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CHINESE MEDICINE & ACUPUNCTURE SOCIETY OF AUSTRALIA LTD
1F 23 John Street Cabramatta NSW 2166 **Email**: cmasatcm@hotmail.com **Tel:** 61 2 97276831

Re: AHPRA revised *Guidelines for mandatory notifications*

Dear Sir/Madam

The **Chinese Medicine and Acupuncture Society of Australia (CMASA)** represents around 1,000 Chinese Medicine practitioners across Australia, including both practitioners trained in Australia and those trained overseas, along with Chinese Medicine tertiary students, and non-AHPRA regulated masseurs and martial arts practitioners.

CMASA strongly supports the policy objective of providing a safe treatment environment for members of the public using regulated health services.

CMASA has a comprehensive Code of Practice which members agree to abide by on joining. Prior to the AHPRA's regulatory framework being put in place in 2012, CMASA carried out the disciplinary functions for the types of wrongdoing that is now the subject of mandatory and voluntary reporting to AHPRA.

CMASA considers that practitioners should be provided with a clear, succinct statement of the Mandatory/Voluntary policy and processes to ensure their understanding and compliance, and as a proper basis against which they can be held to account.

CMASA has concerns that, while well intended, the current amended Guidelines do not adequately meet this requirement of practitioners. It is concerned about the "woolliness' of the way the policy and its underlying risk management system are communicated, and indeed, about some of the policy assumptions within such. The overarching concern is that they may discourage reporting, and in some areas, may actually provide protection for wrongdoing practitioners/students and their employing organisations rather than providing protection of the public.

The wordiness of the Guidelines continues to be a problem, with practitioners having to wade through much information about how the system works and the risk considerations before they can begin to work out what they need to do/not do in a particular situation.

It is not considered useful to have two sets of Guidelines (one for offending practitioners, one for offending students) as it makes it more cumbersome for practitioners who deal with both. Educators/supervisors should also be aware of the practitioner environment, in order to properly prepare students for the standards they need to meet once qualified.

The guidelines need a one page flow chart at the beginning to show the processes from the user perspective. Given the importance of the policy/process, this chart should also be on the

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website. If the policy cannot be communicated simply, it is unlikely that users will be able to comprehend and implement it effectively, and AHPRA thus will risk failing to meet its policy objective. It may be more helpful for practitioners for a Quick Reference Guide to be developed to show the procedure/s, with the Guidelines forming a backup policy document.

An important challenge with this type of regulatory approach is that a lack of uptake will not necessarily reflect a positive situation, in that it could simply reflect poor policy communication/comprehension, or a situation where practitioners and organisations seek out gaps in the policy/process to escape notice/the need to redress those who have been harmed.

It would be helpful for AHPRA to provide a brief outline of the regulatory structure and the scope of action AHPRA and the National Boards can take, and how/why this differs from other reporting obligations such as for child abuse. Additionally, if individual Boards are making separate arrangements to qualify these guidelines, it would be expected that AHPRA would indicate that it reviews such periodically, especially around whether they add to the information burden on practitioners, or provide a way around notification that is inconsistent with the overarching policy objective.

It is particularly unhelpful for AHPRA to indicate early in the amended guidelines that its role is to provide guidance on whether a complaint should be a mandatory or a voluntary one, and that it will not provide advice on particular cases. This seems to serve a bureaucratic purpose around limiting the demand on resources rather than serving the policy objective. It also does not seem to accurately reflect the role of the Boards. Presumably much of this could be screened electronically, prior to the lodging of a notification, and give the concerned practitioner/educator the option of whether to proceed or not.

There needs to be greater transparency about the reasons for exemptions for organisations with internal processes, and an explanation of what controls AHPRA places over such organisations and its employees to properly manage identified risks. Otherwise this arrangement may give the impression of giving a ‘get out of jail free’ card to the more institutionalized end of the system.

Some of the problems with making the Guidelines clear seem to lie in the apparent policy inconsistencies and largely seem to arise from the assumptions in the risk management system that supports the policy framework. It is not clear whether AHPRA has revisited the assumptions behind the original setting up of the policy framework and CMASA considers this should be done regularly, so that any amendments that are needed to the Act and policies can be made.

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The policy needs to be broadened to reflect the diverse clinical situations of regulated practitioners in different fields, from large organisations such as hospitals, fleets of paramedics, single service practices, multidisciplinary clinics and sole practitioner clinics.

Media coverage has revealed some large scale systemic failures by organisations such as NSW Ambulance, and in particular, the additional harm caused by its subsequent failure to adequate respond to identified problems and to inform potential victims of that unmanaged risk. This highlights the need for organizational accountability, in addition to practitioner accountability.

