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Professor Mark Cormack
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Submitted via email: ScopeofPracticeReview@Health.gov.au

Dear Professor Cormack,

APS Response to the Unleashing the Potential of our Health Workforce – Scope of Practice Review

The Australian Psychological Society (APS) welcomes the opportunity to provide a response to the survey for the Unleashing the Potential of our Health Workforce – Scope of Practice Review.

Our response to the Terms of Reference (ToR) and survey questions draws on APS policies, evidence-informed practice, and psychological research. We aim to provide evidence to support the benefits, outcomes and risks associated with psychologists working to, or being prevented from delivering on, their full scope of practice in primary care.

As with all our work, we consider this response in light of the Sustainable Development Goals (SDGs).[1] Of relevance to the current review is SDG 3: Good health and well-being which is focused on ensuring healthy lives and well-being for all at all ages.[2]

We note that the original due date for responses to this consultation was the 16 October 2023 and we thank the Scope of Practice Review team for granting the APS an extension until 30 October 2023. Due to this extension, we were unable to submit our response via the online survey. As such, we have provided our responses to each survey question in this document.

We look forward to participating in future consultation forums and processes to provide additional detail for consideration. If any further information is required from the APS, I can be contacted through the APS National Office at (03) 8662 3300 or by email at z.burgess@psychology.org.au.

Yours sincerely,

Dr Zena Burgess FAPS FAICD
Chief Executive Officer

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APS Response to the Survey Questions: Unleashing the Potential of our Health Workforce – Scope of Practice Review.

1. Which of the following perspectives best describes your interest in the Scope of Practice Review?

Professional association

2. What is your postcode?

3000

3. Who can benefit from health professionals working to their full scope of practice?

- Consumers
- Funders
- Health practitioners
- Employers
- Government/s
- Other – family and carers, taxpayers, researchers

4. How can these groups benefit? Please provide references and links to any literature or other evidence.

The APS notes that the key benefits to all the groups identified above have been outlined in the Terms of Reference consultation paper (p. 3), which cites the Productivity Commission's 2021 report on Innovations in Care for Chronic Health Conditions. Specifically,

"The benefits of health professionals working to their full scope of practice include:

- *better health outcomes for people, who benefit from being able to access culturally safe care and from the skills and expertise of each profession*
- *better health service access for people, where working to full scope of practice increases the range and number of services delivered*
- *improved health system capacity, with each part of the health workforce providing the widest range of services that they can deliver safely*
- *improved health system productivity and efficiency, with care directed to the profession with the most appropriate skills to meet the person's health care needs*
- *Improved job satisfaction and workforce retention."*

Realising these benefits requires the identification of an explanatory model which accounts for how they accrue. At the practitioner level, for example, the psychological research would suggest that working to one's full scope of practice is beneficial to the extent that it helps to promote the satisfaction of basic psychological needs of autonomy, competence and relatedness.

As explained by Self-Determination Theory (SDT), the extent to which practitioners are enabled and encouraged to apply their full set of professional skills, knowledge and expertise promotes the basic needs for autonomy and competence. Doing so in a supported, growth-oriented and multidisciplinary context meets a practitioners' core need for relatedness. These basic needs are not commonly addressed in the health workforce discourse but are crucial to driving the cascading benefits which flow from working to full scope – including health workforce wellbeing (at individual and organisational levels), retention, quality and innovation and, ultimately, effective and safe patient care. While scope of practice has not itself been explored within this research, to our knowledge, the meeting of these basic psychological needs in mental health professionals has been shown to reduce burnout and turnover, and to increase job satisfaction.[3] [4] [5]

5. What are the risks and other impacts of health practitioners working to their full scope or expanded scope of practice?

We note the definition of 'full' and 'expanded' scope of practice as outlined in the Queensland Government's 2014 Ministerial Taskforce report. The APS strongly supports practitioners, including psychologists, being enabled to work to their full scope of practice and to an expanded scope of practice as defined in the above report. However, we would caution against conflating 'full' or 'expanded' scope of practice, on the one hand, and 'extended' scope of practice on the other. We are concerned that extended scope – introducing tasks traditionally outside of the practitioner's scope, which are usually undertaken by other health professions – may be positioned as an 'easy fix' for workforce issues in ways that create longer-term harm, including deprofessionalisation.[6]

Framing a health practitioner's work in terms of discrete tasks can accelerate the deprofessionalisation that has already occurred particularly in the mental health professions. Viewing mental healthcare primarily in terms of technical tasks and activities detracts from recognising the unique underlying disciplinary foundations and broader professional and relational context in which this care takes place.

