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Level 11, 257 Collins Street
Melbourne VIC 3000
PO Box 38
Flinders Lane VIC 8009
T: (03) 8662 3300

Professor Mark Cormack
Lead, Independent Scope of Practice Review
Department of Health and Aged Care
GPO Box 9848
Canberra ACT 2601

Submitted via email: scopeofpracticereview@health.gov.au

Dear Professor Cormack,

Response to *Unleashing the Potential of our Health Workforce:* Scope of Practice Review — Issues Paper 1

The Australian Psychological Society (APS) is pleased to respond to the Scope of Practice Review Issues Paper 1 (*Issues Paper 1*). Working within and to a full scope of practice is important for all health professionals. We welcome the opportunity to provide input regarding into this significant Review by reflecting the relevant issues facing psychologists and other mental health professionals.

The APS is the peak professional body for psychologists in Australia. We advocate on behalf of our members and the community for the implementation of evidence-informed prevention, intervention and systemic reform approaches that deliver health and wellbeing for all Australians. Our work is informed by the United Nations international human rights conventions[1] and the Sustainable Development Goals[2] which champion health and wellbeing as a human right for all.

The APS is a strong advocate for holistic and integrated healthcare where psychology is practiced as part of a multidisciplinary team. The complementary skills and scope of a differentiated workforce is essential in terms of job satisfaction and retention for professionals, and positive health outcomes for patients.

Building on our previous submission, and rather than responding to all the questions in *Issues Paper 1,* we have focussed on two issues through each section: (1) the need to address the underlying cultural and attitudinal issues which limit health professionals from working to their full scope of practice – including existing scopes of practice, and (2) the need to ensure that psychologists are acknowledged as primary healthcare professionals.

If any further information is required from the APS, I would be happy to be contacted through the national office on (03) 8662 3300 or by email at z.burgess@psychology.org.au

Yours sincerely

Dr Zena Burgess, FAPS FAICD
Chief Executive Officer

The Australian Psychological Limited
ABN 23 000 543 788

Response to *Unleashing the Potential of our Health Workforce*: Scope of Practice Review – Issues Paper 1

1. Cultural and attitudinal issues which limit health professionals' scope of practice

Legislation and regulation: Reform processes

Top-down regulatory reform, as envisaged in the Issues Paper, is undoubtably necessary, especially where there are legislative, funding, and other levers which prohibit practitioners from working to their full scope of practice. However, the reform process must identify factors which are currently suppressing practitioners working to their scope of practice. This requires a combination of top-down and bottom-up inquiry. We therefore recommend an audit of regulatory and legislative barriers to scope of practice through the lens of practitioner experience and the everyday human experience of regulatory systems. Without an understanding of the behavioural, emotional, social and cultural experience of practitioners in relation to their scope of practice, any regulatory reform on its own may be limited in its success.

We can learn from highly-regulated professions outside of health (e.g., lawyers) where the development of professional identity and professional flourishing has been explored in different ways.[3] A notable observation is the importance of the local context, relationships and expectations that develop over time, often through ordinary, everyday work – also known as the *habitus*[4,5] – in shaping professional identity and practice. In turn, this has shifted the focus to the development of identity (and 'scope') as a fluid and relational process. There is also recognition that the expectations and relationships which define professional competencies and boundaries are formed starting from pre-professional education and even in the selection of future professionals.

As such, before identifying problems and solutions from the top down (e.g., how multidisciplinary teams should operate, or looking at alternative funding models), we must recognise the often unspoken, but lived out, ways in which scope is defined, negotiated, and limited by existing norms, systems, and identities. Any top-down change will, after all, need to account for the real-life impact on the social and professional dynamics of practitioners (i.e. the accretion of the *habitus*) and the delineation of the field.

Employer practices and settings: Foster a culture of celebration of inter-professional differences

The APS argues that we need to promote professional identity by appreciating and celebrating the distinctiveness of each profession within the health ecosystem. Not only will this encourage non-rivalrous distinction between professions, but it will also bring an appreciation of the unique contribution of each profession to holistic healthcare and build trust and respect. In this way, scope of practice is not a 'zero-sum game', meaning that the valuing of one profession's skills does not indicate a devaluation of another's.

A key component of interprofessional trust is a respect for each other's scope of practice and an understanding of skills and competence. Notably, there is flexibility in scope of practice within each profession. The Psychology Board of Australia describes scope as an individually-negotiated concept within the context of professional norms and support: "Your scope of practice is determined by your formal qualifications, vocational choices, career pathways and experience, including the CPD that you have undertaken" (p.2).[6] Although psychologists have common core competencies, each psychologist must know and understand what constitutes their individual scope of practice.

