Attachment F

Public consultation: A code of conduct for psychologists

The Psychology Board of Australia (the Board) is seeking your feedback about our proposal to update the code of conduct that applies to all psychologists registered in Australia. There are 13 specific questions we would like you to address below. All questions are optional and you are welcome to respond to any that you find relevant, or that you have a view on.

Please email your submission to: psychconsultation@ahpra.gov.au

The submission deadline is close of business, **Monday 14 August 2023**

General questions

1. Do you support the Board's preferred option to implement a regulatory code of conduct?

Your answer:

It is important that there is a Code and also Ethical Guidelines that do not sit within the APS only. Only APS members have access to the documents they have created, and this is problematic for psychologists who choose to be members of other professional organisations. It is also problematic that currently the APS (a private company), hold the Code of Conduct and the Ethical Guidelines.

2. Do you agree with the Board's approach to develop the draft Psychology Board of Australia code of conduct based on the shared *Code of conduct*?

Your answer:

3. Do you support the Board's proposal to adopt the draft Psychology Board of Australia code of conduct as the regulatory code for the psychology profession?

Your answer:

Content of the draft Psychology Board code

4. Does the draft Psychology Board of Australia code of conduct set the minimum standards expected of psychologists by their professional peers and the public?

Your answer:

Policies regarding 'sexual misconduct' with clients are now tighter in the proposed code. However, media coverage regarding cases of sexual misconduct have generated extensive public scrutiny, discourse, and outrage. Public and professional consensus is that a zero tolerance approach is

needed for psychologists for abuse their position of power to sexually exploit clients. Wording within the code needs to mirror public opinion on this issue, condemning the behaviour with an emphasis to purge it from our industry.

5. Are there any specific areas of psychological practice that are not adequately addressed in the draft Psychology Board of Australia code of conduct?

Your answer:

Neurodivergent-affirming practice has not been included. Autism and ADHD neurotypes are not specifically mentioned in the Code, despite being over-represented in clinical populations. For example, Autistic women are over-represented among people in treatment for Anorexia Nervosa (Brede et al., 2020). Autistic and ADHD individuals are also more likely than neurotypical individuals to experience trauma (Antshel et al., 2013; Boodoo et al., 2022; Kerns et al., 2015; Pearson et al., 2023; Peterson et al., 2019; Spencer et al., 2016; Weiss & Fardella, 2018).

Additionally, emerging research is highlighting Autistic burnout experiences, the role of psychological support to recover from and prevent Autistic burnout, and how masking Autistic characteristic can lead to significant mental health challenges including suicidality (Cassidy et al., 2020; Chapman et al., 2022; Higgins et al., 2021; Mantzalas et al., 2022; Miller et al., 2021; Phung et al., 2021; Raymaker et al., 2020).

Autism CRC has established national best-practise guidelines for all forms of therapy with Autistic people (Trembath et al., 2022). The national-best practise guidelines state the importance of *Neurodiversity Affirming Practise* (*defined as: Supports should be neurodiversity-affirming, embracing each child's unique understanding of other people and the world around them, without seeking to 'cure' autism)*. Within these guidelines, it is repeatedly emphasised, and clearly stated, that Neurodiversity Affirming Practise is <u>right</u> for Autistic people. Without additional wording in the Code regarding this, the Code is behind best-practise standards for working with Neurodivergent people.

6. Are there any sections of the draft Psychology Board of Australia code of conduct that would be unworkable for your organisation and/or stakeholders?

Your answer:

1.4: Helping clients in emergencies is essential in psychological practice. The Code's current statements about this, including "…and continue to help until your services are no longer needed" is not practically or ethically appropriate. It is also at odds with the previous statement "..psychologist to consider a range of issues…your own safety…". In private practice psychologists' do not have a crisis service role and we refer appropriately to crisis services; however, clients do not always call the crisis service. The statements in the draft Code would mean that psychologists are responsible for the client's safety, even if we have appropriately referred them to the crisis service. When psychologists refer clients to crisis services, psychologist-provided psychological therapy continues as scheduled and appropriate within the service model.

3.2.a: we need consent to talk to family members and others, this should be specified here.

3.2.e: inclusion of "pictures or visual aids" would be important here.

3.2.i: What does "do not refer to people in a non-professional manner" mean? This is vague and not consistent with tailoring services to clients' needs (e.g., "professional clothing" may not be appropriate when working in some places or with some clients; specifically, a neurodivergent psychologist could take off their shoes in session so neurodivergent clients feel safe to do the same due to sensory sensitivities, and others may deem this as "non-professional"). We agree that

"refraining from behaviour that may be interpreted as bullying or harassment and/or culturally unsafe" is important.

Principle 4: some clients do have "additional needs", some clients have specific or unique needs. Using the term "additional needs" can have negative connotations because it makes those clients sound more difficult; meeting each client's needs means understanding their unique needs. Point 4.1 states "specific needs" and so Principle 4 could use similar language.

4.7: There are problems with the statements in this section. The statements put the responsibility on the psychologist to find additional or referral services for the client. While this is preferred and optimal practice in most circumstances, the client must also take responsibility for engaging with other services. The statements are also unachievable in the current system. For 4.7.a, there are long waitlists for all psychologist and psychological services and therefore it is not always possible to find other psychologists if there is an unexpected emergency for a current and subsequent unexpected leave. This is particularly salient when working as sole traders in private practice and in a specific area (e.g., small town, with specific populations).

4.8.f.: States "recognise that it is mostly inappropriate to share your personal information with clients and/or associated parties, and before doing so, you should consult an experienced colleague to determine whether your purpose for such disclosure is appropriate". There are research studies currently being conducted to define the principles of neurodivergent-affirming practice and pilot data demonstrates the importance of practitioners being and disclosing their own neurodivergence (O'Brien et al., 2023). Research is also demonstrating the importance of Autistic researchers disclosing that they are Autistic when working with Autistic participants (Pellicano et al., 2022). Please see Section 9 of this Submission Form for more information. The information in this point is also unclear to psychologists as to whether supervision is expected in each individual case (which is unrealistic and unaffordable) or whether the psychologist and their supervisor can work together to consider ethical self-disclosure principles as an overarching framework. It is also important to note that some types of therapies have appropriate/ethical clinician self-disclosure built into the foundation of the therapy. For example, schema therapists are encouraged and expected to appropriate self-disclose and share a level of personal information as part of the therapeutic technique *"limited reparenting"*. Multiple studies attest to the benefits of appropriate disclosure of the therapist's personal information as a therapeutic tool in attachment focussed therapies (including schema therapy) (Köhler et al., 2017).

4.8.j: "recognise that your professional obligations continue even after the professional relationship has ended" is broad and unclear. It seems at odds with 5.4, that states that "psychologists who refer or hand over are transferring responsibility for the service to another professional". Psychologists cannot continue to have professional obligations to all clients, even when they have been referred, because we do not have capacity, regardless of the setting we are working in.

5.4.b/c: "understand that your responsibility for the service being provided continues until the referral or handover is accepted" and "understand that, as delegating psychologist you remain responsible for the service being provided and for the decision to delegate" are not consistent with 5.4 that mentions handing over responsibility. Additionally, clients are referred on for many reasons, and psychologists should do what they can to support referral to additional services. However, making psychologists responsible for services until additional services are available is not feasible in the current system. Clients often have to wait to gain access to other services. Medicare has only 10 sessions in a calendar year and psychologists must optimise the service delivery approach within the system limitations; clients might need additional services but cannot afford them, and psychologists cannot be responsible for continuing services if it does not fit with their business model (i.e., they need to have a business that is financial stable so that they can continue to see and help clients). Also, if a psychologist is unsafe with a client and the psychologist has provided referral options (or they might not be able to find referral options), the psychologist must keep themselves safe and discontinue services with appropriate notice and clear communication to the client. Continuing services when a psychologist is unsafe is not appropriate.

6.2: This could include clients with varied neurotypes. Neurodivergent clients (e.g., Autism and ADHD) are over-represented in clinical populations and are not specifically mentioned at all in the

Code. Neurodivergent-affirming practice should be available and provided, and psychologist need to be aware that they should know and learn about it. Additionally, the statement "Effective practice includes that you use your expertise and influence to promote good health and educational and employment opportunities for individuals, communities and populations" assumes that client goals are about health, education, and employment. These are not always the goals clients choose. They are also not always achievable or appropriate goals for clients. It is unclear why this statement is needed in the Code. More details in response to Question 9.

6.3: It is also unclear why "psychologist have a responsibility to promote the health and wellbeing of the community". This statement is broad and unnecessary. It's not linked to service provision or client care. If this is part of the Code (that states, it's purpose as the Code for "safe and effective professional practice; p 4) there needs to be a justification as to why psychologists are responsible for promoting the psychological wellbeing of the community.

7.1.g: "work in practice and within systems to reduce error and improve the safety of clients"; this sentence does not make sense for psychological practice. What is meant by "error"? We work with clients towards their goals and using safety and supportive evidence-based practices. Error may be appropriate in medical settings, but not in psychological settings.

7.1.h: "support colleagues who raise objectively valid concerns about the safety of clients"; why only "objectively valid"? This is not appropriate in psychological practice. There is always a level of subjectivity and clinical judgement.

7. Is the language and structure of the draft Psychology Board of Australia code of conduct helpful, clear and relevant?

Your answer:

The language is vague in some places and too specific in others. There are real risks to practice that is person-centred and for specific groups (e.g., neurodivergent clients). See comments above.

Community impact

8. Would implementation of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for Aboriginal and Torres Strait Islander Peoples? If so, please describe them.

Your answer:

You need to ask Aboriginal and Torres Strait Islander people about this. Information provided in the ACPA hosted seminar by an AHPRA representative indicated that one Aboriginal person was consulted about the draft code. This is concerning and not aligned with best-practice for consultation.

9. Would endorsement of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for other diverse groups or vulnerable members of the community? If so, please describe them.

Your answer:

The Code could result in negative effects on Autistic and ADHD individuals because judicious self-disclosure is essential for neurodivergent-affirming practice, and for neurodivergent clients to feel

safe and understood; the Code states that self-disclosure is "mostly inappropriate" and states that supervision must be sought when a psychologist wants to self-disclose. Neurodivergent-affirming practice is essential for Autistic and ADHD clients. Reframing Autism and other organisations are communicating guidelines for neurodivergent-affirming practice (see Guidelines for Selecting a Neurodiversity-affirming Mental Healthcare Provider - Reframing Autism).

There are research studies currently being conducted to define the principles of neurodivergent-affirming practice and pilot data demonstrates the importance of practitioners being and disclosing their own neurodivergence (O'Brien et al., 2023). Research is also demonstrating the importance of Autistic researchers disclosing that they are Autistic when working with Autistic participants (Pellicano et al., 2022).

The Code states that disclosing shared cultural background is appropriate, but other self-disclosure is "mostly inappropriate". Judicious self-disclosure is essential for neurodivergent-affirming practice. When a psychologist shares that they are neurodivergent it builds rapport and creates safety for neurodivergent clients. Neurodivergent people communicate and connect with anecdotal sharing, meaning that they share similar experiences to build trust and demonstrate understanding. In clinical settings, psychologists should do this judiciously and only when in the best interests of the client; it helps client's feel understood. Neurodivergent psychologists often disclose that they are neurodivergent on their websites and professional documentation because clients want to know and are seeking a neurodivergent psychologist. The draft Code would limit this practice and therefore have negative impacts on clients.

10. Would endorsement of the draft Psychology Board of Australia code of conduct result in any adverse cost implications for health practitioners, higher education providers, employers, clients/consumers, governments or other stakeholders? If so, please describe them.

Your answer:

The Code's statements about continuing services with clients until referral options have been found and having responsibility in crisis situations could have significant negative impacts on the health and wellbeing system, and costs to health practitioners and governments.

The system is already overwhelmed with demand, and psychologists continue to focus on supporting clients within the system, aligned with clients' financial situation, and to ensure businesses survive (i.e., so that psychologists can continue to help others).

The Code's statements about continuing services with clients until referral options have been found and having responsibility in crisis situations have enormous potential to lead to psychologist burnout, and cost businesses, including governments, in additional burnout leave time and in turnover of staff.

Transition and implementation

The Board is proposing to publish an advance copy of the draft Psychology Board of Australia code of conduct **12 months** before it would come into effect.

11. Do you agree with the proposed transition timeframe?

Your answer:

Publishing and providing an "advance copy of the draft" is not sufficient for implementation. Many psychologists were unaware of the draft Code, the consultation, and the submission timeframe. "Transition" and implementation needs to be more clearly defined before comments can be made in agreement or not.

The timeframes also do not allow for practitioners with disability to appropriately make submissions if requiring additional supports.

12. Would there be any implementation issues for your organisation and/or stakeholders that the Board should be aware of?

Your answer:

The implementation plan for the Code is unclear, including what is meant by organisations and/or stakeholder implementation. It would be helpful if the implementation plan for the Code was made available. Providing the document and expecting practitioners to implement it is not sufficient for uptake and understanding.

General feedback

13. Do you have any other feedback or comments about the draft Psychology Board of Australia code of conduct?

Your answer:

There is very real risk that psychologists will be left, confused and anxious about, and disempowered by, these guidelines without further stakeholder consultation from a variety of psychologists. What steps are being taken to ensure that a cross-section of psychologists' opinions heard?

E.g.,

- Psychologists in rural areas

- Psychologists with different endorsement areas

- Psychologists working with unique populations

- Psychologists with their own disability support needs

- Aboriginal and Torres Strait Islander psychologists across Australia

- public expectations for minority groups (e.g., LGBTQIA+ and Neurodivergent voices).

Codes are 'enforced' via systems, but need to be driven and informed by the people who work within these systems and have the day-to-day task of delivering psychology services.

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Please email your submission to: psychconsultation@ahpra.gov.au

The submission deadline is close of business, **Monday 14 August 2023**

General questions
1. Do you support the Board's preferred option to implement a regulatory code of conduct?
Your answer: Yes
2. Do you agree with the Board's approach to develop the draft Psychology Board of Australia code of conduct based on the shared *Code of conduct*?
Your answer: Yes
3. Do you support the Board's proposal to adopt the draft Psychology Board of Australia code of conduct as the regulatory code for the psychology profession?
Your answer: Yes

Content of the draft Psychology Board code

4. Does the draft Psychology Board of Australia code of conduct set the minimum standards expected of psychologists by their professional peers and the public?

Your answer:

Yes, though some clarifications may increase its usefulness. For example 1.2.l sets a minimum standard to ensure not adverse effects of personal views, without reference to the tool of reflexivity that allows the whole person to interact with and make choices about the role of psychologist that they perform.

Following this, it is pleasing to see that principle 1.3.b defines effective practice as free of prejudice due to causal beliefs about client attributes and situations, however a connection to the process of reflexivity may assist in de-stigmatising members of the community who are disadvantaged in opportunities for psychological services. Principle 1.3.e regarding reasonable steps to ensure safety and continue services may place psychologists under pressure when they are ill-equipped to ensure such safety, whilst simultaneously provide an avenue of ongoing stigmatisation due to potential false perceptions of risks to safety. This is a quandary in the ordinary business of forensic psychologists, however, in the absence of publicly available ethical guidelines for forensic practice in Australia, the minimum standards around balancing safety vs stigma may require further finesse.

5. Are there any specific areas of psychological practice that are not adequately addressed in the draft Psychology Board of Australia code of conduct?

Your answer:

Yes. There is still opaqueness around aspects of forensic practice.

For example, the professional values and qualities that promote the "best interest of the client" could indicate recognition that "client can take multiple forms" and that what might be in the best interest of a court or the community / general public might not be in the best interest of a defendant for whom psychological opinion is offered (in much the same way that the regulation of psychologist misconduct operates). This is referenced again in principle 8.12. The protection and promotion of the health of individuals and the community is promoted in value d) and at principle 6.3, however there is little guidance available when these needs on individual vs community conflict. The note for substitute decision-makers (note 3) is patient rather than client oriented and could be expanded outside of a health context. This arises again and more specifically at 3.2.h regarding disclosure of "relevant and timely" information. It also arises at 4.7 with reference to "clients who do not benefit" – where multiple clients are involved in forensic practice, a benefit to the court may not be a benefit to a defendant and vice versa. The definiteness of the statements in this section would preclude much forensic work unless made more inclusive of this area of practice. Changing the wording to "...relationships when there is indicated to be no benefit" opens up to who is benefiting. Similarly at 8.12.g, changing "avoid" to "minimise" might assist forensic practitioners with business practices that require nuanced interpretation of the code. Taking account of this in principle 8.5 regarding client records could also make mention of two-tiered records management system to address multiple client relationships common in forensic practice. The definition of multiple relationships at the end of the document could be further clarified in this regard.

There is also a need in the above note 3 to consider the decision-making capacity for incarcerated people who have much decision making removed from them, with limitations on the voluntariness and informed nature of their consent. This arises again and more specifically at 3.3.b where "reasonably possible" to obtain agreement from clients – this would apply directly to correctional

populations, but the framing in note 3 is narrowly defined to more of a health population. It of course then arises in 4.2, and particularly sections d, e, f. Section e can be difficult if the psychological assessment in question is to determine their decision making capacity, which is a common practice in forensic practice. This section only refers to "emergency" but perhaps legal request would also be an appropriate caveat here. Incarcerated people could be included in section 4.3 as an example of clients who have additional needs.

Principle 4.8.k prohibits expression of beliefs that exploit vulnerability and / or cause distress. Again, in forensic practice, a psychologist may verbally role model prosocial beliefs to vulnerable people in custody who hold strong and pervasive anti-social beliefs, and who will likely experience cognitive dissonance and associated distress during intervention. Rewording the item to a harm minimisation rather than prohibitive instruction may help resolve this ethical dilemma.

6. Are there any sections of the draft Psychology Board of Australia code of conduct that would be unworkable for your organisation and/or stakeholders?

Your answer:

Yes, particularly in large correctional organisations.

For example, 1.1.b requires psychologists facilitate coordination and continuity of care, however often times capacity for continuity is beyond the control of a psychologist (eg a person is released from custody; or a person enters custody; or is moved from one custodial location to another). This arises again in principle 5.4. It would also be good to clarify if the definition of "client" includes those on a waitlist.

Another example is 3.3.d where psychologists in correctional environments may not be able to provide private surroundings and would be required to engage in cost benefit analysis of not providing the service because of privacy concerns – perhaps this type of analysis could receive more attention in the principles?

Another is 10.1.c – in large organisations, pre-existing relationships are common and supervision may occur, particularly in regional and remote areas.

7. Is the language and structure of the draft Psychology Board of Australia code of conduct helpful, clear and relevant?

Your answer:

Yes, only a few minor wordings that could benefit from further clarification. For example, 1.2.g. requires some guidance around the quality of "opinion" where there is absence of evidence for effective practice.

Another example is 3.3.i regarding the necessity for written and informed consent prior to disclosure of information – there are many legislated requirements on psychologists to disclose information without consent, and this speaks to the scope of the code which privileges law over code. This item also requires clarification as to whose information it is when there are multiple clients – courts information, correctional agency's information etc.

Community impact

8. Would implementation of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for Aboriginal and Torres Strait Islander Peoples? If so, please describe them.

Your answer:

As Aboriginal and Torres Strait Islander people are over-represented in the criminal justice system, any disadvantages for this population arising from the code will necessarily further disadvantage Aboriginal and Torres Strait Islander people as well.

9. Would endorsement of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for other diverse groups or vulnerable members of the community? If so, please describe them.

Your answer:

As other diverse groups, such as people from, culturally and linguistically diverse backgrounds, people with disabilities, and people with comorbid mental health and cognitive impairments are also over-represented in the criminal justice system, any disadvantages for this population arising from the code will necessarily further disadvantage these groups of people

10. Would endorsement of the draft Psychology Board of Australia code of conduct result in any adverse cost implications for health practitioners, higher education providers, employers, clients/consumers, governments or other stakeholders? If so, please describe them.

Your answer:

Yes. If principles specific to forensic practice are underemphasised, adhere will likely be a continued cost to government and clients / consumers for a reactive rather than proactive approach to people with psychosocial and cognitive impairments who interact with the legal system.

Transition and implementation

The Board is proposing to publish an advance copy of the draft Psychology Board of Australia code of conduct **12 months** before it would come into effect.

