

College of Organisational Psychologists

**Submission to
The Psychology Board of Australia
on
Consultation Paper 22:
The Review of the Requirements for General Registration,
Continuing Professional Development, and
Recency of Practice.**

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INTRODUCTION

The College of Organisational Psychologists, hereafter COP (a College of the Australian Psychological Society) wishes to make a submission to the Psychology Board of Australia (PsyBA) on three key areas of the regulatory framework for psychologists: general registration (GR) standards, continuing professional development (CPD) and recency of practice (RoP).

Our aim in this submission is to show how some of the Psychology Board's decisions about regulation, including GR, CPD and RoP, are reducing the flexibility and viability of Organisational Psychology as a sub-specialty of psychology in Australia. There are significant negative potential impacts arising from the loss of Organisational Psychology to the broader Business, Government and NGO community - in particular, the capacity of these Organisations to maintain effectiveness in an increasingly competitive and demanding (individually and collectively) global climate.

We hope to highlight that the application of psychological principles applies just as effectively to Organisations as it does to individual interventions and that these interventions are critical to the nation's capacity to compete in a global economy. This skill base, however, is at risk due to regulatory pressures which, by and large, can be moderated to enable the delivery of essential support to both individuals and organisations without effecting professional standards.

A more detailed commentary on all these matters is being made in the College's submission to the Independent Review of the NRAS. That submission is currently being finalised and will be forwarded to PsyBA when delivered to the Independent Reviewer.

OVERVIEW AND SUMMARY

Today is a time of increasing globalisation of industry, commerce, finance, education and other sectors and industries in Australia, requiring sophisticated understanding of the volatile nature and dynamics of complex socio-technical and socio-political systems, effective public and private sector leadership and good governance, forward-looking managerial strategic planning and decision-making, and collaborative, empowering, safe and supportive work cultures to ensure:

- improved organisational performance and productivity, through
- optimum use, development and growth of "human capital",
- in different cultural contexts and
- in widely differing sectors and industries beyond the health sector/industry.

The very diverse profession of psychology has much to offer in all these matters. Its broad and rapidly expanding multi-level knowledge base and range of professional work (including applied and basic research) has long demanded specialisation within the profession.

The challenge we face is that the NRAS is proving not to be "fit for purpose" for regulating *the whole* of our profession. We believe it has not adequately addressed the capacity for Psychology (or more specifically Organisational Psychology) to make a significant

contribution to community needs beyond the delivery of individual-level health services, typically in hospitals, health clinics and other units of the health sector.

A major amplifier of these negatives, specific to psychology, has been PsyBA’s “clinicalisation” policies about general standards, CPD and (in a more minor sense) “recency of practice”.

In psychology, the introduction by the Board of a concept of “general” registration carries with it a simplified view that there is - or ought to be - a common grounding in “general practice” that is analogous to that term in medicine.

In fact there is no equivalent in psychology to medicine’s “general practitioners” who carry out a central gatekeeping and triage role especially regarding referral to specialists. Clients of Organisational Psychologists, for example, do not come via referral from clinical or other types of psychologists. They are not necessarily ‘vulnerable’ individuals seeking help with mental health problems.

Rather, many of them head up or play other senior managerial roles in organisations with challenges in the development, deployment and leadership of their “human capital”, about which they anticipate professional help from Organisational Psychologists expert in the functioning of organisations and their people in complex environments.

The capacity to remove the impediments and create the environment where sustainable and safe high performing Organisations are possible, is the real contribution Organisational Psychologists can - and do - make. Then capacity for COP (largely a volunteer group) to continue to develop qualified professionals to provide this professional service is at risk and the potential for diluting the professional training and expertise required for these specialised is also at risk because of the current regulatory requirements.

We make a number of constructive recommendations for improvements.

RECOMMENDATIONS - Summary

<p>Recommendation 1</p> <p>Revise the “health professional” concept. Broaden it beyond the notion of mental ill-health knowledge and clinical psychological interventions to instead acknowledge the diversity of the profession through use of the well-accepted “scientist-practitioner” model.</p>
<p>Recommendation 2</p> <p>Retain the term “Masters (degree)” but where necessary distinguish between 2-year Masters programs and 1-year Masters programs.</p>
<p>Recommendation 3</p> <p>Remove “practice across the lifespan” from the list of generic competencies that all psychologists must study and gain experience in as part of their psychology education.</p>
<p>Recommendation 4</p> <p>Drop or significantly modify the General Examination in Psychology given its heavy emphasis on mental ill-health issues and clinical interventions.</p>

Recommendation 5

Clarify the Ministerial Standard concerning CPD with respect to individual peer consultation, personal qualities, active CPD assessment and supervision.

Recommendation 6

PsyBA's CPD requirements should allow:

- more choice in CPD activities undertaken,
- activities not related to current practice,
- non-clinical topics
- development in scientific methods.

Recommendation 7

Practice standards should follow the Standards of Proficiency for Practitioner Psychologists developed by the British Health Care Professions Council, viz. generic standards along with specialty area standards.

Recommendation 8

Link Continuing Professional Development, in part, to psychologists' workplace development needs and cycle of work.

Recommendation 9

CPD content should not just be restricted to issues of current practice and can include other professionally relevant topics.

Recommendation 10

Formal assessment of CPD activities should not be mandated, and should be replaced by simple peer feedback and self-assessment.

