NRAS’s regulatory scope.

This broadening is necessary for complaints/notifications purposes, and also for decision-making about registration, CPD and placements/internships/registrarships and course accreditation purposes, and for workforce development needs analysis.

This kind of modification, we urge, should be more clearly recognised and appropriate (relatively simple) legislative changes made. Alternatively (if such a shift cannot be achieved) a different legislative and administrative context for the regulation of those psychological services whose intention is not “individual personal health benefit” would seem necessary.

1.4.2 SPECIFIC CONCLUSIONS AND RECOMMENDATIONS:

Conclusion (a):

The Guiding Principles in the National Law Act 2009 have not been followed in some important ways in regard to psychology (and in some respects, beyond psychology).

Explanation of Conclusion (a):

The National Law Act 2009 includes the following:

“The guiding principles under which the National Scheme will operate (as set out in the National Law) are as follows:
(a) the scheme is to operate in a transparent, accountable, efficient, effective and fair way;
(b) fees required to be paid under the scheme are to be reasonable having regard to the efficient and effective operation of the scheme;
(c) restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.”

All three principles have been seriously breached for psychology. The Scheme’s operation as it relates to psychology is not “transparent, accountable, efficient, effective and fair”, registration fees are not “reasonable having regard to the efficient and effective operation of the scheme”, and too many and unnecessary restrictions have been placed on the practice of psychology peripheral to “safety” and “appropriate quality”. In particular too little attention has been given to identifying unsafe practices and stimulating improvements thereto, despite assertions to the contrary in AHPRA’s most recent Annual Report and PsyBA’s report therein. And there is continuing intervention by some
regulators (mainly but not only by or through PsyBA) in professional education and training, forcing them into an inappropriately narrow “health services” mould.

**Recommendation 1:** That the various features of the NRAS be remodelled where appropriate to ensure that:

(a) the principles and objectives of the Scheme are more clearly recognised and more strictly observed,

(b) (for psychology at least) more emphasis is placed on identifying and preventing unsafe practices, and

(c) assurances given pre-NRAS that the integrity, independence and diversity of the profession and its underlying science would be protected (including through broad composition of PsyBA) be respected and observed.

**Conclusion (b):**

The professional associations are not being treated as co-partners in the regulatory development process (which we regard as essential), but are being viewed as only self-interested parties whose contributions are likely to be biased, sometimes against the "public interest". This unwarranted negative and suspicious view (we believe) detracts from the NRAS’s policy development process, creating misperceptions and unnecessary tensions in relationships, especially between those being regulated and those undertaking the regulation.

**Explanation of Conclusion (b):**

An “adversarial” view of health reform appears to have been inherited from the reports of working groups in the National Competition Commission and the Productivity Commission in the nineteen nineties regarding reform of the health sector. It seems to have permeated administrative and legislative thinking regarding the NRAS, to the point where it seems to be an unchallenged and automatic assumption that stakeholders especially the professions have self-interests essentially antagonistic to the public’s welfare. The professions are explicitly described as territorial and self-protective. In this view, reforms would not be welcomed by the professions, indeed would be actively opposed even if covertly, and thus must be imposed. It is an inaccurate 20th Century view even in economics, driven by notions such as of how to achieve perfect competition. It has unfortunately been repeated in the Victorian Dept of Health’s (VDH) recent submission to the Victorian Legislative Council’s inquiry into AHPRA (too long to be included here, and available in part as Attachment M and in full on the Victorian Government website), where such negative “anti-professions” statements are repeated,
inaccurate data are given about the growth of specialisations in the psychology profession, and corporatisation of the NRAS is recommended in place of collaboration.

The VDH submission also appears to want to recruit consumer representatives to its ideological (“anti-professions”) cause by giving them even greater numbers and powers, a direction which (if our assessment here is valid) may well be counterproductive. We certainly support a clear and effective role for consumer representatives. Greater opportunity for consumer representatives to identify independently possible improvements in their role contributions and any associated increases in their numbers would certainly be valuable and welcomed by us. But in this same spirit we oppose their being treated as prospective ‘recruits’ in a health bureaucracy’s self-described struggle with primarily the medical professions. They must be and remain independent.

More appropriate and realistic “mindsets” are necessary in the 21st Century as the Victorian Dept of Premier and Cabinet has recently urged in the earlier-referenced joint discussion paper “The 21st Century Public Servant”, issued with the University of Melbourne’s School of Government. Better information and more adequate consultation with and involvement of the stakeholders in planning and policy development processes are - as the first Senate Committee’s Report and the second (2011) Senate Inquiry into AHPRA also indicate - important for a more “transparent, accountable, effective, efficient and fair” NRAS and for “better accountability mechanisms”.

We would add “greater sense of ownership” by registrants, and “more meaningful acceptance of policies and active involvement in their implementation”.

**Recommendation 2:** That a genuine co-partnership model built on trust among stakeholders should replace the existing “command and control” model that treats the professional associations as but one stakeholder who cannot be trusted to protect and work for and in the “public interest”.

**Conclusion (c):**

The regulated professions unfortunately continue not to be provided with adequate information about the progress of the NRAS, including about the specific financial modelling being undertaken by AHPRA and the professions’ registration boards, or the actual costs involved – thereby breaching Guiding Principle (a).

**Explanation of Conclusion (c):**

The 2009 Senate Inquiry Committee observed that annual reports and occasional communiqués issued by regulators are not sufficient to provide transparency about the progress and costs of the NRAS. The 2011 Senate Inquiry into AHPRA went further to
recommend a three-monthly reporting schedule to stakeholders regarding the litany of complaints they had made to the Inquiry about AHPRA’s poor administration of registration.\textsuperscript{17} We concur, observing that such a schedule is not yet evident to stakeholders such as ourselves.

It is very important to recognise that the registration boards are an arm of “the state” with members appointed by the Australian Health Workforce Ministerial Council (not elected by the professions). The Psychology Board of Australia is not (and cannot be) representative of the profession or discipline of psychology.

For this and other reasons, the professional associations are generally a better source of expertise and current knowledge than registration boards about professional developments. However, in psychology at least they have had too-limited opportunity for input, and are not (in our judgment) yet being adequately consulted about priorities, strategic plans or even the scope of the NRAS units that are to be funded by the professions through registration fees.

We appreciate that fear of “regulatory capture” of registration boards by the professions (actual and/or publicly perceived) – a theme in many tomes on regulation - may have motivated such limited consultation. Supporters of the NRAS may reply that many calls for submissions have been made, and AHPRA has recently – January 2013 – stressed its intended program of greater consultation. This is very welcome, but the key question will be to what extent such involvement would allow the identification of central regulatory issues for stakeholders and enable real influence by them to achieve meaningful changes in these matters of concern. Thus far such identification and influence have not occurred in any transparent way. For instance, absence of feedback about the impact of submissions, or even just a summary of the thrust of submissions, appears to have eroded stakeholder confidence in the submission-making process.

The loose terms used about the funding of the NRAS - that the NRAS’s “administrative arrangements” are to be “cost-neutral” and “self-funded” - are opaque and uninformative. For example are psychologist registrants to pay for all of the costs of the Australian Psychology Accreditation Council (which are expected to increase substantially given the shift away from pro bono contributions by academics who are under immense funding, workload and “publish or perish” pressures and in whose home universities significant staff losses have been experienced)? For example, closure of the Melbourne and Monash Organisational Psychology Masters courses and the course at the University of South Australia has meant loss of many expert staff, who will no longer be available for pro bono course accreditation activities. Are any compensatory staffing arrangements to be automatically funded by registrants or through the fees charged to the universities seeking re-accreditation of their courses, without any say by those registrants or universities?

Are the full costs of the AHPRA Management Committee and the Australian Health Workforce Ministers Advisory Council also to be included? How will other jurisdictions

\textsuperscript{17} See its Rec.5 in Appendix R to this Review Paper. The 2009 and the 2011 Senate Inquiry Reports are available on the Australian Parliament’s Senate website.
respond to the Queensland proposal that a proportion of registrants’ fees be transferred to cover the costs of operating its to-be-separate disciplinary system? What would be the financial and other consequences in terms of reduced “economies of scale” of operations? And so on. (The Australian Government’s and the Victorian Cost Recovery Guidelines provide the kind of framework that should be used for NRAS regulation and especially the scope of costs to be recovered.)

Recommendation 3: A clearer and more precise definition of the scope of the NRAS including for funding and fee-setting purposes should be developed promptly. The Commonwealth and jurisdictional Cost Recovery Guidelines should be referenced in this task.

Conclusion (d):

The linkage among the strategies and the operations of the NRAS units, and the costs and fee income necessary to fund them, are opaque.

Explanation of Conclusion (d):

We have reached this conclusion despite the most recent (early August 2012) release on the AHPRA website of its Business Plan and Service Charter. Both documents are welcome as an improvement in the information available to registrants and professional associations, but neither makes the kinds of linkages between strategic plans and operations (including expenditures) that are necessary – as a key example - to determine the level of fees that should be charged to cover AHPRA and registration board costs. Neither document gives detailed and precise information about the actual and proposed expenditures of AHPRA and PsyBA, so that at best only a partial picture, of mainly uncosted aspirations, is available to stakeholders.

The publication of profession-specific Health Profession Agreements (including inter alia financial budgets and other information) is a step in the right direction and to be applauded. But they require substantial improvement before they provide real specificity and clarity about strategy-operations-expenditure links and other matters. The perspectives expressed in both documents are largely internal administrative and managerial ones, all no doubt important, but short on focus on strategies to deal effectively from a regulatory perspective with the major professional problems besetting current service delivery by professionals, such as shortage (in psychology at least) of placement opportunities and supervisors, and even more seriously the loss of higher
degree courses and other erosions of opportunity and talent development in fields including but particularly beyond the “clinical”.  

It is no exaggeration to say that the Psychology workforce training ship is sinking while the regulatory band plays on, apparently oblivious to the broader context.

The recommendation flowing from this Conclusion appears as part of Conclusion (e), which deals with related issues.

Conclusion (e):

(1) The funding of the NRAS, or at least its psychology component, is inconsistent with the Guiding Principles in the National Law Act 2009.
(2) Not only are the financial foundations and ongoing costs of the NRAS opaque, but also such evidence as can be found about the fee-setting methodology used by AHPRA and the professions’ registration boards shows up worrying defects logically and technically, including but beyond the fee differentials (i.e. lower registration fees in NSW for some professions including Psychology).
(3) In particular, Guiding Principle (b) has not been followed in the NRAS funding model which - by being CPI-based - does not have regard to the “efficient and effective operation of the Scheme”.

Explanation of Conclusion (e):

In our detailed review of the NRAS we addressed the question: “Are the NRAS’s policies and practices especially at AHPRA and registration board level concerning fees on registrants consistent with the Guiding Principles in the National Law Act 2009?”

We believe not, for the following reasons:

Point (i) : Budgeting based on CPI increases does not recognise or pursue savings:

Statements about the NRAS funding refer frequently to “fee increases”, and very rarely to “fee reductions”. They promote, and we contest, the use of the CPI as the sole basis for increasing registration fees. Such a funding model is not “reasonable having regard to the efficient and effective operation of the scheme”. In fact it ignores any effectiveness and efficiency gains achieved such as from reductions in the number and costs of complaints/notifications, which energetically pursued ought be very considerable. It actually plans and budgets for regular fee increases.

The goals and outcomes referred to in those Business Plans and Agreements tend to be operational and administrative, rather than strategic. Many of them are “standard operating procedures” and standard “good management” practices, elevated descriptively to a higher status than they deserve. None of AHPRA’s Business Plan goals and outcomes refers to improved collaboration with the professional bodies, and only very occasionally to “practitioners”. “Organisational flexibility” is confused with industrial (mainly employment) conditions in the context of developing EBAs within AHPRA. Some goals appear to reflect a desire for greater “micro-management” by AHPRA, such as tighter control over the registration boards and the accrediting authorities.
Better alternatives are available, such as a combination of actual costing, strategy- and goal-based expenditure projections, and the use of more government-appropriate cost-rise indices such as the Local Government Recurrent Expenditure Price Index (LGREPI) developed and used successfully in South Australia.

If the CPI (or the LGREPI) is to be used, it should be as a ceiling, not a recipe for automatic annual increases with underlying assumptions that no improvements will be achieved in the way in which NRAS business is done. Additionally, AHPRA and other NRAS units could well be subjected to the same “efficiency” requirements as have been applied to other public administration units over recent years. That registrants (and in psychology, students as well) and university departments seeking accreditation or reaccreditation are paying the bill is no excuse for failing to apply adequate fiscal discipline (including in regard to staff salaries).

Point (ii): Jurisdictional differences in registration fees:

The significant differences in registration fees across the States and Territories (notably the use of “rebates” for NSW Psychology registrants and some other regulated professions in NSW but not for others) are not clearly explained. Those fee differentials reflect NSW Government policy to retain and fund its rather different (some would cogently argue a better) complaints/disciplinary apparatus, but beyond that “in principle” explanation, much remains unexplained.

Plainly jurisdictional differences in fees are undesirable in a regulatory scheme designed to take a nationally consistent approach, with no barriers to professional service delivery across jurisdictional boundaries and with equitable treatment of the participating practitioners, their clients and complainants irrespective of profession, type of service and service delivery, and geographical location. As a simple example, why should a psychologist in Queanbeyan (just outside the ACT thus in the NSW jurisdiction) pay $96 less annually than a psychologist registered in the ACT, when both are dealing with essentially the same population of clients? And why should the route for the hearing of complaints be different and confusing where the practitioner is based in the ACT (and part of the PsyBA group of ACT, VIC and TAS) and the client in NSW, and vice versa?

Any differences among the professions in fees paid to register or renew registration should be capable of rational explanation using common criteria, variables and formulae – but currently are not. And complaints coverage should be better rationalised and simplified.

Point (iii): No separate identification of “registration/accreditation fees” from “complaints system fees”:

The differences in fees across jurisdictions and professions appear to have no obvious accounting footing despite the Australian Health Workforce Ministerial Council’s directive to AHPRA and the registration boards on 4.11.09 that separate assessments of
the costs of and fees for registration/accreditation c.f. complaints elements be made. If those assessments have indeed been carried out, we are not aware that registrants and the professional associations have been made privy to them.

The Queensland proposal to separate off its disciplinary system and to take part of the NRAS’s registration fee income to fund it, will make such detailed assessment of parameters and costs imperative.

Point (iv): Inadequate adherence to government guidelines re cost recovery in regulation:

The Victorian Treasury and Finance Cost Recovery Guidelines say:

<table>
<thead>
<tr>
<th>“Nature of cost recovery charges”</th>
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<tr>
<td>Cost recovery charges should:</td>
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<td>• be set according to an ‘efficient’ cost base: best practice cost recovery arrangements require that charges are set at a level that recover the ‘efficient’ (i.e. minimum) costs of providing the good/service at the required quality, or of undertaking the necessary regulatory activity”.</td>
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Commonwealth and other jurisdictions’ cost recovery guidelines are similar. (See Appendix L.)

This principle (adherence to minimum costs) does not require or justify, indeed it effectively proscribes, a search by PsyBA or AHPRA for some notion of “professional best practice” in psychology (as they assert they are doing).

We may all wish to provide “best practices”, but that is a matter for professionals individually and collectively, and not a regulatory one. The task of regulators (in consultation with the profession) is to ensure safe professional practice, not “best practice”. (The latest-developed practices – often alleged to be “best practice” - are not necessarily the safest. Regulators are not as well-placed as professionals to tell the difference. Recent disclosures about serious post-operative problems with cobalt prostheses in hip replacements are a good example.)

NRAS units should of course attempt to identify and follow regulatory “good practices” themselves, but that should not be taken to give carte blanche for “gold-plated” administrative systems, staffing, processes or operations. Their “best practice” is minimal regulation at the lowest possible cost.

