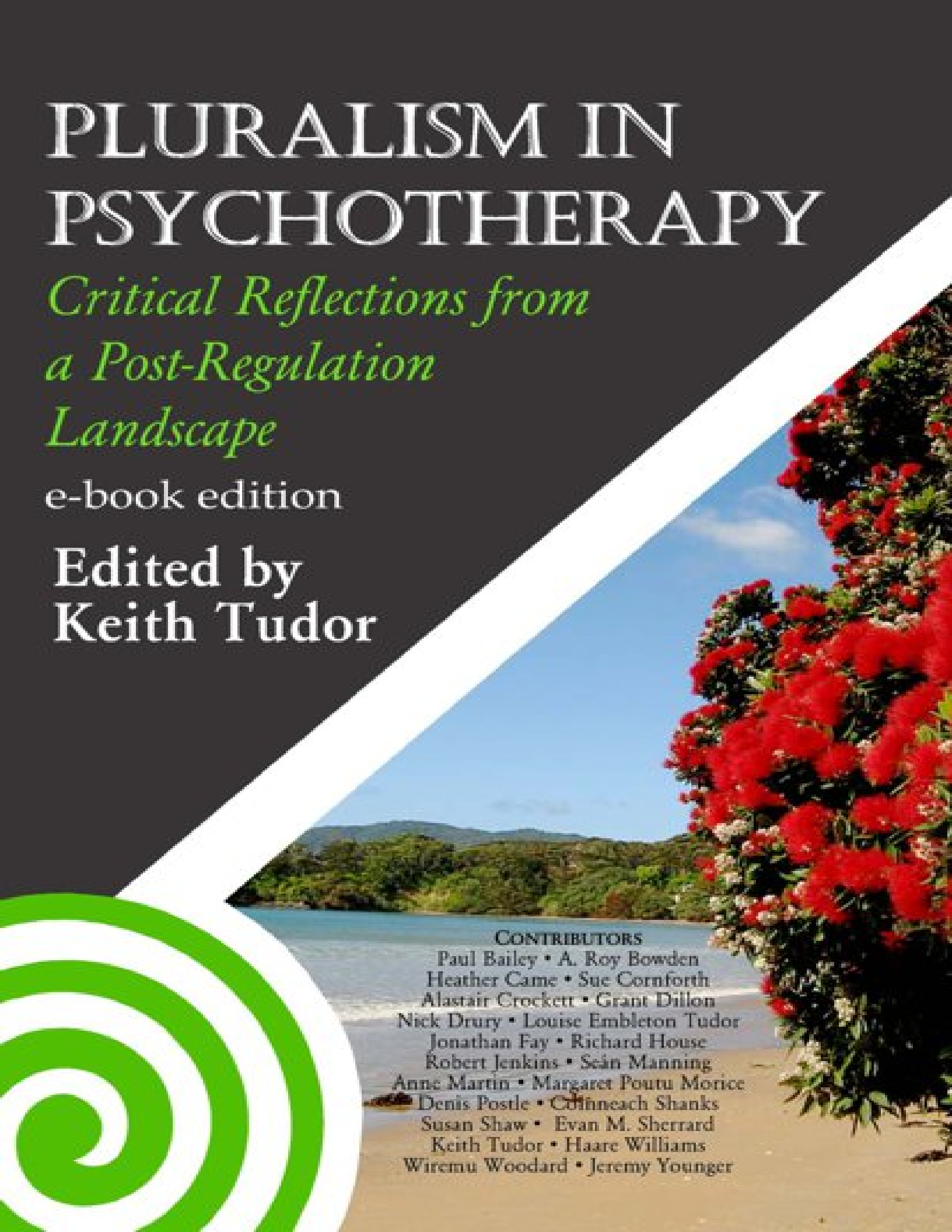
PLURALISM IN PSYCHOTHERAPY

Critical Reflections from a Post-Regulation Landscape

e-book edition

Edited by Keith Tudor



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What colleagues have said about this book

Psychotherapy, as we consider it in most contexts, is a Western idea and practice. Indeed, we have begun to call psychotherapies "psychological treatments" and as such they have been incorporated into the health systems in many, mostly developed countries. However, this ignores the similarities of psychotherapy and indigenous and cultural healing practices. When mental health services are incorporated into health systems and come under the purview of governments, registration (or licensure or certification as it is called in some jurisdictions) and regulations ignore many important aspects of psychotherapy. In The Turning Tide Keith Tudor and colleagues discuss issues of registration and regulation in New Zealand, and we must listen carefully because they are examining the inner core of psychotherapy — what is it? how does it work? who gets to practice it? and, most importantly, who gets to benefit from it? This volume examines an uncomfortable space — and we all need to examine our notions of psychotherapy by learning from the experience of the psychotherapy profession in Aotearoa New Zealand.

