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"Be Careful What You Wish For"

Professional Recognition, the Statutory Regulation of Counselling, and the State Registration of Counsellors

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Abstract

In the context of the debate about the state registration of counsellors in Aotearoa New Zealand, and drawing both on similar debates in the field of counselling in the United Kingdom and on the experience of psychotherapists in this country, this article first articulates a distinction between the terms recognition, regulation, and registration; second, it summarises a number of arguments against the statutory regulation of counselling and the state registration of counsellors; and third, with reference to the cultural, economic, professional, and philosophical context of counselling, it argues for a vision of counselling and counsellors independent of state control of the profession and of its professionals.

Keywords: professional recognition, regulation, registration, the HPCA Act

The three "Rs": recognition, regulation, and registration

While these terms are quite distinct, it is apparent that in debates about professional recognition and regulation they are often conflated—and, sometimes, deliberately so. Broadly, recognition refers to the identification and acceptance of something, in this case, a profession, by an external authority, such as the state; regulation refers to the promulgation, monitoring, and enforcement of rules, and, as such, has personal and developmental as well as professional and organisational connotations; while registration refers to a system whereby names are entered on what was originally a "register," such as that of a professional association or organisation. In the first part of this article, I discuss these three "Rs" in some more detail.

Recognition

One of the arguments made for the statutory regulation of a profession and the state registration of its practitioners is that it gives the profession certain recognition and, thereby, greater status, credibility, influence, and so on. This is an argument that was made by some psychotherapists during debates about seeking regulation under the Health Practitioners Competence Assurance Act 2003 ("the HPCA Act" or "the Act"): "I think we should go for registration as all the other health providers will be. If we don't we lose credibility" (as cited in Manning, 2006, p. 28). There are, however, a number of problems with this argument.

The first is that it discounts both the standing and the independence that the profession, in this case, counselling, already has. As an activity, counselling is already "recognised" by the general public and the media, considerably more so than psychotherapy, which is much less understood; and it fulfils the criteria of a "profession" in terms of the dictionary definition of the word. Moreover, "counsellors" already appear on the list of the Australian and New Zealand Standard Classification of Occupations (Statistics New Zealand, 2013)—as no. 2721, with sub-categories of: careers counsellor, drug and alcohol counsellor, family and marriage counsellor, rehabilitation counsellor, and student counsellor. We all need recognition, indeed, Eric Berne, the founder of transactional analysis, identified recognition as a "human hunger" (Berne, 1970/1973); however, seeking and relying on the state to provide an—or, worse, *the*—external locus of evaluation of such recognition appears to be giving away too much, and perhaps suggests a certain lack of self-confidence and/or identity as a profession.

The second problem is that such recognition appears more reactive than proactive. Moves towards professional recognition through statutory regulation appear largely based on a reaction to what certain other professions are doing, and as the result of an invidious domino effect whereby disciplines such as psychotherapy argue for such recognition, at least in part on the basis that psychologists are registered, and then counsellors argue that they should have it on the basis that psychotherapists have it, and so on. This argument is represented by Rodgers (2012) in his article on shifting landscapes of counselling identities in this country, when he argued (without reference to any sources) that:

> *It has been suggested that for counsellors, not being covered by the HPCA (2003) places them at a professional disadvantage, given that psychologists and psychotherapists are registered under this act…[and] that counsellors may be*

> *seen as less professional than psychologists and psychotherapists, resulting in their restricted employment, or limited access to funding.* (pp. 193–194)

However, the third, and perhaps the greatest problem with the argument for such recognition, concerns seeking professional recognition by means of the HPCA Act. The Act is clearly concerned with the protection of the public from the risk of harm. It is not—and should not be used as—a vehicle for a profession to gain recognition from the state, a point which drew a comment from the Ministry of Health (MoH) in 2010:

> *It was noted during the Director General's review [of the Act] that "a large number of occupational groups are seeking to become regulated, but concern over risk of harm to the public is often not the main driving force." For example, regulation is perceived as giving "mana" to a profession or it may enable the profession to gain funding (eg, Accident Compensation Corporation subsidies or other contracts).* (MoH, 2010c, p. 6)

