APS College of Organisational Psychologists

Level 11, 257 Collins Street, Melbourne Vic 3000
P O Box 38, Flinders Lane PO, Melbourne Vic 8009

Phone +61 3 8662 3300 Fax +61 3 9663 6177
contactus@psychsociety.com.au
www.psychology.org.au
ABN 23 000 543 7888

The Australian Psychological Society Ltd
College of Organisational Psychologists

Submission

regarding

The AHPRA Public Consultation Paper on the Definition of Practice

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This a public document on behalf of the APS College of Organisational Psychologists, prepared by the College's National Regulatory Developments Working Party (NRD WP)

Contact:

Peter Zarris, Chair APS College of Organisational Psychologists
cop.nationalchair@gmail.com

Arthur Crook, Chair NRD WP
aecrook@bigpond.com

PREAMBLE AND SUMMARY

The College of Organisational Psychologists (COP), of the Australian Psychological Society (APS), congratulates the authors of the *"Public consultation paper on the definition of practice"* for the clear, concise and precise articulation of the issues involved in and surrounding the current broad definition of "practice". The questions that they pose are apposite and the answers generated should assist the various national registration boards to review that definition comprehensively.

In contrast to the "not participating" stance of the Psychology Board of Australia (PsyBA), COP considers that the common definition of practice used by the ten regulated health professions *is problematic for psychologists and should be modified*. It is important to stress that Psychology alone has many practitioners who are not "health professionals" providing "health services", an issue relevant to the possible commonality of a definition of "practice".

For Psychology, a profession-specific definition of practice rather than a common one could be adopted (to accommodate its great diversity and scope, particularly beyond "health"). A process of licensing registrants who wish to practice would be used in conjunction with it. This would mean a General Register of Psychologists and Psychology Students (the former practising and non-practising), with a Division therein for Practising Psychologists, sub-divided into "Fully Registered" and "Provisionally Registered". The "Fully Registered" Sub-Division's entries could show "area(s) of practice endorsement".

In such a register structure, the need for a *cross-professions common definition* would be reduced if not entirely removed, for Psychology. That register structure could (in our view, should) also have a separate Student Division, with the names and other details specified in Division 7 of the National Law Act 2009 of those undertaking accredited Masters or doctoral programs in Psychology. Such students need not then be treated (unfairly and dysfunctionally in cost, privacy and equity terms) as "provisional psychologists" (the current situation). The psychology profession is the only profession (under this national scheme) without a student register; and its students alone are charged significant registration fees and exposed to CPD, return to practice and PII requirements as for "provisional psychologists" generally.

The requirements for CPD, recency of practice, and professional indemnity insurance would be relevant only to the Division of Practising Psychologists. Psychologists working in roles that do not involve direct client care would be registered in the Register of Psychologists but not in the Practising Division (unless they themselves considered that their work did have a direct impact on service provision and they wished to "opt in"). Students would (quite properly) not be licensed to practise, and would not have to meet CPD, recency of practice or PII requirements. They would transfer to the Division of Practising Psychologists Register (Provisional Psychologists Sub-Division) on completion of their Masters/doctoral degrees, and from that Sub-Division into the main Practising Psychologists Division on completion of any other PsyBA requirements.

Recency of practice issues would be relevant only to the licensing process and associated transfer into the Division of Practising Psychologists. The definition of practice would of course be very relevant here. We would wish to be consulted further about those issues, especially as "readiness" might be assessed by the contentious proposed National Psychology Examination, whose "clinical" bias would predictably result in unfair discrimination against graduates from non-health accredited programs.

We also offer an alternative definition of practice more suited to Psychology, especially in that it is based on the "scientist-practitioner" model of professional work in Psychology, not on a "health professional" model. This is articulated in our answers to the Consultation Paper's specific questions especially section 3 (Consideration of other options).