Bruce Wampold, Professor of Counseling Psychology and Clinical Professor of Psychiatry, University of Wisconsin–Madison, USA, and the author of The Great Psychotherapy Debate

This is a superb book. It offers rich, nuanced, deepening layers of complexity, in a sophisticated weaving together of politics, history, law, neuroscience, ethics, culture, society, environment and the lived experiences of psychotherapists. Contributors write with personal/political passion and analytical rigour, and dialogue with sensitivity and compassion. The spotlight is upon close readings of the post–regulation landscape in Aotearoa New Zealand, which is absolutely compelling, but the debates in *The Turning Tide* about the contemporary nature/meanings of psychotherapy are applicable everywhere. This is an important book, for its academic insights — and as a call for psychotherapists to think more politically.

Dr Deborah Lee, Senior Lecturer, Nottingham Trent University, UK

I consider this book to be of great importance to the world of psychotherapy — which includes practitioners, clients, and regulatory bodies. It offers a comprehensive and cogent exploration, critique, and conversation regarding regulation and registration. In its breadth and depth, it addresses topics that are vital to the ethos of respect for persons. Autonomy, safety, attention to boundaries, pluralism, social responsibility and many other topics are explored, all of which are of core themes in the politics of the practice of psychotherapy. *The Turning Tide* is relevant not only to New Zealand,

but more widely to issues of regulation that need to be faced in the health field. Simple thinking and polemic often accompany debates around these matters, and regulation is not always sufficiently thought through; as a result of efforts to "protect the public", many other harms can be promulgated. Tudor thoroughly unearths relevant concerns, in a balanced and well–considered way. I commend this book as essential reading in the domain of ethics and professional practice.

Steve Vinay Gunther, Professor of Spiritual Psychology, Ryokan College, Los Angeles, USA, and Director of Gestalt Therapy International

The book *Pluralism in Psychotherapy* is necessary reading for everyone reflecting about regulation of psychotherapy profession. Contributors to the book highlight both the advantages and disadvantages of psychotherapy regulation and state registration. It will be especially appealing to professionals in countries where state registration of psychotherapy is becoming significant political and professional topic of discussion.

Assistant Professor Gregor Žvelc, Universities of Llubljana and Primorska, Slovenia, Clinical Psychologist and Psychotherapist

What colleagues said about the first edition

Anyone with an interest in the vexed question of the regulation of the psychotherapy profession will want this book. In scrutinizing the regulatory processes which have been established in Aotearoa New Zealand, Tudor and his colleagues provide us with an invaluable aid to our understanding of the challenges and pitfalls of regulation. To those of us not yet subject to regulation, Tudor gives a clear warning to be careful what we wish for.

Bernie Neville, Adjunct Professor of Education, La Trobe University, Melbourne, Australia

This is a timely, measured and well–informed explanation of why state regulation of psychotherapy can never go well. Given the uncontrollable subject matter of the work of psychotherapy, there is something implausible about the whole project. Trying to regulate the impossible profession causes politicians and bureaucrats to work themselves up into a colonising frenzy of over–control in which no–one is protected, and certainly not "the public". Coming from a land where cultural and professional diversity is of the essence, and not an optional extra, this volume offers critical voices of resistance in a "post regulation" landscape, and constitutes a significant contribution to the international debate on state regulation of psychotherapy.

Andrew Samuels, Professor of Analytical Psychology, University of Essex, Colchester, UK

… this book will be of great interest to many psychotherapists, counsellors, and "midwives of the human spirit" … Keith Tudor … is to be congratulated for calling forth and editing this most valuable contribution to the national conversation regarding the state regulation of psychotherapy…. [and] I salute my colleagues who, in this book, are contributing to the "turning tide" within this nation…. this book is a must–read!

John McAlpine, Pastoral Care Therapist, Auckland, Aotearoa New Zealand

This book has very considerable relevance to the continuing arguments both in Britain and internationally about the auditing, accountability and the regulation of the psychological therapies…. Part of the book's importance lies in its reclaming of a pluralistic perspective on therapy practice…. When looked at in any conceivable way, the extant literature on the professionalisation of the psychological therapies comes out unambiguously and resoundingly against the supposed beneficence of the kinds of professionalising developments and political manoeuvrings, often driven

by economic and institutional interests, that still, alas, strive to dominate the field in a number of countries. This welcome book makes a significant contribution to flushing out such power — and interest–driven processes, wherever they manifest.

Richard House, Senior Lecturer, University of Roehampton, London, UK

The wave made by state regulation at this juncture in the era of neo–liberal democracy in Aotearoa New Zealand is essentially the same wave that has already washed or will yet wash over many other territories. The undercurrents driving the wave — "public protection", "evidence–based treatments", [and] "value for money in the market–place" — are the same undercurrents. Nobody can afford to ignore that psychotherapy is situated within a political eco–system that influences and is influenced by all its constituent players, however they may think or act…. the contributions in this book will resonate with and be relevant to any and all therapy practitioners, on whichever shore they find themselves, and whatever the state of the tide there.