A defining aspect of being a professional is accepting responsibility for actions within one's scope of practice[7] (as also discussed in *Issues Paper 1*). This professional identity includes a recognition of one's own limits and, therefore the need to build systems and processes which acknowledge that practitioners are capable of defining and working to the limits of their scope of practice. Psychologists are ethically bound to work within their competencies and should be trusted to do so.[8]

By promoting a culture which celebrates interprofessional differences (and similarities) and promotes trust rather than suspicion or hostility, each individual is more likely to be able to work to their full scope of practice.

2. Psychologists as primary healthcare providers

Legislation and regulation / employer practices and settings: Strengthening the place of psychologists within the primary care setting

Psychologists play a key role in health care delivery by supporting mental health and wellbeing. As a discipline, psychology is essential to biopsychosocial practice and is key to a holistic understanding of health and illness.[9] Psychologists can provide care across the primary, secondary, and tertiary sectors, however, their role as primary care providers is often overlooked. We have identified a number of ways that psychologists can be supported work to their full scope of practice as primary healthcare providers, including:

- *Facilitating direct access to psychologists*: the requirement for patients to obtain a referral from a GP before seeing a psychologist to access Medicare-subsidised services limits psychologists' clinical autonomy and their ability to work to their full scope of practice.

  While it is important for people to consult with their GPs in relation to their mental health where appropriate, the need for an initial GP referral to consult with a psychologist denies psychologists' professional competency as a primary healthcare provider 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. This is a clear example of legislative suppression with no established process for reviewing this list in line with current evidence and best practice.

- *Enabling psychologists to refer directly:* as previously discussed, psychologists are aware of their scope of practice and are ethically bound to work within their competence. Given this, psychologists can also recognise when a patient requires specialist diagnosis, assessment, and care from other health professionals, particularly psychiatrists. We recommend psychologists be able to refer directly to psychiatrists in these cases while ensuring that the patient's GP remains informed. This would enable psychologists to take a more active role in multidisciplinary care, increases economic efficiencies, and saves valuable GP time. Such a change is analogous to optometrists being able to refer directly to ophthalmologists.[10]

- *Enabling psychologists to initiate case conferencing*: while we applaud the introduction of the MBS case conferencing items to promote interdisciplinary communication to optimise care, the current arrangements are limiting. Firstly, the restriction to GPs initiating the conference is flawed, as mental health practitioners (such as psychologists) may need to bring an issue to the attention of other practitioners. Furthermore, in the case of psychologists, we argue that two, not three parties (for example, a psychologist and GP) should be sufficient to hold a case conference given that a third professional may not be involved, or in order to manage the complexity and confidentiality of information that may be discussed.

- *Excluding MBS family or carer session from an individual's annual session limit*: currently, psychologists who need to see a family member or carer of a patient to gather information, and to provide psychoeducation and optimal care must do so within a patient's yearly limit of MBS subsidised sessions. This applies restrictions to the treatment psychologists are able to provide to their patients (given the limited number of sessions in Better Access, which already sits well below the optimal therapeutic 'dose') and ultimately affects their ability to work to their full scope.

- *Removing the administrative burden of GP review*: the MBS requirement for GPs to review a patient's progress part way through their treatment with a psychologist is costly and interrupts

the flow of treatment. Psychologists, as experts in supporting mental health and wellbeing are best placed to determine when a patient requires a GP review and when treatment should end. In addition to enabling psychologists to work to their full scope of practice, changing the requirement for GP reviews to either the end of 10 sessions or end of treatment (whichever occurs first) would create a cost-saving to both patients and the MBS – potentially improving treatment outcomes and certainly improving efficiencies within the Better Access initiative.

Education and training: Understanding the scope of psychologists and those with an Area of Practice Endorsement

Within the profession of psychology, there is a range of skills, competencies and, therefore, scopes of practice. As highlighted in our previous submission, there is confusion about psychologist's general scope of practice[11] and the additional scope recognised in the Psychology Board of Australia's (PsyBA) nine Areas of Practice Endorsement (AoPE). In addition to the work of generalist psychologists, psychologists with an AoPE contribute to the wide and diverse scope of psychological practice to support and enhance the wellbeing and lives of Australians across the lifespan and across many different contexts.

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,[12] 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.

Current models of professional practice and higher education funding settings have led to the closures of several AoPE courses across Australian universities. Currently, psychology Masters-level courses leading to an AoPE are categorised in Funding Cluster 2. By comparison, courses in other health professions (e.g. medicine, dentistry, pathology), as well as veterinary studies and agriculture, are in Funding Cluster 4 where units attract a Commonwealth contribution amount more than twice that of Funding Cluster 2. Psychology Masters-level courses receive less funding than courses in nursing, languages, physical sciences and engineering (Cluster 3).

These issues are exacerbated for students undertaking a postgraduate program in Organisational Psychology, which is in Funding Cluster 1 and attracts lower Commonwealth contributions than other psychology courses leading to an AoPE. These courses need to be funded on a par with other AoPE programs.

