The Australian Psychological Society Ltd

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College of Organisational Psychologists

Submission to the

THE SENATE COMMUNITY AFFAIRS COMMITTEE'S

INQUIRY INTO THE NATIONAL REGULATORY SCHEME FOR THE HEALTH PROFESSIONS

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TABLE OF CONTENTS:

		Page
1	SUMMARY	3
2	INTRODUCTION TO THE NATURE OF PROFESSIONAL PSYCHOLOGY AND ITS REGULATORY NEEDS	5
3	OUR DETAILED SUBMISSION	10

LIST OF APPENDICES *18*

APPENDICES:

A:	**Ministerial Second Reading Speech for the Queensland** Health Professional Tribunal and Extracts From The **Explanatory Notes For The (Queensland) *Health Practitioners (Professional Standards) Bill 1999*.**	**19**
B:	**Some Illustrative Government Portfolio Areas Where "Beyond Health Care" Psychological Services Are Employed.**	**25**
C:	**The CoAG/AHMC Structures (Current and Proposed) Involved in the Regulation of the Health Professions.**	**29**
D:	**Legal and Legislative Issues and Dilemmas Involved in the Regulation of Psychology.**	**33**
E:	**Course Accreditation Issues.**	**40**

1 SUMMARY

Many psychologists are very concerned about aspects of the upcoming national registration of psychologists. Our concerns pertain particularly to the Inquiry's Terms of Reference (d), (e) and (f).

The College of Organisational Psychologists[1] wishes to bring those concerns to the attention of the Senate Community Affairs Committee's Inquiry (hereafter "the Inquiry"), as we know those problematic aspects will have adverse consequences for all Australians and their governments if not adequately dealt with now.

Of the 10 professions being regulated, Psychology stands out as the only one that has many members who are not "health professionals" and many of whose services are not "individual health care" in nature, i.e. are "beyond health care". (Examples of "beyond health care" psychological services are provided below.) This is not being adequately recognised and provided for, in the national regulatory scheme.

We have never sought to be excluded from the regulatory scheme, but we do wish to ensure a holistic approach to regulation that:

- provides a clear and legally unambiguous complaints avenue for clients receiving "beyond health care" services,
- gives us the continued right to use the title "psychologist" in "beyond health care" professional work,
- sustains our own forms of specialist tertiary training and post-qualification Continuing Professional Development, and
- includes our types of workforce needs in future workforce planning.

The Health (or Human Services) Departments appear not to be accepting fully the responsibility that goes with their regulatory powers, to regulate for the whole of Psychology and the whole of the community, and not just those members of the Psychology profession and of the community (including employers) who are involved in the health sector and health care service delivery.[2]

That responsibility is, we submit, part of the *"whole of government", "whole of profession" and "whole of community" approach* that in our view should drive the design and operation of the national regulatory scheme for the good of the whole of society.

The negative consequences of following a single "health" model for regulation, and planning only for the workforce needs of the health sector nationally, will include:

- erosion of the public interest and protection of the whole of society through lack of a clear and legally unambiguous avenue for complaints by clients who receive "beyond health care" psychological services (such as reports used in the Family Court[3], accident investigation work in aviation, road and other transport systems, personnel selection assessment, vocational counselling, intelligence testing, or job design/redesign).
- a narrowing of the training, placement and work opportunities for psychologists.

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[1] A part of the Australian Psychological Society.

[2] Personal communications with public servants in Victoria, the ACT and South Australia regarding their introduction of single "health professional" acts to replace Psychology-specific ones.

[3] Such reports and related evidence are said to form the basis for the majority of complaints to Psychology Registration Boards around Australia.

- a consequent shortage of suitably trained and experienced psychologists to provide the full range of professional services that the whole community needs. The disruption of the flow of skilled psychologists will take years to overcome (if ever).
- damage to the holistic delivery of health care services themselves, which are indirectly but still importantly linked to the remainder of the discipline and profession of Psychology, conceptually and in regard to practice innovations based on sound research evidence. These are often drawn from “beyond health care” sources. (See Appendix D.)

In Conclusion

The most important immediate action to help develop suitable regulations and infrastructures is to appoint psychologists from the “beyond health care” specialisations in Psychology to some of the positions on the Psychology Board of Australia (PBA) and subsequently on its proposed committees.

Under CoAG’s and the AHMC’s oversight, the empowering legislation for the national scheme is being crafted and enacted in Queensland, and is to be “incorporated by reference” in the other jurisdictions (rather than Commonwealth legislation being used). Also it seems that the AHMC will appoint the PBA members. We are not able to identify how and to what extent the Senate can influence the development of the national scheme in such circumstances.

Thus we have felt unable to frame specific recommendations for the Inquiry that could be operationalised. However the general thrust of the changes that we would wish to see is, we hope, clear.

We would greatly appreciate the opportunity to appear before the Inquiry, to pursue these and related matters and answer the Inquiry’s questions. In particular we would like to be able to clarify the many distinctive features of the “beyond health care” areas of Psychology by reference to Organisational (including also Industrial and Occupational Psychology), and to demonstrate that a “health care” regulatory model does not cover them at all adequately.

We would also wish to expand on our brief outline (above and in the next section of this Submission) of the actions that we believe can be taken to address these serious problems. In doing so, we hope to gain a greater appreciation of the part that the Senate can play, now and in the future, in monitoring and gaining improvements in the national regulatory scheme.

(END OF SUMMARY)

2 INTRODUCTION TO THE NATURE OF PROFESSIONAL PSYCHOLOGY AND ITS REGULATORY NEEDS

2.1 *What is Psychology?*

Psychology is a field of study and scientific discipline, and a very diverse profession. Psychologists are exposed to a common body of psychological knowledge and theory in their undergraduate training, and adhere to a shared code of ethics.

Professionally psychologists work in and are trained for various specialist fields, not just "mental health", or in "health care delivery". This specialist training occurs at Masters' level, or (for four year graduates) through supervised professional practice after graduation under a registered psychologist qualified in that specialist field, coupled with attendance at relevant professional development programs.

Many psychologists work in positions not titled "psychologist" even though the selection criteria for them may require that the appointee is in fact a registered psychologist. In workforce planning, it is essential to know about this feature, and gather data and plan accordingly.

2.2 *What kinds of services do psychologists provide?*

People from all walks of life, not just those who are mentally ill, use psychologists, for a variety of services beyond "health care". Psychology services are provided society-wide, in education, child development, vocational counselling, job selection, organisation change, leadership development, team development, work and sports performance, life style coaching, crisis response, bereavement, family functioning, aged care, outplacement, etc. These services are *"beyond health care"*. Legally they typically do not constitute "health care", as we now explain.

"Health care services" are legally defined as (for example) providing help to individual persons with health problems, that help being directed at *"human health benefit".* (Unfortunately there are various definitions with significant differences – see Appendix D.)

Many psychologists do provide "health care" services of a psychological kind. However many provide psychological services that are *"beyond health care"* (e.g. are about matters other than health care for individuals, and often directed at groups, teams, organisations, communities or other systems such as economic ones or the justice system). Some psychologists provide both sorts of services, at some time or other, or even concurrently.

"Health care" services are not more (or less) meritorious, valuable to the community, or professional demanding and risky, than are *"beyond health"* services. They are intertwined in many ways, and feed off one another conceptually and in terms of practice innovations. But they also have some important differences, which we outline in Appendix B.

These are not simplistic, clear-cut or "black and white" differences. They are differences of emphasis, depth of knowledge and expertise in particular areas, and forms of cognate knowledge prominently used (explained in Appendices B and D), rather than entirely different areas of knowledge or skills.

Our specialist fields are best regarded as branches of the one tree, rather than different trees. But the tree's trunk is general psychology, not "health" psychology. In these respects their differences are similar to the differences among surgeons, radiologists, physicians, GPs, and so on in the medical field.

2.3 What is wrong with calling all psychological services "health care"?
Unfortunately the proposed national regulatory scheme for psychologists is focused on "health care services" and their "providers". The whole of Psychology as a profession is thus being forced into a health mould, whereby the use of the title "psychologist" (as a public self-description or in a job title) may in effect now be restricted to those who deliver health-care psychological services[4].

This restriction has serious implications for psychologists, and also their employers and their clients.

Employers (especially those outside the health sector) who wish to employ a psychologist to provide "beyond health" psychological services (e.g. senior executive selection) may be prevented from titling the position "psychologist". Or s/he may have to appoint a "health" psychologist in order to be able to offer psychological services commercially or "in house" to their own staff, even though those services are "beyond health care".

For clients, the anomalous situation (unless fixed) could well be created in some jurisdictions where

- a client receiving "health care" psychological services can make a complaint about them or the service provider, but
- cannot do so where the services are not "health care", even though the provider may be the same person. (We explain how in Appendix D.)

2.4 How does this affect the community and Australian society?
Organisational psychologists' capacity (and that of other "beyond health care" psychologists) to contribute across the community (not just in the health sector) is threatened by the State Registration Boards and the COAG/AHMC national initiative to regulate the "health professions" using a "health care" model, and planning only for the future workforce needs of the health sector and only for "health care" services.

Clients using "beyond health care" psychological services must (we urge) be as well protected and their needs as well planned for, as clients of health professionals delivering "health care" services.

2.5 How are professional ethics and Continuing Professional Development relevant?
Psychologists are ethically bound to stay within the areas in which they are suitably skilled.[5] Continuous Professional Development (CPD) is crucial in order to stay up to date with one's specialty, and indeed to have their registration renewed annually. It is also essential in making a transition to a broader or alternative area of practice in an ethically acceptable way (usually in conjunction with advanced formal coursework and/or supervised professional practice in the new specialty).

Thus forcing all CPD into a health mould (instead of allowing people to follow their specialty) would inhibit the achievement of the regulatory aims of ensuring that all

[4] The APS's lawyers, Gadens, have said, *...if the ongoing registration requirements and the accreditation and continuing professional development (CPD) rules under the new scheme do not acknowledge their position, organisational psychologists may not be able to hold themselves out as "psychologists" under the Act without the requisite health/clinical training"*.

[5] The Australian Psychological Society recognises nine categories of psychological practice through its Colleges. Internationally, the American Psychological Association recognises over 50 Divisions of psychology practice, teaching and investigation. The International Association of Applied Psychology recognises 16 Divisions of Psychology. The British Psychological Society has some 10 Sections and Divisions of Psychology.

psychologists keep up to date and can renew their registration. How can they do so if they are forced into (for them) inappropriate CPD?

