Clinical Governance Procedures

Version 2.1 | Effective 12 August 2026

These procedures operationalise the Clinical Governance Policy of Behavioural Edge Psychology Pty Ltd (ABN 95 693 874 645), the practice of Dr Sarah Fischer, Principal Psychologist and sole director. They are read together with the Clinical Governance Policy, the Privacy Policy, the Feedback and Complaints Policy and the Digital Record Retention and Notekeeping Policy. As a sole-practitioner practice, all responsibilities in these procedures sit with the Principal Psychologist unless otherwise stated.

1. Complaints Management Procedure

1.1 Purpose

To establish a clear, accessible and fair process for receiving, managing and resolving complaints from clients and other stakeholders in a manner that is respectful, timely and promotes continuous improvement. This procedure implements the Feedback and Complaints Policy and reflects standards 4.5 and 4.6 of the Psychology Board of Australia Code of conduct for psychologists (2025).

1.2 Scope

This procedure applies to all complaints received about the quality of psychological services provided, professional conduct and behaviour, communication and client interactions, administrative processes (billing, appointments, records), breaches of confidentiality or privacy, and any other aspect of service delivery.

1.3 Principles

Client-centred approach. Complaints are treated seriously and with respect, complainants are not disadvantaged for making a complaint, the complaints process is transparent and accessible, and timely resolution is prioritised.

Fair process. Natural justice and procedural fairness are maintained, decisions are based on evidence and consideration of all perspectives, and bias and conflicts of interest are identified and managed. Because the practitioner and the complaint handler are usually the same person in a sole practice, complaints about the Principal Psychologist's own conduct are managed with the additional safeguards in section 1.6 of this procedure and section 6.5 of the Feedback and Complaints Policy.

Cultural safety. The complaints process is culturally safe and accessible, cultural support and interpreters are available when needed, Aboriginal and Torres Strait Islander peoples receive culturally appropriate support, and diversity in communication needs and preferences is accommodated.

Learning and improvement. Complaints are viewed as opportunities for improvement, systemic issues are identified and addressed, and lessons learned inform practice changes.

1.4 Making Information Accessible

Complaints information is provided in the client information and consent documents and on the practice website, in plain language free from jargon, and in accessible formats upon request. The information covers how to make a complaint, what to expect from the process, timeframes for acknowledgment and resolution, support available, external complaint options (AHPRA, Health Complaints Commissioner, NDIS Commission), and an assurance that making a complaint will not affect the quality of care.

1.5 Complaints Process

Step 1: Receipt of complaint

Complaints may be received in person during an appointment, by telephone, by email, by written letter, through the practice website, or through a third party or advocate with client consent.

Initial response. Acknowledge receipt within 2 business days, thank the complainant for raising the matter, provide information about the process and expected timeframes, offer support (interpreter, advocate, cultural support), and assign a reference number.

Documentation. Record all complaints in the Complaints Register, documenting the date received, complainant details if provided, nature of the complaint, preferred outcome and method of receipt. Create a complaint file separate from clinical records and maintain confidentiality.

Step 2: Assessment and triage

Immediate risk assessment. Assess whether the complaint involves immediate safety concerns, determine whether urgent action is required to protect the client or others, implement immediate protective measures if needed, and consider whether the matter requires notification to AHPRA, the NDIS Commission or other authorities.

Complaint classification. Level 1 (minor): simple administrative issues, miscommunication, easily resolved matters. Level 2 (moderate): service delivery concerns or conduct issues requiring investigation. Level 3 (serious): significant professional misconduct, serious safety concerns, or potential breach of the Code of conduct.

Response pathway. Level 1: direct resolution, target 5 business days. Level 2: formal investigation, target 20 business days. Level 3: comprehensive investigation with external advice or an independent investigator, target 45 business days. Mandatory notification obligations are actioned as soon as practicable where required.

Step 3: Investigation

Planning. Define the scope of investigation, identify information and evidence required, determine who needs to be consulted, establish a timeline, and consider whether independent review is needed.

Information gathering. Review relevant clinical records, correspondence and documentation, interview relevant parties with consent, consult a professional supervisor or peers while maintaining confidentiality, seek advice from the professional indemnity insurer where appropriate, and consult the Code of conduct and Board guidance.

Maintaining objectivity. Approach the investigation with an open mind, consider all perspectives and evidence, document all steps, and maintain separation between complaint handling and ongoing care provision. Where objectivity cannot reasonably be achieved because the complaint concerns

the Principal Psychologist's own conduct, engage an independent external investigator and inform the complainant of external pathways.

Ongoing communication. Provide progress updates to the complainant at least every 10 business days, advise of any delays and revised timeframes, and keep the complainant informed of the process.

Step 4: Analysis and decision making

Review all evidence collected against relevant standards, policies and guidelines. Assess whether service delivery met professional standards, identify systemic issues or contributing factors, consider whether the Code of conduct was breached, and assess the proportionality of the response. Outcomes are recorded as substantiated, partially substantiated, not substantiated, or insufficient evidence.

Step 5: Resolution and response

Prepare a written response within the timeframe for the complaint level, using clear, respectful and empathetic language. The response acknowledges the complaint and its impact, explains the investigation process, states findings and rationale for each aspect of the complaint, outlines actions taken or to be taken, includes an apology where appropriate, and provides information about external review options.

Open disclosure. When an adverse event has occurred, provide open and honest disclosure: apologise for harm or distress caused (noting that Victorian law protects apologies under the Wrongs Act 1958 (Vic), Part IIC), explain what happened and why, outline steps taken to prevent recurrence, offer to answer questions, and provide ongoing support. This implements standard 4.5 of the Code of conduct.

Meeting with the complainant, if requested. Offer to meet in person or by video, allow a support person, create a safe and respectful environment, listen to the complainant's perspective, explain findings and actions, discuss resolution options, and document outcomes.