THE STATUS OF THIS SUBMISSION GIVEN THE PsyBA DECISION NOT TO BE PART OF THE REVIEW

The College is not privy to the thinking behind the decision by the Psychology Board of Australia (PsyBA) not to be part of the consultation process. Even if PsyBA saw no value in modifying the common definition, the fact that 7 other regulated professions were involving themselves in reviewing that definition and were consulting their registrants and other stakeholders about its acceptability and possible modification should in our view have led PsyBA to do so itself. At the very least (we consider) PsyBA should have been prepared to consult registered psychologists (approximately 30,000 in number), about the issue, and explain its position to them and to the other regulated professions, if it wished to see the current common definition retained. It is very disappointing that the existence of this AHPRA public consultation paper has not been revealed in its communications to its registrants.

COP wonders whether that PsyBA decision means that the problems encountered by psychologists with the current common definition, and our proposed (at least partial) solution of a register with divisions will not be considered in the review.

That would be very disappointing, and the College would hope to have its concerns and proposals heard by the Australian Health Workforce Ministerial Council and AHPRA even if PsyBA has opted not to be a participant.

MORE DETAILED COMMENTARY

Purposes:

COP wonders what purposes are served by a common definition of "practice" that could not be achieved by other means, including profession-specific definitions. These purposes need clearer

exposition. We do not consider it sufficient to argue that because the NRAS is designed to take a common approach to all the professions covered by it, a common definition of practice is *ipso facto* required or appropriate. A caveat of "where possible and reasonable" must surely be recognised.

Possible value of a broad definition of "practice":

A very broad definition may be thought by some regulators in Psychology to be useful, at least by (for example) enabling satisfactory coverage of the very diverse range of psychologists and their kinds of work. Indeed this College has consistently argued for comprehensive coverage to recognise, respect and hopefully protect the diversity of the profession.

Many psychologists do not provide individualised health-related services, but rather work as consultants or advisors, often in multi-disciplinary professional teams, at organisational, team or group levels. They may focus on technology and "person-machine" ("socio-technical") systems, to improve the fit between people and the work system in pursuit of improved productivity at the organisational level as well as enhancement of individual job satisfaction and avoidance of physical or psychological harm to employees (such as may arise from ill-designed production systems).

Others kinds of psychologists provide professional advice to judges in the Family Court, or contribute in other arenas such as assessing injured workers, especially in the context of accident compensation. In both examples, the professional service is to the court or the accident compensation authority, and is not a direct service to the person being assessed. Some psychologists work in professional managerial roles with little or no direct contact with individual persons requiring professional help to deal with personal adjustment problems. Many work innovatively and preventatively, not reactively – anticipating and finding or crafting solutions to existing or likely future human problems, rather than or as well as providing support and remedial services to already-damaged people.

Legally these various kinds of professional activities may not be "health services", even indirectly although efforts have been made (unsuccessfully) by those of a "reductionist" mindset to try to encompass them under the rubric of "wellbeing"-related services.
Many psychologists do not provide "health services", however broadly such services are defined, and cannot be properly described as "health professionals". In law it is arguable that the NRAS legislation can apply to them, as that legislation's objectives are explicitly to regulate the health professions.

The current broad definition of practice may be thought to overcome these kinds of "coverage" shortcomings of the NRAS for these psychologists. In our view it does not. It perhaps camouflages but certainly does not address them.

Also, attempts to "rope in" psychologists whose services cannot be defined as "health" by using organisational-level metaphors and analogies (such as "organisational health and wellbeing") fail because they are merely "argument by analogy". The analogy (with human nature and wellness/illness) is too stretched, fanciful and in important respects misleading, to constitute a

legally defensible basis (organisations being artificial identities legally whose nature, structures and processes are not akin to those of a natural person). For Psychology, any definition of practice must encompass the multi-level nature of the discipline and the profession, and not focus just on the individual, mental health level.

We appreciate that regulators are caught on the horns of a dilemma, needing a definition that:

- captures very diverse kinds of practitioners and services, and the multiple levels of conceptualisation, analysis and action, but
- respects the legal parameters and boundaries of the National Law Act 2009, and
- is narrow enough to be capable of sensible application and effective implementation.