11. Do you agree with the proposed transition timeframe?

Your answer:

Yes

12. Would there be any implementation issues for your organisation and/or stakeholders that the Board should be aware of?

Your answer:

Yes – particularly around continuity of care.

General feedback

13. Do you have any other feedback or comments about the draft Psychology Board of Australia code of conduct?

Your answer:

Where the scope of the code requires psychologists to explain and justify their decisions and actions, and simultaneously gives precedence to law over code in, a finer grained nuance of the various interactions between the code and the multitude of state and Commonwealth laws should be incorporated into psychologist training. This is generally an issue that arises when private is pitted against public – privacy of information vs public interest in release (for safety etc). This would assist psychologists to exercise 1.2.d. in balancing the benefit and risk of harm in all decisions. For example at principle 7.1.j reasonable steps are required of psychologists when threat to others is present. However, this is not informative enough and without clearer guidelines perpetuates the exclusion of vulnerable populations, especially those with dual risk, from psychological services. It

needs to be overtly recognised that a sizable portion of people requiring psychological services present a risk to others, and psychologists inside and outside forensic practice workplaces need ethical support to provide services to these people to minimise their risk to community safety and wellbeing, and subsequently their risk to their own wellbeing. Existing ethical guidelines for forensic practice in Australia that speak in detail to the complex nuances of these processes are currently unavailable publicly. These would be particularly relevant for psychologists to interpret principle 8.8 when practicing in the forensic area, as the current code is all that would be available without more nuanced forensic ethical guidelines. For example, 8.8.g should also mention duty to inform about undisclosed crimes. Another example is 8.11.b which, without clarity on who might be "entitled" to ask for information (and guidance on where to find this information) could lead to ethics mis-steps for psychologists.

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General questions

1. Do you support the Board's preferred option to implement a regulatory code of conduct?

Your answer:

Yes. Providing the board considers the true breadth and diversity of psychology practice in Australia. Psychology practice is not just Medicare and CBT.

2. Do you agree with the Board's approach to develop the draft Psychology Board of Australia code of conduct based on the shared *Code of conduct*?

Your answer:

Yes. Providing that the PsyBA adapt the shared Code of Conduct without imposing caveats on psychology practice, such that it is ultimately is as narrow as the current APS version.

3. Do you support the Board's proposal to adopt the draft Psychology Board of Australia code of conduct as the regulatory code for the psychology profession?

Your answer:

Yes. As long as there is capacity for broad interpretation rather than narrow interpretation of what it means to practice psychology in Australia.

Content of the draft Psychology Board code

4. Does the draft Psychology Board of Australia code of conduct set the minimum standards expected of psychologists by their professional peers and the public?

Your answer:

Yes – however it is important that they are not too narrow and prescriptive such that it stifles diversity and innovation.

5. Are there any specific areas of psychological practice that are not adequately addressed in the draft Psychology Board of Australia code of conduct?

Your answer:

Evidence based practice includes client preferences. Client preferences can include a broad range of health care practices including complementary and integrative approaches to mental health, such as nutritional psychiatry and lifestyle medicine. It is important that appropriately trained psychologists are able to incorporate these skills into their practice in response to consumer demand.

I hope the PsyBA acknowledges the potential of the rich and diverse innovation that dual qualified psychologists can bring to the profession. A recent research project I conducted – although not focussed on dual qualifications – highlighted the number and diversity of psychologists with dual qualifications.

Thomson-Casey, C., McIntyre, E., Rogers, K., & Adams, J. (2023). The relationship between psychology practice and complementary medicine in Australia: Psychologists' demographics and practice characteristics regarding type of engagement across a range of complementary medicine modalities. PloS one, 18(5), e0285050.

https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0285050

6. Are there any sections of the draft Psychology Board of Australia code of conduct that would be unworkable for your organisation and/or stakeholders?

Your answer:

Acceptable

7. Is the language and structure of the draft Psychology Board of Australia code of conduct helpful, clear and relevant?

Your answer:

Acceptable

Community impact

8. Would implementation of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for Aboriginal and Torres Strait Islander Peoples? If so, please describe them.

Your answer:

The PsyBA should also acknowledge forms of traditional healing and medicine that are relevant for Aboriginal and Torres Strait Islander people.

9. Would endorsement of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for other diverse groups or vulnerable members of the community? If so, please describe them.

Your answer:

The PsyBA should also acknowledge forms of traditional healing and medicine that are relevant for other cultures in Australia that have strong connections to their traditional healing and medicine, such as Indian and Chinese medicine. The World Health Organisation encourages member states to facilitate research and integration of CM into health care settings and improve access to equitable health care.

WHO Traditional Medicine Strategy

World Health Organization. (2013). WHO traditional medicine strategy: 2014-2023. World Health Organization.

https://www.who.int/publications-detail-redirect/9789241506096

10. Would endorsement of the draft Psychology Board of Australia code of conduct result in any adverse cost implications for health practitioners, higher education providers, employers, clients/consumers, governments or other stakeholders? If so, please describe them.

Your answer:

The PsyBA should ensure that the Code of Conduct enables practitioners to easily work across sectors and settings and that psychologists are able to adapt their practice to diverse community settings. Good psychology is not a narrowly prescribed set of rules. If we limit our capacity to be diverse and innovative we continue down the path of becoming too prescriptive and exclusive. Psychology does not have a monopoly on mental health care.

I encourage the PsyBA to acknowledge the role of traditional, complementary and integrative medicine as forms of health care. Over 70% of people in Australia are using some form of complementary medicine (CM) and psychologists are likely to have clients that use CM. Psychologists should be able to apprise clients of ALL forms of health care that they could choose from, including CM.

Thomson-Casey, C., Adams, J., & McIntyre, E. (2022). Complementary medicine in psychology practice: an analysis of Australian psychology guidelines and a comparison with other psychology associations from English speaking countries. BMC complementary medicine and therapies, 22(1), 171.

https://link.springer.com/article/10.1186/s12906-022-03620-2

Transition and implementation

The Board is proposing to publish an advance copy of the draft Psychology Board of Australia code of conduct **12 months** before it would come into effect.

11. Do you agree with the proposed transition timeframe?

Your answer:

Yes

12. Would there be any implementation issues for your organisation and/or stakeholders that the Board should be aware of?

Your answer:

I hope the new code of conduct is a progressive step forward for the profession.

General feedback

13. Do you have any other feedback or comments about the draft Psychology Board of Australia code of conduct?

Your answer:

Attachment F

Public consultation: A code of conduct for psychologists

The Psychology Board of Australia (the Board) is seeking your feedback about our proposal to update the code of conduct that applies to all psychologists registered in Australia. There are 13 specific questions we would like you to address below. All questions are optional, and you are welcome to respond to any that you find relevant, or that you have a view on.

Please email your submission to: psychconsultation@ahpra.gov.au

The submission deadline is close of business, **Monday 14 August 2023**

General questions

1. Do you support the Board's preferred option to implement a regulatory code of conduct?

Your answer:

No, not without supporting guidelines.

2. Do you agree with the Board's approach to develop the draft Psychology Board of Australia code of conduct based on the shared *Code of conduct*?

Your answer:

No, not without supporting guidelines

3. Do you support the Board's proposal to adopt the draft Psychology Board of Australia code of conduct as the regulatory code for the psychology profession?

Your answer:

No, not without supporting guidelines

Content of the draft Psychology Board code

4. Does the draft Psychology Board of Australia code of conduct set the minimum standards expected of psychologists by their professional peers and the public?

Your answer:

No, not without supporting guidelines.

5. Are there any specific areas of psychological practice that are not adequately addressed in the draft Psychology Board of Australia code of conduct?

Your answer:

Yes, there are no supporting guidelines, therefore, the 'Code' can be interpreted and implemented by the Board, without consultation with those covered by the 'Code'.

6. Are there any sections of the draft Psychology Board of Australia code of conduct that would be unworkable for your organisation and/or stakeholders?

Your answer:

All of it without supporting guidelines.

7. Is the language and structure of the draft Psychology Board of Australia code of conduct helpful, clear, and relevant?

Your answer:

Yes, but it lacks guidelines on how the 'Code' will be implemented.

Community impact

8. Would implementation of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for Aboriginal and Torres Strait Islander Peoples? If so, please describe them.

Your answer:

I believe that psychologists are already sensitive to culturally diverse groups. So, I don't believe so.

9. Would endorsement of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for other diverse groups or vulnerable members of the community? If so, please describe them.

Your answer:

Yes, if supporting guidelines are not consulted on in conjunction with the 'Code', there could be many negative consequences for all, including psychologists.

10. Would endorsement of the draft Psychology Board of Australia code of conduct result in any adverse cost implications for health practitioners, higher education providers, employers, clients/consumers, governments, or other stakeholders? If so, please describe them.

Your answer:

Yes, it must be costing the Board to conduct the development and implementation of the 'Code', and will cost also to develop supporting guidelines.

Transition and implementation

The Board is proposing to publish an advance copy of the draft Psychology Board of Australia code of conduct **12 months** before it would come into effect.

11. Do you agree with the proposed transition timeframe?

Your answer:

I would like a two-year implementation program if it was to occur – to allow one year to iron out any bugs and a second year to bed it in, if it was to go ahead. However, I do not believe it should be implemented without supporting guidelines. They are essential so that psychologists are aware of their responsibilities.

12. Would there be any implementation issues for your organisation and/or stakeholders that the Board should be aware of?

Your answer:

Yes, as there are no supporting guidelines, it will be extremely difficult to follow the 'Code' as it is written in general terms. Just one example is Principle 9 para b. – It would need to be spelled out clearly, to prevent psychologists inadvertently breaching the Code, particularly in relation to vaccinations. Just one example.

General feedback

13. Do you have any other feedback or comments about the draft Psychology Board of Australia code of conduct?

Your answer:

Propose supporting guidelines for consultation, in conjunction with the 'Code' so that psychologists are clear on their legal responsibilities.

Attachment F

Public consultation: A code of conduct for psychologists

The Psychology Board of Australia (the Board) is seeking your feedback about our proposal to update the code of conduct that applies to all psychologists registered in Australia. There are 13 specific questions we would like you to address below. All questions are optional and you are welcome to respond to any that you find relevant, or that you have a view on.

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The submission deadline is close of business, **Monday 14 August 2023**

General questions
1. Do you support the Board's preferred option to implement a regulatory code of conduct?
Your answer:
2. Do you agree with the Board's approach to develop the draft Psychology Board of Australia code of conduct based on the shared *Code of conduct*?
Your answer:
3. Do you support the Board's proposal to adopt the draft Psychology Board of Australia code of conduct as the regulatory code for the psychology profession?
Your answer:

Content of the draft Psychology Board code

4. Does the draft Psychology Board of Australia code of conduct set the minimum standards expected of psychologists by their professional peers and the public?

Your answer:

5. Are there any specific areas of psychological practice that are not adequately addressed in the draft Psychology Board of Australia code of conduct?

Your answer:

6. Are there any sections of the draft Psychology Board of Australia code of conduct that would be unworkable for your organisation and/or stakeholders?

Your answer:

7. Is the language and structure of the draft Psychology Board of Australia code of conduct helpful, clear and relevant?

Your answer:

Community impact

8. Would implementation of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for Aboriginal and Torres Strait Islander Peoples? If so, please describe them.

Your answer:

9. Would endorsement of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for other diverse groups or vulnerable members of the community? If so, please describe them.

Your answer:

10. Would endorsement of the draft Psychology Board of Australia code of conduct result in any adverse cost implications for health practitioners, higher education providers, employers, clients/consumers, governments or other stakeholders? If so, please describe them.

Your answer:

Transition and implementation

The Board is proposing to publish an advance copy of the draft Psychology Board of Australia code of conduct **12 months** before it would come into effect.

11. Do you agree with the proposed transition timeframe?

Your answer:

12. Would there be any implementation issues for your organisation and/or stakeholders that the Board should be aware of?

Your answer:

General feedback

13. Do you have any other feedback or comments about the draft Psychology Board of Australia code of conduct?

Your answer:

Most of the items in 4.8 do not adequately reflect the reality of clinicians working in regional and rural areas where dual relationships are far more common and unavoidable. If it is considered desirable to have psychologists living and working in rural areas, and seeing clients who live in the area, there needs to be greater recognition of the commonality of dual relationships, both intentional and unintentional dual relationships. A clinician might find that their child is at school with the child of a client, or might turn up in the same sporting team or pottery class, or might work at the local real estate office from which the clinician rents their house, or be the best local yoga teacher or the only piano teacher. Dual relationships in regional and rural areas are the norm, not the exception. This code of conduct needs to better reflect the needs of all concerned. Rural

clinicians are often bombarded with requests from people in their friendship circle to see their children, or their friends.Much of this can be avoided, but is harder to avoid if the clinician has an area of expertise for which an alternative clinician is hard to find, and where the need of the client is urgent. The guidelines need to say more about how to manage dual relationships, not just the need to avoid them. Otherwise rural and regional clinicians will stop seeing local people and just offer services by telehealth to city dwellers where the risk of dual relationships can be avoided. This is an unwanted and unintended negative consequence if a code of conduct is overly restrictive or prescriptive.

Attachment F

Public consultation: A code of conduct for psychologists

The Psychology Board of Australia (the Board) is seeking your feedback about our proposal to update the code of conduct that applies to all psychologists registered in Australia. There are 13 specific questions we would like you to address below. All questions are optional and you are welcome to respond to any that you find relevant, or that you have a view on.

Please email your submission to: psychconsultation@ahpra.gov.au

The submission deadline is close of business, **Monday 14 August 2023**

General questions

1. Do you support the Board's preferred option to implement a regulatory code of conduct?

Your answer:

Yes, this is a long overdue and welcome initiative.

2. Do you agree with the Board's approach to develop the draft Psychology Board of Australia code of conduct based on the shared *Code of conduct*?

Your answer:

Yes, this is a practical approach to developing the code. However, care must be taken to consider the code from the perspective of psychologists working outside of health settings and to amend the code as appropriate to ensure relevance to all areas of psychological practice.

3. Do you support the Board's proposal to adopt the draft Psychology Board of Australia code of conduct as the regulatory code for the psychology profession?

Your answer:

Yes, the code of conduct, with considerable amendments, should be adopted by the PsyBA.

Content of the draft Psychology Board code

4. Does the draft Psychology Board of Australia code of conduct set the minimum standards expected of psychologists by their professional peers and the public?

Your answer:

The draft code seems to detail an appropriate standard expected of psychologists working in clinical practice. However, the code should be updated to consider the perspective of psychologists working outside of health settings, particularly in organisational and business contexts, and to amend the code as appropriate.

5. Are there any specific areas of psychological practice that are not adequately addressed in the draft Psychology Board of Australia code of conduct?

Your answer:

The code is problematic from an organisational psychology perspective and should be updated to use more inclusive language, particularly the practice definition.

6. Are there any sections of the draft Psychology Board of Australia code of conduct that would be unworkable for your organisation and/or stakeholders?

Your answer:

There would be some significant implications for organisational psychologists and psychologists working in organisational psychology domains.

The practice definition should be updated and changed “Practice means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a practitioner in their regulated health profession. For the purposes of this code, practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct non-clinical relationship with patients, working in management, administration, education, research, advisory, regulatory or policy development roles and any other roles that have an impact on safe, effective delivery of health services in the health profession.” This definition seemingly excludes organisational psychologists and psychologists working in organisational psychology domains outside of health settings.

It seems to have been changed from the previous definition used that was less health specific “Practice means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a psychologist in their profession. For the purposes of this registration standard, practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct nonclinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of services in the profession.”

7. Is the language and structure of the draft Psychology Board of Australia code of conduct helpful, clear and relevant?

Your answer:

There are a several areas where the language of the code can be improved. The language is very health specific and is not easily interpreted outside of clinical practice settings.

While the code states on page 5 "It is not intended as a mechanism to address: b. employment issues e.g. workplace or industrial disputes, which do not raise broader public safety concerns." I believe this should be taken out. This statement may unduly impact the work of organisational psychologists and psychologists working in organisational psychology domains. Many ethical issues arise in workplace setting and the code can be a useful resource to clarify psychologists' ethical obligations, which are not always aligned with the interests of employers. This statement also conflicts with 4.3 b "be aware that psychologists have a responsibility to help clients address inequities and that increased advocacy may be necessary to ensure just access to psychological services", and 8.12 g "avoid performance targets, quotas and business practices that are inconsistent with your obligations under this code. Where psychologists identify such a conflict, they should seek a constructive resolution that is consistent with this code."

Under professional values and qualities e. "Psychologists are expected to engage in regular self-reflection and peer consultation on whether they are practising safely and effectively, on their relationships with patients and colleagues, and on their own health and wellbeing." The term client should be used in this sentence instead of patient. Client is defined and may include organisations.

Under professional values and qualities h. "Psychologists should be committed to safety and quality in healthcare." Psychologists don't all work in healthcare settings. This should be amended to 'Psychologists should be committed to safety and quality in the provision of psychological services."

Under 1.2 e. "communicate effectively with clients to ensure they have enough information to make an informed decision about their current and future care". Not all psychologists work in healthcare settings. I suggest amending this to 'communicate effectively with clients to ensure they have enough information to make informed decisions'.

Under 1.3 e. "If a client poses a risk to safety, they should not be denied access to services if reasonable steps can be taken to ensure safety". Perhaps this should be amended to health and safety, as there are risks in seeing clients that can impact mental as well as physical health e.g. "If a client poses a risk to health and safety, they should not be denied access to services if reasonable steps can be taken to ensure health and safety".

Principle 3, should be amended from "… assumptions and beliefs influence their interactions with people and families, the community and colleagues." to '… assumptions and beliefs influence their interactions with clients.' Recognising that clients can also be organisations or external parties.

3.2 a. "communicate, respectfully, compassionately and honestly with clients, their nominated partner, substitute decision-maker, carers, family and friends." This is very clinical in focus and does not apply to organisational psychologists or psychologists working in organisational psychology domains. Consider revising to "communicate, respectfully, empathically and honestly with clients and relevant others."

3.2 d. "take all practical steps to meet the specific language, cultural, and communication needs of clients and their families, including by using translating and interpreting services where necessary, and being aware of how these needs affect understanding." Consider revising to "take all practical steps to meet the specific language, cultural, and communication needs of clients and relevant others, including by using translating and interpreting services where necessary, and being aware of how these needs affect understanding."

4.1 a. "be respectful, compassionate and honest", I suggest amending to "be respectful, empathic and honest". Empathy and compassion have subtle different meanings. Empathy is likely more appropriate in an organisational context.

4.1 d. "recognise that there is a power imbalance in the psychologist–client relationship, and do not exploit clients physically, emotionally, sexually or financially". I suggest amending and including the word 'often' as in "recognise that there is often a power imbalance in the psychologist–client

relationship, and do not exploit clients physically, emotionally, sexually or financially." There is an inverse power imbalance when clients are organisations, e.g. psychologists working as external consultants to a business. Context is important.

4.2 j. "obtain financial consent by discussing fees in a manner appropriate to the professional relationship and addressing the costs of all required services and get general agreement about the level of treatment to be provided, preferably before the service starts". I suggest this could be amended to "obtain financial consent by discussing fees in a manner appropriate to the professional relationship and addressing the costs of all required services and get general agreement about the intervention to be provided, preferably before the service starts." This would make it more applicable to psychologists working in organisational psychology domains.

8.13 c. "do not influence clients to provide benefits such as making donations or provision of services to other people or organisations." This might not be practical for psychologists working in consulting and organisational roles, e.g. working on behalf of a union to influence employers to provide better health, safety and wellbeing services to employees.

Under principle 9, "work-related psychological risk factors" should be included in the definitions section, including examples to provide clarity (e.g. high job demands, poor support, violence and aggression, etc). I suggest "work-related psychological risk factors are factors in the design or management of work that increase the risk of work-related stress and can lead to psychological or physical harm. Examples include poor supervisor support or high job demands."

Under 9.2 b "Guidelines: Mandatory notifications about registered health psychologists" should be "Guidelines: Mandatory notifications about registered health practitioners".

10.3 "Provisional psychologists and registrars are learning how best to care for clients." This might be changed to 'how best to work with clients'. The term 'care' is not appropriate for provisional psychologists working in organisational and business contexts. This can also be applied to 10.3 d. and perhaps should be 'what the scope of their role is in working with clients'.

Community impact

8. Would implementation of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for Aboriginal and Torres Strait Islander Peoples? If so, please describe them.