Clearly, as far as the Ministry is concerned, statutory regulation should not be about seeking mana, as a profession should already have it. This had already been confirmed in the review undertaken by the Director-General of Health in 2009 when, as part of the criteria for assessing applications of new professions under the Act, he considered as evidence that service providers "accord any standing or status to the profession and the qualifications" (p. 62) *prior* to the application. In terms of studying the experience of psychotherapy and, specifically, that of the New Zealand Association of Psychotherapists (NZAP) (see Bailey & Tudor, 2011; Dillon, 2011; Manning, 2006), it is clear that the "public protection" argument was not held as the central argument in seeking regulation under the HPCA Act, but that the Act became a means to an end: that of seeking further state recognition and status for the profession and a kind of parity with psychologists. Both prior to regulation and following regulation, it is clear that this strategy has caused considerable divisions within the NZAP and the profession, evidenced by the fact that, currently, some 22% of members of the NZAP are not registered with the Psychotherapists Board of Aotearoa New Zealand (PBANZ, or "the Board").

A further, related argument is that professional recognition through regulation under the HPCA Act would clearly position counselling as a health profession. While this may be uncontentious for some, for others such close alignment with "health" is problematic for a number of reasons, especially as "health" so often means illness; as health and health care are dominated by the medical paradigm; and as health systems,

policies, and practice in this country are predominantly based on Western models of health at the expense of indigenous models of health, wellbeing, and dis-ease (for more on which see the following section and the second part of the article).

Regulation

There are a number of models of regulation (see Figure 1 for a summary).

Figure 1: Models of regulation (based on Macleod & McSherry, 2007)

From this it is clear that in debates about regulation, a profession could—and, arguably, should—consider a range of options, all of which have different implications. With regard to the first three options, broadly "voluntary registration" (as is the scheme in the UK and in most countries in the world), the profession retains more or less control over the scope and processes of regulation. The last three models, broadly "statutory registration", give over regulation of certain professionals and, increasingly, the regulation of the profession as a whole, to government and state control. Practitioners thinking about statutory regulation should be clear that the reservation of title means precisely that: the particular title is reserved for those practitioners who are registered; others may not use the title—or, if they do, they risk prosecution. Currently, under the HPCA Act, the regulated professional titles are: chiropractor; dentist (including dental technician, clinical dental technician, dental therapist, and dental hygienist); dietitian; optometrist and dispensing optician; medical practitioner (such as GPs, psychiatrists, surgeons, and other specialists); medical auxiliary (including medical laboratory technologist, and medical radiation technologist); midwife; registered nurse; occupational therapist; pharmacist; physiotherapist; podiatrist; psychologist; and psychotherapist (including interim, and with child and adolescent speciality).

The protection of the public—and these titles—is administered under the Act by "responsible authorities" (RAs) for each profession (the Chiropractic Board of New Zealand, the Dental Council of New Zealand [DCNZ], etc.) which have the power to extend such "scopes of practice" (see Section [s] 11 of the Act). Since 2003, different RAs have created different titles and have thereby, in effect, regulated, or attempted to regulate, not only the particular clinical practice but also related activities such as consultation, education (and training), management, policy, and research. Several of the RAs do not explicitly define these roles and therefore appear to have no intention to define or control practitioners undertaking them; others, such as the DCNZ and the Pharmacy Council of New Zealand, acknowledge these additional roles and assert that, as they all influence public safety, they require anyone undertaking them to be a registered practitioner. On the basis of the experience of the PBANZ (Fay, 2011b; Tudor, 2011b), and my own research into the various scopes of practice determined by the RAs (Tudor & Shaw, 2013), it is clear:

a) That the various RAs have different views about the extension of scopes of practice beyond the clinical scope (see Tudor & Shaw, 2013).
b) That some RAs (and, notably, the PBANZ) tend to want to extend their influence

over the profession. In his report on the first review of the Act, the Director-General of Health (2009) reported concerns that had been voiced by submissions to the review, "that authorities do not take full account of professional perspectives or experience when they develop scopes of practice" (p. 5), and that is certainly the experience from psychotherapists and other healthcare providers (Tudor, 2011b, 2012).

c) That these differences among RAs represent different models of regulation (see Figure 1), and that some have claimed and are working towards the most restrictive model of reservation of title *and* wholescale practice restriction.
d) That, once a title is regulated under the Act, the profession loses control over its scope or scopes, its development, and, ultimately, its identity.