Our view is that the current definition of practice is too broad and does not work for Psychology (as we outline further below). Alternative means of pursuing the desired purposes should be carefully considered so that the problems with a common definition may be avoided. In Psychology in particular, we suggest that a register with divisions, as outlined in our *Preamble and Summary* above, would help address and reduce the impacts of "practice" definitional problems.

Problems With A Common Definition:

Too high a level of generality:

A central problem with a common definition is that it has to apply to 10 (soon to be 14) very diverse professions (internally diverse as well as very different one from another), and thus must be cast at such a level of generality as to be of limited practical value for each particular profession or as a tool for resolving differences among professions about overlaps in their scopes of services. The broader the definition, the greater the overlap among the professions, and the more contestable at law the inclusion of some types of persons becomes.

The current common definition casts too broad a net of persons to be registered: academics, researchers, policy framers, administrators, managers of health services, and so forth as well as deliverers of direct health services.

In Psychology alone, that problem has been exacerbated by PsyBA's contentious decision that students are to be registered as "provisional psychologists", not as "students". *This decision has unwisely expanded the concept of "practice" beyond independent service provision to include the supervised training of students in Masters and doctoral programs.*

"Practice" poorly conceptualised:

Coupled with the "generality" problem is the "rag bag" nature of the "practice" definition conceptually, especially through its inclusion in and impact on more than one policy area (e.g. CPD, recency of practice and professional indemnity insurance (PII)). It is multi-dimensional in usage, applying not only to many professions, but also to many quite disparate regulatory issues.

Again we must return to the issue of the basic purposes of a common definition. Some usages may well not constitute important purposes or goals.

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

However, such is the complexity and rapidity of conceptual developments that *no one individual can know and do all things psychological*. There is no conceptual justification for arguing that there is an agreed "core" of psychological theory, evidence or application that characterises "practice" (as PsyBA is doing in its "clinical" conceptualisation of such a core such as in its very onerous requirements for completing the "4+2" pathway and in its proposed National Psychology Examination).

In such a diverse discipline and profession, *specialisation is necessary, even on entry into professional work.* Even within specialisms (such as Organisational Psychology), there is great diversity and necessarily sub-specialisations. Competency statements for the various specialisms are in essence compilations of descriptors of the things those specialists do *collectively, not individually*. Very few if any practitioners in a specialism have all of the competencies covered by such statements.

In addition to the need for specialisation, professional practice is generally carried out in multi-disciplinary contexts, different areas of Psychology involving quite different patterns of professional "partnerships". Thus effective and competent practice *requires* "cognate knowledge" - understandings of the basics of the associated professions and disciplines. For example organisational psychologists (collectively rather than individually) know the basics of:

- administrative science and management theory,
- economics,
- production (or aviation or other areas of) engineering,
- industrial sociology,
- labour/employment law,
- "human resource management",
- and much more.

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

These differences in cognate knowledge, although not recognised in the regulatory legislation or by PsyBA (if not also the other registration boards), and not well-researched, are nonetheless (we

consider) among the key discriminators of "practice" dimensions and orientations. They are more than just "context knowledge", being deeper and more conceptual and methodological.
ntrusion into unintended areas of professional life and employment:

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

- higher education activities (syllabuses and features of placements),
- the professional aspects of the management of service delivery agencies,
- the operations of professional policy development units in the public and private sectors.
- the employment of students by placement agencies on sub-professional work, but not as part of a University-arranged and -supervised placement. (Endorsement or encouragement of such work, especially on an unpaid basis, by a regulator is most unwise, as it may constitute breach of an industrial award if in a public sector agency.)