Step 6: Follow-up

Short-term (1 week): confirm receipt of the response, answer immediate questions, offer additional support. Medium-term (1 month): check implementation of agreed actions and complainant satisfaction. Long-term (3 to 6 months): review the effectiveness of changes and whether similar complaints have recurred.

Care continuity. Assess the impact of the complaint on the therapeutic relationship, discuss options for continuing care, facilitate referral to another psychologist if appropriate, ensure a smooth transition if the client chooses to transfer, and document decisions regarding ongoing care.

1.6 External Complaints and Sole-Practitioner Safeguards

Complainants are informed about external options at the outset and again with the written outcome:

- **AHPRA:** www.ahpra.gov.au, 1300 419 495. Manages notifications about registered health practitioners and may take regulatory action.

- **Health Complaints Commissioner (Victoria):** hcc.vic.gov.au, 1300 582 113. Manages complaints about health service providers, with a focus on resolution and system improvement.
- **NDIS Quality and Safeguards Commission:** www.ndiscommission.gov.au, 1800 035 544. Manages complaints about NDIS supports and services.
- **National Health Practitioner Ombudsman:** www.nhpo.gov.au. Reviews the handling of matters by AHPRA and the National Boards.

External complaints are never discouraged, assistance is provided to understand each pathway, and clients continue to be treated professionally if an external complaint is made. For clients located outside Victoria, the equivalent health complaints entity in their jurisdiction applies; contact details are available at www.ahpra.gov.au under 'Raise a concern'. Where a complaint concerns the Principal Psychologist's own conduct, health or performance and cannot be handled impartially in-house, early referral to these bodies or engagement of an independent investigator is the default position.

1.7 Mandatory Notifications

Notification to AHPRA is required where a reasonable belief is formed that a practitioner has practised while intoxicated by alcohol or drugs, engaged in sexual misconduct in connection with practice, placed the public at risk of substantial harm because of an impairment, or placed the public at risk of harm through a significant departure from accepted professional standards. These obligations include self-notification.

Notifications are submitted as soon as practicable after forming the reasonable belief, using the AHPRA notification process, with all relevant information provided, the rationale documented, and advice sought from the professional indemnity insurer.

1.8 Record Keeping

A confidential Complaints Register records the date, nature, classification, timeframes, outcome and actions for every complaint, with de-identified data used for quality improvement. Each complaint has a separate file containing the initial complaint, correspondence, investigation notes, evidence, response and follow-up, retained for a minimum of 7 years after resolution, stored securely with restricted access. Clinical records note that a complaint was received only where relevant to care; complaint details are not recorded in clinical records.

1.9 Learning and Improvement

Each complaint is reflected on for learning opportunities, discussed in clinical supervision, and used to update policies and procedures as needed. Complaint numbers, types, resolution timeframes and complainant satisfaction are monitored and included in the annual practice review.

1.10 Support for the Practitioner

Receiving complaints can be stressful. Support is sought from a supervisor, peers or a mental health professional, the professional indemnity insurer is contacted for advice, professional association support services are accessed where helpful, and self-care is maintained alongside perspective and professionalism.

1.11 Review and Evaluation

This procedure is reviewed annually against accessibility, timeliness, fairness, complainant satisfaction, learning outcomes and regulatory compliance, and updated as required.

2. Conflict of Interest Management Procedure

2.1 Purpose

To establish a transparent and systematic approach to identifying, disclosing and managing conflicts of interest to protect client welfare, maintain professional integrity and uphold public trust, consistent with principle 8 of the Code of conduct.

2.2 Scope

This procedure applies to all potential, perceived and actual conflicts of interest that may arise in professional psychological practice, including financial interests, professional relationships, personal relationships, multiple (dual) relationships, gifts and benefits, commercial activities, and external commitments, including any concurrent external roles or contracting arrangements held by the Principal Psychologist.

2.3 Definition of Conflict of Interest

A conflict of interest occurs when a psychologist's private interests (financial, professional or personal) could inappropriately influence, or appear to influence, their professional judgment and decisions regarding client care.

- **Financial conflicts:** pecuniary interest in companies, products or services recommended to clients; financial benefit from referrals; ownership or investment in healthcare businesses; payments or gifts from commercial entities; financial arrangements with third parties such as insurers, lawyers or organisations.
- **Professional conflicts:** multiple roles with the same client (for example therapist and independent assessor); professional relationships with clients outside therapy; competing professional obligations; research or teaching involving clients; media or expert witness work involving clients.
- **Personal conflicts:** pre-existing personal relationships with clients; social connections with clients; romantic or sexual attraction to clients; treating family members or friends; shared community or social networks.

2.4 Identifying Conflicts of Interest

A conflict of interest review is conducted quarterly, potential conflicts are considered when accepting new clients and before making referrals, and assessments are reviewed when circumstances change, with self-assessment documented in the professional log. Prompts include: do I have any financial interest in this recommendation; would I benefit financially from this decision; do I have any personal relationship with this client; am I being asked to serve multiple roles; could my judgment be influenced by factors other than client welfare; would a reasonable person perceive a conflict; am I uncomfortable with this situation.

Scenarios requiring specific assessment include providing therapy to friends, family or colleagues; accepting clients connected with organisations in which there is a financial interest; recommending products or services in which there is a financial interest; accepting gifts from clients; social media

connections with clients; treating clients with shared community connections; accepting clients referred by family members or friends; and accepting referrals of people connected with an organisation in which the Principal Psychologist holds a concurrent external role or contracting arrangement. In this practice, particular attention is paid to the separation of therapeutic and assessment roles, including medicolegal and independent assessment work.

2.5 Disclosure Requirements

All actual, potential and perceived conflicts must be disclosed as soon as identified, clearly and specifically, with written documentation maintained. Disclosure is made primarily to the client (with documentation in the clinical record), and additionally to the referrer where relevant, to a supervisor or professional consultant, to the professional indemnity insurer where significant, and to third parties as required with consent.

