The Australian Psychological Society Ltd

Supplementary Submission

THE SENATE COMMUNITY AFFAIRS COMMITTEE

Inquiry into the national regulatory scheme for the "health professions"

27 July 2009

From the Australian Psychological Society's College of Organisational Psychologists

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SUMMARY

The College of Organisational Psychologists (COP) considers that Bill B requires substantial redrafting, and other jurisdictional legislation must be amended if the proposed national regulatory scheme is to work. COP also has a number of concerns, some about the impact of Bill B's provisions on the profession of Psychology generally, and some about provisions that are predicted to harm our specialty in particular. A number of solutions are recommended.

PREAMBLE

COP greatly appreciated the opportunity to present to the Committee its views about the proposed national regulatory scheme as part of the Australian Psychological Society's delegation[1]. We were heartened by the Committee's close reading of our first submission. We also appreciated the Committee's indication that further written comments from us would be welcome.

In this Supplementary Submission we focus on the possible solutions that are of serious concern and difficulties that we envisage with the proposed national scheme. These problems may be summarised as: (a) inadequate regulatory coverage - failing to regulate for the whole of the community (particularly all clients of psychologists), all psychologists, and the whole of the profession and its associated underlying scientific discipline; (b) inadequate consideration of the agencies and authorities involved in such regulation, and their interrelationships, especially in terms of the making of complaints against practitioners, and the hearing of them (including appeals routes and processes); and (c) specific provisions in Bill B and decisions made elsewhere (especially Commonwealth funding of the universities) of serious concern to us. We have also applied this classification to our outline below of our suggested solutions.

Our proposed solutions are intended to achieve the desired outcomes that we listed in our first submission to the Senate Committee of Inquiry, stated thus:

"What Outcomes Do We Seek?

We seek:

- *The adoption of a "whole of profession"/"whole of government"/"whole of community" approach to workforce planning and the other regulatory aspects.*
- *A streamlined and uniform complaints process for all clients of psychologists, whether their services are classifiable as "health care" or not. This process must be legally unambiguous, not subject to definitional uncertainties about what constitutes "health care", who is a "health professional", and what constitutes a "health service" complaint. It must allow for cross-jurisdictional operations by Organisational Psychologists and their clients (and other psychologists) so that it does not matter where the service was delivered, or the usual location of the practitioner or the client.*

[1] Canberra, 13.7.09.

- *Genuine practitioner mobility nationally, in the short term (and in the medium term, removal of barriers to international mobility with countries with whom Australia has a Free Trade Agreement.*
- *A genuine effort to downsize the permanent bureaucracy being developed to undertake registration, course accreditation, and workforce planning; and to broaden the scope of workforce planning to encompass the "beyond health care" areas of Psychology.*
- *Efficiencies (as well as greater effectiveness) from "economies of scale" and reorganisation of the remaining jurisdictional structures, such that the fees charged to registrants are no greater than at present, and hopefully less.*
- *Removal of the power of Ministers of Health or public servants to influence the setting of professional standards, through course accreditation, Continuing Professional Development, or other such mechanisms. Such legislative mechanisms as disallowance motions should be considered in place of these Ministerial powers, or (more simply) removal of such powers, leaving the profession-specific national registration boards to set professional standards, in conjunction with the professional associations.*
- *Restoration of parity of funding of post-graduate programs in Psychology.*

<u>Our solutions are modest in scale, low in costs and, where appropriate, readily incorporated into legislation or subsidiary policies. They are:</u>

- *Clearly and unambiguously give the Psychology Board of Australia the legislative power to investigate complaints about any and all kinds of psychological services (not just those classifiable as "health care"); and provide an appeal avenue to a single (cross-jurisdictional) external tribunal competent to review such decisions on both merit and procedural grounds. (This could perhaps be modelled on the Victorian Civil and Administrative Tribunal, which has a section on business regulation under which complaints against psychologists and appeals are heard. However the issue of coverage of different types of practices under "business regulation" as outlined above would need to be examined.*[2]
- *Identify common legal requirements and expectations of professionals (e.g. Working with Children checks as in Victoria) in the various jurisdictions that impact on professional work and impede practitioner mobility; and agree to work towards establishing an overarching national framework of such requirements and expectations, so that once a practitioner has satisfied those requirements and expectations in one jurisdiction, s/he can work in the other jurisdictions. (Most of the work of identifying jurisdictional legal differences has already been done. What is needed is the resolve to address this somewhat demanding but far from impossible or massively expensive task. However the time frame here is not an immediate one.)*
- *In pursuit of international mobility (another medium term rather than an immediate goal), raise professional entry standards to the same level as in our major trading partners, especially the USA, with which Australia has a Free Trade Agreement that (we understand) is now being implemented. (That FTA has a Schedule relating to professional mobility between the two countries, of particular importance to Organisational Psychologists who, more than any other types of psychologists, work internationally as well as nationally.) If there is agreement on the*

[2] Also the source of the Tribunal's power to investigate complaints must be determined. Currently it is common for such tribunals to acquire their powers by explicit delegation from profession-specific regulatory boards, and we understand that such delegations must be redefined if the National Laws are to work.

principle and goal, the task of lifting entry standards to equate to those of our trading partners could (and we believe should) be left to the professional registration boards to implement.