Your answer:

I am unsure about this and suggest consulting with Aboriginal and Torres Strait Islander Peoples.

9. Would endorsement of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for other diverse groups or vulnerable members of the community? If so, please describe them.

Your answer:

There may be implications for organisational psychologists and psychologists working in organisational psychology domains. The code is very health specific and may not be easily interpreted and applied to organisational psychology contexts. This may lead to organisational psychologists and psychologists working outside of health settings choosing to ignore the code and/or terminate their registration, reducing the diversity of the psychology workforce and increasing the risk to the public.

10. Would endorsement of the draft Psychology Board of Australia code of conduct result in any adverse cost implications for health practitioners, higher education providers, employers, clients/consumers, governments or other stakeholders? If so, please describe them.

Your answer:

Not to my knowledge.

Transition and implementation

The Board is proposing to publish an advance copy of the draft Psychology Board of Australia code of conduct **12 months** before it would come into effect.

11. Do you agree with the proposed transition timeframe?

Your answer:

Yes.

12. Would there be any implementation issues for your organisation and/or stakeholders that the Board should be aware of?

Your answer:

Not to my knowledge.

General feedback

13. Do you have any other feedback or comments about the draft Psychology Board of Australia code of conduct?

Your answer:

The code should be easily interpreted and applied in various psychology contexts in both health and non-health related roles. The definition of practice should be amended to use more inclusive language and recognise psychologists working in organisational settings, e.g. business consulting. The code should be revised and changes made to the language of the code to improve its interpretation and application in organisational psychology contexts.

Attachment F

Public consultation: A code of conduct for psychologists

The Psychology Board of Australia (the Board) is seeking your feedback about our proposal to update the code of conduct that applies to all psychologists registered in Australia. There are 13 specific questions we would like you to address below. All questions are optional and you are welcome to respond to any that you find relevant, or that you have a view on.

Please email your submission to: psychconsultation@ahpra.gov.au

The submission deadline is close of business, **Monday 14 August 2023**

General questions
1. Do you support the Board's preferred option to implement a regulatory code of conduct?
Your answer:
2. Do you agree with the Board's approach to develop the draft Psychology Board of Australia code of conduct based on the shared *Code of conduct*?
Your answer:
3. Do you support the Board's proposal to adopt the draft Psychology Board of Australia code of conduct as the regulatory code for the psychology profession?
Your answer:

Content of the draft Psychology Board code

4. Does the draft Psychology Board of Australia code of conduct set the minimum standards expected of psychologists by their professional peers and the public?

Your answer:

5. Are there any specific areas of psychological practice that are not adequately addressed in the draft Psychology Board of Australia code of conduct?

Your answer:

6. Are there any sections of the draft Psychology Board of Australia code of conduct that would be unworkable for your organisation and/or stakeholders?

Your answer:

7. Is the language and structure of the draft Psychology Board of Australia code of conduct helpful, clear and relevant?

Your answer:

Community impact

8. Would implementation of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for Aboriginal and Torres Strait Islander Peoples? If so, please describe them.

Your answer:

I believe it is Standard 9.17 of the Standards for Educational and Psychological Testing which states that clients have the right to dispute assessments with representation. Also, Standard 10.10 states that an employer (or any party with a vested interest) should not interfere in the interpretation of an assessment. I believe that incorporating these two standards will assist in giving Aboriginal and Torres Strait Islander people greater participation and involvement in decisions that are being made about them and lead to greater fairness and justice with those decisions.

9. Would endorsement of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for other diverse groups or vulnerable members of the community? If so, please describe them.

Your answer: The draft code appears to be unintentionally reinforcing an expert decision making model. The *Earned Dogmatism Hypothesis* states that experts are unlikely to consider new information and also non-experts are unlikely to question the expert because they are the expert. Another factor to consider is the social evaluative threat response where an individual who is seen to be questioning the status quo (occurring through a negative reward prediction error) will then be judged negatively. This is why I believe it is critical to have the standards mentioned above included within the code.

The only way we are able to make decisions that are both fair and just is to make decisions based upon hypothetico-deductive reasoning. I recollect these words coming from an Australian psychologist based in Queensland, writing in an international journal but the reference is long since gone.

I am happy to support the Board move away from an expert decision model to the scientist-practitioner.

10. Would endorsement of the draft Psychology Board of Australia code of conduct result in any adverse cost implications for health practitioners, higher education providers,

employers, clients/consumers, governments or other stakeholders? If so, please describe them.
Your answer:

Transition and implementation

The Board is proposing to publish an advance copy of the draft Psychology Board of Australia code of conduct **12 months** before it would come into effect.

11. Do you agree with the proposed transition timeframe?

Your answer:

12. Would there be any implementation issues for your organisation and/or stakeholders that the Board should be aware of?

Your answer:

General feedback

13. Do you have any other feedback or comments about the draft Psychology Board of Australia code of conduct?

Your answer:

[redacted]

Subject: citations [redacted]

[redacted]

[redacted]

Earned Dogmatism Hypothesis

Ottati, V., Price, E. D., Wilson, C., & Sumaktoyo, N. (2015). When self-perceptions of expertise increase closed-minded cognition: The earned dogmatism effect. *Journal of Experimental Social Psychology, 61,* 131–138. https://doi.org/10.1016/j.jesp.2015.08.003

Social Evaluative Threat Response

Dickerson, S. S., Gruenewald, T. L., & Kemeny, M. E. (2004). When the social self is threatened: shame, physiology, and health. *Journal of personality*, *72*(6), 1191–1216. https://doi.org/10.1111/j.1467-6494.2004.00295.x

Negative Reward Prediction Error

Schultz W. (2016). Dopamine reward prediction error coding. *Dialogues in clinical neuroscience*, *18*(1), 23–32. https://doi.org/10.31887/DCNS.2016.18.1/wschultz

Kate E. O'Connor
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The Psychology Board of Australia
AHPRA
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QLD 4001
sent via email to: psychconsultation@ahpra.gov.au

13 August 2023

RE: CONSULTATION ON THE DRAFT CODE OF CONDUCT FOR PSYCHOLOGISTS

I am writing with regards to the proposed code of conduct for psychologists. [redacted] For context, I am a Clinical Psychologist and Board-approved Supervisor working in private practice. I have a decade of experience treating patients and practice primarily from a psychoanalytic framework.

As mentioned in my other correspondence, much of the draft Code appears to be a suitable replacement for the APS Code of Ethics. However, I believe the following specific aspects of the document warrant adaptation. Generally speaking, these issues relate to aspects of the Code that appear to create restriction beyond what I believe falls within the appropriate scope of the Board as a professional regulating body, or secondly, to introduce codification of behaviour better navigated with appropriate clinical judgement.

4.8 Professional boundaries

Firstly, the use of the phrase *"only indicated in exceptional circumstances"* throughout the draft Code lacks clarity and risks suggesting that particular clinical interventions (for example, physical touch and self disclosure) have an inherently illicit or inappropriate quality. For example:

c. recognise that physical contact with clients is only indicated in exceptional circumstances and when it is in the best interests of the client. There are risks associated with assessments and interventions that involve physical contact with client

While there are numerous therapies where physical touch may be generally unnecessary and inappropriate, I suggest that the Code more explicitly make greater provision for deference to clinical judgement in this regard, given that there is not yet such a definitive consensus within all frameworks of psychology about the role of touch in psychotherapy, and given that psychologists working with certain client groups or in certain modalities may use physical touch appropriately and with discernment to therapeutic benefit on a frequent basis. I might suggest rephrasing such as:

c. recognise that the use of physical touch with clients is a meaningful act that can involve risk and requires skill and technical knowledge for it to be appropriate and therapeutic in intention and effect. Psychologists utilise physical touch only when they are competent in discriminating between instances where it may be of benefit therapeutically versus potentially or expectably counter-therapeutic (or unnecessary) touch.

6.3 Psychological health and wellbeing

Psychologists have a responsibility to promote the health and wellbeing of the community.

Effective practice includes that you:

a. *participate in efforts to promote the psychological wellbeing of the community.*

Psychologists work in many different roles and modalities, and are people from all walks of life who having varying levels of energy and time invested in the profession in many forms. On this basis, I believe that obliging psychologists under the Code to engage in specific activities to promote the wellbeing of the community is an overreach of the role of the Board.

8.4 Public behaviour and statements

When making public statements of any kind, including on social media, effective practice includes that you:

a. use respectful language, respect the privacy of others and maintain proper boundaries, and
b. make informed comments using contemporary, peer-reviewed research findings and/or your demonstrated experience and expertise.

The vagueness of these statements leads to what I believe are excessive obligations on all of a psychologist's personal public life beyond the appropriate reach of a professional governing body. It is not clear, for example, the privacy of which "others" this statement refers, nor to which "proper boundaries". Further, banning psychologists from making any public comments about any topic without peer-reviewed research is far beyond the scope of the obligations of the profession. These statements would be better amended to apply only to issues relating to the profession, clients and clinical work.

9.1 Your health and wellbeing

a. seek expert, independent, objective advice when you need healthcare, and be aware of the risks of self-diagnosis and self-treatment

Although psychologists should retain an obligation to ensure they are well enough to provide the services they offer to clients and the community, I believe the Code overreaches in making any specification of an obligation to seek out certain kinds of healthcare. How an individual chooses to manage their personal health is beyond the scope of a professional governing body.

I look forward to the Board's response, and to ongoing transparency and consultation in the process of reviewing this very important document.

Warmest regards,

Kate E. O'Connor
Clinical Psychologist
[redacted]

Attachment F

Public consultation: A code of conduct for psychologists

The Psychology Board of Australia (the Board) is seeking your feedback about our proposal to update the code of conduct that applies to all psychologists registered in Australia. There are 13 specific questions we would like you to address below. All questions are optional and you are welcome to respond to any that you find relevant, or that you have a view on.

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The submission deadline is close of business, **Monday 14 August 2023**

General questions

1. Do you support the Board's preferred option to implement a regulatory code of conduct?

Your answer:

Yes

2. Do you agree with the Board's approach to develop the draft Psychology Board of Australia code of conduct based on the shared *Code of conduct*?

Your answer:

Yes

3. Do you support the Board's proposal to adopt the draft Psychology Board of Australia code of conduct as the regulatory code for the psychology profession?

Your answer:

Yes, as a general principle we believe it is important to have a code of conduct drafted by the Psychology Board of Australia. However, there are significant concerns that would need to be resolved before we could support the adoption of this code of conduct. Our particular concerns are outlined below under 'General Feedback'.

Content of the draft Psychology Board code

4. Does the draft Psychology Board of Australia code of conduct set the minimum standards expected of psychologists by their professional peers and the public?

Your answer:

Ideally, the draft code would set these minimum standards. However, as noted above, there are significant concerns with the present draft as it stands. Our more specific concerns are outlined below under 'General Feedback'.

It is worth noting, some of the matters outlined in this code of conduct appear to be more aspirational than practical (e.g. 6.2 Equity and opportunity) and would be more appropriate in a code of ethics that is available to all psychologists, not just those with APS membership.

5. Are there any specific areas of psychological practice that are not adequately addressed in the draft Psychology Board of Australia code of conduct?

Your answer:

Not that we are aware of.

6. Are there any sections of the draft Psychology Board of Australia code of conduct that would be unworkable for your organisation and/or stakeholders?

Your answer:

Potentially, yes. Please see list of full concerns below under 'General Feedback'.

7. Is the language and structure of the draft Psychology Board of Australia code of conduct helpful, clear and relevant?

Your answer:

Some sections would benefit from clearer and less ambiguous wording. These concerns are outlined below under 'General Feedback'.

Community impact

8. Would implementation of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for Aboriginal and Torres Strait Islander Peoples? If so, please describe them.

Your answer:

Not that we are aware of, but this is not an area of expertise we possess. If it has not already been done, we recommend consultation be undertaken with Indigenous psychologists and consumer stakeholders to ensure this is not the case.

9. Would endorsement of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for other diverse groups or vulnerable members of the community? If so, please describe them.

Your answer:

Potentially, yes. Similar to question 8. above, if it has not already been done, we recommend consultation be undertaken with diverse psychologists and consumer stakeholders to ensure this is not the case. This should include people who have lived experience and can speak to: cultural and linguistic diversity, gender and sexual diversity, disability and neurodiversity.

There is some concern around the prohibition on self-disclosure and how it might impact diverse communities, where self-disclosure regarding shared identity experiences is therapeutically beneficial. See more detailed comments below under 'General Feedback'.

10. Would endorsement of the draft Psychology Board of Australia code of conduct result in any adverse cost implications for health practitioners, higher education providers, employers, clients/consumers, governments or other stakeholders? If so, please describe them.

Your answer:

Yes, there are concerns that a number of the clauses would create onerous requirements on psychologists to comply with according to the code as it is presently written (e.g. requirements around emergency situations and continuity of service). Please see full comments below under 'General Feedback'.

Transition and implementation

The Board is proposing to publish an advance copy of the draft Psychology Board of Australia code of conduct **12 months** before it would come into effect.

11. Do you agree with the proposed transition timeframe?

Your answer:

It is difficult to say without having a clearer picture on what the implementation plan for the code of conduct would be.

12. Would there be any implementation issues for your organisation and/or stakeholders that the Board should be aware of?

Your answer:

It is difficult to say without having a clearer picture on what the implementation plan for the code of conduct would be. Having an implementation plan for the code made available would be helpful in making this determination.

General feedback

13. Do you have any other feedback or comments about the draft Psychology Board of Australia code of conduct?

Your answer:

Thank you for the opportunity to provide feedback on the code of conduct. We believe that creating a code of conduct for psychology is a worthy project and will be important for providing regulatory clarity to stakeholders and psychologists alike. To reiterate, we are in support of a code of conduct, but wish to raise the following concerns we believe require addressing before the code of conduct is endorsed.

The following points elaborate on what has been noted in the submission above.

1.1 Providing Safe and Effective Psychological Services
d. recognise that decisions regarding psychological services are the shared responsibility of the psychologist and the client who may wish to involve their family, carers and/or others.
Where this is desired by the client, it can be helpful to involve other close people in their network. However, Medicare and other funding sources may not fund for such sessions, meaning this may not be possible within current systems.

1.2 Safe and effective psychological services
g. practise within a contemporary, evidence-based and client-centred framework. Where there is an absence of evidence you should be guided by accepted best practice and/or opinion
The wording here is unclear as to whose opinion we should be guided by: our own based on our clinical experience, experts in the field, client preferences, all of the above? Clearer wording would be helpful.

1.3 Decisions about access to psychological services

e. keep yourself and others safe when providing psychological services. If a client poses a risk to safety, they should not be denied access to services if reasonable steps can be taken to ensure safety, and

We are concerned about the vagueness of the wording in this clause around 'reasonable steps' and how this kind of risk assessment would be determined. There are likely to be unconsidered power dynamics that could play out here depending on many factors, such as gender, or between the agenda of an organisation and individual psychologist, or a supervisor and supervisee. 'Reasonable risk' might look very different from all of these perspectives (e.g. female psych with violent male offender who may feel uncomfortable but not be backed by her organisation or a supervisor who sees the level of risk differently because of their gender or because they are not the ones meeting with the offender). Even with more clarity around risk assessment, we believe that fundamentally it should remain the right of a psychologist to discern how to best manage their safety and to refuse services to clients with whom they feel unsafe.

1.3 Decisions about access to psychological services

f. not allow your moral or religious views or conscientious objection to deny clients access to psychological services, recognising that you are free to decline to provide or participate in those services yourself. In such a situation, it is important to respectfully inform the client (where relevant), your employer and other relevant colleagues, of your objection and ensure the client has alternative options for psychological services.

The wording in the last sentence is unhelpfully ambiguous in regards the obligation to 'ensure the client has alternative options for psychological services'. In an organisation it may be more feasibly to pass on a client where there are many other psychologists available. However, in private practice your only option would be to refer on. Is the provision of referral information to the client adequate, or is there a requirement to ensure the client has been picked up by a referral? If the latter, the expectation is unreasonably onerous with current wait times and strain in the private sector.

1.4 Helping in Emergencies

Helping clients in emergencies requires psychologists to consider a range of issues, in addition to providing best care. Effective practice means you should offer help in an emergency that takes account of your own safety, your skills, the availability of other options and the impact on any other clients under your care, and continue to help until your services are no longer needed.

The requirements suggested here are ambiguous and appear not to be practical for psychologists in most settings. For instance, in a private practice setting it is not possible to provide crisis and emergency care outside of the time allotted to therapy with the client, there is no provision for renumeration for this, nor is it best-practice to be available 24/7 for crisis or emergency management to clients. If this clause remains, it would be helpful if the wording of this point is redrafted to account for these practical limitations.

We are aware that this clause has been taken from the Medical Practitioners code of conduct, where this clause seems more relevant given the nature of medical practice. Given the concerns noted above, we query whether this clause is appropriate in the same way for psychologists (as it would be for medical practitioners). Furthermore, given the clauses in the draft code of conduct for psychologists that already exist around managing risk, we also query whether the section on risk management in the code is not sufficient for the type of 'emergencies' psychologists regularly face.

2.2 Cultural safety for Aboriginal and Torres Strait Islander Peoples

As non-Indigenous people, this section reads well at face value, but this is a very poor benchmark. One of us attended a webinar recently with a representative of the psych board, who stated that only one Indigenous person was consulted in the development of the guidelines. This is concerning. Seeking guidance and approval from a wide range of Indigenous stakeholders is essential, including Indigenous psychologists and consumers.

3.2 Effective communication

e. use interpreters, where reasonably possible, from an accredited service provider who abides by the Australian Institute of Interpreters and Translators (AUSIT) Code of ethics and Code of conduct

This intention of this clause is reasonable, however it is not clear if practitioners are expected to bear the financial responsibility of utilising this service. If so, this this financial responsibility might be burdensome for private practitioners.

4.4 Relatives, carers and partners
b. with appropriate consent, or where otherwise permitted, be responsive in providing information. (See also 3.2 a. communicate, respectfully, compassionately and honestly with clients, their nominated partner, substitute decision-maker, carers, family and friends)
These clauses are very concerning. Many clients are in relationships and family systems that may have inappropriate and unhealthy relationship dynamics, including dominance, abuse, and co-dependence. Especially in early stages of treatment, clients may not be able to accurately discern problematic dynamics and will consent to sharing information with family or partners due to feeling anxious, fearful or too passive to assert healthy boundaries (clause *32a* does not even mention the need for consent). We are concerned that the default expectation to be 'responsive in providing information' does not give due regard to these serious considerations. In our clinical opinion, the only time it is appropriate to share information with family and partners is when it is essential to client safety, or, when it is determined after very thorough assessment with the client that it is safe to share information with family/partners and that sharing information is genuinely the best way to support the client to grow therapeutically. In our experience, these conditions are met rarely.

4.7 Maintaining continuity of psychological services
a. make arrangements for other professionals to continue providing services to clients during emergencies or periods of your foreseeable absence
This clause is vague in terms of the time period where this would be relevant. All clinicians have time off for personal leave and illness during the year, and it is not usual to have other professionals provide services in lieu, during these times. The exceptions would be when it is a considerable length of time away from the practice (usually a month or more). Even then, many clients have enough stability and chose to wait for the therapists return rather than see another practitioner. Adding wording at the end of the clause like 'when doing so is determined to by the client and therapist to be clinically important for client care and safety' would make this clause more reasonable.
b. make reasonable plans for the continuity of service to clients in the event you become unavailable, for example due to your relocation, illness or death
This clause does not sound feasible to comply with for private practitioners given the current shortage of available private practitioners across Australia. If one of us became suddenly ill or died, given what we know about current wait times, it would be nearly impossible for all clients on a caseload to find other psychologists to take them on. The wording is also unclear on what constitutes 'reasonable'. Is a list of email addresses for other private practices sufficient (noting we cannot guarantee anyone will have space)? Do we need some kind of written agreement with colleagues that they will take on clients in the case of illness or death (which seems an impossible thing to ask someone to agree to ahead of time)? We have the same concerns regarding 'emergencies' under subclause *4.7a* above.