Framed as a technical activity, there is an illusion that tasks within a practitioner's scope of practice are necessarily interchangeable with tasks carried out by other professions. This overlooks differences in training, regulation, ethical standards, professional support and clinical autonomy which shape the way in which tasks are delivered. Such an approach also ignores the influence of theories of human behaviour, motivation and change which practitioners are applying through their clinical judgment and as part of their professional training and responsibility.

We note that this is a problem that is not unique to psychology as a profession. The risks of deprofessionalisation affect all mental health professions in the context of neoliberalised, transactional and time-limited care, especially at a time when technology and artificial intelligence is seen as a substitute – rather than a complement – to professional services.

It is also important to acknowledge that any change in scope of practice – particularly extensions of scopes of practice – will have a psychological impact on practitioners and professions. A psychological conceptualisation of these effects through social identity theory (SIT) and self-categorisation theory (SCT) may help in the design of reforms and implementation processes in ways that promote good outcomes and minimise avoidable adverse psychological effects.[7] [8]

Health practitioners rightly ascribe positive value and identity to their profession (a practitioner's group identity). The positive identity that practitioners hold about their profession can only be maintained to the extent to which there is a positive distinctiveness between groups. This is not to say that there should be competition or antagonism between professions, but rather an acknowledgement and celebration of differences. Indeed, positive distinctiveness can enable different professions to work together through a recognition of their differences and in service of higher and common goals (a superordinate identity, also known as an interprofessional identity in the health care setting), such as the delivery of safe, high-quality and collaborative patient care.

However, when this positive distinctiveness is eroded, including through extended scopes of practice which have not been developed carefully with the affected professions, the resultant identity threat can lead to a set of counterproductive outcomes. There are countless examples of professions' defensive behaviour when under threat, creating barriers to collaboration and effective care. As such, changes to scopes of practice must be managed in a way in which they are experienced as promoting, not undermining, professional identity and differences in service of broader goals.

6. Please give any evidence (literature references and links) you are aware of that supports your views.

Below are some examples from the peer-reviewed research literature that support our views. The literature references and links are provided in the reference list.

- Professional identity research in the health professions - a scoping review.[9]
- Interprofessional identity in clinicians: A scoping review.[10]
- Interprofessional identity in health and social care: analysis and synthesis of the assumptions and conceptions in the literature.[11]

- Why clinical psychology needs to engage in community-based approaches to mental health.[12] This paper also speaks to the importance of scope of practice requiring cultural awareness, reflexivity, and a decolonised approach.

7. Can you identify best practice examples of health practitioners working to their full or expanded scope of practice in multidisciplinary teams in primary care?

Yes - our response to Question 8 (below) provides examples of health practitioners working to their full or expanded scope of practice in multidisciplinary teams in primary care.

8. Please give examples, and any evidence (literature references and links) you have to support your example.

We are aware of multiple examples of effective outcomes when psychologists are working to their full scope of practice within multidisciplinary teams. Below we have provided a broad range of references from peer-reviewed research literature that demonstrates the potential contribution of psychologists to prevention, early intervention, clinical leadership, multidisciplinary care and support for other providers. The full literature references and links are provided in the reference list.

- Barriers and enablers to integrating mental health into primary care: a policy analysis.[13]
- Psychologists and paediatricians: opportunities for collaboration in primary care.[14]
- Addressing health inequities for children in immigrant families: psychologists as leaders and links across systems.[15]
- Universal mental health screening practices in midwestern schools: a window of opportunity for school psychologist leadership and role expansion.[16]
- Psychologists as leaders in equitable science: applications of antiracism and community participatory strategies in a paediatric behavioural medicine clinical trial.[17]
- Psychologists' role in addressing healthcare provider burnout and well-being.[18]
- A multidisciplinary approach to prevention.[19]
- Excellence in implementation of evidence informed practice, including through the WOKE program which offers dialectical behaviour therapy (DBT) to young people, delivered by provisional psychologists under supervision.[20]
- Interdisciplinary Care to Enhance Mental Health and Social and Emotional Wellbeing.[21]

9. What barriers can government, employers and regulators address to enable health practitioners to work to their full scope of practice? Please provide references and links to any literature or other evidence.

A key barrier limiting psychologists' ability to work to their full scope of practice is enduring misunderstandings about psychologists' role and competencies. Specifically, there is confusion about psychologist's general scope of practice and the additional scope recognised in the Psychology Board of Australia's (PsyBA) nine Areas of Practice Endorsement (AoPE).