Recommendation 11

That the AHPRA definition of practice be amended, as per suggestions in this Paper.

Recommendation 12

Psychologists returning to practice after a significant break to complete a self-directed and self-managed plan for a "return to practice" process, with suitable reports along the way.

A more detailed commentary on these issues follows.

We welcome any opportunity to meet with the Psychology Board of Australia to discuss our range of concerns and ideas for solutions. We would like to be actively involved in shaping a viable regulatory framework that will ensure a future for Organisational Psychology in Australia.

DETAILED COMMENTARY

In this more detailed Section, we make comment on:

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Best Practice Regulation

a) Diversity of the profession not being protected in regulation

When the National Registration and Accreditation Scheme (NRAS) was introduced, we anticipated a broader approach would be taken than in pre-NRAS era to cover more adequately the diversity of the psychology profession. We, among other professions, were optimistic about the possibilities that the national scheme offered.

As we understood it, explicit assurances to this effect were given by the NRAS Project Team partly in response to this College's and the APS's submissions, but very unfortunately have not eventuated – despite:

- the first Senate Inquiry (Community Issues Committee) Report (2009) singling out organisational psychology as a problematic area warranting further review and action, and
- the Western Australian Parliamentary Committee examining the bill to introduce the National Law Act into that State in 2010 noting that the term “health professions” did not cover some parts of the psychology profession.

These explicit independent recognitions, at parliamentary level, that the breadth of psychology goes beyond “health services” and consequent problems need to be addressed, have unfortunately been ignored.

As a key instance, we have long argued for greater diversity in appointments to PsyBA and regional boards. No single person has the breadth of understanding and personal training to regulate effectively for the diversity of psychology by simply a process of generalisation from her/his own experience and knowledge.

Each Area of Practice Endorsement would strongly argue that the uniqueness of their contribution relates to the context in which they practice – a fact strongly confirmed in recent activities that involved all Area of Practice Endorsement designed to differentiate each APS College's primary contribution. It was clear (and illuminating) that whilst our core training in Psychology was common – the divergence of application and the need for ‘specialised’ capabilities in each area of practice was clear and accepted by each of the APS Colleges.

It was, and is, clear that the core Principles of Psychology are applied in a variety of setting with a variety of diverse contexts. It was also patently clear that each of these ‘contexts’ require their own profession training, development and research to maintain this expertise.

Conceptualising the regulation of this rich diversity of professional capabilities as ‘individual diagnoses, treatment plans and interventions’ grossly misrepresents and over simplifies the reality in which the broader psychological profession operates and contributes

The reality, however, is that jurisdictional boards were initially appointed, and later reappointed, by jurisdictional health ministers. They did this on the advice of the heads of their health departments, with specified levels of jurisdictional ‘representation’, and thus were skewed towards health psychology (using that term broadly). Sufficient diversity has never been achieved – and therefore proper representation of the needs of the profession has not ever been achieved.

The perhaps unintended outcome of this will be to marginalise a specific area of psychology practice that has the expertise to enable Australian organisations to be able to make a positive contribution in assisting in performance and sustainability in a globally competitive marketplace.

b) Expectations about independence and freedom from conflict of interest.

We make the following general statements with the strong caveat that they should not be interpreted as any criticism of the individuals currently involved in the NRAS. Rather it reflects current international as well as Australian government expectations about “best practice” in regulation.

Good regulatory policy requires that regulators act in the public interest rather than impose their own perspectives and personal preferences on practitioners, and must avoid any perceived or actual conflict of interests (such as personal benefit arising from particular regulatory policy directions and decisions). Where they might do so, they should make such conflict explicit and transparent, and except in unusual circumstances should withdraw from the decision-making process.

We quote from the Annex to the OECD’s document “*Recommendation of the Council on Regulatory Policy and Governance*” (22 March 1012), in relation to the standard expected:

7. Develop a consistent policy covering the role and functions of regulatory agencies in order to provide greater confidence that regulatory decisions are made on an objective, impartial and consistent basis, without conflict of interest, bias or improper influence.

7.3 Independent regulatory agencies should be considered in situations where:

»» There is a need for the regulatory agency to be independent in order to maintain public confidence;

»» Both the government and private entities are regulated under the same framework and competitive neutrality is therefore required; and

»» The decisions of regulatory agencies can have significant economic impacts on regulated parties and there is a need to protect the agency’s impartiality.

7.4 Mechanisms of public accountability are required that clearly define how a regulatory agency is to discharge its responsibility with the necessary expertise as well as integrity, honesty and objectivity.

7.5 Regulatory agencies should be required to follow regulatory policy including engaging with stakeholders and undertaking RIA¹ when developing draft laws or guidelines and other forms of soft law.

The NRAS is clearly a regulatory system planned, introduced and managed by the departments of health around the country including at Commonwealth level. But it also significantly affects the private sector economically and in other ways. “Competitive neutrality” is thus a key consideration but has received little consideration in terms of the goals, policies or membership of AHPRA and PsyBA.

Consistent with the OECD standard 7, we commend having members of private sector service delivery agencies involved in the regulation of psychology. We do not dispute the value of participation of experienced public servants, and of university staff, with appropriate expertise.

We do, however, wish to ensure that such valuable participation (expanded to cover the non-health fields) is not compromised by real or apparent conflicts of interest. Members of health regulatory bodies such as PsyBA and AHPRA who are also employed or nominated by government departments of health, or employed concurrently by universities providing competing programs in the regulated health fields, are clearly in an especially sensitive position. Their capacity to take a ‘whole of Psychology’ view in determining the professional development plan for a practitioner needs due consideration.