4.8 Professional boundaries
c. recognise that physical contact with clients is only indicated in exceptional circumstances and when it is in the best interests of the client. There are risks associated with assessments and interventions that involve physical contact with clients
d. ensure any assessment and/or intervention that involves physical contact with a client has a clear, evidence-based indication. The reasons for, process of and outcomes of the physical contact must be recorded in the relevant records
e. obtain written consent for any assessment and/or intervention that involves physical contact with a client (See also 4.2 Informed consent)
There are many reasons a clinician might have some physical contact with a client, such as handshakes, a hug solicited by a client at the end of treatment, a comforting touch on the shoulder. We believe a clinician's judgment is important here and that clinicians can use judicious judgment about physical client with clients when it is warranted by the treatment (e.g. tapping in EMDR), or when a reasonable part of the therapeutic relationship (e.g a handshake on meeting, a client-solicited hug at the end of treatment or to mark some other significant milestone). The wording here risks making physical contact excessively restrictive and the requirements to document it and seek written consent unreasonably onerous.

f. recognise that it is mostly inappropriate to share your personal information with clients and/or associated parties, and before doing so, you should consult an experienced colleague to determine whether your purpose for such disclosure is appropriate.
We acknowledge that self-disclosure that is not in clients' best interests and is motivated by non-therapeutic reasons can interfere with therapy outcomes, blur professional boundaries, and be detrimental to clients. However, stating that self-disclosure is 'mostly inappropriate' is not accurate and is not in keeping with the current evidence base on appropriate self-disclosures in the therapeutic context. Noting in the code of conduct that therapists should use appropriate clinical judgment to assess the therapeutic benefits of self-disclosure would be preferable.

To expand on the point above, many minority groups prefer psychologists who share their culture. This includes those who are autistic, ADHD, dyslexic or who otherwise fit within the neurodevelopmental differences side of the neurodivergent community. There is now emerging literature to support the benefit of clients of having practitioners within their cultural group, including neurotype. In this case, self-disclosure about your cultural identity as a practitioner would be of huge therapeutic value and part of why a client has explicitly chosen you.

Many psychoanalytic and psychodynamic therapies also use judicious self-disclosure as a central part of the therapy itself (e.g. discussion of transference and countertransference). Regardless of paradigm, research has found that judicious self-disclosure in therapy can normalise experiences and feelings a client is having, increase trust, model coping strategies and strengthen the therapeutic alliance.

Finally, suggesting that every instance of self-disclosure be reviewed with a senior supervisor is not practical and may undermine the ability for clinicians to respond authentically and relationally in the moment with clients. The ability to be authentic in the moment is an essential part of building a strong therapeutic alliance, the backbone of therapeutic success across all modalities.

Research to support the use of judicious self-disclosure includes:

Yalom, I. D. (2002). The Gift of Therapy: An Open Letter to a New Generation of Therapists and Their Patients. HarperCollins.

Hill, C. E., & Knox, S. (2001). Self-disclosure. Psychotherapy: Theory, Research, Practice, Training, 38(4), 413-417.

Zur, O. (2007). Boundaries in psychotherapy: Ethical and clinical explorations. American Psychological Association.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. Journal of consulting psychology, 21(2), 95-103.

Audet, C. T., & Everall, R. D. (2003). Therapist self-disclosure and the therapeutic relationship: A phenomenological study from the client perspective. British Journal of Guidance & Counselling, 31(3), 257-270.

Elizabeth Pellicano, Wenn Lawson, Gabrielle Hall, Joanne Mahony, Rozanna Lilley, Melanie Heyworth, Hayley Clapham, & Michael Yudell. (2022). "I Knew She'd Get It, and Get Me": Participants' Perspectives of a Participatory Autism Research Project. Autism in Adulthood, 4(2), 120-129. https://doi.org/10.1089/aut.2021.0039

O'Brien, C., Flower, R. L., & Jellet, R. (2023). *"Basically, it's that she accepts me as I am": Autistic Adults' Positive Experiences with Psychologists in Australia*. La Trobe University, Swinburne University.

5.2 Teamwork and Collaboration
When working in a team or collaboratively, effective practice includes that you:

e. act as a positive role model for team members
This clause is aspirational and ambiguous. Even with clearer wording it is not evident why this is aspirational idea is something that would require regulating via a code of conduct.

6.1 Use of Psychological Services Wisely
d. understand that your use of resources can affect the access other clients have to psychological services.
This clause is very poorly worded. It reads as though you are suggesting psychologists should consider whether seeking their own psychological help will affect the access of others in the community. However, according to the psych board rep at the webinar one of us attended, this clause is meant to be about how providing your services to a client might affect their access to other services. If this is the case, the wording needs to be much clearer as most people we have spoken to have the misunderstood this point.

6.2 Equity and opportunity
There are significant inequities in health status and the educational and employment opportunities for various groups in the Australian community. These inequities result from social, cultural, historic, geographic, environmental, physiological, psychological and other factors. Some groups who experience inequities include Aboriginal and Torres Strait Islander Peoples; people with disabilities; those who are gender or sexuality diverse; and those from socially, culturally and linguistically diverse backgrounds, including asylum seekers and refugees. Effective practice includes that you use your expertise and influence to promote good health and educational and employment opportunities for individuals, communities and populations.
This clause is aspirational, and does not appear to be an issue that should be regulated in a code of conduct. Furthermore, it suggests actions that are not practical in the scope of most (if any?) psychologists' practice.

8.13 Financial and Commercial Dealings
e. do not ask for or accept any inducement, gift or hospitality that may affect or be seen to affect the way you provide psychological services for clients
This clause is very prescriptive. It is not unusual for clients to give token gifts to therapists to express their gratitude or as part of their personal or cultural values. It is important to have a clause about ethically managing gift giving to protect clients from being taken advantage and to protect the integrity of the boundaries in a therapeutic relationship. However, clinical judgment and the therapeutic purpose of the gift giving should be centred.

10.3 Provisional psychologists and registrars
Provisional psychologists and registrars are learning how best to care for clients. Creating opportunities for learning improves their psychology practice and nurtures the future workforce.
e. obtain clients' consent for provisional psychologists and registrars to be involved and respect their right to refuse consent.
Given registrars are fully qualified registered general psychologists, they should not require special consent from clients.

Attachment F

Public consultation: A code of conduct for psychologists

The Psychology Board of Australia (the Board) is seeking your feedback about our proposal to update the code of conduct that applies to all psychologists registered in Australia. There are 13 specific questions we would like you to address below. All questions are optional and you are welcome to respond to any that you find relevant, or that you have a view on.

Please email your submission to: psychconsultation@ahpra.gov.au

The submission deadline is close of business, **Monday 14 August 2023**

General questions

1. Do you support the Board's preferred option to implement a regulatory code of conduct?

Your answer:

If it can carry more weight across organisational structures than the APS code of ethics then yes.

I hope you take into account COB AWT, not just AEST

2. Do you agree with the Board's approach to develop the draft Psychology Board of Australia code of conduct based on the shared *Code of conduct*?

Your answer:

I was skeptical at first and feared that standards would be reduced, given the high reputation of the code of ethics. However having read the document I am more hopeful. If the feedback provided is genuinely considered and incorporated to clear up the confusion, I am in support

3. Do you support the Board's proposal to adopt the draft Psychology Board of Australia code of conduct as the regulatory code for the psychology profession?

Your answer:

AA

Content of the draft Psychology Board code

4. Does the draft Psychology Board of Australia code of conduct set the minimum standards expected of psychologists by their professional peers and the public?

Your answer:

I hope so.

5. Are there any specific areas of psychological practice that are not adequately addressed in the draft Psychology Board of Australia code of conduct?

Your answer:

Some of the terminology that causes confusion needs to be cleared up . See section 7. below for details

6. Are there any sections of the draft Psychology Board of Australia code of conduct that would be unworkable for your organisation and/or stakeholders?

Your answer:

7. Is the language and structure of the draft Psychology Board of Australia code of conduct helpful, clear and relevant?

Your answer: Some is clear. Other areas not at all. For example 6.3 (b) on page 17.participates in efforts to promote the psychological wellbeing of the community" What does this mean? Eg. For Forensic psychs does this mean the prison community or does it mean the community at large? The same for inpatient clin psychs? Organisational psychologists? Does this mean that the endorsement of community psychology will be null and void?

4.8(f) "Inappropriate to share personal information". In a small country town the community is likely to know your address, your family or lack of one, your kids at school plus much more.

In many instances, especially when working with the elderly or with disability, it can be helpful for the client to know that you have personal experience of loss of a loved and come out the other side. From my experience the therapist is often asked if they have had experience with the loss of a loved one. Withholding such information could be tantamount to lying. If the therapist has not had such an experience imo, it would be better to be honest and say "no, but I am willing to listen". If they have had such an experience, it would be best to say so, and demonstrate that it is possible to get through. It would be important that the therapist has enough skill/knowledge re countertransference or come to terms with their own losses before accepting a client struggling with the same issue.

I have had clients present having panic attacks about a new diagnosis of glaucoma for example. It can be very helpful to them, if they know that you are well on the way along the same track, and you can model an attitude of calm and gentle enquiry instead; and that they can see that life is not over.

From my many decades of working with elderly clients, I have seen elderly clients protect therapists they suspect have not experienced the loss of a loved, especially if the therapist is much younger, and breathe a sigh of relief if they know the therapist has successfully negotiated such a loss.

If there is a reasonable belief that a personal disclosure would assist therapy it should be allowed. I agree that personal disclosures that have nothing to do with therapy eg one share portfolio should not be disclosed. There are also personal circumstances that may have nothing to do with therapy but one cannot help but share, by just being there e.g pregnancy, or a therapist sporting a physical disability eg blind therapist or in a wheel chair ect

Community impact

8. Would implementation of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for Aboriginal and Torres Strait Islander Peoples? If so, please describe them.

Your answer:

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I leave it up to those who are more competent to answer this question

9. Would endorsement of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for other diverse groups or vulnerable members of the community? If so, please describe them.

Your answer:

None that I am aware of

10. Would endorsement of the draft Psychology Board of Australia code of conduct result in any adverse cost implications for health practitioners, higher education providers, employers, clients/consumers, governments or other stakeholders? If so, please describe them.

Your answer:

Possibly,if the tertiary services in the health department have to fund the health of the community at large using their psychologists, it would mean longer wait lists, which would inevitably mean increased pressure on beds not to mention the cost to the client.

Transition and implementation

The Board is proposing to publish an advance copy of the draft Psychology Board of Australia code of conduct **12 months** before it would come into effect.

11. Do you agree with the proposed transition timeframe?

Your answer:

yes

12. Would there be any implementation issues for your organisation and/or stakeholders that the Board should be aware of?

Your answer:

As previously stated, there are areas of the document that are not clear which could cause stress all round.

General feedback

13. Do you have any other feedback or comments about the draft Psychology Board of Australia code of conduct?

Your answer: I am pleased to see informed consent spelled out so clearly under 3.2 effective communication, 3.3 privacy and confidentiality and 4.2 informed consent.

My experience is that many organisations and other professionals think that written consent is the same as informed consent when such is not the case. Whilst clearly documented in the APS code of ethics such was viewed as not relevant by others. I hope that this code will be taken more seriously by various organisations that employ psychologists.

Attachment F

Public consultation: A code of conduct for psychologists

The Psychology Board of Australia (the Board) is seeking your feedback about our proposal to update the code of conduct that applies to all psychologists registered in Australia. There are 13 specific questions we would like you to address below. All questions are optional and you are welcome to respond to any that you find relevant, or that you have a view on.

Please email your submission to: psychconsultation@ahpra.gov.au

The submission deadline is close of business, **Monday 14 August 2023**

General questions

1. Do you support the Board's preferred option to implement a regulatory code of conduct?

Your answer:

We support the establishment of a code of conduct for psychologists, however we have some concerns that the proposed code of conduct uses language that is subjective, loose, vague, sometimes ambiguous and often refers to concepts that do not allow clarity of interpretation such as 'best available evidence' or 'best available information' or based 'on opinion'. Who determines what is 'best' and on what basis and whose opinion – how is this determined? – People may set themselves up as 'experts' without sufficient basis, as well as indicating expertise in areas that lack an evidence-base. We believe that the use of vague language and general statements that appear in the proposed code may make it difficult for investigators to fulfill their regulatory function and for the public to have a clear understanding of the obligations of psychologists.

2. Do you agree with the Board's approach to develop the draft Psychology Board of Australia code of conduct based on the shared *Code of conduct*?

Your answer:

Ultimately, we think the existing APS Code of Ethics' focus on principles is a more efficient and foundational document, which is prepared specifically for the profession of psychology.

The code of conduct is very long and does appear less formal through reference in most clauses to 'you' when addressing psychologists, rather than using 'psychologist' in the third person form. The use of the second person, 'you', is also inconsistent with the purpose of the code of conduct specified on page 4 as including it being "a guide for members of the public". The use of psychologist in the third person would speak more clearly to members of the public, other stakeholders, as well as to psychologists, and as a result be clearer on the expectations of psychologist conduct.

There is some repetition throughout the document, e.g., 1.1 is titled, 'Providing safe and effective psychological services'; 1.2 is titled, 'Safe and effective psychological services'

3. Do you support the Board's proposal to adopt the draft Psychology Board of Australia code of conduct as the regulatory code for the psychology profession?

Your answer:

As stated above, in its current iteration the code of conduct may not allow investigators to fulfill their regulatory function, and cause confusion for psychologists and members of the public. Although the code of conduct seems to attempt to use plain English and simplify explanations, from our perspective, on occasions it leaves large gaps to allow psychologists to justify any conduct that may be unsatisfactory. For example, on page 5 it mentions that the code is not a mechanism to address disputes between professional colleagues. The implication is that any business dealings do not have to be ethical. It gives an apparent green light to 'dodgy' practice with other psychologists. From experience industrial disputes may also involve ethical misconduct.

Content of the draft Psychology Board code

4. Does the draft Psychology Board of Australia code of conduct set the minimum standards expected of psychologists by their professional peers and the public?

Your answer:

The code of conduct does set minimum standards. One shortcoming is that at times those standards are ambiguous, e.g., '1.2 f - provide assessment and intervention options that are based on the best available information …'. There is no guidance on who and how decisions are made on what is considered to be the best available information?

'1.2 g - … Where there is an absence of evidence you should be guided by accepted best practice and/or opinion'. Whose opinion is implied here? The psychologist's?

'4.8 h – recognise that sexual and other personal (including financial and commercial) relationships with people who have previously been your clients are mostly inappropriate, depending on factors including the extent of the professional relationship and the vulnerability of the client.' Again, it is unclear how and by whom these decisions are to be made. Some clearer guidance to support decision-making is necessary.

Re: 4.8 h - How would the Board view the situation where a psychologist who saw a client once for some careers counselling argued that the extent of the professional relationship was very short and the client was not vulnerable which is why they entered into a sexual relationship six months after the one and only session?

5. Are there any specific areas of psychological practice that are not adequately addressed in the draft Psychology Board of Australia code of conduct?

Your answer:

There is little direction on how to address consent issues when conducting group sessions.

The code of conduct could be clearer on how to obtain consent when working with children of separated parents, and what processes would need to be followed in such situations.

What is the view of the Board on psychologists receiving payments for referrals? It does not seem to be addressed in the code of conduct.

6. Are there any sections of the draft Psychology Board of Australia code of conduct that would be unworkable for your organisation and/or stakeholders?

Your answer:

7. Is the language and structure of the draft Psychology Board of Australia code of conduct helpful, clear and relevant?

Your answer:

We note that usually the introductory statement for each section refers to 'psychologists' and what they do. However, the latter parts of each section then change to addressing psychologists in the second person as 'you'. Clients reading this code may get confused with the use of the word 'you' throughout the code.

There are several clauses which are vague and ambiguous which will potentially make psychologists uncertain about their practice.

Using the term 'providing care' to define the provision of a psychological service creates ambiguous content. 4.2 d states, 'Effective practice includes that you act according to the client's capacity for decision-making and consent, including when caring for children and young people, …' Some readers may interpret this clause as looking after children and young people rather than providing them with a psychological service. Some clients may feel that their psychologist did not 'care' enough for them, even though the psychologist may have been providing an effective psychological service.

'1.3 d - … do not provide or encourage the unnecessary or indiscriminate use of psychological services.'

Re: 1.3 d - What is actually meant by the term 'indiscriminate use'?

'4.3 b – be aware that psychologists have a responsibility to help clients address inequities and that increased advocacy may be necessary to ensure just access to psychological services.'

Re: 4.3 b - Who decides what is 'just' access? In the past some psychologists have justified blurred professional boundaries under the rationale of justice for their clients.

On two occasions the word. 'general' is used where we believe it is redundant. Refer to 3.3. j, and 4.2 j.

'5.1 d – refrain from exploiting your relationship with your colleagues and other professional, for example through your commercial arrangements.'

Re: 5.1 d - How does the Board view the income sharing arrangements in private practice where sub-contractors are sometimes paid less than 40% of the fee charged to the client seen by the sub-contractor. Is that exploitative?

'5.3 – There is no place for discrimination (including racism), bullying and harassment, including sexual harassment, within the provision of psychological services.'

Re: 5.3 – How does the Board view the work of psychologists involved in candidate selection for companies going through a recruitment process who discriminate applicants based on the results of their assessment? Does that work go against the code of conduct?

6.1 is titled 'Use psychological services wisely'.

Re: 6.1 - Is this referring to psychologists accessing psychological services wisely or is it meant to refer to the wise provision of psychological services. Who decides what is 'wise'? Either way, the use of the word 'wise' in this context does not seem that wise.

'8.13 b – do not influence clients to give, lend or bequeath money or gifts or undertake services that will benefit you directly or indirectly.'

Re: 8.13 b – how does this clause apply to clients who **give** money to private practitioners to undertake their psychological services??

'Principle 9 … This includes seeking an appropriate work-life balance and proactively managing work-related psychological risk factors.'

Re: Principle 9 - What is the threshold for an appropriate work-life balance? Does this mean that psychologists who work too hard are acting unethically?

Community impact

8. Would implementation of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for Aboriginal and Torres Strait Islander Peoples? If so, please describe them.

Your answer:

9. Would endorsement of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for other diverse groups or vulnerable members of the community? If so, please describe them.

Your answer:

'8.7 – Advertising - … Advertising that offers a gift, discount or other inducement to attract someone to use the regulated health service or business must state the offer's terms and conditions in plain language'.

Re: 8.7 – This can be misused by businesses and be exploitative of clients. Providing such a green light to inducements to psychological services can prey on vulnerable clients. If 10 sessions are offered for the price of 8, the client may not even need 6 sessions and has therefore paid in excess of what they would have if a decision was made based on the client's need rather than the psychologist's. The psychologist cannot know how many services clients need prior to assessing them and while 1.3 (d) does indicate that psychologists 'do not provide or encourage the unnecessary or indiscriminate use of psychological services' it is not clear that this would cover such use of advertising and certainly puts psychologists (potentially unknowingly) at risk of misbehaviour and the potential abuse of clients.

10. Would endorsement of the draft Psychology Board of Australia code of conduct result in any adverse cost implications for health practitioners, higher education providers, employers, clients/consumers, governments or other stakeholders? If so, please describe them.

Your answer:

Transition and implementation

The Board is proposing to publish an advance copy of the draft Psychology Board of Australia code of conduct **12 months** before it would come into effect.

11. Do you agree with the proposed transition timeframe?

Your answer:

That is a reasonable time frame for activation of what we hope will be an amended version of the current draft code of conduct taking account of feedback from all stakeholders.

12. Would there be any implementation issues for your organisation and/or stakeholders that the Board should be aware of?

Your answer:

Higher education providers will need considerable time to amend established programs covering ethical and professional content.

General feedback

13. Do you have any other feedback or comments about the draft Psychology Board of Australia code of conduct?

Your answer:

There are many minor suggested amendments which are listed below.

The heading in 2.1 should read as Aboriginal and/or Torres Strait Islander People's health. The word 'People's' was omitted.

In 2.2 a - 'Recognise colonisation' may be more appropriate than 'acknowledge colonisation' which implies that an action should be taken which is not always appropriate.

In 3.3 a i) to v) the first word should not have a capital letter

3.3. b would benefit from a cross-reference to *4.2 Informed consent*

3.3 e – for clarity the word 'not' should be inserted before 'authorised'

3.3 h – for clarity there should be an addition at the end of the clause which states, 'that you have responsibility for'

3.3 j – 'generally' have a right should be replaced with 'have a right to access their information with some exceptions …'

3.3 k – some states and/or territories do not have legislation governing the closure of a practice. What guidance can the code offer in these cases.