Disclosure covers the nature of the conflict, how it might influence judgment or decisions, steps taken to manage it, alternative options available to the client, the client's right to seek a second opinion or alternative provider, and the process for ongoing monitoring. A Conflict of Interest Disclosure Form is completed, client acknowledgment is obtained and stored in the client file, and the disclosure is updated when circumstances change.

2.6 Assessment of Conflicts

Each identified conflict is assessed as low risk (minimal potential to influence judgment, easily managed), moderate risk (some potential for influence, requires active management) or high risk (significant potential to compromise judgment, may preclude proceeding), considering client vulnerability, potential for harm, professional standards, public perception, and manageability.

2.7 Managing Conflicts of Interest

- **Strategy 1, avoidance (preferred for high-risk conflicts):** decline to provide services, do not accept the referral, divest the financial interest, or decline the role creating the conflict. Used for sexual or romantic attraction to a client, close personal relationships, significant financial conflicts, irreconcilable multiple roles, or where the client cannot provide fully informed consent.
- **Strategy 2, modification:** restructure financial arrangements, limit the scope of service, engage an independent third party for specific decisions, time-separate conflicting roles, or reduce the extent of the interest. Used for moderate-risk conflicts where client welfare can still be protected.
- **Strategy 3, disclosure and monitoring (for lower-risk conflicts):** full disclosure to the client, informed consent, documentation of the conflict and management plan, regular review in supervision, and heightened awareness. Used where avoidance would disadvantage the client or the conflict is unavoidable.
- **Strategy 4, third-party oversight:** consultation with a supervisor or peer consultant, an independent reviewer for specific decisions, or a second opinion on treatment decisions. Used for moderate to high-risk conflicts requiring independent judgment and accountability.
- **Strategy 5, client empowerment:** provide full information, explain alternatives, support second opinions, and facilitate referral to another provider if preferred. Applied in all conflict situations.

2.8 Specific Conflict Scenarios

Multiple (dual) relationships

Multiple relationships occur when the psychologist serves in more than one role with the same person or has a relationship with someone closely associated with the client, for example treating a friend, colleague or family member, social or business relationships with current clients, supervisory relationships, or providing both therapy and formal assessment for the same client. Multiple relationships are generally avoided. Where unavoidable, rigorous safeguards apply: comprehensive disclosure, written agreement on boundaries, clear delineation of roles, regular supervision, documented rationale, contingency plans, and enhanced informed consent.

Financial interests

Any financial interest in recommended products or services must be disclosed before the recommendation, with alternatives offered and the recommendation based on clinical merit. Payment for referrals is never accepted or made. Relationships with referred providers are disclosed, multiple referral options are provided, and referral rationale is documented.

Gifts from clients

Small, unsolicited gifts (under $50 in value) may be accepted considering cultural context, with receipt documented and any concerns discussed in supervision. Substantial or repeated gifts are generally declined, with professional boundaries explained, the offer and refusal documented, and the impact on the therapeutic relationship considered.

Social media and electronic communications

Friend or follow requests from current clients are not accepted, professional and personal accounts are kept separate, the social media policy is explained to clients and documented in informed consent, and the same confidentiality standards apply online. Clients are not searched for online, and incidentally discovered information is not used in therapy without disclosure.

Community relationships

Unavoidable multiple relationships are common in small or specialised communities, including professional communities. Boundary issues are anticipated and discussed proactively, clear agreements are established about managing community contacts and chance encounters, clients are empowered to raise concerns, boundary management is reviewed regularly, and agreements are documented.

External roles and organisational overlap

Where the Principal Psychologist holds a concurrent external role or contracting arrangement outside the practice, that role is kept separate from private clinical, assessment and medicolegal work. Referrals of people connected with such an organisation are assessed for conflict before acceptance, the existence of the external role is disclosed where relevant, and the referral is declined or redirected where the roles cannot be adequately separated. Decisions and their rationale are documented in the Conflict of Interest Register.

2.9 Documentation Requirements

A Conflict of Interest Register records all identified conflicts (date identified, nature, assessment, management strategy, review dates), is updated as circumstances change, reviewed quarterly, and

stored securely. Individual conflict files contain disclosure documents, risk assessments, management plans, client acknowledgments, supervision notes and correspondence. Clinical records note the existence of the conflict and the management approach.

2.10 Review and Monitoring

All conflicts are reviewed at least quarterly, with the effectiveness of management strategies assessed and adjusted. Reassessment is triggered by changes in client or personal circumstances, changes in the therapeutic relationship, concerns raised by the client or in supervision, and boundary violations or near misses. Red flags include difficulty maintaining boundaries, minimising the significance of a conflict, reluctance to discuss in supervision, client concerns, increased secrecy or discomfort, and rationalisation of boundary crossings.

2.11 Consultation and Supervision

Consultation is mandatory for all moderate and high-risk conflicts, any conflict involving personal attraction, situations where judgment may be impaired, uncertainty about appropriate management, and client-raised concerns. Conflicts are presented in regular supervision to seek guidance, discuss effectiveness, explore blind spots and maintain accountability.

2.12 Training and Competence

Knowledge of conflict-of-interest management is maintained through CPD, boundary management training, currency with Code of conduct updates, reflective practice, and learning from case studies and peer experience.

3. Clinical Emergency Management Procedure

3.1 Purpose

To establish clear protocols for identifying, assessing and responding to clinical emergencies to ensure client safety and appropriate crisis intervention.

3.2 Scope

This procedure covers management of suicidal ideation, intent and attempts; self-harm behaviours; risk of harm to others; medical emergencies during sessions; acute psychotic episodes; severe dissociation or trauma responses; domestic and family violence disclosures requiring immediate action; and child safety concerns requiring immediate action.

