Sonia Street
Psychologist
BA Grad Dip Arts (Applied Psych)

Helping children be their best

13th April 2021

To Whom It May Concern:

RE: Response to public consultation of Revised Regulatory principles for the National Scheme (AHPRA)

AHPRA and the Psychology Registration Board are proposing a notable shift in the balance of expectations on psychologists and other health practitioners towards meeting expectations of the community at large, while also providing an ongoing deterrent to health practitioners to avoid behaviours (be this action or inaction) that may be deemed either irresponsible (at best) or dangerous to the public. While this sentiment may at first consideration appear reasonable, there must be a recognition that decisions made by health practitioners are sometimes made in extremely complex situations, and under tremendous pressures.

Punitive approaches to errors and failings by health practitioners will not actually serve the public in the long term, but rather it will serve to stifle practice. The overriding consideration of all practitioners will then only ever be “am I keeping myself safe from liability”. It becomes focused purely on risk-avoidance. This kind of thinking is inherently different to the ideals of professional self-reflection and growth and the two should not be confused.

There must acknowledgement that in any endeavor that involves working with human beings, there will always be a degree of risk-taking with decisions. We cannot, and should not, approach our interactions, interventions and relationships between health practitioner and patient/client as somehow completely controllable and utterly prescriptive. To think this way is flawed from the outset. It sets up the interaction between health practitioner and service recipient to be so devoid of any reciprocity that makes it ineffective. It is like treating a tumor with a dose of paracetamol – it is a safe option, but it’s completely ineffective.

I am disappointed to see the following phrase significantly altered: *“Our actions are designed to protect the public and not to punish practitioners. While our actions are not intended to punish, we acknowledge that practitioners will sometimes feel that our actions are punitive”* . This statement provided some (albeit quite understated) reassurance to practitioners that while errors may occur, in the overwhelming majority of cases, there is rarely wilful intent by health practitioners to harm others. There must be consideration of this when adjudicating over the behaviours of health care providers. Even now, as a practitioner with now almost 30 years’ experience, I always feel a sense of dread whenever I receive communication from the Psychology Registration Board – there is never a sense of interest or curiosity. I suggest that removing or altering the above statement only increases these feelings of dread and fear.

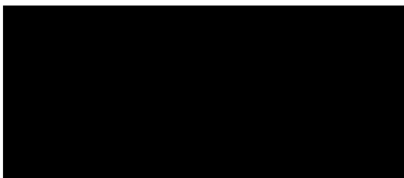
Whenever a change is required in procedures, policies and interventions, it must occur at multiple levels – for individuals, programs, organisations, departments and government. Where possible, any changes required should occur for these different levels at an equally proportionate response. For instance, investigation and/or censure of a stand-alone nurse practitioner in a rural-remote health location should be at a different level than a medical

program taking place in large, well-resourced hospital with a multi-faceted team of health professionals and ancillary staff. Without this distinction, health practitioners of every kind will abandon work opportunities in situations where they believe they will be under inherently disproportionate scrutiny and judgement.

When considering the goal of deterring practitioners from engaging in conduct that has been deemed inappropriate, irresponsible or dangerous, there must be consideration for the complexity that might accompany each unique circumstance. What might be inappropriate in one context may be entirely necessary and advisable in another context. The wording of this principle then should reflect that both actions or inactions may – at surface level, appear to be the same, but judgement about the appropriateness is contingent on a full understanding of the context in which an action by a health practitioner occurs.

It is important to consider that peers are in fact more likely to hold fellow health practitioner colleagues to a higher standard of propriety and care than the community at large, based on their greater level of knowledge. Community expectations may in fact be lower. This might be an important consideration for change in specific policies. For instance, in the case of individuals who tragically take their own lives, it is more fitting to allow mental health professionals to share information with family as an act of compassion and healing, rather than adhering to strict codes around confidentiality. Community expectation in this case is more appropriate than the rigid adherence to what most mental health professionals would consider a sacrosanct rule.

I wish to see greater balance in the presentation of these ideals – that where errors occur in the provision of any kind of health service, the practitioner is given the opportunity to correct, repair, learn and grow, rather than a one-sided approach that considers only protection of the public. I believe that this narrow view of health practitioners in fact continues to perpetrate a wholly outdated stereotype that health practitioners are "demi-gods" from whom the public require protection. I am strongly in favour of the principles of public safety and equitability of service, but the language of this proposed set of principles only furthers the outdated stereotypes. The emphasis should instead shift to empowering the public with clear choices around therapeutic interventions and that it is the responsibility of health practitioners to clearly communicate these options.



Sonia Street, psychologist
Registration #PSY0001120404