This intrusion is particularly true of:

(1) CPD requirements, which - too "health" focused - are now being placed on persons whose work is not direct health care servicing on the false rationale that all psychologists have a duty of care in regard to the recognition of mental disorders. Such a duty of care exists only in the minds of those whose starting point is the *idée fixe* that psychology is only about mental ill-health.
(2) performance standards particularly for dealing with complaints ("notifications"), whose health-service bias is unfair on those registrants working outside the "direct health care delivery" areas (such as and especially in the Family Court arena).
(3) standards for evaluating applicants for registration who are overseas-trained, where persons with Organisational Psychology or other non-clinical qualifications are likely to fail the proposed National Psychology Examination with its narrow clinical focus and emphasis on issues surrounding individualistic direct care delivery[2].
(4) requirements being placed on supervisors regarding the supervision process that are ill-suited to specialist areas other than "clinical", and which are so onerous as to drive many potential supervisors away, and to reduce the number of placements available to students in Masters and doctoral programs. Those placements are already in short supply. For example, placements in policy development areas would seem to be most unlikely to secure PsyBA approval, even though for some kinds of post-graduate courses and some kinds of students (e.g. mature-age students already with some professional work experience) they might be ideal.

Towards a solution:

In response to section 3 ("Options for consideration"), especially "Other Options", in the Public Consultation paper, we indicate the shape of a better definition of "practice" for Psychology. We submit that for Psychology any definition of "practice" must start from *the foundation concept that the psychologist is a "scientist-practitioner",* and not necessarily a "health professional".

[2] PsyBA has just published an Exposure Draft of the National Psychology Examination Curriculum (November 2011).

Certainly some psychologists specialise in the delivery of "health care" services and may justify the term "health professional", but many others do not.

In addition we suggest some modification to the structure of the PsyBA Registers. Separation of practising registrants from non-practising registrants (through a General Register with a Practising Division) would allow the requirements for CPD, recency of practice, and PII to be confined to the latter Division, and thus largely (not entirely) remove, or at least reduce to more manageable proportions, the need for a common definition of "practice".

The distinction between the General Register and the Practising Division would be that members of the latter Division would be *actively offering* and/or *providing* direct psychological services to clients (whether they be mental health services or the many other kinds of psychological services) on an "independent scientist-practitioner" basis. (This refers to professional maturity, not formal employment status such as being privately practising.)

There would be no need for a separate "non-practising" register: all those on the General Register who are not also on the Practising Division would be *ipso facto* identifiable as non-practising. Indeed the notion "not licensed to practice" could well replace "non-practising", being clearer to the public and more accurate legally. (But the General Register need not have such titles.)

This form of separation within the Register of licensed from non-licensed psychologists would solve some of the problems outlined above, especially if the title *"registered health professional"* was dropped. We submit that, while it is retained, the strong legal arguments about the *ultra vires* character of the National Law Act *when applied to psychologists who do not provide health services* would remain, as would the objectionable nature of such a title to many of those psychologists (whose professional identity does not include being thought of as health professionals).

A voluntary "opt in" approach to inclusion on the Practising Division Sub-Register seems much better than a mandatory use approach. An "opt in" approach would also remove or reduce the possibility of complaints ("notifications") being made about misuse of the "health professional" title[3], and would remove the need to try to define "non-practising". (The term "not licensed to practice" is much more self-explanatory and clearer to the public.)

IN CONCLUSION

To sum up, for Psychology any definition of "practice" must start from the foundation concept that the psychologist is a "scientist-practitioner", and not a "health professional". For those psychologists engaged in the delivery of "health care" services, the term "health professional" may be considered appropriate, but for many others it clearly is not. The latter's work is as a scientist-practitioner with a focus on non-health issues, and is not an extension of health services

[3] A member of the public may well consider that (say) an organisational psychologist should not be advertised as a health professional when s/he may have no interest or special expertise in mental health care delivery, and may lodge a complaint on these grounds.

into other sectors. It is *basically* different including in the specialist psychological knowledge and skills and the "cognate knowledge" required *for effective and competent performance*.

We consider that the regulatory authorities have a legal obligation to regulate in the public interest for the whole of Psychology, not just its "health services" parts, and cannot do so by using a definition of "practice" that is not comprehensive *for Psychology*. Yet a "one size fits all" definition is not workable for Psychology. Special provisions, of the kind that we have outlined above, should help provide a way through this conceptual and legal moras

ANSWERS TO THE CONSULTATION PAPER'S SPECIFIC QUESTIONS

Question 1: Are there any other factors that the National Boards should consider when advising whether or not a person needs to be registered?