It is our experience that – as perplexing as it is – there is little interdisciplinary understanding of what each Area of Practice Endorsement does, needs and is skilled in, by other Area of Practice Endorsement. This was starkly highlighted in recent exercises in identifying the uniqueness of each College within the APS where Clinical Psychology aside, routinely other Colleges grossly misunderstood the core capabilities and day-to-day challenges of each Area of Practice Endorsement. This highlights the uniqueness of training and education beyond the Honours Year or its equivalents.

This lack of interdisciplinary understanding is evident in determination of ‘whole of Psychology’ regulatory requirement by both PsyBA and AHPRA – largely, we believe, due to the lack of understanding by Health focused regulators.

An example of one area of knowledge and practice listed by PsyBA that should be re-examined from this perspective, is “whole of life span” knowledge and intervention skills. Ensuring safe practices (in the public interest) does not require – indeed it contraindicates – this requirement for lifespan knowledge. It seems an expectation arising from personal perspective and conviction rather than being data-based and reflective of the training needs of all areas of our profession.

¹ Regulatory Impact Assessment.

The Clinicalisation of Psychology

From the broad perspective outlined above, with its very strong valuing of the profession's diversity, we find most disturbing a common theme running through PsyBA's current specifications as to general entry standards, CPD and recency of practice - an emphasis (in our assessment an over-emphasis) on direct clinical practice, where "one-to-one" mental health services are provided to vulnerable clients.

We term this a process of "clinicalisation", although we recognise it refers to the realities of Area of Practice Endorsement beyond the Clinical College.

PsyBA has conceded that the General Examination in Psychology (the mechanism for operationalising general standards for entry into the profession) has a strong clinical emphasis. It has defended this emphasis as a reflection of the (alleged) nature of current professional practice in Australia **as perceived by the public**.

We believe there is no empirical or logical justification for this position. We do not think that the public at large sees all psychologists as mental health experts and expects them purely to have competencies in that area. Where this may exist, it is stereotype that limits the potential value of the broader profession to the community. PsyBA's position here could elevate public misconceptions and inappropriate expectations to the status of entry-level standards.

Education of the public about different types of psychology is appropriate, not curtailment of the diversity of the profession.

But the PsyBA assertion fails to distinguish among the various "publics" who use psychological services. Even though continued education of the community about the diversity of psychological fields remains vital, few experienced business executives, for example, would mistake organisational psychology services for clinical ones.

Judges know about forensic psychological services; and aviation people know the broad kind of work done by psychologists with specialist knowledge of "human factors" and skills in prevention (e.g. through appropriate design of systems and procedures) and evaluation of aviation incidents and accidents.

Whilst we consider clinical psychology a very important and valuable area of our profession, and the health sector's delivery systems as being in need of substantial improvement, we are deeply troubled by the primacy given to health sector needs and the associated neglect of requirements and needs in the sectors and industries other than "health".

We emphasise that our services are not simply health services delivered in a different context from the health sector/industry. They are qualitatively different; in ways that we trust PsyBA already appreciates.

In our view it is damaging to our clients, members and students, to force the training of industrial and organisational psychologists away from the description provided earlier, in the direction of one-on-one personal mental health services tied to local mental health

frameworks such as the “National Practice Standards for the Mental Health Workforce (2002)” and suited only to the health sector.²

It might well be asserted that the best place for the study of “abnormal psychology” as general background for all graduates is in the later years of undergraduate programs, not as a uniform requirement of every post-graduate program, or of all interns’ training.

Unfortunately the NRAS, through AHPRA and the Psychology Board of Australia, principally through the General Examination in Psychology, is requiring a shift to “clinical” training, no matter the specialty involved. And, in all likelihood, at the expense of the diversity of research in alternative fields.

This is obviously damaging to all the non-clinical areas of the profession and to their various “publics”, not only in our own field of industrial and organisational psychology (hereafter IOP).

It has negative impacts on workforce flow, such as:

1. Substantially increased costs of training for non-clinical fields if it has to be preceded or accompanied by clinical training of the level required to pass the General Examination in Psychology,
2. CPD expectations, and supervision (adversely affecting the availability of placements, the availability and motivation of supervisors,
3. PsyBA “clinicalisation” policies also effectively rule out the “4+2” and the “5+1” pathways for entry into the non-clinical specialties, by allowing little or no room for non-health specialty training.

If there is an “essence” or foundation to our profession, it is that of the “scientist-practitioner” rather than “health professional”. PsyBA’s standards, CPD requirements and “return to practice” policy reflect the latter model, not the former. A substantial overhaul and reorientation is (we consider) required.

A BRIEF HISTORY OF THE CLINICAL EMPHASIS

Pre-NRAS registration boards’ practices and “health template” legislation:

When the NRAS was being planned prior to 2009, psychologists were aware that some jurisdictional boards seemed to have considerable difficulty recognising the psychological work undertaken by those operating in the non-clinical areas of psychology, such as IOP.

For example CPD activities of a non-clinical kind were contestable if a non-“clinical” registrant was “audited” by a registration board and found not to have done much “clinical” CPD.