Bob Jenkins, UKAHPP–accredited Psychotherapist in Independent Practice, Shipley, West Yorkshire, UK

Pluralism in psychotherapy: critical reflections from a post–regulation landscape

Keith Tudor | Editor

The revised and extended edition
of The Turning Tide *(2011)*
e-book edition

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Abbreviations

ANZPA — Australian and New Zealand Psychodrama Association

ANZSJA — Australian and New Zealand Society of Jungian Analysts

ANZTAA — Aotearoa New Zealand Transactional Analysis Association

APC — Annual Practicing Certificate

ASMS — Association of Salaried Medical Specialists

AUT — Auckland University of Technology

CCANZ — Combined Counselling Associations of New Zealand

DHB — District Health Board

HDC — Health & Disability Commissioner | Te Toihau Hauroa, Hauātanga

HPC — Health Professions Council (now Health and Care Professions Council), UK

HPCCA — Health Practitioners Competence Assurance Act 2003

HPDT — Health Practitioners Disciplinary Tribunal

IAPT — Improving Access to Psychological Therapies IPN Independent Practitioners' Network

IRP — Independently Registered Psychotherapists

IRPP — Independently Registered Psychotherapy Practitioners

MoH — Ministry of Health | Manatū Hauora

NZAC — New Zealand Association of Counsellors | Te Roopu Kaiwhiriwhiri o Aotearoa

NZACAP — New Zealand Association of Child and Adolescent Psychotherapists

NZAP — New Zealand Association of Psychotherapists | Te Rōpū Whakaora Hinengaro

NZMA — New Zealand Medical Association

NZPB — New Zealand Psychologists Board

PBANZ — Psychotherapists Board of Aotearoa New Zealand

PHINZ — Psychotherapy and Hypnotherapy Institute of New Zealand, Inc

UKCP — United Kingdom Council for Psychotherapy

Tables and Figures

Acknowledgements

In 1658 an English tinker or tinsmith was indicted for preaching without a license. Two years later he was imprisoned in Bedford jail where he remained for twelve years, during which time he wrote one the major works of Christian literature. The name of the work was *The Pilgrim's Progress*. The name of the unlicensed preacher was John Bunyan.

Prior to colonisation, Māori tōhunga (learned person, practitioner of Māori medicine, priest) practised freely. In 1907 the New Zealand government passed the *Tohunga Suppression Act* which banned such practices — and the political activities of the Tuhoe prophet and tōhunga, Rua (Hepetipa) Kenana. The *Act* was repealed in 1962. In 2017 the New Zealand government released details of its intention to issue a pardon to Rua Kenana for his conviction, and an apology to his descendents.

Dedication

To the Unlicensed –
Preachers, Healers,
Therapists, and Buskers
and to Evan McAra Sherrard (1934-2015),
a preacher, healer, and therapist
(if not a busker!)

Introduction to the e-book edition

Keith Tudor

I am delighted to have the opportunity to publish this book online, and to make it freely available to colleagues all over the world.

The need for a critical and pluralistic perspective in and for psychotherapy has never been greater; and, as may be seen by colleagues' endorsements of this book, the arguments contained within it are relevant far beyond the shores of Aotearoa New Zealand.

In having the opportunity to publish an e-book edition of *Pluralism in Psychotherapy*, I am grateful to the School of Public Health & Psychosocial Studies and the Faculty of Health and Environmental Sciences at Auckland University of Technology (AUT) for supporting this project. I also wish to acknowledge the work of Peter Biggs, who published the previous (printed) edition of the book, in reformatting that version to make it compatible with and presentable in this medium; and to my colleagues at Tuwhera, AUT's open publishing platform, and especially Luqman Hayes, for their work in making this accessible.

The only differences between this edition and the previous edition is that, as this version can be searched by the reader, there is no need for an index of authors or subjects. Otherwise, the text as well as the arguments remain the unchanged – in the hope, of course, that the arguments about the role of registration and regulation in the practice and recognition of psychotherapy continue.

Introduction to the revised and extended edition

Keith Tudor

However we think of psychotherapy — as a practice, a discipline, a vocation, and/or a profession, as an art, and/or a science — it is nothing if not reflective, and this book represents our ability to reflect and to reflect again, and to be reflexive, that is to reflect critically.

It is six years since the publication of the first edition of what was then titled *The Turning Tide*, seven years since most of the original chapters were completed, and ten years since the inception of the Psychotherapists Board of Aotearoa New Zealand ("the PBANZ" or "the Board"), and so it seemed timely to consider and reconsider the impact of the state registration of the title "psychotherapist" and increasing moves towards the statutory regulation of the profession of psychotherapy as a whole, both here in Aotearoa New Zealand and beyond.