If they wish to change areas of practice, they must prepare adequately for that change, but cannot do so if they are not allowed to undertake the relevant CPD. Thus forcing all CPD into a "health care mould" would inhibit career change, and produce unhealthy rigidity in professional career directions.

2.6 Why is government understanding and support important?

These valuable "beyond health care" services are threatened with withering through lack of support from government regulators and planners, lack of training through systemic underfunding of higher education courses, and lack of suitable CPD - these threats arising in the main from a single-minded regulatory focus on health care services.

We appreciate that the regulatory scheme is being developed in the broader context of long-overdue major reform of the health care systems in Australia (reform proposals and activities going back to at least the early 1990s[6]), with now a commendable sense of urgency and commitment in government and public service ranks. We support those reforms.

But the downside of such urgency and dedicated focus is that negative impacts within and especially beyond the health sector are (in our judgment) in danger of not being properly recognised. And where they are, they may be seen as unfortunate but unavoidable "collateral damage" that should not be allowed to impede the health reform process.

Such a view, although understandable as a reflection of the motivation and "dedication to the cause" of the CoAG/AHMC health working groups, is nonetheless simply not appropriate from a broader perspective. *"Getting it right"* is more important than *"getting it done quickly".* And getting it right for the health sector, but wrong for the other sectors and society as a whole, must surely be considered unacceptable.

Unfortunately Australian Health Departments are continuing to adhere to the administratively and legally convenient but false and harmful notion that all (or all but a few) psychologists work in mental health, and that a health care model is appropriate and sufficient for the regulation of and planning for our profession.

This is akin to declaring that all engineers are construction engineers, or that all lawyers are criminal lawyers, and must be trained only for that sub-field of engineering or of law. Would it be sensible to declare the whole of (say) engineering to be a "health" profession on the basis that bio-medical engineers might be considered to be within the 'health' domain?

2.7 Where is the evidence of regulatory problems for psychologists?

We are not catastrophising about these problematic effects. In some States/Territories that are now using a "health care" focus and single "health professional" Acts in place of their previous Psychology-specific acts, we have already experienced negative consequences, such as:

- At least a year of supervised professional experience of a "mental health" kind is now being demanded of new graduates, even for those who will work in "beyond health care" areas such as organisational psychology, interfering with their career

[6] Including The Productivity Commission's "Health Workforce Research Report" 2005.

development and employment arrangements, and seriously distorting the demand/supply balance of professional placements.[7]

- Inappropriate health-type CPD standards have been set (e.g. in NSW), to the neglect of the other essential forms of CPD.
- In the ACT, the competency requirements for initial registration (Standard Statement 11) have a health flavour.
- Elsewhere registration problems have been encountered by members not qualified in "health psychology"[8].

A fundamental underlying problem has been that registration boards as currently constituted in most jurisdictions[9] do not have adequate knowledge of and experience in organisational psychology work. Consequently they sometimes look askance at applications for registration from qualified organisational psychologists who are working in what may seem to registration board members to be unconventional (non-health) fields of psychology.

Some cases of disadvantaged individuals may be able to be presented to the Inquiry under conditions of privacy.

2.8 Reduced Commonwealth funding

At Federal Government level, an adverse funding differential has recently occurred for university post-graduate courses in Organisational Psychology compared against the funding for the other Psychology Masters programs. Reportedly one rationale has been that they are cheaper to run than the other Psychology post-graduate programs, their students not having to undertake laboratory training.

This is a serious misassessment in more than one respect. One of those respects is that organisational psychologists use a very wide range of psychometric tests as assessment tools in personnel selection and staff training work. Such tests and questionnaires are frequently used in research work as well. Yet university Departments of Psychology have great difficulty keeping up to date, as these tests are expensive. (Of course other Masters programs may have similar funding problems regarding psychological test expenses.)

A second aspect of misassessment of costs is that organisational psychologists function nationally and internationally (and will do so more and more due to globalisation trends). Their Masters-level professional placements – and their research work - ought to reflect that broad geographical perspective and role. Some placements should be inter-State, and some international (especially in Asia) if cultural understanding is to be promoted. Associated language training and structured cultural exposure would also be appropriate. We note that some European universities send their students on placement to Australia and other countries. But such placements and training are expensive, and have been virtually impossible in Australia with restricted funding of the universities. They will be even less possible when the full distorting effects of the decision to underfund the Organisational Psychology Masters courses flow through.

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[7] Extant in NSW and (we understand) pending in the ACT.

[8] We cannot ascertain the real extent of such problems due to some registration boards' policies of privacy and non-disclosure of the extent of them, even in a deidentified form. Also disadvantaged members are often too embarrassed to reveal their problems.

[9] Appointees by Health Ministers being very predominantly health psychologists.

2.9 *The way forward:*

The way forward includes recognising the very broad range of psychological services and ensuring that their diversity is facilitated in the new regulatory arrangements, and is not restricted and eroded by them.

Breadth of representation, of the whole profession, not just the "health" parts, is crucial for ensuring that:

- professional standards are crafted to be suitable for each type 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).[10]
- professional placements are arranged to suit the relevant type of specialisation, without a requirement that some or all must be in "health psychology".
- CPD is broadly based to accommodate and promote the diversity of practicing psychologists. CPD must not be forced into a health mould.

Thus the most important immediate action to help develop suitable regulations and infrastructures is to appoint psychologists from the "beyond health care" specialisation to some of the positions on the Psychology Board of Australia (PBA) and subsequently on its proposed committees.

These appointments should include some members who are expert in organisational, forensic, counselling, educational and developmental, community and/or other "beyond health care" fields of Psychology.[11] They must not be restricted to members experienced only in health psychology, the health sector, and health systems of service delivery.

We note with some concern that the recently-announced "professional" appointments to the Agency Management Committee (AMC) are medical/nursing appointees, with none from the "allied health" professions. Will this representational selectivity occur with the professional boards?

Will the AMC be compositionally able (despite the undoubted quality of the appointees) to address the very different kinds of professional-administrative issues that regulation of the "beyond health care" fields of Psychology must identify and manage?

If it cannot, and if it expects to act on advice from the Psychology Board of Australia, broad composition of the PBA is even more essential.

(END OF "INTRODUCTION TO THE NATURE OF PROFESSIONAL PSYCHOLOGY AND ITS REGULATORY NEEDS")

[10] 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.

[11] All of these psychology disciplines have direct impacts on large and important sectors of our society, viz. all private and public organisations and the millions of people they employ, community groups, schools, universities and private colleges, courts, and everyone who needs to talk to a counsellor to sort out personal problems.

3 OUR DETAILED SUBMISSION

3.1 *Who are we and what can we contribute?*

The College of Organisational Psychologists[12] wishes to contribute some specialised input to the Inquiry. Organisational Psychologists[13] have expertise and provide professional services in relation to:

- analysing organisations' and institutions' external environments in terms of turbulence and volatility and their toxic psycho-social effects in organisations, such as impaired managerial or social policy decision-making, disturbed social and work group relationships, negative individual reactions including anxiety and exogenous depression, and adoption of unnecessary and counterproductive policies concerning employees, their work roles and careers (e.g. immediate resort to dismissals, or gender discrimination when laying off staff).
- recommending appropriate holistic organisational/institutional adaptive behaviours, including organisational and unit structures (and their redesign), strategic planning and structural contingencies, appropriate staffing arrangements (including formal and informal social structures such as team size and relationships, and staff management and leadership), and designing and/or assisting with the delivery of appropriate staff training programs and other "organisational development" activities,
- providing input into the design of work tasks, technology and associated social systems from a "human factors" perspective,
- human resource management issues (e.g. personnel selection, job satisfaction), and aspects of industrial relations (e.g. conflict resolution and mediation),
- occupational health and safety issues from a psycho-social perspective (such as workplace causes of stress, important social and supervisory supports, and preventive/remedial actions),
- related matters (e.g. the management of psychological and some aspects of physical workplace injury and rehabilitation such as Return-to-work programs), and
- understanding and providing guidance especially to adolescents and their parents about occupational issues such as sense of vocation, occupational choice points, entry requirements and pathways, typical career stages and patterns, personality and work motivation patterns in different occupations, gender problems occupationally (e.g. the "glass ceiling"), work-family balance, career and lifestyle change and so on.

Because we do not work as health psychologists in health care delivery systems, we believe we can provide fresh and different perspectives to the Inquiry. This input may be of assistance to the Inquiry, in reviewing the development of this very important proposed national regulatory scheme, from a broad holistic perspective rather than just in terms of health issues.

In doing so, we do not speak on behalf of (or contrary to the views of) our parent body, the Australian Psychological Society (APS) or its other Colleges.[14] Ours is a specialised submission, concentrating on "beyond health care" psychological services, as exemplified by Organisational (including Industrial and Occupational) Psychology services.

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[12] Our College has a number of functions including running national biennial Industrial and Organisational Psychology Conferences with large attendances including many overseas colleagues.

[13] The term Organisational Psychology also encompasses Industrial and Occupational Psychology.

[14] We have already contributed in considerable detail to its submissions to the Practitioner Regulation Subcommittee and earlier consultation processes.

3.2 *Our view of the evaluation context and task for the Inquiry.*
The regulatory scheme is "a work in progress", with much still undecided (or at least unannounced), hence it is difficult to evaluate its progress. The development of this national regulatory scheme encompasses many complex questions and issues. These include competing interests (such as the not-so-obvious one of public sector c.f. private sector goals, value systems, regulatory needs, professional work and employment systems, and standards such as performance expectations and norms). The importance and inter-meshing of many of these matters were not apparent in the early stages of the project. Indeed some are still being identified.

Further, projects of this "grand scale" kind cannot be completed quickly or uncontroversially. Any evaluation must recognise these features.

It must also be accepted that "best guesses" (or "working hypotheses") must be made by the working parties developing the legislation and administrative systems for the regulatory scheme. What they are proposing is generally untried and experimental.