One State Registration Board advised registrants in writing that it did not look favourably on placements with “very little of direct one-on-one client contact providing a service that would normally or reasonably been seen as involving counselling or intervention to address an

² The Heads of Departments and Schools of Psychology (HODSPA) have objected strongly to this attempted imposition of mental health standards on university programs.

individual's psychological problems." Supervision plans were rejected, hours of placement activity discounted retrospectively, and students left feeling confused about how they were to become an organisational psychologist if their specialty was not understood by the regulators. For organisational psychologists, extensive one-on-one client contact with individuals seeking personal help is neither normal nor reasonable, because professional work is done typically across levels (at the industry, organisation and group levels as well as the individual level) and is not "mental ill-health" in focus.

This erroneously conceptualises Psychological principles as only being applicable or valuable in mental health crises. This is a gross oversimplification of the profession and limits the potential benefit of focused psychological training in other areas (business, law, schools, community development, etc.)

The application in 1995 in Victoria, of a "health template" to bring together (under a single Act) the various professions so classified, (and the contentious inclusion of psychology therein) in pursuit of legislative and administrative efficiencies contributed heavily to the misclassification and treatment of psychology as only an "allied health" profession.

Post-NRAS attitudes:

The "health" emphasis has continued in psychology. For example the seven areas for psychologists' training specified by PsyBA were (and still are):

- *ethical, legal and professional matters*
- *psychological assessment and measurement*
- *intervention strategies*
- *research and evaluation*
- *communication and interpersonal relationships*
- *working in a cross-cultural context*
- *practice across the lifespan.*

A simple list like this conceals more than it reveals— and what is omitted is also significant. For example knowledge and practice areas such as social, organisational and community behaviour are not listed.

Of much concern to this College is the "practice across the lifespan" specification, as addressing this requirement is very troublesome when it comes to organisational placement and internship activities. Organisational Psychology interns are being forced to change placements or internships, or make disruptive within-agency rearrangements to secure some exposure to clinical work with clients ranging from the very young to the elderly, when the specialty for which they are being trained does not cover it. Certainly some developmental issues are important in Organisational Psychology, but they are specialised treatments relevant to occupational choice, vocational development, personnel selection and training, and some aspects of "human factors" in the design of jobs and work. They should be covered as such in the 6-year coursework program and (where and as appropriate) in the associated placements, not through the inefficient and unnecessarily costly requirement for clinically oriented placements and internships.

In our view general developmental psychology across the lifespan should be taught by expert academic staff as part of the accredited undergraduate and/or fourth-year sequence, not be a requirement for the post-graduate (Masters) syllabuses for specialties such as Organisational Psychology, or for their internships (where supervisors are expert in the specialty but not expert in such wide-ranging developmental issues, and the typical agency does not involve itself in such work).

PsyBA has also prescribed other supervision requirements and placements in terms that similarly best suit the health context and one-on-one practitioner-client clinical-type contact. Non-clinical placements and experienced supervised supervisors with non-clinical backgrounds have reportedly been discouraged. This obviously creates bottlenecks and other serious problems in professional training.

The original PsyBA requirements for CPD carried the same worrying emphases. Thankfully these have been modified in consultation with the APS, whose own CPD requirements have also been modified in a positive instance of mutually beneficial cooperation. However the task of broadening these requirements so that they better reflect the diversity of our profession has yet to be completed. COP is prepared to be involved in such a task.

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General Entry Standards

a) Discarding the notion of “general practice” in psychology

As explained above, the notion of “general practice” (analogous to that term in medicine) simply does not fit in psychology. There are no “general practitioners” in psychology carrying out gatekeeper or triage roles for clients of psychologists.

The referral pathways (including and especially self-referral in fields such as Organisational Psychology) are as diverse as the profession. Such referrals typically do not have the legal status of medical referrals or links with Medicare, but are informal and include “word of mouth” commendations by clients to colleagues about particular practitioners.

This being so, the notion that there is or must be a common base for all psychologists about mental ill-health and clinical interventions is false.

Since we have already described above our position on this issue, we will not comment further other than to recommend:

Recommendation 1: that the “health professional” notion of a common base of mental ill-health knowledge and clinical interventions be dropped, and that in its place the Board adopts the long-accepted and well-articulated “scientist-practitioner” model.

Recommendation 2: *That the list of competencies be amended by deletion of “practice across the lifespan”. (The College would support an expectation that knowledge of developmental psychology covering the lifespan be included in the undergraduate sequence.)*

COP is happy to work with the Board and other APS Colleges to apply this model more thoroughly in practice.

b) Terminology in the description of the academic requirements for the “6 year” pathway to general registration

The College of Organisational Psychologists does not consider it necessary to replace the term “Masters” as a descriptor of the academic requirements in the “6 year” pathway, as PsyBA proposes.

The term “Masters” carries meaning, credibility and reputation within the academic community and hopefully also with clients and employers. A better alternative, we suggest, would be to say: “Masters or an accredited equivalent academic sequence”.

To avoid confusion with one year Masters in the “5+1” pathway, the words “accredited two-year Masters” could be used in the “6 year” pathway, and the words “1-year Masters or accredited academic equivalent” used in the “5+1” pathway. (We include experiential placements as part of the academic sequence because they extend “book learnings” into practice settings, which integration is primarily the task of the academic staff supervising placements, not of the placement agency or its in-house supervisor. The agency provides the experiential opportunities that derive from the kinds of services in which the agency specialises. It should not be treated as a servant of the university, modifying its services to suit it or providing training of an academic kind.)