In most countries in the world that have a distinct profession of psychotherapy, its practice is governed and regulated by the profession itself, through voluntary association and membership, determined by membership criteria and subscription to entry and continuing membership requirements, codes of ethics and professional practice, and membership criteria. In Aotearoa New Zealand, this was the situation for some 60 years since the foundation of the New Zealand Association of Psychotherapists (NZAP) in 1947 (see Chapter 10). In recent times, in some countries, either

the profession itself or a government decided to initiate the statutory registration of the practitioner and/or regulation of the practice of psychotherapy. This has been enacted under more general legislation governing health practice and practitioners in Sweden (in 1985), Italy (1989), Finland (1994), the Netherlands (1998), France (2004), then New Zealand (2007), and, most recently, in Canada (the province of Ontario) and Switzerland (both 2013). In two countries — Austria (1990) and Germany (1999) — such legislation was specific to psychotherapy. In other countries, notably, the United Kingdom (UK), the main professional association, the UK Council for Psychotherapy (UKCP), which had previously been in favour of seeking statutory regulation, following some considerable debate, in 2009, voted against it. As a result, state registration, at least as far as the profession is concerned, is off the agenda and remains voluntary; and the UKCP continues to regulate its members.

The first edition of this book was forged in the heated discussions and debates that followed the NZAP's decision to seek regulation under the *Health Practitioners Competence Assurance Act 2003* ("the *Act*") (see Chapters 3, 4, and 5), and initial responses to the approach and decisions of the new authority responsible for psychotherapy, the PBANZ (see Chapter 7). For my own part, I emigrated to Aotearoa New Zealand in 2009, bringing with me a long–standing position of being strongly in favour of professional self–regulation and strongly opposed to the statutory regulation of psychotherapy (see Tudor, 1999). As I landed; settled; joined the NZAP and Ngā Ao e Rua, a bicultural group of psychotherapists, practitioners, and health care providers; read more; got involved in the profession; and had more conversations with a number of colleagues: I became surprised to find that the NZAP, with its long and honourable tradition of self–regulation, had sought to give away its authority to the state. I was also curious that it did so at the same time that it was seeking to engage with its Māori members and psychotherapists from a state that was and is ambivalent about biculturalism and under legislation (the *HPCA Act*) that did not refer to te Tiriti o Waitangi, the founding contract and document of the New Zealand nation (see Shepherd & Woodard 2012). It appeared that the NZAP had, in effect, ceded governance (kawanatanga) to the PBANZ (to control unruly psychotherapists), but had not thought that this would entail losing — or being in danger of losing — its sovereignty (tino rangatiritanga) with

regard to the profession and field of psychotherapy (see Chapters 3, 5, and 7).

Knowing that the book could — and, in some quarters, no doubt would — be viewed as more biased than balanced and more agitprop than academic, I ensured the following:

a. I initiated a dialogue with Paul Bailey, the architecture of registration, which I included in the original book (Bailey & Tudor, 2011), and which appears, together with a substantial postscript as Chapter 4 in this edition;
b. I invited a contribution from Seán Manning, another proponent of registration who, at the time of the book's publication, was also the President of the NZAP (Manning, 2011), a revised and updated version of which appears in Chapter 17 in this edition); and
c. I had the manuscript independently reviewed by two colleagues outside the field of psychotherapy (see original Introduction), a practice I have also followed with this edition.

A common confusion in the debate — which was present in debates within the NZAP but which is also found elsewhere — is that between registration and regulation. In my work generally and in this book, I distinguish between "statutory regulation" and "state registration" as they are two different terms and processes. The former is legislative, the latter administrative; and, at least in the case of state registration, some form of regulation precedes registration, even if this takes the form of a requirement for a professional to be a member of a professional body — in which case, the state is using its power to require professional self–regulation (for a description of which see Chapter 15). Also, by using the two different adjectives to describe their respective nouns, I imply the possibility of applying other adjectives to such nouns, such as "self–regulation", "peer regulation", and "voluntary registration" (see Chapter 1), a convention that also breaks the easy elision, which some regulatory authorities like to make, from a protected "title" to regulated activity and profession (see Chapter 7).

While the original volume sold well in a comparatively small field (to nearly half of the membership of the NZAP), and was well–received in some quarters, it — and I — was also seen as divisive and "splitting" — sadly, a somewhat ubiquitous accusation levelled by psychotherapists

against colleagues with whom they disagree. Following its publication, the book was favourably reviewed by two colleagues in the UK, reviews which are reproduced here and form Chapter 18. Here, the book and, more broadly, the experience of the NZAP has influenced colleagues in other disciplines in their debates about whether to pursue statutory regulation (see Chapters 2, 14, and 15); and, last year, the New Zealand Association of Counsellors (NZAC) decided to follow a path of professional self–regulation (NZAC, 2016).

In many respects, the heat of the original debates has somewhat cooled and, by and large, most colleagues who are proponents of registration have less animosity towards those of us who aren't; and, in turn, we are less concerned that the state will come knocking on our doors — as indeed, it can (see Chapter 6). Ten years on, overall, the Board appears more reasonable and is certainly less threatening, and, as a result, there is less need for the Organisation of Independently Registered Psychotherapy Practitioners (see Fay, 2011). At the same time, the cooling of the heat of conflict and increased reasonableness has led to a certain complacency and passivity amongst psychotherapists, as a result of which only relatively few people appear bothered about the fact:

1. That the original rationale for registration has been largely discredited and, indeed, has been referred to by an ex President of the NZAP as a "lie" (see Chapter 1).
2. That the Board still does not recognise the NZAP's He Ara (Māori) pathway to membership and, therefore, to registration, currently the only NZAP pathway that the Board does not recognise (see Chapters 5 and 7).
3. That the Board continues to extend its influence and powers unnecessarily and with serious consequences (see Chapter 7).
4. That the Board continues to set high fees, with no justification or apparent consequences from its registrants (see Chapter 7).
5. That the NZAP is still struggling to find its professional purpose and role in our post–regulation landscape, and that a significant proportion of registered psychotherapists are neither members of the NZAP, nor of the New Zealand Association of Child and Adolescent Psychotherapists (NZACAP) — at June 2017, this stood at 146 practitioners, i.e., 28% of all registered psychotherapists. Of the total

> of 524 psychotherapists registered with the Board, 349 are members of the NZAP, 31 of the NZACAP (of which three are also members of the NZAP) — 'though a further 69 are members of the New Zealand Association of Counsellors (see Chapter 19).

Thus, with regard to the profession of psychotherapy in Aotearoa New Zealand, two things are clear: firstly, that we live in a post regulation landscape; and secondly, that we (that is, both psychotherapists and others of us who practice psychotherapy) live in a pluralistic environment. From a theoretical point of view, this shouldn't be a surprise, after all, psychotherapists have been talking and writing about being pluralistic (Samuels, 1989) and "beyond Schoolism" (Clarkson, 1989) — for nearly 30 years. However, it appears that pluralism as regards registration and regulation is disputed and, indeed, the debate in Aotearoa has had the effect of a exposing a division between those who are pluralistic and those who are, in effect, unilateral. This is one of the reasons that I have argued that statutory regulation is a symptom of societal regression rather than progression (Tudor, 2011b). Nevertheless, this book represents pluralism both in theory and in practice and, in this context, I am particularly appreciative of the fact that five of the 22 contributors are registered health professionals here in New Zealand, and that they are willing to contribute to this volume.

In this context and for a number of reasons, including the NZAC vote for professional regulation; certain international interest in our post–regulation landscape; specific developments over the past seven years, such as the work of Waka Oranga, the rōpu or collective of Māori psychotherapists and health care practitioners (see Chapter 5), and having the opportunity to apply for some financial support for a second edition, I decided that it was time to revisit and review *The Turning Tide*. To that end, I wrote to the contributors from the first edition, thus:

> I am writing to you to let you know about an initiative regarding this book to which you contributed some years ago. I have the opportunity to edit a second edition and, importantly, with a publisher, Resource Books, Auckland, who will maintain it through online and print–on–demand sales (to anywhere in the world). This is particularly important as the first edition is

currently out of print, and there is still a lot of interest in it and our experience here in Aotearoa New Zealand in a post–regulation landscape (and hence the change of title). I attach an outline of the proposed second edition.

I also reflected on the research and publications of others in this area since the publication of *The Turning Tide*, as well as my own (Smith, 2011; Tudor, 2011a, 2011b, 2011c, 2012a, 2012b, 2012c, 2013, 2015; Tudor & Duncan 2012; Gunther, 2014; Fay & Tudor, 2015; Smith & Tudor, 2015; Tudor & Fay, 2015; Tudor & Shaw, 2016, 2017); and, bearing in mind that (I think) second editions should be significantly different from their predecessors, designed this revised edition, for a summary of which see Table 1.1.

Table 1.1. The differences between the first edition of *The Turning Tide* and this revised and extended edition

Chapter/Section of this edition	Chapter of 1st edition, 2011	Summary of changes between the two editions
Preface *Williams*	Preface	Unchanged
Introduction to 2nd Ed.		New
Introduction to 1st Ed.	Introduction	Slightly revised so that it is integrated into this edition
Part I. Recognition, Regulation And Registration		
Ch. 1. Recognition,... *Tudor*		New, incorporating Ch. 2 of 1st Ed. plus articles published in 2011 and 2013
Ch. 2. A competency... *Drury*		New, comprising an article published in 2017
Part II. The Background To The State Registration Of Psychotherapists In Aotearoa New Zealand		
Ch. 3. The road to... *Dillon*	Ch. 1	Chapter revised and repositioned
Ch. 4. Letters across... *Bailey* & *Tudor*	Ch. 4	Chapter revised and repositioned
Ch. 5. Māori psychotherapy... *Morice* & *Woodard* with *Came*	Ch. 3	Chapter revised and repositioned
Ch. 6. The law is... *Tudor*	Ch. 2	Chapter revised and repositioned
Ch. 7. The rise and... *Tudor* & *Fay*		New. Based on material in two chapters of the 1st Ed. and an article published in 2011

