Vision for the future? The contribution of the Psychotherapy and Counselling Federation of Australia to the profession

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Ione Lewis, *Australian College of Applied Psychology*

Introduction

The professional identity of counselling and psychotherapy is still emerging in the Australian context. The Psychotherapy and Counselling Federation of Australia (PACFA) is the peak body for counselling and psychotherapy, and since its inception has adopted a model of self-regulation of the profession (Schofield, 2008; PACFA, 2015). PACFA has established ethical and professional standards for training and practice, provides a national register of well-qualified counsellors and psychotherapists, and funds and publishes research to establish and strengthen the evidence base of the profession.

This article provides an overview of the history of PACFA, and outlines the development of counselling and psychotherapy in Australia since its inception. As the history of PACFA is complex, and not documented in a coherent way, except in the minutes of Board and Council meetings, PACFA documents, and submissions to government, this account is an important contribution to the profession. The history of PACFA is important to understand the current organisational structure, why the profession is still not recognised by government or unified, and the future challenges that PACFA will face.

Counsellors and psychotherapists are described as unregistered health professionals or health workers by federal, state and territory governments, and the services they provide are not eligible for GST exemption; they are not registered with the Australian Health Practitioner Regulation Agency (AHPRA) unless they are also members of other health professions regulated by AHPRA; and those not registered with AHPRA have no access to Medicare Provider numbers under the Better Access initiative or Access to Allied Psychological Strategies programs. The low level of recognition of counselling and psychotherapy continues despite PACFA's strong lobbying of government since its inception in 1998. This is the result of the professional dominance of other disciplines such as psychology and social work, which were well established before PACFA was founded and have a much longer history of service provision, and the federal government's fear of rising health costs.

Despite these considerable barriers, counselling and psychotherapy provide an important and widely accessed alternative to psychological services provided by registered health professionals. Counselling and psychotherapy promote health and wellbeing through an holistic focus on clients' needs and attention to individual processes of change, and pose a lower level of ethical risk to the public than psychological services provided by registered health professionals, as demonstrated by the low level of complaints made to Australian health care entities, reported in this article.

This article also examines the evidence base for differences between counselling and psychotherapy, and demonstrates that differences are not well supported by research. The findings of four workforce studies of counsellors and psychotherapists are presented and compared (Schofield, 2008, 2012; Pelling, 2005 and Pelling, Brear and Lau, 2006). The comparison demonstrates the changing demographics of the workforce from part-time to full-time employment, and improvements over time in the level of qualifications of counsellors and psychotherapists. I argue that PACFA's training standards and code of ethics need to change as a result of rapid technological changes in education and practice. Finally, the article concludes with the implications for the future of PACFA and the profession.

History of PACFA

The Standing Conference of Counselling and Psychotherapy Educators and Trainers (SCCPET) established itself in 1996 as a group of academics and trainers committed to professionalising counselling and psychotherapy, and achieving greater recognition of the profession in its own right. Hugh Crago and Ruth Sturmey, counselling academics at the University of New England, invited academics and trainers from around Australia to an inaugural three day meeting in Armidale, New South Wales. This was followed by annual meetings in 1996 and 1997 to report on the progress of working parties established to draft ethical guidelines; common training standards across modalities; definitions of counselling and psychotherapy; and the creation of a viable organisational structure for PACFA. In these early meetings, a great deal of time was spent listening to the assumptions, philosophies and training requirements for diverse practice models. This process established an acceptance of diversity and forged a mutual basis for founding PACFA. The educators who had established SCCPET also founded the Society of Counselling and Psychotherapy Educators (SCAPE) in 1999, which became a member association of PACFA, and is represented on the PACFA Board (SCAPE, n.d.).

PACFA became an incorporated association in 1998 (PACFA, 2015). As an organisation that operates nationally, PACFA is also required to report annually to the Australian Securities and Investments Commission, and has Deductible Gift Recipient (DRG) status with the Australian Taxation Office as a charitable organisation. The PACFA Council meets twice per annum, with membership comprising two nominated delegates from each member association, Board members, Chairs of PACFA committees, and the CEO. Council is responsible for electing the Board, setting the overall policy directions of PACFA, implementing the objects of PACFA, and determining the level of annual fees paid by member associations. The Board implements Council decisions, develops

strategy and policy in consultation with Council and member associations, is responsible for governance, and manages the business and affairs of PACFA (PACFA, 2015). There have been five elected Presidents of PACFA to date: Jim Crawley; Ron Perry, awarded a Medal of the Order of Australia for his service to counselling and psychotherapy; Tim Johnson-Newell; Professor Ione Lewis; and the current incumbent, Charles Wilson. Board members, Committee Chairs, committee members, course accreditation and professional conduct panels have all served on a voluntary basis and successfully conducted the core activities of PACFA. PACFA has been led by four chief executive officers (CEOs), with the longest-serving being the current CEO, Maria Brett (PACFA, 2013b).