Recommendation 3: *That the Board retains the term “Masters (degree)” but where necessary distinguishes between 2-year Masters Programs and 1-year Masters Programs.*

c) Discarding the General Examination in Psychology

We do not consider the General Examination in Psychology (hereafter GEP) to be an adequate instrument for the various assessment purposes which PsyBA has in mind for it:

- general entry to registration as a Psychologist,
- specialist forms of entry (such as overseas applicants for registration with permission to use the title of say “organisational psychologist”),
- a standard for assessment of practitioner competence in complaints evaluation,
- an implied (but powerful) standard for university Masters programs, and
- a set of expectations about training goals in placements and internships.

We have already made detailed submissions to PsyBA on this matter, and continue to recommend

Recommendation 4: *That the GEP be discarded or significantly modified - especially if it is to remain a single version with a heavy emphasis on mental ill-health issues and clinical interventions.*

At the very least multiple versions are required, to cover the other fields of psychology adequately and also to provide alternative forms when the detailed content of the GEP becomes known in the psychology community and assessment is thereby compromised.

We do not consider a paper-and-pencil knowledge test (even if put into “scenario” form) to be an adequate tool for assessing professional competencies, and thus would also urge the Board to consider alternatives.

Continuing Professional Development Issues

a) CPD traditionally an area for “light touch” regulation

Historically psychologists have been eager participants in CPD on a voluntary self-directed basis. They have not needed a regulatory “big stick” to motivate them to continue to be so.³ Heavy-handed regulation is contraindicated.

Nevertheless, PsyBA has promulgated two sets of guidelines relating to the quantum and the broad nature of Continuing Professional Development (CPD) expected of “general” registrants including those with “practice area endorsement(s)” – the 2010 original set, and a revised set in 2011.

These Guidelines expand on and operationalise the *Ministerial Standard on CPD*, and outline specific requirements including Peer Consultation (PC). Ten hours of PC is mandatory over the annual 30-hour CPD cycle.

The remainder is currently “active CPD” with a requirement that the CPD activity be assessed. This policy has important implications and consequences, some useful, some objectionable.⁴

b) Concerns with stated CPD and PC requirements

Some elements are of continuing concern even though collaboration between PsyBA and the profession has generated some real improvements in CPD requirements from the original 2010 Guidelines to the 2011 revision.

³ See in particular the article by Grenyer et al. in the *Australian Psychologist*, v.45, No. 3, Sept. 2010, pp 154-167. This showed that pre-NRAS – in the 2008 Australian Psychologists Workforce Survey by jurisdictional registration boards in conjunction with the APS – there was an 80% level of participation in conferences, workshops and seminars, and a 75% level of involvement in CPD through private study of journals and other readings.

⁴ The APS CPD requirements are now the same as PsyBA’s even though its concept of “peer consultation” was previously quite different, as outlined later in this commentary.

The Ministerial Standard for CPD includes the following definitions (with our underlining shown):

“**Continuing professional development** is the means by which members of the profession maintain, improve and broaden their knowledge, expertise and competence, and develop the personal qualities required in their professional lives.

Peer consultation means supervision and consultation in individual or group format, for the purposes of professional development and support in the practice of psychology and includes a critically reflective focus on the practitioner’s own practice.

Active CPD refers to continuous professional development activities that engage the participant in active training through written or oral activities designed to enhance and test learning.”

The main positives are in the emphasis on improvement and broadening of knowledge, expertise and competence. We have the following concerns:

Concern 1: “Personal qualities required in their professional lives”.

It is sufficient (we believe), in order to ensure safe practice, for a regulatory authority to screen applicants for registration for “good character” and carry out police checks on criminal record, and also assess for adequate prior training and supervised experience.

Requiring registrants to develop “personal qualities” and to assert (or at least imply) the capacity to specify, assess and monitor such “personal qualities” is of Orwellian proportions, as well as incapable of operationalisation as it is not tied to any known body of work with robust generalisable findings about personal qualities essential for professional performance.

Concern 2: Active CPD to be “training” and assessable.

We do not consider CPD (“active” or any other form) to be in essence “training”, which is normally understood to involve a trainer, specific teaching/learning objectives, and assessments, all in pursuit of lifting the trainee’s knowledge and/or skills to a desired higher level.

Our view is that it may include a formal “training” element, but the Ministerial Standard implies that the “active CPD” component must be all “training” and must be assessable. It should be reworded to remove this implication. Nor should formal assessment be mandated.

We support the PsyBA-proposed amendment in which the concept of “active CPD” is removed and (presumably) the requirement that it be assessable is also dropped.

Concern 3: Unclear recognition of the provision of “supervision” and “mentoring” as part of CPD.

Presumably, under the Ministerial Standard, providing *supervision or mentoring* may comprise part, or even the whole, of the requisite PD hours. Clarification should be sought that this is the intended interpretation of the Ministerial Standard.

Recommendation 5: That clarification and some rewording of the Ministerial Standard be made, including excision of the reference to “individual peer consultation”, the reference to “personal qualities required in their professional lives”, and the requirement that active CPD be assessed. The Standard should also clarify whether the provision of supervision or mentoring is counted as CPD, and if so in what circumstances and to what extent.

Concern 4: Other ongoing concerns with the latest CPD Guidelines.