Part III. Reflections On, And Responses To, Regulation And Registration		
Ch. 8. The question of... *Tudor*	Ch. 9	Chapter revised and repositioned
Ch. 9. Whence, why,... *Shaw*	Ch. 5	Chapter updated and repositioned
Ch. 10. Regulation by... *Bowden*	Ch. 13	Chapter edited and repositioned
Ch. 11. Once was... *Sherrard*	Ch. 7	Chapter unchanged but repositioned
Ch. 12 The baby ... *Younger*	Ch. 10	Chapter unchanged but repositioned
Ch. 13. The neuroscience... *Embleton Tudor*	Ch. 11	Chapter unchanged
Ch. 14. Registering... *Cornforth*	Ch. 12	Chapter unchanged
Ch. 15. Recognition,... *Crocket*		A new chapter based on an article published in 2013
Ch. 16. Regulatory... *Shaw*		New
Part IV. Reflections On The Turning Tide And On Seven Years Of State Registration Of Psychotherapists In Aotearoa New Zealand		
Ch. 17. Responses to... *Manning, Martin, Postle, & Shanks*	Afterwords 1, 2, & 3	New. Incl. a revised version of one of the contributions, and repositioned
Ch. 18. Reviews *House* & *Jenkins*		New. Based on 2 reviews of the 1st Ed. published in 2011 & 2012
Ch. 19. Taking the... *Tudor*		New
Appendix 1. Glossary *Woodard*	Glossary	Updated and repositioned
Appendix 2. The Code of Health...		New
Appendix 3. The powers of... *Tudor*	Appendix 1	Slightly revised and repositioned

The original Introduction (i.e., to the first edition) still stands as an introduction to those chapters that have been carried forward (i.e., Chapters 3, 4, 5, 6, 8, 9, 10, 11, 12, 13, 14, and 17). All of these chapters, as well as the new contributions, have been edited and peer–reviewed; where and how chapters have been revised is noted in the introduction or a footnote to the respective chapters. As a result, I hope that this volume is of interest not only to those who have read the first edition, but also to those who are reading this book for the first time. In that Introduction, one of the examples of the pluralism of the book I cited was that different contributors referred to te Tiriti o Waitangi ("te Tiriti"), the founding document of the New

Zealand nation, in both te reo Māori (the Māori language) and/or English (i.e., the Treaty). Whilst I still support contributors' autonomy, I should point out that the use of the phrase in Māori acknowledges, explicitly or implicitly, the privileging of the Māori version of te Tiriti (as distinct from the English language version of the Treaty (the translation of which is highly disputed), and is in accordance with the principle of contra proferentem as enshrined in international documents such as the United Nations' (2008) *Declaration on the Rights of Indigenous Peoples*.

Here, I briefly introduce the new chapters.

Chapter 1 comprises a revised, expanded, and updated version of an article original published in the *New Zealand Journal of Counselling*, which clarifies the distinction between recognition, regulation, and registration and, in many ways, sets the scene for subsequent contributions. Much of the debate about registration and regulation focuses on just that and so I am delighted that, in Chapter 2, Nick Drury offers a critique of the competency mechanism that is implicit in the *HPCA Act* and other similar legislation and policies. In the original edition, much of what is now Chapter 6, regarding the *HPCA Act*, also contained sections on the Board. With the benefit — and challenges — of the past seven years, I have revised this chapter so that it focuses solely on the *Act*, including information and analysis regarding a second review of the *Act* which the Ministry of Health initiated in 2012. To the original material about the Board, I have added new material on its activities over the past seven years in a new chapter (Chapter 7) which I have co–authored with Jonathan Fay. A revised Chapter 8 still contains a summary of the various arguments for and against regulation and registration, illustrated with reference to the New Zealand experience, but which is aimed to inform colleagues in other countries about our post–regulation experience. Chapter 15 is a contribution from Alastair Crocket on recognition, regulation and registration, in which, on the basis of his experience in the NZAC, he proposes a "third way" of regulation, one which maintains a certain independence of the professional association but which also engages government. In Chapter 16 Susan Shaw revisits the subject of regulation, this time offering a critical perspective on territorialism in relation to risk, geography, profession, and culture. Chapter 18 comprises two reviews of the original edition. In a final chapter (Chapter 19), I reflect on the theme of the ebb and flow of the tide of registration and

regulation and make some concluding remarks in favour of professional pluralism — in practice and theory.

In preparing this volume, I am grateful to a number of people:

- To all the contributors to the first volume, some of whom agreed to withdraw their original contributions, i.e., Jonathan Fay, and Susan Green; and others of whom agreed to reproduce their original contributions or endorsements with only a light edit, i.e., A. Roy Bowden, Sue Cornforth, Louise Embleton Tudor, Anne Martin, Bernie Neville, Denis Postle, Andrew Samuels, Coinneach Shanks, Susan Shaw, and Jeremy Younger.
- To Isabelle Sherrard for her permission to reproduce Evan Sherrard's original chapter as, sadly, Evan died in 2015. I am particularly grateful to her for doing so as Evan was a staunch advocate of professional regulation, who originally saw state registration as a solution to the problem of unscrupulous and abusive practitioners, but who later changed his mind about this — in what he himself described as his "uie" or U–turn. However, and contrary to what one mutual colleague told me, Evan did not change his mind again, something to which Isabelle, I, and other close colleagues and friends can attest.
- To contributors from the first edition who have updated their contributions, i.e., Paul Bailey, Grant Dillon, Jonathan Fay, Seán Manning, Margaret Poutu Morice, Susan Shaw, and Wiremu Woodard.
- To other colleagues who agreed to contribute new pieces to this volume, i.e., Alastair Crocket, Nick Drury, Richard House, Bob Jenkins, and Susan Shaw, as this has helped make this a genuinely revised and revitalised edition.
- To Heather Came for her input and contribution to Chapter 5.
- To the *New Zealand Journal of Counselling* for its permission to reproduce two articles that were original published in the journal (Chapters 1, 2 and 15) and to its editors, Margaret Agee and Philip Culbertson, for effecting this.
- To *Psychotherapy and Politics International* for its permission to reproduce an article and a review which form parts of two chapters (Chapters 7 and 18, respectively).
- To *The Transactional Analyst* for its permission to reproduce a review which forms part of Chapter 18).