A key policy weakness lies with the narrow definition of **impairment.** Recent research findings indicate that competency is not only adversely affected by drugs and alcohol but also by sleeplessness, fatigue and chronic stress, and particularly with a combination of all three. Systems relying on shift work are particularly vulnerable if a second job is undertaken in the down time.

The weightings under the risk management structure are confusing, particularly with the use of terminology about thresholds for reporting being low for sexual misconduct (meaning it MUST be mandatorily reported) and high for other forms of wrongdoing (meaning they may or may not have to be mandatorily reported but may be more likely to fall into the voluntary reporting category). A more direct form of expression is needed to communicate the policy intention.

While it is appropriate that sexual misconduct must be mandatorily reported, it is unclear why the other 3 forms of identified wrong doing are held to a lower standard, and may not even constitute a mandatory reportable problem. The long term injuries on many women caused by the [redacted]' suggests that the scale of injury from **improper/substandard professional practice** can be lifelong and severely debilitating. It is noted that although many people must have been aware of this problem practitioner, it seems not to have triggered regulatory action for several decades and until many, many women suffered lifelong damage.

It is also unclear why the only type of wrongdoing by students within a clinical setting that constitutes a mandatory reportable offence is **impairment**. It is not explained why **sexual misconduct**, or **unacceptable professional practice**, and **drug and alcohol intoxication** should be lesser types of wrongdoing within a clinical setting. Tertiary institutions, which are organisations likely to have internal policies for dealing with wrongdoing behavior, have recently been shown to have covered up serious safety problems such as sexual abuse rather than properly dealing with the problem.

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The treatment of **impairment/intoxication** also raises questions as to why there isn't a **zero tolerance policy**, as is standard for particularly frontline workers in industries such as public transport and firefighting.

Further major policy confusion lies with the apparent 'leniency' shown to offending practitioners when they are under professional care. This needs to be explained, particularly relative to what checks and balances are in place on the offending practitioner for self-reporting, along with any penalties/measures for failure to comply. The Guidelines have only one small reference to self-reporting and the relevant section of the Act is not attached, making it harder for practitioners to put the full picture together.

Although AHPRA is to be commended on the considerable efforts made to make the document more user friendly, the effort has unfortunately led to some degree of over-simplification, the scattering of linked information and the inclusion of flow charts that are more about the structure of the document than communicating obligations and risk assessment. As a result, practitioners and others are likely to find it difficult to work out how to proceed when they have identified a concern, which will result in underreporting.

Please find attached the CMASA response form.

Yours sincerely

[redacted]

CEO of CMASA

Aboriginal and Torres Strait Islander Health Practice
Chinese Medicine
Chiropractic
Dental
Medical
Medical Radiation Practice
Nursing and Midwifery
Occupational Therapy
Optometry
Osteopathy
Pharmacy
Physiotherapy
Podiatry
Psychology

Australian Health Practitioner Regulation Agency

CMASA Response: AHPRA revised *Guidelines for mandatory notifications*

Please send your response to: AHPRA.consultation@ahpra.gov.au

Please use the subject line: Feedback on guidelines for mandatory notifications

Responses are due by: **6 November 2019**

General information about your response

Are you responding on behalf of an organisation?	
Yes	What is the name of your organisation? **CMASA (Chinese Medicine and Acupuncture Society of Australia)**
No	Are you a registered health practitioner? **Yes**/No If yes, which profession(s)? Acupuncture/Chinese Medicine/Chinese Medicine dispensing Are you a student? Yes/**No** If yes, which profession?

We may need to contact you about your response. Please write your name and contact details below. **(Skip if you wish to remain anonymous)**	
Name (optional)	[redacted]
Contact details (optional)	[redacted]