Under the National Law Act and the various jurisdictions’ costs recovery guidelines, we would expect simple, “lean” and efficient systems, staffing, processes and operations consistent with Guiding Principle (c) which do not reflect or allow the kind of legalistic and administrative “upward creep” which Justice Bell, then (2008) President of VCAT,
warned against in his inaugural speech, and which the Victorian Treasury and Finance Cost Recovery Guidelines and other jurisdictional guidelines also explicitly proscribe.

The AHPRA Business Plan for 2012 (see Appendix B) gives rise to real concern that it does not share this expectation. It is ambitious in a number of respects –

- a broader set of roles,
- greater authority,
- more control over the registration boards and accrediting bodies,
- more influence with education providers,
- more staff,
- more training, and
- more complex and costly internal systems.

Point (v): unfairly passing onto registrants much of the substantial cost of developing this large, ambitious and complicated new regulatory system:

Apparently substantial costs have arisen from addressing the many legal ambiguities caused by the design of the Scheme and inadequate definitions of scope and terms used, and sorting out the particular employment structures and staff industrial terms and conditions of employment for AHPRA arising from governmental decision to create an “independent statutory authority” (one nonetheless reporting to the parliaments and with links to other bodies with new or revised charters).

However, despite the huge amounts expended by AHPRA and PsyBA on legal advice, nothing fresh has (so far as we can determine) been communicated to registrants, the APS and its Colleges, or the public generally about the legal ambiguities repeatedly drawn to the regulatory bodies’ attention in a number of our previous submissions. We note in particular the very high expenditure on legal advice incurred by PsyBA, much higher than most other professions. To what purpose? With what outcomes?

Point (vi): Conflict of interests:

The NRAS is effectively a system funded (at AHPRA and registration boards level) by levies on the registrants and (through the Australia Psychology Accreditation Council) charges to the universities to accredit courses. In effect AHPRA determines the registration fees and the proportion of fee and other income to be paid to AHPRA, following ‘consultation’ with the registration boards. There is no publicised formal external input as to rationale for and quantum of fees, or for AHPRA staff salaries and sitting fees for panel members. We note that the salary levels paid to AHPRA staff are well above those paid to the jurisdictional registrars and supporting administrative staff in the pre-NRAS days. The Reviewer and his project team may be better placed than we are to quantify these differences.
There is an obvious conflict of interest when the setting of fees is determined by persons whose personal remuneration and conditions of employment including future career prospects are affected by fee levels.

Point (vii): Not a genuine “user/beneficiary pays” funding system:

No fees or other charges are obtained from other people (clients of registrants, employers and government staff) who are among the main users or beneficiaries of the “quality assurance” services provided by the registration boards in conjunction with AHPRA, such as information about qualifications and registration status of particular professionals and their disciplinary records.

Governments currently have no financial stake in paying even a small part of the ongoing costs of the registration, course accreditation and (except in NSW) the complaints elements of the NRAS. (We recognise that governments pay - rightly - for the Ministerial Council level and the other units of public administration involved, as specified in Appendix A to the IGA, and also paid for Health Workforce Australia – which has now been disbanded, saving some $250M. Its functions are to be taken back into the Commonwealth Department of Health – one wonders how, given the “efficiency” stringencies imposed on all Commonwealth departments in recent years. We hope that at least some HWA money goes to the Dept of Health to assist in the transfer of HWA’s hitherto very costly functions, especially in regard to funding of relevant research.)

There is no apparent regular oversight beyond the AHPRA Management Committee, which is not a fully independent watchdog (even though its members are not directly involved in health services and have some oversight responsibilities), hence (we suggest) there is not the requisite level of government interest in fiscal discipline and accountability that comes when governments have to pay some of the bill.

It is too easy (we fear) for registrants to be treated (consciously or unthinkingly) as “cash cows”, which the Victorian Cost Recovery Guidelines and others identify as a generic problem in regulation. Later in this Submission we give a more detailed assessment and arguments why a government level of financial input of say 5% of AHPRA and registration boards’ budgets would strengthen both financial accountability and direct governmental interest in the financial costs of regulation as well as reflect the benefits that accrue to governments and the taxpayer from regulation including the improved operation of the Medicare and accident compensation systems, and governments’ own service provision activities.

Parenthetically we note that psychologists working outside the health sector/industry receive no benefits from these Medicare and workers compensation efficiencies yet are still helping to subsidise them, an anomaly in “user pays” or “beneficiary pays” systems.

In particular the current budgeting system fails to pass any of the costs of regulation onto employers, significant beneficiaries of regulation, possibly more so than individual
registrants in terms of “quality assurance” especially capacity to make multiple checks of potential employees through AHPRA services. They use essentially free services. Industrial courts approving modern awards and Enterprise Bargaining Agreements have generally not endorsed the notion of the employer paying the employee’s registration fees as part of award-set remuneration, which stance may rule out that avenue for indirectly charging employers, but other avenues should be explored. One such avenue could be also to register health service provider organisations (such as those providing Medicare-rebatable or health insurance rebatable services), and charge them registration fees. Alternatively (and more simply) a usage fee could be charged for employer-focused services. Such government and employer (and ultimately taxpayer) contributions to cost recovery would predictably help to install a greater sense of fiscal discipline in the NRAS system than appears to be the case now.

Point (viii): An expensive system:

To elaborate briefly on why the issue of fiscal discipline is raised here, the level of expenditure shown in the 2012 AHPRA Annual Report ($157M) is surprisingly high to us. In Britain psychologists’ registration fees are much lower than Australia’s, and the expenditures of the regulatory body are similarly much lower. (See Appendix D and the Reviewer’s own project team’s assessments of comparative fees.) AHPRA even costs more to run annually than the Australian Prudential Regulation Authority, arguably the nation’s widest-scope and most significant regulatory body (some $157M compared with around $130M)! This quantum does not include the annual costs of operation of the Health Workforce Authority (HWA), which were even higher (circa $250M).

That AHPRA made a surplus of over $7M in 2011/12 (compared to an accumulated deficit of $10.935M the previous financial year) is no ground for congratulation. It is not a profit-making company, and the surplus appears to represent overcharging of registrants, as does AHPRA’s accumulation since 2009 of “equity” amounting to $35.74M (of which some $33.6M was inherited from the State/territory registration boards before they were wound up).

Equally worrying are deficits, which signal “living beyond one’s means”. AHPRA and the registration boards are expected to be self-funded, which should be taken to mean “break even” budgets and financial performance. The deficit incurred by PsyBA in the last financial year of over 1 million dollars was ultimately funded from the $1.5M (approx) accumulated “legacies” inherited from the previous jurisdictional psychology registration boards, with a total budget income of a little over $7M. Its ‘reserves’ of legacy funds will at this rate be exhausted within a year. What then?

These data suggest in our view an inadequate level of fiscal discipline, heightened by the fact that PsyBA (like the other registration boards in collaboration with AHPRA) has put up registration fees each year by at least the CPI (which the previous State/Territory psychology registration boards generally refrained from doing), with significant compounding effects on fees. Yet there is no clear avenue for protest or complaint about the fiscal environment in the NRAS. Even jurisdictional parliaments have difficulty in
these regarding, as the Victorian Legislative Council’s Legal and Social Issues Legislation Committee’s Report No. 2 March 2014 on AHPRA shows. (For example its Finding 2.6 says “The tabling of an annual report by AHPRA in each State and Territory Parliament does not constitute sufficient accountability and scrutiny measures.” – Report p.31.)

These costs and regular increases remain a “running sore” of practitioner and client discontent and complaint, as is reflected in the evaluations reached in our internal review processes and as found expression by participants at the recent biennial Industrial and Organisational Psychology Conference in Perth.

Point (ix): Gender skew:

We note from the latest available staffing data (June 2011) that the AHPRA staffing structure then was significantly skewed by gender, women occupying the majority of “lower” positions and males the vast majority of the “higher”. Unless the more recent staffing figures (not yet available to us) show a distinct improvement, some prompt “affirmative” action seems warranted here. (See Appendix E.)

In summary, these various problems must be addressed urgently if the NRAS costs and fees to registrants are not to:

(a) be unnecessarily high (for example registrants generally appear to be overcharged collectively especially considering the very small number of complaints made against them). It has been reported to us that no member of our College has been the subject of a complaint since the inception of regulation in Victoria in 1966. The tight confidentiality maintained about notifications provides us with no real data on this point.

(b) be seen to permit and enable if not actively encourage “gold-plating”, “cost padding” and “regulatory creep” by government and NRAS units’ staff (e.g. creating many senior staff positions, sourcing - but not making fully public - expensive external legal opinion, acquiring and developing the latest IT systems, etc.) and unnecessary “red tape” (under the banner of “best regulatory practice”), rather than provide only for the actual costs of the basic yet adequate “no frills” administration that flows from Guiding Principle (c) restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.”

Recommendation 4: That:

(a) the current CPI-based funding model (including fee-setting) be replaced with a strategy-based model which is consistent with Guiding Principle (b) of the National Law Act 2009.

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19 These are terms used in the Victorian Dept. of Treasury and Finance’s “Guidelines for Cost Recovery, March 2010”.

20 See Appendix E.
(b) the detailed funding model be developed by a COAG-funded independent expert panel with stakeholder representatives (including and prominently the professional associations), in consultation with (for example) Treasury officials and the Australian Bureau of Statistics (ABS).

(c) that model is to separate the costs of registration/accreditation from those for the complaints component of the NRAS. This separate accounting should also be applied to the operations and staffing of the subsidiary State/Territory boards and administrative units of the national registration boards.

(d) funding through registrants' fees be restricted to only the “administrative” operations (and not the “complaints” operations) of AHPRA and the relevant professional registration board.

(e) within AHPRA and registration board budgets, registrants should not be required to pay for costs that are not due to registration or course accreditation activities. Such indirect additional costs as industrial negotiation of Enterprise Bargaining Agreements for AHPRA staff should be treated as neither “administrative” nor “complaints” expenditures, and should be funded from the original COAG establishment grant of $19.8M or some other non-registrant source.

(f) the costs of legal advice about features of the NRAS or changes thereto be a charge to governments, not the regulated professions.

(g) in the calculation of the costs of the complaints component, the quantum of costs recovered from litigants before external tribunals be recognised.21

(h) consideration be given to what accountability mechanisms are available in or legitimately derivable from the current National Law Act and the IGA regarding financial management at AHPRA and registration board level especially in regard to conflicts of interest in fee-setting.

(i) the very high allocation to AHPRA from registration boards for AHPRA’s administrative services (currently some 70% of PsyBA’s total income) be reviewed with a view to substantial reduction.

(j) the case for reduction in fees for the registration of practitioners be examined, taking into account our recommendations for a smaller governance and regulatory footprint and for reductions in the number and costs of notifications.

(k) our proposals, either to include health service providers (private and public sector employers) as organisations benefitting from regulation and to charge them registration fees, or to introduce AHPRA services’ usage fees, be examined.

(l) a proposal that governments contribute 5% of the annual budgets of AHPRA and the various registration boards be considered.

(m) the skewed gender distribution evident in the 30 June 2011 data for the AHPRA staffing structure be addressed in future appointments (if still evident in AHPRA’s staffing structure).

21 These costs are commonly awarded and substantial where the accused registrant is found guilty by an external tribunal. Currently no accounting recognition appears to be given to them within the NRAS. In one case alone costs recovered totalled $60,000.
Conclusion (f):

Registration board membership appointments are still insufficiently reflective of the diversity of the psychology profession.

Explanation of Conclusion (f):

(a) The making of appointments to the national registration boards (and in psychology at least, their subsidiary jurisdictional groups) has thus far been based on the notions of parity of jurisdictional representation, and the appointment of people with previous experience (and socialisation) in the separate pre-NRAS health-oriented State/Territory registration systems. Using such criteria is contrary to the process of open, merit-based appointments which the Implementation Team told stakeholders would be adopted.

The Reviewer should be aware that the issue of jurisdictional representation was subsequently raised at the 2009 Senate Inquiry into the proposed NRAS. The Hansard record shows that Dr Morauta (the head of the Implementation Team) assured the Senate Inquiry Committee that while jurisdictional representation had been added into the proposed NRAS legislation (then known as Bill B) post-consultation, sufficient flexibility was available to the Health Ministers Council to ensure that broadly-composed registration boards could still be achieved.

In its Final Report the Senate Inquiry Committee observed:

“Recommendation 3

2.178 The Committee recommends that the Australian Health Workforce Ministerial Council ensure that the national registration and accreditation scheme (NRAS) contains sufficient flexibility for the composition of National Boards to properly reflect the characteristics and needs of the individual professions.

2.179 Evidence from psychology associations indicated that that profession is unique to the extent that it might be considered to have health and non-health streams; and that the NRAS as proposed needs to better accommodate these different streams in the design of its accreditation, registration and complaints processes.” (See Appendix R for extracts.)

It is, regrettably, clear that neither set of observations was respected subsequently, with significant negative consequences.

While experience in health regulation might have been seen as a useful criterion in initial appointments, it has proved too limiting for psychology and if maintained would certainly not provide adequate expert input to Board decisions about the fields of psychology beyond the health sector and health industry. It does not promote the desired degree of diversity of understanding of those different fields of psychology, or genuinely national and international rather than local perspectives.
It also discriminates unfairly against possible high-quality appointees from other types of professional backgrounds and competencies. It has (we consider) resulted in an overemphasis on “clinical” and “health care” aspects of psychology, a lack of care (indeed we consider a serious failure in meeting statutory obligations) and attention to the other areas of psychology and the other sectors/industries in the Australian economy, with insufficient innovative capacity to recognise and respond to the emerging challenges of the very dynamic world in which psychologists are trained and provide services to the community.

An apparent flow-on effect of this “clinical” skew has been that the three nominees just made by PsyBA to the Australian Psychology Accreditation Council Board are all “clinical” Associate Professors.

(b) Grouping some jurisdictions:

In psychology the basis for the grouping of some jurisdictions but not others is not publicly explained. A prime instance is the failure to group the ACT with NSW, but instead to link it with Victoria and Tasmania. The grouping process undertaken by PsyBA has resulted in questions about coverage problems regarding complaints (e.g. why should a complaint about an ACT psychologist be heard by a Vic/Tas/ACT group, rather than by a NSW/ACT group?), and also distortions in participation by psychologists in regulatory bodies, with worrying under-representation in four of the States. *Queensland and NSW occupy 14 of the total number of 32 regulatory board positions around Australia (including PsyBA’s 8).* (Queensland has 4 psychologist members, and the two boards in NSW have 5 members each.) *Also the Chair of PsyBA is from NSW.* (See Appendix F.) Victoria, Tasmania, South Australia and Western Australia have only 2 each. Both Territories have 1 each. Since all these members meet from time to time, the skew is significant in terms of dominance of NSW and Q’ld perspectives (as well as significant over-representation in all jurisdictions of the “clinical” areas of the profession).

(c) AHPRA’s Business Plan includes “succession planning” for registration boards’ appointees to ensure “continuity”.

*We consider this an objectionable role for AHPRA or indeed the registration boards.* The processes followed for such appointments have in our view (as outlined above) been less than adequate even though in the most recent round of appointments some “open” (but limited) advertising of appointment vacancies was said to have been undertaken. (However almost all previous members were reappointed.) They are not as “clear, transparent, fair and merit-based” as should have been the case had (for example) the British Government’s “Nolan Rules” for statutory appointments been followed. These “rules” provide a valuable code of practice in the making of such appointments. The College commends them to the Reviewer (as well as requests the original assurance that

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22 On purely functional (especially public interest) grounds, it makes sense to link NSW with the ACT so that complaints/notifications involving NSW clients receiving services from ACT practitioners, or vice versa, are not bedevilled by disputes about jurisdictional coverage. (See Review Paper 5.)
appointments would be merit-based be honoured). (The original Nolan Report Vol. 1 is available on the internet.)