- *Keeping the staffing of the various jurisdictions' regulatory units at not more than the present levels, so that while staff employment is not unnecessarily disturbed, there is no net increase and hopefully some decrease through natural attrition. The remaining jurisdictional structures should be reorganised to fit into the national scheme. In regard to the proposed workforce planning unit(s), a business case should be made for the major work cycles in such planning, the associated structure(s) and methodologies to be adopted and their staffing needs. Temporary secondment to or other forms of staff involvement in the workforce planning area from non-health departments should also occur, to ensure a "whole of government" analysis of workforce needs for psychological (and other professional) service delivery. Such secondments and the judicious use of contractual arrangements with relevant experts should help keep permanent staffing costs down. There should also be provision for input from State/Territory departments, local government agencies, the higher education course providers, and the private sector, whose current staffing needs and future projections must also be considered in an holistic ("whole of community") approach to workforce planning, at least for Psychology."*

However in this Supplementary Submission we concentrate on the issues of immediate concern to us, rather than the longer-term ones such as practitioner mobility internationally, or ones of concern to all registrants such as downsizing the proposed bureaucracy and reducing the costs and complexity of the proposed system. First we summarise the defects and problems, and then recommend more specific solutions than we proposed in our first submission. These proposed solutions are italicised.

PROPOSED SOLUTIONS TO IDENTIFIED AREAS OF SERIOUS CONCERN :

(a) Inadequate regulatory coverage: In recent years health departments in most jurisdictions sought to have the then-existing profession-specific regulatory acts replaced by "omnibus" or "health template" legislation that would cover all the "health professions". In doing so, and in searching for a suitable generalisation for this omnibus legislative approach, they misclassified Psychology as a "health profession". The consequence has been that the new jurisdictional legislation, and the proposed national scheme (including its workforce planning elements), are in effect designed to regulate only the "health" sector, and do not account for therefore effectively de-regulate the other sectors where psychological services are provided. We consider that, as a matter of principle, regulators should be required in the public interest to regulate for the whole of the community, not just the health sector; for all psychologists, not just those trained for and working in health systems; and for all clients, not just those receiving health services. Also they need to plan comprehensively for future psychological service delivery, not just for those services used in "health" contexts (which are mainly "mental health" and "clinical").

The general solution proposed here is that the regulators and workforce planners (including the public service staff supporting Ministers) should be knowledgeable about, and reflect, the diversity of psychologists' involvement in providing public sector and

private sector services, and not be drawn solely from health portfolio areas or departments. CoAG should itself set that scene by now recognising and stating explicitly that for at least the profession and scientific discipline of Psychology there is much more involved than "health". It should agree that all Ministers at Commonwealth and jurisdictional levels whose portfolio areas and departments make significant use of psychologists should be involved in key decision-making and forward planning of workforce requirements, not just the Australian Health Ministers Conference, its subsidiary structure of units and the health departments. For example proposed decisions impacting on the Defence portfolios' employment and deployment of psychologists should be referred to the Defence Ministers for their views. Similarly for the portfolio areas of Justice, Family Services, etc. (Please see Attachment 1 for a fuller list.)

It would assist in dealing with our concerns if the Second Reading Speeches for Queensland's introduction of Bill B, and for the consequential companion legislation in the other jurisdictions, alluded specifically to the coverage issue for psychologists, and indicated that broad coverage is intended, of all psychologists and their services, not just those in the health sector. As the Committee of Inquiry is already very well aware, such Speeches are of major importance in any subsequent judicial interpretation of the objectives and scope of the legislation, or more mundanely, in the development of the subsidiary features of the new national scheme such as regulations. Those regulations should (we consider) also reflect and respect the diversity of the profession, and not be health-focused.

The Psychology Board of Australia should not (we consider) comprise just health psychologists and "health" community representatives. Its composition should reflect the diversity of the profession and of its clientele. Similarly, its disciplinary, course accreditation and Continuing Professional Development panels and committees should be diverse in composition. Its policies must not be "health myopic": they should contemplate issues arising in all areas of service delivery and all specialisms. It appears to us to be necessary that the PBA and its sub-units are reasonably large compositionally to accommodate that diversity in a satisfactory way. In a genuinely national system, such diversity should take precedence over geographical representation as a principle for appointing members of registration boards, committees and panels. The goal of accessing local knowledge of professional service delivery and complaints-handling contexts has already been respected by the decision to retain jurisdictional boards, panels, administrative supports, and complaints-handling arrangements. The protection of jurisdictional political interests is already assured by the roles of the Premiers in CoAG and of State/Territory Health Ministers in the AHMC. It would be most concerning to us if the crucial component of diversity of representation, on the PBA and its subordinate units, of major areas of professional specialisation, were denied on the grounds that jurisdictional interests must take precedence even here.

(b) <u>Inadequate consideration of complaints avenues and agencies/authorities</u>: As explained in our first submission, a number of regulatory agencies and authorities may be involved in the making of complaints and/or in the hearing of them, including appeal avenues and procedures. These include: the profession-specific registration boards and their various panels; the Health Care Complaints Commissioners in the States and Territories; the Commonwealth Ombudsman; the Privacy Commissioner; a new office of Public Interest

Assessor created in Bill B; jurisdiction-unique authorities such as the ACT's Human Rights Commissioner and Queensland's Health Practitioner Tribunal (part of its County Court system) as well as its Health Rights Commissioner and (quite separate) its Health Care and Complaints Commissioner; the statutory "administrative" tribunals such as the Victoria's VCAT and Western Australia's SAT; new offices at the jurisdictional level of "public interest assessors" also created by Bill B; and the courts, for appeals as well as for "common law" routes for client redress of perceived harms inflicted by professionals, such as torts of professional negligence or Trade Practices Act breaches. Action may be taken by complainants in more than one of these avenues concurrently or sequentially.