3.3 Principles

Client safety is the paramount concern, with immediate action taken to prevent harm and a preference for erring on the side of caution while balancing autonomy with duty of care. A collaborative approach is maintained wherever possible, involving support systems with consent and coordinating with other services while preserving the therapeutic alliance. Responses are evidence-based, using validated risk assessment approaches and documented clinical reasoning. The least restrictive effective intervention is used, respecting client autonomy to the greatest extent possible and escalating only when necessary for safety.

3.4 Emergency Contacts and Resources

Service	Contact
Emergency (police, ambulance, fire)	000
Police Assistance Line (Vic)	131 444
Lifeline (24/7)	13 11 14
Suicide Call Back Service (24/7)	1300 659 467
Beyond Blue (24/7)	1300 22 4636
Kids Helpline (ages 5 to 25, 24/7)	1800 55 1800
MensLine Australia (24/7)	1300 78 99 78
1800RESPECT, domestic and family violence (24/7)	1800 737 732
QLife (LGBTIQA+)	1800 184 527
13YARN (Aboriginal and Torres Strait Islander)	13 92 76
Safe Steps, family violence response (Vic, 24/7)	1800 015 188
Sexual Assault Crisis Line (Vic)	1800 806 292
Area mental health triage (Victoria, 24/7; service determined by the client's residential address)	Alfred Mental and Addiction Health Triage (inner south east) 1300 363 746; Monash Health Psychiatric Triage (south east) 1300 369 012
Interstate telehealth clients	The local area mental health triage or crisis service for the client's location is identified at intake and recorded in the client file
Child Protection Crisis Line (Vic, 24/7)	13 12 78

The contact details of each client's GP, psychiatrist (if applicable) and nominated emergency contact are recorded at intake and used with consent, or without consent where necessary to lessen a serious threat to life, health or safety.

3.5 Prevention and Preparedness

Suicide risk screening is conducted at intake using a validated approach, with ongoing risk assessment throughout treatment and heightened vigilance during high-risk periods: treatment transitions, discharge from hospital, major life stressors, relationship breakdowns, anniversary dates of trauma, and after sentinel events. Early warning signs monitored include changes in mood or behaviour, withdrawal, giving away possessions, talking about death or suicide, hopelessness, increased substance use, reckless behaviour, and sudden calmness after depression.

Proactive planning includes developing and regularly reviewing safety plans with all clients at risk, ensuring clients have crisis contact information, and establishing emergency contact protocols. Practice preparedness includes keeping the emergency contact list current and accessible, knowing the location of the nearest hospital and the practice address for emergency services at each consulting location, maintaining a first aid kit, and keeping these protocols readily accessible, including during telehealth sessions where the client's physical location is confirmed at the start of each session.

3.6 Suicide Risk Assessment and Management

Assessment

Screening uses a standardised tool (for example PHQ-9 item 9 or the Columbia-Suicide Severity Rating Scale). A positive response triggers detailed assessment across:

- **Ideation:** frequency, duration, intensity, content (passive versus active) and triggers
- **Intent:** current intention to act, desire to die versus escape pain, ambivalence, reasons for living versus dying
- **Plan:** specificity, lethality of intended method, availability of means, preparation or rehearsal, timeline
- **Capability:** prior attempts (number, recency, lethality), history of self-harm, impulsivity, substance use, access to lethal means
- **Risk factors:** mental health diagnosis, substance use disorder, chronic pain or physical illness, recent significant losses, social isolation, financial or legal problems, history of trauma or abuse, family history of suicide, recent discharge from psychiatric care
- **Protective factors:** reasons for living, future orientation, social support, coping skills, help-seeking, treatment engagement, cultural or religious beliefs, responsibility to others
- **Warning signs:** talking about death or suicide, seeking means, giving away possessions, saying goodbye, withdrawal, sudden mood improvement that may indicate a decision has been made

Risk categorisation

Low risk: thoughts of death or passive ideation without intent or plan, no prior attempts, good protective factors, strong support system.

Moderate risk: ideation with plan but no intent, or intent without a specific plan; prior attempts (not recent); some protective factors; willingness to engage in safety planning; support available.

High risk: ideation with specific plan and intent, access to means, recent attempt or multiple prior attempts, few protective factors, impulsivity or agitation, psychosis or severe mental illness, substance intoxication, or unwillingness to engage in safety planning.

Imminent risk: current intent to act immediately, access to means, stating an intention to act upon leaving, preparing to act, agitation or inability to collaborate, or a recent serious attempt. Requires immediate intervention.

Management by risk level

Low risk, outpatient management. Acknowledge and validate distress, explore thoughts and feelings, develop or review the safety plan, strengthen protective factors, provide crisis resources, schedule the next appointment within 1 week with more frequent contact considered, and encourage connection with supports. The safety plan is developed collaboratively in writing, covering warning signs, coping strategies, support contacts, professional contacts and reducing access to means, with the client keeping a copy. Document the assessment, risk determination, safety plan, client agreement and follow-up arrangements.

Moderate risk, intensive outpatient management. Conduct a thorough risk assessment, develop a detailed safety plan, increase session frequency, consider referral for medication review, involve the support system with consent, identify 24/7 support arrangements, and agree on clear criteria for presentation to an emergency department. Consult a supervisor, consider consultation with a psychiatrist with consent, and notify the GP with consent. Next appointment within 3 to 5 days, with brief phone contact if agreed. Document comprehensively.

High risk, urgent intervention. Do not leave the client alone. Complete a comprehensive risk assessment and consider immediate hospitalisation. Contact emergency services if the client is at imminent risk. Involve the support system immediately, with or without consent if the threat is life-threatening. Support removal of access to means, and consider the area mental health crisis team. If safety can be assured in the community, this requires daily or more frequent contact, 24/7 supervision by family or supports, crisis team involvement, immediate psychiatric consultation, removal of means, client commitment to the safety plan, and review within 24 to 48 hours. If safety cannot be assured, hospitalisation is required: voluntary admission is preferred, the client is supported to present to the emergency department, accompaniment is arranged, information is provided to ED staff, and post-discharge follow-up is arranged. Document the clinical reasoning for all decisions.

