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:

ACPA welcomes an independent Board authored regulatory code of conduct which describes the standards of behaviour and practice the Board requires of all psychologists. It is a welcome initiative and welcome update to the APS code of ethics 2007 and a tool to set standards expected of all psychologists as well as communicate standards to professionals and public.

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:

Given there are many aspects so conduct that are shared across health professions we agree that the shared code of conduct which is based on an evidence-based model seems is a useful base from which to develop the specific Board authored code of conduct for psychologists. The code of conduct draft document has amended and added based on the specific requirements of the profession of psychology. The 10 principles are linked to specific behaviour and knowledge requirements in a way that clarifies them.

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:

ACPA supports the draft Psychology Board of Australia code of conduct but also recommends important changes. ACPA members have raised several concerns which are addressed in the Additional Comments section of this submission.

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 important to clarify that this code of conduct represents the minimal standards for behaviour which should improve the public and professional ability to interpret the requirements. It does not represent the more aspirational qualities of best possible practice. However, it makes clear that the code is the expectation is that psychologists will use the code to guide their professional judgement to achieve the best practice. In its current form, the code protects and supports our clients, but does not include guidelines for psychologists protecting themselves.

There are other more specific practice standards outlined in other documents issued by the Board and/or regulatory bodies. Unfortunately, the specific ethical guidelines that the APS developed are not available to non-members. We suggest that the Board may have a role in further developing and authoring independent specific ethical guidelines that can be assessed by all psychologists.

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:

As psychological practice has and continues to go through significant changes with development of telehealth services the board may wish to make specific comment to the standards relating to psychology provision via telehealth and E-health.

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:

The emphasis on cultural safety as defined is appreciated and so is the recognition of diversity throughout the document.

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:

We would not anticipate that would be 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:

We would not anticipate that would be the case.

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 time frame for transition allows for a timely implementation. However, ACPA is concerned there is no specific implementation plan; best practice implementation science states that an implementation plan should be in place at an early stage of development.

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:

The suggested transition time of one year will support psychologists to become familiar with any changes to the code of conduct and assess whether they need to plan for any additional CPD or seek further information to make the transition. It also allows time for psychologists to start integrating the new code into their practice and engage in discussions with their professional networks about the changes.

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:

Stipulation of supervisory requirements

The code makes clear the expectation that psychologists will use the code to guide their professional judgement to achieve the best practice. This suggest ongoing professional development and supervision may be required to ensure the code can be utilised thoroughly in addition to more specific guidelines. Currently the requirement is 30 hours of CPD, 10 of which are required to be peer consultation. We recommend a change in the code of conduct that includes a requirement for ongoing formal supervision.

The importance of clinical judgement

ACPA members have commented that in many instance the high level of prescription in the code undermines the role of clinical judgement. Clinical judgement is usually better than a generic rule because the work of clinical psychologists involves many unique situations (which may have been less of an issue with codes of conduct for other regulated professions). Psychologists have over time been required to do more training, more CPD, more clinical supervision, and when we add clinical experience to that list, we might expect a code of conduct to refer to clinical judgement more often. Under circumstances when clinical judgement takes precedence over the code, will practitioners have a higher risk of complaints being made against them?

We understand from our PsyBA webinar that a psychologist can use their clinical judgement in discharging their duty of care and be able to justify their decision-making in their navigation of a range of circumstances to ensure safe practice. However, ongoing concerns of ACPA members would be allayed if there was explicit reference to the acceptance of clinical judgement throughout the code.

1.3 Decisions about access to psychological services

The code requires that psychologists not prejudice the care of client because they have contributed to their situation. ACPA members are concerned about who ultimately defines prejudice in scenarios where they attempt to inform someone (including another mental health service) of a client's self-destructive or self-sabotaging behaviour or behaviour motivated by secondary gain?

Who decides what are "*unnecessary or indiscriminate use of psychology services*"? Some guidance around this requirement is warranted.

The code needs to be clear that if a client poses a risk to safety, the psychologist has the right to protect their own safety. Practitioners need to apply discretion to refuse to take on clients with whom they feel unsafe. This includes clients who bully or harass their psychologist.

In ensuring that the client has alternative options for psychological services, a 'best efforts' clause is required. In the cases of low-cost services, there are not always alternative options - clients cannot be subsidised for limited sessions and then psychologists held responsible for the lack of baseline public systems.

1.4 Helping in emergencies

We note this item has been taken from the code for medical practitioners; medical skills are highly relevant and of finite duration for many emergencies, whereas psychology skills are not. Furthermore, there are publicly funded medical services that a medical practitioner can reasonably expect that a patient will be handed over to; psychologists do not have the same luxury. The point at which our services are no longer needed may never arise given that emergency departments are tending to discharge or refuse to admit clients who are still at active risk of self-harm. Once again, psychologists cannot be held responsible for the failures in downstream systems that are available to other health professions that may reasonably have this clause in their code of conduct.

The standard should state that it is important to also consider the well-being of the psychologist in emergency situations.

3.2 Effective communication

Communication with a client's "nominated partner, substitute decision maker, carers, family and friends" needs an added statement that this is only appropriate when within the bounds of confidentiality.

