A snapshot of the counselling and psychotherapy workforce in Australia in 2020: Underutilised and poorly remunerated, yet highly qualified and desperately needed

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There is increased demand on the mental health care system in Australia (Lakeman et al., 2020), with evidence showing that 46% of Australians aged 16 to 85 years will be diagnosed with a mental illness during their lifetime (Australian Institute of Health and Welfare, 2021), and that the recent impacts of COVID-19 are also likely to further increase this demand (Rossell et al., 2021). Despite this need, there is currently a shortage of mental health services in Australia. People seeking mental health services have reported lengthy waiting times (Petrie et al., 2021) of up to several months for appointments with psychologists and psychiatrists, with these service delays negatively impacting the availability of mental health care (Boseley & Davey, 2020; Dunlevie, 2020; Policy Writing Group, 2020; Rosenberg et al., 2020). Similarly, the Productivity Commission’s Draft Report (Productivity Commission, 2019) acknowledges current gaps in mental health service provision and client outcomes. A more inclusive approach to the Stepped Care model in Australia is needed, including a wider range of health professions, along with a more efficient and appropriate use of the existing health care workforce, increased focus on collaborative care models, and a mental health system that places the wishes of clients, their families, and carers at the centre of decision-making processes (PACFA, 2020, p. 6).

While psychologists and psychiatrists typically have long waiting lists (Petrie et al., 2021), previous workforce studies indicate that counselling and psychotherapy professionals are chronically underutilised (Lewis, 2015; Pelling, 2005; Pelling et al., 2006; Schofield, 2008; Schofield & Roedel, 2012). Although the practices of counselling and psychotherapy have a long history in Australia, commencing with the formal establishment of the National Marriage Guidance Council in 1948 (O’Hara & O’Hara, 2015; Schofield, 2013), these professions are not recognised in the class of allied mental health professionals (Health Insurance Act 1973, Section 19A) registered to provide Medicare Benefits Schedule services. It is worth noting that psychotherapy, which constitutes a smaller workforce when compared to counselling, is included as a skills shortage in the list of skilled occupations for migration to Australia (Lewis, 2015). The profession of psychotherapy and counselling is still emerging in the context of Australia and the southern hemisphere, although it has almost doubled in size since 2011. According to the Australian Government (n.d.) Job Outlook data, between 2011 and 2018, the number of counsellors

increased from 13,100 to 25,900, and it is anticipated that by 2023 there will be as many as 30,500. However, these figures may underestimate the actual size of the workforce, because some people working as counsellors and psychotherapists may identify with other professions (e.g., nursing, psychology, social work, and teaching) when official employment data is collected (Schofield, 2013). Traditionally, counsellors and psychotherapists have multidisciplinary backgrounds, illustrated by the fact that about one third of them belong to other regulated or well-recognised professions such as psychology, social work, nursing, medicine, and psychiatry. Given that these professionals affiliate themselves with PACFA through professional registration, this association suggests that PACFA is fulfilling an unmet need for recognition of counselling and psychotherapy as a unique profession with highly specialised training and supervision requirements (Schofield, 2008, p. 9).

Workforce studies provide data used to inform workforce planning, the provision of services, and professional development. Two counselling workforce studies (Pelling, 2005; Pelling, Brear & Lau, 2006) and two psychotherapy and counselling workforce studies (Schofield, 2008; Schofield & Roedel, 2012) have been published in Australia. These earlier studies inform the current study and provide a basis for comparative analysis of this changing workforce. The current 2020 workforce study is based on questions from these previous surveys, so meaningful comparisons can be made to past data.

Given the lack of recognition of the psychotherapy and counselling workforce in Australia (Day, 2015), along with the considerable contributions PACFA-registered practitioners can make to the mental health system, there is a clear and continuing need for advocacy work. Consequently, the aim of the 2020 workforce survey was to profile professionals affiliated with PACFA in order to inform future policy and service planning. This profiling serves several potential purposes, including: (a) informing the selection, training, and development of professionals; (b) supporting professionals with a view to preventing burnout; (c) understanding the influence of professionals on therapeutic processes and outcomes; and (d) defining the workforce to facilitate government and service planning (Schofield & Roedel, 2012). As such, workforce survey data allow for a better understanding of the available workforce for managing Australia's increasing demand for mental health services and are an important part of developing policy submissions, such as advocating for the addition of counsellors and psychotherapists as Medicare providers.