Principle 4 – it would be helpful to have a definition of 'adverse events' occurring in practice.

4.1 would benefit from placing the sentence in the third person, i.e., 'An effective professional relationship between psychologists and their clients requires high standards of personal conduct.'

4.2 would benefit from inserting 'accessing' between 'about' and 'psychological services'

8.4 – there is a typo – ‘in to’ should appear as ‘into’

‘8.8 When third-parties contract with psychologists to conduct a psycho-legal assessment of a person who is not their client for legal, insurance or other reasons, the usual psychologist-client relationship does not exist. …’

Re: 8.8 - It is not clear. The use of ‘their’ is ambiguous – is it referring to the third party or the psychologists? And if the usual psychologist-client relationship does not exist, what is the impact on any confidentiality requirements?

‘8.9 – The community places a great deal of trust in psychologists and consequently they should only make verbal or written statements that they know, or reasonably believe are true and objective.’ The use of they in this sentence is ambiguous. Is it referring to ‘the community’ or ‘psychologists’? We suggest amending the sentence to read, ‘The community places a great deal of trust in psychologists who consequently should only make verbal or written statements that they know, or reasonably believe are true and objective.’

Attachment F

Public consultation: A code of conduct for psychologists

The Psychology Board of Australia (the Board) is seeking your feedback about our proposal to update the code of conduct that applies to all psychologists registered in Australia. There are 13 specific questions we would like you to address below. All questions are optional and you are welcome to respond to any that you find relevant, or that you have a view on.

Please email your submission to: psychconsultation@ahpra.gov.au

The submission deadline is close of business, **Monday 14 August 2023**

General questions
1. Do you support the Board's preferred option to implement a regulatory code of conduct?
Your answer: Yes
2. Do you agree with the Board's approach to develop the draft Psychology Board of Australia code of conduct based on the shared *Code of conduct*?
Your answer: No. The approach has left inadequate time for comments and has not been adequately communicated to all stakeholders. I found out about the draft Code of Conduct in discussion with a colleague, and not from the Board themselves.
3. Do you support the Board's proposal to adopt the draft Psychology Board of Australia code of conduct as the regulatory code for the psychology profession?
Your answer: No, because sections of the draft PsyBA code of conduct are unworkable. See question 6.

Content of the draft Psychology Board code

4. Does the draft Psychology Board of Australia code of conduct set the minimum standards expected of psychologists by their professional peers and the public?

Your answer: See question 6 below.

5. Are there any specific areas of psychological practice that are not adequately addressed in the draft Psychology Board of Australia code of conduct?

Your answer: See question 6 below.

6. Are there any sections of the draft Psychology Board of Australia code of conduct that would be unworkable for your organisation and/or stakeholders?

Your answer:

Section 4.8 of the draft Code of Conduct, "Professional boundaries", states that a psychologist should "recognise that it is mostly inappropriate to share your personal information with clients and/or associated parties, and before doing so, you should consult an experienced colleague to determine whether your purpose for such disclosure is appropriate".

Therapeutic self-disclosure is an evidence based therapeutic skill that is well documented in the literature and in professional development training courses (Danzer, 2018; Marich, 2023; Ansara, 2022, 2020) and appears even in introductory counselling manuals (e.g., Sutton & Stewart, 2008).

Therapeutic self-disclosure is frequently used by LGBTIQA+ practitioners, in neurodiversity-affirming practice, in clinical yarning when working with Aboriginal and Torres Strait Islander communities, and when working with CALD clients, people of colour, and other diverse and/or minority groups (Ansara, 2020). Appropriate limited therapeutic self-disclosure of the therapist's past mental health struggles can be important in destigmatising and normalising the experience of mental health issues (Marich, 2023).

Therapeutic self-disclosure is part of anti-oppressive practice. Self-disclosure can be used to break down power dynamics in the therapy room. In an NICABM training video, prominent trauma informed practitioner Pat Ogden discusses the importance of self-disclosure and acknowledgement of her relative position of power as a white practitioner when working with people of colour. Without doing so, the practitioner unconsciously perpetuates privilege-oppression dynamics such as "colour blindness" (Ogden, 2020).

This proposed section of the draft Code of Conduct prevents LGBTIQA+ and neurodiverse practitioners from disclosing and discussing their own minority status. Therapeutic self-disclosure can be used for modelling responses to discrimination, and can reduce internalised homophobia, shame, and self-hatred (Danzer, 2018; Ansara, 2020). Failure to disclose LGBTIQA+ status by an LGBTIQA+ practitioner can be perceived as shaming, and can impair client self-expression (Danzer, 2018). To stop me and my clients from discussing my lived experience within appropriate boundaries hampers my ability to practice. Self-disclosure is both verbal and non-verbal (Danzer, 2018), and occurs when I enter the room presenting as a visibly transgender and queer practitioner. The assumption that self-disclosure can be avoided perpetuates white, cisgender, heterosexual and neuronormative power dynamics towards both practitioners of LGBTIQA+ status and their clients (Ansara, 2020), and forces me to censor my presentation and non-verbal self-expression as an openly queer practitioner.

Neurodivergent clients use, and expect mutual self-disclosure as part of rapport building (Hoagland, 2023). Neurodivergent practitioners may also use appropriate self-disclosure as part of neurodivergent-affirming practice. Neurodivergent-affirming practice involves the practitioner adapting their communication to better align with neurodivergent modes of communication, which frequently involves mutual self-disclosure (Hoagland, 2023). If neurotypical modes of communication are privileged and enforced, practitioners are perpetuating micro-aggressions in their clinical practice (Dallman et al., 2022).

Communication in Aboriginal and Torres Strait Islander communities is collaborative, and uses a communication style based on mutual storytelling known as yarning. Clinical yarning prioritises Aboriginal and Torres Strait Islander communication styles, and involves a two way dialogue of self-disclosure by both client and practitioner (Burke et al., 2022). Western clinical modes of communication which centre the practitioner as expert and avoid mutual self-disclosure create barriers to interpersonal communication between practitioners and Aboriginal and Torres Strait Islander clients (Lin et al., 2016).

A blanket rule that psychologists should not self-disclose would therefore be harmful to the above-described and other minority communities. Inclusion of this rule in the code of conduct would perpetuate privilege and power imbalances between the psychologist and minority clients, and may perpetuate internalised stigma against LGBTIQA+ status, neurodiversity, diversity in race, colour and culture, and mental health conditions (including stigma against the professional themselves having lived experience; Marich, 2023). While the evidence-based uses of therapeutic self-disclosure which I have described above might be considered valid exceptions to this rule under the draft Code, it would be impractical for a practitioner such as myself whose work focuses on the LGBTIQA+ and neurodivergent communities to do as the draft Code of Conduct requires and discuss in supervision prior to every use of self-disclosure.

Indirect discrimination occurs when a ruling appears to treat all people in the same way, but has the effect of disadvantaging minorities (Equal Opportunity Tasmania, 2023). The proposed Code of Conduct would lead to a power imbalance between white cisgender, heterosexual and neurotypical practitioners and practitioners from minority groups, which would silence practitioners from self-disclosing their minority status, and from appropriately modelling their lived experience of positively navigating discrimination and internalised stigma as a person of minority status. This section of the Code of Conduct would also prevent the use of therapeutic self-disclosure as a form of neurodiversity-

affirming practice. This means that the draft Code of Conduct would be considered a form of indirect discrimination.

This proposed section of the Code of Conduct is therefore incongruous with and conflicts with section 6.2, Equity and opportunity, which acknowledges the power imbalances which minority groups experience when seeking healthcare. Further, this proposed section of the draft is incongruous with section 4.8 a, which states that ethical practice requires that the psychologist "recognise the inherent power imbalance in the psychologist–client relationship".

For further reading on the importance of therapeutic self-disclosure when working with minority and diverse communities, and in trauma-informed therapy, I would urge the Board to read the recent editorial in the PACJA journal by Dr Y. G. Ansara on the use of therapeutic self-disclosure in anti-oppressive clinical practice (see Ansara, 2020).

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7. Is the language and structure of the draft Psychology Board of Australia code of conduct helpful, clear and relevant?
Your answer: No answer.

Community impact

8. Would implementation of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for Aboriginal and Torres Strait Islander Peoples? If so, please describe them.
Your answer: Yes, please see question 6 above.
9. Would endorsement of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for other diverse groups or vulnerable members of the community? If so, please describe them.
Your answer: Yes, LGBTIQA+ clients, neurodiverse clients, people of colour, people experiencing mental illness, and clients of all other minority statuses, see question 6 above.
10. Would endorsement of the draft Psychology Board of Australia code of conduct result in any adverse cost implications for health practitioners, higher education providers, employers, clients/consumers, governments or other stakeholders? If so, please describe them.

Your answer: No answer

Transition and implementation

The Board is proposing to publish an advance copy of the draft Psychology Board of Australia code of conduct **12 months** before it would come into effect.

11. Do you agree with the proposed transition timeframe?

Your answer:

12. Would there be any implementation issues for your organisation and/or stakeholders that the Board should be aware of?

Your answer:

General feedback

13. Do you have any other feedback or comments about the draft Psychology Board of Australia code of conduct?

Your answer:

Attachment F

Public consultation: A code of conduct for psychologists

The Psychology Board of Australia (the Board) is seeking your feedback about our proposal to update the code of conduct that applies to all psychologists registered in Australia. There are 13 specific questions we would like you to address below. All questions are optional and you are welcome to respond to any that you find relevant, or that you have a view on.

Please email your submission to: psychconsultation@ahpra.gov.au

The submission deadline is close of business, **Monday 14 August 2023**

General questions

1. Do you support the Board's preferred option to implement a regulatory code of conduct?

Your answer: I would prefer a code of ethics. A code of conduct feels authoritarian and does not recognise the extensive education and general good will of the majority of psychologist. Further, this code robs both psychologists and clients of their agency and is infantilising. It is also placing a level of responsibility for clients on psychologists that is not required by other health professionals and that is unsustainable in private practice settings which is where 70% of psychologists are employed.

2. Do you agree with the Board's approach to develop the draft Psychology Board of Australia code of conduct based on the shared *Code of conduct*?

Your answer:

Unable to answer. Don't know the history of it

3. Do you support the Board's proposal to adopt the draft Psychology Board of Australia code of conduct as the regulatory code for the psychology profession?

Your answer:

I would prefer it remains a code of ethics rather than behaviorally based. Also in it's current form there is not enough definition of what behaviours are considered a breach and leaves it open to

manipulation by both the regulator and the psychologist. However mostly it feels very restrictive to practice.

Content of the draft Psychology Board code

4. Does the draft Psychology Board of Australia code of conduct set the minimum standards expected of psychologists by their professional peers and the public?

Your answer:

It is far too restrictive and at the same time can out psychologists in an unwinnable situation.

Do not practice outside of competence conflicts with not being able to terminate therapy unless a referral has been accepted. It is fairer to provide the client with three referral options and place the agency with the client to find another practitioner.

The requirement to respond to emergencies means placing psychologists in private practice with 24/7 responsibilities. Instead it is more reasonable to provide clients with emergency response and crisis services.

5. Are there any specific areas of psychological practice that are not adequately addressed in the draft Psychology Board of Australia code of conduct?

Your answer:

6. Are there any sections of the draft Psychology Board of Australia code of conduct that would be unworkable for your organisation and/or stakeholders?

Your answer:

The requirement to respond to emergencies means placing psychologists in private practice with 24/7 responsibilities. Instead it is more reasonable to provide clients with emergency response and crisis services.

The requirement to continue to see clients who are unsuitable until another referral is accepted is unworkable and places me at risk of burnout and leaves me and other psychologists open to complaints from clients who we choose to terminate who wish to remain in therapy for non-therapeutic reasons.

7. Is the language and structure of the draft Psychology Board of Australia code of conduct helpful, clear and relevant?

Your answer:

The language is at times clear in it's every day usage but lacks clarification with examples. For example: what is the definition of personal information?

For those using therapies where appropriate self-disclosure is considered therapeutic or where we hold identities that may be relevant to the therapy, is that breaching the code of conduct?

Community impact

8. Would implementation of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for Aboriginal and Torres Strait Islander Peoples? If so, please describe them.

Your answer:

Practitioners who take an anti-racism and anti-sexism stance could be penalised by the current code as it allows clients to complain if their views are challenged.

This impacts ATSI people broadly as it condones racism in the therapy room.

9. Would endorsement of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for other diverse groups or vulnerable members of the community? If so, please describe them.

Your answer:

Practitioners who take an anti-racism and anti-sexism stance could be penalised by the current code as it allows clients to complain if their views are challenged.

10. Would endorsement of the draft Psychology Board of Australia code of conduct result in any adverse cost implications for health practitioners, higher education providers, employers, clients/consumers, governments or other stakeholders? If so, please describe them.

Your answer:

I anticipate that psychologists will be reluctant to take on clients with suicidality, given the emergency response requirements and that there will increased screening out of people with personality disorder diagnosis.

I anticipate that some psychologists will leave the profession as the code as it stands is too restrictive to practice and still be a human.

Transition and implementation

The Board is proposing to publish an advance copy of the draft Psychology Board of Australia code of conduct **12 months** before it would come into effect.

11. Do you agree with the proposed transition timeframe?

Your answer:

12. Would there be any implementation issues for your organisation and/or stakeholders that the Board should be aware of?

Your answer:

General feedback

13. Do you have any other feedback or comments about the draft Psychology Board of Australia code of conduct?

Your answer:

Please revise this code so that psychologists can have agency and respect the agency of our clients. No other profession seems to be held to this level of responsibility and restriction of personal autonomy or even personality.

Attachment F

Public consultation: A code of conduct for psychologists

The Psychology Board of Australia (the Board) is seeking your feedback about our proposal to update the code of conduct that applies to all psychologists registered in Australia. There are 13 specific questions we would like you to address below. All questions are optional and you are welcome to respond to any that you find relevant, or that you have a view on.

Please email your submission to: psychconsultation@ahpra.gov.au

The submission deadline is close of business, **Monday 14 August 2023**

General questions

1. Do you support the Board's preferred option to implement a regulatory code of conduct?
Your answer: Yes
2. Do you agree with the Board's approach to develop the draft Psychology Board of Australia code of conduct based on the shared *Code of conduct*?
Your answer: Yes
3. Do you support the Board's proposal to adopt the draft Psychology Board of Australia code of conduct as the regulatory code for the psychology profession?
Your answer: Yes, but not in it's current form

Content of the draft Psychology Board code

4. Does the draft Psychology Board of Australia code of conduct set the minimum standards expected of psychologists by their professional peers and the public?

Your answer: No, it currently sets the ideal and in some cases massively unrealistic and in some cases inappropriate standards. It needs to become much more 'minimum' before becoming regulation.

5. Are there any specific areas of psychological practice that are not adequately addressed in the draft Psychology Board of Australia code of conduct?

Your answer:

Work within small communities (whether location or cultural) and the differences in practice required with these.

Work in evidence based but less mainstream modalities such as schema, attachment, or somatic therapies where boundaries are in a different place to surface level CBT or traditional 'blank slate' psychoanalysis. This work doesn't need to be specifically acknowledged but current guidelines forbid many of it's useful principles.

6. Are there any sections of the draft Psychology Board of Australia code of conduct that would be unworkable for your organisation and/or stakeholders?

Your answer: Absolutely. I have attached my annotated commens.

7. Is the language and structure of the draft Psychology Board of Australia code of conduct helpful, clear and relevant?

Your answer: Yes in most places it is clear and understandable.

Community impact

8. Would implementation of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for Aboriginal and Torres Strait Islander Peoples? If so, please describe them.

Your answer: I am unsure, but I would expect it would primarily be in the areas involving multiple relationships and other boundaries, in that it would make it difficult to find a psychologist in small communities that do not have these clashes.

9. Would endorsement of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for other diverse groups or vulnerable members of the community? If so, please describe them.

Your answer: Yes. As mentioned above, all small communities (geographically or otherwise).

Also, all psychologists practicing modalities other than CBT.

10. Would endorsement of the draft Psychology Board of Australia code of conduct result in any adverse cost implications for health practitioners, higher education providers, employers, clients/consumers, governments or other stakeholders? If so, please describe them.

Your answer:

The wide ranging expectations of psychologists to be responsible for everyone associated with a service, forever even following the discontinuation of the service, to maintain care until alternative services are found (when there may not be any given the short funding of public psychological services), to reveal nothing about themselves, and to have no right to a personal life and behaviour that sits separately to their job as a psychologist, is all incredibly burdensome and damaging to a psychologists mental health, in an already mentally strenuous and poorly remunerated job.

We already carry significantly more restrictions on our practice and behaviour than most health practitioners, and in many cases we work with more populations likely to make vexatious complaints than other fields, and yet our guidelines appear to be even more restrictive and give us more wide ranging responsibility than we have any hope of being remunerated for.

This document needs to be heavily cut down to provide a true ‘minimum standard’ rather than the potentially damaging, unrealistic, and occasionally ill informed and inappropriate document it currently is.

Transition and implementation

The Board is proposing to publish an advance copy of the draft Psychology Board of Australia code of conduct **12 months** before it would come into effect.

11. Do you agree with the proposed transition timeframe?

Your answer: Yes, if sufficient 2-way consultation is done with opportunities to discuss the feedback you receive

12. Would there be any implementation issues for your organisation and/or stakeholders that the Board should be aware of?

Your answer: Unknown

General feedback

13. Do you have any other feedback or comments about the draft Psychology Board of Australia code of conduct?

Your answer: I have attached annotated comments on several areas of the draft that are very harmful to psychological practice.

I request confidentiality for my submission. I am happy for my comments to be published but not with my name or identifying information.

APHRA

11 August 2023

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Author for correspondence:
[redacted]

To the panel for submissions on the Draft Code of Conduct for Psychologists,

Executive Summary

We recognise the positive potential of transitioning from the APS Code of Ethics to a new Code of Conduct, if the shortcomings of the former are improved by the latter. We find the Draft mostly appropriate in its current form. Despite recognising this, we also find that what the problematic sections of the Draft Code have in common is that they give what we feel is too much weight to prescribing behaviour rather than to identifying relevant ethical consideration, as applied to each case. We find this fundamentally problematic for a profession like Psychology, which sees great variety among daily Client presentations and requires individually tailored treatments to function ethically. This problem can be resolved to some extent with the Code specifying greater reliance on Psychologists' clinical judgment in certain sections. We offer suggestions for minor editing that we feel would easily address these concerns.

Further, we find a number of phrases in the Draft to be less than optimally worded for the identified (umbrella) ethical principle, with the effects of i) making the Code less clear as a guide for behaviour than it might be, and ii) making the Code prejudiced against some modes of long-term and in-depth psychological services, most especially psychoanalytic treatment as it should be ethically conducted.

General Remarks

Codification versus Clinical Judgement

We acknowledge and endorse the "Purpose of the code" as "public protection and public confidence in the safety of psychological services". We feel a Code of Conduct will best serve that end by supporting and empowering Psychologists to behave ethically based on their expert knowledge of the profession and of its ethical conduct. The codification of Conduct is, like all prescriptive approaches to ethical behaviour, inherently at risk of belying what is ethically optimal in any specific situation, by referencing only the generic or global issues.

The Draft Code need not seek to codify specific behaviours in any places where clinical judgement could be invoked instead, because of the aforementioned principle that clinical judgement can always consider the specifics of the case at hand, in a manner that any prescriptive ethical principle (by definition) cannot. We feel that the Draft Code should explicitly defer more to clinical judgement than it currently does.

Specified deferral to clinical judgement recognises and makes valid use of the expertise of Psychologists, which flows naturally from the Board's requirements of them in training and continuing professional development. The requirements of psychological training (as scientist-practitioners) have continued to increase over time, as have those of ongoing professional development, and ongoing clinical supervision. We find this increase generally positive. We feel the value of these requirements is nullified to the extent that clinical judgement of these trained professionals is excluded if not proscribed. Complex issues like professional boundaries, multiple relationships, conflicts of interest, and ethically unusual situations simply cannot be codified in advance without compromising benefits to and protection of the Client (and by extension the public).

We acknowledge that the Code "is not intended to be an exhaustive guide to professional ethics", yet we acknowledge that it cannot be considered adequate in any area where it restricts Psychologists from responding in more ethical modes of conduct for that situation.