PACFA's constitutional objects are to promote the development of the science relating to the art and practice of psychotherapy and counselling; develop a united, professional identity while respecting the diversity of approaches within the field; and gain professional recognition with government and the community (PACFA, 2015). PACFA has aspired to achieve these objectives by: (1) developing and promoting professional ethical and training standards; (2) providing a national register of qualified and ethical practitioners who undertake ongoing professional development and supervision; (3) fostering research and guidelines for evidence-based practice to advance the practice of psychotherapy and counselling; (4) accrediting education programs that meet PACFA training standards; and (5) providing an independent complaints process for consumers (PACFA, 2015). PACFA makes written submissions to the government in response to consultations, and has provided expert witnesses for Senate inquiries in 2007 and 2010, and the Department of Health and Ageing's Natural Therapies review of private health insurance rebates in 2013 (Lewis, 2014).

Key achievements of PACFA to date have been: the broad take-up of its education course accreditation program, with 34 programs delivered by 25 providers currently accredited (PACFA EPAC, 2015); the external audit of the Register in 2010, which resulted in Medibank Private provider numbers being issued to PACFA Registrants; the NSW government's inclusion of approved counsellors in the Workcover scheme; the Tasmanian government's inclusion of approved counsellors in its Adoption Information Service; the development of the PACFA Code of Ethics in 2011, currently undergoing major revision; oversight of the development of literature reviews on the evidence base of the major modalities represented by PACFA, available on the PACFA website; the commencement of the Psychotherapy and Counselling Journal of Australia, an open access journal, in 2013; the establishment of the Australian Register of Counsellors and Psychotherapists (ARCAP), a unified national register owned and operated jointly by PACFA and the Australian Counselling Association (ACA); and lobbying of government for better recognition of counsellors and psychotherapists in partnership with ACA. PACFA is a member of the Mental Health Council of Australia (MHCA) and participates in the advocacy efforts of MHCA to increase awareness of mental health and funding of mental health services. MHCA has provided grants to support PACFA conferences, and provides carer and consumer representatives for PACFA's research and conference committees (Lewis, 2014).

PACFA's organisational structure is as a federation of separate member associations, originally forty and now twenty-nine, which represent diverse modalities of counselling and psychotherapy. Member associations belong to register sections and have the capacity to set their own training and register standards at higher levels than those set by PACFA. PACFA sections include: Body-oriented Psychotherapy; Integrative Counselling and Psychotherapy; Hypnotherapy; Integrative Psychodynamic Psychotherapy; Psychotherapy and Counselling Educators and Psychoanalysis/Psychoanalytic Psychotherapy (PACFA, 2015).

PACFA's strength in representing counselling and psychotherapy has always been its diversity and inclusiveness. However, over the last five years, there has been a trend of some modalities leaving PACFA to form national associations which represent their own specialised interests. These include psychoanalysis and hypnotherapy. The emerging division between counselling and psychoanalysis in Australia mirrors the historic split which evolved in the UK (McGivern, Fisher, Ferlie, & Exworthy, 2009). In the US, training and practice in counselling and psychoanalysis are highly differentiated. PACFA's vision for a unified yet diverse profession is being seriously challenged by emerging divisions in Australia and international trends.

While there are many complex reasons for PACFA's slow progress in gaining recognition, the most significant factor is that PACFA's formation as a professional peak body is relatively recent compared to other long-established and well-respected professions. The Australian Association of Social Work was founded in 1946 (AASW, n.d.), and Australian psychologists first formed an association as a chapter of the British Psychological Society in 1946, which then evolved into the Australian Psychological Society in 1966 (APS, 2015). In comparison, PACFA was founded in 1996, some 50 years later (PACFA, 2015).

Some professional advantages for health professions are now enshrined in legislation and difficult, if not impossible, to change. An example is GST legislation, which provides exemption from GST for specified health services. PACFA lobbied the Federal Treasurer in 2011 for inclusion of counselling and psychotherapy as one of the health professions exempt from GST. PACFA accepted the advice of the then Assistant Treasurer Bill Shorten that a private ruling from the ATO was the only way to gain tax exempt status in relation to GST, which PACFA's legal counsel advised would be unsuccessful. An amendment to GST legislation requires that all state and territory governments support the change, which would reduce their revenue share, and was therefore unlikely to succeed (PACFA, 2013a).

