

SUBMISSION IN RELATION TO “PROPOSED REGULATION OF COUNSELLORS AND PSYCHOTHERAPISTS UNDER THE HEALTH AND SOCIAL CARE PROFESSIONALS ACT 2005.”

Some content of this submission is taken directly from the doctoral thesis of the author of this submission, Dr Finian Fallon. References included in this submission are included in the reference section of the thesis. The original thesis in full is available at:

http://doras.dcu.ie/21379/1/Finian_Fallon_10104097_Final_Submission.pdf

Background

The provision of psychological services with the aim of alleviating suffering among those in mental distress essentially emerged with the “discovery” of the talking cure by Freud and others in the late nineteenth century. Since then, particularly in Western culture, the provision of such services has evolved in complex and interacting socio-political, cultural, research and academic contexts.

During the intervening period, ownership of the talking cure function has been contested among various power groupings. In addition, in more recent years, the advent of technology has begun to threaten the eminence of the talking cure. Technology is challenging whether or not mental health interventions, or significant elements of these interventions, might be equally or better served in a technological milieu, rather than primarily in a face to face context. Also, the discovery and use of psychotropic medication has had a huge impact on the provision of services, leading to deinstitutionalisation in many Western countries. The use of medication has also led to a significant reduction in the provision of psychotherapeutic interventions in cases of more severe mental distress. Effectively, psychotropic medications are also competing with the provision of psychotherapeutic interventions in wider arenas of mental health distress.

It is generally recognised that there is a significant increase in mental distress in the West, particularly in relation to depression and anxiety, and that the prevalence of such distress may continue to rise. It is also recognised that talking therapies provide some benefit in alleviating suffering, equivalent to or better than the efficacy of medical interventions in the area of disease, in many instances (Lambert 2013). It has also been recognised that mental health interventions have the potential to save money for the State and may also reduce the known adverse mortality impact of mental illness. Acknowledgement of these facts, has led some countries to implement national policy changes that recognise the importance of mental health interventions for the general population. These actions have formalised the implementation of these policies through varying degrees of state involvement and regulation.

In Ireland, the history of the provision of services to alleviate mental distress has evolved in public and private contexts. Broadly speaking, these contexts might be described in the contemporary discourse as “medical” and “non-medical” contexts. Again broadly speaking, in Ireland the regulation of that element of the national mental health burden taken on by the State has been essentially formalised through the historic establishment and recognition of the Psychiatry profession and more recently by regulation of Psychologists under the auspices of the 2005 Act. In relation to the unregulated remainder of the field, wherein services have been provided in unregulated contexts, in the early 1990s the late Taoiseach, Charles Haughey described, “professions that only operate in the private sector” when he denied a request at that time to extend state regulation to what he then described as “non-medical psychological disciplines” (Feldstein 2011, p.67).

While there has been much debate about the use of titles such as psychologist, psychotherapist and counsellor it may be of relevance to remember that Carl Rogers began using the term “counsellor”

when he was unable to get certification as a psychotherapist (Totton 1999). In essence, it could be argued, there may be no difference between what might or should be achieved for clients whether a counsellor, psychotherapist (or psychologist) is providing the service. However, given the history of the power groupings involved, it seems that the differences in titles are as much derived from the self-interest of these groupings, as they may be derived from a desire to assist clients or patients.

Whether the professions of counsellor and/or psychotherapist ought to be subject to State regulation.

I will outline here a number of perspectives that have been offered in relation to this issue and then offer an opinion based on my experience of the Irish context.

Foisy et al. (2001) suggested that how psychotherapy is seen in different countries is dependent on a number of factors, including historical national and organisational factors, mental health priorities in national contexts, cultural issues, economic factors and social pressure. All of these factors may be at play in the Irish context. Foisy et al. also found that these elements were interlinked and generate complexity.

The regulation of psychotherapy in the US began largely as a result of psychotherapeutic malpractice cases taken against psychiatrists there in the 1960s (Freiberg 1978). This regulation coincided with the emergence around that time of alternatives to traditional psychoanalysis and the growth in the numbers of practitioners trained outside medical and psychiatric contexts. Freiberg recalled that the issue of training standards in psychotherapy was connected in law with the concept of standard of care (Prosser 1971) which placed not just an ethical obligation on a practitioner to be sufficiently well trained but also imposed a legal onus in this regard. Freiberg pointed out that the law required that practice should be grounded in the informed consent of clients and that where there was a conflict of interest between the interests of the practitioner and client, that the client's interest should generally take precedence.