- To Associate Professor Kris Gledhill, of Auckland University of Technology's (AUT) Law School for his close and generous reading of my reading of the law, specifically in this Introduction and Chapters 1, 6, 7, and 8.
- To Steve Gunther (Canada), Deborah Lee (United Kingdom), Bruce Wampold (USA), and Gregor Zvelc (Slovenia) for their reading of and endorsements of this edition.
- To the School of Public Health and Psychosocial Studies, AUT, for its financial support of this project, and, specifically, in providing me with Brigitte Viljoen for research and editorial assistance. I have had the good fortune to have Brigitte's support on a number of projects over the past 18 months and I have appreciated her thoroughness, promptness, and interest with regard to this particular publication.
- To Peter Biggs of Resource Books, Auckland, for his support and skills in seeing this through the process of production and publication. This is the second book on which I have worked with Peter a process which, with regard to both volumes, has been an absolute pleasure.
- To my close colleagues, friends, and family for their continued support for my research, writing and publications; and for their patience at times when I have been — and am — more distracted and less available.

Public statutes

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Preface

Haare Williams

This is the Preface to the First Edition

Waves — Nga Ngaru nunui

Te Tainui

Te Tai Roa

Te Tai Tuawhenua

Three waves drawing us inexorably on to the land.

Having to deal daily with unequal treatment is a way of life for Māori. Dr Ranginui Walker (1990) gave us this greenstone gem: “so long as this unequal power relationship persists, the struggle of Māori for a just and equitable society is a ‘Struggle without end’.” (p. 46)

And today, as Māori assert who they are and the legitimacy of their voice in Big Organisation, the emergence of Waka Oranga is an example of one way to deal with exclusion.

Māori assertiveness, while it’s always been that way, its surfacing is a view from the high ground of a new millennium. I cannot blame people for what they do not know, but they can be held accountable for what they do not

know today, especially if their ignorance of the nature of our history is wilful and results in a perpetuation of inequality and injustice.

Māori straddled an economic and cultural wave back then, and are doing it again as they enter the economic spirit of the twenty–first century riding another wave — the "knowledge wave economy — Te ngaru tua whenua".

What I see is a leadership wherein all New Zealanders, of diverse backgrounds, are prepared to pledge themselves to a re–shaping of New Zealand into the society which embraces the concept of two basic cultures: Māori as first settlers and Pākehā as second; and who, between them, create a new "New Zealand culture" in which both tikanga Māori and tikanga Pākehā are accepted, respected, honoured and protected for their separate but complementary values, and which make provision for recognition of later cultural influences.

Iwi corporate developments cannot be ignored. They have set up "Māori centres of excellence" such as iwi business enterprises and, in one iwi authority alone in central North Island, has on its books $16.9 billion in assets. Other impact centres include Kohanga Reo, Kura Kaupapa, Wānanga, Kapa Haka and Māori Television. Today, educational achievement is probably the most significant determinant of socio–economic advancement and there are now signs that Māori are making big gains. Sadly though, Māori collectively are still over–represented in lower economic groupings, but the tide is changing. So too must Big Organisation. Today, there are many cultural crossovers in language and life styles: Māori idioms are being translated into English and readily used. Yet, entrenched organisational opposition is still there.

I see great hope in a new brand of leaders — Mark Solomon, Tahu Potiki, and Hana O'Reagan in Ngai Tahu; they are bilingual, confident and well educated. Few Pākehā match their skill set. Others — look out for Shane Jones, watch him rise; Jones is steeped in traditions, educated at Harvard and politically astute — Hekia Parata is a rising star in National Party ranks. The future of Māoridom glistens with talent; by 2021 Māori will number 750,000. By 2050 about a quarter of all school children will be of Māori descent. The question could be: "When will we have a Pākehā PM?" Whatever the upshot, there will be more Māori MPs in the House come the next General Election.

Society can no longer ignore the emancipative wave in Māoridom. I see a precise reading of the barometer of a culture in change. Māori culture isn't fading away into some homogenised heap at the bottom of the garden.