The national system cannot be seen as simply an extrapolation from or a hybrid form of the existing State/Territory systems, which have long had significant defects. See as a prime example the defects identified in the Second Reading Speech in the Queensland Parliament for the introduction of the Health Practitioner Tribunal, a new part of the County Court designed to rectify some of the shortcomings in the Queensland health regulation legislation and administration. (Relevant extracts from that Second Reading Speech are attached as Appendix A, as are extracts from the Explanatory Remarks for the introduction of the (Queensland) *Health Practitioners (Professional Standards) Bill 1999*, explaining some of the defects in the profession-specific legislation.)

Nor does overseas experience of similar regulation provide models to be followed in much detail here, although there are certainly important lessons to be learned. Thus some risk is inherent in the scheme being designed. Of course the risk must be minimised. Administrative and legal expediency should never be used as arguments to justify adoption of systems (including legislation) that predictably will damage individuals and their civil and legal rights.

This makes it imperative that the scheme is not set in concrete legislatively or in other ways, and that an *"institutional learning and adjustment"* paradigm is adopted now and down the track.

This paradigm is outlined in the OECD publication *"Designing Independent and Accountable Regulatory Authorities for High Quality Regulation" (2005).* An *"institutional learning and adjustment"* paradigm involves: "open" data-based, rather than "closed" prescriptive thinking; comparative studies; mutual learning exchanges; and careful analysis and planning taking into account regional complexities and idiosyncrasies.

In an *"institutional learning and adjustment"* paradigm applied to this national project, rapid identification of problems, *including and especially unanticipated ones beyond the health sector,* should be of crucial on-going importance. The parties involved must *"follow where the data lead",* however inconsistent with their expectations the data may be, i.e. policy directions are evidence-driven, and evidence and data are not policy-driven (i.e. selected to support political or ideological agendas).

The OECD report strongly favours fully independent regulatory authorities, unlike the current Australian scheme where the regulators are to be part of the apparatus of the "state", not independent of it. In effect one of the major sets of employers of health professionals (State/Territory and Commonwealth Departments of Health or Human Services) are to administer and oversee the national and jurisdictional regulation of those professions, with obvious (but so far unaddressed) dangers of conflicts of interests.

We see the Inquiry as an important part of this paradigm. It provides *inter alia* a most desirable degree of independent scrutiny of the government working parties' plans and proposals.

3.3 *What is our sense of the progress made so far?*

3.3.1 *Only the health sector has responded to calls for submissions.*

Thus far (we consider) the regulatory scheme is being developed expertly *from a "health systems" perspective*, with detailed and careful attention being given to most key questions as they emerge and to consultation with health stakeholders. The consultation papers have been well-crafted, and calls for submissions have been widely publicised within the health sector.

However respondents to those calls have been almost exclusively from people and institutions (including professional associations) functioning in the health sector. The very low number of contributions from other sectors, whose functioning will be affected significantly by these regulatory developments, should surely be a matter of some concern. It is likely that the non-health sectors do not know of the project or do not appreciate the import of the proposed scheme for them (seeing it as "health business"), rather than they do not care about it.

In Appendix B we outline some of the portfolio areas in government (federal, State/Territory and local) where valuable "beyond health care" psychological services are delivered, either through salaried employment of psychologists, or contracted-out arrangements. This outline shows (we submit) the strong relevance of the regulatory developments to government (and contracted-out) portfolio areas beyond the conventional "health" portfolio. Yet no commentary has been received (so far as we know) from those portfolio areas.

3.3.2 *Insufficient feedback to stakeholders.*

The communication loop has not been fully closed. Subsequent to those calls for and receipt of submissions, decisions appear to have been made by the working groups (or higher) on some features, without adequate advice to the public or adequate feedback to the recognised stakeholders.[15]

Thus it is not possible to identify with any certainty which features are now decided, and which are still open to debate. This leaves potential contributors uncertain about how to proceed, or what may be supported or fairly criticised, and may undermine their motivation to do the large amount of work required in responding to further calls for submissions on specific topics. "Submission fatigue" may indeed have already set in.

[15] Chosen almost exclusively from the health sector including "community representatives", but with some higher education sector representatives.

3.3.3 Despite our general endorsement of the consultation process, for the "beyond health care" fields of Psychology there are serious problems that have not yet been carefully addressed.

Of course the much-needed and -valued health reform process should not be derailed. But unintended damage caused by the regulatory proposals must be sensed and acted upon, and also the potential benefits and synergies from an holistic approach of value to us all must be captured. The linkage between the regulatory proposals and the overall reform plan is not a tight one: there is still time to prevent the damage and achieve the benefits, without delaying the overall health reform program.

The potential positives are real and substantial. For example, the involvement of "beyond health care" senior public servants (including from the Australian Bureau of Statistics) in workforce planning for governments' service delivery to the whole community is surely vital for an expert, comprehensive and hopefully accurate forecast of professional employment needs. Such involvement was commended as far back as in the 1994 book *"Better Health Outcomes for Australians"*, published by the Commonwealth Department of Human Services and Health under Minister Dr Carmen Lawrence.

At present, in the health systems, workforce needs analysis tends to be little more than an aggregation of rough and short-term workforce estimates by hospitals, clinics, health departments and the like. The absence of valid, comprehensive and properly-structured data and inconsistent definitions (especially of "psychologist") have been noted as seriously problematic by the CoAG/AHMC working groups and other bodies. The Australian Health Workforce Advisory Committee in its *"The Australian Allied Health Workforce –An Overview of Workforce Planning Issues, AHWAC Report 2006.1, Sydney"* did not include Psychologists (even "health" psychologists) among its "allied health workforce" analyses and projections!

The very important issue of loss of trained professionals from the health sector into the other sectors (and vice versa) seems not to have been considered, at least in the consultation papers. The issue of professional "talent retention" is not mentioned at all.

In Psychology the registration boards and the APS have embarked on collection of employment data through the registrants themselves, a major improvement on past very inadequate surveys. But even this (while very valuable) is not enough. Registrants are generally not privy to the workforce plans of their employers, hence this survey cannot generate projections about aggregate future workforce needs from an employer perspective (except perhaps where a registrant is also an employer of fellow psychologists and is able to comment as an employer on her/his likely future workforce needs).

Current employment statistics reflect the cumulative effects over decades of past staffing (and other) policy decisions and other factors, and do not foretell future workforce needs. This is especially so where there is environmental volatility and turbulence affecting the main drivers of workforce needs and creating a break in the actuarial trends of the past.

We urge the Inquiry to commend to governments that a "whole of profession", "whole of government", and "whole of community" approach be adopted, in place of the current preoccupation with just the health systems.

Below we make specific recommendations about the practical implications of that holistic approach.

3.3.4 <u>What is our preliminary evaluation of the project against specific CoAG and AHMC goals and criteria?</u>

As the Inquiry is well aware, CoAG and AHMC promised the public and the 10 professions affected (including Psychology) a national registration scheme that would give them:

- A national register for each profession.
- A streamlined and uniform complaints avenue for all complainants.
- Mobility around the country.
- Reduced red tape and bureaucracy.
- National course accreditation.
- Expert workforce planning.
- But (by implication and oral assurances at least) no political interference in course accreditation or professional standards-setting.

In our assessment, these promises – other than the first (a national register) - are not being fully delivered by the COAG/Health Departments' working parties charged with developing the new structures and systems! (See Appendix C for an outline of the complex CoAG/AHMC structure of committees and working groups.)

Taking those promises in turn:

- A national register will no doubt be developed (a contract has already been advertised for its construction), but the associated protection of the public will be reduced for Psychology. The benchmark here must be the Psychology-specific acts that applied until some jurisdictions substituted generic "health template" regulatory legislation in pursuit of legislative and administrative efficiency.[16] The generalisation "health professional" does not fit many psychologists, and many psychological services cannot be classified as "health care". Thus in most of those jurisdictions, clients who receive "beyond health care" psychological services no longer have a clear complaints avenue for <u>serious</u> complaints that may lead to the deregistration of a psychologist, or her/his suspension from practice.

  How is this so? It was decided by CoAG in the InterGovernmental Agreement (IGA) that (despite the provisions and broad powers later set out in the new Act) the proposed new national scheme will retain the separate jurisdictional complaints arrangements. Consequently the incomplete complaints coverage in those arrangements will be preserved, at least for serious complaints. (*Minor* complaints about "beyond health care" services could, we understand, probably be legitimately investigated by the proposed Psychology Board of Australia, although even that might be susceptible to legal challenge.) The exception appears to be Victoria, where the Victorian Civil and Administrative Tribunal seems able constitutionally to deal with "business regulation", and hence with complaints against any type of psychologist and appeals relating to them, presumably provided that they are registered as a company. (Partnerships, for example, may not be covered.) This means an even more complicated, and legally ambiguous and uncertain, complaints system, with continuing significant jurisdictional differences interacting with attempted national complaints processing by the Psychology Board of Australia.[17]

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[16] Of arguable success.

[17] As an example of complexity, just the Explanatory Notes to the (Q'ld) Health Practitioners (Professional Standards) Bill 1999 were 71 pages long! (See Appendix D.)

- Mobility of practitioners will continue to be inhibited by the different legal requirements in the different jurisdictions, including but beyond complaints procedures (e.g. police checks for working with children). In the past, multiple registration (in more than one jurisdiction) has been formally required of psychologists (particularly affecting organisational psychologists), "criminalising" professionals who function nationally without the approval of each jurisdictional registration board. A national register should overcome such problems, but it is not clear that it will in fact do so, or how.
- A large new bureaucratic structure is apparently being built on top of the current State/Territory systems, not in place of them (see Appendix C); and will predictably be unwieldy, complex and expensive. Red tape is sure to increase, as probably will the fees charged to registrants. The expectation seems to have developed that the costs of regulation, course accreditation and health workforce planning - essential government functions - will be paid for by registrants ("cost neutrality"). This expectation appears to have led to a less-than-restrained attitude by the planners to staffing levels in the new bureaucracy. The Australian Government's own Guidelines for Cost Recovery seem not to be in systematic and transparent use by the planners.
- As outlined above, workforce planning will focus only on health system needs (hospitals, clinics, etc.), ignoring the needs of important non-health sectors and types of psychological service delivery.
- State/Territory Ministers of Health and their public service staff, typically untrained in Psychology, will be able to influence the setting of professional standards for Psychology through the mechanism of course accreditation or in other ways.