The statutory regulation of counselling, via the state registration of counsellors, is, however, not inevitable. The MoH has made it clear that:

> *Occupational regulation can occur through a range of mechanisms. Statutory regulation is one option, but other industry-led mechanisms are also effective.… Self-regulation allows these groups to assure the public of quality and promote the good standing of their professions.* (MoH, 2010b, p. 6)

In a recent document regarding the 2012 review of the HPCA Act, the Ministry of Health (2012) included an appendix on models of occupational regulation, including one which is described as "The simplest form of regulation…for a responsible authority to maintain" (p. 47). This is in line with the concept of "right touch regulation" (Council for Healthcare Regulatory Excellence, 2010; see Bilton & Clayton, 2013).

One issue with counsellors seeking regulation under the HPCA Act is that it would clearly mean that they and counselling as a whole would be aligning themselves with the above "health professions." Indeed, one of the purposes of the Act is to provide for "a consistent accountability regime for all health professions" (s 3(2)(a)) and, indeed, the 13 professions originally encompassed by the Act were all health professions closely allied to medicine. More recently, the MoH (2010a) has asserted that: "Having one legislative framework allows for consistent procedures and terminology across the professions now regulated by the Act." Clearly, the idea was—and is—that any profession regulated under this Act is viewed as a health profession, and that it adopts "accountability regimes," "procedures," audits, etc., terminology which represents medical and managerial paradigms, for a critique of which see Postle and House (2009), King and Moutsou (2010), Cornforth (2011), Embleton Tudor (2011), and

Tudor (2011c). What this ignores or discounts is the fact that counselling is a practice which is different from other health professions and their practices—of prescribing (medicine, and pharmacy), or which involve certain invasive procedures (dentistry, optometry, medicine) or physical manipulation (chiropractic, osteopathy, physiotherapy, and podiatry). For a discussion of the nature of the HPCA Act, see Tudor (2011b).

A second issue with the HPCA Act is that it contains no reference to Te Tiriti o Waitangi/The Treaty of Waitangi. At the time (in 2003) the MoH justified this omission on the basis of Crown Law advice and a Waitangi Tribunal (2001) finding in the Napier Hospital claim that the New Zealand Public Health and Disability Act 2000 makes adequate provision for Crown Treaty responsibilities in the health sector (see p. 57, for further discussion of this point).[1] This was questioned by a number of submissions to the recent HPCA Act Review, which the MoH has summarised (MoH, 2013).

Another concern for counsellors and counselling is that once a profession gives away its regulatory authority and power to the state, it is virtually impossible to reclaim it. For psychotherapists, and the field of psychotherapy as a whole, some of the implications of this were not anticipated—although many of the problems encountered were noted in earlier literature (cited above). This has included the Psychotherapists' Board attempting:

1. To extend its scopes of practice from the clinical scope to encompass "all roles that a psychotherapist may assume such as client care, research, policy making, educating and consulting" (PBANZ, 2008)—but doing so *without consultation*, and thus in breach of the Act (s 11, s 14(2)).
2. To create an additional scope of practice, that of an overseas "Visiting Educator," which it later had to withdraw due to the widespread response from the profession (for a detailed analysis, see Tudor, 2012).
3. To accredit psychotherapy education/training programmes, despite the fact that there is no need to do this as it already recognises training courses which provide "current Board approved qualifications" (see PBANZ, 2013), and the fact that there is no research evidence to support the view that such courses need to be accredited in order to protect the public.