Prejudice against Diverse Modes of Treatment

While the Draft may seem suitable for the practice of many symptom-focussed brief interventions, it is prejudiced against the normal practice of psychoanalytic therapies, to the point of making aspects of the standard practice of such therapies impossible without breaching the Code.

This is an important consideration for the Board, because this form of psychological service is practiced by many Psychologists and sought by many Psychologists for their own personal therapy with another member of the profession.

Background of the Authors

The authors of this submission have a cumulative century of clinical experience. Among them are Psychologists:

- who have authored and taught postgraduate units on Clinical Ethics and Moral Philosophy in a number of Master of Clinical Psychology training programs at Australian Universities

- whose input was integrated into previous drafts of the Australian Psychological Society's (APS) Code of Ethics

- who have held full-time academic positions including Coordinators of Master of Clinical Psychology programmes, Psychology Clinic Directors, and Supervisors of Research Higher Degrees

- who are registered Supervisors of Clinical Registrars, and have decades of experience supervising clinical Psychologists and other registered professionals (including Psychiatrists, General Practitioners, and Social Workers); and, on the issues related specifically to Psychoanalytic Therapy, Psychologists:

- who are former National Office Bearers for the APS's psychoanalytic Interest Group, which has been among the most populous of the Society's interest groups

- Psychologists with decades of specialised training in Psychoanalytic Therapies from local and overseas institutions.

Sections of the Code

1. Safe, effective, and collaborative practice

We question the wording of Principle 1., which includes the phrase "using client-centred approaches". As all Psychologists know "Client-centred" is the name of one specific approach to clinical therapies, both major and enduring, and so its inclusion in this context cannot be intended. We suggest amending this phrase to read "using Client-sensitive approaches".

The same applies to §1.2 g.

4.8 Professional Boundaries

f. To declare that it is "mostly inappropriate" to share personal information is in its current form simply untenable, because it prejudices psychoanalytic therapies."Personal information" about the Psychologist might not be of material relevance to some non-psychoanalytic treatments, but there is a long-established body of theory and technique regarding therapist-disclosures, which are integral to psychoanalytic therapies. The Code must not trivialise what many Psychologists study and seek supervision in order to learn and to refine. It is difficult to overstate the centrality to transference/countertransference analysis of personal disclosure, to the point that phrase f. in its current form makes it impossible for Psychologists properly trained in this approach to conduct their practice. This skill must be recognised in those who are competent to practice this way. When used properly, it is of irreplaceably therapeutic value. And Psychologists who are educated in the psychoanalytic model understand where (and how) the sharing of their subjectivity and subjective experience has such singular therapeutic benefit. The Code should not prejudice Psychologists with these skills, for the sake of other Psychologists who do not. We suggest the following wording:

f. recognise that sharing personal information with Clients requires skill and technical knowledge for it to be appropriate and therapeutic in intention and effect. Psychologists share personal information only when they are competent in discriminating

between disclosures for therapeutic ends and potentially or expectably counter-therapeutic (or irrelevant) disclosures.

h. and i. We agree with the spirit of these statements, but feel that they might be more effective as a guide for conduct if the phrase "**are mostly inappropriate**" were changed to "**are inappropriate in most cases**". This makes it easier for this Code to be used as a guide for behaviour. The mandate to protect the public must be paramount in this important question of post-treatment relationships, but it must be weighed against the "respect" and "trust" outlined in Principle 4., to avoid infantilising both the Psychologist and the previous Client. It may also be an opportunity to add explicit mention of the judgement of the Psychologist in considering the best interests of all parties involved. We suggest the following wording:

h. recognise that sexual and other personal (including financial and commercial) relationships with people who have previously been your Clients are inappropriate in most cases, depending on factors including the extent and nature of the professional relationship, the vulnerability of the Client, and your clinical and ethical judgement in determining the potential harms and potential benefits of that other relationship to all associated parties

i. recognise that sexual and other personal (including financial and commercial) relationships with associated parties of previous Clients are inappropriate in most cases, depending on factors including the extent and nature of the professional relationship, the vulnerability of such people, and your clinical and ethical judgement in determining the potential harms and potential benefits of that other relationship to all associated parties

j. We find this assertion in its current form untenable. It would be in permanent conflict with the possibility of other kinds of relationships afforded by h. and i., (not withstanding how expectably rarely those relationships might be ethically pursued). Thus j. represents an internal inconsistency of the document, at the very least. It would be inappropriate for a Registration Board to seek to impose restrictions on the personal freedoms of citizens across the rest of their lives, simply because they had once been in psychological treatment, be they Psychologists or Clients. This aspect is spoken to in h. and i., but the obverse assertion (i.e., the positive continuity of obligations themselves) must have a recognisable natural end. We would think that a Psychologist should feel only some professional obligations to continue to be relevant towards, say, a Client whose treatment terminated ten years ago, the most obvious being to preserve confidentiality. There is even a time-limit on the ethical retention of notes and files after a period of time; should professional obligations exceed this time limit? The Psychologist and the Client are in the first place human beings, and their human rights must outlive their professional relationship. Therefore, they must (both) be identified as outliving the proper constraints of the professional setting at some point, which only the two people in question (especially the Psychologist) can judge. We suggest the following wording:

j. recognise their clinical and professional judgement will be required when determining the appropriateness of maintaining any specific professional obligations beyond the termination of psychological services

4.9 Multiple relationships

The multiple relationships defined in the Draft Code would mean that §4.9 renders postgraduate training programmes, in their current form, proscribed. We feel the issue of multiple (and by these definitions sequential rather than concurrent) relationships is more complex than the Draft Code allows. Again, it comes down to clinical judgement which cannot be avoided as the ultimate guide on whether (for example) a former research- or clinical-supervisee might later become a recipient of clinical services. There are instances in which such a sequence of relationships could promote benefit to the Client and enhancement of the services and other instances in which it could be deleterious. The Code does not currently afford such nuance.

The ethical onus on the Psychologist would be properly increased by changing the second paragraph to read "obliged" to "justified":

Psychologists discontinue, or avoid, multiple relationships unless they hold a reasonable belief that they are ethically, legally or organisationally justified to continue or enter into such relationships.

This would sanction the near ubiquitous practice that sees Psychologist-lecturers become clinical supervisors or research supervisors of the same student (Client) within a Postgraduate Masters programme, without shifting the burden of ethical justification onto "organisational factors", just as the rest of that section requires with points a. to d.

We also suggest that phrase c. be clarified with a simple "where appropriate", in order to prevent an obligation to disclose information that is otherwise sensitive or ethically inappropriate to disclose. We suggest:

c. where appropriate and not potentially harmful, inform all parties to the multiple relationship that there is potential for conflicts of interest and explain the possible implications of this situation, and

5.3 Discrimination, bullying, and harassment

We feel it would be better to include explicit mention of the situation in which Clients engage in "discrimination, bullying or harassment" of the Psychologist and affirm the Psychologist's right to refuse services to anyone on those grounds. We suggest adding:

i. do not tolerate or feel obliged to endure discrimination, bullying or harassment from Clients, nor that you feel obliged to treat or continue to treat Clients who direct discrimination, bullying or harassment towards you, but instead you address that Client's behaviour directly and determine whether continuation of the service is possible or advisable.

5.4 Delegation, referral, and handover

We find this section lacking consideration of the limits of a Psychologist's *ability* to complete delegation, referral, or handover contingent on the cooperation (or lack of cooperation) on the part of the Client. It reads as though the Client has no say nor influence, where they are actually decisive. For example, to say (b) "**that the responsibility for the service continues until the referral or handover is accepted**" offers no recognition of the Client's role in the "acceptance" of the handover. The Client may wilfully fail, in practice, to attend the referral, in which case the Psychologist cannot be "responsib[le] for the service" indefinitely. We suggest:

b. understand that your responsibility for the service being provided continues until the referral or handover is either accepted or rejected by the Client, both by agreement and in practice.

7.1 Risk management

Here we think a few simple inclusions would create a more balanced consideration of the nature and direction of risk, as well as the appropriateness of different strategies for its management. We suggest:

c. participate in quality assurance and improvement systems where available and appropriate to the services offered

f. ensure systems are in place for raising concerns about risks to Clients and/or Psychologists, if you have leadership/management responsibilities

h. support colleagues who raise objectively valid concerns about the safety of Clients and/or Psychologists.

8.12 Conflicts of interest

We agree with the spirit of this section, but we have concerns about the seemingly equal stationing of i) conflicts of interest and ii) perceived conflicts of interest. We suggest the addition of a statement here to clarify that *actually* avoiding and/or managing conflicts of interest is of greater ethical importance than avoiding and/or managing *perceived* conflicts of interest, especially when actual ones are avoided or managed successfully. The *perception* by others must remain of less ethical significance and substance to ethical Psychologists than the *actual* practice itself. For example, on the question of accepting gifts (d) two Psychologists, depending upon their theoretical training and practice, could *perceive* the acceptance of a gift from a Client differently. Further, it is easy to imagine a situation in which two Psychologists disagree on the ethical standing of the acceptance of a Client's gift, and where they disagree equally on the ethical standing of the refusal of a Client's gift. The theoretical underpinning of the treatment offered will determine the meaning of the gift, and, therefore, determine whether acceptance of the gift will

further or hinder the progress of that particular treatment, i.e., whether acceptance of the gift is *ethical*. We suggest the following minor addition:

h. place greater emphasis on the influence and potential influence that conflicts of interest have on your ability to provide services, above the emphasis you place on the perceived influence and potential influence, deciding in each case whether it is in the interest of the relevant Client to address and/or redress the perception where incorrect.

8.13 Financial and commercial dealings

We suggest one minor addition to this section, to make it more consonant with other important sections of the code, especially those regarding cultural sensitivity. We suggest the following adjustment:

e. do not, as a rule, give gifts to Clients, unless the cultural and/or other aspects of the case specific to that Client make it reasonable to expect that the giving of such a gift would further rather than hinder the progress of the treatment.

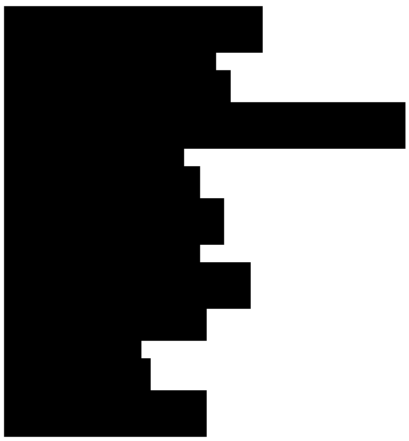
9.1 Your health and wellbeing

We agree with the spirit of this section and all its paragraphs, except for b., regarding immunisation, which stands out among the other paragraphs of this section for the fact that it nominates a position on a specific medical intervention. We find this paragraph irrelevant and redundant at best, given that the practice of psychology involves neither the administration of vaccinations, administration of medical advice, nor the physical contact conditions to render it prone to contribute meaningfully to any greater risk of transmission of communicable disease than the general population (unlike, say, medical practices, where physical contact is expectable, and where people who are unwell with such diseases seek treatment). At worst, it is patently unethical to require Psychologists to take a *professional* position on any particular medical intervention and would be in breech of the Code itself: Psychologists are required to act within their area of competence, (Principle 1.1), and not being trained in medicine, they have no grounds for taking any position on any medical issue as a matter of their profession.

For their own health and well-being, Psychologists can consult their health practitioner (as they would with all other health matters) and need not be directed by a *professional* Code on personal health matters.

In summary, we believe these changes will improve the Code's ability to achieve its stated aims and prevent any unintended prejudice or exclusion of sectors of the psychologist community.

Faithfully,



[redacted]

[redacted]

To Whom It May Concern,

Re: DRAFT Psychology Board of Australia code of conduct

Thank you for consideration of the below points with regard to the proposed code of conduct.

I appreciate and understand the necessity and value of such a code to guide the professional conduct of registered psychologists. The code is extensive in the expectations and conduct of psychologists, but I do not consider it well balanced with psychologists' inalienable rights to freedom of conscience, freedom of opinion, freedom of association, and free speech. I support the status quo rather than the adoption of this new draft code.

Sections 4.8 and 4.9 is of particular relevance is psychologists living and working in rural and regional locations. By the very nature of living in these communities, it is impossible to control daily interactions with clients whilst going about regular personal and social activities. Section 4.8 (i) even goes so far to state the mostly inappropriate nature of relationships 'with associated parties of previous clients'. It suggests to me the authors of the draft have never lived and worked in regional and rural communities that this could even be considered reasonable or workable. I can give many examples from my own experience and that of my colleagues where we navigate these issues on a regular basis. Section 48 (h) and (i) lacks respect for psychologists to professionally and appropriately navigate these situations sensitively and professionally as I myself have done in over 30 years of practice without a single issue! This proposal has lead to significant concern and distress in my regional colleagues and is a substantial overreach into psychologists personal lives. Rather than this being an easily managed dynamic as is currently the case, it will likely instil fear and anxiety that sanctions could ensue over unavoidable associations with clients, previous clients, or associated parties of previous clients. Clients in any small or medium-sized community would regard psychologists who do not engage in normal human discourse as impolite and untrustworthy and this dynamic would cause disrepute of the profession. To treat anyone who has ever seen a psychologist as being somehow 'separate' to psychologists in daily activities is also potentially harmful and demeaning to the clients themselves, who should surely have the right to make a decision for themselves who they interact with and how. I consider the wording and the implications of these sections potentially very damaging to both psychologists and clients, and in turn the broader communities they live and work in.

Of further concern is Section 9.1 (b) 'understand the importance of immunisation against communicable diseases and take reasonable and effective steps to prevent the transmission of communicable diseases'. I consider this part of the code irrelevant to psychologists in the day to day professional work we engage in, and can only speculate why it has been included. As members of the broader community, we are interacting with a large number of people on a daily basis but in our professional setting we are sitting across the room from our clients in a socially distanced manner. When the COVID-19 mandates were in

place for psychologists (as health professionals), it was unusual to note that (in Queensland at least), sex workers, hairdressers and beauticians were able to work unvaccinated, as were lawyers who work in a similar physical space as psychologists, but psychologists could not. This can only be considered discriminatory and setting psychologists apart from other workers and professions with no evidence based rationale. This item should be dropped from the COC.

Section 4.7 (a), (c) and (g) do present challenges in regional areas where availability of services is limited and often significant wait times apply. There could be occasions where a client may have to be supported and managed by their GP until such time as a psychologist has an opening for new clients as an example. Section 4.7 (g) is of particular concern in that it requires the psychologist to 'facilitate arrangements for the continuing care of all current clients' – depending on the psychologist's circumstances, this could pose a severe burden and is potentially unworkable. It is unclear why this is the psychologist's responsibility only, and why it would not be considered also the client's responsibility / shared responsibility. I am not aware of this requirement extending to other health care professionals. The further requirement for 'transfer, or appropriate management of all client records' is unclear about the rationale for this (for example a brief handover letter or phone discussion with the new psychologist may be appropriate), and could be particularly burdensome and expensive (in the case of an extensive paper file). In my interactions with other health care workers I am unaware of a requirement to transfer client records, where is the rationale for this to be required of psychologists?

In summary I believe the code is overly rigid and authoritative and needs to be more flexible and respectful of psychologists and the unique challenges we manage in the work we do and balancing this with living a full and balanced life, especially in regional and rural communities. There are aspects of the code that are an intrusion into the civil rights of practising psychologists.

Thank you for your consideration.

Regards

[redacted]

[redacted]

[redacted]

To Whom it may concern

AHPRA – proposed "Code of Conduct"

I am submitting my response which is to reject the proposed AHPRA code of conduct.

I endorse the current code.

Rejection is based on the inclusion in the proposed code of overreach, intrusion and alienation of the rights of psychologist as individuals by the use of absolute statements (such as the use of the words 'never', 'you must'), and the compulsion to adhere to the political or ideological narratives that may or may not be necessarily scientifically proven in regards to medical intervention or historically and/or presently truthful in regard to cultural claims. The current code is adequate in these matters.

Example of a 'never' - the absolute rule of 'never' in regard to all personal matters including financial and commercial is untenable, particularly in smaller communities where the son of the client may be the only plumber, builder, doctor, specialist available. Similarly the rule will isolate the Psychologist personally and the Psychologists family from interactions with the community.

Concerns are warranted in regard to the proposed code intruding into psychologists medical decisions for their own health. The section regarding immunisation is unnecessary for effective psychological practice. This inclusion goes beyond reasonable consent and leaves little flexibility, especially when medical science has been used coercively and experimentally as we have experienced in the recent years.

The board already imposes other standards and guidelines that impact upon psychologist. For example the current COVID position statement. There is no need for further additions to the current code.

To conclude I reiterate that I do not support the proposed new AHPRA code of conduct for psychologists.

Sincerely

[redacted]

Attachment F

Public consultation: A code of conduct for psychologists

The Psychology Board of Australia (the Board) is seeking your feedback about our proposal to update the code of conduct that applies to all psychologists registered in Australia. There are 13 specific questions we would like you to address below. All questions are optional and you are welcome to respond to any that you find relevant, or that you have a view on.

Please email your submission to: psychconsultation@ahpra.gov.au

The submission deadline is close of business, **Monday 14 August 2023**

General questions

1. Do you support the Board's preferred option to implement a regulatory code of conduct?

Your answer:

2. Do you agree with the Board's approach to develop the draft Psychology Board of Australia code of conduct based on the shared *Code of conduct*?

Your answer:

3. Do you support the Board's proposal to adopt the draft Psychology Board of Australia code of conduct as the regulatory code for the psychology profession?

Your answer: NO.

It is insufficiently detailed, not specific about behaviours – full of terms like 'reasonable efforts'. Most of the items in the Code mean absolutely nothing, as there is no specification of definition of what they mean or what these things would actually look like in practice.

Content of the draft Psychology Board code

4. Does the draft Psychology Board of Australia code of conduct set the minimum standards expected of psychologists by their professional peers and the public?

Your answer: No. see above.

5. Are there any specific areas of psychological practice that are not adequately addressed in the draft Psychology Board of Australia code of conduct?

Your answer:

6. Are there any sections of the draft Psychology Board of Australia code of conduct that would be unworkable for your organisation and/or stakeholders?

Your answer: The areas related to scope of responsibility and referral are unworkable.

The Code requires psychologists to end treatment with clients "who do not benefit from their services" (4.7). Yet 5.4 b states that: "your responsibility for the service being provided continues until the referral or handover is accepted". The second item directly contradicts the first.

If I am ending the relationship because the therapy is ineffective or insufficient to their needs, or the service context is inappropriate for that client (eg "private practice Better Access, one weekly/fortnightly in-office CBT session" is not adequate for someone with higher suicide risk) then it would be unethical and potentially unsafe for me to keep seeing them. If treatment was ineffective, what am I going to be doing with them until they are successfully handed over? And am I supposed to retain responsibility for them when I have specifically identified to them and their referring doctor that my service is not appropriate for their needs and their safety? The solution needs to be that another service needs to be identified and referred to, as an urgent priority, not that the previous inappropriate service is still responsible for them indefinitely until something comes up.

Better Access only allows 10 sessions – am I supposed to be using up those 10 sessions on what I have already identified as ineffective or inadequate treatment? So they then will have no medicare sessions left when they do get picked up by a more appropriate service?

These Code items do not appear to have been written with any consideration of the context in which psychologists are actually practicing. You seem to be imagining a service context where we personally refer someone on to another nice, available psychologist and we just need to see the client one more time to ensure that nothing went wrong and they've transferred over ok.