4.3 Children, young people, and other clients who may have additional needs.

While this provision is virtuous, addressing inequity and increasing advocacy for clients with additional needs is beyond the remit and capacity of the typical psychologist. Wording could be changed to "the psychologist should consider ways that may assist the client address inequalities".

A requirement that psychologists are responsible for advocacy (especially if this is out of session time in a private setting) could have the unintended consequence of resulting in higher charges to the client, encroaching on time available for clinical care, or may become a disincentive to work with children or marginalised populations.

4.7 Maintaining continuity of psychological services; 5.4 Delegation, referral and handover

The draft code appears to indicate that clients be held until they are accepted by another service and that additional measures are to be taken to handover care during emergencies or periods of foreseeable absence. We understand from our PsyBA webinar that a psychologist can use their clinical judgement in discharging their duty of care in such situations and will be able to justify their decision-making should they be subject to a complaint or notification. However, ongoing concerns would be allayed if there was more explicit reference to the acceptance of clinical judgement in circumstances where continuity of care is not easily implemented. The language could be moderated to "makes efforts to" or "where possible".

There are many instances where a psychologist may be unable to offer continued care. For example, where a client needs psychological care but does not agree to accept their referral, where they can no longer afford to access psychological services, where they need a level of management that requires a mental health team, or where the psychologist is at personal risk. It is not reasonable for a private practitioner to become a pseudo mental health team and share risk with a general practitioner. The scarcity of public sector mental health services in many jurisdictions makes such scenarios unmanageable.

In another example, how does this guidance work for assessment clients? Many clinical psychologists predominantly conduct assessments, and should clients then need therapy details of practitioners can be provided. But it is not achievable to ensure clients have therapy in place, given the scarcity of available mental health services.

4.8 Professional Boundaries

ACPA welcomes the change in the professional boundaries provisions that proposes the removal of the two-year rule that prevented psychologists form engaging in sexual relationships with clients for a period of two years after treatment ceased.

The draft code widens the definition to all relationship and shifts focus from what was an arbitrary time frame. As the psychologist has a continuing duty to protect the client it is never appropriate to engage in relationships with clients.

However, we recommend that the code explicitly consider the commonality and navigation of dual relationships in rural and regional areas. Such relationships are inevitable and are often in the best interests of clients (though not necessarily for the psychologist!). If psychologists were to follow this code to the letter, they would end up lonely and bored, avoiding contact with the world, or they would stop seeing local clients and opt for telehealth of city dwellers to avoid any dual relationships. We are aware of regionally based clinicians who do this. It is a negative unintended consequence if the rules are inflexible and not well suited to the geographical context.

The disclosure of personal information

ACPA members who are neurodivergent reported that they judiciously self-disclose in alignment with neurodivergent-affirming practice principles. There is growing understanding and evidence that demonstrates the importance of lived experience in clinical settings and ACPA is concerned that the new code will be problematic for psychologists who judiciously self-disclose.

In another example, there are many psychologists who practice psychoanalytically who are trained precisely on how/when/why to disclose personal information, referred to as interpretation of the transference/countertransference matrix.

The section on personal disclosure should make it explicit that training and skill will make that practice safe, not proscription. Consultation on each instance of disclosing is not practical, because judicious self-disclosure is usually a clinical decision in the moment, and not something that can be advised on by a supervisor or peer at that time. There are some instances of planed judicious self-disclosure, but they would be in the minority.

Examples could be helpful (e.g., does personal information mean home address, the accountant we use, our share portfolio, or something entirely different?).

ACPA members recommend an alternative clause that self-disclosure should reasonably be believed to be in the best interests of the client. The primary issue in self-disclosure is whether it's in service of therapeutic outcomes (including therapeutic relationship) versus whether it is self-serving for the therapist and blurs boundaries without a corresponding benefit.

6.2 Equity and opportunity

ACPA members thought that promoting equity and opportunity outside our usual clinical roles is virtuous but will sit outside the scope and capacity of many. This guidance is not consistent with the notion of the code as minimal practice standards.

8.3 Integrity of assessment methods and techniques

Protection only applies to some assessments, others are (and should be) freely available and if so transparency and honesty should prevail. Much of this secrecy is protectionist and clients would be better served by giving them transparent information.

8.13 Financial and commercial dealings

Long term therapeutic relationships have an attachment aspect and gift giving can be an important part of this in certain circumstances. Schema therapy encourages appropriate tokens as part of limited reparenting, and it can demonstrate care that can be clinically helpful.
If a statement on gifts must be included here, it needs to be less dogmatic. The attachment relationship is the key vehicle of change in psychological therapy and this statement appears to show no awareness of this.

Of note, this clause is completely absent from the medical practitioner code of conduct, despite the attachment relationship being less crucial in that scenario.

10.3 Provisional psychologists and registrars

Registrars are fully qualified and registered psychologists and should not require special consent.

Definition of terms

Vague terms like "respect" or "mostly inappropriate" without explanation of what is meant by the term are unhelpful and problematic.