PSYCHOLOGY COUNCIL of New South Wales

Welcome from Council President, Associate Professor Caroline Hunt

Welcome to the Summer 2014 edition of the Psychology Council of New South Wales Newsletter.

In this newsletter we highlight the Council's Performance Program, including the role of Performance Assessors and Performance Review Panels. I also encourage everyone to read the features on dual professions, which is about psychologists practising another profession or skill, and confidentiality in the context of regional, rural and remote practice.

Each month, the Council deals with many complaints in relations to reports written by psychologists. A number of these complaints are discontinued when it becomes obvious to the Council that a member of the public is distressed by an outcome of a report, rather there being a problem with the conduct or performance of a psychologist in undertaking that report writing. However, there are a number of matters that are frequently the subject of a complaint where the psychologist has not taken sufficient care. For example, disputes about fees arise when a psychologist has not been explicit about how much a client may be charged for a report, and has not checked the client's understanding of this. Some psychologists who are an individual's treating practitioner have not made their role clear in their reports, which are presented as independent, yet are often based on just one person's perception (their client's) of the situation and cannot be impartial. It is critical that psychologists do not write reports regarding individuals who they have not themselves assessed.

In this issue, the Council is introducing a regular feature on cautionary tales. These are to remind us to be mindful of potential consequences of our actions.

Finally, we present the third article in a series on maintaining good self care in the practice of psychology, titled 'The impacts of sleep deprivation and sleep hygiene strategies'. Also included are two more ethical vignettes, as well as a response to a vignette presented in a previous newsletter. Thank you to Anna Moulynox and her supervisor, Meredith Jordan, for providing this excellent response.

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The Psychology Council's Performance Program

Introduction

The *Health Practitioner Regulation National Law (NSW) No 86a* (Law (NSW)) provides the legislative framework under which the Psychology Council of New South Wales (Council) fulfils its role in managing complaints and notifications about the professional performance of psychologists. The Council aims to ensure that all psychologists working in New South Wales are fit to practise psychology at the high standard the public is entitled to expect.

The Council has established a performance program which is non-disciplinary – the matters that give rise to a performance assessment do not have the characteristics of reckless, unethical, criminal or wilful conduct that would require disciplinary action against the practitioner. Rather, the program is educative, aiming at early intervention and remediation.

When a complaint or notification is made, it is considered by the Council in conjunction with the Health Care Complaints Commission (the Commission) and a decision is made as to whether the professional performance of the psychologist is to be assessed. This involves an assessment team visiting the practitioner's practice to assess their performance in a number of key areas. Following the assessment, the assessors' report is presented to the Council for its consideration as to the appropriate course of action. Options available to the Council include the following:

- take no further action;
- counsel the practitioner;
- convene a Performance Review Panel (Panel / PRP);
- make a complaint against a practitioner to the Health Care Complaints Commission;
- refer the matter to the Health Program with a view to convening an Impaired Registrants Panel (IRP); or
- take urgent action under section 150 of the Law (NSW).

Performance Assessment: Pre-assessment

In dealing with a matter through the performance program, the Council is concerned with the overall performance of the practitioner, not just the triggering matter. Consequently, the matters raised in the complaint may not be the only issues investigated.

If a matter is to be dealt with as a performance issue, the Council will advise the psychologist of the details of the matters giving rise to the assessment. The psychologist will be given the opportunity to provide information to assist the assessment process.

Generally two assessors – selected for their skill, training, expertise and experience – are appointed by the Council to conduct the assessment.

The Law (NSW) provides assessors with a number of powers. Whilst these powers will seldom need to be exercised to their full extent, it is worth noting their existence as they provide a mechanism by which the Council can compel a psychologist to take part in a performance assessment. Assessors have the power to enter premises and to:

- examine any equipment used in psychological practice;
- take photographs;
- require production of any records;

- copy records;
- question persons on the premises; and
- require provision of assistance from the owner or occupier of the premises.