For Psychology programs, effective and efficient course accreditation is already being undertaken nationally in collaboration between the Australian Psychological Society and the Council of Psychology Registration Boards. Our views about the course accreditation issues are explained in greater detail in Appendix E.

3.4 *Our services are not "health care" services.*
Most psychologists do not have Provider Numbers (unlike the members of the other professions being regulated).

Organisational Psychology and other *"beyond health care"* services are not *"health services"* as defined by the ATO, hence are not GST-exempt.

Nor do they qualify as Medicare-rebatable items.

For Organisational Psychologists at least, but also for many other *"beyond health care"* psychologists, their services are received by groups or organisations, via their representatives (e.g. a CEO, a Human Resources Manager or a judge or magistrate), not by an individual "natural person" in need of "health care". The term "patient" (used in health systems) is foreign in our contexts, as is "intern" as a label for probationary registrants completing two years of professional supervision[18].

We stress that nonetheless our work is of sufficient risk to the public that it should continue to be regulated. Poor performance (e.g. misassessing structural problems that might be leading to dysfunctional interpersonal tensions in work groups, or using the wrong assessment tools) or ethical breaches (such as unauthorised release of psychological test data or confidential personal information) may lead to many serious problems, for individuals, work groups, organisations and communities.

[18] Except apparently in NSW in recent times.

A broader description of our work appears in Appendix B. Our suggestions about how to deal with the problems arising from our misclassification as “health professionals” appear below.

3.5 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.
- 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.

3.6 What would they involve or require of Governments?

Our objectives can be readily met if there is acceptance of the problems and the motivation to develop solutions. We would hope that our concerns about the erosion of our types of professional services, and of our clients’ access to complaints and appeal avenues, are not brushed aside as “unfortunate but unavoidable collateral damage” in a major health reform drive.

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

- 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.)

- 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 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.

The professional society (the APS) should of course also be consulted, such as regarding its membership growth and how the various areas of practice are developing.

(END OF SUBMISSION. APPENDICES FOLLOW.)

LIST OF APPENDICES

A: **Ministerial Second Reading Speech for the Queensland Health Professional Tribunal and Extracts From The Explanatory Notes For The (Queensland Health Practitioners (Professional Standards) Bill 1999**

B: **Some Illustrative Government Portfolio Areas Where "beyond health care"Psychological Services Are Employed.**

C: **The CoAG/AHMC Structures (Current and Proposed) Involved in the Regulation of the Health Professions.**

D: **Legal and Legislative Issues and Dilemmas Involved in the Regulation of Psychology.**

E: **Course Accreditation Issues.**

APPENDIX A:

Ministerial Second Reading Speech for the Queensland Health Professional Tribunal and Extracts From The Explanatory Notes For The (Queensland Health Practitioners (Professional Standards) Bill 1999

Extracts from Ministerial Second Reading Speech:

Second Reading
Hon. W. M. EDMOND (Mount Coot-tha—ALP) (Minister for Health) (10.42 a.m.): I move—
"That the Bills be now read a second time."
The Health Practitioners Registration Boards (Administration) Bill and the Health Practitioners (Professional Standards) Bill represent the first stage in the comprehensive reform of 12 Acts and 15 pieces of subordinate legislation which will deal with the registration of health practitioners in Queensland. These Bills address, in a generic way: the provision of administrative support to the health practitioner registration boards; the making of complaints about registrants; the investigation of complaints regarding registrants; the discipline of registrants; the management of impaired registrants; and the relationship between registration boards and the Health Rights Commission.

The Bill addresses a number of deficiencies in the existing laws related to the discipline of registered health practitioners. The Government considers that the disciplinary provisions of the existing Acts compromise the State's ability to protect the public in that—
the grounds for taking disciplinary action against registrants are too narrow;
the disciplinary actions which may be taken against registrants are limited and inflexible;
the boards' investigative powers are inadequate or non-existent;
the boards' powers to respond to imminent risks posed by registrants to the life, health or safety of others are generally inadequate; and the Acts do not dovetail with the Health Rights Commission Act 1991, creating the potential for delays and for professional standards issues to be overlooked.
Each of these issues is effectively addressed by the Bill.
In addition, the Government is concerned that the current Acts do not comprehensively set out the rights of registrants during the investigative and disciplinary processes or provide complainants with any rights during disciplinary proceedings. For example, complainants currently have no right to attend disciplinary proceedings which are triggered by their complaints. The Bill sets new standards in respect of the rights of registrants and complainants.
The Government also considers that the existing Acts are inflexible in that they provide only one process for dealing with disciplinary matters. With the exception of the medical profession, registration boards can currently only deal with disciplinary matters by way of an inquiry. This means that all disciplinary matters, regardless of their seriousness, are dealt with in the same way. Finally, the disciplinary provisions of the current Acts are not uniform.
They do not meet community or professional expectations, or conform with current drafting practice or fundamental legislative principles.
The Government has responded to health consumer demands for greater involvement in

the regulation of the professions by including members of the public and the professions on all disciplinary bodies established under the Bill. The Government has also responded to concerns about the limitations of the existing disciplinary arrangements by expanding the grounds for complaints and the grounds for disciplinary action against registrants.

Consistent with recent reforms in Victoria, in the future, disciplinary action may be taken against any registrant whose conduct is below the standards considered acceptable by the profession or by the community.

In addition, the Bill broadens the range of sanctions which may be imposed where a registrant satisfies the grounds for disciplinary action. For example, the capacity to impose conditions is a significant innovation for health practitioner legislation in Queensland. This reform enables a disciplinary body to impose a sanction which will limit a registrant's activities to the extent necessary to protect the public. This is clearly preferable to the imposition of a more onerous penalty which, in some cases, could go beyond what is necessary to protect the community.

The Bill requires certain disciplinary actions to be recorded on the board's register and provides a discretion in respect of the recording of others.

The Government considers that, in the absence of any competing public interest issues, the community is entitled to know the details of all conditions on a registrant's right to practise.

The Bill also establishes a flexible three-tiered disciplinary structure which will enable matters to be heard in a way which is appropriate to their severity. For example, minor matters will be dealt with by way of an informal but inquisitorial process by the registration board themselves.

The boards' powers to deal with these minor matters will be limited to cautioning, counselling and reprimanding registrants or entering into voluntary undertakings. The professional conduct review panels will deal with more routine disciplinary matters. The panels will have all the disciplinary powers of a board and an additional power to impose conditions upon a registrant's registration. It is intended that panels will operate in a relatively informal way and, where appropriate, a collaborative and redirective way, with the objective of determining whether a registrant satisfies the grounds for disciplinary action and, if so, the sanction which should be imposed to achieve the objects of the Act.

The Bill provides that, for the first time, all serious disciplinary matters regarding registered health practitioners will be heard by a Health Practitioner Tribunal constituted by a District Court judge. This significant innovation will ensure that disciplinary matters are dealt with fairly by a totally independent adjudicator.

This is a new jurisdiction for the District Court and this reform is evidence of the Government's commitment to the creation of a fair process for the protection of the community from misconduct by registrants.

The tribunal will adjudicate all cases of sexual

misconduct by registrants and other equally serious matters.

The Bill provides for disciplinary proceedings before the tribunal to be conducted in public unless there are special circumstances which warrant the proceeding or part of the proceeding being held in camera. While the Medical Assessment Tribunal has sat in public in recent years, there is no statutory requirement for this to occur. The Government considers that, unless there are special circumstances, it is in the public interest for all allegations of serious misconduct by health practitioners to be heard in public. Open hearings enhance public confidence in the regulation of the professions and have been effective in encouraging additional complainants to come forward. These additional complaints are often vital in securing appropriate disciplinary decisions.

The Bill provides, for the first time, a comprehensive approach to dealing with registrants who are impaired through alcohol or drug addiction or another mental or physical disability that affects their ability to practise. The Bill provides a two-stage process to deal with impaired registrants and the relevant provisions are designed to ensure a supportive and rehabilitative focus is available where this is appropriate. Importantly, all conduct which appears to provide grounds for deregistration or suspension, even if due to an impairment, must be dealt with by the Health Practitioner Tribunal.

This Bill also clarifies the respective roles and responsibilities of the Health Rights Commission and the registration boards and makes a number of amendments to the Health Rights Commission Act 1991 to address routine operational concerns raised by the Health Rights Commissioner. For the first time, there will be a coordinated and integrated approach to the management of health complaints about registrants. The Bill creates parallel grounds for complaint to the boards and the Health Rights Commission and requires consultation to occur in respect of various action decisions regarding registrants.

These strategies will ensure that professional standards issues are readily identified and dealt with appropriately.

Under the new arrangements, the principal responsibilities of the commission will be the receipt and assessment of complaints about registrants and the resolution of disputes through conciliation. In addition, the commissioner will have an enhanced role in overseeing investigations undertaken by the boards. The boards will focus on the protection of the public by investigating and initiating disciplinary proceedings for unsatisfactory professional conduct. Importantly, the reforms to the Health Rights Commission Act 1991 in respect of registered health providers will enable the commission to more readily carry out its statutory function of overseeing, reviewing and improving the health system.

The Bill also addresses operational problems with the Health Rights Commission Act 1991. The problems addressed are—

inefficiencies related to the receipt and consideration, and assessment phases of the Act;

the lack of power to refer complaints to other bodies at the conclusion of assessment;

the inability to take more than one action on a complaint; and

the inability to split complaints involving multiple issues or respondents into

component parts.
The Health Practitioner Registration Boards (Administration) Bill and the Health Practitioners (Professional Standards) Bill represent a milestone in the reform of the regulation of health practitioners in Queensland. The Bills enhance the regulation
of the professions for the benefit of the community as a whole. The Government wishes to acknowledge the efforts of many individuals and organisations who have worked
toward this important goal over the last six years. I commend the Bills to the House.
Debate, on motion of Miss Simpson, adjourned.

Extracts from The Explanatory Notes For The (Queensland Health Practitioners (Professional Standards) Bill 1999

GENERAL OUTLINE
Policy objectives of the Bill
The principal policy objectives of the Bill are:

- to protect the public by ensuring health care is delivered by registrants in a professional, safe and competent way
- to uphold the standards of practice within the health professions
- to maintain public confidence in the health professions
- to establish a uniform approach to the handling of complaints about registrants, the investigation and discipline of registrants, and the management of impaired registrants
- to provide a system to deal with complaints about registrants that is complementary to that of the Health Rights Commission ("the commission") established under the Health Rights Commission Act 1991.