One typical assumption by regulators is that registrants are actively practising. In Psychology many people want to use the term "psychologist" to describe their vocation, their qualifications and/or their interests, even though they are not actively practising. They should not be prevented from doing so, if that is an accurate statement, or (worse) "criminalised" if they do so.

In Psychology (as outlined above) there are special problems of coverage, because many psychologists are not working in the health sector or provide health services. It is wrong to classify them as "health professionals". But if they are not registered they are not allowed to use the title "psychologist".

In effect the use of the title "psychologist" is being commandeered by the health sector. Something must be done to redress this unacceptable situation.

Direct clinical roles / patient or client health care

When health practitioners provide advice, health care, treatment or opinion, about the physical or mental health of an individual, including prescribing or referring, it is clear that there is a level of risk to the public. The public and the practitioners' professional peers would expect that this group of health practitioners would have the qualifications and the contemporary knowledge and skills to provide safe and effective health care within their area of practice. It would be expected that these practitioners will meet the standards set by the Board and therefore should be registered.

Question 2: Do you support this statement? Please explain your views.

Our views are partially explained above. The statement seems supportable for psychologists who do provide services of a "health" kind but is very "clinical" in focus and does not transfer readily to non-clinical settings and services. However registration boards are an arm of government and should not be expected to nurture the professions involved. Other stakeholders carry that responsibility – especially professional associations, higher education providers, employers, and individual psychologists.

Professional developments (and the growth of understandings and improvements in techniques arising from their underlying scientific disciplines) cannot be directed by "the state". By the time new developments have been codified in legislation or subsidiary rules, they have been surpassed. Rigidity and out-of-date prescriptions result.

Registration boards should concentrate on entry-level standards, and not attempt to impose standards beyond that. Even with entry-level standards, collaboration and consultation are vital: *registration boards should not attempt to dictate to the professions or conceptualise the basic foundations of professional work solely from their own perspectives and frames of reference.*

While there is clearly some risk associated with clinical service delivery, other types of psychological services may also carry risk. There is broad consensus that they too should be regulated, but not under the rubric of "health services" or "health practitioners". The only lasting

solution here is to broaden the objectives of the National Law Act 2009 to include psychological services of a non-health kind, and psychologists who cannot be sensibly described as "health practitioners". The phrase *"health and cognate professions"* is one example of such broadening.

Health practitioners who are in roles in which they are directing, supervising or advising other health practitioners about the health care of individuals would also be expected to have the qualifications and contemporary knowledge and skills to do so as there is potential to alter the management of the patient/client.

Question 3: Do you support this statement? Please explain your views.

Our support is qualified. Again this is a very "clinical" perspective not readily applicable beyond health contexts and services. But even there care must be exercised in regard to expectations about managerial and supervisory roles and associated qualifications and experience, especially if those expectations have the status of mandatory requirements rather than "desirable but not essential".

The only acceptable answer (in our view) to the "knowledge and skills" question must be a contingency ("it all depends") one. It depends on:

- the level of professional independence granted to or earned by the employee practitioner, which may turn in part on whether the employment relationship is a salaried ("contract of service") or contractor ("contract for services") one;
- whether the organisational structure of the unit in which the professional is located is hierarchically and "mechanistically" layered with strict responsibility and accountability processes and routinised procedures, or "flat" and more "organic" and unstructured in form and processes;
- to what extent professional teamwork (which may be one profession, or multi-professional) is involved c.f. individual professional roles;
- whether in reality (rather than as a tenet of faith) a non-professional could sensibly oversee the work of professionals, which in turn is related to the levels of those persons in the organisation (the higher the level, the greater the likelihood of successful non-professional oversight);
- whether the supervisory relationship is merely administrative or actively professional, and involves only "headship" or genuine professional "leadership", and the extent of intervention into professional decision-making;
- the level of funding and other support provided to professionals;
- and other such factors.