Continuing shortcomings in PsyBA’s CPD Guidelines include:

- (i) not recognising consistently and systematically enough that psychologists are first and foremost “scientist-practitioners” not “health professionals”
- (ii) still too little allowance made for individual practitioner decision-making,
- (iii) requirements which might encourage psychologists to stare at their professional navels at the expense of seeing “big picture” broad professional, multidisciplinary and interdisciplinary developments,
- (iv) incentives that are likely to operate against undertaking CPD via conferences and large-group meetings with colleagues (e.g. doing 30 hours of Peer Consultation with two colleagues satisfies the full CPD time requirement), and
- (v) the suggestion by the Board (downgraded from a formal requirement) that all “active CPD” should have an assessment component – this turned out to be impractical and so should either be dropped or replaced by simple feedback methods. We welcome the Board’s proposed removal of the term “active CPD” (and presumably the assessment requirement) but there remains an implied term “other CPD” which might cause some confusion in some contexts. (For example, is listening to an address by an aeronautical engineer about the human factors involved in an air accident an acceptable form of CPD? We believe it is.)

More generally CPD should be regarded as a self-development process to be encouraged but not prescribed in content by PsyBA; and as an emergent one, very individualistic in character, in part linked with the natural cycles of professional work being performed rather than tied to annual “learning plans” framed at the start of the registration year (even if “fluid” and capable of revision). In short, there should be greater opportunities and encouragement for doing new things, as well as doing the same things better.

Recommendation 6: That the following changes be made to PsyBA’s CPD requirements:

- *In principle CPD should continue to encourage and ensure minimum standards of attentiveness to CPD, but with minimal interference in individual registrants' choices of actual CPD activities; and there should be no requirement that CPD be necessarily related to one's "current practice".*
- *There should be no requirement for a "clinical" focus to CPD.*
- *CPD provisions should allow for significant continued development of practitioners in "scientific method" (theory-building and research methods in "pure" or "applied" research).*

A relevant and useful example from overseas shows how it could be done here in Australia. The British Health Care Professions Council has a well-structured set of practice standards, called the "Standards of Proficiency for Practitioner Psychologists" which cover both general standards for all psychologists as well as specialty area standards. These provide both generality where appropriate and specificity.

Recommendation 7: *Practice standards should follow the Standards of Proficiency for Practitioner Psychologists developed by the British Health Care Professions Council, viz. generic standards along with specialty area standards.*

c) Inadequate provision for part-time psychologists:

While there are arrangements in place for those psychologists who are not practising at all for short periods of time to therefore not require registration, those who are working less than full time are not catered for at all well in regard to CPD or indeed other aspects such as registration fees. In many cases these are highly experienced mature aged workers whom government surely would sooner see continue in at least part-time work than exacerbate the psychologist shortage and force them to rely on government pensions.

A March 2013 report by the Australian Law Reform Commission (ALRC) on Older Workers noted that some professional body CPD or licensing requirements are potentially discriminatory for this already highly skilled group.

ALRC made the following recommendation (4-10): *Professional associations and industry representative groups are often responsible for developing or regulating licensing or re-qualification requirements. The Australian Human Rights Commission should facilitate the development of principles or guidelines to assist these bodies to review such requirements with a view to age-based restrictions in favour of capacity-based requirements.⁵*

⁵ Australian Law Reform Commission, *Access all Ages: Older Workers and Commonwealth Laws*, March 2013, pg 100.

The ALRC makes the point that removing discrimination for one group will remove it for others. In this case, younger but experienced psychologists who are working shorter hours while raising a family or caring for elderly parents would be equally well served by less rigid and more flexible CPD arrangements which would still ensure a well-qualified psychology workforce. The 'one-size-fits-all' model simply ignores the realities of today's working lives.

d) Specifiable “best practice” isn’t always agreed

PsyBA seems to assume there are known and specifiable “best practices” about which there is consensus, which we all should learn to perform, and which we would not undertake unless forced by the regulator. The notions of “best practice” and professional “consensus” may appear uncontroversial but in fact has been heavily criticised on conceptual as well as practical grounds.⁶

As already argued, CPD at its most meaningful is (in our view) an emergent self-directed process. Too little room was available in the Board’s original guidelines for the essence of CPD – *self-direction, being able and motivated to follow where one’s own interests, needs and ongoing learnings lead, and being positive about novelty and personal change, rather than defect-focused and remedial*. The Board appears recently to have modified its emphases to reflect more individuality and more opportunity *for doing new things rather than just doing the same things better*, which action we applaud, but has not modified its other requirements such as annual “learning plans” which appear to constrain individuality and practice novelty more than encourage them.

This PsyBA approach re “learning plans” seems to be part of a broader “command and control” mindset about regulation, rather than a participative and collaborative one which trusts registrants to be self-directed and self-motivated to improve.

e) CPD occurs in the natural cycle of work, not annually necessarily

PsyBA’s preferred annual CPD action plans do not seem to us the best approach to take to CPD. One better alternative (we consider) is to encourage registrants to review their role and performance in the natural cycles of professional work in which they have been involved, and to derive some of their CPD needs from that review. Thus (for example) completion of an applied program evaluation exercise would trigger such a review by the whole team involved, in a “formative” (“developmental”) not an “administrative” (“summative”) way. Some team members may identify a need to improve their data-analysis skills, others their understanding of organisational dynamics or leadership competencies, and so on. This kind of review does not have to wait on the completion of the project – urgent CPD needs for at least some project staff may be identified during the project. Such reality-based identification of CPD needs is more likely to attract managerial support than annual CPD plans not tied directly to natural cycles of professional work.