The present level of funding is not proportionate to the cost of delivering a postgraduate AoPE psychology program. There has been sustained advocacy over many years, including by the APS,[13] that this lower level of funding relative to other courses risks undermining the sustainability of postgraduate psychology programs leading to an AoPE in Australia. For example, students in a psychology Masters or Doctoral program must undertake multiple supervised placements. The cost of administering and delivering these placements is borne by each university, with no national coordination, funding or support.[14] Postgraduate AoPE and professional psychology programs also often have specialised facilities (e.g., an on-site training clinic) and must maintain high staff-student ratios in order to deliver high-quality and intensive professional training as required to develop future psychologists. It is essential that appropriate funding models are in place to ensure that the full scope and diversity of the psychology profession is available to the Australian community.

Not only does the resultant loss of professional diversity represent a loss of advanced knowledge and competencies in particular fields within psychology, it also risks other mental health professionals having to work outside their usual scope of practice.

Funding: Opportunities to utilise the full scope of psychologists' skills in the public sector

There is variation between States and Territories in terms of both the availability of psychology roles and the types of psychologists that can be employed within Health Departments. To make the public

sector attractive as a workforce destination, there needs to be consistency of employment opportunities as well as consistent terms, conditions, and salaries for all psychologists to ensure they can work to their full scope of practice. Current work practices and awards in many States and Territories suppress the scope of practice of psychologists. Psychologists working in the public sector are often grouped with other allied health or mental health workers under a generic public sector award which fails to recognise their distinct scope of practice.

In addition, workforce shortages, the pressures of high workloads, and chronic underfunding in public health has resulted in psychologists being overwhelmed by the demand for care. The result of the long-term strain on an under-resourced system has consequences for individual psychologists' ability to work to their full scope of practice which ultimately can affect the quality and timely delivery of health services. Although States and Territories have a key role to play to address these issues, the Federal Government must also help address this crisis.

Other factors preventing psychologists from working to their full scope of practice in the public health system include:

- *Psychologists working as case managers* – Many psychology positions in public mental health are generic in nature and generally provide 'case management' or 'clinical management' within a biomedical model of care. Our members report that patients often have very limited (or no) access to psychological treatment in the public mental health system. This means that highly trained (for example, Masters or Doctoral level) psychologists are not using their skills to deliver psychological interventions and instead are undertaking the work of case managers. Ideally, case managers should be administrators trained for that purpose and psychologists' skills and expertise reserved for mental health treatment and recovery.
- *Treatment and recovery are deprioritised* – With stretched resources within the public sector, psychological treatment is often deprioritised because it is viewed as 'labour intensive', despite its demonstrable efficacy.[15–17] Instead of concentrating on treatment toward recovery, unfortunately the focus is sometimes placed on enabling patients to exit the hospital system. This does not allow psychologists to work to their full scope of practice and limits the treatment provided and ultimately outcomes for patients.
- *Poor resourcing of multi-disciplinary care* – Psychologists in both public and private settings have reported the need for more support via multi-disciplinary case conferencing. The ultimate provision of care can be achieved when medical, psychologists, and allied health practitioners work collaboratively, and to their full scope of practice, to share insights and plan treatment for patients.
- *Limited opportunities to increase efficiency* – Current caseloads and high demand for care means there are limited opportunities to identify cost and process efficiencies. APS members report a high burden from administrative tasks which could be streamlined if the opportunity and resourcing were afforded, allowing practitioners to work to their scope of practice.
- *Lack of support for placements and supervisors* – Student placements working under qualified and experienced psychologists are critical to the training and registration of psychologists nationally. There are currently a number of barriers which disincentivise potential supervisors from undertaking this crucial training and mentoring role. This includes the high demand and lack of time available for such tasks, as well as the mandatory training which supervisors need to undertake using their own funds and in their own time. Providing leadership and mentorship is a key part of a psychologist's scope of practice and must be enabled.
- *Loss of talent from the public system* – As described, the challenging working conditions facing psychologists in the public health system, and limited career pathways, has led to a movement of the workforce out of the public sector into private practice. In private settings, psychologists are better remunerated and are typically able to choose their own hours, work to the scope of their practice and training which helps them to manage burnout and work-life balance. Loss of talent to

the private sector places additional strain on the psychologists who remain, limiting their opportunity to work to their full scope of practice and potentially impacting patient care.

Technology: Rural and remote Australians, and other considerations

The reality of vast geographical distances means that psychologists based in rural and remote parts of Australia often have a broad scope of practice as they need to take on a greater diversity of patients compared to their metro counterparts. Although telehealth and other technological advances can help, this is no replacement for having psychologists with the necessary skills being embedded within the community. In keeping with our previous advocacy, we urge the Government to implement initiatives to support psychologists to train, live, and work in rural, regional, and remote areas equivalent to those afforded to GPs.