The current jurisdictional structures and interrelationships were developed independently from one another. Hence they are lacking the clear sense of national unity or national coordination that appears to be assumed by the drafters of Bill B. Bill B does not address adequately these problems of unintegrated and unlinked structures. It proposes to allow the jurisdictional arrangements to continue more or less unaffected, but with the complication of the introduction (without consultation or explanation) of the new offices of a national Public Interest Assessor and jurisdictional "public interest assessors" (both of these innovations being cross-profession). Bill B has also apparently not accounted for the situation that in WA, for example, the SAT (a key player in regard to the hearing of complaints of a serious nature, and appeals) is not empowered by its own legislation to cover complaints against psychologists (or any other professionals or occupational workers). It derives its power by delegation from the regulatory legislation specific to the particular profession or occupation (e.g. for psychologists, to the Psychologists Act 2005). If Bill B in effect puts the Psychologists Act 2005 (and the other profession-specific acts in WA) out of action, the SAT loses its power to hear complaints against psychologists and those other professionals. We understand that similar "power by explicit delegation" provisions apply to the Australian Administrative Tribunal (AAT) and perhaps all such administrative tribunals.

There is no other solution apparent to us than to examine in detail every piece of jurisdictional and Commonwealth legislation for every player in the field of complaints-making and -hearing, and to amend or cancel it in the necessary ways. We are not expert in such legislative drafting processes but imagine that (for example) the WA SAT legislation would have to be amended to cross-refer to Bill B (when enacted) in place of the profession-specific registration acts.

In our first submission, we suggested that the PBA be empowered to deal with complaints about all kinds of psychological services, and with serious as well as minor complaints. In making this suggestion, we envisaged that, after initial evaluation of the complaint, the PBA would be required to pass serious cases on to an external authority (we suggested a single external administrative tribunal) where there would be proper protection of accused registrants' legal rights. Whether a tribunal such as the AAT might be appropriate is a question the Committee could perhaps address.

(c) Specific provisions in Bill B of serious concern:

(i) Definitions: Our main concerns include ambiguity and jurisdictional differences with regard to the definitions of "health practitioner" and "health services". Bill B proposes to retain jurisdiction-specific legislation and the definitions embedded therein. Current jurisdictional definitions appear to limit complaints to those about services of a "health" kind (i.e. to an individual person, and for his/her "health benefit"), as we outlined in detail in our first submission. Such problematic definitions, and the significant cross-jurisdiction differences in them, will complicate complaints processes, and inhibit practitioner mobility and the development and operation of multi-jurisdictional psychological service delivery businesses (e.g. most consultancy businesses). *The recommended solutions here involve undoing the decision to leave the jurisdictional laws intact, at least in regard to their definitions, and to create nationally-consistent legal definitions which cover all types of psychological services for complaints purposes. Bill A (now the National Law Act 2008) has attempted to do so, but its definitions do not, we suggest, override the definitions applied by the HCCCs and other external tribunals and courts (which definitions are independent of the National Laws).*

(ii) Denial of use of title "psychologist" to psychologists outside the health sector: Under Bill B and the National Law Act 2008, it is possible that the Psychology Board of Australia could deny registration as a psychologist to non-health psychologists, on such grounds as that they do not have sufficient training and experience in health systems and health care delivery. (That is, the PBA could in effect reserve the title "psychologist" to those working in health systems and trained in "health psychology", denying other types of psychologists use of their title, with great detriment to their professional employment and income-earning capacity.[3]) *One partial solution here is to make it clear, in the recommended further CoAG statement, and in the appropriate Ministerial Second Reading Speeches, that this truncated use of the title "psychologist" is not intended, and that to the contrary all psychologists, "health" and "non-health", are to be registrable and able to use that title (and relevant adjectival derivatives).*

(iii) Applicability to public sector (Commonwealth and State/Territory) as well as private sector psychologists: In our earlier submissions we asked whether public sector psychologists (Commonwealth and State/Territory) were to be covered by the provisions of Bill B. (A large number of psychologists are employed in the public sector, but many Organisational Psychologists are private sector employees or independent consultants.) We noted the "federated" status of the legislation, and (contentiously) that exemptions appear to be made in Bill B for health departments from employer-focused disciplinary provisions. If they are to be covered, is there a difference legislatively between them and psychologists

[3] The Committee may be interested to know that a neuropsychologist registered in Europe has been refused use of the title "neuropsychologist" under the new Health Professions Council's registration policies in Britain, apparently because neuropsychology is thought by the HPC to be a sub-set of clinical psychology. This refusal has had serious negative ramifications for the applicant's area of practice in his home state as well as in Britain. This is but one instance of problems with titles due to variations in regulators' perspectives and policies that we are very keen to avoid.