What proportion of psychologists in Australia are working in the private/NFP sector under Better Access funding? This is a huge sector for psychologists, and you don't seem to have considered at all that :

1) **Can we actually refer? Many of the services we would be recommending (eg SA Health Mental Health Community Teams) require a Medical officer to refer – we are not allowed to refer clients directly to these services. I have to recommend this referral to the doctor, communicating appropriate level of urgency, and I then have no control at all over when, or even whether, that referral takes place.**
   It can't be my responsibility to ensure a referral has been actioned and accepted, by a service to which I am not allowed to refer in the first place. That would be the referrer's responsibility - the GP.
   4.7c specifies that I must "make reasonable plans for the continuity of service to clients when the professional relationship must end, including helping identify alternative service providers and passing on relevant information with clients' consent". I will identify alternative service providers, provide these recommendations in writing to both client and referring GP - the GP now needs to be responsible for their own professional conduct and for acting on my recommendations. It is *not* appropriate that I should be responsible for continuing to provide service until the GP has done their job, or in fact to make them do their job.
2) **Are services available? services are not necessarily available right away, as most services have a wait list – there simply are not enough services, especially free or government funded or Mental Health Services. It is obviously not workable to specify that we retain responsibility for provision of service until the next one has started.**
3) **Is it ethical? – if we have identified that our service/treatment is not appropriate/effective/adequate, it would be blatantly unethical to continue providing that service, especially over the periods of time that can be involved.**
4) **What counts as 'providing service"? If I see a Better Access client for one initial session, identify that my service is not appropriate and advise the client and GP that I therefore won't be able to take them on as a client (and provide alternative recommendations, of course) am I still responsible for providing service until the GP gets them in with someone else? I've specifically identified that our service is not suitable. After how many sessions are they 'mine' and I retain responsibility to provide service until someone refers them somewhere else?**
5) **Are we responsible for other registered professionals' conduct? If I have written back to the GP who referred the client to me, and detailed why it is unsuitable for me to continue to provide service, and I have identified suitable alternative providers, then that should be my responsibility discharged. It is now the GP's responsibility to act on recommendations made and to make, and follow up, appropriate referrals. The way the draft code is currently written implies that is will be my responsibility to keep treating this person until the GP does their job, and to somehow make the GP do their job. As you may guess from my concern about this issue, this has been a problem many times – I don't know if they don't read my recommendations or just ignore them, but sometimes they just don't refer. Not my responsibility!**

Obviously, if there is immediate risk, we will do whatever we can to ensure safety and continuity of care to manage that risk – I hope that goes without saying and is part of our ethical obligation in managing risk. But that needs to be a clinical decision, to reflect exceptional circumstances, not the norm for every client regardless of situation.

Psychologists have very little authority or control over referrals and services for their clients. GP's are specifically placed to refer and coordinate services, and they have all of the authority to do so.

I can't refer to Mental Health services, I can't refer to a psychiatrist, I can't prescribe, I can't even refer to a psychologist, under Better Access! I have no control or authority in the system, and I can therefore not be responsible for referrals and outcomes over which I have no control.

These may seem like extreme examples – and frankly I have no idea if this is what was intended by these items of the draft Code as they are so vaguely written. But the way it is written now leaves it open to all of these concerns.

The language in the draft Code is not specific enough – the lack of detail and specifics means that these items can be interpreted to their extreme limit, the implications of which are unworkable, unethical and unacceptable.

7. Is the language and structure of the draft Psychology Board of Australia code of conduct helpful, clear and relevant?

Your answer: No, it is extremely vague and general in language and expression.

The preamble documents indicate that the purpose of the Code is to

Community impact

8. Would implementation of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for Aboriginal and Torres Strait Islander Peoples? If so, please describe them.

Your answer:

9. Would endorsement of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for other diverse groups or vulnerable members of the community? If so, please describe them.

Your answer:

Yes, see my answer above in Q6 re people at higher risk.

10. Would endorsement of the draft Psychology Board of Australia code of conduct result in any adverse cost implications for health practitioners, higher education providers, employers, clients/consumers, governments or other stakeholders? If so, please describe them.

Your answer: Yes, see my answer above to Q6.

Transition and implementation

The Board is proposing to publish an advance copy of the draft Psychology Board of Australia code of conduct **12 months** before it would come into effect.

11. Do you agree with the proposed transition timeframe?

Your answer: No, as it needs to be re-worded and revised before proceeding to this stage.

12. Would there be any implementation issues for your organisation and/or stakeholders that the Board should be aware of?

Your answer:

General feedback

13. Do you have any other feedback or comments about the draft Psychology Board of Australia code of conduct?

Your answer:

Attachment F

Public consultation: A code of conduct for psychologists

The Psychology Board of Australia (the Board) is seeking your feedback about our proposal to update the code of conduct that applies to all psychologists registered in Australia. There are 13 specific questions we would like you to address below. All questions are optional and you are welcome to respond to any that you find relevant, or that you have a view on.

Please email your submission to: psychconsultation@ahpra.gov.au

The submission deadline is close of business, **Monday 14 August 2023**

General questions

1. Do you support the Board's preferred option to implement a regulatory code of conduct?

Your answer: Yes. This is far preferable than relying on an industry body that does not represent all psychologists.

2. Do you agree with the Board's approach to develop the draft Psychology Board of Australia code of conduct based on the shared *Code of conduct*?

Your answer: Qualified yes. Some aspects of the proposed code do not well reflect psychology specific practice and tend toward medicalisation and the practice of medicine.

3. Do you support the Board's proposal to adopt the draft Psychology Board of Australia code of conduct as the regulatory code for the psychology profession?

Your answer: Qualified yes. Some aspects of the proposed code do not well reflect psychology specific practice and tend toward medicalisation and the practice of medicine. Some aspects are not well defined and could be considered contentious.

Content of the draft Psychology Board code

4. Does the draft Psychology Board of Australia code of conduct set the minimum standards expected of psychologists by their professional peers and the public?

Your answer: Qualified yes. Some proposed standards extend outside the practice of psychology. I am particularly supportive of proposed standards: 1.2.a 'support the right of the client to seek a second professional opinion'; 5.3 'Discrimination, bullying and

harassment; 8.2 'Vexatious notifications (concerns)'; 8.12(g) avoiding performance targets that conflict with ethical obligations.

5. Are there any specific areas of psychological practice that are not adequately addressed in the draft Psychology Board of Australia code of conduct?

Your answer: No.

6. Are there any sections of the draft Psychology Board of Australia code of conduct that would be unworkable for your organisation and/or stakeholders?

Your answer: Yes. The draft code is tending very much toward medicalisation of psychology practice. Specific examples include:

Preamble, Professional values and qualities, section h (p. 5), 'Psychologists should be committed to safety and quality in healthcare': The referenced ACSQHC document National Safety and Quality Health Service Standards is an unwieldy document that largely focusses on the provision of medical care in medical practices and hospital contexts. There is limited relevance to independent or even group psychology practices. Indeed, compliance with these standards would be overly onerous for many psychologists who already provide excellent safety and quality for clients consistent with the size and scope of the practice. Having worked in the public health sector in two organisations going through the accreditation process for the standards above, a commitment to meeting those medically-derived standards would far exceed the requirements of quality and safety of psychological practice. The reference to those standards might be considered by a future Board as meaning unnecessary accreditation is required for psychologists and psychological practices, which will be costly and time consuming with little evidence of value in terms of client safety and quality above current practise. Having also been through the audit and accreditation for NDIS registration for psychological, early childhood, and behaviour support provision, I can state from experience that the process was an expensive exercise in 'box-ticking' administrative aspects of practise that were largely of dubious (in some cases no) relevance to the services provided, as the standards designed for large and complex organisations were applied to a two-person practice with little understanding of the services provided or small organisational structure. While the statement 'Psychologists should be committed to safety and quality in healthcare' is not problematic, tying that statement to largely irrelevant medical standards opens the way to bureaucratic interpretations of the requirements of psychological practice rather than what it would seem to mean in a plain language sense.

S 1.4 (p. 7): See in the following section.

S 6.2 Equity and opportunity (p. 17)(see also the following section): 'Effective practice includes that you use your expertise and influence to promote good health and educational and employment opportunities for individuals, communities and populations'. It is not the role of all psychologists to actively promote good health and educational and employment opportunities for individuals, communities and populations. Furthermore, this could be inferred as meaning that psychologist are advocates for these interests to the extent that they must go outside their practice to engage with communities and populations. The code should not be impinging on what psychologists do outside their hours of practice as long as their conduct brings no harm to clients or the profession. In my opinion, directing psychologists to engage in their private lives to 'actively' promote educational and employment opportunities in their practice when not directly relevant is not appropriate for the proposed code. Further to this, directing psychologists to actively engage in such activities outside practice hours is beyond the powers of the Board and interferes with personal rights.

S 6.3b Psychological health and wellbeing (p. 17), 'participate in efforts to promote the psychological wellbeing of the community': In my opinion this statement exceeds the power of the Board to mandate engagement in activities outside the practice of psychology. The code should not be mandating that psychologists must engage in community activity that occurs in the psychologists' own time. In my experience, many psychologists work long hours in practice and have few resources for leisure and self-care activities, let alone to be expected to 'participate' in promotional activities. In the case that the intention of the code is not to mandate such participation, the wording of the section needs to be changed.

7. Is the language and structure of the draft Psychology Board of Australia code of conduct helpful, clear and relevant?

Please note that I have made multiple comments about the content and grammar contained in the draft code. These comments are not included to be pedantic. I am very proud of my profession and have worked hard over the last 20+ years to enshrine ethical and professional practice of psychology across a broad range of contexts. In reflecting the professional of psychology, I consider this document is also a reflection on my practice and conduct as a professional. The language used, including grammar and punctuation, provides psychologists, other professionals, and the community with a sense of how psychology as a discipline and profession considers itself. My comments are made to ensure the highest quality standards are applied to the code in content, intent, and the expression of how the profession perceives and presents itself. I would ask that when my submission is reviewed the statements made are taken in such light.

Your answer: Qualified yes. However:

S 1.4 Helping in emergencies: It is not clear what 'help' is to be offered and the definition of what is an 'emergency'. Is this a psychological crisis, a natural disaster, a medical emergency, or a traumatic situation of some other origin. The word 'emergency' has lost clear meaning (e.g., "climate emergency") and in the current context can be interpreted as urgency as opposed to emergency, per se. I see this as a source of potential conflict through alternative definitions that could be used as a mechanism of complaint or censure according to moral or political positions, rather than ethics.

S 2.1 Aboriginal and/or Torres Strait Islander health: I agree wholeheartedly with the statements contained in the wording of this section. However, some of the content is political and moral in nature and is not directly relevant to the 'conduct' aspect of the proposed code. A code of conduct is a set of expectations and not an opportunity to make a particular moral stand, regardless of how accurate the words are. In my opinion, this significant and valid information does not belong within the proposed code, but rather in a specific associated document pertaining explicitly to the health of Indigenous Australians. [redacted] **I make this statement with great respect for Indigenous Australians and full acknowledgement of the intergenerational disadvantage experienced by many of those people across the wider community.**

The entire section on 'Aboriginal and/or Torres Strait Islander health and cultural safety' contains significant redundancy. Many of the cultural safety issue apply to migrants and refuges, and these could all be included as a single section. Many of the cultural safety issues also apply to mainstream Australians (e.g., gender, disability, race, ethnicity, religion, sexuality, age or political beliefs), so it is unclear why they are included in a section specifically titled as pertaining to Indigenous Australians.

The term 'Aboriginal and/or Torres Strait Islander' is legalese. It only needs to refer to 'Aboriginal and Torres Strait Islander' or 'Aboriginal or Torres Strait Islander' (the first option is grammatically more aligned with the phrase as used). The use of "and/or" adds unnecessary complexity and potential confusion in terms of linguistic and interpretive respects. See also ss 4.8(d), 4.8(f), 4.8(k), 5.3(g), 5.4(a)[twice], 8.2(b), 8.4(b), and 8.11; see

also s 5.3(e) where 'leadership/management role' is better phrased as 'leadership or management role'; see also s 7.2(f) and s 8.1, where 'employer/s' is better phrased as 'employer' as it would apply to any and all employers.

S 3.2 states 'check to confirm a client understands any information communicated to them'. 'A client' is singular and 'them' is plural. This would be better written: 'check to confirm clients understand any information communicated to them'. Contrary to current usage, 'them' used as a singular pronoun is not inclusive language and is simply poor grammar (to clarify, the Victorian Mental Health Complaints Commission Gender Neutral Pronoun Guidance [Language Guide, p. 13] lists 9 sets of gender-neutral pronouns, with 'they/them' only one). See also ss 4.3(c)(i), s 4.3(c)(iv), 4.6(d), s 7.2, 7.2(e), and 8.8(g).

S 5.4(b) states 'understand that, your responsibility …' There is no comma required after 'that' in a grammatically correct sentence in this case. However, the inclusion of the word 'that' is redundant as the phrase introducing the list already contains the word 'that'. As such, the wording is better, 'understand your responsibility …"

S 5.4(c) states '. understand that, as delegating psychologist you …' There is a comma required after 'psychologist' in a grammatically correct sentence in this case. However, the inclusion of the word 'that' is redundant as the phrase introducing the list already contains the word 'that'. As such, the wording is better, 'understand, as delegating psychologist, you …"

S 6.1(b) states 'psychological services, and, whenever possible, help …' There is no comma required before the word 'and' in a grammatically correct sentence in this case.

S 6.2 Equity and opportunity (p. 17): The first paragraph is redundant as it was previously stated. This is also a moral statement and not about conduct. Furthermore, the following general sentence (see immediately following) has dubious relevance to the specific leading statement about Indigenous Australian.

S 6.2 Equity and opportunity (p. 17)(see also the previous section): 'Effective practice includes that you use your expertise and influence to promote good health and educational and employment opportunities for individuals, communities and populations'. This is a vague statement that could be interpreted as placing a burden on psychologists to do things outside their practice. A psychologist provides services to clients, but there seems no reason for that psychologist to enter into discourse or advocacy with the community outside the provision of those services in his or her own time. In my opinion, requiring a psychologist to become a de facto case manager is well beyond the scope of a code of conduct. There is too much risk of misinterpretation of this entire section.

S 6.3(b) Psychological health and wellbeing (p. 17), 'participate in efforts to promote the psychological wellbeing of the community': See previous section. In my opinion this statement exceeds the power of the Board to mandate engagement in activities outside the practice of psychology. The code should not be mandating that psychologists must engage in community activity that occurs in the psychologists' own time. In my experience, many psychologists work long hours in practice and have few resources for leisure and self-care activities, let alone to be expected to 'participate' in promotional activities. In the case that the intention of the code is not to mandate such participation, the wording of the section needs to be changed. Individual psychologists should not be held responsible for some amorphous idea of community psychological wellbeing. This proposed section of the code is open to being interpreted as meaning that were a psychologist not to actively participate in some form of community wellbeing program it would be considered a breach of the code. I recommend removing these words or, in the event they were considered necessary, to clarify what the expectations are of psychologists expected to comply with the requirements of s 6.3b.

S 7.2(b) states: "Your health and wellbeing, if you know …" The comma is unnecessary in a grammatically correct sentence.

S 7.4 states: "The National Law requires psychologists to do CPD". The word 'do' is vague and open to interpretation. It would be preferable for the document to use more descriptive verbs (e.g., 'engage in', 'complete', 'participate in'). (See http://slavenorth.com/columns/do-

be-thee.htm for an excellent discussion on why professional writing is better when 'do' and its derivates are omitted.)

S 8.10 appears to be redundant, as it is discussed in previous sections.

S 8.11(b) states: 'information relevant to an investigation into your own, or a colleague's conduct, performance or health'. The two commas are unnecessary.

S 8.12(b) states: 'when making referrals, and when giving or arranging services'. The comma is unnecessary.

S 8.13(d) states: ' non-sentimental value and if you do accept a token gift, make a file note …' A comma is required before the word 'if'.

Community impact

8. Would implementation of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for Aboriginal and Torres Strait Islander Peoples? If so, please describe them.

Your answer: Maybe. The focus on Indigenous Australians suggests that there is a homogenous cultural group of people facing the same disadvantage that is unique. While fully acknowledging that the information about Indigenous Australian disadvantage presented in the draft code is correct, the way the information is written could be considered as implying that Aboriginal and Torres Strait Islander People are universally affected by challenges that separate their psychological functioning from others in society. Indigenous Australians are often proud people who celebrate their local cultural distinctness from others, including other tribal groups. The strengths of each tribal group and each individual have the potential to be masked by the keen focus on disadvantage. I fully support the draft code's encouragement of cultural understanding, but the ongoing spotlight on that disadvantage must be balanced with understanding that the ways of thinking and spirituality of Indigenous Australians do not always turn to that disadvantage. In my opinion, there is a risk stemming from the information in the draft code of entrenching the stereotype of Aboriginal and Torres Strait Islander People as 'victims', rather than the potential agents of enhancing psychological wellbeing. My concern is about the potential for a primacy effect of presenting the factual information about invasion and disadvantage before looking at actual conduct will mean that any message of strength and agency of individuals from Indigenous Australian heritage will be lost.

9. Would endorsement of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for other diverse groups or vulnerable members of the community? If so, please describe them.

Your answer: See my response immediately above.

10. Would endorsement of the draft Psychology Board of Australia code of conduct result in any adverse cost implications for health practitioners, higher education providers, employers, clients/consumers, governments or other stakeholders? If so, please describe them.

Your answer: See section 6 above. The application of medical models of safety and quality to psychological practice would provide an enormous burden on practitioners.

Transition and implementation

The Board is proposing to publish an advance copy of the draft Psychology Board of Australia code of conduct **12 months** before it would come into effect.

11. Do you agree with the proposed transition timeframe?

Your answer: Yes.

12. Would there be any implementation issues for your organisation and/or stakeholders that the Board should be aware of?

Your answer: No, as long as the points addressed above are resolved.

General feedback

13. Do you have any other feedback or comments about the draft Psychology Board of Australia code of conduct?

Your answer: The code is best utilised as a document that clearly sets out the expected standards of 'conduct' applicable to the practice of psychology in Australia. In my opinion, the code should not include virtue signalling or moral aspirations, nor information that is extraneous to actual conduct (regardless of its correctness or importance in a broader sense). Including aspirations in a code of conduct opens a legal minefield and opens the document to misuse. It is my further opinion that apart from conduct that harms clients or brings the profession of psychology into disrepute, the code must not encroach into the private lives of psychologist and time spent not practicing psychology, including ensuring that vague statements about required 'participation' in community and population wellbeing activities are omitted from the document. As it stands, it is my opinion that the draft code is too long and that it could easily be condensed to be a clearer and more workable document.

Attachment F

Public consultation: A code of conduct for psychologists

The Psychology Board of Australia (the Board) is seeking your feedback about our proposal to update the code of conduct that applies to all psychologists registered in Australia. There are 13 specific questions we would like you to address below. All questions are optional and you are welcome to respond to any that you find relevant, or that you have a view on.

Please email your submission to: psychconsultation@ahpra.gov.au

The submission deadline is close of business, **Monday 14 August 2023**

General questions
1. Do you support the Board's preferred option to implement a regulatory code of conduct?
Your answer: YES
2. Do you agree with the Board's approach to develop the draft Psychology Board of Australia code of conduct based on the shared *Code of conduct*?
Your answer: YES
3. Do you support the Board's proposal to adopt the draft Psychology Board of Australia code of conduct as the regulatory code for the psychology profession?
YES

Content of the draft Psychology Board code
4. Does the draft Psychology Board of Australia code of conduct set the minimum standards expected of psychologists by their professional peers and the public?

Your answer:YES

5. Are there any specific areas of psychological practice that are not adequately addressed in the draft Psychology Board of Australia code of conduct?

Your answer:

I think working with children might be one such area.

The raising of awareness of culture (in general) is another area.

For the latter, expanding the very well addressed (and needed) area of increased awareness for cultural safety for the Aboriginal and Torres Straits Islander people to explicitly include 'all minority cultural groups' might help those in the minority cultural communities to also gain access to our profession's services.

6. Are there any sections of the draft Psychology Board of Australia code of conduct that would be unworkable for your organisation and/or stakeholders?

Your answer: NO

7. Is the language and structure of the draft Psychology Board of Australia code of conduct helpful, clear and relevant?

Your answer: YES

Community impact

8. Would implementation of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for Aboriginal and Torres Strait Islander Peoples? If so, please describe them.

I WOULDN'T HAVE THOUGHT IT COULD HAVE ANY NEGATIVE EFFECTS.

9. Would endorsement of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for other diverse groups or vulnerable members of the community? If so, please describe them.

NO

10. Would endorsement of the draft Psychology Board of Australia code of conduct result in any adverse cost implications for health practitioners, higher education providers, employers, clients/consumers, governments or other stakeholders? If so, please describe them.

THE ONLY COST THAT I CAN IMAGINE MIGHT OCCUR IS THAT OF GAINING KNOWLEDGE REGARDING THE FIRST NATIONS AND OTHER CULTURAL GROUPS CULTURES.

I THINK IT IS A COST WELL WORTH UNDERTAKING.