The Board has also, in effect, extended its scopes of practice as it has introduced a supervision policy whereby it approves (or disapproves) the psychotherapist's choice of supervisor (PBANZ, 2012). When two senior practitioners, who were not registered,

applied to be "Board approved supervisors," their applications were declined not because they were incompetent supervisors (the HPCA Act is concerned with competence), but on the basis of their opposition to the Act and to state regulation!

Questioning and challenging the PBANZ has entailed a lot of time and energy for some people, at some considerable cost. For further, detailed discussion and critique of the Board's activities, see Fay (2011b), Sherrard (2011), Tudor (2011b, 2012).

This discussion of regulation has focused on some of the implications of regulatory policies and authorities—in effect, the politics of regulation. There is, however, another aspect to this which concerns the neuroscience of regulation: attachment, hierarchical organisation and homeostasis, co-regulation and self-regulation, self-esteem and gaze. These two aspects of regulation—the political and the neuroscientific—have been brought together by Embleton Tudor (2011) in a text which challenges us to think about both the personal motivations behind moves towards statutory regulation by, in effect, another, and about whether, as an operating philosophy and practice, such external regulation matches NZAC's values, as expressed in its Code of Ethics (NZAC, 2002/2012), including those of partnership, autonomy, and social justice. As Webb (2000) put it:

> *Ideally a professional association will work best if its own operating philosophy matches that it wishes to promote in relation to its core focus. Thus, the philosophy of a counselling association, its systems and practices, should reflect the beliefs about human nature, human relationships, and human change and development, which underpin the practice of counselling.* (p. 303)

In my view, statutory regulation does not reflect the human need—developmental and organisational—for co-regulation and the support for and development of self-esteem, or the ability to act in and on the world for good.

Registration

There are essentially two forms of registration: voluntary registration, that is, with a professional association; and state registration, that is, in this country, for health professionals, with an RA under the HPCA Act.

The logic of registration under a regulatory scheme which reserves a specific title is (as noted above) that only those people who are registered may refer to themselves using that title. There are, however, some significant differences between the last three models in Figure 1.

With regard to the fourth model, "Reservation of title," while the title (chiropractor, dentist, etc.) is reserved, the practice is not; thus, currently in this country, it is possible to practise psychotherapy without being a psychotherapist, as being a psychotherapist is not mandatory. As long as a practitioner does not "hold themselves out" to be a psychotherapist, then s/he may practise psychotherapy as a counsellor, a kaiwhakaruruhau/wahine Māori social and mental health practitioner, a priest, a psychodramatist, a psychoanalyst, a transactional analyst, a traumatologist, etc.—and we know from the history of counselling and psychotherapy in Aotearoa New Zealand, and of the NZAP and its admissions process, that there are many members of the NZAC who, on the basis of their training, experience, and practice, would legitimately claim to be practising psychotherapy. While some advocates of state registration would claim that this point is one by which opponents of state registration are looking for legal loopholes, such claims (and, at times, accusations) both misunderstand the nature of the relevant legislation, i.e. the HPCA Act, and, more importantly, deny fundamental human rights such as freedom of expression and practice.

The fifth model is significant in that it marks a transition between the reservation of title only and the reservation of certain core practices, a model which restricts both the title and some activities or practice, usually designated as "restricted activities," such as certain surgical procedures, clinical procedures involved in the insertion and maintenance of certain orthodontic or oral appliances, etc. For a while (2007–2010), there was an additional restrictive activity of "performing a psychosocial intervention with the expectation of treating a serious mental illness"; however, in April 2008, the MoH consulted on a proposal to remove or amend this, following which it recommended to the Minister of Health that Cabinet approval be sought to revoke this restricted activity, which it did in December 2009, an authorisation which came into force in January 2010 (see MoH, 2010b). This was particularly significant as it was the only restricted activity identified by the government as relating to the profession of psychotherapy (see MoH, 2007) and, importantly, suggests that the government is only wanting to restrict the title "psychotherapist" to those who are registered with the Board, and not to pursue a model of practice restriction. This makes the Board's moves to further restriction of practice even more worrying, and of concern not only to psychotherapists and those practising psychotherapy, but also to those such as counsellors seeking registration with a similar "responsible authority."