Method

Design

The 2020 workforce study was a mixed-method design intended to gather quantitative and qualitative research via an online anonymous survey distributed primarily to members of PACFA. Participants were recruited via email, posts on the PACFA website and

Facebook page, and through the membership newsletter. This purposive sampling method ensured targeted access to a broad sample of psychotherapists and counsellors in Australia. The data were gathered via an online survey, with a total of 959 respondents.

The survey, which was live from 1 October 2020 to 15 November 2020, included a combination of multiple choice and open-ended questions relating to participants' demographic characteristics, qualifications, and professional development. The survey recorded participants' length of registration, type and location of employment, their positions, hours, pay, professional association membership, their sources of client referrals and main client groups, main client presentations, and main practice modalities. Finally, the survey included questions querying each participant's perceptions regarding the impact of the COVID-19 pandemic. The data were analysed using SPSS and thematic analysis.

The current study builds on previous workforce studies, the earliest of which was conducted in 2004 (Schofield, 2008). The University of Adelaide's Human Research Ethics Committee granted approval for this research (H-2020-170), and all participants were required to provide informed consent prior to responding to the survey questions.

Participants

Eligible participants were qualified counsellors and psychotherapists currently working (in a paid or unpaid capacity) in Australia. The 959 responses to the online survey represented 27.4% of people in the PACFA registry.

Data Analysis

Responses to the questions were summarised using descriptive statistics (frequencies and percentages) and due to the non-normality of the data within the continuous variables, medians (*Mdn*) and interquartile ranges (*IQR*) were used as measures of central tendency and spread.

Findings

Demographic Characteristics

Participants reported predominantly identifying as female (79.8%), having a median age of 55 years (*IQR*=16), and being married (57.9%) (see Table 1). A broad range of cultural identities was reported, with the most common being Australian (35.1%, n=337). Nine respondents self-identified as Aboriginal people (0.9%). No respondents identified as Torres Strait Islander people. (For further information, see Table 1 and the Limitations section regarding demographic characteristics.)

Table 1. Demographic Characteristics

	n	%
Gender		
Female	765	79.8%
Male	161	16.8%
Preferred not to say	5	0.5%
Non-binary/gender diverse	2	0.2%
Gender identity not listed	2	0.2%
Other	2	0.2%
Age		
below 30	34	3.5%
30 to 39	72	7.5%
40 to 49	188	19.6%
50 to 59	281	29.3%
60 to 69	232	24.2%
70 to 79	70	7.3%
80 and above	5	0.5%
Relationship/family status		
Single	203	21.2%
Partnered	164	17.1%

Married	555	57.9%
Has children	383	33.9%
Indigeneity		
Aboriginal	9	0.9%
Torres Strait Islander	0	0.0%
Cultural identity [a]		
Australian	337	35.1%
Anglo/Anglo Saxon	66	6.9%
Australian European	39	4.1%
Anglo-Australian	52	5.4%
Asian	11	1.1%
Caucasian	38	4.0%
European	20	2.1%
Mixed/multi-cultural/culturally and linguistically diverse	11	1.1%
No response	149	15.5%

Note. N=959. [a] Identities stated by <1% of participants not reported. Although APA 7th edition style guidelines recommend using terms for gender (woman, man, non-binary, etc.) rather than sex (female, male, intersex) where applicable, use of “female” and “male” in this manuscript reflects participant self-identification rather than author classification.

Qualifications, Personal Development, and Years of Registration

Two thirds of participants had postgraduate education (67.1%), with almost half having completed master's degrees in counselling or psychotherapy (43.4%) (see Table 2). A similar percentage of participants indicated that counselling or psychotherapy for personal development was a requirement of their courses (43.5%), and approximately one third of participants had been registered for 10 years or more (34.0%).