1. How easy is it to find specific information in the revised guidelines
While it is clear that considerable effort has been made to create a simple set of guidelines, the document is structurally problematic, in that it is far too long, fragmented in its messaging and not effective in catering to the information needs of its end users (practitioners/employers/educators). It is simply not easy to find out what to do without trawling through the whole set of variables. The earlier document, while slightly officious and too lengthy, was better structured and clearer in its communications. The tone of the amended guidelines is an improvement, but occurs at the expense of proper policy outline. The central problem is that the reader has to familiarise themselves with a range of variables before being able to understand whether the concern they have requires them to make a mandatory report, a voluntary report, report internally, or do nothing. They may still be uncertain but they seem to be discouraged from seek advice/clarification from AHPRA (page 2), apart from whether a concern fits into a mandatory or voluntary classification.
2. How relevant is the content of the revised guidelines?
The Amended Guidelines do not provide the reader with a clear concise tool to easily report concerns about a practitioner. Practitioners need clarity and AHPRA may need to produce a Quick Reference Guide, with the Guidelines forming a policy backup. The content has been compromised by oversimplification and the dispersal of linked information, as well as from the separation into two documents. Simplification of language often leaves out essential information. Policy integrity is undermined by lack of consistency in the treatment of practitioner with the same kind of wrongdoing, and with the absence of any justification/explanation for the risk management weightings built into the model, or what checks and balances are put in place to ensure compliance. This comes across to the reader as a confused presentation of information. The table on p3 adds to the confusion. The Guidelines also fail to explain what the consequences are for those about whom a mandatory report is made, apart from a statement on page 2 that it is a 'serious step that should only be taken on sufficient grounds' . Presumably the consequences might include that an impaired person is helped to overcome their drug/alcohol addiction and the public is safer.
3. Please describe any content that needs to be changed or deleted in the revised guidelines.
In order to provide practitioners/employers and educators with a single, clear policy guideline, the guideline for practitioners should incorporate the arrangements for students (currently set out in a separate document), and the differences explained. It would be beneficial for the overarching tone to encourage reporting, rather than to discourage. See page 1 Mandatory Notification Requirements. Similarly on p3 "There are different reporting LIMITS for the different groups who must report a concern'. The document needs a comprehensive statement of the policy and policy objectives, the obligations the Act places on practitioners and others accessible by practitioners to easily understand their obligations or the consequences of failing to meet their obligations. It also needs to spell out the differences between Mandatory and Voluntary reporting. The document needs a one page flow chart at the start to provide practitioners with a quick

reference summary/guide to the mandartory /voluntaryreporting framework (that also shows obligations that fall outside of the AHPRA framework).

AHPRA needs to explain its risk assumptions and to relate these to its findings from having overviewed the National Board reporting processes.

Practitioners would benefit from a Quick Reference Guide as the Guidelines are too long and difficult to follow.

It may also be beneficial to have an online tool to sort out the 'classification' of the concern.

The table of contents needs reformatting as it seems to indicate the whole document is only an Executive Summary.

The Executive Summary needs a subheading (such as Who reports when) before points 3,4 & 5 to cover the following three headings 3.

The Appendix on National Law extracts needs to also include s130 self reporting

Information about procedures should be consistent eg. Reporting to AHPRA '**and**' the relevant national Board on p2 but '**or**' on p3.

The introductory paragraph on page 6, 2. Concerns to Report, should also refer to the important concept of 'substantial risk of harm to the public'.

4. Should some of the content be moved out of the revised guidelines to be published on the website instead?

If yes, please describe what should be moved and your reasons why.

It is important that this important matter be visible on the website, and should have a one page flow chart to show the policy and procedures within the context of broader reporting obligations.

The placement of material on the website should align as far as possible with the written material (hard copy) to reduce the information burden on practitioners/readers and to thus facilitate comprehension (and successful implementation of policy objectives).

It may be beneficial to support the Guidelines with an online tool that sorts concerns raised into the appropriate category, thereby reducing the explanatory task within the Guidelines. This could be provided as an inquiry type facility (or pre- reporting tool) to cover all types of AHPRA reporting, which would sort the concern into the appropriate category (mandatory, voluntary and self reporting), and give users the option of proceeding or not (especially useful for weeding out vexatious and minor/insubstantial matters).

5. How helpful is the structure of the revised guidelines?

Needs considerable restructuring and re-integration of the two sets of guidelines into one comprehensive Guideline.

The core of the document should be headed with meaningful messages for the practitioner, such as:

- What is a mandatory report and why do AHPRA regulated practitioners need to make them? How this fits with other types of reporting: Voluntary, internal management, self reporting, and non-reporting.
-

