1. Current situation Psychotherapeutic Professions

1. Identity of the psychotherapeutic professions.

In Australia, psychotherapy is a practice rather than a profession. There is no legally sanctioned definition of psychotherapy and not necessarily a consensus among those who claim to practice psychotherapy as to what activities are and are not included within the rubric of psychotherapy.

There is evidence of low public awareness of psychotherapy, and little research about public perceptions of the practice of psychotherapy. One study showed that the public preferred counsellors to psychologists or psychiatrists (Sharpley, Bond, & Agnew, 2004). There is evidence that psychotherapy (especially when practiced outside the most widely recognized professions) is not widely appreciated within the health system. In a major national mental health study, only 11% of women with a diagnosable mental disorder and 1% of women without a diagnosable disorder consulted a mental health professional other than a psychiatrist or psychologist (e.g. counsellors, social workers, welfare workers) in the previous year (McLennan, 1998).
This is no doubt due to the very low rate of referrals made by general practitioners in Australia, which in turn is influenced by the lack of Medicare rebates available for counselling services provided by non-psychologists (see section 3 below). The most comprehensive study to date found that only 2.7% of all GP referrals to allied health professionals in 2004-2005 are made to counsellors (AIHW: Britt et al., 2005). Since the AIHW study was undertaken, the Australian government has introduced national health insurance (Medicare) rebates for treatment of mental health problems with psychological services provided by psychologists or approved social workers. There is evidence that this has resulted in a substantial increase in referrals of people with disorders such as anxiety and depression to recognized professionals providing approved psychotherapy services. However this rebate does not extend to similar services provided by counsellors or psychotherapists who are not members of recognized professions such as psychology. Anecdotal evidence suggests that this has resulted in reduced referrals to psychotherapists and counsellors not recognized by Medicare.

Historically, the practice of psychotherapy has been organized in accordance with two broad categories of affiliation. One form of affiliation is with organizations that represent traditional human services and health professions or disciplines such as psychology, psychiatry and social work. The other form of affiliation is with organizations that represent specific forms of psychotherapy practice such as family therapy, psychoanalysis and psychodynamic therapies, experiential therapies, and cognitive behaviour therapy. The two forms of affiliation are not mutually exclusive and many psychotherapists are affiliated both with a profession and with a specific psychotherapy group. There are around 50 professional associations in Australia that are focused primarily on psychotherapy and/or counselling.
The distinction between the two forms of affiliation is important and relevant to the development of a national organization for psychotherapy, as will be discussed below. Some of the larger professional associations (such as psychologists) have sub-groups or interest groups with a specific focus on a form of psychotherapy practice. An example is the Psychoanalytic Psychotherapy Interest Group of the Australian Psychological Society.

**Affiliation by professional organization**

The traditional human services and health professions engaged in practice of psychotherapy are psychologists, social workers, medical practitioners (especially psychiatrists and general practitioners), occupational therapists and nurses. All of these, apart from social workers, are subject to registration at State level. This means that practice quality in general and psychotherapy practice in particular are subject to review by independent tribunals in the event of complaints initiated by the public or by a registration board.

In addition there are some emerging professions that are less clearly recognized but have sought professional standing. These include music, creative arts and other expressive therapists, and various types of counsellor (who come from a wide variety of Human Services backgrounds). These professions are not subject to registration and any review of service quality is undertaken by the professional associations. In some cases these associations are affiliated with the Psychotherapy and Counselling Federation of Australia (PACFA), whose role is discussed in greater detail in the following subsection.

**Affiliation by form of psychotherapy practice**

Australia has a large and diverse group of associations and organizations that support and promote specific approaches to psychotherapy. Requirements for membership of these
associations are quite variable and they vary greatly with respect to size of membership and level of activity.

PACFA is a peak body for this category of organizations. Altogether, 39 such organizations are currently affiliated with PACFA. To illustrate the diversity of groups affiliated with PACFA, members include the The Music and Imagery Association of Australia, the Dance Therapy Association of Australia, the Western Pacific Association of Transactional Analysis, the Australian Hypnotherapists Association, the Australian Association of Group Psychotherapists, Gestalt Australia New Zealand, Psychoanalytic Psychotherapy Association of Australasia, Victorian Association of Family Therapists. Notable by its absence is the Australian Association of Cognitive Behavioural Therapists, with whom a large number of psychotherapists, especially psychologists, are affiliated through the various state branches.

PACFA groups member organizations into the following categories:

- psychoanalysis/psychoanalytic psychotherapies,
- body-oriented psychotherapies,
- experiential therapies,
- expressive arts therapies,
- family/relationship therapies,
- integrative psychodynamic psychotherapies, and
- general counselling/psychotherapy.