Table 2. Qualifications, Personal Development, and Years of Registration

	n	%
Highest qualification		
PhD/professional doctorate in counselling/psychotherapy	32	3.3%
Master's degree in counselling/psychotherapy	416	43.4%
Graduate diploma/graduate certificate in counselling/psychotherapy	196	20.4%
Bachelor's degree in counselling/psychotherapy	101	10.5%
Diploma in counselling/psychotherapy	18	1.9%
Non-AQF-accredited training course accredited by PACFA	9	0.9%
Non-AQF-accredited training course not accredited by PACFA	3	0.3%
Currently enrolled in qualifying course	11	1.1%
Other	44	4.6%
Course requirement of counselling or psychotherapy [a]		
Yes	417	43.5%
No	385	40.1%
Years of registration as a counsellor or psychotherapist		

Less than 1 year registered	22	2.3%
1 to 4.5 years registered	290	30.2%
5 to 9.5 years registered	224	23.4%
10 to 14.5 years registered	97	10.1%
15 to 20 years registered	160	16.7%
20.5 to 29 years registered	44	4.6%
30 and more years registered	25	2.6%

Note. N=959. AQF=Australian Qualifications Framework; PACFA= Psychotherapy and Counselling Federation of Australia. [a] For personal development.

Type and Location of Employment

Participants commonly listed counsellor (46.5%) and psychotherapist (24.1%) as the job titles of their primary positions (see Table 3). Qualified counsellors and psychotherapists predominantly had roles in practice (85.3%), as did those who were registered (83.9%). Describing their work activities, over half of the participants indicated that they were individual practitioners working in private practice (56.8%), and one quarter were employed in non-governmental or charitable organisations (24.0%). Although most of the participants worked in major cities (59.6%), a significant proportion worked in regional cities (22.9%), rural areas (7.6%), and remote areas (2.1%).

Table 3. Type and Location of Employment

	n	%
Job title in primary position		
Counsellor	446	46.5%
Psychotherapist	231	24.1%
Student	34	3.5%

Manager/Administrator	23	2.4%
Academic/Trainer	21	2.2%
Other health professional [a]	112	11.7%
Roles of qualified counsellors and psychotherapists		
Practice	818	85.3%
Managerial/administrative role	71	7.4%
Academic role	67	7.0%
None of these roles	49	5.1%
Roles of registered counsellors and psychotherapists [b]		
Practice	805	83.9%
Managerial/administrative role	55	5.7%
Academic role	53	5.5%
Enrolled in a counselling and/or psychotherapy training course	57	5.9%
Work activities [c]		
Individual practitioner in private practice	545	56.8%
Individual practitioner in a shared group practice	74	7.7%
Employed by an NGO/charity	230	24.0%
Employed by private health service providers	61	6.4%
Volunteer with an NGO/charity	56	5.8%

Employed by a statutory body (e.g., Mental Health Commission)	11	1.1%
Employed by a school/college as a well-being support/school counsellor	57	5.9%
Employed by a school/college/university as a teacher/trainer/lecturer	45	4.7%
Employed by a school/college/university as an academic researcher/ supervisor	14	1.5%
Student	46	4.8%
Other	106	11.1%
Work location		
Major city	572	59.6%
Regional city	220	22.9%
Rural area	73	7.6%
Remote area	20	2.1%

Note. N=959. NGO=non-government organisation. [a] Not case worker, psychologist, or social worker. [b] Intern, provisional, or clinical registration with a professional registration body, such as Australian Counselling Association or Psychotherapy and Counselling Federation of Australia. [c] Participants could select up to three activities.

Positions, Hours, and Pay

Most participants held one paid full-time or part-time position (57.7%) and worked 20 or fewer hours per week (54.7%) (see Table 4). Although half the participants were satisfied with the amount of paid work they had per week (49.7%), over one quarter indicated they would like to work more hours (27.1%). Income from counselling- or psychotherapy-related activities for the last financial year varied widely between participants, with over half of those who reported their annual income earning under $75,000 (58.9%).

