APS Response to the Scope of Practice Review Issues Paper 2 Consultation

Online submission to the Scope of Practice Review

26 May 2024

The APS provided the following responses to the Scope of Practice Review's consultation survey for Issues Paper 2.

Leadership in primary care

1. What leadership do you consider important to ensure reforms are successfully implemented? For example, what is required at the professional, practice, organisation and/or profession level?

The Australian Psychological Society (APS) is pleased to see the recognition given to leadership in primary care by the Review team. As noted in our previous submission, effective leadership in primary care first requires significant investment in cultural change to address the underlying inhibitors of interprofessional collaboration and change. The need for this cultural change, and the need to recognise the role of policy and regulatory settings in supporting (or undermining) such change, however, does not seem to be reflected in the Review's considerations to date. We therefore reiterate our call for the following:

1. The reform options proposed in this Review must unequivocally affirm the unique and distinctive contribution of each health profession to the primary care ecosystem. This requires systematic efforts to promote trust, respect and cooperation and to create a learning culture, including through promoting a non-rivalrous understanding of each profession's contribution to primary healthcare.
2. We must review and evaluate current models of leadership in primary care before considering further leadership reforms. In particular, there needs to be an acknowledgement that implicit hierarchies have privileged some professions over others as primary care leaders – including within this Review. Primary care leadership should be premised on a non-hierarchical view of professions, recognising that through mutual learning and cooperation, effective leadership can empower the entire primary care workforce and sector. Conversely, ineffective leadership will lead to further fragmentation and tension in professional relationships, knowledge and practice.
3. Leadership in primary care should reflect the Australian community's expectations. Research from a representative sample of the Australian population, recently published in the APS *Thinking Futures* report,[1] showed that the role of psychologists as primary care providers and leaders in mental health is affirmed by a strong majority of

[1] https://psychology.org.au/thinking-futures-report-2024

Australians. People expect that psychologists, as highly trained professionals working within their communities, to have a greater role in shaping the delivery and organisation of health services. The APS and our members are ready and willing to support governments through expert, evidence-based insights and clinical leadership.

4. We require further investment in the leadership capacity of primary care practitioners and their representative bodies. There is currently extremely limited governmental support for primary care practitioners to develop as leaders. While individual professions have their own leadership programs (such as the APS Emerging Leaders Program),[2] investment is needed to coordinate and support both intra- and inter-professional leadership programs. We recommend the establishment of a cross-disciplinary Australian Primary Care Leadership Institute with the Government committing to fully-funded positions for emerging leaders from across health professions to develop and learn from each other and with the involvement of peak bodies, including the APS.

Options for reform developed in relation to workforce design, development and planning are:

- **National Skills and Capability Framework and Matrix**
- **Develop primary health care capability**
- **Early career and ongoing professional development includes multi-professional learning and practice.**

2. To what extent do you believe the combined options for reform will address the main policy issues relating to education and training and employment practices you have observed in primary health care scope of practice?

The APS considers that the reform options proposed in Issues Paper 2 are overly constrained in scope and, without cultural change and structural investment, will have no net positive impact on helping health practitioners work to their full scope of practice. On the contrary, we fear that the reforms suggested may work to constrain practitioners' overall scope of practice into the future.

We address our concerns about the National Skills and Capability Framework and Matrix (the *Matrix*) below, but note that the implementation of the Matrix would not address issues relating to the education, training and employment of psychologists in Australia. As we have noted in previous submissions and our broader advocacy, issues relating to the psychology workforce must be addressed through direct policy reform including:

- Making it viable and sustainable for universities to offer postgraduate courses leading to registration as a psychologist. Current higher education funding settings disincentivise universities from offering, or expanding, such courses, severely constricting the training pipeline for psychologists;
- Promoting the diversity of psychologists' scope of practice, including through a reinvigoration of training pathways for the nine areas of practice endorsement (AoPE)

[2] https://psychology.org.au/for-members/member-services/emerging-leaders-program

for psychologists. This would reverse the trend towards the closure of courses and degree options in AoPEs other than clinical psychology. This also requires rectifying illogical disparities in funding (e.g. where postgraduate courses in Organisational Psychology receive significantly less Commonwealth funding than courses in other AoPEs);[3]

- Supporting provisional psychologists and their placement supervisors, including through:
    - Financial support to enable provisional psychologists to undertake placements in rural and remote locations;
    - National coordination of placements to reduce administrative duplication and burdens on students, supervisors and universities, and to develop new placement opportunities;
    - Enabling provisional psychologists on placement to be eligible to receive the newly announced Commonwealth Prac Payment; and
    - Providing ongoing support for psychology supervisor training.