In public sector units, current professional staffing structures have become typically short, not tall, with few entry positions, mostly mid-level "independent practitioner" positions, and few if any senior positions. (Some health departments are reported to have decided not to offer professional placements, and some other departments (state and Commonwealth) apparently have virtually abolished base P1 positions.) Such structures, especially the absence of senior positions, create problems of lack of integration, absence of forward planning of professional services, staff "churn" due to poor career progression, and morale and other problems. They, and the opportunity taken by some school principals to pass the costs of psychological services from

their school budgets on to Medicare, have also led to the regrettable absence of expert school psychologists to provide more than "clinical" services to individual troubled or troublesome children (e.g. advisory services to principals and teachers regarding broader educational and people management issues). Such school-focused services often have a systemic and preventative orientation, resulting in the reduced need for subsequent more clinically focused, and possibly more costly, interventions.

While we do not support such staffing structures, and particularly the destruction of professional managerial roles and networks as has happened over the last decade in (for example) some State departments of education, it would be unrealistic not to expect that at some stage in the hierarchical layering of an organisation, professionals of a particular kind will have to report to a person with a different background. The purely "professional" ladder has to stop somewhere. However it should go high up, as professional issues are typically (or ought to be) very important in the organisation's overall strategic planning including its "capability assessment".

Non-clinical roles / non-patient-client care roles

There are experienced and qualified health practitioners who contribute to the community in a range of roles that do not require direct patient/client contact and whose roles do not "*impact on safe, effective delivery of services in the profession*". Examples are some management, administrative, research and advisory roles.

Question 4: Do you believe that health practitioners in non-clinical roles / non-patient-client care roles as described above are "practising" the profession? Please state and explain your views about whether they should be registered and if so for which roles?

We do not consider that they are "practising" as that term is commonly understood (i.e. providing direct services to a client). But if they have Psychology qualifications and experience, their use of the title "psychologist" should not be prevented or criminalised (as outlined earlier above). Hence we recommend a General Register on which such persons may be included, and a Division of Practising Psychologists in which they need not be included.

Indirect roles in relation to care of individuals

Education and Training
Experienced health professionals are vital to the education and training of health professionals. Their roles in education have an impact on safe and effective delivery of health services both directly and indirectly.
Question 5: For which of the following roles in education, training and assessment should health professionals be registered?
 Settings which involve patients/clients in which care is being delivered ie when the education or training role has a direct impact on care, such as when students or trainees are providing care under the direction, instruction or supervision of another practitioner

 Settings which involve patients/ clients to demonstrate examination or consulting technique but not the delivery of care

 Settings which involve simulated patients/clients

 Settings in which there are no patients/clients present

Are there any other settings that are relevant and if so, what are your views about whether health practitioners should be registered to work in these settings?
Please explain your views.

Before responding to this question, we emphasise that many people other than members of the profession of concern may be involved in the training of students and in higher-level training and CPD. In Psychology geneticists, cognitive scientists, neurologists, statisticians, philosophers, sociologists, industrial relations specialists including labour lawyers, administrative scientists, and psychiatrists may provide input to training by way of lectures, papers, seminars, practical workshops, etc. They obviously need not be registered. The notions of discipline diversity and cognate knowledge, as already discussed in this submission, are very pertinent to this issue.

In general, students should not be providing direct client care except under strict supervision by a suitably qualified and registered practitioner (who may be a member of staff of an accredited university or a placement agency supervisor). Such activities should not be considered to be "practising".

Supervision (gradually tapered to suit the trainee's developing competence) should be required until the trainee gains the status of independent practitioner. Further, employers of fresh graduates should expect that they will have to train them in their particular professional requirements. It is a mistake to accede to expectations that the new graduate is "ready to go" as a mature and independent practitioner.

However we consider *registration by settings* to be unworkable and unnecessary. In the training arena, regulation should be minimalist, "light touch" and flexible, to accommodate many forms and levels of training, from initial to sophisticated.