Table 4. Positions, Hours, and Pay

	n	%
Number and type of positions		
One paid full-time position	243	25.3%
One paid part-time position	311	32.4%
Two paid part-time positions	133	13.9%
One paid casual position	153	16.0%
Two paid casual positions	3.2	31.0%
Number of paid hours provided per week [a]		
No paid hours	42	4.4%
Less than 10 paid hours per week	202	21.1%
10 to 15 paid hours per week	157	16.4%
16 to 20 paid hours per week	123	12.8%
21 to 25 paid hours per week	111	11.6%
26 to 30 paid hours per week	66	6.9%
31 to 38 paid hours per week	77	8.0%
39 and more paid hours per week	42	4.4%
Satisfaction with number of hours of paid work per week [a]		
Yes, I am satisfied	477	49.7%
No, I would like to work less hours	50	5.2%

No, I would like to work more hours	260	27.1%
Not sure	49	5.1%
Annual income from counselling- or psychotherapy-related activities [b]		
No income	62	6.5%
Below $1,000	9	0.9%
$1,000 to $4,999	20	2.1%
$5,000 to $9,999	38	4.0%
$10,000 to $29,999	123	12.8%
$30,000 to $49,999	129	13.5%
$50,000 to $74,999	183	19.1%
$75,000 to $84,999	93	9.7%
$85,000 to $99,000	37	3.9%
$100,000 and above	61	6.4%

Note. *N*=959. [a] As a counsellor or psychotherapist. [b] Income for the last financial year.

Professional Association Membership

Most participants were members of PACFA (76.5%) (see Table 5) however some participants were members of the Australian Counselling Association (8.2%) and other associations (17.4%). Some members reported more than one membership.

Table 5. Professional Association Membership

	n	%

Association membership		
PACFA only	522	54.4%
PACFA and ACA	47	4.9%
PACFA and other associations	148	15.4%
PACFA, ACA and other associations	17	1.8%
ACA only	13	1.4%
ACA and other associations	2	0.2%

Note. N=959. ACA=Australian Counselling Association; PACFA= Psychotherapy and Counselling Federation of Australia.

Source of Client Referrals

More participants reported word of mouth as a source of client referrals than any other method (57.6%) (see Table 6).

Table 6. Sources of Client Referrals to a Practice or Organisation

	n	%
Source of referrals		
Advertising	144	15.0%
Community organisation	218	22.7%
Medical practitioner	174	18.1%
Mental health service	139	14.5%
Professional association register	82	8.6%

Social media	105	10.9%
Web listing	251	26.2%
Word of mouth	552	57.6%
Other	186	19.4%

Note. N=959.

Main Client Groups

Participants could select multiple options here and reported working mainly with adults (76.6%), young people (27.9%), children (17.3%), LGBTIQA+ people (10.0%), and migrants (7.6%) (see Table 7).

Table 7. Main Client Groups

	n	%
Main groups		
Aboriginal people	57	5.9%
Adults	736	76.6%
Children	166	17.3%
Indigenous people	47	4.9%
LGBTIQA+ people	96	10.0%
Migrants	73	7.6%
Incarcerated people	20	2.1%
Refugees	27	2.8%

Torres Strait Islander people	18	1.9%
Young people	268	27.9%
Other	77	8.0%

Note. N=959. LGBTIQA+=lesbian, gay, bisexual, trans/transgender, intersex, queer/questioning, and asexual. The survey term “prisoners” has been updated here to incarcerated people.

Main Client Presentations

Participants reported that their most common client presentations were anxiety (67.5%), depression (55.3%), relationships (52.1%), grief and loss (51.6%), and life stress/transitions (47.2%) (see Table 8).

Table 8. Main Client Presentations

	n	%
Presentations		
Alcohol and other drugs	150	15.6%
Anxiety	647	67.5%
Body image issues	106	11.1%
Culturally and linguistically diverse	50	5.2%
Child abuse	167	17.4%
Cross cultural	86	9.0%
Depression	530	55.3%
Domestic violence	225	23.5%

Eating disorders	91	9.5%
Eco-anxiety	23	2.4%
Family conflict	369	38.5%
Gender identity	73	7.6%
Grief and loss	495	51.6%
Indigenous people	57	5.9%
Intimate partner violence	114	11.9%
Life stress/transitions	453	47.2%
Personality issues	180	18.8%
Post-traumatic Stress Disorder	309	32.2%
Relationships	500	52.1%
Sexuality	131	13.7%
Suicidality	205	21.4%
Spirituality	156	16.3%
Wellbeing	320	33.4%
Other	99	10.3%

Note. N=959.