**Recommendation 5:** Appointment processes for the psychology registration board should follow the precepts and code of practice set out in the British Government’s “Nolan Rules”. The practice of separate jurisdictional representation should be replaced by merit-based appointments, and person specifications should be developed to reflect the full range of responsibilities and tasks of members of registration boards. In the case of psychology, these include the regulation of psychological services that are not “health services” as conventionally defined legally, in sectors and industries other than health. Advertisement of vacancies and later appointments should ensure breadth of understanding of the full diversity of psychology and of the regulatory needs of and realistic possibilities in the very different sectors. Neither AHPRA nor PsyBA (nor the AHMAC and its Governance Committee) should engage in “succession planning” for appointees to PsyBA, which planning would breach the Nolan Rules and other principles and goals for such appointments. They should restrict their activities to advertising vacancies and ensuring broad dissemination of that information.

**Conclusion (g):**

PsyBA is attempting to “clinicalise” the whole profession and regulate only for the health sector, rather than protect and nurture psychology’s existing diversity and regulate also for its “beyond health” clienteles. PsyBA policies regarding the syllabus for all fourth year graduates and for its General Examination in Psychology, its misclassification of students as “provisional psychologists”, specialist titles and practice area endorsements, Continuing Professional Development (hereafter CPD) and supervision have all attracted substantial and justified criticisms which have yet to be effectively addressed by PsyBA.

**Explanation of Conclusion (g):**

PsyBA’s thinking appears to be too narrowly focused on clinical situations in “personal health care delivery” contexts. Its views about syllabus content reflect an attempt to impose on the whole profession this narrow perception of the core of the profession, which perception has not of course been received with acclaim or support from the profession and the scientific discipline that underlies it. Such a perception lies at the heart of a number of problems – in its damaging “clinical” supervision requirements and CPD specifications in particular. A looming problem is the growing unacceptability, to the profession and the scientific discipline, of PsyBA’s expectations about the “clinical” content of university courses in psychology, at undergraduate and higher degree levels.

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23 The APS said effectively the same thing in its oral submission to the 2009 Senate Inquiry (see Appendix R).
24 See for example the many submissions made recently to APAC’s call for responses to its proposals re professional standards to be achieved by the universities and other education providers at Masters and doctoral levels, available on the APAC website.
(Later in this Submission we elaborate on the significance to psychologists, particularly in the regulatory context, of the concept of “scientist-practitioner”, which we believe must be the starting point for regulation of psychology, not the notion of “health professional”.)

**Recommendation 6**: That the following PsyBA policies be reviewed and amended in consultation with the APS and its Colleges, the Australian Psychology Accreditation Council, and academic psychologists involved in the training of psychologists (through HODSPA): the purposes, structure and content of the General Examination in Psychology; classifying students as provisional psychologists and charging them fees; specialist titles and “practice area endorsements”; Continuing Professional Development; supervision requirements and supervisor training.

**Conclusion (h):**
Notifications procedures, complaints mechanisms and mandatory requirements all require revisiting and improvement.

**Explanation of Conclusion (h):**

The 2009 Senate Committee reporting on its Inquiry into the NRAS said:

“6.19 In relation to complaints about health practitioners, the committee identified a number of areas where improvements are required including inconsistencies in application of complaint processes, the prescriptiveness of the application form and the way in which vexatious complaints are handled. The committee considers that further development of the complaints process is urgently required……..

**Recommendation 5**
6.20 The committee recommends that complaints processing within AHPRA be reviewed to ensure more accurate reporting of notifications and to reduce the impact of vexatious complaints on health practitioners.
6.29 The committee received extensive evidence concerning the mandatory notification requirements under the National Law. The committee has noted that this is a difficult area of regulation and the safety of the Australian public must be paramount. However, the committee considers that there is merit in examining the operation of the mandatory notification regime operating in Western Australia……..

**Recommendation 10**
6.30 The College recommends that the Commonwealth Government seek the support of the Australian Health Workforce Ministerial Council to implement a review of the mandatory notifications requirements and in particular take into account the Western Australia model of mandatory reporting.”
Our College has examined the system of notifications from the perspective of trying to manage the negative consequences of the design-stage decision to retain separate jurisdictional complaints handling mechanisms. It has also identified the failure thus far in the development of this aspect of the NRAS to take an evidence-based approach to achieve better handling of incompetence and misconduct allegations. Research into practitioners’ decision-making is highly instructive (e.g. Professor Andrew Neal’s work at the University of Queensland into surgeons’ decisional dilemmas outlined in his keynote address to the Industrial and Organisational Psychology Conference 2013 on safety critical systems) but rarely recognised in the NRAS.

Also the approach of regulatory authorities in the various states in the USA has not yet been sufficiently considered, such as some US States’ exempting treating practitioners from mandatory reporting requirements, in recognition of the counterproductive nature of mandatory reporting where a practitioner seeking professional help with problems has to be reported. Indeed even the significant developments in NSW, and in Victoria (by VCAT under Justice Kevin Bell and subsequently) of better informal conflict resolution processes, seem not to have been adequately appreciated by PsyBA or AHPRA.

However we are pleased to note that the Queensland Health Ombudsman Act 2013 makes provision for exemption of the treating practitioner from mandatory reporting under certain circumstances. This provision should, we believe, be considered for application in the other jurisdictions.

The College also notes the failure of AHPRA and PsyBA to address systemic causes of performance problems – individuals are likely to be blamed even where systems are the cause of the defects. A simple example for psychologists is where a public sector department employing psychologists refused to provide access to the latest psychological tests, which left them exposed individually to complaints by parents that their assessments of children in schools had been compromised by use of out-of-date tests. Legally “my employer made me do it” is not considered a defence, yet there is no effective mechanism for regulatory action against delinquent employers. Registration of employers could provide a partial mechanism for such action, as South Australia proposed in draft legislation that was overtaken by (but not included in) the National Law Act. (Our alternative proposal, to charge them AHPRA services usage fees, would not be effective in this context.)

Examination by us and others (notably some industrial and employment law experts) of industrial award/EBA cases over recent years in the public health sector reveals instances of employers failing to provide adequate levels of “in house” professional supervision, CPD support, and encouragement of pursuit of higher qualifications and specialist expertise. Yet registrants working there may face regulatory expectations about time available to supervise trainees and their own CPD (necessary to maintain the level of expertise expected by panels and tribunals hearing complaints against registrants and sometimes their supervisors) that are not possible to achieve under their employer’s
provisions. Greater industrial reality is needed in the NRAS context to ensure complementarity and synergy between employer practices and regulatory provisions so that the former are improved and the latter are more realistic. Registrants also need to be more aware of court judgments about professional liability incurred when supervising interns and registrars, especially the expectations therein about the extent and scope of supervision. This could be a collaborative task of AHPRA, the registration boards, and the professional associations.

The College notes the absence of publicised regulatory strategic plans for future improvements. More should be done to assess and address the systemic causes of alleged practitioner shortcomings, such as the Family Court’s very welcome efforts (in conjunction with the APS initially and later including PsyBA) to reduce the incidence of complaints against expert witnesses (particularly psychologists) as a legalistic manoeuvre to undermine their reports, in preparation for an appeal against an unsuccessful outcome from the original hearing. Also work overload issues and inadequate provision of up-to-date professional tools by employers should be considered.

Unfortunately the regulatory bodies’ willingness to address such systemic issues may have been eroded by the provisions in the IGA which read:

5.6 The Parties to this Agreement confirm that they do not intend the proposed national registration and accreditation scheme to have any role in regulating employment conditions, rates of pay or other employment matters with regard to the health professions proposed to be regulated.

5.7 The Parties to this Agreement further confirm that they do not intend the proposed national registration and accreditation scheme to have any role in relation to resourcing, management or governance of State and Territory health institutions.”

**Recommendation 7:**

(a) That Recommendations of the 2009 Senate Inquiry about mandatory reporting be implemented; and

(b) That the Health Workforce Ministerial Council clarifies with COAG the IGA provisions 5.6. and 5.7, to ensure that systemic causes of individual practitioners’ performance deficits can be recognised and addressed and cannot be ignored on the grounds that they may reflect employment conditions, resourcing, management or governance matters.
Conclusion (i):

Major erosions (including some closures) of psychology courses have occurred and are continuing, due to a confluence of adverse developments that include funding shortages, university research imperatives rather than professional training, shifts in university staffing resources away from professional training, and regulatory preoccupation with health reform with associated distortions in the education and continuing professional development of psychologists. These are overriding the issues of redesigning course delivery and professional training models in Australia to reflect assessments of recent European and US developments (where appropriate).

Explanation of Conclusion (i):

The College strongly supports the standards-setting, coordinating and integrating roles of the Australian Psychology Accreditation Council (APAC) in course accreditation, and would object to the (rumoured) contracting out of its vital “public interest” functions to an external private consultant group which has no transparent accountability and responsibility requirements or formal participative mechanisms similar to APAC’s. The College supports the process of reviewing developments in course structure and professional training models in Europe (such as the European Bologna Process) and the USA. Of course we do not necessarily support the conclusions that might be reached by a particular body or bodies from such a process.

We note approvingly that APAC has just been renewed as the accreditation body for psychology for the next four years. While this is a minor improvement on the previous contractual period, we would have preferred a longer (or indefinite) term of appointment as accreditation cycles are 5 years, and institutions need greater certainty than just four years ahead if they are to embark on the development or maintenance of full- and part-time professional programs and associated “critical mass” of staffing and other infrastructure.

However in light of the very damaging erosions of psychology courses currently occurring, pondering over course designs and trying to “move with the times” in terms of European and USA developments would to many seem pointless if fewer and fewer courses are left to accredit. There are now only 8 higher education providers active in accredited post-graduate (Masters and doctoral levels) course provision relevant to industrial and organisational psychology: none in the ACT, Tasmania and the NT; only 1 in Victoria and South Australia; and two in each of NSW, WA and Qld.25

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25These collectively provide for a total nation-wide intake of up to some 160-200 new students for these 8 two-year programs (some places being needed for continuing students), whose output will be significantly less bearing in mind the slower-than-maximum progress of some students, and the typical “wastage” due to financial problems, difficulty with studies, and other reasons. Some 80 to 120 graduates would (we suspect) be an optimistic estimate for a two-year period, were programs to be run over the same time span (which of course is not the case). This level of output would, we expect, probably not be sufficient to replace natural attrition from our specialty area of the profession.
Of course the “bread and butter” activities of accreditation must continue, but surely APAC must as its highest priority also attend to the identified strategic issues of great concern, especially loss and/or lack of, or serious threats to, courses and places for the training of psychology students particularly in the non-clinical areas of the profession?

**Recommendation 8:** That (a) the Australian Psychology Accreditation Council (APAC) be retained indefinitely as the accrediting authority for psychology courses; and (b) COAG seeks briefings from APAC, the APS, PsyBA, the universities and other stakeholders about adverse developments affecting the psychology profession with a view to addressing them urgently.

**Conclusion (j):**

*For many psychologists the NRAS is morally flawed and is without moral authority. In the NRAS moral (ethical) issues have been used (inappropriately) to justify rejection of the profession’s wish to have specialist titles, and also to justify requiring clinical training for all psychologists. The proposed use as a goal in CPD of certain “personal qualities”, alleged to be necessary for professional work, is rejected. The definition of “practice” requires amendments.*

**Explanation of conclusion (j):**

**Point (i): the critical role of moral issues in regulation:**

It seems not widely enough recognised that regulation is **primarily** a moral endeavour based on values about the competence, ethics, conduct and “good character” of service providers as expressed in their treatment of their clients – rather than primarily an administrative and legal endeavour. Registration takes such moral values into some account, e.g. “good character” requirements and ethics, but appears to us to overemphasise administrative and legal matters. We note that *specifications as to “personal qualities” required in professional work* (signalled for development in PsyBA’s CPD guidelines) in our view are not essentially “moral” issues, and are unnecessary and not evidence based. The prospect of *requiring* all psychologists to possess or develop the personal qualities implicit in (say) empathy and unconditional positive regard in counselling is a very unwelcome one.

**Point (ii): a serious moral dilemma:**
Regulation cannot begin with or be founded on a lie or a misrepresentation. If it does, it will not acquire moral authority, and its continuing lack of moral authority will bedevil it in its various operations. Psychologists in practice are essentially “scientist-practitioners” applying scientifically-derived knowledge to the understanding and solution of real-life problems. Many psychologists do not accept being classified as “health professionals”. For them that classification is a serious public misrepresentation of their qualifications, professional interests and services. It is simply not factually true. Many do not provide health services (however broadly defined). Such a misclassification is often seen as a deliberate legalistic device and a legal fiction created for perceived administrative convenience, if not perhaps also for retention of jurisdicdonal regulatory power (welcomed or only reluctantly accepted) by the health departments and Health Ministers. To accept being so classified requires those psychologists to misrepresent themselves to others, as having the knowledge, skills and professional interests to warrant that classification of “health professional”. Any form of misrepresentation is unethical. Thus a serious dilemma is created for them, involving conflict of imperatives (moral/ethical vs legal). Worse, the regulatory bodies either fail to recognise and understand this dilemma or if they do, they ignore it, seriously eroding their credibility.

So for those psychologists the NRAS lacks moral authority. For the many psychologists who happily accept the classification of “health professional”, no personal dilemma may be encountered, although they may sympathise with affected colleagues.

This will remain the case so long as the misclassification is kept. Only by broadening the scope of the NRAS to recognise and properly include in their own right psychologists who are not “health professionals” will they avoid the moral dilemma and be able to accept the moral legitimacy and authority of the NRAS. In Britain some recognition of this dilemma appears to have been achieved, with the change of title of the overarching regulatory body from “…Health Professions Council” to “…Health and Care Professions Council”. (However this change would not have our support in Australia.)

Thus we urge the Reviewer to consider and act on this moral dimension for those many psychologists who cannot accept misclassification as “health professionals”. (See our Recommendation 9 about changes to the scope of the National Law Act 2009 by recognising “cognate” professions which are linked conceptually with but are not equivalent to or classifiable as “health”.)

Point (iii) greater recognition needed of multi-disciplinary professional work:

In addition to the need for specialisation, professional practice is often carried out in multi-disciplinary (sometimes termed “interdisciplinary” or “transdisciplinary”) contexts, different areas of psychology involving quite different patterns of professional “partnerships”. This is particularly the case in organisational psychology. Such partnerships are not typically short-term, client-centred arrangements of the kind that may occur in health service delivery (e.g. a few Medicare-supported client sessions with a clinical or general psychologist arranged by a GP). They are longer-term and more likely to be project-centred and/or function-centred than client-centred, e.g. a “change
management” program running over a couple of years, or an executive selection contract of indefinite duration. There are somewhat different ethical issues relating to such “partnerships” and their professional interactions which in our view require greater attention than they have received in the NRAS context.

Effective and competent practice in multidisciplinary teams requires “cognate knowledge” - understandings of the basics of the associated professions and disciplines. For example organisational psychologists (collectively rather than individually) know the basics of:

- administrative science and management theory,
- economics,
- production (or aviation or other areas of) engineering and associated socio-technical systems (such as types of production technologies, e.g. continuous flow, large batch, small batch and “one-off”),
- industrial sociology,
- labour/employment law and other elements of “industrial relations”,
- “human resource management”,
- occupational health and safety,
- and much more.

In their patterns of “cognate knowledge”, they differ substantially from (for example) their clinical brethren, whose cognate knowledge is more about psychiatry, welfare systems, rehabilitation, health service provision, neuroscience and neurology, and other related conceptual and practice fields.

We regret concluding that PsyBA has mis-treated some of those “cognate knowledge” elements that are reflected in College competency statements as topics of required psychological knowledge (and has ignored the others). For example the very complex and multi-disciplinary fields of Human Factors and Industrial Relations are not wholly (or in the case of Industrial Relations even mainly) “psychological”, but are vast areas of “cognate knowledge” much of which is important for effective work in many (but by no means all) areas of organisational psychology. To treat them as just a couple of many “psychology knowledge” topics – but also ones required of all those seeking the “organisational psychology” practice area endorsement - merely illustrates the regulator’s failure to understand the field being regulated and seriously erodes confidence in it.