This section has demonstrated how the recent history of PACFA, and its emergence within already established health professions, has to date limited its effectiveness in lobbying government for better recognition of counselling and psychotherapy services. The next section examines the differences between counselling and psychotherapy to understand emerging divisions in the Australian context.

The counselling and psychotherapy workforce

Counselling and psychotherapy are professional activities with many features in common. A large workforce study (n = 1,003) conducted in 2009 found that more than one third of the sample identified as both counsellors and psychotherapists (Schofield & Roedel, 2012). This dual identification suggests a considerable overlap in practice between counselling and psychotherapy. However, these similarities and differences have been the subject of considerable debate within PACFA and internationally, resulting in splits and disunity. These divisions are particularly evident in debates over regulation of the profession (Kwiatkowski, 1998; McLeod, 2009; Pointon, 2004).

PACFA describes the overlap as follows:

Psychotherapy and counselling are professional activities that utilise an interpersonal relationship to enable people to develop self-understanding and to make changes in their lives. Professional counsellors and psychotherapists work within a clearly contracted, principled relationship that enables individuals to obtain assistance in exploring and resolving issues of an interpersonal, intrapsychic or personal nature. Professional counselling and psychotherapy … utilise a range of therapeutic interventions and should be differentiated from the use of counselling skills by other professionals (PACFA, 2013b).

Despite these commonalities, the aims and foci of counselling and psychotherapy are seen to differ in significant ways:

The focus of counselling is more likely to be on specific problems or changes in life adjustments. Psychotherapy is more concerned with the restructure of the personality or self. At advanced levels of training, counselling has a greater overlap with psychotherapy than at foundation levels (PACFA, 2013b).

While there are many modalities within psychotherapy, psychoanalytic psychotherapy differs most from counselling in terms of its training, philosophy and methods. Psychoanalytic training is tripartite, and involves theoretical training, supervision and personal analysis (PACFA, n.d.). However, many forms of contemporary psychotherapy, for example Gestalt, also require personal therapy during training. Tripartite training is therefore not a defining feature of psychoanalytic psychotherapy.

A search of electronic databases EBSCO-host and Google Scholar using the search words “difference”, “counsel*” and “psychoth*” found there was sparse research evidence to support any difference between counselling and psychotherapy. A study in the UK by Kwaitkowski (1998) systematically examined the views of professional bodies, materials produced by training providers, and published literature, and found only slight differences between counselling and psychotherapy. Terms such as “depth” and “time” associated with psychotherapy create only vague distinctions, Kwaitkowski (1998) argues. Differences are based in perception and context, rather than in techniques and training. In contrast to the view that differences between counselling and psychotherapy are superficial, Pointon (2004) argues that counselling and psychotherapy have emerged

from quite different traditions and that training in the two differs in length and intensity. Psychoanalysis has historically been associated with medicine, and counselling with education and pastoral care.

Pointon (2004, p. 6) contrasts the view of the British Association of Counsellors and Psychotherapists that there are few “concrete differences” between counselling and psychotherapy with the assertion of the United Kingdom Council of Psychotherapists that it is important to clarify differences that do exist, and that length of training and frequency of personal therapy during training make a difference to professional practice and outcomes.

A meta-analysis of the specific ingredients of various counselling and psychotherapy methods (Ahn & Wampold, 2001) drew on 27 component studies, which aimed to isolate the effects of ingredients by comparing studies with and without those ingredients. Ahn and Wampold (2001) found no evidence that specific ingredients were responsible for the beneficial outcomes of counselling and psychotherapy. This finding is also supported by other research which demonstrates that relational competence is primarily responsible for effectiveness (McLeod, 2009). Owen (1999), in a comparison of person-centred counselling and psychodynamic psychotherapy, points to the inconsistency of the evidence base for both counselling and psychotherapy. Owen (1999, p. 176) argues there is a lack of “evidence into the key experiences of unconscious processes, insight and empathy … and … a fragmented series of case histories”.

A UK study (Chiesa, Fonagy, & Bateman, 2007) of differences in client populations referred to psychotherapy and counselling services found that clients referred for psychotherapy (n = 853) had more severe symptoms of psychosis, self-harm and poor social functioning, whereas clients referred for counselling (n = 384) had higher levels of anxiety, somatisation and passivity. However, while the psychotherapy sample scored more highly on severity of symptoms and risk, and patients were more likely to report interpersonal difficulties, a comparison of CORE clinical scores showed a high degree of overlap between the two samples. Chiesa et al. (2007) recommend greater collaboration between counselling and psychotherapy services, based on these findings.