- What does AHPRA/Board do when it receives a mandatory report?
    - Accepts
    - Rejects (?and reclassifies as Voluntary??)
- What other complaint making mechanisms are available for lesser offences (AHPRA and others)?
- What the range of Reportable/Notifiable offences are and what the drivers are for them to be categorised as mandatory or another type of report.
    - impairment, intoxication, sexual misconduct, departure from professional standards
- Non AHPRA mandatory reporting and overlaps for practitioners/educators/employers with AHPRA reporting under professional conduct requirements.
- What has to be considered in working out whether a concern is 'notifiable' and serious enough to warrant a mandatory report?
    - AHPRA's Risk assessment framework and its assumptions
- Options for when Mandatory reporting is not appropriate but the concern is valid
    - Voluntary reporting – when a concern exists but does not meet the high mandatory reporting levels for
        - all practitioner offences other than sexual misconduct (impairment, intoxication, departure from professional standards) and for
        - all student offences except impairment (intoxication, sexual misconduct, departure from professional standards)**.**
- Why there are differences in the reporting obligations of practitioners in different circumstances and in certain jurisdictions:
    - treating another practitioner/student (except in WA…because..)
    - not treating another practitioner/student but with concerns to report),
    - employers (except in WA…) and
    - educational officers .
- Applying risk management framework in practice: circumstances where a voluntary report is more appropriate than a mandatory report, or when no report is needed (internal organisational processes are sufficient to manage the risk to patients/public and provide transparency of process) + accountability requirements
- The potential consequences of failing to raise a serious concern about another practitioner under AHPRA requirements, or of lodging a voluntary report rather than a mandatory report, or of failing to make any report.
- How to take the first steps in raising serious concerns to the regulator and where to get advice on both taking action and exposure from failing to take action
    - make a Mandatory Report, a Voluntary report or instigate an internal process, encourage offender to make a self report
    - scope of advice likely to be available from legal advisors and insurers

- Attachments:
    - AHPRA's oversighting of concerns raised with National Boards and scope of problems within the regulated health sector, along with policy review processes
    - List of all qualifying documentation issued, including by National Boards

In addition, improvements are needed to:

- **Table of Contents**: seems to indicate the **Executive Summary** is the full document.(formatting problem)
- **Attachments:** Expand to include s130 self reporting .

6. Do the revised guidelines clearly explain when a mandatory notification is required and when it is not?

Please explain your answer.

The guidelines leave the reader muddled. They would benefit from greater clarity about the risk management framework and how its assumptions frame the action needed to be taken.

The inclusion of a far wider range of examples would help, given the broad range of service provision covered, and the number of variables to be considered.

Risk profiling is confusing. The rationale for risk weightings of certain wrongdoing in certain situations is not explained. On top of this, the terminology adds to the lack of clarity. For example, on p 9 ".. a **lower threshold for making a mandatory notification applies for sexual misconduct"** – is meant to indicate in most instances it must be mandatorily reported.

The next paragraph talks about other circumstances where there is a reasonable belief that there is a substantial risk of harm. " ***a substantial risk of harm is a very high threshold for reporting risk of harm to the public' .***This means that it should not be reported unless there is a substantial risk of harm but seems to be saying the opposite. The justification given does not adequately explain that the wrongdoing practitioner is considered as less of a risk when under the care of another practitioner (although not specifically for that condition), as indicated by." ***This allows practitioner-patients to seek and have treatment for conditions without fearing mandatory notification***."

In the absence of a full explanation, this approach seems to give the offending practitioner a 'get out of jail free' card if they seek treatment from a practitioner (without any specification of the reason for that treatment). A similar underrating of risk seems to apply to those in integrated teams.

7. Are the flow charts and diagrams helpful?

Please explain your answer.

There is no overarching flow chart plotting the procedures for making a mandatory report, a voluntary report, taking internal action, reporting externally to another regulator, or doing nothing.

The Flow charts do not seem to address the information needs of practitioners/employers etc so much as to support the structure of the document eg. p 3. This means that they impose an additional reading task on the reader for little benefit.

The flow charts, such as on p11,13,15, are clumsy in set out and should focus more on giving an indication of what those captured by the requirements are, with less focus on those who fall outside of the requirements.

8. Are the risk factor consideration charts helpful?

Please explain your answer.

The risk grading flow charts are a good approach but too broad in their application to be meaningful and may reflect a seemingly untested bias towards wrongdoers working in large institutions. AHPRA needs to demonstrate that any such assumptions are born out by evidence.

It is important that the parameters at either side of the assessment lines measure the same thing. Eg.

- Nature, extent & severity:
  - Lower: minor (presumably referring to severity of impact but not clear about whether it is referring to the impact on only one or a small number of patients), while
  - Higher: 'wide ranging and severe' (should also refer to numbers likely to be impacted)
- How well can impairment be managed with treatment
  - lower: highly receptive (but not covering likelihood of implementing the advice) while
  - 'higher:' unreceptive (and needs to indicate 'fails to implement').

A further concern about this table is the bias shown in the assumption that an offender within an integrated team is less likely to cause harm than one in a single practice or isolated. This ignores the problems of organisation loyalty, and the tendency of large organisation to cover up wrongdoing to protect their reputation.