In addition, the Bill amends the Health Rights Commission Act 1991 to address various operational issues with the administration of the Act raised by the Health Rights Commissioner ("the commissioner").

Reasons why the proposed legislation is necessary
Currently, the discipline of registrants occurs under eleven separate health practitioner registration Acts, namely:

- Chiropractors and Osteopaths Act 1979
- Dental Act 1971
- Dental Technicians and Dental Prosthetists Act 1991
- Medical Act 1939
- Occupational Therapists Act 1979
- Optometrists Act 1974
- Pharmacy Act 1976
- Physiotherapists Act 1964
- Podiatrists Act 1969
- Psychologists Act 1977
- Speech Pathologists Act 1979

This legislation, which was enacted between 1939 and 1991, is not uniform in respect of the grounds for disciplinary action, the adjudicative processes or the sanctions which may be imposed where a registrant is found guilty of misconduct.

Also, the disciplinary provisions of the existing Acts do not meet community or professional expectations, nor do they conform with current drafting practice or fundamental legislative principles (for example, all boards rely on the application of the Commissions of Inquiry Act 1950 to undertake disciplinary proceedings).

The disciplinary provisions of the existing Acts compromise the State's ability to protect the public in that:

- the grounds for taking disciplinary action against registrants are unreasonably narrow (in comparison with jurisdictions such as Victoria--this issue is discussed below)
- the disciplinary actions which may be taken against registrants are too limited (for example, there is currently no disciplinary power to impose conditions on a registrant's registration)
- the boards' powers to investigate complaints and breaches of professional standards are inadequate or non-existent
- the non-medical registration boards have no power to immediately suspend or impose conditions on a registrant where there is an imminent risk to the life, health or safety of a person
- complainants have no statutory rights in the disciplinary process (for example, there is no requirement to notify complainants of disciplinary proceedings and no right for them to attend the proceedings).

An additional concern is that the current disciplinary provisions are not very detailed and, consequently, the rights of registrants during the investigative and disciplinary processes are not comprehensively set out.

The existing disciplinary processes are, arguably, unfair to registrants in that the non-medical boards both prosecute and adjudicate disciplinary matters.

The disciplinary provisions of the current Acts are also deficient in respect of inadequate external accountabilities. For example, disciplinary proceedings for the non-medical boards are not required to be open to the public and disciplinary decisions and the reasons for decisions are not required to be publicly accessible or otherwise reported. The Minister also no explicit power to require a board to investigate a complaint about a registrant.

The existing Acts are inflexible in that they generally only provide one process for dealing with disciplinary matters. With the exception of the Medical Act 1939, which establishes the Medical Assessment Tribunal to hear disciplinary matters regarding medical practitioners, registration boards can currently only deal with disciplinary matters by way of an inquiry (utilising the powers under the Commissions of Inquiry Act 1950). This means that all disciplinary matters, regardless of their seriousness, are dealt with in the same way.

The disciplinary provisions of the current Acts do not dovetail with the Health Rights Commission Act 1991 and this creates the potential for delays and increases the risk that professional standards issues will be overlooked.

Of particular concern are:

- the absence of parallel jurisdictions to accept complaints (the commission's jurisdiction to accept complaints is broader than the grounds for disciplinary action in some respects and narrower in others)
- doubts about the admissibility of the commission's investigation reports in board disciplinary proceedings and the inadequate powers of the boards to investigate disciplinary matters (currently, the commissioner may only refer a complaint

where he or she is satisfied the board has adequate functions and powers of investigation)

- deficiencies in the statutory consultation requirements (for example, the commissioner is not required to consult a board before making an "assessment" decision and a board is not required to advise the commissioner when disciplinary proceedings are being commenced); and inflexible referral requirements (for example, boards must immediately refer all complaints to the commissioner, including complaints which are more appropriately dealt with through intervention by a board to protect the public)
- also, the commissioner cannot refer complaints to a board without assessment--which causes unnecessary delays in matters being addressed.

The main operational problems with the Health Rights Commission Act 1991 addressed by this Bill are:

- inefficiencies related to the receipt and consideration, and assessment phases of the Act
- the lack of power to refer complaints to other bodies at the conclusion of assessment
- the inability to take more than one action on a complaint
- the inability to split complaints involving multiple issues or respondents into component parts.

(END OF APPENDIX A.)

APPENDIX B

Brief Descriptions of Some "Beyond Health Care" Fields of Psychology

As indicated earlier in this Submission, legal definitions (some archaic) construct a distinction between "health care services" and services that are not "health care". We do not like this distinction but are compelled to address it here.

Psychologists may provide one or the other type of service, or both. One class of service is not more meritorious, valuable to the community, or professionally demanding and risky, than the other. They are intertwined in many ways, and feed off one another conceptually and in terms of practice innovations.

But they also have some important differences. These are not simplistic, clear-cut or "black and white" differences. They are differences of emphasis, depth of expertise, and types of cognate knowledge prominently used (explained below), rather than entirely different areas of knowledge or skills.

In these respects they are similar to the differences among surgeons, radiologists, physicians, GPs, and so on in the medical field. The specialist fields are best regarded as branches of the one tree, rather than different trees. But the trunk is general psychology, not "mental health" psychology.

FAMILY SERVICES, EDUCATION AND EMPLOYMENT FIELDS

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. Thus they *inter alia* help to keep down the costs of Medicare, through their capacity to assist teachers and parents handle problematic children without referral to Medicare-rebatable private health care service providers (which referral - if not decided on sound professional grounds - may "medicalise" and externalise children's developmental issues without adequately addressing the "at-school" or family context, either causally or in the school's or parents' management of the child's problems and their causal context).[19] 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.

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

[19] Unfortunately (we hear anecdotally) such referrals may sometimes be made primarily as a form of cost-shifting from very limited school budgets to Medicare, and/or as an expression of a belief in contracting out specialist service delivery, rather than being the result of a sound professional assessment by a school psychologist.

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.

Our 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 Areas:

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.

For example, the T-bar aircraft landing system was designed by a psychologist with an aviation engineering background. This system uses visual perception principles to provide immediate and continuous feedback to the pilot about his or her flight path for the particular aircraft type, relative to the optimal for his/her final approach. It has operated very successfully over many years in landing fields in remote areas where it would not be economical to set up standard air traffic control arrangements.

Other 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. The major contributions of the highly-respected Monash University's Accident Research Centre provide an excellent example of such work and of psychologists playing leading roles in these multidisciplinary contexts.

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.

MILITARY FIELDS

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.

In military contexts, selection is highly valued and its potential cost benefits are well known (e.g., training a military pilot to "wings" standard costs in the order of two million dollars, so that every pilot training failure incurs substantial costs that effective selection and training systems can help to minimise).

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.

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.

POLICE, FORENSIC, LEGAL, INTELLIGENCE AND JUSTICE FIELDS

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.

FINANCE FIELDS

What do "beyond health care" psychologists do in regard to the world of finance? They work in many "beyond health care" contexts, 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 (which stimulated the emergence of the European Democracy at Work movement, and has been transmitted to Australian contexts through the ACTU's document "Australia Reconstructed"), 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.

Please note that these are only samples (and incomplete descriptions) of the "beyond health care" fields of Psychology, intended to illustrate how they differ in focus from "health psychology". The Inquiry may obtain more complete descriptions from the relevant Colleges of the APS.

Also please note that many "beyond health" activities contribute - in addition to their own specific non-health outcomes – to health-related outcomes within workplaces, communities, and society in general. A number of World Health Organisation (WHO) publications and policy statements clearly recognise this double-barrelled contribution – see comments included in Appendix D of this submission. But this fact should not be taken as a rationale for deeming all psychological services to be "health care" ones, thus excluding the "beyond health care" services from effective regulation.

(END OF APPENDIX B.)

APPENDIX C:

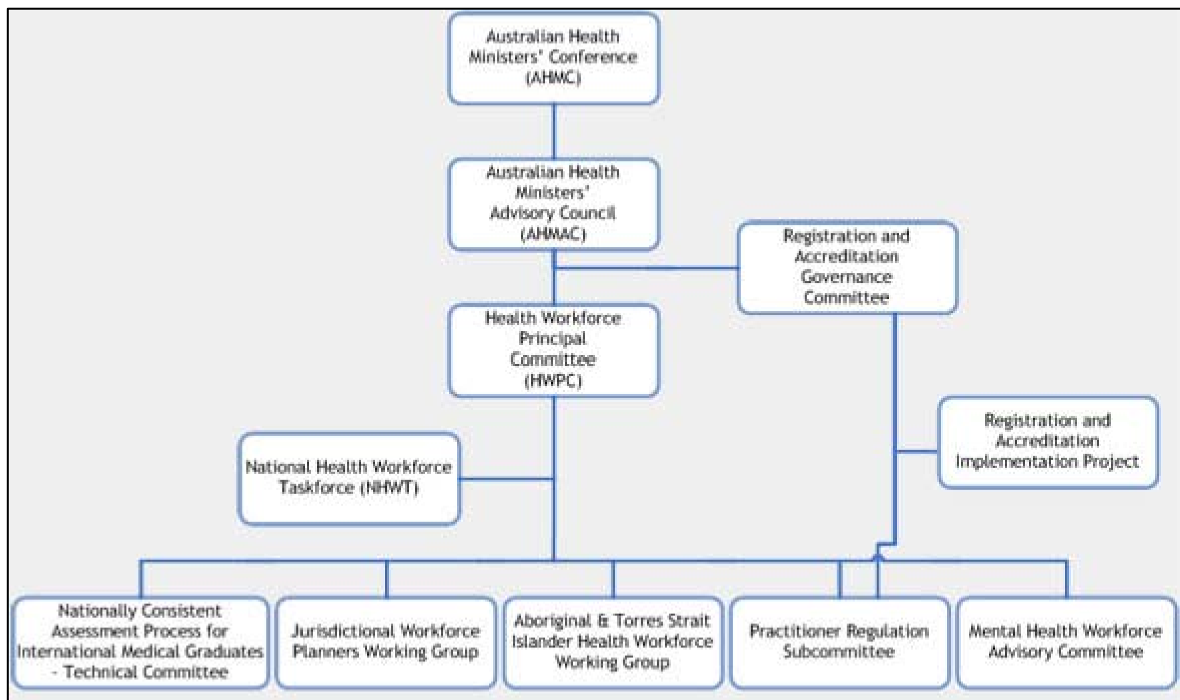
CoAG'S ORGANISATIONAL STRUCTURE FOR THE DEVELOPMENT OF THE NATIONAL REGULATORY SCHEME

As at 25 October 2008

Downloaded from:

http://www.nhwt.gov.au/documents/AHMAC%20Committee/AHMAC%20Workforce%20committee%20structure.pdf)

and other sources.