Arguments against the statutory regulation and state registration of counsellors

In the second part of this article, I note the key arguments against statutory regulation of psychotherapy and counselling and the state registration of psychotherapists and counsellors, and give references to the extensive literature on the subject—see Hogan (1979), Dawes (1994), Mowbray (1995), House and Totton (1997), Wampold (2001), Postle (2007), Parker and Revelli (2008), Postle and House (2009), King and Moutsou (2010), Smith (2011), and Tudor (2011d, 2011e, 2012). Despite repeated calls for proponents of regulation and registration to present coherent, robust, and evidence-based arguments in favour of regulation and registration, none has been forthcoming.

From my reading of the literature, I suggest that the arguments against regulation and registration fall into three main categories (see also Tudor, 2011a).

1. ***Objections in principle to the statutory regulation of counselling and the state registration of counsellors***

These objections encompass a number of perspectives, including:

- Generic and specific arguments against professionalisation.
  See Totton (1997a, 1997b, 1999), House (2003, 2010), and Pollard (2009).
- Philosophical objections to regulation and registration.

Mowbray (1997) identified four assumptions which underlie and perpetuate most "arguments" in favour of regulation and registration: the assumptions of inevitability, necessity, benefit, and preference, each of which he refuted (see also Tudor, 2011c).

- A critique of the notion that regulation and registration protect the public—when they do not.

See Gross (1978), Hogan (1979), Koocher (1979), Alberding, Lauver, and Patnoe (1993), Mowbray (1995), and House (2009).

- A critique of the assertion that registered/licensed practitioners are less harmful than those who are not registered—when they are not.

As Rogers (1973) put it:

> *There are as many* certified *charlatans and exploiters of people as there are uncertified.… Certification is* not *equivalent to competence…[and] tight professional standards do not, to more than a minimal degree, shut out the exploiters and the charlatans.*

- That regulation and registration are not in the public interest.

As Pfeffer (1974) observed:

> *It must be concluded that the outcomes of regulation and licensing are frequently not in the interests of the consumers or the general public. It is difficult to find a single empirical study of regulatory effects that does not arrive at essentially this conclusion.* (p. 474)

Pfeffer continued:

> *In a review of the outcome of regulation and licensing, we have found that the effect is almost always to enhance the position of the industry or licensed occupation at the expense of the public at large.… There is evidence that administrative regulation and licensing has actually operated against the public interest; and that rather than protecting the public from the industry, regulation has frequently operated to protect and economically enhance the industry or occupation.* (p. 478)

- That it entails a net harm.

  See Freud (1926/1959), and Hogan (1979). According to Hogan (1979) licensing laws are a significant factor in:

  1. *unnecessarily restricting the supply of practitioners [by introducing monopolistic factors into the market];*
  2. *decreasing their geographic mobility;*
  3. *inflating the cost of services;*
  4. *making it difficult for paraprofessionals to perform effectively;*
  5. *stifling innovations in the education and training of practitioners and in the organization and utilization of services; and*
  6. *discriminating against minorities, women, the poor, and the aged [by raising entry requirements in terms of time, cost, and academic prerequisites]. (pp. 238–239)*

- That it takes too much responsibility for clients.

  See Freud (1926/1959) and Gloster-Smith (2009).

- That it creates a false security.

  See Mowbray (1995), House (1996/1997), and Postle (2007).

- That it leads to and/or promotes a regulatory culture in the field of counselling.

  This is based on a legalistic, managerial response to the exigencies of professional organisation and relationships, which seeks to standardise and simplify experience, relationship, and dialogue about professional and ethical behaviour (see House, 2009; Postle, 2007).