**Point (iv): definition of ‘practice’:**

The current broad definition of practice developed by AHPRA also appears to have been used, in Psychology at least, to legitimise and empower the registration board’s intrusion into areas of professional life and employment not intended when the NRAS

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26 Extract from AHPRA Glossary: **Practice** This definition of practice is used in a number of National Board registration standards. It means any role, whether remunerated or not, in which the individual uses their skills and
was being developed -

- higher education activities (syllabuses and features of placements),
- the professional aspects of the management of service delivery agencies (e.g. PsyBA’s taking a negative view about “in-house” professional supervision, a view which can only be described as lacking in rationality, practicality and good sense organisationally),
- the operations of professional policy development units in the public and private sectors through too-clinical specifications about supervisor qualifications,
- the employment of students by placement agencies on sub-professional work, but not as part of a University-arranged and -supervised placement. (Endorsement or encouragement of such work, especially on an unpaid basis, by a regulator is most unwise, as it may constitute breach of an industrial award if in an award-covered agency. It also seems to breach the IGA provision 5.6 The Parties to this Agreement confirm that they do not intend the proposed national registration and accreditation scheme to have any role in regulating employment conditions, rates of pay or other employment matters with regard to the health professions proposed to be regulated. We would consider employment of students outside university-arranged and -supervised placements to be one of the “other employment matters” covered by 5.6."

We also consider the AHPRA definition footnoted above to be an example of confusion of “intentions” with “outcomes” as previously addressed. This could be overcome simply, by changing the last line in the definition to read: “other profession-relevant roles that are intended to impact on safe, effective delivery of health services in that health profession. “ (Our underlining.)

We also consider that the words “education” and “research” should be removed from the definition, to ensure that the science (discipline) of psychology is clearly excluded from regulation under the NRAS.

**Recommendation 9:**

(a) That the scope of the NRAS (legislatively and in other ways) be broadened to encompass not only the “health professions”, but also “cognate professions” (meaning “related” professions).
(b) That to achieve (a), the words “health professions” (and “health professionals”) be replaced with “health and cognate professions” (and “health professionals and knowledge as a practitioner in their regulated health profession. Practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct non-clinical relationship with patients or clients, working in management, administration, education, research, advisory, regulatory or policy development roles and any other roles that impact on safe, effective delivery of health services in the health profession."

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professionals in the designated cognate professions”) in the NRAS legislation and subsidiary regulations and policies– the cognate professions to be listed in an annex, and to include Psychology. 27

And

**Recommendation 10:** That (a) the various current PsyBA statements of required psychological knowledge be redefined immediately as “suggested” or “indicative” rather than “mandatory” so that they may not be used as the basis for assessment of professional performance and competence in the complaints/notifications arena; and (b) PsyBA be required to review them in consultation with the APS and its Colleges.

And

**Recommendation 11:** That the AHPRA definition of practice be amended to read:

“Practice  This definition of practice is used in a number of National Board registration standards. It means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a practitioner in their regulated health profession. Practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct non-clinical relationship with patients or clients, working in management, administration, advisory, regulatory or policy development roles and any other profession-relevant roles that are intended to impact on safe, effective delivery of health or cognate services in that profession.”

We would be able to make recommendations to the Reviewer about training and CPD to explain how the notion of “cognate knowledge” could be recognised in those areas of regulation.

**ADVERTISING AND TESTIMONIALS**

The College considers that the AHPRA policy injunctions against the use of advertising and testimonials require review and revision. They seem not to take into account

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27 Note Re The Term “Cognate”

There should be no legislative drafting problem or Parliamentary confusion over the introduction of such a term. Parliaments are familiar with “cognate”, which has long been used in framing or reviewing legislation to “rope in” other related acts or areas of activity that the main descriptors of the scope of legislation may not, or may not appear to, incorporate. See for example the “New South Wales Law Reform Commission Report 41 (1983) - Accident Compensation Interim Report: Workers’ Compensation (Amendment) Bill 1982 and Cognate Bills.” The term “cognate” has also been applied to words used in legislation, thus:“(NSW) INTERPRETATION ACT 1987 - SECT 7 Cognate Words: If an Act or instrument defines a word or expression, other parts of speech and grammatical forms of the word or expression have corresponding meanings.”

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perfectly valid and ethical practices such as where a government body calls for tenders to provide services, and as part of its decision-making processes, asks for information about the tenderers’ competent performance of previous similar work – in effect a testimonial.

**RECOMMENDATION re testimonials**

**Recommendation 12 (a):** THAT the provision of testimonials as part of a competitive tendering process, where such provision is requested by the tenderer, not be considered advertising for the purposes of AHPRA or PsyBA policy regarding ethical conduct and/or advertising of psychological services.

**Recommendation 12(b):** THAT the provision to a potential client organisation of a list of companies or other organisations which have used the psychologist’s services not be considered advertising for the purposes of AHPRA or PsyBA policy regarding ethical conduct and/or advertising of psychological services.

**Conclusion (k):**

*Despite the issuing of many calls for submissions by NRAS bodies, significant defects have occurred in regulatory impact assessment and consultation.*

**Explanation of Conclusion (k):**

Only one full-scale regulatory impact assessment (RIA) was carried out at the start of the development of the NRAS, and then in a “health sector”-focused and persuasive way rather than objectively. RIA defects have also been noted by the (Commonwealth) Office of Best Practice Regulation at both COAG and Australian Health Workforce Ministerial Council levels. Public service units (effectively the heads of jurisdictional health departments and their staff) with no statutory role in the NRAS have intervened in the consultation process, and in decision-making about professional matters. They appear to have at times displaced the statutorily-recognised Australian Health Ministers Advisory Council in the provision of advice to the Australian Health Workforce Ministerial Council about some significant NRAS matters. Less than optimum consultation has been

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28 An “in principle” Regulatory Impact Statement was issued by COAG (through a supporting Senior Officers group) on 28.4.2007 as a prelude to the development of the Intergovernmental Agreement.
undertaken by the Australian Health Professions Regulation Agency (AHPRA) and the Psychology Board of Australia (PsyBA), principally in terms of failure to advise contributors of the thrust of the submissions and what changes, if any, were to be made as a result of the submissions.

Neither PsyBA nor AHPRA has used the notion of the psychologist as a “scientist-practitioner” as the starting point for their thinking about the regulation of the profession. Rather they have treated all psychologists as necessarily “health professional”. A shift in mental sets is (we believe) required.

**Recommendation 13:** THAT any definition of practice must start from the foundation concept that the psychologist is a “scientist-practitioner”, and not necessarily a “health professional”.

**Recommendation 14:** THAT attention is given to improving the quality of Regulatory Impact Assessment in the NRAS context by closer adherence to the Commonwealth Office of Best Practice Guidelines and our other cited references.

**Recommendation 15:** THAT the respective roles of the statutorily-prescribed bodies within the NRAS structure vis-à-vis non-statutory “units of public administration” (such as the Governance Committee of the Australian Health Ministers Advisory Council) be clarified.

**Recommendation 16:** That the Australian Health Workforce Ministers Advisory Council (as recognised in the National Law Act 2009):
(a) be reinstated;
(b) be the principal source of advice about key elements of the NRAS that are contentious or otherwise problematic; and
(c) have its role clarified and (if necessary) expanded to include the independent oversight of regulatory impact assessments (both the need for them and the process of conducting them).

**Recommendation 17:** That AHPRA and PsyBA be required to provide public analyses of the submissions they receive in response to discussion or consultation papers, and

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29 I.e. under the National Law Act 2009.
give feedback to registrants about changes to be made to draft or existing policies following submissions.

**Recommendation 18:** That the development be considered of alternative (“open system” and “post-Taylorist”) approaches to regulation such as are commended by Lateral Economics in its “Beyond Taylorism: Regulating for innovation”, 28th August 2007.

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**Conclusion (I):**

The pre-NRAS consultation promise of independence of the profession of psychology and its underlying scientific discipline has not been delivered. There are a number of serious problems affecting psychology badly. The misclassification of students of psychology as “provisional”, the failure to develop and maintain a student register (with an attendant loss of data and privacy), and unjustified charging of registration fees are of major concern. Issues of concern are manifold: imposition of a clinical syllabus (through the misapplication of the National Psychology Examination); “clinical” restrictions of placements and internship supervision and supervisors affecting the flow of training; simplistic views about professional liability and duty of care; and misuse of trainees on placements.

**Explanation of Conclusion (I):**

The Psychology Board of Australia (PsyBA) – alone of all the NRAS registration boards – is refusing to classify students as students, create and maintain a Student Register, and provide the privacy safeguards contained in the National Law Act 2009. Also, contrary to the Act, it is charging psychology students the substantial registration fees set for provisional psychologists, which fees are at the same level as for general psychologists. These fees add to the substantial financial burden on students as earlier argued.

We consider that it is inconsistent, unfair and indeed legally wrong to classify students as “provisional psychologists” who by definition must be capable of undertaking paid professional service delivery (even though supervised) from which agency income is derived. In our view students are in fact not ready for such work. They should be used in observational not active service delivery roles. There are serious legal and ethical pitfalls for student and supervisor in their being involved in direct service provision.

In our view they should not to be paid if their placements are to be genuine as defined by Fair Work Australia. PsyBA actively encourages unpaid employment in psychology.

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30 Available on the Internet, and as Appendix D.
agencies outside the supervisory and training framework provided by the university, and appears not to have considered the *industrial especially employment law* applicable here. Its policies on student employment appear inconsistent with the Fair Work Ombudsman’s policies (see the Ombudsman’s Fact Sheet on Internships, Vocational Placements and Unpaid Work copied in Appendix C), capable of abuse of student employment in psychological practices, and potentially contentious industrially.

We also consider that the Board’s misclassification of psychology students denies those students the “reasonable adjustments” provided for students with impairment, under the Disability Discrimination Act 1992. We note the following observation by General Counsel in AHPRA’s Legal Practice Note 5:

“STUDENTS WITH AN IMPAIRMENT LPN 5 (2 April 2012)

“Students

The DDA requires reasonable adjustments to be made, for example, by education providers so that the program of study and its delivery is free from unlawful discrimination. Reasonable adjustments would include building accessibility, vision aides, hearing loops and the presence of note takers.

Similarly, for a student to be competent in clinical practice reasonable adjustments may be acceptable for the student to complete their studies.”

From the outset of PsyBA’s policy-setting, our College has strongly objected to these specific features of the PsyBA’s policies re students, and continues to do so. The following recommendations address those features.

**Recommendation 19:**

**THAT COAG requires the AHWMC to ensure that the assurances given during the consultations in the lead-up to the introduction of the NRAS that the independence of the higher education sector and the professions to be covered are to be respected, and the Ministerial Council requires suitable modification of those regulatory policies drawn to their attention through the AHMAC Review of the NRAS where interference with those areas of independence is identified.**

**Recommendation 20:** **THAT**

(a) post-graduate students (Masters and professional doctoral) be classified as students for regulatory purposes (as is the case with the other professions).

(b) a Register of Students of Psychology is established as soon as possible, and properly maintained.

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31 Disability Discrimination Act.

32 Similar observations were made in AHPRA’s Legal Practice Note PRACTITIONERS AND STUDENTS WITH IMPAIRMENT LPN 12 (10 August 2012).
(c) registration fees are not charged to students of Psychology except where they already meet the normal criteria for provisional or full registration independently of their current academic studies (e.g. experienced psychologists with general registration upgrading their academic qualifications by undertaking an accredited Masters program).

(d) PsyBA does not conflate (through its policies) the three pathways to general registration as a psychologist (the “6 year” pathway through Masters or professional doctorate level training, the “5+1” pathway, and the “4+2” pathway to general registration, involving only four years of accredited academic study but followed by two years of professional work experience supervised by experienced professional psychologists), or confuse the experiential placements in the “six year” program with the post-graduation supervised professional practice components of the other two pathways.

(e) PsyBA’s recent policy on “working beyond placements” be suspended pending consultation with the profession and the education bodies involved in post-graduate Psychology training.

(f) PsyBA reconsiders its proposed multi-purposes use of the General Psychology Examination in regard to, but also more broadly than, its intended application to post-graduate students. The device of making an “exemptions” provision for Masters and professional doctoral applicants at Board policy level (until 2016) is not acceptable to us, being too susceptible to reversal or other unacceptable modification without consultation or need for higher-level approval. The scope of the Examination also requires much greater breadth and less emphasis on knowledge of abnormal behaviour and skills in clinical diagnosis and interventions, and it should be sectioned according to specialisms.

Recommendation 21: That already-registered psychologists enrolled in accredited higher degree programs nonetheless should be recorded in the Register of Students under a suitable sub-category so that a full and clear picture of the student cohorts is available for workforce and other planning and policy-development purposes.

Recommendation 22: THAT there is more explicit recognition by regulators of the “cornerstone” need to balance regulatory safeguards to prevent abuses of the professional supervision of trainees and for adequate quality of that supervision, with flexibility of regulatory requirements to ensure adequate opportunities for supervision and appropriateness of those requirements to all sectors, not just the health sector.
Recommendation 23: THAT the Psychology Board of Australia work closely with the profession to ensure full involvement and expert input into reshaping the Board’s supervision policies and training and other requirements for supervisors to minimise adverse impacts on the availability of internships across the full spectrum of psychological work, consistent with adequate quality of services and clients’ and fellow practitioners’ safety, and to ensure that supervisors are not subject to such risk of successful complaints against them as to drive them away from supervisory roles.

Recommendation 24: THAT the Board and the Australian Psychology Accreditation Council (APAC) make clearer that students on professional placements are not to deliver direct psychological services to clients, but are to have an observational role; and that the “duty of care” placed on the academic staff co-supervising the student does not extend to the clients of the placement agency except insofar as the student’s observational role may affect service delivery.

Recommendation 25: THAT APAC (and if necessary the Australian Health Workforce Ministerial Council - AHWMC) make clearer that students on placement should be assessed against only the relevant objectives and other features of the APAC-accredited course, and not against separate requirements such as “clinical” skill development set by PsyBA or a higher regulatory body.

Recommendation 27: THAT research be commissioned by the AHWMC or other appropriate body into the prevalence of the various types of supervision arrangements for psychology trainees (students, interns and registrars) and their main features including benefits, abuses and costs to trainees and agencies providing supervision.

Recommendation 28: THAT clarifying legal advice be sought by the AHWMC about the industrial circumstances, obligations and entitlements of psychology trainees under professional supervision, and about the issues of “duty of care” and professional and other forms of liability (including those of line managers who are not “professional supervisors”) when interns and registrars are involved in professionally supervised direct service delivery.
Recommendation 29: THAT advice be sought by the AHWMC from appropriate bodies (e.g. Workforce Australia, the Fair Work Commission, the ACCC, the Australian Bureau of Statistics, the Productivity Commission, the Australian Tax Office, the ACTU) about the fairness, equity, absence of normal employee protections and entitlements, systemic workforce implications, labour displacement effects, unfair competitive advantage, and other issues arising from the use of “unpaid labour” when students, interns and registrars are expected to perform productive work without remuneration in student placements or supervised professional experience arrangements).

Recommendation 30: THAT the Reviewer considers the need for and value of establishing (through the Fair Work Commission) a common set of minimum remuneration standards and terms and conditions of employment for interns and registrars in currently unregulated sectors industrially, such as those already found in industrial awards like the Health And Community Employees Psychologists (State) Award.

Recommendation 31: THAT the Reviewer examines the fairness, equity and industrial implications of payment by trainees for their own professional supervision.