practising in the private sector or in NGOs (e.g. in regard to mandated professional indemnity cover)? If public sector psychologists are treated differently legislatively, how and why? And is there a difference between the legislative treatment of Commonwealth-employed psychologists (and their employers), and that of State/Territory-employed ones (and their employers)? Are self-employed independently-practising practitioners treated differently legislatively from salaried-employed practitioners? How do any differences impact on their duty of care? *The possible solutions here are generally not specifiable until these questions are answered. However we would seek to have the Bill B exemption of health departments from the employer-focused disciplinary provisions removed. This exemption appears to reflect a serious conflict of interest on the part of the health departments involved in drafting Bill B. Those departments must set the example of "good employer", and certainly not be shielded from the consequences of unacceptable employer actions for which other employers will be held accountable. More generally, all psychologists and their employers should be treated equally, not in an unfairly discriminatory way. Bill B should be amended accordingly, where necessary.*

(iv) Forcing beyond-health psychology into a "health" mould: As we said in our first submission, professional standards should be crafted to be suitable for all types of professional services in Psychology (in a "horses for courses" approach). "Health psychology" standards must not be applied to all types (in a "one size fits all" approach).[4] Professional placements should be arranged to suit the relevant type of specialisation, without a requirement that some or all must be in "health psychology". Continuing Professional Development (CPD) should be broadly based to accommodate and promote the diversity of practicing psychologists, and not forced into a health mould. *The proposed solution here is to ensure that the composition of the PBA and its subsidiary CPD committee(s) (and other committees) reflect the diversity of the profession and the breadth of its underlying scientific discipline. Also the regulations that the AHMC develops and the policies of the PBA should* inter alia *recognise that diversity in a real and meaningful way. To achieve this, draft regulations should (we urge) be referred to Ministers in other portfolio areas (Commonwealth and State/Territory) for their examination for their effects on their psychological service delivery, now and in the future, and the APS consulted. (The APS is committed to respecting and protecting that diversity.) The PBA's policies should be developed in consultation with the APS, and be required by one or more of the regulations to adhere to a criterion of broad suitability across the profession and absence of disadvantage to the beyond-health areas of the profession.*

(v) Registers and scope of practice: Bill B opens up more options regarding how specialisms may be recorded and publicised to the public than were apparent in the consultation paper on this matter (or indeed in Dr Morauta's replies to the Committee's questions on 14th July 2009). The options include: specialist titles; endorsements to individual registrants' entries on the register; specialist service descriptors; and listing of registrants (not services provided) in one or more specialist registers or Divisions of

[4] As earlier indicated, the various branches of professional psychology are equally demanding. Their specialised standards, while different in content, are of the same high quality.

registers. *Our view: We applaud that increased flexibility and wish to see it retained, even though it also raises unexplored issues including about intra-profession scopes of practice that have not so far been recognised in the consultation papers. Given (a) clear and strong assurance in the Ministerial Second Reading Speeches that the full range of current specialisations will be recognised, and (b) that an acceptably broad composition of the Psychology Board of Australia and its committees and panels will be achieved, the College would be more relaxed about leaving to the PBA the issue of which options regarding specialisms should be recommended. But if those assurances are not forthcoming, the College would probably take a different view, preferring that the legislation itself specifies that the broad specialisms should be based on the APS's existing structure of Colleges (without necessarily identifying and cementing in the APS structure). A related issue is that Bill B does not define any scope of practice for psychologists, which would appear to constrain the exercise of this flexibility about specialisations. We would wish to see the addition of "scope of practice" provisions such as those that restrict the use of psychological (sometimes termed psychometric) tests to registered psychologists. However we will leave further argument on these matters to the APS Board of Directors and National Office, acting on behalf of the profession as a whole, as the provisions for specialisations, scope of practice and psychological testing restrictions are matters of major concern to all psychologists.*

(vi) Mandatory reporting: These provisions have many worrying features. *Our proposed partial solutions: We recommend a complete change of orientation, from the current "identify and punish" (with implications of "presumption of guilt"), to one which emphasises improvement in practice, productive support for impaired practitioners, and more generally greater respect for the civil rights of practitioners as members of the Australian community. In particular, practitioners who are treating other practitioners in regard to personal problems affecting their performance or fitness should be exempt from any requirement to report those clients. Mandatory reporting of clients who are motivated to make progress on their problems and are actively working on them is counterproductive, seriously impeding if not completely destroying the therapeutic relationship, and often driving problems underground. Moreover, the Bill's wording is very health-oriented and does not make much sense in the business/commercial/industrial contexts in which Organisational Psychologists function. This wording should be made more generic.*

(vii) Specific provisions and their wording in Bill B: We have a number of concerns regarding the thrust and/or specific wording of clauses in Bill B. *Our proposed solutions: Rather than document our concerns and suggestions about rewording here, we would appreciate the opportunity to discuss them with the drafters of the Bill. In general we support the kinds of criticisms and proposed changes recommended by Mr Bruce Crowe, an Honorary Fellow of the APS and a member of COP in his personal submission to the Committee of Inquiry. We understand that he has already e-mailed his comments to the Secretary of the Committee. Those comments are attached for the record, as Attachment 2.*

(SUPPLEMENTARY SUBMISSION ENDS. ATTACHMENTS 1 AND 2 FOLLOW.