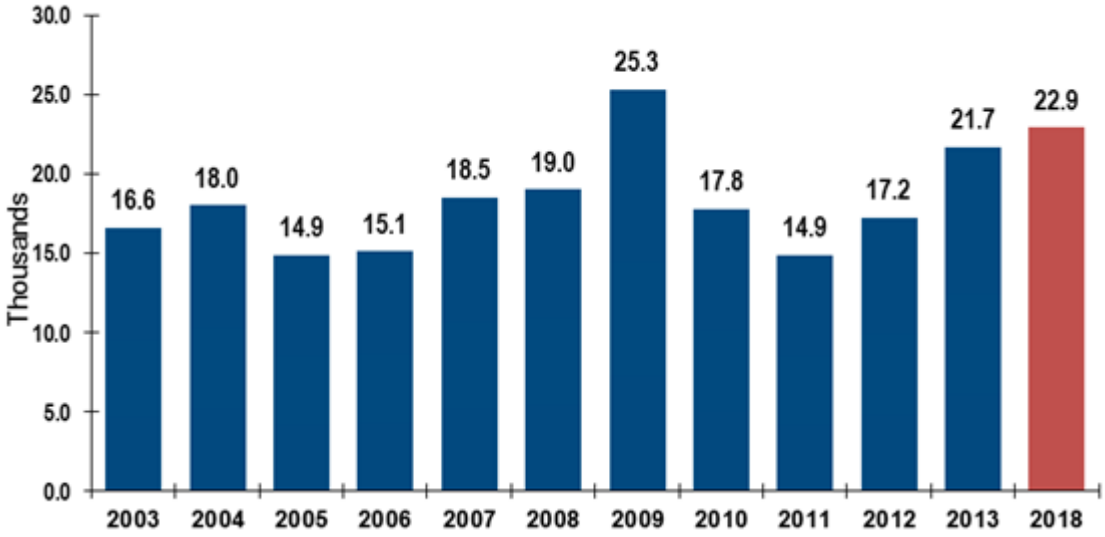
The literature reviewed here on differences between counselling and psychotherapy demonstrates that debates within the profession have relied largely on input factors: the length, type and content of training, without the support of research evidence on differences in outcomes. Richardson, Sheean and Bambling (2009, p. 80) challenge the profession to “translate the differences, as represented on a continuum of skill and knowledge level, into definitions of specific levels of training and experience required to deal with specific issues”. The PACFA Professional Practice Committee (PPC) is currently examining the need for standards for second training programs, which will go some way to address this recommendation (PPC, 2015).

In the following section, the composition and demographics of the workforce of counsellors and psychotherapists are examined.

The counselling and psychotherapy workforce

Approximately 21,700 counsellors currently work in Australia, according to census data collected by the Australian Bureau of Statistics on occupations (Australian Government, 2015). By 2018, the number of counsellors in the workforce is predicted to rise to 22,900. Figure one demonstrates fluctuations over time in the counselling workforce from 2003 to 2018. There was a sharp decline in the number of practitioners who identified their occupation as counselling in 2010 and 2011. This downward trend followed the introduction of the Better Access initiative by the Australian Government in 2006 and 2007, which led to a progressive shift in referrals towards practitioners with Medicare provider numbers (Littlefield, 2015).

Figure one: Counsellors' employment 2003 – 2018



Source: Australian Government (2015).

Psychotherapy is not currently tracked by the Australian government as an occupation, despite agreement from the former Labour Minister for Mental Health, Mark Butler, that the Labour government would include psychotherapy in occupational information made available to the public (correspondence with PACFA, 2011). Surprisingly, statistics on psychotherapy are not tracked by government, and yet psychotherapy is included as a skills shortage in the list of skilled occupations for migration to Australia. Psychotherapists comprise a smaller workforce compared to counselling. A 2009 workforce study found that 13% of the sample identified as psychotherapists, and 39% as both counsellors and psychotherapists (Schofield & Roedel, 2012).

Two major counselling workforce studies (Pelling, 2005; Pelling, Brear, & Lau, 2006), and two major counselling and psychotherapy studies (Schofield, 2008; Schofield & Roedel, 2012), have been conducted in Australia. Workforce studies are important means of providing data to inform workforce planning, provision of services, and professional development (Schofield, 2008). The major findings of these studies in terms of workforce characteristics are demonstrated in Table one below.