Imminent risk, emergency response. Call 000. Stay with the client. Remove any means of harm from the immediate environment where safe to do so. Keep the client and yourself safe, speak calmly and supportively, contact the support person, provide information to emergency responders, and accompany the client to hospital if possible. If the client leaves before emergency services arrive: do not physically restrain, call 000 immediately, provide a description, direction of travel and risk information, contact the nominated emergency contact, document all actions, and follow up to confirm safety.

3.7 Self-Harm Management

Assessment distinguishes suicidal from non-suicidal self-injury, covering frequency, methods and severity, the function the self-harm serves, the risk of accidental lethality, and triggers and patterns. Immediate management ensures medical attention for injuries where needed, assesses current urges and risk, and develops a safety plan specific to self-harm.

The practice takes a trauma-informed, harm-minimisation approach that does not rely on pain or sensory-shock substitution techniques. Strategies developed with the client include:

- **Delay:** strategies to postpone acting on an urge, allowing intensity to pass
- **Distract:** engaging alternative activities that shift attention and regulate arousal
- **Soothe:** sensory-soothing and grounding strategies consistent with the DBT-informed skills used in this practice, such as paced breathing, warmth, weighted or textured objects, music and movement
- **Express:** safe ways to express emotion, including writing, drawing and physical activity
- **Seek support:** identified people and services to contact when urges are high

Treatment planning addresses underlying issues such as trauma and emotion regulation, teaches coping and emotion regulation skills, processes the function of self-harm, takes a gradual reduction approach, and monitors regularly.

3.8 Risk of Harm to Others

Assessment covers specific threats or intent, access to the intended victim, history of violence, substance use, psychosis or delusional beliefs, impulsivity, and access to weapons.

Low risk: explore thoughts and feelings, assess precipitants, develop regulation strategies, address underlying issues, monitor in ongoing treatment.

Moderate risk: detailed assessment, consider psychiatric referral, increase session frequency, involve appropriate others with careful attention to confidentiality, consult a supervisor, and document decision making.

High risk: duty to warn an identifiable potential victim of a specific, serious and imminent threat; contact police if danger is imminent; consider assessment for involuntary treatment under the Mental Health and Wellbeing Act 2022 (Vic); document thoroughly, including the legal and ethical considerations; seek legal advice if needed; and notify the professional indemnity insurer.

Duty-to-warn decisions weigh whether the threat is specific and serious, whether the victim is identifiable, and whether the threat is imminent, balancing confidentiality against the duty to protect, with consultation sought and decision making documented.

3.9 Acute Psychosis Management

Recognition: hallucinations, delusions, disorganised thinking or speech, grossly disorganised behaviour, flat or inappropriate affect, paranoia or agitation. Immediate management: ensure the safety of the client and self, remain calm and non-threatening, use simple and clear language, avoid arguing about delusions, and assess risk to self and others, substance intoxication, and the need for emergency services. Risk assessment attends to command hallucinations, paranoid delusions, insight, agitation and capacity for self-care.

If the client is cooperative and at low risk: contact the treating psychiatrist if there is one, involve the support system, arrange psychiatric follow-up within 24 hours, ensure a safe environment and supervision, and check medication adherence. If the client is at high risk or uncooperative: call 000, do not leave the client alone if it is safe to stay, and provide information to emergency responders.

3.10 Medical Emergencies

For chest pain, difficulty breathing, loss of consciousness, seizure, severe allergic reaction or severe injury: call 000, follow the emergency operator's instructions, provide first aid if trained and safe, stay with the client, contact the emergency contact person, and document the incident. Current first aid certification is maintained, a stocked first aid kit is accessible at each consulting location, and the location of the nearest AED is known where available.

3.11 Severe Dissociation or Trauma Response

Recognition: disconnection from the present, flashbacks, altered consciousness, unresponsiveness to the environment, panic or freeze responses. Intervention: speak calmly and gently; use grounding techniques including orientation to the present (date, location, safety), 5-4-3-2-1 sensory grounding, physical grounding (feet on floor, holding an object) and breathing exercises; do not touch without permission and warning; allow time and space; and stay present and supportive. Afterwards, process the experience, assess safety, identify triggers, plan prevention strategies, and consider trauma-focused treatment consistent with the practice's phase-based approach.

3.12 Domestic and Family Violence

Recognition: physical injuries, fear of a partner or family member, controlling relationship patterns, isolation from supports, financial control, escalating patterns. Immediate safety assessment: is the client safe to return home today; are children at risk; is there immediate danger; does the client have a safe place to go.

Intervention: believe and validate the client, engage collaboratively in safety planning and document it, provide information about services, offer to call services with or for the client, respect client autonomy and timing, and document concerns with attention to safety where records may be accessible. Resources: Safe Steps 1800 015 188, 1800RESPECT 1800 737 732, police on 000 if there is immediate danger, and local family violence and crisis accommodation services. Mandatory reporting applies where children are at risk.

3.13 Child Safety Concerns

Although this is an adults-only practice, information indicating that a child is at risk may arise in adult work. On disclosure or recognition of indicators of abuse or neglect: listen and believe, do not investigate (that is not the psychologist's role), consider the child's immediate safety, follow mandatory reporting obligations, and document carefully and objectively with direct quotes where possible.

Reports are made to Victoria Police (000 if immediate danger) or Child Protection (Child Protection Crisis Line 13 12 78, 24/7) when a reasonable belief is formed that a child is at risk of significant harm. The obligation cannot be delegated, proof is not required before reporting, and the report is made immediately.