ATTACHMENT 1:

COMMONWEALTH, STATE AND TERRITORY DEPARTMENTS EMPLOYING PSYCHOLOGISTS

(Adapted from Appendix B to COP's first submission to the Committee of Inquiry.)

(The following headings reflect broad government portfolio areas other than "health" and "human services", not specific Departmental titles.)

FAMILY SERVICES AND EDUCATION PORTFOLIOS

In educational and family services areas, school and other educational psychologists, developmental psychologists (working with children and their families), vocational psychologists, community psychologists, organisational psychologists, sport psychologists, and social psychologists (as well as "health" psychologists) make significant contributions, to policy as well as operationally.

Educational and developmental psychologists deal with individual, family and systemic problems. School psychologists may also be the "first port of call" in the assessment of disability and the professional management of the many adjustment and institutional support issues associated with disability, for the school and the family as well as the disabled child.

EMPLOYMENT PORTFOLIOS

In the employment portfolio areas, organisational psychologists, vocational psychologists, and community psychologists (as well as "health" psychologists) make significant contributions, to policy as well as operationally. As a particular example, Organisational Psychologists assist people to work effectively in organisations, and assist organisations to employ, allocate, group and motivate people productively. They contribute directly to the economy by optimising the productivity of individuals and work teams, and helping to design safe and stimulating jobs and evidence-based work methodologies through use of knowledge of normal human attributes. They also play important roles in job search and company (and government) staff selection activities.

COMMUNITY WELFARE AND INDIGENOUS PORTFOLIOS

Community Psychologists are important in many ways, such as in regard to "social issues" like social inclusion (including for indigenous communities) and multicultural issues. They bring to bear knowledge of social systems and communities, and action strategies for achieving desirable self-directed and/or collaborative goals. There is considerable potential for Community Psychologists to work with Organisational Psychologists to develop work-organisation models that involve work methods and technologies tailored to the kinds of material resources available in remote areas as well as the competencies of the community members, as has been done successfully in South Africa. Tourism is an obvious example, but there are other mainly unexplored possibilities.

AVIATION, ROAD AND OTHER TRANSPORT PORTFOLIOS

Nationally and internationally psychologists work in “beyond health care” contexts in air safety, accident investigation, aviation and aircraft systems design, road-rail-marine accident prevention and investigation, and related areas. Psychologists, many internationally respected, have been prominent in the accident research and prevention field. Most do not work in face-to-face, individual case work, but are found in research centres, multi-disciplinary research or project teams, program evaluation teams, policy development units, and training centres.

Many valuable and effective projects in practical transport research and transport safety policy development have also involved psychologists of similar calibre and standing, e.g. the Australian Road Research Board.

Also consultants in organisational psychology provide valuable advisory services to departments, local government, NGOs and other such bodies involved in transport and related matters.

DEFENCE PORTFOLIOS

Psychology in the military contributes to capability, effectiveness and the preservation of personnel through a range of health care and “beyond-mental health” tasks and functions. While valuable “mental health” psychological services are provided to military personnel, Defence Public Service staff and other client groups (e.g., veterans), many psychologists work partly or wholly in key “beyond-mental health” contexts. These include:

- psychological selection and assessment (e.g. of ability, aptitude and motivation) of candidates for general service and officer categories of entry into the Australian Defence Force,
- similar assessment tasks for internal allocation and re-allocation, particularly to specialist military trades such as aircrew, explosive ordnance demolition personnel and military police;
- “human factors” work in domains such as military aviation, including roles such as accident investigation, training support and safety systems management;
- management training for senior NCOs and officers, involving areas as diverse as principles of team development, effective leadership, and career management counselling;
- the validation of psychological tests and other selection procedures such as assessment centres for specialist occupations;
- design and evaluation of training programs in terms of adult learning principles and good curriculum design based on task, role and occupational analyses;
- specialist advice to Commissions of Inquiry into issues such as systems error, human performance limitations and indiscipline;
- support to strategic human resource management and associated research (e.g., retention initiatives, organisation development, attitude and opinion surveys);
- performance enhancement in individuals and teams, including cognitive effectiveness techniques, shared cognition in teams, and skill maintenance.

Psychologists in or associated with the military are involved in various Defence-related research projects; and for several this is their primary role. This research includes many “beyond-health care” fields such as retention, command and safety climate, and fatigue and its management.

Research outcomes have helped inform personnel policy, training programs, and the design of better systems and procedures.

POLICE, FORENSIC, LEGAL, INTELLIGENCE AND JUSTICE PORTFOLIOS

Here psychologists work in many "non-health care" contexts, e.g. in Intelligence work, forensic assessment for the courts, psychological profiling in criminal investigations, Family Court counselling and expert witness services, specialised staff selection testing and interviewing, in-house training, staff development, and community development as with indigenous communities (the latter again involving the important but not well known area of Community Psychology mentioned earlier under "Education"). New methods, for example of profiling, assessment and intervention with family problems, have been developed.

Also consultants in Organisational Psychology provide valuable advisory and training services to these departments about strategies, structures, staffing, systems and other such matters.