One of the problems that will become increasingly challenging for the professions is that defining a boundary for what these professions do is becoming increasingly difficult. As has been referred to above, the introduction of technological interventions may eventually make significant elements of the professional intervention obsolete. As technological solutions are tested and enhanced, it will become increasingly difficult to corral and define what should be administered and to whom. Though statistics are scant, it appears that many people choose to begin their wellbeing journey online before they will consider approaching a psychological professional.

In the UK context, in discussing regulation McGivern et al. (2009) found that psychotherapists reported a fear that clinical psychologists were becoming the most dominant grouping arising from National Institute of Clinical Evidence (NICE) guidelines and IAPT policies. This fear is also expressed in an Irish context by colleagues. There is a fear that the existing State recognition of Psychologists under the 2005 Act has already given Clinical and Counselling Psychologists a professional advantage over those who have become practitioners via other routes, as this advantage may relate to employment in HSE contexts. As such, it may be necessary for the survival of the "non-medical" professionals to be treated on a par with Psychologists by means of State regulation through the same mechanism.

McGivern et al. (2009) in the UK, reported that there was no overriding political agenda driving development and implementation of regulation but rather that "a far wider process of regulatory assemblage is taking place, in which governmental organisations, professional groups, and a range of interested stakeholders are competing for position and influence." (p.8). Importantly, they

questioned whether state regulation was the appropriate route given the difficulty of regulation capturing the subtleties of practice saying:

But our data leads us to ask whether mandatory professional regulation, owned by the profession(s) of psychotherapy and counselling, in practice, may be a more effective way to protect the public than statutory regulation by a quasi-governmental body. (p.9)

Reeves and Mollon (2009) observed critically, that rather than being described as statutory regulation, the process of overseeing psychotherapy should be described as state regulation. In exploring the emergence of Empirically Supported Treatments and in supporting a principle-based rather than rule-based approach to regulation, Heidi, Neimeyer and Williams (2005) observed the difference between the US and European approaches to regulation in many economic spheres. They observed that the US approaches tended to be rule-based and somewhat prescriptive while European and Australian oversight tended to be more principle focused. They made an argument for principle-based approaches based on this cultural difference that was also grounded in the complexity of therapy.

Lees and Cleminson (2013), in discussing the common issues affecting psychotherapy and complementary and alternative medicine (CAM), proposed that there were critics of government proposals for regulation of psychotherapy among psychotherapists. They contended that therapists opposing current efforts to regulate saw this as an infringement of individual rights that externalised control and that was based on a consumerist perspective of therapy. They maintained that over-centralised power had been challenged by those who stand outside or apart from that power and that these kind of groupings were important in challenging prevailing ideas. They believed that psychotherapy contained two inherent contradictions “between radicalism and conformism” (p.203) and between political involvement and being detached or uninterested in political issues. The authors wondered whether contemporary psychotherapy and CAM would continue to offer the potential for a challenging position in light of legal requirements and what they perceived as the selfish dynamics of regulation.

Though they do not clearly differentiate between the terms psychology and psychotherapy Van Broeck and Lietaer (2008), in their review of European regulation of psychotherapy and psychology, asked if there is an ongoing need for psychotherapy, as other professionals in the health care field utilise evidence-based practice (EBP) interventions. These other professionals may include nurses and physiotherapists acting in psychological practice areas, with pain management or motivation training as exemplars. The potential benefits of technological interventions, proven under the auspices of EBP research principles, also threaten significant elements of the practice domain of psychotherapeutic interventions.

House (2006) reminded us of the George Bernard Shaw quote “All professions are conspiracies against the laity” and reasoned against what he describes as old fashioned hierarchical frameworks for psychotherapy in a postmodern world. Speaking in relation to the evolving regulation in the UK at the time, House believed that sound arguments against professionalization had never been adequately rebuffed. He also maintained that there seems to be an “inexorable and inevitable” (p.384) move towards professionalization with no grounding in logical argument. He presented the academicization of psychotherapy via university settings as giving adherents social standing, in contrast with what he described as the possibility of a vocational, craft-based practice grounded in practical skills and the ability to respond to intimacy, but which he believed also has low social standing.

Strawbridge (2010) contended that professionalization relates to the status claims and regulation of groups. She also outlined how professional power can be seen in the context of social control and referred to Foucaultian ideas of disempowering the individual that may ensue from professional status. She stated that “power struggles characterize the process of professionalization and emerging professions” (p.3). She pointed out that in contrast to the pursuit of power there were also the claims of altruism made by professions. From this, it may be seen that the realities of the dynamics between competing organisations that comprise the business of mental health should not be ignored as they act partly from self-interest while implementing delivery of altruistic activities. This aspect of the dynamics of mental health services seems to generate little comment in the Irish context, with the notable exception contained in the book edited by Higgins and McDaid (2014).