Main Practice Modalities

Collectively, participants used a broad range of practice modalities (see Table 9). The most reported modality was person-centred therapy (19.5%).

Table 9. Main Practice Modalities

	n	%
Modality		
Art therapy	11	1.1%
Body-oriented therapies	19	2.0%
Cognitive behavioural therapy	48	5.0%
Couples therapy	38	4.0%
Dance therapy	2	0.2%
Eclectic therapy	45	4.7%
Emotion-focussed therapy	28	2.9%
Existential therapy	13	1.4%
Family therapy	25	2.6%
Gestalt therapy	44	4.6%
Hypnotherapy	8	0.8%
Integrative therapy	71	7.4%
Narrative therapy	25	2.6%
Person-centred therapy	187	19.5%
Psychoanalytic therapy	11	1.1%
Psychodynamic therapy	60	6.3%

Psychodrama	11	0.1%
Solution-focused therapy	41	4.3%
Spiritually informed	4	0.4%
Soul-centred Psychotherapy	9	0.9%
Transactional analysis	5	0.5%
Other	134	14.0%

Note. N=959.

Impacts of the COVID-19 Pandemic

Many participants reported gaining more new clients (34.6%) and seeing regular clients more often (15.7%) during the pandemic. Almost half of the participants indicated they were using online platforms to work with clients (47.4%). Three quarters (73%, *n*=701) of the participants reported having received a median 5 hours of training in telemental health (*IQR*=12 hrs). Participants reported that technical difficulties were the most common effect of the COVID-19 pandemic on practice (30.4%) (see Table 10).

Table 10. Impact of the COVID-19 Pandemic

	n	%
Effect on client numbers		
More new clients	332	34.6%
Seeing my regular clients more often	151	15.7%
No drop off	146	15.2%
Some drop off	180	18.8%
Major drop off	66	6.9%

Other	148	15.4%
Effect on practice		
Payment	129	13.5%
Ethical issues	97	10.1%
Financial issues	191	19.9%
Technical difficulties	292	30.4%
Other	382	39.8%
Ways of working with clients		
Online platforms such as Zoom and Skype	455	47.4%
Phone	274	28.6%
Face-to-face	287	29.9%
No change due to COVID-19	54	5.6%
Other	100	10.4%

Note. N=959.

Discussion

The findings of this study show that psychotherapists and counsellors continue to be a highly qualified workforce. Two thirds of the participants had postgraduate qualifications and the majority were registered with PACFA, a finding that is broadly consistent with the figures from the 2012 survey of the Australian counselling and psychotherapy workforce (Schofield & Roedel, 2012).

Although personal therapy is widely recommended in the professional training of counsellors and psychotherapists, it is not a mandatory requirement internationally (Edwards, 2018; Ivey & Waldeck, 2014). For two fifths of participants, undergoing counselling or psychotherapy for professional development was an aspect of their training courses. The rationale for personal therapy during training is multifaceted, including to

enhance the trainee's capacity for empathy towards the client and to enhance the trainee's knowledge of techniques and capacities for use in practice. Furthermore, personal therapy during training may reduce the likelihood of future harm towards clients, contribute to the trainee's personal growth, and help the trainee gain deeper insight into therapeutic processes (e.g. mitigate the effects of transference and counter-transference) (Edwards, 2018). This is arguably an indicator of quality and a valuable point of difference for the profession from other allied health workers.

Overall, the demographic profile of counsellors and psychotherapists in this study is similar to those obtained from surveys conducted previously (Pelling, 2005; Pelling et al., 2006). The previous Australian counselling and psychotherapy workforce survey was conducted in 2015 and involved an online survey of 1,022 respondents (Lewis, 2016). The 2015 study found that most practitioners identified as female (79.0%) and were aged between 46 and 65 years (67.0%). The dominant cultural identity reported by practitioners was "Australian", followed by "English" (Lewis, 2016).