⁶ The current controversy over metal hip implants (some failing due to metal debris leading to blood poisoning and bone erosion) is an example of “best practice” being founded on consensus (affected by marketing influences from implant manufacturers and suppliers and apparent short-term success) that lacked the necessary medium- to long-term evidence base.

Recommendation 8: *That PsyBA adopt and promote the concept of CPD being linked, at least in part, with the psychologists' roles and performance in the natural cycles of professional work. Some CPD needs can be derived from an "in house" or personal review of their contributions to the processes and outcomes of those work cycles.*

f) Some specifications about CPD would force psychologists to forgo broad **professional, multidisciplinary and interdisciplinary development.**

PsyBA's use of the concept of Peer Consultation (PC) is in our view misapplied, including specifications about Peer Consultation. The APS developed the "peer consultation" concept prior to the introduction of national regulation, as a way of dealing with some state registration boards' push (unwisely) to require all psychologists, whatever their level of maturity, expertise and seniority, to be formally supervised. In the APS model, PC was to **replace** supervision when the person reached a suitable level of professional maturity and independence (usually recognisable in their employment status).

PC did not require direct focus on each participant's practice. In fact it was in part considered a way to help academics and other "non-clinical" psychologists, and senior psychologists with system-level responsibilities (e.g. Directors of psychological services in public service departments), to undertake CPD while recognising that they do not have a conventional "practice" yet were required to register. Discussion of (say) profession-wide or system-wide or international developments including the latest basic and applied research was recognised as a suitable (in fact highly desirable) PC activity in the APS model. Prescription of the content of PC activities was to be minimal, leaving the participants free to determine their own agendas. PC was not to be a "one size fits all" model suited only to "practitioners" in the narrow sense of those having a defined practice.

It was also a model characterised by *respect for, trust in and empowerment of members* to fit their PC to suit their individual circumstances and needs. Genuine conceptual and practice innovation – *the real goals of continuing professional development*, not mere conformance to a health-focused regulator's notion of what is currently "best practice" in mental health service provision - cannot be prescribed or pre-ordained.

Now unfortunately PsyBA requires every full registrant to have PC, confusing PC with supervision in a "career development" sense (everyone must do PC, even highly qualified and vastly experienced psychologists, not just recently registered persons who may still be under some level of supervision), has also failed to recognise broad, general professional *and scientific* issues as acceptable PC topics, appears to frown on multidisciplinary and interdisciplinary forms of CPD, and has not provided for registrants who do not have a "practice".

Recommendation 9: *That PsyBACPD policies be modified to allow the acceptance of but not require a direct practice focus in PC and other CPD, where it is appropriate and desired by the peer support group members.*

CPD and PC – In conclusion

In sum, there are serious negative (and we imagine unintended) consequences flowing from making PC mandatory, and counted as PC only when focused on the individual's own practice. Participants are required to apply a narrow frame of reference ("practice relevance") from the outset, and they are not encouraged to see much beyond the confines of their own practice or the practices of their colleagues.

We are yet to be convinced that these are good features for CPD in contemporary psychology. For some registrants the requirements are easily met and PC "works", but for others they are not easily met and PC does not "work".

The simplest way to deal with the problems associated with the current PC model involving a group of like-minded psychologists may well be:

- (a) to give credit on an hour-for-hour basis for all the group's PC activities, whether one is the focal person or not, i.e. to make the total requirement = 10 hours, not 10N hours (where N is the number of group members); and
- (b) remove the "focus on direct practice" requirement, allowing all sorts of other professional issues to be considered. *A direct practice focus should of course be acceptable, where it is appropriate and desired by the peer support group members. But other psychologists, without defined "practices", or with broader and more systemic interests and needs, should be able to pursue them. In other words, a "horses for courses" approach should replace the current "one size fits all" approach adopted by PsyBA.*

If this is done, there are fewer problems with regard to "active CPD" hours – participants in PC would get no credit at all for it from that PC, but must get it in other ways. The need to include assessment and other "active CPD" requirements into PC is removed; and conference (and other group) attendance is encouraged as alternative ways for participants to acquire their required "active CPD" hours. *This appears a much more balanced approach that will encourage the pursuit of the basic goals of CPD much more effectively.*

Lastly, the requirement that all "active CPD" is assessed must be removed. While we can understand that PsyBA wishes to try to ensure that CPD activities are valid learning activities, assessment is not the way to go. It is impractical. Valid and reliable assessment tests that are not tokenistic have to take into account the individual participant's beginning knowledge and/or skill at the start of the CPD session and separately at the end of the session. That is, they measure "gain" not final understandings. They are difficult and expensive to develop, would take valuable time out of the CPD session (especially administering and scoring "pre-session" and "post-session" tests), eat up time in terms of calculating scores and differences between pre- and post-scores, may result in failure of some participants, with consequent controversy, and do not have any clear destination or further use other than in a "done" sense.

For example if the decision about "pass" or "fail" in CPD "learnings" is based on the "gain" (difference between pre and post scores), the expert participant who already knew the knowledge area perhaps better than the presenter and possessed the requisite skills may be failed because her/his "gain" score would be zero or very little. A "beginner" with little or no knowledge or skill could well show a large "gain" score and thus easily pass even though her/his final level of understanding is of lower quality than the "expert". The expert would be

more competent than the novice, yet would be failed! Using only “post-session” assessment does not solve the problem: it does not measure “gain” which reflects in-session learnings.