Recommendation 32: THAT the Reviewer considers the feasibility and potential impacts of recording in a publicly-available, transparent form those agencies offering “voluntary” (unpaid) internships which meet appropriate criteria (to be developed) that ensure they:

1 are genuine in regard to alleged altruistic “social benefit” purposes (and not for the purpose of competitive advantage through free labour),
2 involve professional service delivery that is within the competence of the intern and which would otherwise not be affordable by and provided to needy clients,
3 do not substitute for normal paid professional labour or displace registered general psychologists who have a reasonable expectation of performing such services on a paid basis, and
4 provide interns with valuable supervised professional experience with adequate professional indemnity cover including the agency’s taking proper legal and ethical responsibility for service delivery.
Conclusion (m):

The National Psychology Examination (NPE) is not “fit for purpose” and requires substantial and fundamental rethinking as to purposes and its lack of diversity. It tries to serve too many purposes and “falls between stools”. It is clinically biased and creates serious problems if used with trainees or overseas applicants from non-clinical backgrounds. Workforce planning is needed in psychology and work already done should be extended, with support from COAG.

Explanation of Conclusion (m):

The shortcomings of the National Psychology Examination (NPE) are considerable, as our comments earlier in this Submission have indicated. They include: having multiple purposes which are not mutually compatible in terms of design of the key features of the NPE; being deliberately “clinical” in content, reflecting an admitted bias by PsyBA towards clinical work as its perception of what constitutes the “core” of applied psychology; and other problematic features (reflected in the specific recommendations below).

Recommendation 34. That assessments about qualifications be purpose-tailored and specific, not the “shotgun”/“one size fits all” form that the National Psychology Examination constitutes.

Recommendation 35. We recommend against a single multi-purpose curriculum and examination.

Recommendation 36: That in the assessment of overseas applicants, provision be made for decision categories beyond “Pass” or “Fail”, such as “Provisionally registered with the condition that (e.g. English language competency is established by completing satisfactorily the XXX test by a specified date)”.

Recommendation 37: That if a National Psychology Examination (with a number of different area-specific versions) is to be created, the various Colleges of the APS be part of a broader consultation process, to develop a wide range and large number of questions about their areas of practice that a commencing psychologist should be able to answer.

Recommendation 38: That PsyBA, in consultation with APAC and the APS33, extends the workforce planning work done in the reports in the September 2010 special issue of the Australian Psychologist, from “current snapshots” to “projections of future professional work and associated workforce needs”, particularly beyond the health sector.

33 Australian Psychological Society.
**Full Set of Recommendations to the Reviewer.**

**Recommendation 1:** That the various features of the NRAS be remodelled where appropriate to ensure that:
(a) the principles and objectives of the Scheme are more clearly recognised and more strictly observed,
(b) (for psychology at least) more emphasis is placed on identifying and preventing unsafe practices, and
(c) assurances given pre-NRAS that the integrity, independence and diversity of the profession and its underlying science would be protected (including through broad composition of PsyBA\(^{34}\)) be respected and observed.

**Recommendation 2:** That a genuine co-partnership model built on trust among stakeholders should replace the existing “command and control” model that treats the professional associations as but one stakeholder who cannot be trusted to protect and work for and in the “public interest”.

**Recommendation 3:** A clearer and more precise definition of the scope of the NRAS including for funding and fee-setting purposes should be developed promptly. The Commonwealth and jurisdictional Cost Recovery Guidelines should be referenced in this task.

**Recommendation 4:** That:

(a) the current CPI-based funding model (including fee-setting) be replaced with a strategy-based model which is consistent with Guiding Principle (b) of the National Law Act 2009.
(b) the detailed funding model be developed by a COAG-funded independent expert panel with stakeholder representatives (including and prominently the professional associations), in consultation with (for example) Treasury officials and the Australian Bureau of Statistics (ABS).
(c) that model is to separate the costs of registration/accreditation from those for the complaints component of the NRAS. This separate accounting should also be applied to the operations and staffing of the subsidiary State/Territory boards and administrative units of the national registration boards.
(d) funding through registrants’ fees be restricted to only the “administrative” operations (and not the “complaints” operations) of AHPRA and the relevant professional registration board.
(e) within AHPRA and registration board budgets, registrants should not be required to pay for costs that are not due to registration or course accreditation activities. Such indirect additional costs as industrial negotiation of Enterprise Bargaining Agreements for AHPRA staff should be treated as neither “administrative” nor “complaints”

\(^{34}\) The Psychology Board of Australia.
expenditures, and should be funded from the original COAG establishment grant of $19.8M or some other non-registrant source.

(f) the costs of legal advice about features of the NRAS or changes thereto be a charge to governments, not the regulated professions.

(g) in the calculation of the costs of the complaints component, the quantum of costs recovered from litigants before external tribunals be recognised.  

(h) consideration be given to what accountability mechanisms are available in or legitimately derivable from the current National Law Act and the IGA regarding financial management at AHPRA and registration board level especially in regard to conflicts of interest in fee-setting.

(i) the very high allocation to AHPRA from registration boards for AHPRA’s administrative services (currently some 70% of PsyBA’s total income) be reviewed with a view to substantial reduction.

(j) the case for reduction in fees for the registration of practitioners be examined, taking into account our recommendations for a smaller governance and regulatory footprint and for reductions in the number and costs of notifications.

(k) our proposals either to include health service providers (private and public sector employers) as organisations benefitting from regulation and to charge them registration fees, or to introduce AHPRA services’ usage fees, be examined.

(l) a proposal that governments contribute 5% of the annual budgets of AHPRA and the various registration boards be considered.

(m) the skewed gender distribution evident in the 30 June 2011 data for the AHPRA staffing structure be addressed in future appointments (if still evident in AHPRA’s staffing structure).

Recommendation 5: Appointment processes for the psychology registration board should follow the precepts and code of practice set out in the British Government’s “Nolan Rules”. The practice of separate jurisdictional representation should be replaced by merit-based appointments, and person specifications should be developed to reflect the full range of responsibilities and tasks of members of registration boards. In the case of psychology, these include the regulation of psychological services that are not “health services” as conventionally defined legally, in sectors and industries other than health. Appointments should ensure breadth of understanding of the full diversity of psychology and of the regulatory needs of and realistic possibilities in the very different sectors. Neither AHPRA nor PsyBA (nor the AHMAC and its Governance Committee) should engage in “succession planning” for appointees to PsyBA, which planning would breach the Nolan Rules and other principles and goals for such appointments.

Recommendation 6: That the following PsyBA policies be reviewed and amended in consultation with the APS and its Colleges, the Australian Psychology Accreditation Council, and academic psychologists involved in the training of psychologists (through

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35 These costs are commonly awarded and substantial where the accused registrant is found guilty by an external tribunal. Currently no accounting recognition appears to be given to them within the NRAS.
HODSPA\textsuperscript{36}: the General Examination in Psychology; classifying students as provisional psychologists and charging them fees; specialist titles and “practice area endorsements”; Continuing Professional Development; supervision requirements and supervisor training.

**Recommendation 7:**

(a) That Recommendations of the 2009 Senate Inquiry about mandatory reporting be implemented; and
(b) That the Health Workforce Ministerial Council clarifies with COAG the IGA provisions 5.6. and 5.7, to ensure that systemic causes of individual practitioners’ performance deficits can be recognised and addressed and cannot be ignored on the grounds that they may reflect employment conditions, resourcing, management or governance matters.

**Recommendation 8:** That (a) the Australian Psychology Accreditation Council (APAC) be retained as the accrediting authority for psychology courses; and
(b) COAG seeks briefings from APAC, the APS, PsyBA, the universities and other stakeholders about adverse developments affecting the psychology profession with a view to addressing them urgently.

**Recommendation 9:**

(a) That the scope of the NRAS (legislatively and in other ways) be broadened to encompass not only the “health professions”, but also “cognate professions” (meaning “related” professions).
(b) That to achieve (a), the words “health professions” (and “health professionals”) be replaced with “health and cognate professions” (and “health professionals and professionals in the designated cognate professions”) in the NRAS legislation and subsidiary regulations and policies— the cognate professions to be listed in an annex, and to include Psychology.\textsuperscript{37}

And

\textsuperscript{36} Heads of Departments and Schools of Psychology Association.

\textsuperscript{37} Note Re The Term “Cognate”

There should be no legislative drafting problem or Parliamentary confusion over the introduction of such a term. Parliaments are familiar with “cognate”, which has long been used in framing or reviewing legislation to “rope in” other related acts or areas of activity that the main descriptors of the scope of legislation may not, or may not appear to, incorporate. See for example the “New South Wales Law Reform Commission Report 41 (1983) - Accident Compensation Interim Report: Workers’ Compensation (Amendment) Bill 1982 and Cognate Bills.” The term “cognate” has also been applied to words used in legislation, thus:“(NSW) INTERPRETATION ACT 1987 - SECT 7 Cognate Words: If an Act or instrument defines a word or expression, other parts of speech and grammatical forms of the word or expression have corresponding meanings.”

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**Recommendation 10:**

That (a) the various current PsyBA statements of required psychological knowledge be redefined immediately as “suggested” or “indicative” rather than “mandatory” so that they may not be used as the basis for assessment of professional performance and competence in the complaints/notifications arena; and (b) PsyBA be required to review them in consultation with the APS and its Colleges.

And

**Recommendation 11:**

That the AHPRA definition of practice be amended to read:

> Practice This definition of practice is used in a number of National Board registration standards. It means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a practitioner in their regulated health profession. Practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct non-clinical relationship with patients or clients, working in management, administration, advisory, regulatory or policy development roles and any other profession-relevant roles that are intended to impact on safe, effective delivery of health or cognate services in that profession.”

**Recommendation 12:**

(a) THAT the provision of testimonials as part of a competitive tendering process, where such provision is requested by the tenderer, not be considered advertising for the purposes of AHPRA or PsyBA policy regarding ethical conduct and/or advertising of psychological services.

(b) THAT the provision to a potential client organisation of a list of companies or other organisations which have used the psychologist’s services not be considered advertising for the purposes of AHPRA or PsyBA policy regarding ethical conduct and/or advertising of psychological services.

**Recommendation 13:** THAT any definition of “practice” must start from the foundation concept that the psychologist is a “scientist-practitioner”, and not necessarily a “health professional”.

**Recommendation 14:** THAT attention is given to improving the quality of Regulatory Impact Assessment in the NRAS context by closer adherence to the Commonwealth Office of Best Practice Guidelines and our other cited references.

**Recommendation 15:** THAT the respective roles of the statutorily-prescribed bodies within the NRAS structure vis-à-vis non-statutory “units of public administration” (such as the Governance Committee of the Australian Health Ministers Advisory Council) be clarified.

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38 I.e. under the National Law Act 2009.
Recommendation 16: That the Australian Health Workforce Ministers Advisory Council (as recognised in the National Law Act 2009):
(d) be reinstated;
(e) be the principal source of advice about key elements of the NRAS that are contentious or otherwise problematic; and
(f) have its role clarified and (if necessary) expanded to include the independent oversight of regulatory impact assessments (both the need for them and the process of conducting them).

Recommendation 17: That AHPRA and PsyBA be required to provide public analyses of the submissions they receive in response to discussion or consultation papers, and give feedback to registrants about changes to be made to draft or existing policies following submissions.

Recommendation 18: That the development be considered of alternative (“open system” and “post-Taylorist”) approaches to regulation such as are commended by Lateral Economics in its “Beyond Taylorism: Regulating for innovation”, 28th August 2007.

Recommendation 19: That COAG requires the AHWMC to ensure that the assurances given during the consultations in the lead-up to the introduction of the NRAS that the independence of the higher education sector and the professions to be covered are to be respected, and the Ministerial Council requires suitable modification of those regulatory policies drawn to their attention through the National Review of the NRAS where interference with those areas of independence is identified.

Recommendation 20: THAT

(g) post-graduate students (Masters and professional doctoral) be classified as students for regulatory purposes (as is the case with the other professions).
(h) a Register of Students of Psychology is established as soon as possible, and properly maintained.
(i) registration fees are not charged to students of Psychology except where they already meet the normal criteria for provisional or full registration independently of their current academic studies (e.g. experienced psychologists with general registration upgrading their academic qualifications by undertaking an accredited Masters program).
(j) PsyBA does not conflate (through its policies) the three pathways to general registration as a psychologist (the “6 year” pathway through Masters or professional doctorate level training, the “5+1” pathway, and the “4+2” pathway to general registration, involving only four years of accredited academic study but followed by two years of professional work experience supervised by experienced professional psychologists), or confuse the experiential placements in the “six

39 Available on the Internet, and as Appendix D.
year” program with the post-graduation supervised professional practice components of the other two pathways.

(k) PsyBA’s recent policy on “working beyond placements” be suspended pending consultation with the profession and the education bodies involved in post-graduate Psychology training.

(l) PsyBA reconsiders its proposed multi-purposes use of the General Psychology Examination in regard to, but also more broadly than, its intended application to post-graduate students. The device of making an “exemptions” provision for Masters and professional doctoral applicants at Board policy level (until 2016) is not acceptable to us, being too susceptible to reversal or other unacceptable modification without consultation or need for higher-level approval. The scope of the Examination also requires much greater breadth and less emphasis on knowledge of abnormal behaviour and skills in clinical diagnosis and interventions, and it should be sectioned according to specialisms.

Recommendation 21: That already-registered psychologists enrolled in accredited higher degree programs nonetheless should be recorded in the Register of Students under a suitable sub-category so that a full and clear picture of the student cohorts is available for workforce and other planning and policy-development purposes.

Recommendation 22: THAT there is more explicit recognition by regulators of the “cornerstone” need to balance regulatory safeguards to prevent abuses of the professional supervision of trainees and for adequate quality of that supervision, with flexibility of regulatory requirements to ensure adequate opportunities for supervision and appropriateness of those requirements to all sectors, not just the health sector.

Recommendation 23: THAT the Psychology Board of Australia work closely with the profession to ensure full involvement and expert input into reshaping the Board’s supervision policies and training and other requirements for supervisors to minimise adverse impacts on the availability of internships across the full spectrum of psychological work, consistent with adequate quality of services and clients’ and fellow practitioners’ safety, and to ensure that supervisors are not subject to such risk of successful complaints against them as to drive them away from supervisory roles.

Recommendation 24: THAT the Board and the Australian Psychology Accreditation Council (APAC) make clearer that students on professional placements are not to deliver direct psychological services to clients, but are to have an observational role; and that the “duty of care” placed on the academic staff co-supervising the student does not extend to the clients of the placement agency except insofar as the student’s observational role may affect service delivery.

Recommendation 25: THAT APAC (and if necessary the Australian Health Workforce Ministerial Council - AHWMC) makes clearer that students on placement should be assessed against only the relevant objectives and other features of the APAC-accredited
course, and not against separate requirements such as “clinical” skill development set by PsyBA or a higher regulatory body.

**Recommendation 27:** THAT research be commissioned by the AHWMC or other appropriate body into the prevalence of the various types of supervision arrangements for psychology trainees (students, interns and registrars) and their main features including benefits, abuses and costs to trainees and agencies providing supervision.

**Recommendation 28:** THAT clarifying legal advice be sought by the AHWMC about the industrial circumstances, obligations and entitlements of psychology trainees under professional supervision, and about the issues of “duty of care” and professional and other forms of liability (including those of line managers who are not “professional supervisors”) when interns and registrars are involved in professionally supervised direct service delivery.

**Recommendation 29:** THAT advice be sought by the AHWMC from appropriate bodies (e.g. Workforce Australia, the Fair Work Commission, the ACCC, the Australian Bureau of Statistics, the Productivity Commission, the Australian Tax Office, the ACTU) about the fairness, equity, absence of normal employee protections and entitlements, systemic workforce implications, labour displacement effects, unfair competitive advantage, and other issues arising from the use of “unpaid labour” when students, interns and registrars are expected to perform productive work without remuneration in student placements or supervised professional experience arrangements).

**Recommendation 30:** THAT the Reviewer considers the need for and value of establishing (through the Fair Work Commission) a common set of minimum remuneration standards and terms and conditions of employment for interns and registrars in currently unregulated sectors industrially, such as those already found in industrial awards like the Health And Community Employees Psychologists (State) Award.