For a fuller picture, this diagram must be considered along with the diagram provided in the *"Consultation Paper – Supplementary Issues to IGA"* (available from the nwt website above). The diagram above seems to represent the governmental bureaucratic structure (temporary and permanent) for implementing the national health strategic framework (particularly from a "health workforce" perspective), while the Consultation Paper diagram is narrower and focuses on the permanent units of registration and accreditation to be established under the IGA.

In fact the only common units are the AHWMC and the AHWAC. The other units in the latter diagram are National Boards, National Committees, State/Territory committees, the Agency Management Committee, the National Office, and State and Territory Offices.

The following seem to be the key and/or new structural elements or modified units (titles and roles) in the first diagram.

Australian Health Workforce Ministerial Council (AHWMC - apparently new and separate from the Australian Health Ministers Council (AHMC) which may have been retitled Australian Health Ministers Conference?):

Comprises all health ministers (State/Territory and Commonwealth). Differs from AHMC in its specific focus on "health workforce" issues. *The registration of health professionals and course accreditation are taken to be "workforce" issues.*

Australian Health Ministers Advisory Council (alternative title Australian Health Workforce Advisory Council? The IGA's definitions use both titles but do not make clear whether they are the same unit or two different units):

AHMAC played the major role in forming and overseeing a group entitled the Australian Health Workforce Advisory Committee (date of establishment not known but has been active for some time). AHMAC is now required to provide advice to the above Ministerial Council on "matters relating to the scheme" – a change of or addition to function?

Members of AHMAC were appointed by CoAG initially and then by the Ministerial Council (AHMC), for 3-year terms. Membership: N=7: *"independent and eminent chair"* (not current or recent practitioner), and 6 other members *"of whom 3 should have appropriate health and/or education expertise".* To be funded by government.

The fate of the Australian Health Workforce Advisory Committee is not known. It may have metamorphosed into the AHWAC (Council, not Committee) above. It comprises/comprised a State health departmental secretary as chair, two nominees of the Commonwealth Dept of Health and Ageing, two nominees of the AHMAC, a nominee of the Aust. Institute of Health and Welfare, a nominee of the Aust. Medical Workforce Advisory Committee, two nominees of the Aust. Vice-Chancellors' Committee, a nominee of the Community Services and Health Skills Training Council, a nominee of the Commonwealth Department of Education, Science and Training, a nominee with "expertise in consumer issues", and three public service observers from the national Health Workforce Secretariat, the Aust. Institute of Health and Welfare, and the Aust. Health Workforce Officials' Committee – more on the last committee below.

Registration and Accreditation Governance Committee: We can find no information about this Committee.

The Health Workforce Principal Committee is a group of senior public service officials from Health departments in each State, Territory and the Commonwealth, chaired by the Secretary Dept. of Health and Human Services in Tasmania, 8? + Commonwealth representative(s), total N=10 or so. Its primary focus is *"national workforce policy and strategic priorities"* but its role is not restricted to the health workforce. It is also responsible for overseeing the regulatory developments as part of a reform agenda for the health workforce and its fit with health service delivery. It is examining ways of changing health care delivery systems as well as the nature of the health workforce.

Reporting to the HWPC is the National Health Workforce Taskforce, a significant if not highly visible player in the proposed regulatory developments, its brief being to "undertake project-based work and advise and develop workable solutions on workforce innovation and reform". Its job is to *"develop strategies to meet the National Health Workforce Strategic Framework outcomes which encompass:*

1 *Education and Training.*
2 *Innovation and Reform.*
3 *Planning, Research and Data.*
4 *Secretariat support for the HWPC, its subcommittees and working parties."*

It called for tenders (by 9th October 2008, through the Victorian Government) for *"a suitably qualified and experienced party to undertake a significant body of national health workforce research over a three-year period through a National Health Workforce Planning and Research Collaboration".* This appears effectively to be a "public-private partnership" arrangement over a three-year period. The focus is entirely on health systems, health policy objectives, and health workforce issues (using the term "health" conventionally).

The Registration and Accreditation Implementation Project:

We could find no detailed information about this Project or a project team but understand that it is headed by Dr Louise Morauta. It appears not to be a formal unit of organisation.

Practitioner Regulation Subcommittee:

This is a "bottom rung" operational unit currently calling for submissions re registration arrangements and complaints/performance/etc. Apparently also chaired by Dr Louise Morauta, it reports to the HWPC. Membership unknown but probably solely public servants.

Jurisdictional Workforce Planners Working Group:

Website says *"established to provide a forum for Commonwealth, State and Territory health departments to discuss workforce issues"*. Its role is *"to promote effective workforce planning by facilitating information exchange about nationally consistent approaches to workforce planning methodologies, process, strategies, projects and standardisation of date sets/information".* Terms of Reference and membership are apparently not finalised.

Health Care Workforce Advisory Committee:

No details known, including whether or how it relates to the Australian Health Workforce Advisory Committee (membership also unknown). It is possible that the latter has been disbanded, or that the MHWAC is a sub-set of the AHWAC.

AHWAC was part of a triad of committees overseeing *"a national health workforce work program of research projects …. designed to inform and guide national health workforce policy … funded from the AHMAC cost shared budget and report to AHMAC".* The other two committees were the Australian Health Workforce Officials' Committee and the Australian Medical Workforce Advisory Committee. The fate of these two committees is not clear. We suspect they have been or are to be closed down or transformed into another group or groups under the very recent restructure.

The other two "bottom rung" committees: appear specialised and *may* not be directly relevant to registration, course accreditation or other matters of current concern.
IMPLICATIONS:

A large, multi-layered and complexly differentiated health-focused regulatory bureaucracy has been created, including (not discussed above) the retention of much of the previous State/Territory regulatory structures (especially their disciplinary/complaints hearing processes and structures), "integrated" by an overarching framework of joint State, Territory and Commonwealth groups, some old, some new.

Whether this "patchwork quilt" will work effectively and efficiently, or simply be even more complex, differentiated in functions, unwieldy and costly than the previous structure will be a

matter of experience. The new system is at this time opaque to the average member of the public or professional.

(END OF APPENDIX C.)

APPENDIX D

LEGAL AND LEGISLATIVE ISSUES AND DILEMMAS IN THE REGULATION OF "BEYOND HEALTH CARE" PSYCHOLOGISTS

A WE ARE NOT "HEALTH PROFESSIONALS" AND THE LAW SHOULD NOT SAY THAT WE ARE:

A1: Definitional Problems:
The legislative definition of all psychologists as "health professionals" providing "health care services" is, in our view, most confusing to the public (turning back the public education clock to reinforce the old misperception of Psychology as akin to psychiatry), unacceptable to us (including on ethical grounds), meaningless to our clients, and quite dysfunctional for registration, course accreditation and workforce planning purposes in our areas.

Thus we have major concerns about being regulated under the rubric of "health professional".

There are multiple legal definitions of the terms "health professional", "health care" and "health service", depending on the relevant pieces of legislation and their purposes. But whatever they may be, none sensibly applies to "beyond health care" psychologists and their services. Even the new Act (the *Health Practitioner Regulation (Administrative Arrangements) National Law Bill 2008*) does not remedy this ambiguity. It refers frequently to "health practitioners" and "health services", without defining them. "Psychology" is designated as a "health profession", but this does not necessarily mean that ***all*** of Psychology is so defined, or (more significantly) that all psychological services will be interpreted by the Health Care Complaints Commissioners or external tribunals as "health care". (Those Commissioners and tribunals operate under different legislation.)

Even the Queensland *Health Quality And Complaints Commission Act 2006,* which makes perhaps the most careful and most recent attempt at definition and listing of "health service", "health service provider", etc., does not cover non-health psychological services.[20] Psychological services such as senior executive testing and interviewing, are not directed at the "human benefit" of an "individual". Psychologists are not listed as a designated profession in Schedule 1, although they are indirectly included by the listing of the Psychologists Registration Board in Schedule 2, and even more indirectly covered if they provide opinions in regard to a claim under the Workers' Compensation and Rehabilitation Act 2003, or "*for the purpose of a notice, order, or appeal under the Workplace Health and Safety Act 1995*".

For the Health Care Complaints Commissioners in the States and Territories, those terms are narrowly defined, and must be if the complaints system is not to be clogged with excessive number of cases and potential for challenges to the HCCCs' powers if the definitional net were to be cast widely.

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[20] "Health service" is defined as:

"8 Meaning of health service
Health service means--
(a) a service provided to an individual for, or purportedly for, the benefit of human health--
(i) including a service stated in schedule 1, part 1; and
(ii) excluding a service stated in schedule 1, part 2; or
(b) an administrative process or service related to a health service under paragraph (a)."

At least one Health Care Complaints Commissioner (Tasmania) has reportedly rejected a complaint about grief counselling on the valid grounds that grief is a normal human experience, not a health defect requiring "health care".

This was so despite the relatively broad approach taken there to "health" matters. In 1997 the Minister announced the establishment of this office thus: *"The Health Complaints Commissioner is independent of the State's hospitals and the Department of Community and Health Services. It has the power to investigate and conciliate complaints. It has the right and authority to make recommendations on the delivery of health care services across the State. It can deal with complaints from both the private and public sector not only those traditionally recognised as providers of health related services but also providers of alternative health care and diagnostic services such as naturopathy, massage or acupuncture."*

What would be a Health Care Complaints Commissioner's view (or an external health practitioner tribunal's view) about the acceptability of a complaint concerning (for example) the redesign of work systems using Socio-Technical System concepts and methods, if an individual service to a bereaved person is not considered a "health service"?

Thus the legal device of defining psychologists as health professionals "because the act says so" (regardless of reality) just does not work if complaints are to be dealt with under separate legislation empowering the HCCCs or higher order tribunals who will make up their own minds about how far to cast the definitional net.