- That it enforces the status quo and closed systems.
  See Shaw (2011).
- That it actually lowers professional standards.
  This is due to the fact that, in an attempt to encompass the whole field, regulatory authorities tend to set the entry bar at a low common denominator.
- That it restricts trade and practice.
  See Freud (1926/1959), Mowbray (1995, 1997), and House (2009).
- That it leads to defensive practice.
  See Bollas and Sundelson (1995), Mowbray (1995), and Clarkson and Murdin (1996); also that regulation tends to ossify therapeutic practice (Hogan, 1979; House, 2009), and restricts creativity, diversity, and development of the field (Rogers, 1973; Richardson, 1997; Director-General of Health, 2009).
- That it reduces access to the variety of therapies or approaches to counselling.
  As the experiences of colleagues in the USA, the UK and, more recently, Australia, demonstrate, government involvement in the field of therapy tends to lead to economic restrictions on what forms of therapy, including counselling, are approved for funding (see Layard, 2005), despite the evidence of research.
- That it is anti-therapeutic.
  See Postle (2007), Pollard (2009), Rogers (2009), and Gloster-Smith (2009).
- That it restricts therapeutic thinking.
  See House (2003, 2009), Postle (2007), and Association of Independent Psychotherapists et al. (2009).
- That it compromises academic freedom.
  See Association of Independent Psychotherapists et al. (2009), Edwards (2009), Gloster-Smith (2009), House (2009), Postle (2007), and Rogers (2009). Following the example of the New Zealand Psychologists' Board (NZPB), it appears likely that the PBANZ will seek to require that the educators/trainers of students/trainees training in psychotherapy must themselves be registered psychotherapists, and any counselling registration authority would be likely to follow this thinking.

2. An objection to the fact that the Act makes no reference to Te Tiriti o Waitangi / The Treaty of Waitangi

At the time the Health Practitioners Competence Assurance [HPCA] Bill was in progress through Parliament, this omission of Te Tiriti/the Treaty was justified by the MoH (2003) in a three-page statement in which it asserted that:

> *The Treaty of Waitangi provisions in the NZPHD [New Zealand Public Health and Disability] Act [2000] convey what the Crown, itself and through its DHBs, has done, is doing, and will do under the Treaty for Maori health.*
>
> *The HPCA Bill establishes a regime for the registration and discipline of health practitioners. No additional or new Treaty interests are put in issue under the HPCA Bill.* (p. 2)

The issues raised by this omission and assumption, as well as other omissions, are taken up and discussed with regard to psychotherapy by Morice and Woodard (2011).

Given the NZAC's commitment to biculturalism, and the various explorations of the meaning of this commitment and, indeed, of te Tiriti/the Treaty itself for counselling (Campbell, 1990; Crocket, 2009, 2012, 2013; Davis, Elkington, & Winslade, 1993; Drury, 2007; Durie, 1999, 2007; Hepi & Denton, 2010; Lang, 2003a, 2003b, 2004, 2007; Manthei, 1990; Mulqueeney, 2012), it would appear that the absence in the Act of any reference to te Tiriti/the Treaty would—or should—give the NZAC second thoughts about the regulation of counselling under this Act. Moreover, if there were any danger that current Māori counsellors would be disadvantaged and, potentially, not eligible for state registration—the PBANZ has, to date, refused to recognise the NZAP's He Ara Māori pathway for membership (see NZAP, 2013) as a pathway for state registration—the concept of "distributive biculturalism" (Sharpe, 1997; see also Crocket, 2013) would also suggest that the NZAC would reject such a regulatory regime.

3. Concerns that the HPCA Act is not the appropriate legislation for the regulation of counselling by means of the registration of counsellors

In addition to the critiques noted above, these concerns encompass a number of issues:

- Regarding the risk of harm.

In order for counselling to be included under the framework of the HPCA Act, the NZAC and other counselling organisations would have to make the case to the MoH that counsellors pose a significant risk to the public. Elsewhere I have noted the contortions in which NZAP engaged in order to meet this criterion (see Tudor, 2011b). Since then the MoH has put out a discussion document, *How Do We Determine if Statutory Regulation is the Most Appropriate Way to Regulate Health Professions?* (MoH, 2010c), in which it proposed applying six "second-level criteria" to the assessment of the risk of harm (see Table 1).