TREASURY AND FINANCE PORTFOLIOS

Psychologists work in many "beyond health care" contexts in these portfolio areas, ranging from the very practical to the highly abstract (often as consultants or researchers but also in salaried employed roles such as "in house" policy development ones), e.g. in:

- "culture" change in organisations/departments,
- staff selection testing and interviewing,
- in-house training and staff development,
- the analysis of consumer behaviour such as motivational factors affecting decision-making in purchasing situations,
- the improvement of the quality of management of small and medium as well as large businesses through better understanding and handling of staff and client relationships,
- advertising and other media work,
- occupational safety and psychosocial risk assessment,
- (at the more abstract end of the spectrum) the applications of social psychological theories such as Socio-Technical Systems Theory to integrate work technology with social factors in organisations, and
- applications of elements of "chaos and catastrophy theory", to achieve better understanding of the dynamics and drivers of "real-world" turbulence and stability (crucial issues for government and corporate investment and other decision-making).

Also consultants in Organisational Psychology provide valuable advisory and training services to finance departments in government bodies, NGOs, etc., about strategies, structures, staffing, systems and other such matters. New methods of assessment and intervention with organisational problems and in the promotion of organisational change have been developed.

Attachment 2:

Mr Bruce Crowe's personal submission to the Senate Committee of Inquiry

BILL B RECOMMENDATIONS - DETAILS

PRELIMINARY

The following Recommendations are organised into matters that appear to warrant:

1. clarification, i.e. something that would benefit from being made more explicit;
2. correction, i.e. a fact or typographic that needs to be made more accurate;
3. changes, i.e. variations sought to what is proposed; and
4. inclusion, i.e. additions suggested to what is proposed.

The detailed references and Notes supporting the recommendation are attached.

1. CLARIFICATION

The following matters could benefit from clarification to make explicit matters that may be implicit, to link matters to related matters, and/or to make matters plainer for lay readers.

1.1 Division 12, Subdivision 4 **Advertising**, refers in (3) to court proceedings for advertising offences listed in (1) (a) to (e).
Clarify: does this mean the National Board (NB) will pursue false advertising in the courts? And also pursue the use of testimonials (c)? Or, what will the NB pursue in the courts? And which courts?

1.2 Subdivision 6, **General**, 148 (1) proscribes inciting and directing a health professional to unprofessional conduct or professional misconduct, and in (2) it exempts owners and operators of (a) public health facilities and (b) other health facilities licensed under Commonwealth Law or participating jurisdiction, i.e. the public health system, where most problems reported publicly seem to occur.
Comment: This is amazing duplicity. If a colleague suggests a little misconduct they are in trouble; if a health facility owner or operator prescribes unprofessional practices they are not covered by this clause, while the practitioner and the inciting colleague can be done for misconduct. No Nuremberg Defence allowed here?
Clarify: Does this mean that hospital executives/operators can issue inappropriate edicts to managers who are registered health professionals and those managers will be liable under this section if they pass on the edicts to registered practitioner staff, but the hospital executives/operators will be immune from prosecution?

1.3 235, **Compensation**, (1) for any loss or expense due to the exercise of powers by investigator may be claimed from National Agency (NA/AHPRA), and (2) compensation may be claimed for loss or expenses incurred in complying with requirements of this Division.

Comment: The scope of this could cover the usual damage to property and photocopying, and might also cover business interruption and business recovery, e.g. if computer is taken and current client files are taken and have to be reconstituted, or if clients can't be seen for some time due to disarray or the things a person is compelled to do for the investigator consume time.
Clarify: The specific scope of compensation by giving indicative examples of acceptable costs that may be claimed, and name the parties able to apply for costs including (presumably) the accused, accuser and the registration regulator, if this is intended to be the case.

1.4 246 **Appealable decisions** listed (a) National Board (NB) imposed conditions on registration, (b) professional standards panel, (c) health panel and (d) NB reviewable decisions.
Clarify: Do conditions in (a) include interns' conditions for provisional registration?

1.5 Division 12, **Miscellaneous**, 253, If disciplinary action is decided by an NB or a disciplinary body, and the NB has been advised by the practitioner that they are employed by a third entity, then the NB must give written **notice of their disciplinary decision to the employing entity** in writing as soon as practicable. Note at foot of (1) refers to s144 in which NB may ask for employer information from a registered practitioner.
Comment: Even though 144 says "may ask", the following subsections say that the information cannot be unreasonably withheld and that to do so is not an offence but may be a disciplinary matter.
Clarify: Would it be more truthful in the Note to say the NB "can" ask for the data, or just leave the Note out, as it appears misleading in its current wording?

1.6 269 **National Registers** to contain details for all health practitioners except specialists, as per Table National Boards (pp. 126-127).
Comment: the table includes a column headed "Division of National Register" in which subsets of the National Register professions can be listed.
Clarify: Could subsets of psychologists be entered in the Divisions column?

1.7 270, **Specialist Registers** to contain details of specialist health practitioners.
271, **Information to be recorded in registers**, listed (2)(a) to (o), include (f) type of registration held by practitioner, viz. division (g), specialist (h), limited (i), conditional (j), suspended (k), endorsed (l), and cancelled (3);
Clarify Could this sub section 271(2) be used to include records of professional memberships and post nominals relevant to registrants' registered status?

1.8 271 (2) requires ("must") each **National Board register to include** (a) to (o); (m) includes "any qualifications relied on by the practitioner to obtain registration", which may not be interpreted to include professional memberships, e.g. MAPS; "o" provides for the inclusion of "any other information the Board considers appropriate", which could be used to include APS membership and post nominals.
Comment: Standing in a professional association is useful for a Board and a member of the public as an indication of professional standing and professional practice areas that complement a practitioner's registered status, e.g. when identifying suitable persons to assist with professional standards matters;
Clarify: Can specific provision be made for the inclusion of professional memberships and post-nominals relevant to the area(s) of practice for which a practitioner is registered?