So far as the higher education sector is concerned, regulation should be restricted to course accreditation. Regulatory interference in the syllabuses, placements or other features of that sector other than through formal course accreditation processes should be prevented (as was promised in the earlier consultations about the reach of the NRAS).

3. Options for consideration

Option 1 – No change
Practice *means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a health practitioner in their profession. For the purposes of this registration standard, practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of services in the profession.*

The current definition of "practice" captures all activities and settings in which an individual with qualifications as a health practitioner might be involved professionally. It protects the public by requiring health practitioners to be registered and to meet the registration standards.
Question: Do you support this option? Please explain your views.

No. We consider this definition seriously problematic (as outlined above).

Option 2 – Change the definition to emphasise safe and effective delivery of health care
As stated above, the current definition of "practice" captures the various settings in which a health practitioner may use his or her knowledge and skills and provides for the changing nature of health care delivery.
The current definition could be changed to place the emphasis on safe and effective delivery of health care.
Practice *means any role in which the individual uses their skills and knowledge as a health practitioner in their profession in any way that impacts on safe, effective delivery of health services.*
Question: Do you support this option? Please explain your views.

For professions other than Psychology, this may be a satisfactory revision. For Psychology, it remains problematic in that many psychologists do not provide health services. Yet it remains desirable for the protection of the public that those psychological services not classifiable as "health" are nonetheless regulated.

Other Options
There may be other options that the National Boards have not put forward at this stage, such as maintaining the current definition but providing further guidance on when a practitioner needs to be registered and the circumstances when non-practising registration will be appropriate. Stakeholders are asked to provide feedback on any alternatives to the above options.

We consider that in Psychology a two-part solution is required, thus:

(i) a General Register with two Divisions, one for Practising Psychologists (sub-divided into Fully Registered and Provisionally Registered), and the other for Students in accredited Masters and doctoral programs;

(ii) a definition of "practice" along the following lines:

"*Practice" means any ongoing role or set of roles in which the individual uses, and advertises (or otherwise portrays) to potential users her/his use of, evidence-based*

psychological knowledge and skills in ways that impact directly on the safe, effective delivery of psychological services by the individual or by graduates from accredited academic programs under the individual's direct professional supervision. "Psychological services" are those derived from and applying theory- and research-based concepts and knowledge, and scientifically-validated behaviour change methods and measures of human behaviour. They are intended for the betterment of society and its members, by facilitating (including improving or overcoming barriers to) effective human functioning and well-being, individually or collectively (in families, groups, teams, organisations, communities or society at large). "Practice" does not include the teaching of Psychology, the undertaking or supervision of research into psychological phenomena, or the practical training of students to graduate level in the various recognised pathways to registration.

We accept that it is a massively difficult task to achieve consensus on such a definition, such is the vast diversity of psychology as a science and a profession. Typically any definition offered in the professional or regulatory literature has been accompanied by much explanation, examples of the very diverse and multi-level nature of psychological theory and professional work, and caveats. This has not been possible here.

But the above offering does at least try to move the debate beyond the damaging notion that psychological services

- are limited to "psychotherapeutic assessment and intervention",
- are part of "allied health" workers' addressing mental health care needs,
- and are focused on individual vulnerable clients. (Such a notion underlies most of the thinking in the creation of the NRAS.)

It also explicitly excludes teachers and researchers from being licensed to provide direct services to clients unless they wish to do so. And it excludes students' practical training in their accredited courses including on supervised course placements.

However the existence of a General Register would allow the registration of teachers and researchers if they wished to use publicly the title "psychologist". Such registration would of course not involve CPD, recency of practice or PII requirements.

For ease of administration and to avoid excessive "red tape", persons temporarily not undertaking active practice (such as those on parental leave, sick leave, long service leave, etc.) should remain on the Practising Sub-Division, but should notify PsyBA if their absence is so long or their illness/injury so severe as to create reasonable concerns about their capacity to practice or their ability to return to practice without some refresher training.

It should not be the goal of regulation to set standards for, or keep detailed records of, registrants' *availability for practice*.

(END OF SUBMISSION)