**Recommendation 31:** THAT the Reviewer examines the fairness, equity and industrial implications of payment by trainees for their own professional supervision.

**Recommendation 32:** THAT the Reviewer considers the feasibility and potential impacts of recording in a publicly-available, transparent form those agencies offering “voluntary” (unpaid) internships which meet appropriate criteria (to be developed) that ensure they:

(a) are genuine in regard to alleged altruistic “social benefit” purposes (and not for the purpose of competitive advantage through free labour),

(b) involve professional service delivery that is within the competence of the intern and which would otherwise not be affordable by and provided to needy clients,
(c) do not substitute for normal paid professional labour or displace registered general psychologists who have a reasonable expectation of performing such services on a paid basis, and  
(d) provide interns with valuable supervised professional experience with adequate professional indemnity cover including the agency’s taking proper legal and ethical responsibility for service delivery.

**Recommendation 33.** That assessments about qualifications be purpose-tailored and specific, not the “shotgun”/“one size fits all” form that the National Psychology Examination constitutes.

**Recommendation 34.** We recommend against a single multi-purpose curriculum and examination.

**Recommendation 35:** That in the assessment of overseas applicants, provision be made for decision categories beyond “Pass” or “Fail”, such as “ Provisionally registered with the condition that (e.g. English language competency is established by completing satisfactorily the XXX test by a specified date)”.

**Recommendation 36:** That if a National Psychology Examination (with a number of different area-specific versions) is to be created, the various Colleges of the APS be part of a broader consultation process, to develop a wide range and large number of questions about their areas of practice that a commencing psychologist should be able to answer.

**Recommendation 37:** That PsyBA, in consultation with APAC and the APS, extends the workforce planning work done in the reports in the September 2010 special issue of the Australian Psychologist, from “current snapshots” to “projections of future professional work and associated workforce needs”, particularly beyond the health sector.

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40 Australian Psychological Society.
IN CONCLUSION:

The NRAS remains a scheme designed for the Australian domestic health sector only, and administered and overseen on COAG’s behalf by health ministers, health departments and professionals with health backgrounds and perspectives. As such, its introduction has perhaps been as well managed (from a conventional 20th Century administrative perspective at least) as one might expect, especially given its very large and complex structure (although that structure and its introduction and management have not been free of justified and substantial criticism).

But the NRAS is not a suitable contemporary model for psychology as a whole. Nor is it a suitable 21st Century regulatory model for service provision either in the health arena or in the many sectors and industries other than “health” which use psychological services. Its introduction and application, intersecting with negative external developments especially in the underfunding of the universities, are proving very damaging to psychology in ways that are becoming increasingly evident.

Continued restriction of regulatory focus to just the health sector and personal health services, understandable as it is in terms of being part of a broader health reform agenda, would nonetheless in regard to psychology as a whole constitute a serious failure in regulatory effort, and result in much damage to the other sectors and industries when (rather than if) the workforce “pipeline” dries up for their kinds of psychological service providers.

We hope that the AHMAC (Snowball) Review will assist in bringing a stronger, better-informed and more balanced regulatory focus on the whole of psychology, in all its diversity, and produce more appropriate and equitable regulatory policies and actions that ensure the fair and broad discharge of responsibilities and statutory obligations for the regulation of psychological services, now and into the future, wherever they are provided.

We also hope that more contemporary thinking about the overall shape and key features of the NRAS will be stimulated by our College’s submission, especially to take it into the 21st Century by making it more change-friendly and less locked in to the conceptual and policy status quo, albeit with sensible and effective safeguards against misuse of that flexibility.
END NOTES:

1 Psychologists are “scientist-practitioners”, not “health professionals”:

For Psychology, any definition of “practice” must (we consider) start from the conceptualisation of the psychologist as a scientist-practitioner (not as a “health professional”) and thus of “practice” as the application of theoretically well-grounded knowledge and sound theory, based on good scientific research evidence, across the full spectrum of human behaviour (normal as well as abnormal), and of associated methods and skills (including but not restricted to “clinical interventions”) known to be valid, effective, reliable and fair.

2 Assessment of Vic. Dept of Health Submission to Victorian Legislative Council Committee enquiring into AHPRA: This very long and wide-ranging submission with many appendices had clearly been a long time in preparation, having been submitted very quickly after the announcement of the Victorian Inquiry. It often speaks for AHPRA (revealing a sense of ownership of the NRAS?), usually in a protective way. Nonetheless it does make some concessions that reflect our past and current evaluations, such as Table 5 on pp 38-39 “Advantages and disadvantages of the National Scheme, compared with previous Victorian arrangements”. There the Dept lists as disadvantages (our abbreviations of its phrasing): substantial increases in registration fees; more complex accountability arrangements; increased confusion in lines of responsibility; difficulty in navigating the Scheme; increased complexity in governance arrangements in the relationships between National Boards and AHPRA (portending an argument for greater control by AHPRA over the Boards); reduced scrutiny of regulatory arrangements by Victorian integrity agencies; reduced diversity of regulators that may adversely impact on innovation in regulation; and greater rigidity. These are offset by many perceived advantages. This Submission also alludes to 13 “practice area endorsements” in psychology (wrongly – there are 9), and cites two areas of “adverse workforce impacts” - “medical specialties” and “psychology area of practice endorsements, requirements for psychology supervisors and supervision and reporting requirements for provisional registrants”. Worryingly it commends substantial reduction of the number of our practice area endorsements. It is overall a mixed bag of positives and negatives, but the underlying thrust is to excuse most defects as a function of establishment difficulty and to press for greater not less governmental and public service control over the regulated professions. Tactically it seems designed to portray the Dept of Health as an objective assessor whose conclusions are balanced and in the public interest. It does not adequately acknowledge the Department’s role in designing and implementing parts of the NRAS and in evaluating submissions made to the NRAS authorities at various times. It does not acknowledge its vested interest in maintaining the NRAS and strengthening the role and powers of AHPRA. (See also Appendix M.)

3 The notion of “cognate knowledge”:

Differences in cognate knowledge, although not recognised in the regulatory legislation or by PsyBA (if not also the other registration boards), and not well-researched, are nonetheless (we consider) among the key discriminators of “practice” dimensions and orientations. They are more than just “context knowledge”, being deeper and more conceptual and methodological. Some foundation should be provided in undergraduate and post-graduate courses in applied psychology so that students are to be better able to “hit the ground running” (or at least walking) after graduation. For instance, examples of Socio-
Technical Systems theory-building research in the mining, motor assembly and cotton weaving operations arenas are a good basis for teaching about organisational theory and providing some “cognate knowledge” about related types of production systems (e.g. large-batch, small-batch, one-off, and continuous flow) and their design (including “Fordist” and “post-Fordist” approaches to car assembly) as well as about diverse cultural contexts (Britain, Norway and Sweden, and India) and their industrial relations systems.

END OF SECTION 1
SECTION 2:

PARAMETERS FOR THE NATIONAL REVIEW OF THE NRAS.

Parameters for the National Review:

How might Mr Snowball and the oversight panel commissioned by the Ministerial Council to carry out the National Review of the NRAS judge its implementation? The following parameters appear relevant, and the College has adopted them for its own assessment of the NRAS’s development.

Parameter 1: The IGA’s objectives:

The published objectives were stated by COAG thus (italics added):

“5.3 The objectives of the national scheme, to be set out in the legislation, are to:
(a) provide for the protection of the public by ensuring that only practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered;
(b) facilitate workforce mobility across Australia and reduce red tape for practitioners;
(c) facilitate the provision of high quality education and training and rigorous and responsive assessment of overseas-trained practitioners;
(d) have regard to the public interest in promoting access to health services; and
(e) have regard to the need to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and enable innovation in education and service delivery.

5.4 The scheme will operate under the following principles, to be set out in the legislation:
(a) it should operate in a transparent, accountable, efficient, effective and fair manner;
(b) it should ensure that fees and charges are reasonable; and
(c) it should recognise that restrictions on the practice of a profession should only occur where the benefits of the restriction to the community as a whole outweigh the costs.

5.5 The legislation will provide that all bodies within the scheme will have regard to the objectives of the national scheme.

5.6 The Parties to this Agreement confirm that they do not intend the proposed national registration and accreditation scheme to have any role in regulating employment conditions, rates of pay or other employment matters with regard to the health professions proposed to be regulated.

5.7 The Parties to this Agreement further confirm that they do not intend the proposed national registration and accreditation scheme to have any role in relation to resourcing, management or governance of State and Territory health institutions.”

We note, and agree, that workforce issues should be as much a subject for review in 2014 as the other aspects, despite the very recent closure of Health Workforce Australia (HWA).

Parameter 2: The Guiding Principles in the National Law Act 2009:

The National Law Act 2009 (reflecting the principles stated along with the Scheme’s objectives in the IGA) includes the following:

“The guiding principles under which the National Scheme will operate (as set out in the National Law) are as follows:
(a) the scheme is to operate in a transparent, accountable, efficient, effective and fair way;
(b) fees required to be paid under the scheme are to be reasonable having regard to the efficient and effective operation of the scheme;
(c) restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.”

Note 1:

Parameter 2 may appear only to repeat the IGA’s principles in Parameter 1. However there are significant differences.

First, whereas the IGA is a politically rather than a legally binding document, the Guiding Principles are embedded in the National Law Act, hence have an especially strong status in the evaluation process – as mandatory rather than merely aspirational or desirable. (Nonetheless we note that the relatively detailed specifications as to funding and other
matters in Appendix A of the IGA should have significant status in the review of the NRAS.)

Second, in Guiding Principle (b) regarding fees charged to registrants, the following words have been added to the IGA statement – “having regard to the efficient and effective operation of the scheme”. This is a very important (and welcome) addition, as will become evident.

Third, there is the unexplained deletion in the National Law Act of the words “and charges” from the IGA statement. We think this might reflect some concern over the scope of the term “charges”. Unfortunately it gives rise to some ambiguity of interpretation. One interpretation is that the National Law Act allows only the charging of fees, and not other “charges”. If that is not the case, we have taken the view that any “charges” (such as to the higher education providers for course accreditation purposes) should also be “reasonable” even though that benchmark is only politically and not legislatively stated. We would certainly hope (and expect) that Guiding Principle (b) is not taken to provide a loophole for the imposition of charges (in addition to fees) that are beyond the “reasonable” or need not be tied to the efficiency and effectiveness of the Scheme.

Fourth, we note that clause 5.4(c) in the IGA has been changed in the National Law Act.

The former read:

(c) it should recognise that restrictions on the practice of a profession should only occur where the benefits of the restriction to the community as a whole outweigh the costs.

However the National Law Act reads: (c) restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.”

This rewording may perhaps be seen positively as a focusing on the critical issues of safety and quality assurance. But it might equally be seen as a shift away from the broad “cost-benefit analysis” approach in the IGA to a narrower and potentially weaker test of the acceptability of such restrictions, especially in that no test of the costs of them is required under the National Law Act. Mere assertions of greater safety and quality flowing from restrictions might well be made by a regulatory body without evidence or any consideration or objective test of how onerous they may be to the community as a whole (including the professions). It is difficult to see how proper accountability for restrictions and reduction in “red tape” (another NRAS goal) can be achieved without the discipline of such evidence, consideration and test.

Further, the formulation (c) above could limit practice restrictions to “health services” by the use of the words “a health profession” in place of the IGA’s “a profession”. This would appear to exclude psychological services that are not delivered to a vulnerable individual for her/his personal health benefit. Thus (it could be argued) PsyBA cannot
make policy about psychological services that are not designed “for individual health benefit” in nature, and cannot place practice restrictions on them. Such a limitation would mean, as a very important example, that services delivered by industrial/organisational psychologists that were intended to promote organisational performance and productivity, develop greater group cohesion, and enhance individual workers’ skilled and motivated performance, but do not provide an “individual health benefit”, could not be regulated under the NRAS legislation.

Parameter 3: COAG and individual governments’ specifications for “best practice regulation”:


NRAS-specific specifications are contained in and some may be inferred from the Australian Health Ministers' Advisory Council Governance Committee’s “National Registration and Accreditation Implementation Project - Regulatory Impact Statement for the Decision to Implement the Health Practitioner Regulation National Law 3 September 2009”. (Available as Appendix O, or from the Australian Health Ministers Advisory Council’s Governance Committee.)

We have also used the Australian Government’s two sets of Guidelines – Governance Arrangements for Australian Government Bodies and Australian Government Cost Recovery Guidelines July 2005 (summarised in Appendix L.) It is possible that these do not apply directly to some or all NRAS units, but they do provide guidance, however informal, to such criteria.

In case they do not apply we have also used State guidelines as the NRAS is not (we believe) exempt from jurisdictional standards of public administration unless by nullification of specific jurisdictional acts in that jurisdiction’s version of the National Law Act 2009. In particular we have referred to the Victorian Government’s (Department of Treasury and Finance) publication “Cost Recovery Guidelines March 2010” (Appendix P) especially in our evaluation of AHPRA’s and PsyBA’s fee-setting processes and other aspects of their financial performance. We expect that other jurisdictions have similar guidelines.

Parameter 4: The moral values basis for the NRAS:

As outlined in Section 1, regulation of professional service delivery in the public interest is first and foremost a moral endeavour in that its primary goals reflect moral values concerning the provision of professional services to members of the public or other clients (primarily safety and quality of service, respect for clients and their “human rights”, and ethical standards of behaviour more generally). Without a shared moral
values base, the many units in the NRAS will have little hope of developing a shared identity, common purpose and mutually supportive policies and practices.

It would be a mistake to regard the development of the NRAS as primarily a legislative (or politico-legislative) task or an administrative arrangement, missing its essentially “moral values” character. Certainly there are important political, legal/legislative and administrative elements. Regulation may be imposed by law, and the law helps facilitate compliance (including but beyond providing a deterrent to and punishment of discovered non-compliance)\(^41\). But the law or politico-legislative activities cannot generate (even though they might arguably reinforce) the crucial commitment and meaningful cooperation that a shared identity and moral purpose, between the regulators and the regulated (and other stakeholders), can help ensure. In regard to the law, there is of course often a significant moral dimension to the evaluations made and the judgments reached by the courts and lesser tribunals about complaints against practitioners.

Administratively regulation would hopefully be well-structured and well-administered, but administrative arrangements service, and do not drive, good regulation. An administratively suboptimal but morally sound regulatory system is likely to function better than and outperform an administratively and legislatively sound but morally flawed system in terms of actual protection of the public.\(^42\)

Of course the ideal is a morally sound, legally well-framed and well-administered regulatory system whose component parts are internally consistent. Is the NRAS capable of being so described? This is a central question in our evaluation of it.

In saying that, we emphasise that psychologists are not in the business of forcing people into conformity with conventional social mores, or institutional or organisational mores. The moral values base of the profession should not be mistaken for societal, institutional or organisational control mechanisms; and the effectiveness and morality of the work of psychologists should not be misconstrued in this way.

**COMPOSITE BENCHMARKS FOR OUR REVIEW**

The anchoring points or benchmarks for our evaluation of the NRAS are the parameters outlined above, and in addition profession-related criteria of:

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\(^{41}\) For example the essentially “moral” nature of the role and functions of a tribunal such as VCAT in the NRAS is clearly articulated in a wide-ranging and powerful speech by Justice Kevin Bell, the (then) newly-appointed President. He pointed out very strongly the moral basis of such a tribunal, emphasising its foundation on and respect for human rights as well as its growing use of alternative dispute resolution, its awareness of the dangers of “creeping legalism”, the importance of speedy handling and otherwise good management of cases (“justice delayed is justice denied”) and other significant statements. See "The role of VCAT in a changing world: the President’s review of VCAT". Speech delivered to the Law Institute of Victoria 4 September 2008.