2. CORRECTION

The following items appear to require changes to make them accurate, meaningful and/or typographically correct.

2.1 Subdivision 3, **Health panels (HP)**, the members of any particular Health panel (200) are drawn from a list of persons approved that the NB "may" appoint according to a process approved by the Ministerial Council (unstated) (201,(2)).
Comment: No alternative is offered for the sourcing of health panels if the NB chooses not to appoint a list!! Could leave jurisdictions without health panels to draw from.
Recommendation: That provision be made to ensure that lists are available from which panels can be appointed.

2.2 245, **Review of reviewable decisions**, (1) who may review, (2) what review decisions can be made, (3) notice must be given, but (4) if a review decision is not decided in 30 days of receipt by the NB then it is taken that the reviewable decision has been confirmed.
Comment: There is a typo in the second last word of 245 (4) where "review" should be "reviewable" if the language in the preceding subsections (1) and (2) is followed.
Recommendation 1: in the second last word of 245 (4) change "review" to "reviewable".
Comment: If this assumed typo is correct, then all the NB has to do is to ignore its intray and after 30 days the review applicant has to assume the review request has been unsuccessful!
Recommendation: Re-think the situations where a decision is hard to make so that the practitioner gets the benefit of any doubt, by reversing the "no action, you're guilty" to "no action, we found it all too hard, you've been given the benefit of the doubt" which is more consistent with procedural fairness, civil liberties and legal practices.

2.3 266 requires ("must") **National Board to publish certain decisions**, viz. under Div 5 of Pt 8, and professional standards panels and health (panels), unless NB decides it is not in the public interest to publish the information.
Comment: Another example of a "must" requirement being negated by an exception "unless"; poor drafting and contradictory. Suspect typo in 266(1)(c) in that "health" should be followed by "panels", so that the subsection refers to professional standards panels and health panels.
Recommendation: that "health" become "health panels", if that is the intention.

3. CHANGES

The following items would benefit from the changes suggested which clarify and/or relate the matters more closely to the Bill's apparent intent and practice realities.

3.1 73, **Private Indemnity Insurance** arrangements, must be held at the time of registration and (73,1,(a)) must not expire before the end of the registration.
Comment: If this is applied, then all APS PI insurance holders registered in NSW would not now comply, because the registration due date and the PI renewal date are not the same, with the registration date preceding the PI renewal date by about 1 month, which leaves a gap of 11 months in PI coverage at the time the registration renewals are due. **Recommendation**: This inconsistent requirement should be replaced by one that requires ("must") a registered practitioner to be continuously covered by suitable PI insurance.

3.2 82 (1) **Registration Period** is stipulated as “not more than 2 years”.
Comment: This is OK as a limit on the length of time that can be granted at any one time, but doesn’t mention extensions for those who need more time to complete a satisfactory internship. Could be over-interpreted as limiting internship to 2 years, which doesn’t fit 3 year post graduate DPsych programs or employed interns whose programs get interrupted for business and personal reasons (e.g. family reasons).
Recommendation: Suggest adding at end of 82(1)**: “**Extensions of not more than one year at a time may be granted by the National Board.”

3.3 Division 7, **Student registration**, 105 empowers NB to “ask for” “particulars” of students enrolled in approved courses, and to record them.
Comment: “particulars” is broad enough to encompass unnecessary details that intrude into privacy.
Recommendation: Replace “particulars” with a list if enabled (“may”) items, a selection of which could be obtained and recorded, e.g. name, study institution, course, current year/stage of progress.

3.4 160, (1) **NB to advise practitioner** within 28 days of receipt of a complaint against them, unless (3) the NB believes doing so would prejudice an investigation or endanger someone’s health or safety or lead to intimidation or harassment.
Comment: This is used to keep investigations secret from practitioners, when, in fact, it is practitioners who can be at risk from clients who are critical of them, and who could set them up for additional complaints or do them harm, as happened in WA, SA and Vic in years past. It also allows investigations to use entrapment, which is illegal. NA has a duty of care to registered health practitioners that should be exercised by deleting (3).
Recommendation: Remove the exception by deleting 160(3).

3.5 167, **Rejection by NB of a complaint**; (1) gives 3 grounds; (2) says the information may be taken into consideration later as part of a pattern of conduct by the practitioner; and ((30 and (4)) advise the complaining entity.
Comment: (2) suggests that all information will be retained and used against the accused in future (to bias any appreciation of contemporary events, or as is stated demonstrate a pattern of conduct, even though no determination was made about the earlier conduct). In court proceedings, earlier records of criminal offences are not mentioned until after an accused is found guilty and is then taken into account for sentencing, but not for determining a “pattern of conduct”. Suspect civil liberties and reasonable processes are being ignored here.
Recommendation 1: That for dismissed complaints, only findings are kept in a brief form such as “date, complaint dismissed”. This will signal that there have been past complaints, but there will be no details to taint contemporary proceedings.
Comment: Further, in the case of “frivolous” and/or “vexatious” complaints, can provision be made for action to be taken against the entities that originate them?
Recommendation 2: That frivolous and vexatious complainants have entries made in their Register records that they made such a complaint, and issue them a caution or warning to be more careful in future, or in nasty cases take action under 158 to discipline the vindictive/frivolous complainant.