Davies (2009) pointed out that professionalization had been a consideration for psychotherapy since its beginning, in that a difference between those who had been trained and not trained was created. Professional organisations with oversight were also a part of this impetus. In relation to the UK, he believed that three periods of professionalization had been experienced by psychotherapy. The first was the establishment of training up to the mid-1970s, the second was as a result of the establishment of accrediting bodies thereafter and the third was the wave of state regulation and ratification in the 21st century. He reasoned that professionalization gave standing and kudos to the professional. However, he claimed that psychotherapy was relatively young as a profession and stood on the outside asking to get in rather than being on the inside. He argued that the pursuit of state approval and regulation presented a risk to psychotherapy in that it may become more involved in promoting its interests as it became more regulated.

In 1999, Kaye wrote about the possibility of practice that was not dependent on a hierarchical approach to therapy. Kaye contended that the act of providing psychotherapy was potentially supportive of the status quo in that it might seek to normalise behaviour. He believed in the importance of a position that derives from the client rather than from an authoritative position of the therapist, which may derive from the State. He believed in a socially critical psychotherapy which facilitates a client in locating their position in the social landscape. This argument, the need and possibility of maintaining a socially critical client-focused perspective in the provision of therapy, might be used in support of the need for a perspective that is somewhat independent of a state sanctioned or regulated provision.

Davies (2009) was concerned about the possibility of professionalization as generating a legalistic dynamic threatening the existing discourse between therapist and client. He also saw this as a threat to the way in which changes took place in culture and that those deemed to infringe the legal burden placed on practitioners would be punished. Davies reminded us that Freud accommodated the variation that existed among practitioners in practice and that each should be allowed to work in a way that suited their character and temperament. He recalled that Freud and Jung were aware of the dangers of rigidity and of the absence of any structure. Davies described a balancing act between creativity and a technical demand. He warned against the proceduralisation of practice which he believed could reduce creativity and innovation. His concern was that the rigidities of professionalization could wipe out the benefits of clinical knowledge and skill. He was concerned that the practice of therapy could become overly objectified.

It is my view that the non-medical professions being considered for this submission have so far failed to generate sufficient public awareness of their benefits and have not differentiated from others who may offer similar interventions. The regulation of the professions may force a leap into professionalization for the relevant organisations. However, this leap may sustain and enhance a

self-interested stance on the part of these organisations, rather than pushing forward the interests of clients.

In my opinion, the current structure of the “business” of psychological therapies has not served clients as well as it might. There are an excessive number of different organisations representing the interests of various modalities. This may be confusing for the public. It may better serve the public and reduce confusion to have all practitioners engage in a basic training, as suggested by the QQI standards, and include additional specialisations during or after this training. In essence the public should be confident of a minimum standard for all practitioners and the market should be allowed to decide over time which modalities are preferable.

If so, whether the professions ought to be regulated under the Health and Social Care Professionals Act 2005 or otherwise.

Given the existing situation with the regulation of Psychologists under the 2005 Act, if the professions are to be regulated, I believe that for the credibility of the non-regulated professions, they must be regulated under the same legal framework. Otherwise there is a risk of creating or sustaining a “second division” view of those who are not regulated under the 2005 Act.

If the professions are to be regulated under the 2005 Act whether it would be appropriate to regulate one or two professions under one registration board.

As referred to above, the use of the term “counsellor” evolved as a means to overcome barriers that Carl Rogers was experiencing in acting outside traditional power groupings (Totton 1999). As such the practical meaning of the description of a counsellor in a psychological context is perhaps no different to the meaning of psychotherapist (or psychologist in my view). No one profession should own each of the terms counsellor or psychotherapist separately, as there is essentially no difference between them. Regulation should not enshrine differences in meaning or ownership of these terms through assigning it to one particular grouping which has acquired it through historical accident. In my view any person who attains the specified QQI standard of training should be allowed to use any of these terms interchangeably to describe their work.

The appropriate level of “grand parenting” qualifications to be set for existing practitioners having regard to the QQI Awards standards

We have seen how US regulation evolved from malpractice suits in the 1960s (Freiberg 1978). Prosser (1971) reasoned that given the requirements of a duty of care towards clients or patients, in law the practice of psychotherapy should be grounded in formal learning. Therefore, it could be argued, an appropriately high level of education is necessary for a given intervention, particularly in the area of mental distress where lives are at stake.