An AoPE is a legal mechanism under section 98 of the National Law which enables a notation to be included on the public register. The notation identifies psychologists who have advanced training, having completed a postgraduate qualification and a registrar program, in one of the nine approved areas of practice,[22] i.e., clinical neuropsychology, clinical psychology, community psychology, counselling psychology, educational and developmental psychology, forensic psychology, health psychology, organisational psychology, and sport and exercise psychology.

While AoPEs provide regulatory recognition of advanced training and competencies in psychological practice across a diverse range of fields, there is a wide common substrate of competencies and tasks which can be fulfilled by all psychologists with general registration, as set out by the PsyBA's professional competencies for psychologists.[23]

The APS has observed, with great disappointment, the closure of several AoPE courses across Australian universities particularly over the past five years. Postgraduate courses in an AoPE which were previously provided at 15 universities are no longer available. Apart from clinical psychology, programs in the other eight AoPEs are available at fewer than five universities across Australia, limiting the number of future

psychologists in these important areas of psychological practice. Funding for psychologists other than clinical psychology, or generally registered psychologists, is inadequate. Current funding models for higher education and professional practice continue to privilege clinical psychology. This trajectory signals a looming risk that the unique competencies and scopes of practice of other Australian psychologists will be lost.[24]

Further, the differentiation of clinical psychologists and other psychologists has historical origins in the context of the Better Access initiative, but the distinction is often applied in other settings without any justification – particularly in terms of scope of practice. The APS is disappointed, for example, when positions for psychologists are advertised (including by public sector agencies) requiring an endorsement in clinical psychology where this is not necessary. Such actions limit the full engagement of the psychology workforce in areas of critical need. This is particularly concerning given existing difficulties to meet current psychology workforce demands and maintain a sustainable psychology workforce.

10. What enablers can government, employers and regulators address to enable health practitioners to work to their full scope of practice? Please provide references and links to any literature or other evidence.

Addressing the barriers outlined in our response to Question 9 can go some way to enabling psychologists to work to their full scope of practice. That is, removing the constraints on university funding and resources needed to train future psychologists. This topic was discussed in length in our Pre-Budget Submission 2023-24.[24]

Subsequently, the APS was pleased that the Federal Budget 2023/24 announced $91.3 million in funding over five years to boost psychology numbers through the addition of increased psychology post-graduate placements, internships, supervisor training and a redesign of psychology higher education pathways.[25] We are hopeful that this and ongoing funding will be provided to support training for psychologists and workforce development, with a particular focus on building programs across all nine AoPEs to maintain the diversity in scopes of practice in psychology.

Psychologists who provide services under the Better Access initiative work a significant number of unpaid hours, particularly when compared to other practitioners.[26] This high level of unbillable time effectively limits their capacity to work to their full scope of practice, with job satisfaction also being negatively affected. Funding that supports the full scope of practice for private psychologists is required to address this issue.

Further, the gatekeeping role played by GPs within the Better Access initiative limits psychologists' clinical autonomy and their ability to work to their full scope of practice.[27] That is, while it is important for people to continue to maintain GP visits where appropriate, the need for an initial GP referral to consult with a psychologist denies the professional competency of the latter to undertake assessment, diagnosis and treatment planning for mental health disorders. In addition, the limited range of treatment options allowed under the Better Access initiative restricts psychologists from working to their full scope of practice where other unlisted treatments may be more effective and financially viable.

11. Please share with the review any additional comments or suggestions in relation to scope of practice.

In May-June 2023, the APS conducted a survey of members in relation to their experience of working with the NDIS. Almost 800 responses were received. The results pointed to cultural and regulatory factors within the NDIS which are limiting psychologists' ability to work to their full scope of practice. Results to note include:

- Almost half (49%) of respondents who provide NDIS services reported that their assessments or reports have been rejected or disregarded because their qualifications as a psychologist are not recognised by planners or the NDIA. 30% of respondents said that this happens sometimes, often or always.
- 72% of NDIS-active respondents disagreed or strongly disagreed with the statement that NDIS planners have a good understanding of the role and scope of psychologists. Only 9% agreed that planners understand the difference between psychology and behaviour support services.
- 85% of respondents providing NDIS services said that their clients have been inappropriately advised by planners to use Medicare-subsidised psychology session instead of receiving funding for the most appropriate supports through the NDIS.

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