Table one: Comparison of workforce study findings

Study	Pelling (2005) n = 289	Pelling et al. (2006) n = 317	Schofield (2008) n = 316	Schofield & Roedel (2012) n = 1003
Sample	ACA members	Counsellors advertising in the Yellow Pages	Members of PACFA Member Associations	Members of 10 professional associations (including PACFA and ACA)
Characteristic studied				
Qualification level				
Bachelor, Graduate Diploma or Postgraduate Diploma	34.4%	36.9%	31.8%	43.0%
Master/ Professional Doctorate or PhD	22.9%	40.0%	42.2%	41.0%

Other	42.7%*	23.1%	26.0%	7.0%
Gender				
Female	76.0%	70.3%	78.6%	77%
Male	29.7%	22%	21.4%	23%
Intersex	0.8%	NA	NA	NA
Professional experience				
Mean experience in years	8.5	14.8	12.7	13.7
Employment				
Hours of work	22.4% full-time 62.7% part-time	NA	NA	51% part-time 49% full-time
More than one position	NA	NA	61.5%	44%
Geographical location				
Urban/metropolitan	69.3%	73.8%	NA	73%
Regional, rural and remote	30.7%	26.2%	NA	28%

* 16% of respondents were counselling students

The predominance of female practitioners in the counselling and psychotherapy profession has been stable over time (mean = 75.5%). The dominance of women in counselling and psychotherapy is similar to other caring professions, such as nursing, social work and teaching (Lewis, 2004), which historically are seen as extensions of women's domestic labour (Shoemaker, 1998) and have traditionally been associated with low social status, prestige and income (Alston, 2001). Professional inequality is amplified for practitioners who compete for positions and private practice referrals with graduates from more established health professions that claim a scientific evidence base (Rogers &

Pilgrim, 2010). These aspects of the profession, combined with PACFA being a relatively new peak body in an established field, have resulted in inequity and disadvantage for practitioners, and restriction of consumers' choice of psychological interventions when accessing government-funded services.Pelling (2005) recruited ACA members as participants, which resulted in a higher level of 'other' qualifications, 42.7 % (including 16% who were students), compared to more recent studies. The ACA register includes Diploma-qualified members; and the PACFA Register includes a proportion of practitioners with training that meets PACFA Training Standards but has not been government-accredited. Table one suggests there are declining numbers of practitioners in the workforce over time who do not have Bachelors' or postgraduate qualifications, 7% in Schofield and Roedel's (2012) study. Results for hours of work displayed in Table one suggests there has been an increase in hours worked over time, as has been the case for most Australian workers. The implications of this more highly educated workforce are better services for consumers, a workforce with higher career aspirations, and a stronger base for lobbying government and private health funds for greater recognition.

However, the success of the AASW, also a self-regulating, female-dominated profession, in gaining federal government recognition for inclusion in mental health programs such as the Better Access initiative (BAi) and Access to Allied Psychological Services (ATAPS), provides hope for the future of counselling and psychotherapy. PACFA's current lobbying of government via ARCAP, its effective management of consumer complaints, and progress in developing the evidence base for the profession, are likely to prove successful in gaining government recognition over time. PACFA has raised concerns with government that there is over servicing of some clients in the BAI by requiring mental health plans from general practitioners for referral, and treatment of mild to moderate mental health conditions by clinical psychologists, as more cost effective services could be provided by counsellors and psychotherapists (PACFA, 2014b).

The change from Labour to a Coalition government in 2013 also required PACFA to recommence joint lobbying with ACA with a new government. The Health Minister Peter Dutton met with PACFA and ACA in June 2014 and in principle agreed that suitably qualified counsellors and psychotherapists were able to provide mental health services, however expressed reservations that this step would increase the funding needed for mental health services (Lewis & Brett, 2014). This demonstrates that the current government's goal of reducing expenditure on health has been a barrier to better recognition of counsellors and psychotherapists.

The counselling and psychotherapy workforce is distributed widely across Australia, with 26.2% to 30.7% located in regional, rural and remote areas. Other health professions are less likely to be located outside of capital cities. In rural, regional and remote Australia, only 4% of psychiatrists and 21.5% of psychologists provide services (Vines, 2011), compared to 28.3% (mean) for counsellors and psychotherapists, displayed in Table one. This wider distribution across Australia demonstrates the importance of better

government recognition of counsellors and psychotherapists as part of the mental health workforce, to ensure access for consumers to the services they need in their local communities.