In 1984 (Feldstein 2011), the accreditation requirements for full membership of the Irish Association for Counselling and Psychotherapy (IACP) were one year’s experience of providing counselling with an average of six hours supervised practice per week, or a training that was regarded as acceptable by the Executive Committee of the IACP. An accreditation committee was established by the IACP in 1986. As of 2014, the accreditation requirements included completion of an accredited or approved training, four hundred and fifty hours client work after completion of training, a ratio of ten hours client work to one hour of approved supervision during a minimum two-year period after training and a quarter of accreditation work in group, family or couple contexts (IACP website).

In my opinion, the low threshold historical accreditation standards are difficult to support in a regulatory and increasingly litigious context. Can the state support historically low thresholds for practitioners in the face of a potential legal action being taken against it for negligence?

Though the regulatory requirements appear to be arbitrary, and may be connected to a desire for professionalisation among practitioners, given the realities of the present setup and the State's duty of care, it seems necessary that the unregulated professions move towards higher training standards for existing and future practitioners.

Also, there is a general move in European contexts, where psychotherapy is regulated, to a Master's level training standard (Van Broeck and Lietaer 2008). In a European context, in the interest of maintaining the marketability and mobility of Irish qualifications it may be important to implement a Master's level training standard.

In the Irish context we have seen the PSI move to a Doctorate level training for Counselling Psychologists. Though this may be a decision made on the basis of altruism, it would also appear to benefit the standing of PSI members. As such, it represents a competitive move which might have the impact of driving out practitioners with lower academic levels of attainment in the similar way as so-called "good" currency is said to drive out "bad" currency. If we accept that this decision is also a step taken to gain competitive advantage over other practitioners, it can be seen how the fragmented nature of the professions in Ireland may need strong oversight in order to ensure a fair, equitable and orderly development of the market.

It is my belief that training standards (or more correctly academic attainment) relates to the credibility of the professions and its standing in relation to and among other professional groupings who may be encountered such as GPs and Psychiatrists. As such, if the professions are to have credibility among other professionals, this may partly have to do with the academic attainment expected of practitioners. It may be that a higher academic attainment may also give more credibility among the public. Furthermore, given the requirements in professional trainings for supervision and review, it may be that longer trainings can enhance the possibility of excluding those who are unsuitable for the profession.

In relation to grandparenting, it may be sufficient to give existing practitioners a generous amount of time to bring their training standard to the required level. The timescale for this could facilitate practitioners in attaining new qualifications at a cost broadly similar to the current annual continual professional development (CDP) expectations. Attaining these additional qualifications could, as would be expected, meet the annual CDP requirements of the existing accreditation bodies. An additional two year break from CDP requirements could be given to those who are required to attain Master's level training in this context, so as to further alleviate any additional cost burden that may arise from the added training expectations.

The appropriate level of qualifications to be set for future applicants for registration having regard to the QQI Awards standards

Given all of the above and the general direction of European oversight of the profession, I believe that a minimum standard of a Master's degree should be put in place. In summary, the benefits of this may be: increased credibility among public and other professionals and the increased possibility of ensuring unsuitable practitioners are excluded.

From the calculations made in my thesis referred to at the start of this submission, it seems that Ireland has one of the highest per capita ratios of therapists in Europe. There may be an

“oversupply” of therapists here. Though this is open for debate, if there is an oversupply, the implementation of a Master’s level training requirement may serve as a brake on excessive numbers of new entrants coming into the professions. It remains to be seen whether this is desirable for the Government.

The title or titles that ought to be protected for the exclusive use of registrants.

This submission has shown that the term “counsellor” was originally used to facilitate a break from the power groupings that prevailed at the time of Roger’s efforts to demystify the provision of psychologically supportive therapies. However, in Ireland we have managed to create a hierarchy of terms or professions (Clinical Psychologist, Counselling Psychologist, Psychotherapist and Counsellor), which in essence provide essentially the same service in dealing with clients who are distressed: the talking cure.

Given the expressed desire of government policy (in the Vision for Change document) to move away from diagnostic frameworks to a case formulation paradigm, it could be an appropriate time to begin to remove the focus on titles and professional boundaries from provision of services to a skills based approach to recruitment and regulation in the service of clients. In addition, where the QQI standards for the profession are met in trainings, there should be no practical need to differentiate between a counsellor and psychotherapist. To begin with, at a minimum, the terms counsellor and psychotherapist should not be separated. However, it should be that these terms are protected, where they are used in the context of providing psychological care.

Dr Finian Fallon MIACP 30/11/16

Address: ABC Counselling, 33 Kildare Street, Dublin 2.

Phone: 0876666425