Feedback from participants to presenters is a much more realistic and sensible way to go. Formal assessment should be replaced by simple feedback methods from participants to presenters that might include a voluntary and brief self-assessment questionnaire. To require more formalistic processing of test results would add enormously to costs, to what end?

Recommendation 10: *That formal assessment of CPD activities should not be mandated, and should be replaced by simple feedback methods from participants to presenters that might (for example) include an optional brief self-assessment questionnaire.*

Recency of Practice

a) Definition of ‘practice’:

The current broad definition of practice developed by AHPRA⁷ may be misused to legitimise and empower a registration board’s intrusion into areas of professional life and employment not intended when the NRAS was being developed:

- interference with higher education activities (syllabuses and features of placements), where an assurance was given pre-legislation that the independence of the science (discipline) and of the teaching institutions would be preserved and protected,
- the professional aspects of the *management* of service delivery agencies - also to be protected from regulatory interference by the provisions (notably 5.6) in the Intergovernmental Agreement (IGA) preceding the National Law Act 2009,
- dysfunctional disturbance of the operations of professional policy development units and other units in the public and private sectors through too-clinical specifications about supervisor qualifications, cutting across internal staffing structures, especially supervisor roles and powers,
- appearing to legitimise the employment of students by placement agencies on sub-professional work, but not as part of a University-arranged and -supervised placement.

⁷ Extract from AHPRA Glossary: **Practice** This definition of practice is used in a number of National Board registration standards. It means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a practitioner in their regulated health profession. Practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct non-clinical relationship with patients or clients, working in management, administration, education, research, advisory, regulatory or policy development roles and any other roles that impact on safe, effective delivery of health services in the health profession.

Endorsement or encouragement of such work, especially on an unpaid basis, by a regulator is most unwise, as it may constitute breach of an industrial award if in an award-covered agency. It also seems to breach the IGA :

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

We would consider employment of students outside university-arranged and -supervised placements to be one of the “other employment matters” covered by 5.6.

We also consider the AHPRA definition footnoted above to be an example of *confusion of “intentions” with “outcomes”*. This is not a peripheral issue, as it appears to legitimise regulatory action where it was never intended under the NRAS legislation. Virtually any action, by anybody, may be said to have an unintended effect on an individual’s or a group’s health - legislative requirements, managerial decisions, government policies, OHS practices, marriage and other personal relationships, etc. Unless it is recognised that the NRAS covers only *intended actions founded in professional, evidence-based knowledge and experience, not any and all unintended health outcomes*, regulators may easily exceed the legitimate boundaries of their activities.

This confusion is overcome simply, by changing the last line in the definition to read: “other profession-relevant roles that are intended to impact on safe, effective delivery of health services in that health profession” (our underlining), and by adding the words “and cognate” before “services”. The term “cognate” is very important for broadening the focus of regulation beyond “health services”. It refers to a knowledge base and associated methods which are very similar but not identical to those used in “health” service provision.

Without this broadening, the NRAS (including its complaints management system) is limited to “individual services that impact on the client’s physical and/or mental health” (the normal legislative definition of “health service”) and in most jurisdictions cannot legally cover non-health services such as characterise most of what industrial/organisational psychologists (and some other specialists) do. This “legal coverage” conundrum must be addressed, not ignored as it seems to have been thus far.

We also consider that the words “education” and “research” should be removed from the definition, to ensure that the science (discipline) of psychology is clearly excluded from regulation under the NRAS. If PsyBA wished to regulate the science (discipline), it would be acting contrary to assurances of protection and non-interference given in the lead-up to the introduction of the NRAS legislation.

Recommendation 11: That AHPRA amend its definition of practice to:

“Practice: This definition of practice is used in a number of National Board registration standards. It means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a practitioner in their regulated health profession. Practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct non-clinical relationship with patients or clients, working in management,

administration, advisory, regulatory or policy development roles and any other profession-relevant roles that are intended to impact on safe, effective delivery of health or cognate services in that profession.”

c) Recency of Practice provisions

Much of our commentary here reflects our statements above about the definition of “practice”. The following comments should be read in that light.

The current provisions regarding return to practice (rather than “return to work”, a term more suited to the field of workers’ compensation where it originated) do not, in our view, adequately recognise the diversity of the profession, especially by the possible use of the intended clinical form of the National Psychology Examination to decide whether a registrant who has been absent from professional practice (but may or may not have been working in other roles) is ready to return to practice.

We prefer the following process:

Recommendation 12: Psychologists returning to practice after a significant break should:

(a) be invited to complete a self-directed and self-managed plan for a “return to practice” process, whereby they refresh and update themselves regarding the knowledge base and professional skill requirements in the area of work to which they are returning; and

(b) be required to submit at least two reports, one (or more) a progress report, the other a final report.

With the Board’s approval, the “return to practice” plan may commence before actual return to employment or upon actual return. Its duration would be established by negotiation with the Board, depending on the psychologist’s time out of practice and CPD history. The Board could place conditions on the registration granted relating to successful completion of the plan including submission of the reports.

Alternatively, if a suitable version of the General Examination of Psychology exists, the returning psychologist may choose to undertake it.

END OF COP SUBMISSION