The relationship between counselling and other health professions is complex. Table two displays comparative data on the occupational size and predicted growth for counselling, psychology, social work, occupational therapy and psychiatry. Of these professions, social work is predicted to grow most strongly to 2017. However, the roles undertaken by social workers are diverse and extend beyond the provision of counselling to encompass social policy, research, casework, and community development. The data shows that occupational therapy is likely to experience low growth, and psychiatry negative growth.

Table two: Comparison of health occupations

Profession	Counselling	Psychology	Social Work	Occupational Therapy	Psychiatry
Size in 2012	17,100	20,000	25,800	12,800	2,900
Predicted size by 2017	20,500	23,900	31,000	13,900	2,700

Source: Australian Government (2013).

The practice of counselling and psychotherapy extends across a range of professions. In addition to practitioners trained specifically in counselling and psychotherapy, psychologists, social workers, occupational therapists and psychiatrists provide therapy as part of their work roles. Schofield's (2008) workforce study identified that practitioners from diverse professions, including mental health nursing, medicine, art therapy, and the ministry, were providing counselling and psychotherapy. This multidisciplinary composition of the workforce is challenging for the establishment of a unified profession.

Such diversity of professional training and backgrounds is both a strength and a challenge. Some practitioners who belong to PACFA member associations and are listed on the PACFA register also belong to other professions such as psychology and psychiatry, and have dual or multiple professional identities and affiliations. These practitioners must comply with diverse codes of ethics and professional standards, and be regulated by both PACFA and AHPRA. The profession can therefore be easily fragmented across disciplinary boundaries, which undermines its coherence, credibility and legitimacy (Schofield, 2008). Moreover, commitment to the counselling and psychotherapy profession and its development is weakened when other professional identities are more socially and financially rewarding for practitioners (Lewis, 2004).

The current restructure of PACFA to allow individual membership, combined with organisational membership, and the establishment of psychotherapy, counselling and relationship counselling colleges, will support modalities in their unique identities and foster greater unity (PACFA, 2015).

Professional regulation

The professionalising of counselling and therapy over the past two decades has been in part a search for group identity, unity and recognition. Professional boundaries are achieved by establishing boundaries and demarcations to include others with similar training, values and experiences, and exclude those seen as unqualified by the dominant group (Stokes, 1997). Listing on the PACFA Register and PACFA's accreditation program for counselling and psychotherapy courses symbolically demonstrate shared professional identity.

However, in establishing a defined territory of practice, knowledge, skills and standards, practitioners from other trainings and work roles remain unrecognised. The entry level to the profession is set by PACFA at Bachelors' level on the Australian Qualification Framework, or equivalent training. Thus, graduates of Vocational Education and Training qualifications such as the ubiquitous Diploma of Counselling are excluded from intern, provisional and clinical membership, and are unable to list on the PACFA Register unless they undertake further training.

Counselling and psychotherapy are not included in the professions identified as a high risk to the public by state and federal governments. Therefore, at the formative stage of establishing PACFA, the profession was not targeted for statutory regulation by government. PACFA developed a self-regulation model with financial support from the Victorian Department of Human Services (Schofield, 2008). In 2009, the Victorian government informed PACFA that its self-regulation model was seen as an acceptable means to regulate counselling and psychotherapy, and that the government would not pursue statutory regulation of the profession (Department of Health Victoria, 2009).

However in 2011, the Australian Health Ministers' Advisory Council (AHMAC) requested a report from PACFA on the number of ethical complaints made to PACFA and its member associations for the period 2006-2011, and the outcomes of investigations of complaints (AHMAC, 2011).

PACFA reported to AHMAC that the number of ethical complaints against counsellors and psychotherapists reported to PACFA and its member associations for the period 2006 to 2011 was low, although a proportion of these are very serious, as demonstrated in Table three.

Table three: Ethical breaches reported to PACFA and Member Associations 2006-2011

Complaint category	Number of complaints to PACFA	Number of complaints to Member Associations	Total
Breach of confidentiality	1 1.6%	6 9.8%	7 11.4%
Sexual misconduct	0 0%	5 8.2%	5 8.2%
Dual and multiple roles	4 6.6%	7 11.4%	11 18.0%
Discrimination	1 1.6%	2 3.3%	3 4.9%
Practising under influence of alcohol and other drugs	0 0%	0 0%	0 0%
Other misconduct	5 8.2%	19 31.1%	24 39.3%
Unsatisfactory service	1 1.6%	2 3.3%	3 4.9%
Complaint processes	1 1.6%	0 0%	1 1.6%
Fees/costs	0 0%	2 3.3%	2 3.3%
MA functions/activities	3 4.9%	2 3.3%	5 8.2%
Total	16 26.1%	45 73.7%	61 100%