3.6 Div 7, Subdivision 2, **Professional standards panels**, 180 can establish panels of at least 3 with at least half but less than 2/3 registered practitioners and at least 1 community

representative, drawn (181) from lists appointed by the NB. 183 (2) requires a panel to observe principles of natural justice but not bound by rules of evidence, and (3)(b) allows the panel to consider any information it considers relevant,

Comment: This allows the panel to be a kangaroo court, and to accept hearsay and other unreliable forms of input that do not constitute evidence and which place civil rights at risk. Under the proposed Bill, any pack of lies and false statements can be used to ruin a person, and this is especially likely in an environment where the investigating body sees its role as protecting the public against professionals' poor practices and behaviour, and is predisposed to consider the complaint true because it has proceeded through several stages of examination and review before reaching a panel or tribunal, and cognitive dissonance and social conformity does the rest to convict a person. These outrageous conditions need to be removed if the whole disciplinary process is to have any respect at all. Another element missing that is usual legal procedure is the right to face the accuser. This whole process protects the accuser from exposure to the accused, and makes a virtue of it; this process makes it easy and without consequence (unless you are a registered practitioner) to make complaints.

Recommendation: that all investigative and punitive procedures be required to follow rules of evidence, and that an accused be permitted under appropriate circumstances to cross examine their accuser, so that fairness can be preserved. By appropriate circumstances is meant that mentally ill people be excused from cross examination but that entities and corporations be subject to cross examination.

3.7 273, **Inspection of registers**, provides for extracts and "a copy of the register" to be sold to "a person" if the NA is satisfied it would be in the public interest.

Comment: Sweeping access to a whole register seems unnecessarily generous, especially when given a name, suburb and postcode the register information can be matched to Yellow Pages and similar listings to locate the person; and if there is any motivation to seek out an individual or group of registrants for good (a mail drop to all in a division) or bad reasons (to attack registrants who supported/opposed a child custody matter, or to persecute registrants suspended for crimes), then privacy is compromised and so may be the duty of care of the NB that has provided the means for access to registrants.)

Recommendation: Restrict access to reasonable individual community member needs, and remove the sweeping capacity to sell the whole register to commercial operators. Establish a "need to know" that is not unreasonably withheld. Try to avoid release to vindictive and exploitative persons/entities.

3.8 286, **Parliamentary scrutiny**, if in a majority of participating jurisdictions (2) a House of Parliament disallows a regulation (1), the regulation ceases (3).

Comment: This is similar to the votes needed to change the Constitution, and could be a blockage to responsive change.

Recommend: a more responsive process be legislated; e.g. changes recommended by National Agency to MC be adopted pro-tem until confirmed by Legislatures, if really necessary; as the Regulations are made by MC, why can't MC be the authority to change them (first option)? And then the majority of legislatures step be followed if the MC refuses to make changes?

4. INCLUSION

The following matters need to be added to the Bill to ensure its capacity to cover matters that may arise.

6, Definitions, include a definition of "patient" as a service recipient, e.g.

"*patient,* a direct recipient of a health service from a health practitioner"

4.1 Division 11, Subdivision 1, 129, **Restrictions on use of titles**, reserves the title "psychologist" for use by registered psychologists, and makes clear in (a), (b) and (c) that others cannot use a title that can be "reasonably understood to induce a belief that a person is registered under this Law".

Comment: could titles that do not induce the belief proscribed be used by, e.g., retired psychologists, to retain their professional identity, such as "retired psychologist", "unregistered former psychologist", "former psychologist", "psychologist emeritus?" Alternatively, when asked what do you do or what did you used to work at, are retired psychologists required to be rude and say "I can't tell you", or "I am proscribed by law from saying what profession I practiced in for 45 years" such that there must be a 45 year gap in a life because past professional activities cannot be named? Of course, the title psychologist could be used during a eulogy because it is plain that the psychologist is not able to practice and has ceased to be registered. The term "non-practicing psychologist" cannot be used because it will have a specific meaning within the Law.

Recommendation: Provision needs to be made for a title for psychologists who are no longer registered because they do not practice but whose professional identity is bound up with their profession, e.g., "retired psychologist", "unregistered former psychologist", "former psychologist", "psychologist emeritus?".

4.2 Subdivision 1, **Self-referral**, 192 (a) (iii) allows ("may") the NB to accept an undertaking from the practitioner or student which (2) can be monitored for compliance as a way of resolving a self referral.

Comment: This is a model for dealing with the intern "placement" issue, in that an intern could give an undertaking to work only in I/O psychology (positive option, that excludes all other professional work) or to not register with Medicare or to do mental health work until suitably qualified to provide relevant services (negative option that leaves all work other than Medicare and mental health work open) for a minimum of 5 years after full registration, where the activities could be monitored by annual submission of a block log or job description. This would eliminate the need for I/O interns to do health placements.

Recommendation: That Regulations provide for Interns' undertakings with respect to practice and placement matters to be recorded, and that this recording and consequent monitoring of agreements be used to relieve interns of the need to do supervised placements outside their chosen areas of practice.