To say that we are all "health professionals" providing only or mainly "health care" services requires a stretching of the legal terms "health" and "health care" to the point of legal absurdity. For example, in Victoria it was seriously suggested that practising "non-health" psychologists such as organisational psychologists could be registered as "non-practising health professionals", a double error of classification. A provision in the Victorian Health Practitioners Act 2005 appears to implement that suggestion. However subsequent legal advice is that the Victorian Act is obscure on the professional roles that non-practising professionals can undertake.[21]

We understand that there is considerable difference of legal opinion on the acceptability of stretching legal definitions beyond their conventional meaning, even acknowledging that the law may call a horse a camel. Certainly the judiciary object to having to work with absurd legislation.

Health Practitioners Act 2005 Victoria

11Non-practising registration

S. 11(1) amended by No. 25/2007 s. 10.

(1) A person who is entitled to or eligible for registration under section 6 but who does not intend to practise as a health practitioner or to provide regulated health services of the type that the person is qualified to provide under section 6 or 7 may apply to be registered as a non-practising health practitioner.

S. 11(2) amended by No. 25/2007 s. 10.

(2) The responsible board may register a person as a non-practising health practitioner subject to the condition that the person is not to practise as a health practitioner or to provide regulated health services of the type that the person is qualified to provide under section 6 or 7 during the period of registration and any other condition imposed by the responsible board.

(3) The responsible board must not impose a condition on the registration of a non-practising health practitioner under this section relating to professional indemnity insurance.

Such stretching would clearly be a highly undesirable feature of a regulatory system whose objectives include education of the public and crafting clear legal definitions in order to enable and enhance public protection and provide a clear complaints avenue.

A2: Protection of the title "psychologist":
Protection of title has also proved more difficult to achieve than first thought. In the ACT's health professionals registration act, the legislative drafting attempt to deal with these definitional problems by using a high degree of specificity led to the title "psychologist" not being protected at all: only the term "registered psychologist" was protected. Even in Victoria, it *may* not be an offence under the Act for an unregistered person to say "qualified to practise Psychology" (where this is a true statement) providing that there is no claim to being a registered health professional.[22] However this advice *may* be at odds with s. 80 of the Victorian Act.[23] Caveats abound here, as these interpretations have not been tested in the courts.

A3: Perceived irrelevance of a health complaints avenue:
The absence of complaints against organisational psychologists in the past does not signify perfect professional practice by us. It simply reflects the perceived irrelevance to our clients of a health care complaints avenue administered by a State or Territory Health Department. Our clients clearly indicate that they see a "health" complaints avenue as quite inappropriate for their kinds of complaints.

B: IN THE CRAFTING OF REGULATORY LEGISLATION, THE FOLLOWING ISSUES AND DILEMMAS ARE PROMINENT.

B1 *Psychology Is Not Just About Abnormal Behaviour And Mental Ill-Health:*
Psychology canvasses the full spectrum of human behaviour from the normal to the abnormal, and from the individual (and the underlying physiological and biological bases of individual behaviour) to the group, organisational and society/community levels. But many people still adhere to the misperception that Psychology is only about the individual's mental health, especially the diagnosis and treatment of mental *ill*-health.

Legal developments should not cement in this misperception. In fact they should "move with the times" and anticipate developments ("be ahead of the game").

Organisational psychologists in particular (but not exclusively) function across a number of levels of analysis and action (group and team, organisation, industry, community, and society),

[22] Advice from then-Registrar Mr David Collier.

[23] **Claims by persons as to registration**
s. 80

(1) A person who is not a registered health practitioner must not intentionally or recklessly—

(a) take or use the title of "registered health practitioner" whether with or without any other words; or

(b) take or use a title, name, initial, symbol, word or description that, having regard to the circumstances in which it is taken or used, indicates or could be reasonably understood to indicate—

(i) the person is a health practitioner in a regulated health profession; or

(ii) the person is authorised or qualified to practise in a regulated health profession; or

(c) claim to be registered under this Act or hold himself or herself out as being registered under this Act; or

(d) carry out any act which is required to be carried out by a registered health practitioner by or under an Act; or

(e) claim to be qualified to practise as a health practitioner in a regulated health profession.

using multi-level perspectives, theories and methods that are essentially about "normal" human processes much more than about "abnormality".[24]

Legal definitions about types of services and types of practitioners must be sensitive to these various levels of professional work. It should not be assumed for legal purposes that psychological services are only delivered to fragile individual "patients" who are seeking help with mental disorders or serious problems of functioning. They are not the only people at serious risk if professional services are incompetently or unethically delivered.

B2: *Differences In "Cognate Fields Of Knowledge":*
Because Organisational Psychologists often work in multidisciplinary ways and contexts, they must know about relevant cognate fields, e.g. they typically or often have (in addition to their training in Organisational Psychology) **"cognate field knowledge"** such as about business management theory, relevant aspects of engineering (e.g. production systems), economic systems (globally as well as locally), administrative theory and administrative law, industrial sociology, industrial relations, and so on. Although some of this "cognate knowledge" is taught in our general undergraduate degrees (e.g. the physiological and biological bases of behaviour) or in our specialist post-graduate courses, much has to be acquired "on the job" as part of supervised professional experience and subsequent independent practice, or through specialist CPD.

By contrast, health psychologists need to have a working knowledge of cognate fields such as medicine, psychiatry, health economics, and mental disorder, disability and impairment assessment systems (such as the DSM volumes and the ICD system of appraisal and categorisation of mental disorders, and the American Medical Association's protocols for impairment assessment – AMA5 being the latest), etc.

Other "beyond health" psychologists also have their own important sets of "cognate knowledge". (The following illustrative descriptions of just two other areas of professional practice are offered with apologies to our colleagues for any significant defects in our very brief descriptions.)

- Educational psychologists need to know about teaching-learning issues, educational systems, their structures, management and funding, involvement of parents in school councils, legal concepts of "duty of care", welfare systems and referral procedures, and so on.
- Forensic psychologists need more than passing acquaintance with the law (especially but not solely criminal), police forensic work, court-related issues especially expert evidence requirements, disability and impairment assessment systems, etc.

Regulatory legal terms, provisions and systems must recognise (but not rigidify and cement in) these intra-profession differences, and nurture them.[25] If they fail to do so, health-preoccupied regulators will fail to see that organisational (and other "beyond health") psychology qualifications, cognate knowledge, and experience are valid, and will want all registrants to

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[24] Industrial and organisational psychology has been a discipline for over a century and has had a significant contribution in areas such as psychometrics, motivation theory, leadership theory, group and team behaviour, models for predicting and measuring behaviour and job performance etc.

[25] There is much overlap in professional work and the "cognate knowledge" that individual psychologists have acquired. For example, many Organisational Psychologists know about workers' compensation systems and assessment methods and work in that sub-field and in rehabilitation. The descriptions above are intended only to illustrate the point that significant differences in "cognate knowledge" exist among the main fields of professional practice, a point overlooked by our jurisdictional regulators. We have indicated the main combinations merely for illustrative purposes, without asserting clean-cut divisions among the different types of psychologists or that these patterns of cognate knowledge form the basis of separate scopes of practice.

have or develop only the professional and “cognate fields” knowledge and skills of health psychologists (as is now happening in some jurisdictions).

In particular, course content and CPD must not be restricted to the “health” areas of psychological knowledge and cognate knowledge, and associated assessment and intervention skills.

Also the legal language must fit the profession if it is to be credible and meaningful, and not be a source of cognitive dissonance or confusion for all involved (including the public trying to access psychological services or make a complaint about them).

B3 *Practitioner Mobility, Employment Titles And Client Characteristics Issues:*
Organisational Psychologists are much more mobile than most other types of psychologists. We do not sit in a private clinic or hospital waiting for a worried person to ask to see us or be referred. We go to our clients, working with them in their environments and on their premises, whether that be in Melbourne, Darwin, Canberra, Asia, etc.

Our clients are not ill, or experiencing problems of personal functioning. They are often high-functioning people such as CEOs or senior executives of large companies or government bodies (usually national and often multinational), seeking our (evidence-based and theoretically sound) help to address major organisational issues such as:

- restructuring to adapt better to external turbulence or volatility at industry or broader levels,
- improved staff selection,
- better-focused and effective leadership training, or
- better design of work systems and technology to suit the operators individually and collectively.

Organisational Psychologists contribute in these and other ways to the functions of governments at all levels (Commonwealth, State/Territory and local) as well as extensively in the private sector.

Many other clients are well-functioning people wanting advice or counselling about career development, skills development regarding “people management”, enhancing their work or sporting performance, handling stress at work, and so on.

Regulatory legal definitions and provisions must be sensitive to these differences, and not use only the language of health systems or apply narrow, health-derived mental models about professional practice. Practitioner (and client) mobility and diversity must be recognised.

In our assessment, the current proposals do not recognise adequately this need for breadth. As but one example, the question of whether psychologists employed by the Commonwealth (especially but not only in “beyond health” areas) are to be exempt from national registration has not, to our knowledge, been addressed.[26]

A second example is that the regulatory planners have not (transparently at least, if at all) examined the problematic jurisdictional registration boards’ approaches to “recency of practice”. These are health-focused, and do not recognise that psychological knowledge and

[26] In some jurisdictions (e.g. Queensland), attempts are made to “rope in” Commonwealth service providers but limitations on powers exist here that are recognised but not elaborated in the legislative wording.

skills are frequently exercised by psychologists whose formal position titles do not include the word "psychologist". Hence many such qualified psychologists would be declared not to meet recency of practice requirements, with serious negative consequences.

B4: Some Important International Perspectives:

The World Health Organization (WHO) *'Declaration on Workers Health' (2006)* includes the following statements which indirectly yet powerfully support our recommendation for a "whole of community/whole of government"/"whole of profession" approach to the regulation of Psychology:

"Para 9 – There is increasing evidence that workers' health is determined not only by the traditional and newly emerging occupational risks, but also by social inequalities, such as employment status, income, gender, and race, as well as by health-related behaviour and access to health services. Therefore, further improvement of the health of workers requires a holistic approach, combining occupational health and safety, with diseases prevention, health promotion and tackling social determinants of health and reaching out to workers families and communities.