Table 1. Criteria for statutory regulation (based on MoH, 2010c) and responses

Criteria	Responses with regard to counselling in Aotearoa New Zealand
Criterion 1: The activities of the profession must pose a significant risk of harm to the health and safety of the public.	There is no research-based evidence that they do.
Criterion 2: Existing regulatory or other mechanisms fail to address health and safety issues.	The mechanisms of membership within the NZAC do not fail to address health and safety issues, in addition to which, all healthcare providers are covered by the *Code of Health and Disability Services Consumers' Rights* (Health and Disability Commissioner, 1996).
Criterion 3: Regulation is possible to implement for the profession in question.	This is possible—but the question is whether it is desirable (see references to literature).
Criterion 4: Regulation is practical to implement for the profession in question.	It may or may not be practical—the view from and experience of psychotherapy is that statutory regulation has, in effect, excluded elders and marginalised Māori practitioners, as well as alternative forms of regulation and registration.
Criterion 5: The benefits to the public of regulation clearly outweigh the potential negative impact of such regulation.	In terms of the research evidence, they do not.
Criterion 6: It is otherwise in the public interest that the provision of health services be regulated as a profession.	There is no evidence that the regulation of counselling is in the public interest; moreover, this criterion assumes that counselling is and/or should be considered as a health profession.

- Regarding the question of whether counselling is best viewed, positioned, and regulated as a health profession.

Under the Act a "health practitioner" or "practitioner" means a person who is registered with a "responsible authority," e.g. the PBANZ, as a practitioner of a particular health profession (see HPCA Act, s 5(1)). The fact that psychotherapy is regulated under this Act brings it into line with other health professions. Indeed, one of the purposes of the Act is to provide (s 3(2)(a)): "for a consistent accountability regime for all health professions"—and it is clear that the 13 professions originally encompassed by the Act were all health professions closely allied to medicine (see above). More recently, the MoH (2010a) has asserted that: "Having one legislative

framework allows for consistent procedures and terminology across the professions now regulated by the Act." Clearly, the idea was—and is—that psychotherapy is viewed as a health profession and that it adopts "accountability regimes" (in itself an interesting term), "procedures," audit, etc., terminology which represents *medical* and managerial paradigms, for a critique of which see Postle and House (2009), King and Moutsou (2010), Cornforth (2011), Embleton Tudor (2011), and Tudor (2011c). What this ignores or discounts is the fact that psychotherapy and counselling are practices which are *different* from other health professions and their practices—of prescribing (medicine, and pharmacy), or which involve certain invasive procedures (dentistry, optometry, medicine) or physical manipulation (chiropractic, osteopathy, physiotherapy, and podiatry) (see Tudor, 2011c).

- Regarding the question of the appropriate responsible authority (RA).

If counselling were to be accepted as a profession to be regulated under the Act, there would be an issue of having a relevant RA for counsellors. When psychotherapy was applying to the MoH to be considered as a regulated profession under the Act, the NZPB made it very clear that it would not welcome a joint board (or council) to regulate both psychologists and psychotherapists; given the history of the largely separate development of these psy-professions in this country, it seems likely that the same argument would be made with respect to counselling and counsellors by both the NZPB and the PBANZ. However, since 2007, times have changed, and the present government is reluctant to create any new RAs. Indeed, the government is seeking to amalgamate some RAs or even all the RAs into a single RA (see Director-General of Health, 2009), although the majority of submissions to the 2012 review did not support this (MoH, 2013), and it certainly wishes to establish a shared secretariat for RAs (see MoH, 2012). In this context, if counselling were to be regulated under the HPCA Act, it is most likely that counsellors would be regulated by some generic or "super" RA, and thus lose rather than gain a sense of professional identity.