\(^{42}\) An example of the latter would be where morally unacceptable but not illegal regulatory decisions were made for administrative convenience, to achieve cost savings for government, or for other allegedly pragmatic purposes but which were in essence unethical or would have a negative social impact including failure to protect the public. An instance would be accepting as a “pragmatic imperative” an organisation’s failure to pay interns for the work they do, or its exposing them to client needs and problems of greater complexity than they were ready to handle, with attendant liability exposure, or failing to provide them with proper professional supervision.
• the impact of the NRAS on the whole of the psychology profession and its underlying scientific discipline;
• its impact on students, their welfare and opportunities, and
• its impact on the character of the psychology workforce, now and into the foreseeable future.

We have also used the Productivity Commission’s research into the quality of Regulatory Impact Statements (RIAs) to assess the adequacy of regulatory impact assessment as a very important process in the establishment and implementation of the NRAS.\footnote{See for example the Commission’s \textit{Regulatory Impact Analysis: Benchmarking August 2012}}

In addition we have sought, where appropriate and possible, to provide information and data about the profession such as its current size and rate of growth (relevant for example to current and future administrative demands to be placed on regulatory bodies regarding registration of qualified practitioners).

A key reference here is the NBEET/Australian Research Council 1996 publication \textit{“Psychological Science in Australia”}, prepared by an eminent Working Group for the National Committee for Psychology of the Australian Academy of Science. This book provides not only some baseline data but also expert insights and views about the very diverse profession of psychology that are highly relevant to regulation, especially for assessing how well the then-recommended lines of development of the profession and its underlying science have been achieved over the last one and a half decades at least.

In particular \textit{“Psychological Science in Australia”} presents the key areas of professional practice for which trainees should be prepared in the first four years of psychological education and training and subsequently, emphasising the very diverse nature of the science and the profession, and strongly advocating flexibility for the higher education institutions in their design and delivery of appropriately different psychology programs for the different fields of psychology.

\textit{“Organisational Psychology” and “Human Factors” were two of the designated key areas, the other two areas being “Clinical Psychology” and “Neuroscience and Physiological Psychology”}. This provides \textit{inter alia} a baseline for evaluation of the academic backgrounds that ought to be considered acceptable particularly for the “four + 2” pathway to registration or for the registration of overseas applicants for registration.
ABBREVIATIONS USED IN THIS SUBMISSION:

AHPRA  The Australian Health Registration Authority
APS    The Australian Psychological Society
APAC   The Australian Psychology Accreditation Council
COP    College of Organisational Psychologists (a part of the APS)
COAG   Council of Australian Governments
HWA    Health Workforce Australia
IGA    Intergovernmental Agreement
NRAS   National Registration and Accreditation scheme
PsyBA  The Psychology Board of Australia

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APPENDICES ARE CONTAINED IN A SEPARATE ELECTRONIC FILE AVAILABLE ON REQUEST TO aecrook@bigpond.com.
SECTION 3:

Our Responses to the Reviewer’s Questions

Our responses to these questions are in summarised form (e.g. “Yes” or “No” with perhaps a short comment). Usually the issues are complex and require a more nuanced reply. We have provided this by alluding to relevant Recommendations made in our Submission, and the relevant pages of our Supporting Commentary therein. Some of our Recommendations are not covered by our Supporting Commentary, and our reasons for them are stated as part of the responses below.

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

Yes, it should be reconstituted. Some of its role has been carried out instead by AHWMAC and the latter’s Governance Committee, e.g. views about the use of specialist titles c.f. practice area endorsements. It could also play a part in the Snowball Review. See our Recommendations 1 and 5 and Supporting Commentary pp. 27-28 and 40-42.

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

Given little if any information about such cross-professional issues, we are unable to answer this question. In general one would think that in the first instance some face-to-face dialogue between the professions involved would occur, rather than immediately refer such a matter to the independent Advisory Council. Only if such an informal dispute-resolution approach broke down could referral to the Advisory Council perhaps be appropriate.

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

Not for psychology (which is not one of the 9 low workload professions, although industrial and organisational psychology certainly would be in terms of absence of complaints). Psychology’s multifaceted identity and diversity are likely to be even more unrecognised if lumped together with other professions. There are dangers in using an apparently “common template” to cover the 9 professions (whose only commonality may well be number of practitioners). This template would be likely to involve inaccurate assumptions (some perhaps unrecognised) about the commonalities thought to exist across the professions covered (other than size). This has been a central problem with the regulation of psychology, in that all branches of psychology were deemed to be a “health profession” (for administrative convenience in 1995 in Victoria’s reform of its regulatory legislation and in 2009 in the National Law Act) when they were plainly not. See our Recommendations 9 to 12(b) and Supporting Commentary pp 42-52.
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.

This is possible in regard to purely administrative functions, but not in regard to the three types of panels required to investigate notifications against registrants. Profession-specific expertise is essential.

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

Yes. See our Rec. 4 and Supporting Commentary pp 32-39.

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?

Yes but with the following provisos:

(i) sufficient professional expertise is recruited to the risk/cost benefit assessment task;

(ii) it should also be open to a small profession (in a field not already covered by one or more of the currently-regulated professions) to volunteer to be included, in which case acceptance could be valid even if the risk to the public was small. There is more to such a decision than just the risk-management economics of the situation.

(iii) if a field is judged to be not worth regulation (e.g. by refusal of a request for regulation), the attraction of incompetent providers or charlatans to that field may be increased. The small risk to the public today may be increased to a worrying level by the rejection decision.

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

Yes, providing that (where membership of a profession body is another “regulatory means”) those professions are given the legal clout to discipline aberrant members. This could include (a) the making of notifications to AHPRA and Health Care Complaints Commissioners without the danger to the notifier of legal action by the accused and (b) the legal capacity to eject safely aberrant members. This change could provide a mechanism for the registration of psychologists who do not deliver health services (e.g. membership of the College of Organisational Psychologists). However there is the perennial problem that the NRAS legislation covers only “health services” and thus as currently framed could not legitimately cover or make law or administrative provisions about professions that do not provide health services. Our recommended expansion of coverage to include “cognate professions” and to list the cognate professions in an appendix to the National Law Act should allow effective action on this front. See our Rec. 9 and Supporting Commentary pp 47-52.
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?

Yes, providing that it has the requisite expertise within its membership or available to it through robust consultative and collaborative mechanisms including quality Regulatory Impact Assessment.

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

It needs simplification, streamlining such that a “one-stop shop” is available to complainants, prompt processing, and greater transparency in most (not all) circumstances. Some of the principles and concepts of rehabilitation legislation (such as and particularly the “spent convictions” acts lost with the introduction of the National Law Act) should be applied. A better evidence base for understanding how errors occur in service delivery, and in how well different types of rehabilitation may work, is needed. See our Rec. 7, and Supporting Commentary pp 43-45.

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

Partial adoption is possible now. The Queensland Health Ombudsman Act has only recently been passed, and we consider it may be premature to flow it on to other jurisdictions in full without the requisite RIA and other steps set out in the IGA. However some aspects such as its mandatory reporting changes and its efforts to handle the problematic issue of unregistered service providers could be adopted across jurisdictions, in concert with the main elements of the WA approach. This (design of a revised mandatory reporting system) is not just a legislative matter and should be the subject of further consultation and advice.

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

Yes. However this need not mean that every jurisdiction has to replicate the full apparatus for complaints/notifications. A skeleton administrative arrangement could be appropriate, with expertise located mainly in a central unit, but some degree of decentralisation of expertise may be needed if only because of jurisdictional variations in the avenues for proceeding with notifications of a serious nature (mainly civil and administrative tribunals). We suggest that a decision as to the appropriate staffing structure and allocated functions and accountabilities should be the subject of further study, investment in which may well save much expense and wasted effort down the track.

12. Should performance measures and prescribed timeframes for dealing with complaints and notifications be adopted nationally?
Yes, up to a point. Prompt processing of notifications is essential if injustices to both notifier and practitioner are to be avoided. “Justice delayed is justice denied”. They should be underpinned by evidence-based strategies at AHPRA and registration board level to identify problem areas and take effective action to eventually reduce the incidence of reportable behaviors. This has been done successfully in regard to the Family Court, a major source of complaints for some types of psychologists. Such efforts should be rewarded by way of reduced fees for registrants. See our Rec. 4 and Supporting Commentary pp.32-39.

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?

No (there is insufficient transparency) but improvement is a fraught process. In the industrial/organisational psychology arena, virtual absence of notifications about our members means that no data are available on which to base our views. Such absence probably reflects the different power dynamics of our client-practitioner relationships as well as client perceptions of irrelevance of a health-focused complaints system. Clients unhappy with our services simply refrain from further use of them.

However we are able to make some general observations. First, service providers involve more than the individual practitioner, and employers may force the employed or contracted practitioner to adopt practices that are sub-optimal or worrying professionally (including ethically). Notification assessment processes should incorporate examination of the role of the employer or principal contractor where such exist.

Rehabilitation of a guilty practitioner (or delinquent employer or principal contractor) should be the goal rather than immediate punishment including “naming and shaming”. Presumption of innocence is key, which requires (for satisfactory treatment of the complainant) speed coupled with expertise in assessing complaints/notifications. Privacy legislation should be respected for the practitioner (and employer/contractor) as well as the client. The timing and extent of release of details of complaints/notifications is crucial. Initial processing should be done by expert assessors, not treated as an easy “triage” function which anybody can do. Public release of information should generally be educative in purpose rather than punitive, and the practitioner’s details may not need to be revealed (depending on the assessed risk to the public in the individual case).

The first step should usually be an offer of informal conciliation (overseen by trained conciliators who may include lawyers but also psychologists and some other professionals), at which stage complete confidentiality is appropriate. It is important that informal conciliation does not become quasi-legal deal-making. However the notifier’s family may well have a significant interest in and play a valuable support role regarding the making and pursuit of the notification/complaint (especially where client mental illness and dependency on a family support system are involved), and could be included in the informal dispute resolution process, with appropriate guarantees (by all parties) of protection of confidentiality at least until this stage is concluded. The other complexities
indicated above need to be carefully thought through and trialled before full implementation.

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?

Yes, with the caveat above about inclusion of some family members or other persons where appropriate and resolution in individual cases of the question of who is or are the responsible service provider(s).

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

We repeat our concern about the negation of “spent convictions” legislation generally and by extension for health practitioners (whose rehabilitation should be a major objective), and note that its principles and parameters could still be used as guidelines even if that legislation continues to be negated. There is still a need to address the question of who is the service provider responsible for the breach of standards, and the legal capacity (currently we believe not available) to make an adverse finding against an employer or principal contractor, such finding to be recorded and made known to the public in the same way as for individual practitioners. Otherwise we leave it to our parent body (the APS) to answer on behalf of all psychologists.

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

No – they require change. In our area of practice, the capacity to incorporate testimonials into tenders is very important. Our competitors (non-psychologists) are able to do so. See our Rec. 12, and Supporting Commentary pp 42-52.

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

Psychology has only “protection of title”, not of scopes of practice. The concept of “practice area endorsements” with de facto specialist titles has been applied, not to our general satisfaction. We shall leave it to our parent body (the APS) to respond in more detail.

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?

A National Code of Conduct may well prove an inadequate tool for conformance to professionally sound standards, particularly if it lacks legal “teeth”. Also please see our response to your Q.7.
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?

Yes. See our Rec. 7, and Supporting Commentary pp 43-45.

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?

They are failing. See our Introduction, and in Section 1 our Recs. 1 and 4, and Supporting Commentary pp 27-28 and 32-39.

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

Probably not, at least not on its own, given its role and personnel limitations. The issue of workforce planning to cover gaps in requisite services is very complex and multi-sectoral, requiring considerable specialised expertise. Also there is an inherent tension between state-driven expectations about workforce development on the one hand, and emergent developments in the focus and directions taken by scientific disciplines (mainly located in the universities) which may or may not underpin professional practice. Federal Government funding is a major threat to quality of higher education including and especially professional training. Dialogue rather than “command and control” impositions is the better way to go. Also students need to be more carefully considered in such dialogue, including by the higher education providers. Funding pressures and associated “publish or perish” pressures in the universities, with some deregulation, have distorted their internal “market forces” towards pursuit of research grants and away from professional training such that unforeseen and very undesirable workforce outcomes are now occurring. See our Introduction and in Section 1 our Recs. 7 and 19, and Supporting Commentary 43-45 and 54-58.

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?

There has been considerable effort to establish meaningful competency statements. However there is still in psychology a too-narrow focus by PsyBA on mental ill-health and associated current clinical services, provided in clinics and hospitals in the health sector (despite which serious gaps exist especially in psychological treatment rather than initial assessment services, and there is still a worrying lack of jurisdictional cooperation). Services in other sectors appear to be largely ignored, or wrongly seen as merely an extension of what is done in the health sector. Accreditation of courses (at least in the psychology profession) gives insufficient attention to multidisciplinary
collaboration as do PsyBA policies more broadly (e.g. re CPD). See our Introduction and in Section 1 see Rec. 30, and Supporting Commentary pp 54-58.

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

Greater dialogue among not only regulators and educational institutions is needed. Other employers should also have a say about future workforce needs such as Commonwealth and jurisdictional departments outside the health sector and also and especially the private sector. However a “command and control” approach would in our view be dysfunctional. Educational institutions are not servants of the state, and even where they may wish to produce more graduates for certain workforce areas, there may be considerable difficulties including time lags in building up the requisite staffing numbers and academic supports to provide essential “critical mass”. Dialogue, cooperation and mutual understanding should not be replaced by coercion. Adequate funding is crucial.

We note with concern that the minimum qualification pathway into the psychology profession – the “4+1” route – is now very difficult for trainees to find or complete, due to PsyBA excessive requirements and expectations on trainees, agencies and supervisors. Internships are being treated inappropriately as quasi-post-graduate training. On-site supervisors are being expected to teach and train interns to pass the clinically-oriented National Psychology Examination, as if they were primarily clinically- and academically-expert agents of PsyBA and not (as they in fact are for the non-health areas of psychology) private sector psychologists or public sector departmental psychologists providing ‘niche’ sub-sets of professional services (whether on a fee-for-service basis or not) to a segment of the community beyond the health industry. They typically do not have the time, motivation or necessarily the very broad academic and professional skill set to do that teaching/training. See also our Rec. 6 and 14, and Supporting Commentary pp 40-42 and 52-54.

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

We would not automatically reject such a notion providing that certain safeguards were in place (e.g. that genuinely independent members of the National Board, all appointed on merit, elect the Chair rather than the latter being imposed administratively, and that such an appointment was not intended to constitute a means of diminishing the roles, inputs and influence of the professional members of the Board).

25. 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?

In Rec. 8, we indicate a wish to retain APAC as the accrediting authority, and to extend its contract from 4 to at least 5 years or longer to better fit the higher education sector’s needs for predictably of accreditation requirements especially in regard to academic
staffing mix. Nonetheless we are concerned about the too-“clinical” composition of both PsyBA and APAC and also the “clinical” impositions made by the Psychology Board, and those now also being made by APAC, about course content and the nature and goals of post-graduate course placements. Both APAC and PsyBA need their membership broadened to accommodate more satisfactorily the diversity of the discipline and the profession.

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

The National Law Act makes adequate provisions for political and administrative oversight of accreditation broadly, but (appropriately) not of individual decisions. There are no real mechanisms for appeal or expressions of concern about trends in accreditation by either registrants or interested stakeholders such as the higher education providers, employers, students and professional associations.

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

Judging by the number and scope of the proposed amendments, we consider that our own proposals for legislative change are very modest and uncomplicated. See our Rec. 9, and Supporting Commentary pp 42-52.

Our comments on the Reviewer’s specific proposed amendments are set out below.