Performance Assessment: The assessment

The purpose of an assessment is to observe the psychologist in his or her own environment with real clients/patients, to assess whether their professional performance is at or below the standard reasonably expected of a psychologist of an equivalent level of training or experience. Psychologists are expected to cooperate with the assessment and failure to do so is considered to be evidence of unsatisfactory professional conduct.

A typical performance assessment follows a set format:

- introductions, and confirmation of intentions;
- general interview with the psychologist;
- observed practice;
- record review;
- interview with colleagues (when applicable); and
- clinical practice interview.

Following the performance assessment, the assessors will report in writing to the Council. The psychologist will usually be provided with a copy of the report and given two weeks to make a submission that will accompany the report to the Council.

Performance Assessment: Post-assessment

On consideration of the report and the psychologist's submission (if any), the Council, may decide that:

- no further action is to be taken;
- the psychologist should be counselled;
- to convene a Performance Review Panel;
- a complaint against the psychologist should be made to the Commission if there appears to be a significant issue of public health or safety, or indications of a case of professional misconduct or unsatisfactory professional conduct;
- a referral should be made to the Health Program; or
- the matter should be dealt with urgently under the provisions of section 150 of the Law (NSW).

Performance Review Panels: Pre-hearing

The purpose of a Performance Review Panel is to review the professional performance of the psychologist by examining the evidence placed before it to establish whether the psychologist's practice of psychology meets the standard reasonably expected of a psychologist of 'an equivalent level of training or experience'. The performance assessment report and the psychologist's submission are the key evidence before the Performance Review Panel.

The psychologist is entitled to attend the performance review and make oral or written representations to the Panel. However, a Performance Review Panel may proceed in the psychologist's absence, as long as the psychologist has been informed of the performance review and has been given notice.

Performance Review Panels: The hearing

During the proceedings, the Panel:

- observes the rules of procedural fairness;
- will be inquisitorial rather than adversarial;
- sits in absence of the public;
- is not bound by the rules of evidence;
- may conduct the performance review and inform itself as it sees fit;
- admits any material it deems to be relevant; and
- adjourns as required.

At the conclusion of the hearing, the Panel may deliver its decision. More commonly, however, the Panel will provide a written decision at a later date regarding what action, if any, to be taken to rectify deficiencies in the performance of the psychologist and to protect the public.

Performance Review Panel: The decision

Once a decision has been made, a Panel must within one month, provide a written statement of that decision, including reasons for the decision, to:

- the psychologist;
- the Council; and
- the Council may provide a copy of the statement of decision to any persons the Council or Panel thinks fit, for example, the assessors.

If the Panel finds that the psychologist's professional performance is unsatisfactory, it may:

- impose conditions on the psychologist's registration to practice;
- order that the psychologist complete a specified educational course;
- order that the psychologist report on their practise of psychology;
- order that the psychologist seeks and takes advice from specified persons; and/or
- direct that the psychologist's professional performance is re-assessed at a future date.

The exact nature of the remediation specified in conditions will depend on the needs of the individual. It will be the responsibility of the psychologist to implement the Panel's orders/conditions, including covering the cost of any education.

It should be noted that the Panel must recommend to the Council that a complaint be made to the Health Care Complaints Commission if the Panel finds the practitioner's performance raises a significant issue of public health or safety that requires investigation by the Commission or raises a *prima facie* case of professional misconduct or unsatisfactory professional conduct by the psychologist.

Performance Review Panel: The outcomes

A Panel may order that conditions are imposed on the psychologist's registration. Conditions fall into two main categories: those relating to remediation; and those designed to protect the public.

Psychologists whose performance is found to be unsatisfactory will be given the opportunity to rectify that deficiency through retraining and re-education. It is likely that such an action will be prescribed by the Performance Review Panel in the form of a condition requiring training or education.

It may also be necessary for the Panel to impose conditions that will protect the public while the practitioner attends to his or her remediation. Such conditions may require the practitioner to be supervised or to refrain from an area of practice.