3.14 Documentation Requirements

Emergency documentation includes the date, time and duration of the incident; the presenting situation; the risk assessment process and findings; the risk level determination; all interventions attempted; consultation sought; client capacity and cooperation; family and support involvement; emergency services involvement; the outcome; the follow-up plan; and the clinical reasoning for all decisions. Documentation occurs contemporaneously or immediately after the event, with exact times of key decisions noted. Files of high-risk clients are flagged and documentation is accessible for continuity of care.

3.15 Post-Emergency Follow-Up

Within 24 to 48 hours: contact the client to check safety, confirm follow-up appointments, review the safety plan and adjust as needed. Ongoing: frequent appointments while risk is elevated, regular risk reassessment, review of intervention effectiveness, contact with the support system with consent, and coordination with other providers. Treatment planning addresses underlying issues through a trauma-informed approach, builds coping skills, strengthens protective factors, and considers adjunct services such as medication review, groups or care coordination.

3.16 Practitioner Self-Care After Emergencies

Immediately: debrief with a supervisor or peer, take a break if needed, use grounding and calming strategies, and contact the professional indemnity insurer if indicated. Ongoing: process the event in supervision, seek personal therapy if vicarious trauma emerges, monitor for signs of burnout, maintain work-life boundaries, and access peer support.

4. Business Continuity and Emergency Preparedness Procedure

4.1 Purpose

To ensure continuity of client care and protection of client information during disruptions, emergencies or disasters, and to establish protocols for maintaining essential practice functions or safely suspending services.

4.2 Scope

This procedure addresses natural disasters (bushfire, flood, earthquake, severe weather), pandemic or infectious disease outbreaks, technology failures and cyber incidents, practitioner illness, injury or incapacity, practice location unavailability, utility disruptions, and other unforeseen disruptions.

4.3 Core Principles

Client care and safety is the primary concern: continuity of care is maintained where possible, service disruptions are communicated clearly, alternative arrangements are provided, and client information is protected. Planning is proactive, with plans tested and updated regularly and redundancies built into systems. Responses are proportionate to the nature and severity of the disruption, with flexibility to adapt and a return to normal operations when safe. Communication with clients is timely, clear and maintained through multiple channels, with regular updates during extended disruptions.

4.4 Risk Assessment and Planning

High probability, high impact: practitioner short-term illness, technology or internet failure, extreme weather events, pandemic or infectious disease.

Low probability, high impact: serious practitioner illness or incapacity, natural disaster destroying a practice location, death of the practitioner, major cyber attack or data breach.

Moderate probability, moderate impact: extended power outage, building access issues, equipment failure, transport disruptions.

For each scenario, triggers for activating the plan are identified, essential and non-essential functions are defined, alternative service delivery methods are established, and required resources are identified.

4.5 Essential Practice Functions

Critical functions (must continue): care for high-risk clients, emergency response capability, access to client records, communication with clients about changes, protection of client information, and mandatory reporting obligations.

Important functions (continue if possible): scheduled appointments for moderate-risk clients, new client assessments, routine follow-up appointments, administration, and billing and payments.

Non-essential functions (can be suspended): marketing and business development, professional development activities, non-urgent administrative tasks, and practice improvement projects.

4.6 Communication Systems

Current contact details and multiple contact methods are held for all clients, a nominated emergency contact is recorded for each client, and a clear voicemail message directs clients during disruptions.

4.7 Alternative Service Delivery

Telehealth capability. Telehealth is delivered through Cliniko's telehealth capability, with Doxy used for MeDirect independent medical examination work. Platforms meet privacy and security requirements, are tested regularly, and a backup platform is available. Telehealth consent is obtained and clear delivery protocols apply.

Telephone support. Phone counselling capability, structured phone check-ins for high-risk clients, crisis support by phone, and documentation of phone sessions.

Extended disruption options. A reduced schedule maintaining high-risk clients only, referral to other providers, temporary transfer of care, and secure asynchronous support within professional boundaries.

4.8 Information and Records Management

Data backup. Daily automated backup to encrypted cloud storage, monthly testing of restoration, multiple backup locations, and access from any location with internet.

Physical records. Fireproof and waterproof storage in a secure location, duplicates of essential documents stored separately, and digital backup of critical paper records.

Remote access. Secure remote access to practice systems with multi-factor authentication, from more than one device.

Technology redundancies. Backup internet connection (mobile hotspot), backup computer or device, battery backup for essential equipment, and paper-based fallback for critical functions.

Cloud-based systems. Practice management and telehealth: Cliniko. Psychometrics and scoring: NovoPsych. Intake and screening questionnaires: Jotform. PAI administration and scoring: PARiConnect. Wechsler administration and scoring: Q-interactive and Q-global. Telehealth for MeDirect IME work: Doxy. Document storage: secure OneDrive account. Email: Gmail on the practice domain. All systems are accessible remotely.

4.9 Financial Continuity

Online banking access, multiple client payment options, digital invoicing, and remotely operable accounts receivable are maintained. Financial reserves equivalent to 3 to 6 months of operating expenses are targeted, with access to emergency funds. Professional indemnity and public liability insurance are kept current, with coverage for disruptions understood; policy details are held in the practice insurance register.

4.10 Practitioner Incapacity Planning

Short-term planned absence (surgery and similar). Clients receive a minimum of 2 weeks notice, appointments are rescheduled, crisis contact information is provided, colleague coverage is arranged for emergencies, and out-of-office messages are activated.

Short-term unexpected absence (sudden illness, accident). A designated emergency contact person notifies clients using prepared template messages, a current list of clients and contacts is accessible to that person under confidentiality obligations, crisis resources are provided to all clients, and a colleague is on standby for true emergencies.

Medium-term incapacity (weeks to months). Transfer of care arrangements with a colleague, provision of records to the new provider with consent, ongoing communication with clients, and a documented plan for return to practice.

Long-term or permanent incapacity. A professional will and succession plan identifies an executor or practice closer and holds instructions for client notification, records transfer, records storage and eventual destruction, financial wind-down, and completion of professional obligations. The plan is stored with the will or a trusted colleague and updated annually.