Amendment Set 1:

Commonwealth Reforms to Freedom of Information Legislation
The National Law and the Western Australian Law apply the following Commonwealth Acts for the purpose of the National Scheme:
• the Privacy Act 1988 (applied by section 213)
• the Freedom of Information Act 1982 (applied by section 215), and
• the Ombudsman Act 1976 (applied by section 235).
Subsequent to the commencement of National Scheme, the Commonwealth enacted legislation to reform the Commonwealth freedom of information arrangements. The legislative amendments commenced on 1 November 2010. The legislation includes the enactment of the Australian Information Commissioner Act 2010 which, among other things, establishes the positions of Information Commissioner and Freedom of Information Commissioner.
The National Law is to be amended to adopt the reformed Commonwealth legislation under the National Scheme. This would require an amendment to the existing provisions in relation to the Privacy Act by removing reference to the Office of the Privacy Commissioner and the Privacy Commissioner, which are no longer established under that Act. An equivalent provision to those currently in place in relation to the Privacy Act, FOI Act and Ombudsman Act will need to be included in the National Law for the Australian Information Commissioner Act. Similar amendments to the above would also be required in the Western Australian Law.

Comments:
These changes seem required and logical.
Amendment Set 2:

Tabling of Regulations
The National Law (section 245) provides that the Ministerial Council is to make regulations under the National Law. The National Law provides that the regulations are to be published by the Victorian Government Printer. However, this provision does not apply under the Western Australian Law. Instead, the publication provisions under Western Australia’s Interpretation Act 1984 apply.

The National Law (sections 246 and 247) provides that a regulation made under the National Law may be disallowed by a House of Parliament in a participating jurisdiction in the same way that other regulations in that jurisdiction may be disallowed. The provisions also state that the disallowance applies as if the regulation had been tabled in the relevant Parliament on the first sitting day after the regulation is published by the Victorian Government Printer. This provision is relevant in terms of establishing the number of days within which a regulation may be disallowed. However, a regulation that is disallowed in a Parliament is of no effect unless it is disallowed in a majority of the participating jurisdictions.

In Western Australia, the National Law was modified so that sections 246 and 247 do not apply. Instead the provisions under the Interpretation Act 1984 in relation to tabling and disallowance apply. Importantly, the Western Australian Law does not provide for the majority disallowance of regulations.

The following amendments to the National Law are to be made:
• the provision dealing with the publication of regulations by the Victorian Government Printer (section 245 (3)) be repealed
• section 246(1) of the National Law be replaced with a provision which states that:
  — a regulation must be published or notified in the same way that other regulations in the relevant jurisdiction are published or notified, and
  — a regulation must be tabled in a House of Parliament in the same way that other regulations in the relevant jurisdiction are tabled, and
  — a regulation may be disallowed in the same way that other regulations in the relevant jurisdiction may be disallowed.

The provisions dealing with majority disallowance (section 246(2) and (3)) are to be retained. However, the Western Australian Law will not be amended to provide for majority disallowances.

As regulations are made by the Standing Council on Health, rather than the Governor in-Council (in the respective State), Parliamentary Counsel’s advice is sought on whether modifications to the application of any State law is required.

Independent Review of the National Registration and Accreditation Scheme for health professions

Comments:

These changes seem acceptable although we wonder why the Western Australian Law is not to be amended in regard to majority disallowance, or alternatively why the National Law Act is not to be amended in the other jurisdictions to mirror the WA Law if it is considered superior in important respects.

Amendments Set 3.

Statutory protection for health practitioners reporting serious offences to police
Queensland’s now repealed Medical Practitioners Registration Act 2001 (s.176) dealt with circumstances where a medical practitioner obtains information that the practitioner honestly and reasonably believes indicates an indictable offence has taken place.

Under the Act, a medical practitioner who provided such information to a police officer was not liable, civilly, criminally or under an administrative process, for giving the information about the indictable offence or the circumstances of the indictable offence.
This provision was applied, for example, when persons presented to emergency departments with gunshot or stabbing wounds, or apparent victims of domestic violence. This provision was not replaced in Queensland legislation and practitioners are of the view that an important statutory protection is no longer available. The National Law and the Western Australian Law are to be amended to include an equivalent provision, but the provision is to apply to all registered health practitioners. In addition, feedback on this proposal indicated that the reference to ‘indictable offence’ may not capture all violent crimes. As such, it is proposed that the legislation refer to a ‘serious offence’ and that advice from Parliamentary Counsel be sought on the best way to define this in the legislation.

Comments:
Acceptable although we wonder about the data supporting the assertion that “practitioners are of the view that an important statutory provision is no longer available”. Our College has certainly not been consulted.

4. COAG Standing Council on Health
COAG has agreed on a new Ministerial Council system. In relation to the health portfolio, COAG has established a Standing Council on Health which will assume the role of the Australian Health Ministers’ Conference and the Australian Health Workforce Ministerial Council.
Under the Health Practitioner Regulation National Law, the ‘Ministerial Council’ means the Australian Health Workforce Ministerial Council comprising Ministers of the governments of the participating jurisdictions and the Commonwealth with portfolio responsibility for health. All States and Territories are ‘participating jurisdictions’ for the purposes of the National Law.
Legislative amendments are to be made to the National Law and the Western Australian Law to recognise the COAG Standing Council on Health to be the Ministerial Council for the purposes of the legislation. An issue with these amendments is that the New Zealand Health Minister is proposed to be a member of the COAG Standing Council on Health, but does not have a role in administering the National Law, as New Zealand is not part of National Scheme. The proposed approach is to state in the National Law that decisions relating to National Scheme under the National Law can only be made by the members of the Council from participating jurisdictions and the Commonwealth.

Comment:
The reasons for the change to a Standing Council are obscure. The Ministerial Council was (we understand) created explicitly for the NRAS. How has this arrangement been problematic? How would a Standing Council with the same membership improve matters?

5. Other Amendments
Section 149 (Preliminary assessment)
Section 149 of the National Law deals with the preliminary assessment by the National Boards of notifications made to the boards. Section 149(1)(c) is to be amended to clarify that a National Board must, in all instances, decide whether or not a notification received by a board could be made to a health complaints entity.
The section is also to be clarified to state that, as a result of the assessment, the National Board must decide whether to:
• take no further action in relation to the matter
• refer the matter to another entity
• deal with the matter under section 150 (which requires a National Board to consult
with a health complaints entity on matters that could be addressed by either the board or a health complaints entity), or
• deal with the matter under another division of the Act, for example, by undertaking an investigation.

Comment:

We continue to consider that, under the National Law (its objectives in particular), notifications and disciplinary action must legally be restricted to “health professionals” and “health services”. The latter are not adequately defined in the National Law. Conventionally (in the Health Care Complaints Commissioners’ empowering legislation) they are defined as “services provided to the individual for her/his personal health benefit”. In our view defining them circularly as “the services provided by health professionals”, while defining “health professionals” as “those who provide health services” is unhelpful and does not satisfactorily address concerns about the scope of the National Law. Put simply, are non-health psychological services covered by the National Law Act?

Section 151 (When a National Board may decide to take no further action)
This section is to be amended to clarify that this section only applies to decisions made under Division 5 (Preliminary assessment).
Section 151 is also to be amended by explicitly stating that a board may decide to take no further action on the preliminary assessment of a notification if the notification:
• relates to a person who is not a health practitioner or registered student
• relates to a matter that is not a ground for notification under the Act, or
• the matter has been referred to another entity.

Comment:

The concerns raised about the previous proposal apply even more strongly here.

Section 167 (Decision by National Board), 177 (Decision by National Board) and section 180 (Notice to be given to health practitioner or student and notifier)
It is important that notifiers and health practitioners are advised, where appropriate, at key milestones during the consideration of health, performance and conduct issues. To achieve this, the following amendments are to be made:
Section 167 (Decision by National Board):
• if an investigation resulted from a notification, the board must give a written notice to the notifier of the board’s decision under this section; where no further action is proposed, the board is to provide reasons for taking no further action on the matter
• if the board has previously advised the practitioner or student of the investigation under section 161 (Registered health practitioner or student to be given notice of investigation), the board must give a written notice to the practitioner or student of the board’s decision under this section.
Section 177 (Decision by National Board):
• if a health assessment or performance assessment resulted from a notification, the board must give a written notice to the notifier of the board’s decision under this section; where no further action is proposed, the board is to provide reasons for taking no further action on the matter
• the board must give a written notice to the practitioner or student of the board’s decision under this section.
Section 180 (Notice to be given to health practitioner or student and notifier) is to apply to all decisions made under Division 10 (Action by National Board), which
requires a notice to be given to the practitioner or student or, if the decision resulted from a notification, the notifier.

Time-frames for taking proceedings for offences
The National Law does not provide for standardised time-frames within which alleged offences under the Act may be proceeded summarily to a court. This creates operational complexities for AHPRA in administering the legislation. A concern raised by AHPRA is that alleged offences may only come to light at the time of renewal of registration, by which time up to 12 months may have elapsed since the alleged offence occurred. For this reason, it is proposed that the time-frame set under the National Law be 24 months.

Comment:

We are not convinced by AHPRA’s reason for the amendment. Why would alleged offences only come to AHPRA’s attention at time of renewal? This timing is suggestive of inadequate communication of notifications and outcomes therefrom within the disciplinary system. Provision for even greater tardiness of processing of notifications seems inappropriate. ‘More and better particulars’ are required here.

Table 17: Proposed further legislative amendments made by AHPRA and the National Boards

<table>
<thead>
<tr>
<th>Issue</th>
<th>Legislative amendment proposal</th>
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<tbody>
<tr>
<td>Commencement of registration</td>
<td>At this time, registration commences on the date of the decision by the Board or the delegate (e.g. s 56(2)(a) however, the point is relevant for all registration types). There are a number of instances when it would be of value for the Board to commence registration on a date to be determined. Such an amendment would be of particular value in the event that further professions were registrable under the National Law.</td>
</tr>
<tr>
<td>Multiple registration subtypes including limited registration</td>
<td>At this stage, it is not possible to obtain limited registration in a different sub-type within the same profession (s. 65 (1). This has a negative effect on individuals who are registered, for example, as a dental hygienist but who then want to undertake limited registration, for example, for the purpose of undertaking examinations to progress to become eligible for registration as a dentist.</td>
</tr>
<tr>
<td>Contravention of undertakings</td>
<td>s.112(2)(b) makes the failure to comply with conditions on registration a basis on which the Board may refuse to renew an applicant’s registration. We consider that undertakings should have similar weight and suggest Section 112(2)(b) – and ‘or undertaking’ to … ‘any condition or undertaking</td>
</tr>
</tbody>
</table>

Comment:

Acceptable provided that there is corresponding introduction of partial (time-proportionate) registration fees.

Insufficient detail makes it impossible for us to assess with respect to the psychology profession.

Contravention of undertakings
s.112(2)(b) makes the failure to comply with conditions on registration a basis on which the Board may refuse to renew an applicant’s registration. We consider that undertakings should have similar weight and suggest Section 112(2)(b) – and ‘or undertaking’ to … ‘any condition or undertaking
to which …’

Comment:

Supported. Contravention of an undertaking is a serious matter and except in rare circumstances should lead to appropriate Board action.

Actions following suspension

There is no avenue for ending a suspension imposed under section 156 (immediate action). This is problematic as a National Board may want to end a suspension or revoke an undertaking not to practice; and impose conditions. In addition, if a health panel suspends a practitioner under section 191 (3)(b), there is no requirement under the National Law for the panel to set a review period. We think that this would be of benefit.

When a renewal date arrives during a period of suspension of the practitioner, the National Law does not currently import a clear process for management of practitioner’s registration and the subsequent application for registration/reinstatement after the conclusion of a period of suspension.

Under the National Law practitioners who are suspended over a renewal period are not eligible for renewal – section 207 provides that during a period of suspension a practitioner is taken not to be registered and section 107 provides that renewal is only available to registered practitioners. As a consequence, the practitioner will cease to appear on the register and needs to make a new application for registration.

Comment:

Supported.

Information on the Register

Section 226 of the National Law sets out when the National Board may decide to exclude certain information from publication on the National Register. The section contemplates that conditions or undertakings entered into by impaired practitioners may be excluded for privacy reasons (s226(1)). The section also contemplates practitioners requesting information not be published where the inclusion of the information in the register would present a serious risk to the practitioner’s health or safety s226(2)). The section does not provide for the National Board to consider the exclusion of information where a third party may be adversely affected nor does it allow for the National Board to consider such applications other than on the application of the practitioner. This concern could be addressed by the inclusion of ‘or any other affected person’ after ‘the practitioner’ in both s226(2)(a) and (b).

Comment:

Supported.

Conditions on registration

Under Part 7 of the National Law, the Board is able to impose conditions when registration is first granted, when someone is reapplying for registration and when it is renewed. Consideration could be given to giving a Board the power to accept an undertaking from a registrant to achieve the same purpose, rather than achieving this only by imposing conditions. This would align with the provisions of Part 8 that provide for either conditions or undertakings on registration.
Comment:

Supported.

Where conditions are amended under sections 125 and 126, there is no requirement for a review period to be set and we think that this would be of benefit to practitioners.

Comment:

Supported.

Co-regulatory issues – under sections 125(2)(b), 126(3)(b) and 127(3)(b), there is no equivalent section in the National Law (NSW) to allow a co-regulatory jurisdiction to change a condition imposed by an adjudication body in a National Board jurisdiction (Part 8) if the adjudication body decided, when imposing the condition, that the subdivision applied. An equivalent section be added to the legislation in all co-regulatory jurisdictions (including NSW and QLD).

Comment:

Supported.

Abrogation of right against self-incrimination

The Health Practitioner Regulation National Law (ACT) has a variant to Clause 2 of Schedule 5 that abrogates the right against self-incrimination. It provides that any information, answer or document required to be given, answered or provided is not admissible in evidence against the individual in a criminal proceeding. The same provision applies in NSW under section

The Medical Defence Organisations have advised that they consider such an approach as desirable, as their members wish to cooperate with the Boards without fear that any information provided could be used against them in criminal proceedings.

From a practical perspective, an amendment with application across the scheme would notifications timeframes where there are extant criminal processes. Further, it may enable practitioners to better defend immediate action proposals as they will be able to freely give their version of events.

Comment:

Supported.

Notice requirement at section 180

Section 179 of the National law sets out the requirements for a show cause process to be applied, if a Board proposes to rely on its powers to caution, accept an undertaking or impose conditions under section 178 of the National Law. Section 179(3) provides that a show cause process is not required when a Board has investigated the practitioner under Division 8 of Part 8, or conducted a health or performance assessment under Division 9 of Part 8.

Section 180(1) provides that a National Board must give written notice of a
decision made under section 179(2). If the Board is not required, because of
section 179(3), to use a show cause process, then the effect of section 180(1) is
that a notice of the decision to take action is not required.
Section 180(1) could be amended to read, ‘As soon as practicable after making
a decision under this Division, the National Board must give written notice of
the decision to …’

Comment:

Supported.

Appellable decisions
Division 13 of Part 8 of the National Law (sections 199 to 203) sets out
provisions dealing with appeals against certain decisions made under
the National Law. Appeals made under the National Law are made to the
responsible tribunal in each of the participating jurisdictions.
There are no consistent provisions about the length of time that a person
affected by a Board decision has to make an appeal to each responsible
Tribunal. While some jurisdictions have time limits in place because of
their respective tribunal legislation, it is submitted that single, nationally
consistent time limit ought to be included in the legislation.
A new subsection (3) could to be inserted at section 199, so that an appeal
made under this section is to be made within 28 days from the date that the
person making the appeal receives notice of the reasons for the Board’s or
Panel’s decision, unless the appropriate responsible tribunal otherwise orders.

Comment:

Supported.

Obtaining information from other government agencies
Consideration should be given to the addition of a section in Part 8
that mirrors Part 4 section 27, to remove any doubt about the ability of
investigators to obtain information from other government agencies.

Comment:

Further information and examination of implications is needed for our support.

Notice of a decision to take action
s.206 requires that notice of a decision to take action against a registered health practitioner is
communicated to the practitioner’s employer. This definition might be expanded to require notice to all
places of practice – making it clear that s.206 applies equally to contractual arrangements.

Comment:

Supported.