Monitoring

Following the decision of the Performance Review Panel, the Council will assist the psychologist to comply with the Panel's orders and monitor the psychologist's compliance.

Appeals

The psychologist may appeal to the NSW Civil and Administrative Tribunal against a decision of the Panel under section 160 of the Law (NSW) or under section 160A on a point of law.

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Hilaire Belloc's: "Cautionary Tales" for Practitioners

The Council is introducing a regular feature on cautionary tales. We have chosen to name this section after Hilaire Belloc, a prolific writer who penned such gems as "Jim: Who ran away from his nurse, and was eaten by a lion" and "Matilda: Who told lies, and was burned to death".

Cautionary tales warn of a danger. Whilst the Council does not anticipate such an unpleasant fate befalling a psychologist in their day-to-day activities, the Council does encourage you to be mindful of potential consequences of your actions.

A recent complaint to the Council raised an interesting problem – the danger of loose lips!

The essence of the complaint was that a psychologist had walked out into the reception area and was said to have passed a comment about a client to a staff member. There was no suggestion that it was anything other than an off-hand remark. Unbeknown to the practitioner, however, the mother of the patient about whom the comment was made, was sitting in the waiting room. She recognised the subject and jumped up ... we don't know what happened next!

It is easy for all of us to make off hand remarks in circumstances where others may hear. In professional practice, however, practitioners should try to ensure that such remarks will not be audible to third parties. The message is simple, even when you think you can speak freely, you can't, so it is best not to do so at all!

If you have a cautionary tale, the Council would love to hear it. If not, make one up. A cautionary tale warns of a danger and is expressed in three parts. It goes as follows:

(1) A prohibition is stated – something is said to be dangerous.
(2) The narrative is told – someone performed the forbidden act.
(3) An unpleasant fate ensues – often related in grisly detail.

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Dual professions – Psychologists practising another profession / skill

Infrequently, though consistently within the range of complaints, the Council receives notice that a psychologist is practising an approach that is not in accord with accepted psychological practice. Clients have subsequently complained that they have also received such diverse treatment as chakra, Shamanism, past life regression, astrology, and other non evidence-based interventions. When a client is referred to a psychologist or presents privately, they expect, and should receive, therapy that is accepted by the profession as valid psychological treatment. It is confusing for the client to be confronted with some mix of psychology and one of the above approaches.

In the practice of psychology, also practising another profession with the same client is not implicated. Psychologists are required to base treatment and clinical interventions on sound scientific and professional knowledge of psychology. Clients should be fully-informed as to the treatments available, their respective benefits, and to give informed consent to the treatment they receive.

When the Council explores this issue with the psychologist concerned, it is often the case that both the psychology and non-psychology treatment is displayed by artefacts within the office, or on the website, or indeed advertised on the card of the psychologist.

To prevent the discomfort clients report, and their confusion, the Council suggests that psychologists make explicit the service offered. In all cases where a client presents/is referred for treatment of a psychological condition, it is psychology interventions alone that they should receive from the treating psychologist. It is therefore recommended that the psychologist ideally practise the other approach/skill in a different office, separate any related non-psychology advertising, business cards, websites, posters/leaflets or similar, from that of psychology practice, so that this is clear to the public.

If the psychologist is qualified to practise a complementary, alternative medical approach, the same recommendations as above apply.

It is important to remember that if a psychologist providing psychological interventions to a client also performs another role with the same client, for example, massage therapy, this would constitute a dual role and risk client confusion.

Similarly, the Council has received complaints where a psychologist has been a provider of various products, for example, goji juice, dietary supplements, mobile telephones/plans, and similar. This is unethical professional practice where boundaries are crossed, and dual roles are performed: such practices should not occur. If in any doubt, please refer to ethical guidelines and standards of professional practice, and speak to colleagues about the matter.