Transition and implementation

The Board is proposing to publish an advance copy of the draft Psychology Board of Australia code of conduct **12 months** before it would come into effect.

11. Do you agree with the proposed transition timeframe?

Your answer:YES

12. Would there be any implementation issues for your organisation and/or stakeholders that the Board should be aware of?

Your answer:NO

General feedback

13. Do you have any other feedback or comments about the draft Psychology Board of Australia code of conduct?

NO

Attachment F

Public consultation: A code of conduct for psychologists

The Psychology Board of Australia (the Board) is seeking your feedback about our proposal to update the code of conduct that applies to all psychologists registered in Australia. There are 13 specific questions we would like you to address below. All questions are optional and you are welcome to respond to any that you find relevant, or that you have a view on.

Please email your submission to: psychconsultation@ahpra.gov.au

The submission deadline is close of business, **Monday 14 August 2023**

General questions

1. Do you support the Board's preferred option to implement a regulatory code of conduct?

Your answer:

Yes. The APS Code is outdated and lacks detail, leaving readers to interpret, often by way of referring to Ethical Guidelines. The Draft is modern and reflects 21st Century concerns and issues.

2. Do you agree with the Board's approach to develop the draft Psychology Board of Australia code of conduct based on the shared *Code of conduct*?

Your answer:

Yes. See 1 above.

3. Do you support the Board's proposal to adopt the draft Psychology Board of Australia code of conduct as the regulatory code for the psychology profession?

Your answer:

Yes. The APS has a substantial membership and coverage but other organisations have sprung up in competition. A whole of profession approach to ethics and conduct would simplify matters, and encourage all three professional organisations to cease reliance on their own codes.

Content of the draft Psychology Board code

4. Does the draft Psychology Board of Australia code of conduct set the minimum standards expected of psychologists by their professional peers and the public?

Your answer:

Not entirely. See 5 below.

I was pleased to see the Draft Code's dropping of the "two year rule" regarding sexual relationships with former clients. [redacted]

5. Are there any specific areas of psychological practice that are not adequately addressed in the draft Psychology Board of Australia code of conduct?

Your answer:

Yes. In its introduction the Draft Code states that it does not cover commercial relationships. [redacted] **I treated the issues as involving how best to protect the best interests of the client, for example by way of ensuring clients had the right to choose their service provider.** [redacted]

I see this aspect of professional practice, while ostensibly a business and commercial matter, as having serious implications for client welfare, and therefore one that should come under the umbrella of the Board's proposed Code of Conduct.

6. Are there any sections of the draft Psychology Board of Australia code of conduct that would be unworkable for your organisation and/or stakeholders?

Your answer:

Not applicable.

7. Is the language and structure of the draft Psychology Board of Australia code of conduct helpful, clear and relevant?

Your answer:

Yes. I was well satisfied with the language in particular.

Community impact

8. Would implementation of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for Aboriginal and Torres Strait Islander Peoples? If so, please describe them.

Your answer:

Not as far as I could see.

9. Would endorsement of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for other diverse groups or vulnerable members of the community? If so, please describe them.

Your answer:

No

10. Would endorsement of the draft Psychology Board of Australia code of conduct result in any adverse cost implications for health practitioners, higher education providers, employers, clients/consumers, governments or other stakeholders? If so, please describe them.
Your answer: **Not applicable in my case.**

Transition and implementation

The Board is proposing to publish an advance copy of the draft Psychology Board of Australia code of conduct **12 months** before it would come into effect.

11. Do you agree with the proposed transition timeframe?

Your answer:

Yes. I support the plan as it allows people to familiarise themselves. The Board's legally backed ability to require psychologists to attend to the Code is an advantage. [redacted]

12. Would there be any implementation issues for your organisation and/or stakeholders that the Board should be aware of?

Your answer:

Not applicable.

General feedback

13. Do you have any other feedback or comments about the draft Psychology Board of Australia code of conduct?

Your answer:

Section 1.3: I suggest re-wording to state "discrimination, lawful or otherwise".

Section 3.3 (e) states "and/or authorised". I believe this should read "not authorised" or "unless otherwise authorised".

3.3 (h) The issue of consent (to release information) could better address the clinical issue of the need to re-address consent as time passes and circumstances change.

4.6 (d) When complaints arise indemnity insurers require a psychologist to cease communication with the complainant, including when a complaint is threatened or anticipated.

4.6 (g) Transfer of files is best covered as a contractual item, and is relevant to client welfare.

8.11 (d) In referring to coronial matters, there is no reference to subpoenas. When a client has died and an inquest takes place, I believe a psychologist should not simply hand over information when requested. A subpoena is needed as a client's death does not mean easy access to confidentially held information.

Attachment F

Public consultation: A code of conduct for psychologists

The Psychology Board of Australia (the Board) is seeking your feedback about our proposal to update the code of conduct that applies to all psychologists registered in Australia. There are 13 specific questions we would like you to address below. All questions are optional and you are welcome to respond to any that you find relevant, or that you have a view on.

Please email your submission to: psychconsultation@ahpra.gov.au

The submission deadline is close of business, **Monday 14 August 2023**

General questions

1. Do you support the Board's preferred option to implement a regulatory code of conduct?

Your answer:

Yes

2. Do you agree with the Board's approach to develop the draft Psychology Board of Australia code of conduct based on the shared *Code of conduct*?

Your answer:

Yes. However, there are significant matters and obligations specific or emphasised in psychology, especially assessment and therapy (e.g.; confidentiality and when it needs to be breached) that need attention in the draft code. See feedback in Q13.

3. Do you support the Board's proposal to adopt the draft Psychology Board of Australia code of conduct as the regulatory code for the psychology profession?

Your answer:

Yes

Content of the draft Psychology Board code

4. Does the draft Psychology Board of Australia code of conduct set the minimum standards expected of psychologists by their professional peers and the public?

Your answer:

In general, yes. However, amendments are needed and suggested. See feedback in Q.13.

5. Are there any specific areas of psychological practice that are not adequately addressed in the draft Psychology Board of Australia code of conduct?

Your answer:

Yes, see Q.13.

6. Are there any sections of the draft Psychology Board of Australia code of conduct that would be unworkable for your organisation and/or stakeholders?

Your answer:

7. Is the language and structure of the draft Psychology Board of Australia code of conduct helpful, clear and relevant?

Your answer:

See feedback in Q.13 for suggested changes.

Community impact

8. Would implementation of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for Aboriginal and Torres Strait Islander Peoples? If so, please describe them.

Your answer:

9. Would endorsement of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for other diverse groups or vulnerable members of the community? If so, please describe them.

Your answer:

10. Would endorsement of the draft Psychology Board of Australia code of conduct result in any adverse cost implications for health practitioners, higher education providers, employers, clients/consumers, governments or other stakeholders? If so, please describe them.

Your answer:

Transition and implementation

The Board is proposing to publish an advance copy of the draft Psychology Board of Australia code of conduct **12 months** before it would come into effect.

11. Do you agree with the proposed transition timeframe?

Your answer:

Yes

12. Would there be any implementation issues for your organisation and/or stakeholders that the Board should be aware of?

Your answer:

General feedback

13. Do you have any other feedback or comments about the draft Psychology Board of Australia code of conduct?

Your answer:

Below are a number of suggested amendments for consideration. The detailed changes are set out by reference to the sections in the draft Code of Conduct.

Preamble:

Introduction and Purpose.

Change 'effective' to 'competent' and/or 'good' here and throughout the document.

Competence is the factor/measure by which performance is evaluated as satisfactory/unsatisfactory. Effectiveness cannot be guaranteed even if the practitioner meets the requisite standard. Effective has a particular meaning in empirical outcome measurement.

Also, in a number of sections, the term 'ethically' would be better than 'effectively'.

'Good' is the descriptor used in the Shared code and also carries a conventional meaning in ethics that fits better with the purpose of a code of conduct being to emphasise what is morally and safely necessary.

Professional values and quality.

Missing from the overarching list is the principle that is frequently tested in assessing the judgment and performance of a practitioner: 'Responsibility to anticipate the foreseeable consequences of their professional decisions'. See APS Code of Ethics, General Principle B: Explanatory Statement.

I also prefer the related wording in this section of the APS, C of E, and recommend these principles be more clearly articulated in this section of the draft viz.

'provide services that are beneficial to people' (the principle of beneficence has history)

'and do not harm them' (similarly, a long understood and accepted ethical tenet)

'psychologists take responsibility for their professional decisions'

See APS, C of E. Professional Responsibility. B.3, especially (b, c, e) for the particular standards being cited.

Specifically,

Re: (a) Include 'ethnicity' in the list of 'differences'.

Re: (d) Add 'and safety' after 'health'.

Re: 1.2.g. Add 'scientific' after 'contemporary'.

Re: 1.2.i. Replace 'a second' with 'other'.

Re: 1.2 c. Add 'are identified by you and declared, as necessary, and' after 'personal views'.

Re: 1.2.m. To be more inclusive in this section, and in the whole document, insert 'interpersonally,' before 'culturally safe'.

Alternatively (my preference) delete the word 'culturally', in order to be consistent with the purpose of the section, as expressed in its beginning paragraph, and to be comprehensive of all forms of safety.

Re: 1.2.n. Amend as for (m) above.

Re: 1.3.b. For clarification, 'prejudice' needs a definition just as 'discrimination' has below. The client factors listed e.g., mental health status may have contributed to their situation and legitimately be considered in any functional analysis of variables leading to care. This form of appraisal by the practitioner needs to be differentiated from 'prejudice'.

Re: 1.3.f. Insert 'social, political' after 'moral', in the interest of inclusiveness.

Privacy and Confidentiality (3.3)

These factors require an individual section. Given privacy and confidentiality are differentiated as concepts, there should be a definition for each.

Re: 3.3 a (iii). One of the most important and challenging decisions for a practitioner has always been to determine if the conditions giving rise to a disclosure of confidential information are met. The standard for disclosure needs to be more explicit than a reference to the Australian Privacy

Principles in a footnote. The existing APS, C of E, section A.5 needs to be more adequately represented in this standard.

Re: 3.3 a (v) The differentiation of this section from (iv) is unclear, especially as 'consent' is covered in the overarching purpose expressed in (a). Was 'collecting' meant to be 'disclosing'? If not, there should be a 'disclosing' section for associated parties, as there is for clients.

Re: 3.3.b. There needs to be a definition for 'agreement' in order to differentiate from 'consent'.

Re: 3.3.h. Delete 'may'.

Re: 4.1.d. After 'exploit clients', insert 'in any way, including'.

Re: 4.3.b. Further consideration is needed for this section. To express 'advocacy' as a 'responsibility' of psychologists raises the prospect of a conflict of interest through a multiple relationship (see 4.8). 4.1.c. above may be sufficient.

Re: 4.3.c. (v.) Add after 'law' 'or for ensuring safety of the person or others'. The purpose is to cover breach of confidentiality as a duty of care/to warn.

Re: 4.4.b. Before 'providing' insert 'receiving and'.

Re: 4.6.d. The demand to 'ensure' in the case of a Notification is likely to be unfeasible or too onerous a standard for the practitioner to meet.

Re: 4.7 After 'benefit' insert 'or are likely to benefit'.

Re: 4.8.f. The criteria of inappropriateness need to be articulated, or reference made to a "Guideline". See my comments in 4.8.h below regarding the ambiguity of using 'mostly inappropriate'.

Re: 4.8.h. To express the ethic being sought, the starting point is to say plainly that psychologists should never form sexual relationships with former clients. Then the reasons which might alter the risk of harm can be stated as the exceptions, essentially the showing of non-exploitation because of common sense factors, such as the trivial or limited nature of the original service/therapeutic relationship.

Further, the use of the adverb 'mostly' before 'inappropriate' creates an ambiguity. The intent, I interpret, is to identify that a number of such relationships are inappropriate i.e., almost all. However, it could be read as referring to the degree of (in)appropriateness of any one such relationship i.e., it is mainly inappropriate but not fully so. If my interpretation of this intent is not the case, then it shows how an ambiguity exists.

My recommendation is that 4.8.h. be recast as

'never pursue or establish a sexual or personal (including financial or commercial) relationship with people who have been your clients, unless factors, including the extent of the personal relationship and the degree of vulnerability of such people, enable an exception to be allowed'.

Re: 4.8.i. Change as per 'h' above.

Re Principle 5. Delete 'effective' and insert 'Working relationships with other professionals'.

Re: 6.1.c. This is not a conduct standard.

Re: 6.1.d. It is not clear what this sub-section means.

Re: 6.2. The principle is indeed valued and desirable. However, the standard (paragraph 2) is not a matter of "conduct" for the purposes of the National Law. This action is more in the nature of a desirable professional contribution. The wording highlights the problem of using 'effective' throughout as the descriptor of the practice being sought.

Re: Principle 7. and 7.1. The continuing specific referencing of "cultural safety' is occurring at the expense of other forms of safety e.g., interpersonal, social (bullying, exploitation, violence) that should have equal standing. Cultural safety is well covered in Principles 2 and 3.

My recommendation is to delete ',including cultural safety,' and leave 'safety' to stand alone.

Re: 7.1.c. This is not really a code of conduct standard, but more an employee obligation – expected workplace behaviour.

Re: 7.1.h. Not a conduct standard as expressed. Replace with "be available to consult with colleagues'.

Re 7.2.e. As for 7.1.h.

Re: 7.3. Delete 'culturally', keep 'safe' for the reasons above.

Re: 7.3.and 7.4. These standards relate to competence/professional performance in general, not just Risk Management. They are better placed in Section 1. Competent, Safe, and Collaborative Practice.

Re: 8. I prefer that the Principles of Propriety and Integrity, as per the APS, C of E, were conveyed as the core, overarching characteristics of Professional Behaviour. Trustworthiness and Honesty are important component to covered under those headings

Re:8.8. It seems contradictory, at least of the definition of "client", to say "the usual psychologist-client relationship does not exist". Surely the person referred under this circumstance becomes a client in the usual way and all the standards apply.

Re:10.1.f. The first part of this sentence is circular.

Re: 10.3. The standard in the APS, C of E, A.4 (b) regarding protections of students could be more explicitly included in this section.

Overview Comment

The draft Code contains prescriptive and proscriptive standards, as it should. However, the number is large. A proportion of that number do not seem appropriate or necessary for the core purposes of the regulation of the profession. Some seem more in the nature of discipline skills, expected workplace practices, and general social mores, beliefs and attitudes. I suggest that the document be reviewed to test it against a criterion that the standard is essential or necessary, more than just desirable, in order to achieve the objectives of the National Law. After all, it is a code of conduct for that purpose. Some sections may fit better within Guidelines.

AHPRA should be in all capitals.

Attachment F

Public consultation: A code of conduct for psychologists

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The submission deadline is close of business, **Monday 14 August 2023**

General questions
1. Do you support the Board's preferred option to implement a regulatory code of conduct? Yes
Your answer:
2. Do you agree with the Board's approach to develop the draft Psychology Board of Australia code of conduct based on the shared *Code of conduct*? Yes
Your answer:
3. Do you support the Board's proposal to adopt the draft Psychology Board of Australia code of conduct as the regulatory code for the psychology profession? Yes
Your answer: Makes sense, we're used to this.

Content of the draft Psychology Board code

4. Does the draft Psychology Board of Australia code of conduct set the minimum standards expected of psychologists by their professional peers and the public? No

Your answer: The update of the 2-year boundary to 'never' having relationships – sexual or personal- seems unnecessarily harsh as it takes away the free will of two consenting adults, and does not take into account circumstances e.g. rural areas, length of time consulted, degree of vulnerability of patient, context of relationship. Psychologists should be trusted as trained professionals to uphold, weigh and judge ethical issues of their own accord, provide guidelines to support reflection and develop self-awareness rather than be prescribed to 'never' establish a relationship with someone outside of therapy. (Reference AMA Board for a guideline)

5. Are there any specific areas of psychological practice that are not adequately addressed in the draft Psychology Board of Australia code of conduct?

Your answer:

6. Are there any sections of the draft Psychology Board of Australia code of conduct that would be unworkable for your organisation and/or stakeholders? Yes

Your answer: I refer to section 4.8.f, where it is deemed mostly inappropriate to share personal information. My clients benefit from a disclosure of neurodivergence and there is ample research to show that clients are more comfortable discussing their neuroidentity with someone who shares their neurotype. When referring a client on, in their words (with consent to share), "there's no way I'd ever tell someone who didn't also have it. They can ask about it, but I won't talk to them much." Given the impacts of understanding one's neurotype on mental health, this disclosure is important. This may also serve as important modelling when done in certain cases and professionals should be guided regarding when self-disclosure is appropriate and provided guidelines around this, rather than to recognise it is mostly inappropriate. There are times when it is essential for guiding the progress of clients and in developing felt safety, particularly with paediatric clientele. Additionally, most therapists self-disclose in one form of another, some through our skin colour, or through what we wear, or through our preference of working hours for example. (e.g. 10am to 2pm consults could mean therapist is a working parent with school-aged children). Rather than avoid self-disclosure, a more appropriate guideline would be to help therapists develop critical thinking skills around appropriate self-disclosure and its complex factors to take

into consideration, which more senior therapists may be able to do independently. (Johnsen & Ding, 2021).

Regarding referrals (5.4) and having practitioners be responsible for service until referral or handover is accepted, perhaps a more prudent guideline could be around notice periods and reasonable effort made to support an appropriate referral or handover. I am considering colleagues who are going on maternity leave for example, or taking leave of absences for personal or medical reasons, but clients may be reluctant to try someone new despite therapist encouragement.

References:

Pellicano, E., Lawson, W., Hall, G., Mahony, J., Lilley, R., Heyworth, M, Clapham, H, and Yudell, M.. (2022) "I Knew She'd Get It, and Get Me": Participants' Perspectives of a Participatory Autism Research Project. Autism in Adulthood.Jun 2022.120-129.

Johnsen, C. & Ding, H. T. (2021) Therapist self-disclosure: Let's tackle the elephant in the room. Clinical Child Psychology and Psychiatry. 26(2), pp 443-450

7. Is the language and structure of the draft Psychology Board of Australia code of conduct helpful, clear and relevant?

Your answer: Yes

Community impact

8. Would implementation of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for Aboriginal and Torres Strait Islander Peoples? If so, please describe them.

Your answer: Unknown

9. Would endorsement of the draft Psychology Board of Australia code of conduct result in negative or unintended effects for other diverse groups or vulnerable members of the community? If so, please describe them. Yes

Your answer:

As outlined above.

Additionally, neurodivergent members of the community have relational communication styles where rather than turn taking in conversation, they share a fact about themselves. Therefore in order to elicit details about a client's feelings or whereabouts, they first need to have it modelled through authentic sharing in conversation. Additionally, the cautious sharing of personal information for relationship formation is central to the therapist-client relationship when reflecting on CALD populations. In order to unpack ideas like racism and understanding minority stress for example, a client may first want to know the therapist's origins to know they truly understand their perspective. This is also salient when reflecting on the idea that many clients from CALD backgrounds have not had emotions modelled to them when they were younger and therefore feel uncertain entering a therapist-client relationship. Research highlights that lived experience practitioners provide value and contribute experiential knowledge to the field and that self-disclosure enhances the therapy relationship. (Cleary & Armour, 2022). Our guiding ethical principles should operate in line with the best available evidence to us.

References

Cleary, R., Armour, C. (2022) Exploring the role of practitioner lived experience of mental health issues in counselling and psychotherapy. Counselling and Psychotherapy Research, 22(4), pp1100-1111

https://www.bps.org.uk/psychologist/neurodiversity-not-just-those-we-work?fbclid=IwAR0bkspb_eCLVOavzjWwxjX9c5OKmir9CLOwyzcJYGCyqWkRHWvrXDwcBLc

10. Would endorsement of the draft Psychology Board of Australia code of conduct result in any adverse cost implications for health practitioners, higher education providers, employers, clients/consumers, governments or other stakeholders? If so, please describe them.

Your answer: No

Transition and implementation

The Board is proposing to publish an advance copy of the draft Psychology Board of Australia code of conduct **12 months** before it would come into effect.

11. Do you agree with the proposed transition timeframe? Yes

Your answer:

12. Would there be any implementation issues for your organisation and/or stakeholders that the Board should be aware of?

Your answer: No

General feedback

13. Do you have any other feedback or comments about the draft Psychology Board of Australia code of conduct?

Your answer: No