The majority of practitioners (70.0%) worked in central and metropolitan areas of major cities. The remaining 30.0% worked in regional, rural and remote areas, which is a similar finding to previous workforce studies (Lewis, 2015). Participants worked predominantly in major cities (71.0%), across many types of employers (e.g., public health services, private schools, and higher education), with almost three quarters working in private practice (70.0%). Over half the counsellors and psychotherapists held multiple positions (56.0%), with their most common primary positions being counsellors (41.0%) and psychotherapists (27.0%). Most had annual incomes of $75,000 or less (85.0%) (Lewis, 2016).

The counsellors and psychotherapists in the 2015 survey commonly reported having caseloads of 1 to 25 hours per week (86.0%) working across a broad range of client presentations, the most common of which was relationship issues (70.0%). Other main client presentations included life stress/transitions (67.0%), grief and loss (62.0%), and trauma (53.0%). The four main modalities practised by counsellors were Cognitive-Behavioural Therapy (CBT), Narrative and Solution-Focused Therapies, Couple and Family Therapy, and Humanist and Existential Therapies. For psychotherapists, the four main modalities practised were Psychodynamic and Psychoanalytic Therapies, Humanist and Existential Therapies, Couple and Family Therapy, and Integrative Therapies (Lewis, 2016).

In line with results from the previous workforce survey (Lewis, 2016), most respondents from the current survey reported identifying as female, with a median age of 55 years. The extent to which gender imbalance in the workforce could be problematic is uncertain. Although two respondents reported identifying as non-binary or gender diverse, the numbers of non-binary professionals and binary women and men of trans experience and/or identity in the workforce are also unknown.

Recent research conducted in the United Kingdom (Liddon et al., 2018) and Australia (Black & Gringart, 2019) has shown that the majority of clients do not have a preference for the gender of their therapists. However, this appears to be different for LGBTQIA+ and culturally and religiously diverse therapy participants. For example, LGB clients seem more likely to seek out a therapist of a similar sexuality (Burckell & Goldfried, 2006; Kaufman et al., 1997). In addition, counsellor preferences are likely to be different in different contexts. In some cultural groups, for example among strict Muslims or strict Orthodox Jewish clients, a gender match is critical as it is forbidden to be in the same room with a counsellor of a different gender. In other countries with a history of colonial oppression, having a white counsellor may be perceived as re-creation of an oppressive structure (Ilagan & Heatherington, 2021). Similarly, this applies to clients who have experienced marginalisation and related disparities based on race and gender, among other factors (Jackson, 2015). A recent meta-analysis revealed that collaboratively working with clients to accommodate their preferences was associated with positive counselling outcomes (Swift et al., 2018). Hence, counsellors need to be open to a range of relationship models and practices that avoid privileging the ‘dominant discourses at the expense of other descriptions’, as well as being willing to work within the client’s cultural framework (Simon & Whitfield, 2000, p. 144; Swift et al., 2018).

In contrast to the 2015 findings (Lewis, 2016), the most common client presentations participants encountered in practice were anxiety and depression. This finding is consistent with international evidence from the World Health Organization, which found that depressive and anxiety disorders were the most frequent psychological problems seen in primary health care (Sartorius et al., 1996). Many of the other presentations that participants identified, for example eco-anxiety and post-traumatic stress disorder, also typically present with symptoms of anxiety and depression to varying degrees.

Previous surveys conducted in Australia (Lewis, 2016; Pelling, 2005; Pelling et al., 2006; Schofield & Roedel, 2012) and overseas (e.g., Barth & Moody, 2019) have consistently found that counsellors and psychotherapists draw upon multiple therapeutic modalities in their practices. In the present survey, participants indicated their main practice modality rather than all modalities that influenced their practice. The most common modalities were person-centred therapy, integrative therapy, psychodynamic therapy, cognitive behavioural therapy, eclectic therapy, Gestalt therapy, and solution-focused therapy. The prominence of these modalities is consistent with international evidence that found cognitive behavioural, person-centred/interpersonal, strength-based, and solution-focused approaches were the four most widely used modalities (Barth & Moody, 2019). It is important to contextualise this finding alongside the common factors research finding that client factors and the therapeutic alliance have a more significant impact on therapeutic effectiveness than modality *per se* (Duncan et al., 2010).