Ms Wendy McCartney
Council Member (Psychologist)

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Confidentiality in regional, rural and remote practice

It is still debated whether there are different legal and ethical issues involved in practising in regional, rural and remote (RRR) Australia. It is argued by some that current ethical codes and guidelines are 'urban-centric' and ignore specific ethical dilemmas that can arise in the rural context. Others maintain that the key issues remain the same, no matter what the geographic context. The general consensus seems to be, however, that there are at least several ethical challenges that differentiate between regional, rural and remote practice and its metropolitan counterpart – namely, confidentiality and dual/multiple relationships with clients in a small community (Thomson, 2011). Recent notifications to Council have again raised this complex issue, so it is worthwhile to re-explore guidelines in relation to appropriate conduct in this area.

As Professor Thomson clearly delineates: unlike their metropolitan colleagues whose professional lives are largely separate from their personal and social lives, those who practice in RRR Australia are frequently unable to 'quarantine' their professional lives, and often find themselves interacting with their clients/patients outside the therapeutic setting (in local community activities and in carrying out daily tasks such as shopping, banking etc). As a consequence, maintenance of confidentiality (a crucial component of psychological treatment) is harder to maintain. For example, a client or consumer may be identified whilst attending and accessing sessions at the practitioner's offices in the centre of town, which can reveal to others that the person concerned is seeking treatment. A psychologist may also become aware that clients know each other within the same small community, and must be careful not to make disclosures revealing treatment details (or even the accessing of treatment) to either.

At times, maintenance of confidentiality creates a difficult 'tight rope' on which to walk. For example, when patients are 'at risk' and the practitioner needs to request support or advice from others (e.g. supervisor, another service provider with knowledge of relevant facilities, etc), even small amounts of information can inadvertently lead to the identification by others of the patient about whom the enquiry is made. For most, this is not problem. However, for some (particularly within close ethnic groups where therapy and treatment are not 'the norm' or may not be viewed positively) such inadvertent identification can create exceedingly stressful situations for the client. Whilst such enquiries and requests for referral information on the part of the psychologist may not create a problem within a metropolitan context, they can create ripple effects in small communities non-conducive to the well-being of the patient. If made, it is important that such enquiries need to be done with full client consent and possible participation. Observance of formal protocols (e.g. signed consent forms; participation of the client in joint meetings; confidentiality agreements with all other treatment/advice providers, etc) needs therefore to be 'tighter' for practitioners in small communities, where the risks of 'indiscretions' (albeit in the cause of optimising treatment for the patient) can have unexpected effects. There can sometimes also be the unwritten assumption that 'we in small communities' look after each other, and this can sometimes lead to inappropriate informal discussion or disclosures by psychologists (even momentary) that can badly impact on someone seeking treatment.

Those practising in rural locations need to be particularly mindful of the need for adherence to codes of professional conduct, particularly in relation to confidentiality (and its limits, which need to be explained). This is the 'cornerstone' of any therapeutic relationship, no matter what the geographic location, and those practising in regional, rural and remote Australia need to be particularly scrupulous in maximising it, unless clear risks indicate otherwise.

Dr Robyn Vines
Council Member (Psychologist)

References/Resources
APS Code of Ethics: https://www.psychology.org.au/Assets/Files/APS-Code-of-Ethics.pdf

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Self care for psychologists – Sleep, diet and exercise: Key determinants of health and well-being (Part 2: The impacts of sleep deprivation and sleep hygiene strategies)

As outlined in the previous Newsletter (see 'Making physical activity a priority'), for many of our clients, lifestyle factors play an extensive part in their presenting psychological conditions. Sleep deprivation, poor diet and lack of exercise all contribute to – if not the cause then at least the maintenance of – conditions such as stress, anxiety and depression. Imbalance in these core behaviours also seems to contribute both to the development and maintenance of the 'secondary' addictions such as excessive alcohol consumption, smoking, other drug disorders and excessive caffeine consumption.