3. How should the National Skills and Capability Framework and Matrix be implemented to ensure it is well-utilised?

The cornerstone of the proposed reform options, the Matrix, does not appear to be well-positioned to drive effective scope of practice reform. The Matrix does appear to be a suitable tool for addressing short-term workforce gaps by finding areas of skill overlap across professions. We strongly submit, however, that this should not be the primary focus of the Review, and that the two issues must not be conflated.

In particular:

- **The Matrix is reductionist and would lead to a loss of skill and capability.** By necessity, the creation of a Matrix would require an artificial simplification and delineation of "specific skills and capabilities of health professionals". This is inconsistent with the complexity of clinical practice. For example, a skill that could be included in the Matrix is "assessment of a mental health condition". This is undoubtedly within a psychologist's scope of practice, but the way in which evidence-based psychological assessment occurs can take myriad forms, depending on the patient's needs, history, sociodemographic factors, and the context in which the assessment is occurring. We also recognise that other mental health professionals can also conduct assessments, but would bring different theoretical orientations and competencies into their work. These differences need to be recognised and affirmed so that the right kind of assessment by the right kind of professional can be provided at the right time. The surface-level description of the skill may appear to be the same, but the underlying differences – both within and between professions – should be recognised as part of professional distinctiveness, and, therefore, different scopes of practice. A drive towards the unnecessary simplification of clinical skills and capabilities should be

[3] https://psychology.org.au/psychology/advocacy/submissions/professional-practice/2023/response-to-to-the-australian-universities-accord

therefore strongly resisted in order to prevent the deprofessionalisation of the primary care sector via professional substitution.

- **The Matrix would not capture variation in skill and capability within professions.** It would be very difficult to create a Matrix for a diverse, multi-faceted profession such as psychology. There are broad general competencies across all registered psychologists as well as nine AoPEs reflecting specialised areas of further study and training.[4] There are also significant differences in the settings in which psychologists work, their patient populations and the funding systems that shape their practices. There are sizeable differences in the theoretical orientations and treatment modalities used by psychologists, although they all fall firmly within the wide umbrella of evidence-based practice. Reducing this variation to one set of generic skills would be to discard the variability within professions that is needed to contribute to the capability and capacity of the health workforce to serve a diverse population in patient-centred ways.
- **The Matrix is not aligned with the dynamic nature of a practitioner's individual scope of practice.** A reductionistic summation of a practitioner's skills and capabilities is inconsistent with the definition of "full scope of practice" set out in Issues Paper 2:
    - "Individual scope is time-sensitive and dynamic. Scope of practice for individual practitioners is influenced by the settings in which they practise, the health needs of people, the level of their individual competence and confidence and the policy requirements (authority /governance) of the service provider." (p. 2)

  The APS endorses this statement, which is compatible with the Psychology Board of Australia's statement that:

  > "Your scope of practice [as a psychologist] is determined by your formal qualifications, vocational choices, career pathways and experience, including the CPD that you have undertaken."[5]

  These statements recognise that there are multiple factors at individual, organisational and social levels influencing a practitioner's scope of practice, and that these factors change over time. While a Matrix may provide a broad profession-level view of skills and capabilities, it is misaligned with the realities of how scope of practice is expressed and lived out by practitioners.
- **A Matrix is static and does not reflect practice innovation, scientific developments and social change.** Skills and capabilities in primary care are constantly changing and evolving. A regular, transparent and consultative process for review would be needed to keep up with these changes. Even with such a process, the Matrix would always lag behind changes to clinical practice reflecting an evolution of the evidence base, changes to presenting problems and populations, and other social, economic and institutional drivers of healthcare use and delivery. For example, it is unlikely that a Matrix would capture the significant changes to practitioners' skills and capabilities that emerged quickly during the COVID-19 pandemic, including the use of technology in

[4] There are nine AoPEs recognised by the Psychology Board of Australia: Clinical Neuropsychology, Clinical Psychology, Community Psychology, Counselling Psychology, Educational and Developmental Psychology, Forensic Psychology, Health Psychology, Organisational Psychology, and Sport and Exercise Psychology.
[5] https://www.psychologyboard.gov.au/Registration/Continuing-Professional-Development.aspx

new ways as part of clinical service delivery. It is unlikely that a Matrix will be able to keep pace with the effects of AI in primary care within the next 5 years.