The charts could be improved by showing where along the line of progression, the concern will trigger a mandatory report, a voluntary report, an internal organisational report, or no action etc.

The chart on p14 in the section on departure from professional standards, includes a factor 'capacity to judge the extent of the departure' which seems to be assessing the person making the report and not the reported practitioner, whereas the last factor refers to the person being reported (Extent of reflection). This confuses the intent of the table, so that it is unclear whether the first factor 'practice context' refers to the reporting person or the offending person.

The flow charts need to be supported by far more examples where similar degrees of risk to show how they are assessed with the same or different outcomes depending on who reports etc.

9. Are the examples in the revised guidelines helpful?

Please explain your answer.

Yes, but not adequate for the wide range of circumstances covered and the complexity of the decisions being made, and needs a far greater range to be meaningful.

10. Should there be separate guidelines for mandatory notifications about students or should the information be included in guidelines about practitioners and students (but as a separate section)?

Please explain your answer.

It is desirable for practitioners to have all information in one easy to use document. Both documents are too long and wordy and difficult to distill core information.(34 pages + 6.pages) , and also include references to other documents, sites eg. voluntary reporting, so involve further reading.

In relation to students, there is a need to clearly state in the Guidelines why it is only impairment that is the grounds for mandatory reporting of students (within a clinical context),and what the rationale is for not covering sexual misconduct , intoxication and unprofessional standards of practice. The underlying risk assumptions need to be made transparent.

The revised guidelines explain that it is not an offence to fail to make a mandatory notification when required, but a National Board may take disciplinary action in this situation.

11. Is this made clear in the revised guidelines?

Please explain your answer.

This is a highly confusing situation as there are no clear boundaries, and it is possible to make a voluntary report instead of a mandatory report, or handle internally, and to justify this by indicating (?to whom/under what circumstances?) that the assessed risk was adequately taken into account.

It may be beneficial to explain the difference between an 'offence' and the resultant penalties, and disciplinary action that may be taken by AHPRA.

It is covered but seems to be scattered and needs a separate heading, and to also make a clear statement about not making vexatious, petty or malicious reports (and any potential consequences).

12. Is there anything that needs to be added to the revised guidelines?

The Guidelines should have an introductory section which places Mandatory Reporting within the context of all types of reporting and gives an explanation of why these different arrangements are in place. This should be supported by a flow chart.

As outlined above, the structure needs to be improved to give a greater user perspective.

There needs to be an explanation of the policy framework and the risk assessment framework that guides the weightings given to particular forms of wrongdoing in particular types of circumstance, and when reported by practitioners/employers in particular relationships with the wrongdoer. Without a clear enunciation of the drivers of the policy, it comes across as illogical, difficult to grasp and very difficult to weigh up the variables. This works against meaningful reporting.. .

There are several important policy issues that need to be revisited, especially the scope of coverage of 'impairment' to include not only drugs and alcohol, but also other things now know to impair judgements and/or put the practitioner's mental wellbeing at risk

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13. It is proposed that the guidelines will be reviewed every five years, or earlier if required.

Is this reasonable?

Please explain your answer.

The Guidelines, as well as the Act, and the Reports should be reviewed on a regular basis and amended from time to time, particularly as scientific evidence comes to light about circumstances that impact on the core concepts and assumptions. Eg.the scope of impairment is now understood to include sleeplessness, fatigue and chronic stress, particularly in combination, as they have a similar effect on decision making capacity as drug and alcohol intoxication. Although the amended Guidelines mistakenly say that the Act does not define impairment, it does appear to limit it to the concepts of drug and alcohol intoxication and thus is likely to need to be amended.

Given the expanded coverage of health sectors that AHPRA regulates, it is vital that there be a regular review of the adequacy of the policy framework and of the associated assumptions in the risk management system that sits behind it. Presumably, this should be done when a new health sector comes under regulatory control.

14. Please describe anything else the National Boards should consider in the review of the guidelines.

As outlined above, there are a number of policy matters and risk assumptions that seem flawed and need to be revisited, particularly as the size of the regulated sector grows.

Consideration should be given to zero tolerance policies, as are standard in front line service delivery by Fire Fighters, public transport providers and so on.

Automatic anonymity should be provided to those making notifiable reports, particularly as whistle blowers have often not fared well in Australia. .

. Need a practical Quick reference guide.

15. Please add any other comments or suggestions for the revised guidelines.

Suggest a policy review process to address the concerns with matters such as the definition of impairment, and particularly the assumptions in the risk management framework.