Again, it is worth noting the absence of any provision for cognitive or behavioural therapies. What this means is that, at the present time, PACFA is peak body for psychotherapy, other than cognitive behaviour therapy.
The members of PACFA affiliated organizations will in many cases also be members of the traditional human services and health professions. However, it is important to note that it is not the traditional profession that is affiliated with PACFA but rather an organization with a focus on a specific modality of psychotherapy.

PACFA has been active in research of its members and a reasonable amount is known about the orientation and work practices of those psychotherapists who belong to PACFA affiliated organizations.

(a) The majority of PACFA-affiliated psychotherapists work primarily in private practice (50%) in Australia and a further 20% work in non-government organizations or community health (Schofield, 2008). Few work in government mental health services.

(b) A 2004 survey found that 30% of PACFA members identified psychodynamic as main theoretical influence, 26% eclectic/integrative and 12% humanistic/existential/experiential (Schofield, 2008). This contrasts with an earlier survey of Australian counselling psychologists (Poznanski & McLennan, 1998) which identified the main theoretical orientations as cognitive-behavioural (30%), followed by psychodynamic (17%), family systemic (11%), behavioural (8%), and eclectic (7%). This difference is probably reflects failure of the main association with which CBT therapists affiliate (AACBT) to affiliate with PACFA. This means that, while CBT may be the dominant psychotherapeutic orientation in Australia, relatively few of these psychotherapists are affiliated with PACFA.

(c) Whereas the traditional professions (aside from social work) are regulated by State government authorities, PACFA has undertaken a self-regulation role for
affiliated practitioners, in close consultation with government bodies. PACFA is working towards incorporation into a government led national regulatory model.

The Australian Counselling Association (ACA) also claims peak body status and, like PACFA, aims to provide uniform training standards and complaints procedures. ACA claims a membership of approximately 3000 individuals but its level of organizational affiliation is far below that of PACFA. It recognizes a greater diversity of training programs including a large number of programs offered by private providers. While the boundaries between counselling and psychotherapy are rather fluid in Australia, we think that PACFA more clearly represents associations whose focus is primarily psychotherapy, whereas ACA represents a broader group that includes some associations with a psychotherapy focus but also includes both individuals and associations whose focus would be more properly described as counseling.

2. Relations among the psychotherapeutic professions.

While there is a broadly collegial climate among professions, there are identifiable tensions that are associated with:

- Differences in whether the practice of the psychotherapist is regulated by government or not, and whether or not it is recognized formally as a profession. Being recognized as an allied health profession is increasingly being used as a gateway to other forms of recognition. Notwithstanding the progress made by PACFA, psychotherapy is not currently recognized as a profession. Professional recognition depends on the psychotherapist being a registered professional such as a psychologist or a nurse or belonging to a profession such as social work that is recognized by government in various ways other than by registration.
• Differences in earning capacity between professions (partly related to level of state subsidy of services – see 3, below). Practitioner’s providing psychotherapy are inevitably aware that a colleague may earn two or three times the fee while providing the same service. Fees are not subject to usual market forces because the amount paid by the client is substantially a function of the level of subsidy provided either by the state or by employers or private insurers. Level of remuneration in salaried positions is usually a function of profession rather than services provided. A salaried psychiatrist providing psychodynamic psychotherapy will have substantially greater earnings than a social worker providing the same form of psychotherapy, even though the social worker may have more specialist training in the specific therapeutic approach.

• Differences in authority within professions (e.g. clinical psychologists compared with counselling psychologists). There may be tensions associated with claims to expertise within a recognized profession that are not mutually recognized.

• Perceived differences regarding level of expertise, capacity to make clinical judgments and assume clinical responsibility, level and appropriateness of training between people who are identified with or affiliated with different models of or approaches to psychotherapy, Cognitive behaviour therapists frequently claim a stronger evidence base for their practice and this claim has influenced public funding for psychotherapy services. Psychoanalysts and psychoanalytic psychotherapists have specific training requirements that include substantial periods of personal therapy and tend to have reservations about other training models.

As a result of these differences, it has been difficult to form a coherent national approach to the organization of psychotherapy. PACFA has provided the primary impetus towards the
development of a coherent national organization of psychotherapy and has met with substantial success through affiliation of groups representing a wide range of approaches to psychotherapy. However, as noted in section 1, above, there has been notable failure to affiliate with CBT therapists and to engage the major professions such as psychology, medicine and social work, although these professions are represented among the membership of PACFA affiliated associations.

3. Relation of the professions to the health care and/or social service systems.

Australia has a national and state funded health care system (including a compulsory national health insurance scheme), with a parallel private practice service environment. Public mental health services receive block funding and have a substantial degree of autonomy as to how this funding is used, but relatively little goes specifically to fund psychotherapy. Most mental health positions within the government health sector are restricted to core professional groups such as psychiatry, psychology, occupational therapy, social work and mental health nursing. There are some exceptions to this such as substance abuse counselling, and child and youth mental health services where drug treatments are less universally employed.