4.11 Pandemic and Infectious Disease Protocols

Activation triggers include public health directives, government restrictions on face-to-face services, significant community transmission, practitioner exposure or symptoms, and client or household exposure or symptoms.

Phase 1, preparedness: monitor public health information, review infection control procedures, maintain supplies (masks, sanitiser, cleaning products), ensure telehealth systems are functional, and communicate preparedness to clients.

Phase 2, modified operations: implement infection control measures (hand hygiene, surface cleaning between clients, physical distancing, masks if required, health screening questions, ventilation), offer telehealth as an alternative, reduce waiting time, and stagger appointments.

Phase 3, restricted operations: telehealth for most clients, face-to-face only where telehealth is not viable, enhanced infection control, and a reduced schedule if needed.

Phase 4, suspension of face-to-face services: all services by telehealth, phone support for clients unable to use video, regular check-ins with high-risk clients, crisis support maintained, and clear communication about the service model.

Phase 5, recovery: graduated return to face-to-face services, continued telehealth options, ongoing infection control, client choice of modality, and review of lessons learned.

If the practitioner contracts an infectious illness: cancel appointments immediately, notify clients, offer telehealth if well enough, refer urgent needs to a colleague, follow public health isolation requirements, and communicate regularly about return to practice.

4.12 Natural Disaster Preparedness

Bushfire: monitor fire danger ratings, cancel appointments early on catastrophic days, use the client notification system, maintain an evacuation plan and emergency kit, and keep off-site backups of all records.

Flood: elevate essential equipment and records, use waterproof storage for critical documents, identify an alternative location, and review insurance coverage.

Earthquake: secure heavy items, keep emergency supplies on hand, maintain evacuation procedures, and complete a post-event safety assessment.

Severe weather: monitor warnings, apply a flexible cancellation policy, prioritise client safety over appointments, and follow damage assessment protocols.

Post-disaster recovery includes a safety assessment before returning to the practice location, damage documentation for insurance, client welfare checks, referrals for disaster trauma support, graduated return to operations, and support for clients affected by the disaster.

4.13 Cyber Security and Technology Disruptions

Prevention: regular software updates, strong passwords and multi-factor authentication, antivirus and firewall protection, encrypted data storage and transmission, regular security reviews, and tested backup and recovery systems.

Cyber incident response. Detection indicators include unusual system behaviour, unauthorised access alerts, missing or encrypted files (ransomware), suspicious emails, and client reports of suspicious communications. Immediate actions: disconnect affected systems from the internet, do not pay ransom demands, document the incident, engage an IT security professional, notify the professional indemnity insurer, and assess data breach implications.

If a data breach is suspected: contain the breach, assess its extent, notify the OAIC and affected individuals if the breach meets the eligible data breach threshold under the Privacy Act 1988 (Cth), consider notification obligations to AHPRA and other regulators, document all actions, implement remedial measures, and review security protocols. See the Privacy Policy, section 9.

Technology failure response: switch to backup systems, use alternative service delivery (phone or a different platform), notify affected clients, engage IT support promptly, and document for insurance purposes.

4.14 Building or Location Unavailability

Scenarios include building damage, utility failure, access restrictions, lease termination and safety concerns, at either consulting location (Caulfield South or St Kilda). Immediate response: assess safety and accessibility, cancel appointments if unsafe, notify clients promptly, switch to telehealth temporarily or use the alternative consulting location, and arrange retrieval of essential items if safe. For extended unavailability: secure a new location, notify clients, update practice materials, and complete address change notifications (AHPRA, Medicare, WorkSafe, TAC, NDIS, insurer and other registrations, noting that Medicare and WorkSafe provider numbers are address-specific and new provider numbers must be obtained and recorded before billing from a new location).

4.15 Activation Protocols

The decision to activate this plan considers the nature and severity of the disruption, the impact on essential functions, safety considerations and likely duration.

Level	Impact and example	Response and communication
Level 1: minor disruption	Short-term, minimal service interruption (brief internet outage, minor illness)	Use backup systems, reschedule few appointments; individual client contact as needed; brief note in the practice log
Level 2: moderate disruption	Service modifications for several days (extended outage, moderate illness, severe weather)	Alternative location or modality; notify all affected clients, update voicemail and website; incident log maintained
Level 3: major disruption	Significant service changes, extended duration (pandemic restrictions, building unavailability, serious illness)	Comprehensive alternative arrangements, possible temporary suspension; all clients notified through multiple channels with regular updates; full incident documentation

Level	Impact and example	Response and communication
Level 4: critical incident	Practice closure, indefinite duration (death or permanent incapacity, complete destruction of premises)	Practice closure procedures and full client transfers; formal notifications and transition support; complete records transfer and legal notifications

4.16 Return to Normal Operations

Readiness is assessed against safety, system functionality, resource availability, practitioner fitness to practise, and client safety. Return is graduated, with high-risk clients prioritised, continued flexibility in modality, and monitoring for issues. Clients are notified of the return to normal services, any ongoing changes are outlined, appointments are rescheduled, and client wellbeing during the disruption is checked. The response is then debriefed: what worked well, improvements needed, plan updates, lessons documented, and discussion in supervision.

4.17 Documentation Requirements

Continuity plan documentation comprises the current plan, current contact lists, communication templates, activation protocols, recovery procedures, and a review and update log. During a disruption, an incident log records the date, time, nature and actions taken, along with client communications, service modifications, decisions and rationale, consultation sought, and outcomes. After a disruption, a summary report covers impact assessment, response evaluation, lessons learned and plan updates, reviewed in supervision.