The Government must also ensure that: (a) there is necessary infrastructure funding to maintain stable and affordable internet connectivity in rural and remote areas and, (b) there is sufficient digital literacy in the community to enable access to telehealth. When in-person support is not possible, accessible telehealth enables psychologists to work to their scope of practice to provide services to rural and remote Australians.

References

1. United Nations Office of the High Commissioner. (2023). *The core international human rights instruments and their monitoring bodies*. https://www.ohchr.org/en/core-international-human-rights-instruments-and-their-monitoring-bodies
2. United Nations, Department of Economic and Social Affairs. (2023). *Sustainable development goals*. https://sdgs.un.org/goals
3. Holmes, V., Foley, T., Tang, S., & Rowe, M. (2012). Practising Professionalism: Observations from an Empirical Study of New Australian Lawyers. *Legal Ethics*, *15*(1), 29–55. https://doi.org/10.5235/146072812801292737
4. Bourdieu, P. (1990). *The Logic of Practice*. Stanford University Press.
5. McLean, M., & Pecoraro, C. (2021). Health Care Practitioners 'Becoming' Doctors: Changing Roles and Identities. In D. Nestel, G. Reedy, L. McKenna, & S. Gough (Eds.), *Clinical Education for the Health Professions* (pp. 1–20). Springer Singapore. https://doi.org/10.1007/978-981-13-6106-7_140-1
6. Psychology Board of Australia. (2023). *Continuing Professional Development*. https://www.psychologyboard.gov.au/Registration/Continuing-Professional-Development.aspx
7. O'Gorman, J. (2010). *Psychology as a Profession in Australia* (General edition). Australian Academic Press.
8. Australian Psychological Society. (2007). *APS Code of Ethics*. Australian Psychological Society. https://www.psychology.org.au/getmedia/d873e0db-7490-46de-bb57-c31bb1553025/18APS-Code-of-Ethics.pdf
9. Wahass, S. H. (2005). The role of psychologists in health care delivery. *Journal of Family & Community Medicine*, *12*(2), 63–70.
10. Australian Government Department of Health and Aged Care. (n.d.). *Medicare Benefits Schedule—Note AN.0.14*. MBS Online. Retrieved March 7, 2024, from https://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=AN.0.14&qt=noteID
11. Psychology Board of Australia. (2023). *Professional competencies for psychologists*. Australian Health Practitioner Regulation Agency. https://www.ahpra.gov.au/documents/default.aspx?record=WD23%2F32537&dbid=AP&chksum=nrm1%2FMn4vf6%2Bfx7poWRgew%3D%3D
12. Psychology Board of Australia. (2023). *Guidelines on area of practice endorsements*. https://www.psychologyboard.gov.au/Standards-and-Guidelines/Codes-Guidelines-Policies/Guidelines-area-of-practice-endorsements.aspx
13. Voudouris, N. (2011). The future of higher education funding for psychology. *InPsych*, *6*. https://psychology.org.au/for-members/publications/inpsych/2011/dec/the-future-of-higher-education-funding-for-psychol
14. Australian Psychological Society. (2023). *Build, Support, Prepare: Investing in Australia's Future—APS Pre-Budget Submission 2023-24*. https://psychology.org.au/psychology/advocacy/submissions/professional-practice/2023/aps-pre-budget-submission-2023-24#:~:text=The%20APS%20believes%20that%20the,member%20of%20the%20Australian%20community.
15. Roshanaei-Moghaddam, B., Pauly, M. C., Atkins, D. C., Baldwin, S. A., Stein, M. B., & Roy-Byrne, P. (2011). Relative effects of CBT and pharmacotherapy in depression versus anxiety: Is medication somewhat better for depression, and CBT somewhat better for anxiety? *Depression and Anxiety*, *28*(7), 560–567. https://doi.org/10.1002/da.20829
16. Merz, J., Schwarzer, G., & Gerger, H. (2019). Comparative Efficacy and Acceptability of Pharmacological, Psychotherapeutic, and Combination Treatments in Adults With Posttraumatic Stress Disorder: A Network Meta-analysis. *JAMA Psychiatry*, *76*(9), 904–913. https://doi.org/10.1001/jamapsychiatry.2019.0951
17. Haber, P. S., Riordan, B. C., Winter, D. T., Barrett, L., Saunders, J., Hides, L., Gullo, M., Manning, V., Day, C. A., Bonomo, Y., Burns, L., Assan, R., Curry, K., Mooney-Somers, J., Demirkol, A., Monds, L., McDonough, M., Baillie, A. J., Clark, P., … Morley, K. C. (2021). New Australian guidelines for the treatment of alcohol problems: An overview of recommendations. *Medical Journal of Australia*, *215*(S7). https://doi.org/10.5694/mja2.51254