There is an expectation that public services will be responsive to people most in need, which means that intensive, longer-term psychotherapeutic treatments are unlikely to be the dominant form of service provision. There are a range of non-government services that are in receipt of public funding and which provide psychotherapeutic services, typically counselling.

Level of public funding for the private practice environment, under Medicare (the national, universal health insurance system) is highly variable both as to reimbursement per session of treatment and as to number of sessions subsidized. Psychotherapy provided by private psychiatrists receive substantial subsidy per session at a rate of $150 per session approx for an
extended duration of treatment. Psychotherapeutic services provided by professionals such as psychologists, social workers and occupational therapists are subsidized in the range of $75 (psychologist) and $110 (clinical psychologist) per session for up to 12 sessions of treatment. There is no subsidy for other practitioners.

II. Future Prospects of Psychotherapeutic Professions

4. Factors instigating change in the psychotherapeutic professions.

   Government bodies have a strong commitment to “evidence-based practice” and this has largely been defined by public funders of psychotherapy services as CBT and interpersonal psychotherapy (IPT). For instance, Medicare rebates are restricted to these narrowly defined empirically supported treatments. PACFA has been widely engaged in an education and advocacy role to expand understanding of EBP among policy makers. It has drawn on the APA guidelines on evidence-based psychological practices for this work. However, the influence of the CBT adherents is very strong and the proposition that there are one or two evidence based psychotherapies is appealing to policy makers because it simplifies decisions as to what services will be funded.

   There is anecdotal evidence that many practitioners subvert the intention of policy by describing their interventions as CBT, even though they may have very weak fidelity to standard manualised CBT interventions.

5. Basic skills to be required for training and practice in the psychotherapeutic professions.

   As indicated in section 1, above, this issue has to be considered at two basic levels: the level of the recognized human services and health professions and the level of associations for
specific modalities of psychotherapy. Training and practice requirements are set by both levels. Because the individual practitioner will often be both a member of a recognized profession and a member of a specific psychotherapy association, both levels of training may be relevant.

Professional organizations such as those for social work and nursing typically require as a minimum a generic skill set and do not specify advanced training in psychotherapy. However, some professions such as psychology and psychiatry provide for specialist recognition for people who have undertaken additional and more specialist training in psychotherapy. Some of the more established psychotherapy bodies do accredit more specialised levels of training, as well as accredit trainers and supervisors.

PACFA has defined broadly a minimum set of training standards that are generic enough to be able to be applied across all therapeutic modalities. There has not been a strong focus on skill-sets or competencies in the past, but these concepts are now being pushed more by government bodies. One example is a push for counselling competencies within the Vocational Training Sector. Another example is within the family mediation area, where government has developed one year Vocational Diplomas to train family dispute resolution specialists to undertake the sort of work that would previously have been undertaken by a much more highly trained family/couple therapist or relationship counsellor. There is a concerning trend that such skills are being seen by bureaucrats as essentially problem-solving and mediation issues rather than involving the need to address complex relational dynamics.

PACFA’s current training standard specifies at least Bachelor degree or equivalent plus a minimum of two years, 200 hours of person-to-person psychotherapy and/or counselling training and 50 hours of supervision relating to 200 hours of client contact. A minimum of 10 hours of supervision relating to 40 client contact hours must have taken place within the training program.
as part of the 50 hours of supervision). From 2009, two training pathways are recognized: a Postgraduate Equivalent qualification, over a minimum of two years, 200 hours of person-to-person psychotherapy and/or counselling training and 50 hours of supervision relating to 200 hours of client contact, OR an Undergraduate Equivalent qualification, over minimum of three years, 350 hours person-to-person training in counselling and or psychotherapy and 50 hours of supervision relating to 200 hours of client contact. Both pathways require a minimum of 10 hours of supervision relating to 40 client contact hours within the training program as part of the 50 hours of supervision.

Specific psychotherapy organizations set their own training standards, some of which substantially exceed those specified by PACFA. Some forms of psychotherapy, most notably those in the psychoanalytic tradition require personal therapy as well as knowledge, skills and practice training.

6. Relation of psychotherapy research to the psychotherapeutic professions:

Evidence-based practice (EBP) is strongly endorsed among all professions providing psychotherapy and among publicly funded services. However, there is not a common understanding as to what EPB means. For some it means application of empirically supported treatments but the majority would endorse something closer to the APA statement. Publicly funded mental health services routinely collect outcome data under a national program that has been operating for more than 5 years, however this has not so far been successful as a means of evaluating the effectiveness of specific treatments. There is a widely held perception that CBT is the only or most evidence based psychotherapy. The public funding of psychotherapy provided in private practice settings by psychologists, social workers and occupational therapists is restricted to provision of a set of interventions that could be broadly termed CBT.
References