The most common source of referrals to counsellors and psychotherapists was word of mouth, a finding that underscores the importance of maintaining good professional reputations. This finding also seems to suggest that there has been a shift in where potential clients were obtaining information about counsellors and psychotherapists. An

Australian study of adults in the general public conducted during 2001 and 2002 showed that most people would seek help from a medical doctor to find a counsellor (82.0%), followed by friends (62.0%) and family members (41.0%) (Sharpley et al., 2004). In addition, web listings were the source of 26.2% of clients for counsellors and psychotherapists in the present study, whereas no electronic medium was mentioned in the report on the 2001/2002 study. The studies are not directly comparable, in that the earlier study asked people in the general public about their intentions (many of whom may not have been considering counselling or therapy), whereas the present study asked participants where clients were sourced in general. Even so, there is some evidence that there has been a shift away from referrals through medical practitioners, as clients increasingly rely on word of mouth (which may be family and friends) and online sources of information about counsellors and psychotherapists.

Unemployment in the counselling and psychotherapy workforce is below average when compared with other industries in Australia (Department of Jobs and Small Business, 2019), and the COVID-19 pandemic has increased demand for services (Australian Institute of Health and Welfare, 2021, March). However, approximately one third of study participants were dissatisfied with the hours they worked, with most of these counsellors and psychotherapists indicating that they would prefer to work more hours. This finding is at odds with evidence of shortages of mental health services in Australia (Boseley & Davey, 2020; Dunlevie, 2020; Policy Writing Group, 2020; Rosenberg et al., 2020).

There are several possible reasons why some counsellors and psychotherapists may be underemployed despite significant demand for mental health services. For example, the services of counsellors and psychotherapists who are not eligible to register with the Australian Health Practitioner Regulation Agency (AHPRA) are not being recognised as providing psychological therapies that attract a rebate under the Medicare Benefits Schedule (as prescribed under the Health Insurance Act 1973). Medicare rebates under the *Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access)* initiative are only available for: (a) clinical psychologists providing psychological therapy, and (b) psychologists, social workers, and occupational therapists providing focused psychological strategies (Department of Health, 2019). Through Better Access, a two-tier rebate system has been established in which most counsellors and psychotherapists are not eligible to have their services subsidised. This also means that because psychotherapists and counsellors are not recognised as providing subsidised services, they pay 10.0% GST, where recognised clinicians providing comparable services do not, thus imposing inequitable taxation. However, research has highlighted that use of Better Access is skewed towards the more affluent client and has also demonstrated that there is a lack of services in remote and rural areas (Papadopoulos & Maylea, 2020; Rosenberg & Hickie, 2019). Some potential clients may find it more cost-effective to seek the services of psychologists through general practitioner referrals.

Underemployment may also be partly due to there being an insufficient number of funded positions for counsellors or psychotherapists (non-AHPRA health professionals) to meet community demand (Department of Health and Human Services, 2018). There is not a

shortage of qualified practitioners, but rather there is a lack of appropriately funded and graded positions. Finally, some counsellors and psychotherapists may find it challenging to promote their services. Strategies to raise the profiles of counsellors and to assist counsellors and psychotherapists to develop their practices (e.g., training in business development) may need to be pursued.

It is also noteworthy that 33.0% of counsellors and psychotherapists are working in regional cities and in rural and remote areas, in contrast to only 17.0% of psychologists and 15.0% of psychiatrists (Australian Institute of Health and Welfare, 2021). Given the higher incidences of mental health emergencies and suicides, combined with a lower uptake of Medicare-subsidised mental health services in rural and remote areas (Farmer et al., 2020), the demography and availability of counsellors and psychotherapists represents an underutilised source of psychological support for the Australians who need it most. Given that accessing counselling is generally accepted to be more affordable and less stigmatising than seeking psychological treatment, greater recognition and funding of counsellors and psychotherapists could support rural and remote mental health more effectively.