The role of sleep in the maintenance of health and well-being is complex. Sleep disturbance/sleep difficulties are frequently listed as key symptoms in most common mental disorders such as depression, work-related stress, anxiety, eating disorders and post-traumatic stress. However, it is arguable that sleep deprivation is not just the consequence of these conditions but may in fact play a causal role in at least their maintenance, of not origin. Indeed, the role and efficacy of anti-depressants (still an area of unresolved research activity) is claimed by some researchers to be directly connected with the positive impact they have on sleep – i.e. an increase in hours of sleep is one of the factors involved in improving levels of depression and anxiety. There is also some research that highlights possible links of sleep deprivation to the development of other adverse health conditions such as diabetes, heart disease, stroke, obesity (see Harrington, 2012) as well as behavioural outcomes e.g. poor study results for students, increasing rate of accidents, loss of libido (see WebMD).

Sleep deprivation and sleep disturbance is common in our society with causes ranging from having a newborn baby to drinking too much coffee, to excessive use of phones (e.g. in adolescence) and general lifestyle disorganisation. It is still not known how much sleep is optimal as it varies from person-to-person and with stage of life. However, general estimates suggest that newborn infants require about 16 hours of sleep per day over a 24 hour period (with varying patterns), with the need for sleep consolidating over time to between 12-14 hours in the second year of life, 10–12 hours by age 3, and about 10 hours from ages 8-12. Some research indicates that teenagers require between 9-10 hours and mature adults, in general, between 7-9 hours and that this continues into old age (see Harrington, 2012). Many people experience some fluctuation in the amount of sleep they receive from night to night and as they move through life. Some people need more sleep than others. However, persistent problems with the quality or quantity of sleep can signal a serious issue called insomnia (see APS, EQIP).

For many of our patients, sleep patterns are erratic, with some avoiding 'tackling sleep' by delaying going to bed until the early hours of the morning – due to anxiety about lying in bed for hours, mulling over distressing issues in their lives. This then becomes a self-perpetuating cycle in which exhaustion feeds negative thinking and behavioural disorganisation, further decreasing optimal hours of sleep. The teaching of 'sleep hygiene techniques' is crucial in the treatment of most mental disorders – indeed many argue that they need to be incorporated from the beginning of therapy, as gradual improvement in hours of sleep can diminish levels of depression and anxiety, and enhance the capacity to implement coping strategies (both cognitive and behavioural).

Fundamental to good sleep hygiene is:

- the establishment and maintenance of regular sleeping hours;
- techniques for physical relaxation such as the traditional Jacobsen Relaxation Techniques (see Bernstein et al, 2000); and
- cognitive skills enabling management of and detachment from worrying thoughts.

There is much research literature focused on the integration of these techniques into a cognitive behavioural framework of therapy. It is important that we learn to incorporate them for our clients as part of an evidence-based approach to treatment.

Dr Robyn Vines
Council Member (Psychologist)

References/Resources

- APS: EQIP: Information Sheet on Insomnia: http://eqip.psychology.org.au/information-sheets/insomnia/
- Australasian Sleep Association: http://www.sleep.org.au/
- Bernstein, DA, Borkovec, TD and Hazlett-Stevens, H: New Directions in Progressive Relaxation Training: A Guidebook for Helping Professionals; Praeger Publishers, 2000
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- WebMD: Coping with Excessive Sleepiness: Ten things to hate about sleep loss: http://www.webmd.com/sleep-disorders/excessive-sleepiness-10/10-results-sleep-loss
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Ethical Vignettes

Case 1

A young male patient attends for anger management. He tells you he has met a nice girl and wants to settle down. He has recently resigned from a bikie gang. He gives you details of his involvement in various anti-social acts including a vicious bashing which you recall was covered by the media about 12 months previously when a reward was offered for information leading to the conviction of the perpetrator.

Are you obliged to report the bashing to the police? What further information would you need to make this decision?

Case 2

A woman in her early 30s attends for help with managing her mood and to deal with her history of unstable relationships. During the course of your assessment, she reveals that she had been sexually abused by her uncle from the ages of approximately 8 to 15. She has not disclosed this information to anyone previously.

Are you required to make a report to the relevant child protection agency? What further information would you need to make this decision?