Source: PACFA (2011)

Despite the evidence supplied by PACFA, AHMAC (2013) concluded that counsellors and psychotherapists are a risk to the public. This conclusion was based on consumer submissions to the consultation on the harm caused by unqualified counsellors. Following the AHMAC consultation, the NSW government revised its Unregistered Health

Practitioners Act in 2013 and reissued its Code of Conduct for Unregistered Health Practitioners. The government of South Australia issued a very similar Code of Conduct for Unregistered Health Practitioners in 2013. In Queensland, a new service, the Office of the Health Ombudsman, was established in 2014 to replace the former health care commission, and is empowered to accept complaints against registered and unregistered health practitioners. In these states, health care complaints against counsellors and psychotherapists can be referred to the state health care entity or health ombudsman for investigation and sanctions can be imposed.

In 2014, AHMAC announced national consultations on a single national Code of Conduct for unregistered health practitioners to be enacted in each state and territory, combined with statutory powers to enforce the code by investigating breaches and issuing prohibition orders. In 2015, a final report was published, *A National Code of Conduct for health care workers* (AHMAC/COAG Health Council, 2015). Clearly, a generic national form of regulation will be imposed on those health professions not registered with the Australian Health Practitioner Regulation Agency. However, PACFA is concerned that the codes already in place in New South Wales and South Australia do not recognise important differences between the health professions grouped together by the legislation, and that existing means of professional self-regulation have not been recognised by government. Self-regulation or co-regulation provide greater assurance to the public by maintaining the accountability of practitioners to their profession, as well as providing a specialised response to complex ethical breaches that may arise in therapeutic relationships.

Despite the government rhetoric of risk, establishing health care entities with the power to accept and investigate consumer complaints has not resulted in increased complaints against counsellors and psychotherapists in New South Wales and South Australia. Health care complaints entities require complaints by consumers, carers or advocates to be made in writing, and request a response from the health professional who is the subject of the complaint, and a copy of the complainant's health records. Complaints may be referred to a resolution service, the relevant professional body or another government agency, be investigated by the health care complaints entity, or not acted upon. In New South Wales, nine complaints were made against counsellors to the Health Care Complaints Commission for the period 2012 to 2013, which comprised only 0.3% of total complaints. Three complaints were made about psychotherapists, 0.1% of total complaints; 12 complaints against counsellors and psychotherapists in total. In comparison, 134 complaints were made against psychologists for the same period, which comprised 4.5% of total complaints (HCCC, 2013).

The South Australian Health and Community Services Complaints Commissioner (HCSCC) reported only four complaints accepted against unregistered health care providers for the period 2012 to 2013. One complaint was made against a hypnotherapist and three against unregistered health care practitioners (occupation unspecified). For the same period, there were nine complaints against psychologists (HCSCC, 2013).

Reporting by the NSW and South Australian governments demonstrate that counselling and psychotherapy service users make fewer complaints than service users accessing registered health professionals such as psychologists.

However, upheld complaints against counsellors and psychotherapists represent breaches of trust and breakdown in therapeutic relationships, and are very complex and serious. Generic legislation for health workers is not sufficient to provide an ethical framework of safety for clients. Self-regulation of the profession through ethical codes and consumer complaints processes continues to be a necessary adjunct to generic legislation regulating health workers.

The following section considers the future of counselling and psychotherapy in the context of social and technological changes.

The future of counselling and psychotherapy

Large numbers of counselling and psychotherapy graduates enter the field each year, and finding employment in the early years of their career can be difficult. To some extent, these difficulties are faced by new graduates in almost all professions. However, the higher status of other professions combined with limited government recognition of counselling and psychotherapy, makes competition for jobs with graduates from other professions, in particular psychology and social work, challenging (Richardson, Sheean, & Bambling, 2009). At the same time, the industrial landscape is changing in the community sector. Some agencies, in the context of reduced government funding, are changing their workforce composition from employees to contractors, who must hold their own professional indemnity insurance, and have no entitlement to paid leave. Many graduates aspire to private practice, and find building a viable practice with referral networks takes time, as they are in competition with other professionals registered with Medicare to provide mental health services (Richardson et al., 2009). PACFA has provided training in mental health in partnership with University of Canberra, and established a specialist listing, Mental Health Practitioner, on the Register, to assist consumers to identify and access practitioners equipped to provide mental health services (PACFA, 2013c).