We therefore recommend that the Matrix be reconsidered as the main vehicle for informing the scope of practice reforms. We suggest that other steps should be implemented in place of the development of a Matrix:

- Invite (and fund) professions, via their peak bodies, to map the variation in scope of practice within their profession, and to share the results of this systematic and human-centred research with government, regulators and other professions. The intent would be to capture the full range of skills and capabilities that can be exercised by professionals, as well as common patterns within professionals' individual scope of practice. This should be supported by practitioner journeys, narratives and data.
- Based on the information collated by professions, work together to identify common individual-level and systemic factors that contribute to variability in scope of practice. This information can also be used to identify drivers of gaps in scope and workforce capability and to devise and test solutions that address the causes, rather than just the symptoms, of these problems.
- Rather than take an ahistorical view of scope of practice, we should map out how policy decisions have directly and indirectly affected practitioner's scope of practice over time. For example, has the closure of AoPE programs – caused by higher education funding settings – meant that other psychologists are taking on skills previously held by psychologists with that AoPE, or is there a gradual extinction of those skills? How has the NDIS influenced psychologists to expand their scope of practice in relation to early childhood interventions, and what happens when anticipated cuts to NDIS funding and eligibility affect the ability of these psychologists to practice sustainably.

4. Who do you see providing the necessary leadership to ensure the National Skills and Capability Framework and Matrix achieves the goal of contributing to health professional scope of practice in primary care?

See our response to question 3 for concerns and alternatives to the National Skills and Capability Framework and Matrix.

Legislation and regulation

Evidence gathered to date has contributed to three proposed reform options related to legislation and regulation:

- ***Risk-based approach to regulating scope of practice to complement protection of title approach***
- ***Independent, evidence-based assessment of innovation and change in health workforce models***
- ***Harmonised Drugs and Poisons regulation to support a dynamic health system.***

5. To what extent do you believe the combined options for reform will address the main legislative and regulatory policy issues you have observed in primary health care scope of practice?

All professions would need to be represented in an independent national body for assessing evidence underpinning reforms to scope of practice. There would need to be consensus around decision making and steps to build a non-hierarchical inter-professional culture. Without this, this advisory group would risk becoming an instrument to validate policies and practices that are not necessarily aligned with the interests of all professions.

6. To what extent do these options for reform strike the right balance between maintaining protection of title where appropriate, and introducing risk-based regulatory approaches in specific circumstances?

The APS does not support any departure from current protection of title provisions in relation to psychologists under the National Law.

7. What factors should be considered when implementing the changes to legislation and regulation to ensure they are effective?

See our responses to questions 5 and 6.

Funding and payment policy

Two options for reform have been developed relating to the theme of funding and payment policy:

- ***Funding and payment models incentivise multidisciplinary care teams working to full scope of practice***
- ***Direct referral pathways supported by technology***

8. To what extent do you believe the combined options for reform will address the main funding and payment policy issues you have observed in primary health care scope of practice?

The APS supports the development of direct referral pathways, including the ability for psychologists to refer to psychiatrists and other relevant health professionals. We also support investments in technology to facilitate referrals and inter-professional communication. We note that at present, there is no consistent two-way electronic service for psychologists and GPs to communicate with each other (e.g. for psychologists to receive referrals from GPs and for psychologists to provide their required reports back to the GP). One popular commercial system is free for GPs to use, but a subscription fee is required for allied health providers to send messages to GPs. The uneven playing field reflects the lack of government investment in digital technologies for allied health providers working in primary care.

We refer to our previous comments about the necessary cultural change and leadership that is required for multidisciplinary care teams to be effective. Funding models developed in the absence of this change would lead to suboptimal outcomes for both patients and practitioners.

9. What other implementation options should be considered to progress the policy intent of these options for reform?

In our previous submission, we identified lost-cost, high-benefit opportunities to enhance multidisciplinary care opportunities within the current practice environment. For example, removing the unnecessary limitations for the case conferencing MBS items would enable psychologists and other Better Access providers to initiate a case conference with a GP directly. This change would facilitate direct and timely communication about a patient's care and would encourage this collaboration by paying providers for their professional time.

We suggest that other reforms would be better identified through direct human-centred research and engagement with providers and peak bodies, rather than primarily through economic and funding levers in the absence of a deep understanding of practitioner experience.

10. What additional actions relating to leadership and culture should be considered to encourage decision-makers to work together in a cooperative way to achieve the intent of these policy options?

See our response to question 1.

Last word

11. Are there additional reform options which have not been considered that could progress the intent of this Review?
See within our responses to the other questions, and our previous submission, for a range of other alternative options for effective and efficient scope of practice reform processes and solutions.
12. Are there additional considerations which have not been raised that could progress the intent of this Review?
The APS would welcome opportunities for direct engagement with the Review team to ensure that the real-world experiences of and expertise of psychologists can inform the design and development of reform options. If any further information is required from the APS, we would be happy to be contacted through the national office on (03) 8662 3300 or by email at z.burgess@psychology.org.au