Being careful what you wish for

I am aware of the NZAC's commitment to move towards either (state) registration or self-regulation. In his endorsement of *The Turning Tide* (Tudor, 2011e), and referring to the context in Australia, Bernie Neville, Adjunct Professor of Education at La Trobe University in Melbourne, wrote: "To those of us not yet subject to [statutory] regulation, Tudor gives a clear warning to be careful what we wish for." It is the spirit of being informed about the difference between what I have referred to as the "three

R's," and being forewarned about the consequences of the different options and the implications of such a move, that I offer this contribution. There is, of course, always a context to moves towards the statutory regulation of a profession and the state registration of its practitioners.

As far as the cultural—bicultural—context is concerned, there is little argument that regulation and registration under the HPCA Act would enhance a bicultural perspective for counselling as clearly it would not; worse, it could further marginalise tangata whenua and indigenous traditions of and approaches to healing.

As far as the economic context is concerned, as Webb (2000) has pointed out, "Calls for registration regularly occur at times of employment saturation in a profession and this should mean that the NZAC moves with caution in this area" (p. 312).

As far as the professional context is concerned, such regulation represents, according to Caplow (1966), the fourth and final step towards professionalisation. (The first three are: the formation of a professional association; changing the association's name to reduce its identification with any occupations considered of lower status; and promulgating a code of conduct.) A number of authors have questioned the increasing professionalisation of the psy-professions (see citations above) and, some twenty years ago, Miller (1994) articulated significant concerns about the distraction that professionalisation represents to the NZAC. The question here is where and how the NZAC wishes to position itself as a professional association and whether it takes the fourth and final step (in Caplow's model) of seeking legislation to protect the profession, or whether it takes a different stance about its organisational development and political position. Nearly fifty years on from Caplow's analysis of professions, we have more information about the impact of such moves. As Webb (2000) put it:

> *As a certifying body, a professional association risks becoming a mere puppet of the State. A counselling association, which should be addressing social injustice, risks losing its independence to challenge dominant mythologies and, through communicating in the language of the State, becoming subverted to its causes.* (p. 304)

Internationally, most countries in the world do not regulate counselling; in the UK, psychotherapists and counsellors have made a significant move away from statutory regulation and towards self- and co-regulation, a move which was supported by the then (in 2010) new Conservative–Liberal Coalition government. Counsellors in this country could follow their colleagues in psychology and psychotherapy in seeking

professionalisation through regulation, or they could align themselves with their international colleagues in remaining as a profession independent of state control.

As far as the philosophical context is concerned, counselling as an activity encompasses a number of philosophical—and psychological—traditions (theoretical orientations or modalities), each of which has a particular view about:

- The essence of things (ontology), including the nature of human nature and human development, and about the nature of the social/political world, our capacity for change, and so on—and, of course, about the nature of counselling;
- Theories of knowledge (epistemology);
- The philosophical basis of how we research counselling (methodology);
- How we conduct such research (method);
- How we organise ourselves (organisation).

Thus, each of these traditions has something to say about the relationship between counselling (including client and counsellor) and the state. Thus, if, for instance, one thinks of counselling as a vocation, or as a political and/or spiritual activity, or as a subversive activity, then it makes little sense to ask the state to regulate such activity. I am, of course, not saying that everyone shares these views; I am suggesting, however, that these views would be compromised by the statutory regulation of counselling.

In terms of the psy-professions in this country, psychology is, with few honourable exceptions, allied very closely to the medical model and the state; psychotherapy, with the exception of a reasonable and relatively organised resistance (see Fay, 2011a) is, for the most part, regulated by the state; and psychotherapists are for the most part uncritically acceptant of whatever the PBANZ implements. It is only the counselling profession and, notably, the NZAC, which stands for, and has the opportunity to stand for, a professional integrity—for counselling, for counsellors, and for clients—to continue to associate freely, free from state control.

Endnotes

1. The Waitangi Tribunal investigated a claim by Māori that the downgrading of facilities and services at Napier Hospital by Healthcare Hawke's Bay constituted a breach of Te Tiriti o Waitangi/The Treaty of Waitangi; for further details see Waitangi Tribunal (2001).

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