This latest survey of the Australian counselling and psychotherapy workforce was conducted during the COVID-19 pandemic. Public health measures implemented in response to the pandemic focused on domestic and international border control, personal protective and other equipment and testing capabilities, contact tracing, and social distancing (Johnston, 2020). Although successful in reducing disease outbreaks, these measures contributed to widespread mental health problems (Fisher et al., 2020; Rossell et al., 2021). This was particularly noticeable for people who experienced highly negative impacts from the restrictions on their daily lives, those who were greatly worried about contracting COVID-19, and those who lost their jobs (Fisher et al., 2020). The COVID-19 pandemic influenced participants' practices in several ways. More participants reported increased demand for services than reduced client numbers. This finding is consistent with the overall increase in demand for mental health services evident in Australia during the pandemic (Australian Institute of Health and Welfare, 2021, March). The most common challenges for participants seem to have been technical difficulties, likely due to the significant use of online platforms to work with clients.

Limitations

This research has several limitations. First, the advertising of the survey was skewed towards people on the PACFA registry. Although the researchers intended to promote the survey through the Australian Register of Counsellors and Psychotherapists, access to this public register could not be negotiated. Despite this setback, promotion of the survey was still able to attract participants who did not have membership with PACFA. Second, the cultural identity item facilitated free-text responses and elicited a broad range of identifications, including nationality, race, ethnicity, religion, and sexual orientation. The diversity of interpretations of this item means that specific conclusions cannot be drawn regarding the cultural identities of counsellors and psychotherapists. While the

demographic of the counselling workforce seems to lack diversity, as mentioned, this may be due to a limitation in how this information was collected, given that PACFA's College of Aboriginal and Torres Strait Islander Healing Practitioners (which was only formally established after this survey had been conducted) accommodates 145 members.

A more nuanced demographic profile of counsellors and psychotherapists would be beneficial, as research has shown that some clients prefer therapists whose demographic characteristics (e.g., ethnicity, race, sexuality) match their own (Cabral & Smith, 2011). That is particularly important for clients who have experienced marginalisation and related disparities based on race, gender, and other factors (Jackson, 2015). Further research is required to explore preferences based on client disability, sexual orientation, socio-economic status, and religion. With respect to future counselling and psychotherapy workforce surveys, multiple choice items should be used to elicit more nuanced data on client demographics.

Summary

This survey shows that the demographic profile of Australian counsellors and psychotherapists has changed little since earlier surveys. The responses to this latest survey indicate that counsellors and psychotherapists registered with PACFA are highly educated and commonly work in private practice. They meet rigorous training, accreditation, and qualification standards, annual requirements for professional development and supervision, adherence to a Code of Ethics, and professional indemnity and liability insurance requirements.

Psychotherapists and counsellors in this survey reported consistent capacity to support people with challenges relating to self-awareness, behaviour change, relationship challenges, or grief and loss, all of which are recognised to contribute to protective factors and the prevention of mental health conditions. Furthermore, our findings document that accredited counsellors and psychotherapists provide evidence-based talking therapies to treat serious mental health conditions such as trauma and eating disorders.

As this snapshot demonstrates, the workforce is significantly qualified (i.e., over two-thirds postgraduate), experienced (i.e., approximately one third registered for 10 years or longer), with almost half having undergone development through personal therapy, which is an indicator of quality in therapeutic outcomes research (Bennett-Levy, 2019; Moe & Thimm, 2021). Working largely in a person-centred way with common presentations of anxiety, depression, relationships, post-traumatic stress, and loss and grief, counsellors and psychotherapists make a pivotal contribution to mental health services in Australia. In a registered workforce of 3,500 practitioners currently working around 20 hours per week and signalling a desire to work more hours, this represents around 100,000 hours per week of potentially subsidised sessions currently unavailable to the public due to ongoing professional discrimination against registered counsellors and psychotherapists.

Conclusion

The shortage of mental health services in Australia, especially in remote areas, and the desire for more working hours among one quarter of registered counsellors and psychotherapists, mean this workforce needs to be far better utilised to meet public demand. The government's longstanding erasure and exclusion of registered counsellors and psychotherapists from policy and funding decisions presents a roadblock to service provision at a time of enormous and expanding need for community-based mental health services. Government recognition of registered counsellors and psychotherapists through subsidised sessions under the Better Access scheme would substantially reduce the ongoing access barriers to mental health services across Australia.

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