Moreover, information communication technology is rapidly changing the way we study and work. Australians feel time-poor and no longer want to come on-campus to study (Grovo Learning, 2014). Tertiary education has gone online in a very short period of time, and the majority of higher education providers are currently investing strongly in online delivery and educational technologies for the future (Lai, 2011).

With theoretical content provided via digital means outside of timetabled teaching hours, a flipped classroom approach has developed, in which teachers have become facilitators of online discussions and on-campus intensives which promote active learning, rather than delivering content in class time. In one Australian study of students taught via the flipped classroom approach, 75% found the experience beneficial to their learning (Butt, 2014). A de-centred teaching style challenges the expert practitioner model which has

dominated counselling and psychotherapy training and supervision in the twentieth century. Active, flexible and participatory models of education are replacing didactic pedagogy, especially with younger students who are accustomed to using technology to learn and communicate (Lai, 2011). There is as yet little recognition of these changing educational practices in PACFA's Training Standards (PACFA, 2014a). The flow-on effect of less expert-oriented training for the practice of counselling and psychotherapy is yet to be seen. However, as novice practitioners model their trainers and supervisors, arguably the practice of new graduates trained in flipped classrooms is likely to be more democratic and responsive to the needs to clients, and be more open to providing online services. There is also evidence that consumers' needs and goals have changed within a digital environment with greater expectations of convenience and ease of access to services (King, 2014).

Client demand for online therapeutic services is rapidly increasing, although the attainment of a national broadband system which delivers improved connectivity is required (King, 2014). As a result of these technological and social changes, the PACFA training standards and code of ethics need to continuously evolve to keep pace with changes in counselling and psychotherapy education and practice. The current PACFA Training Standards demonstrate considerable resistance to changing modes of service delivery: "client contact hours, first and foremost, comprise face-to-face, in the same room contact with the client" (PACFA, 2014a, p. 9). The current revision of the PACFA Code of Ethics includes a recommendation to include the ethical implications of technology in service provision (PACFA Ethics Committee, 2015).

Implications and conclusion

This paper makes an important contribution to the literature analysing psychotherapy and counselling in Australia by providing a history of PACFA, linked to an analysis of the composition of the psychotherapy and counselling workforce, professional developments in training and ethical standards, within the context of rapidly changing educational practices in a digital environment.

The major implications for the profession of this analysis of the workforce is that gaining recognition for the profession as a whole is more important than the identity of the diverse modalities that PACFA represents, given the lack of research evidence for differences in outcomes. The current move towards individual membership and the establishment of colleges within PACFA is very necessary to unify the profession, provide a strong base for lobbying government, and improve funding for PACFA's activities (PACFA Restructure Working Party, 2015). The current fragmentation of modalities into separate national associations poses the biggest risk to PACFA's mission of unity and better recognition of counsellors and psychotherapists by government.

Additionally, the rise of technology is bringing about rapid changes in how health professionals are trained and practice. To date, the PACFA Training Standards and Code of Ethics have not kept pace with technological developments in education and practice, and hence provide little guidance for practitioners. The development of e-therapy services

is particularly relevant for rural, regional and remote Australia, and for consumers who desire anonymity and greater control over the service they receive (King, 2014). It is important that PACFA ensures that training and ethical standards provide an appropriate service framework for practitioners and consumers in the future, rather than basing standards on professional traditions developed in the twentieth century for very different social contexts.

In lobbying government, the lower ethical risk of counselling and psychotherapy compared to health professions such as psychology should be emphasised as a key point of difference. A focus on risk has been a successful strategy in the US. Lobbying of government about ethical risks to consumers during a period of high publicity over sexual abuse by health professionals was successful in establishing state licensure of practitioners (personal communication from the National Board of Certified Counselors).

Australian individuals, couples and families continue to choose counselling and psychotherapy for healing and personal growth. The community services sector provides employment opportunities for qualified counsellors and psychotherapists, and many experienced practitioners work in the private sector. Counsellors and psychotherapists are more widely spread throughout regional, rural and remote Australia than psychologists. Practitioners who use empathy and work with clients' individual processes are widely preferred, compared to directive, diagnostic and short term models of intervention, and pose fewer ethical risks for the public. As a result, the counselling and psychotherapy profession continues to expand. A combination of government and self-regulation of the profession is likely to result from federal, state and territory legislation. PACFA will continue to play a significant role in regulating counsellors and psychotherapists by setting professional standards for training and practice, combined with rigorous complaint processes for consumers.

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