Para 10 – We are aware that many solutions to health problems at work lie beyond the scope and capacities of the health sector. There is potential to prevent and solve many problems through incorporating workers health into the policies on employment, social and economic development, trade and environmental protection."

If this whole regulatory scheme is intended to enhance the nation's health outcomes (as intimated in the Productivity Commission's Report 2005 in response to the ageing of our population and other threats to national productivity), this WHO statement identifies that non-health players clearly have a role to play in a more holistic approach to community health (in this example, workplace health), through policy development and practice in non-health sectors such as employment, family and community, and the like.

Similarly, the International Labour Organisation's (1985) *'Convention 161 Occupational Health Services Convention'*, clearly identifies factors within the occupational health space that are traditionally the province of organisational psychologists, not health psychologists (eg, *'advice on planning and organisation of work, including the design of workplaces'* and *'development of programmes for the improvement of work practices'*).

Rantanen (2005), President of the International Commission on Occupational Health, in response to priorities identified by the Joint ILO/WHO Committee on Occupational Health, published a paper entitled 'Basic Occupational Health Services', which includes the following passages:

"Occupational health is an important strategy not only to ensure the health of workers, but also to contribute positively to the national economies through improved productivity, quality of products, work motivation, job satisfaction, and contribute also to the overall quality of life of working people and society" (p.4)

In defining OH&S, Rantanen states that (p.6): *"OHS should be multidisciplinary by addressing not only health but also safety, ergonomic, psychosocial, organizational and technical aspects of work and working conditions …"*.

This definition of OH&S, crafted by one of the world's leading experts in occupational health, clearly delineates ergonomics/human factors, psychosocial and organisational elements from 'health' elements per se.

Other WHO documents on occupational health also refer to the importance of organisational / social climate in facilitating a healthy and productive workforce, and also non-workplace wellbeing (eg, WHO's (1995) *'Global Strategy on Occupational Health for All – the Way to Health at Work*'.

In summary, we hope that we have demonstrated here the complexity and diversity of modern Psychology as both a scientific discipline and a profession, and that its regulation as a profession cannot be effectively carried out under just a "mental health" model.

IMPLICATIONS FOR REGULATION

Important health care issues arise in most fields of Psychology, not just in the health sector, and may be handled by psychologists other than or as well as "clinical" or "health" psychologists. But this is no justification for the use of only a health care or mental health model for regulatory purposes. Many other "human behavioural" issues, of "normal" as well as "abnormal" kinds, are also implicated in the complex mix of services provided by psychologists, and are equally important for "good practice".

Simplistic terminology and categories do not capture this mix. The PBA must be constituted, and empowered, such that it can also use a "beyond health" focus as and where appropriate, and make flexible and tailored provisions for training, professional placements, CPD and (to the extent that it will be involved) workforce planning.

Thus the legal framework must be designed with these elements and needs in mind, particularly in regard to definitions, powers, delegations, or other flexibility provisions.

So far a reasonably flexible framework for the regulation of "health care services" and "health service providers" appears to have been crafted, but the same cannot be said about the jurisdictional-based regulatory provisions for "beyond health psychological services" and their service providers. These need much more careful attention and appropriate consultation.

(END OF APPENDIX D.)

APPENDIX E:

COMMENTARY ON THE CONSULTATION PAPER "Proposed Arrangements for Accreditation"

(dated 9.12.08)

The consultation paper adopts the definition of accreditation used by the Productivity Commission in its report Australia's Health Workforce (2005): 'the processes whereby education and training courses are assessed and evaluated in order to "guarantee" standards and consistency in health professional education and training' (p. 8). It later describes the purpose of accreditation as ensuring that 'graduates have the required skills,knowledge and competence to practise safely and meet registration requirements '(p. 9).

Still later the paper describes the linkage between accreditation and registration, noting that the two functions will be carried out under separate governance arrangements but both will ultimately be the responsibility of the relevant national board (p.17), to ensure that an applicant for registration with an accredited qualification is not denied registration on the grounds that his or her qualification is not considered adequate.

The paper is in six sections, with section 3 (10 of the paper's 21 pages) outlining the proposed new accreditation arrangements. It includes 23 proposals that give effect to the thinking outlined in the section. These proposals do not take up the question of transition arrangements outlined in the intergovernmental agreement (IGA) that forms the basis for the legislation. These arrangements provide for the Ministerial Council to assign accreditation functions to existing accreditation bodies, and within three years for the relevant national board to determine, in consultation with the accrediting body and the profession, the appropriate future arrangements and make recommendations to the Ministerial Council.

The comments that follow briefly summarise the proposals in section 3 and provide observations on them in the light of the profession of organisational psychology. Observations are in bold font.

Recognition of Specialities

The first three proposals in the paper take up the issue of specialist qualifications and the accreditation of specialist training courses. Proposal 3.4.1 provides for national boards to consider the need for specialist endorsements. Proposal 3.4.2 is relevant only to the medical profession. Proposal 3.4.3 implements the IGA in providing that once the national scheme is in operation additional specialties will require Ministerial approval. The paper notes that accreditation bodies will need to accredit postgraduate education and training courses for the purposes of specialist recognition. The paper further notes that approval of specialties for access to the Medicare Benefits Scheme will continue to be managed through separate Commonwealth processes.

An implication of these proposals, given the exclusion of Medicare funding as a possible source of confounding of the issue, would seem to be that Organisational Psychology can be recognised as a specialty under the national scheme with its own particular requirements.

Core Accreditation Functions

The next four proposals relate to the functions of accreditation bodies. These specify the core functions of accreditation bodies (3.4.4), the capacity of boards to delegate additional functions to accreditation bodies (3.4.5, 3.4.7), and the capacity of boards to expand the range of courses covered by accreditation (3.4.6).

The core functions include the development of standards, assessment of courses, assessment of overseas accrediting authorities, assessment of overseas qualifications where these are not otherwise accredited, and the process of 'internal merits and process review' of decisions made with respect to courses and institutions.

The question of assessment of courses is taken up later and it is simply noted here that if specialist recognition is to form part of the national scheme and this is to be implemented through accreditation of postgraduate education and training arrangement it is imperative that assessment of courses be undertaken by those with expertise in the particular specialty area.

Governance Arrangement for External Accreditation Bodies

Proposals 3.5.1, 3.5.2, 3.5.3, 3.5.8 relate to contracting between the board and the accrediting body for the provision of the accreditation function, including the matter of fees involved. Proposal 3.5.4 relates to consultation by the national agency with boards when the national agency is drawing up standards for registration and accreditation. Proposal 3.5.5 allows for delegation by an accreditation body and Proposal 3.5.6 requires that standards be published on a website. Proposal 3.5.6 requires that accreditation bodies consult widely when developing standards for accreditation. What 'consult widely' means is not delimited by any accompanying comment, and some specification of meaning, as is done elsewhere by referring to the profession and the community, would help tighten this proposal.

Although not part of a proposal, the paper notes that existing accrediting bodies assigned accreditation functions under the new scheme may need to change the ways they are currently constituted to provide for continuity beyond 1 July 2010 and to include representation from the community, education providers, and the professions. How the continuity matter is handled could lead to entrenching certain individuals or interests and more explication of this point seems desirable. The matter of wider representation calls for full discussion by all parties. In the case of the psychology accrediting authority, the profession or certain sections of it are already represented, but education providers have been specifically excluded in the past, and the question of representation by the community has yet to be considered.

Accreditation Committees

Proposals 3.6.1 through to 3.6.4 pertain to the situation where there is no existing accreditation body for a profession and thus seem irrelevant to psychology.

Review and Appeals

Proposal 3.7.1 provides the opportunity for 'any organisation' disadvantaged by an accreditation decision to seek an internal review of the decision and if still unsatisfied to seek an external review. Although the words 'any organisation' are used in the proposal the accompanying text narrows this to educational institutions.

Indemnity

Proposal 3.8.1 is concerned with providing indemnity for all bodies and persons involved in accreditation.

Accreditation Processes

Proposal 3.10.1 is directed to the national agency and requires it to consider the document "Standards for Professional Accreditation Processes" developed by Professions Australia, ways of ensuring that relevant international standards are met in accreditation, and the need to ensure that 'assessment panels' provide public accountability and independence. The Standards proposed by Professions Australia (to which the APS does not belong) are reasonably detailed but do not include anything that is not already familiar to educational

providers in Australia subject to regular quality audit by the Australian Universities Quality Agency.

The Standards take up the matter of assessment panels ('assessment teams' is the term used in the Standards): *"The accreditation agency describes the role and responsibilities of its assessment teams, the qualifications required, and the way in which the team composition is determined. It has policies on the selection, appointment, training, and performance review of team members. Its policies provide for the use of competent and knowledgeable individuals, who are qualified by experience and training, to assess professional education and training programs. The members of the review or assessment team should include a majority with a background in education or practice in the relevant profession and other skills appropriate to the specific assessment. The accreditation agency's policies provide for the institution being assessed to be informed about the proposed members of the assessment team and to have the opportunity to draw attention to potential conflicts of interest. The agency's policies describe how it manages conflict of interest in the survey team and confidentiality."* (Standards for Professional accreditation Processes, p. 5).

The consultation paper reflects these ideas in the text that accompanies Proposal 3.10.1. It notes that the expectation is that panellists are appointed through a process that is 'open and transparent' and that it is important to ensure that panel decisions are 'well informed'. If specialist recognition is to be part of the national scheme for psychology and if organisational psychology is to be recognised as a specialty, then the composition of panels for the assessment of programs in organisational psychology should have a majority membership of organisational psychologists, and decisions about these programs (subject to the normal appeal processes) should be influential in the registration process for graduates of these programs.

Relationship between Registration and Accreditation
Proposal 3.10.2 allows for ongoing monitoring of education courses in terms of their curricula and resourcing so that steps can be taken to ensure standards are maintained and prevent the situation of graduates completing a course in good faith and then failing to be registered.

Conclusion

The profession should support the provision for specialist recognition discussed in the consultation paper and the accreditation processes outlined that make this possible. Organisational psychology should be one of the specialties to be included and the profession should ensure that membership of the national board for psychology, its accreditation body, and particularly the accreditation panels that implement the assessment of programs adequately reflect an informed understanding of organisational psychology.

(APPENDIX E ENDS HERE)