4.18 Annual Review Checklist

- Review the entire continuity plan for currency and relevance
- Test all backup systems and data backup restoration
- Update all contact lists
- Review insurance coverage and policy numbers
- Review and update communication templates
- Assess technology redundancies
- Review financial reserves and arrangements
- Update the professional will and succession plan
- Brief the emergency contact person on any changes
- Review lessons from any disruptions during the year
- Update the plan based on changes to the practice
- Document review completion and changes made

5. Adverse Events Management Procedure

5.1 Purpose

To establish a systematic approach to identifying, reporting, managing and learning from adverse events to enhance client safety and continuously improve quality of care, consistent with standard 4.5 of the Code of conduct.

5.2 Scope

This procedure applies to all adverse events, near misses and safety concerns occurring in the provision of psychological services, including events related to clinical care and treatment, communication failures, administrative processes, the physical environment, technology and equipment, and confidentiality breaches.

5.3 Definitions

Adverse event: an incident in which harm resulted to a person receiving health care, including psychological services.

Sentinel event: an adverse event resulting in death or serious harm (physical or psychological) requiring immediate investigation and response.

Near miss: an incident that had the potential to cause harm but did not, either by chance or through timely intervention.

Root cause: the fundamental reason an adverse event occurred, the underlying system failure rather than individual error.

5.4 Types of Adverse Events in Psychological Practice

- **Clinical:** suicide attempt, deterioration, harm during treatment, inadequate assessment
- **Communication:** consent failures, miscommunication, information gaps
- **Confidentiality:** unauthorised disclosure, privacy breach, lost records
- **Administrative:** wrong records used, billing errors, missed appointments for high-risk clients
- **Environmental:** client injury on premises, safety hazards
- **Professional conduct:** boundary violations, practising outside competence, discrimination

5.5 Severity Classification

Level	Description
Level 1: near miss	No harm occurred, but the potential existed
Level 2: minor	Minor temporary harm, minimal intervention required
Level 3: moderate	Moderate temporary harm, intervention required
Level 4: major	Significant harm, substantial intervention, long-term impact
Level 5: sentinel	Death or permanent serious harm

5.6 Immediate Response

Sentinel events (Level 5): ensure the safety of all persons, provide or arrange emergency care, notify emergency services if required, notify the professional indemnity insurer immediately, make any mandatory notification to AHPRA as soon as practicable, do not alter records, and seek immediate consultation.

Major events (Level 4): address safety concerns, provide care and support, notify the insurer within 24 hours, document thoroughly, implement corrective actions, and seek consultation.

Minor and moderate events (Levels 1 to 3): address immediate concerns, document the event, implement improvements, and discuss in supervision.

5.7 Open Disclosure

Open disclosure is required for all events causing harm (Levels 2 to 5). The process is: prepare by reviewing the facts and consulting the insurer or supervisor; make initial disclosure as soon as possible, expressing regret, providing a factual account, acknowledging impact and outlining actions; maintain ongoing communication, providing updates and answering questions; and make formal disclosure after investigation, sharing findings, explaining what happened and why, outlining changes made, and apologising where care fell below standard. Victorian law protects apologies from use in most civil proceedings (Wrongs Act 1958 (Vic), Part IIC).

5.8 Investigation

Investigation is mandatory for all Level 4 and 5 events, usual for Level 3 events, and triggered for recurrent Level 1 and 2 events and client complaints. Timing: sentinel events, commence immediately and complete within 45 days; major events, commence within 48 hours and complete within 30 days; moderate events, commence within 1 week and complete within 21 days.

The process establishes the facts (gather information, review records, interview parties, build a timeline), identifies contributing factors (client, practitioner, task, environment, system and external factors), conducts root cause analysis by repeatedly asking why until system-level issues are reached, identifies improvements for each cause, and develops specific, measurable, achievable, relevant and time-bound recommendations. The hierarchy of controls is applied: elimination, substitution, engineering, administrative and personal controls, in descending order of effectiveness.

5.9 Action Planning

Each recommendation specifies the action required, the person responsible, resources needed, a timeline, success measures and a monitoring method. Safety-critical actions are implemented within days; actions with significant impact within 1 to 3 months; system improvements within 6 to 12 months.

5.10 Monitoring and Review

At 1 month, immediate actions are verified and effectiveness assessed. At 3 months, progress is evaluated and outcomes measured. At 6 to 12 months, a comprehensive evaluation and sustainability check is completed.

5.11 External Reporting

- **AHPRA:** mandatory notifications (for example sexual misconduct, impairment placing the public at risk) as soon as practicable after forming the reasonable belief
- **Professional indemnity insurer:** all Level 4 and 5 events and any potential claims
- **OAIC:** eligible data breaches meeting the serious harm threshold
- **Coroner:** reportable deaths, including client death by suicide
- **NDIS Quality and Safeguards Commission:** reportable incidents connected with NDIS supports, within the required timeframes

5.12 Documentation

An adverse event report records objective facts, contributing factors and immediate actions. An investigation report records the process, findings, root causes, recommendations and action plan. Clinical records carry a brief factual note where the event impacts care, with a cross-reference to the separate incident file. A de-identified Adverse Events Register supports trend analysis and is reviewed quarterly.

5.13 Learning and Prevention

Individually: reflect on each event, identify learning needs, attend training, update practice, and discuss in supervision. At the system level: identify themes, update policies, analyse trends quarterly, and complete an annual comprehensive review. Prevention strategies include regular risk screening with validated tools, clear documentation, appropriate consultation, staying within competence, regular CPD, and self-care.

5.14 Supporting the Practitioner

Adverse events can cause guilt, shame, self-doubt, anxiety, decreased confidence and professional isolation. Support includes immediate supervision, trusted colleagues, personal therapy if needed, self-compassion, practitioner health programs, and professional association support.

Document Control

Item	Detail
Version	2.1 (supersedes version 2.0, 12 August 2026, and the undated prior version)
Approved by	Dr Sarah Fischer, Principal Psychologist and sole director
Effective date	12 August 2026
Next review	August 2027
Parent document	Clinical Governance Policy, Behavioural Edge Psychology Pty Ltd