Waka Oranga (a living omnibus if you like) is vibrant, fiercely determined, generous and outgiving through the successes of Cherry Wilson, Wiremu Woodard and Margaret Poutu Morice, who have used their joint propensities with Jonathan Fay, Grant Dillon, Susan Green and others to achieve equal treatment of its Treaty partner within the ranks of the New Zealand Association of Psychotherapists. They cannot do the job alone. They must never walk alone. They will continue to fight and put trust in a "partnership" which they hope can be brought to account in the professional and cultural measures within its ranks.

Waka Oranga has made a good start but still have a long way to go; it rides the wave which will help their colleagues dip a little deeper into the social and spiritual wells of our country and learn what it means to be people of the land: tangata whenua.

"*Waves*" — Alvin Toffler (1980) used the motion of waves to indicate the power of change. Power and change is in the crest of the rising wave: "*Rehutai*, the sea spray that represents new thought."

Make Māori richer and we are all richer as a nation. That is the nub of the Treaty in the wake of the rights revolution.

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Introduction to the first edition

Keith Tudor

To begin, I acknowledge and thank Haare Williams for his poetic — and political — Preface. I first met Haare on a bus taking participants in the 2008 Annual Conference of the New Zealand Association of Psychotherapists from Auckland to Waitangi. He and Joan Metge, the esteemed anthropologist, were our guides and mentors for the journey which I and other were privileged to experience in their company — and, indeed, for much of the Conference and our time at Waitangi. Amongst the memories I have of that Conference, I have a particular one of Haare, leading a small group of us from the Te Tii Marae over the road to the shore and greeting the dawn: sea, waves, tides, partnership, and change. I thank Haare for those introductions to Waitangi, the place of partnership; I acknowledge all the work he has done to support the work of partnership in psychotherapy in Aotearoa New Zealand; and I am honoured that he has greeted this particular wave and prefaced this book which describes the turning tide with regard to regulation and registration in psychotherapy in Aotearoa New Zealand and elsewhere.

In Aotearoa New Zealand, the term "psychotherapist" is regulated by statute under the *Health Practitioners Competence Assurance Act 2003* (hereafter referred to as "the *HPCA Act*" or "the *Act*"). Since 15th October 2007, when the Order in Council, made earlier on 21st May that year, came into effect, whereby psychotherapy was included as a "health profession" under the *Act*, the term "psychotherapist" has become a protected one.

Practitioners who wish to refer to and advertise themselves as psychotherapists, must register with the "responsible [regulatory] authority" for psychotherapy i.e. the Psychotherapists Board of Aotearoa New Zealand (hereafter "the PBANZ" or "the Board"), or risk prosecution and/or fine — and, it transpires, harassment.

The move to the state regulation of psychotherapy and the statutory registration of psychotherapists was, for many, uncontroversial and uncontentious and, according to Bailey (2004), the prime mover in recent times of psychotherapy registration, it was not contended. Others who were around at the time report, rather, that challenge, opposition and dissent to this move was dismissed. Despite the literature available at the time which challenged the arguments for regulation, including Hogan (1979), Dawes (1994), Mowbray (1995), House and Totton (1997), and Wampold (2001), and the fact that, in most countries of the world, psychotherapy was — and still is — not regulated by state or statute, the majority of psychotherapists or, at least, those within the New Zealand Associated of Psychotherapists (NZAP), agreed with or were persuaded by arguments or assertions that regulation and registration was desirable. Whilst the NZAP was the key stakeholder in the move to and the discussions about registration, it is important to note there are many psychotherapists — or practitioners practicing psychotherapy — who are members of other professional organisations and associations such as the New Zealand Association of Counsellors (NZAC). Indeed, a 2006 survey of NZAC members, revealed that, of the 305 respondents, 282 had had specific psychotherapy training, and 77 were members of both the NZAC and the NZAP (Bocchino, 2006). The arguments for registration rest principally on two assertions: that regulation and registration a) protects the public from unregistered practitioners, and b) enhances the status of psychotherapy and psychotherapists, especially and specifically those working in the public health sector — arguments which, along with other arguments are addressed and rebutted in this book.

The objections to statutory regulation and state regulation may be summarised as falling into four main areas [as detailed in Chapter 8]:

1. In principal objections to the statutory regulation of psychotherapy and the state registration of psychotherapists;

2. An objection to the fact that the *Act* makes no reference to te Tiriti o Waitangi | the Treaty of Waitangi;
3. Concerns that the *Act* assumes that regulation of health practitioners is a good thing, and that it protects the public; and
4. Concerns that the *Act*, and the move to statutory regulation and state registration assumes that psychotherapy is best viewed, positioned and promoted as a "health profession".

In addition to these points, there are particular concerns about how the Psychotherapists Board of Aotearoa New Zealand has operated since its establishment in 2007. In many ways these concerns reflect broader problems inherent in the role of registration boards, about which Susan Shaw offers an historical analysis in Chapter [9]. The specific problems with the current Psychotherapists' Board are addressed by [myself and] Jonathan Fay in Chapter [7] and are referred to elsewhere [in Chapters 6 and 8]. For those of us who promote pluralism and partnership in psychotherapy in Aotearoa New Zealand (a term of reference which, itself, reflects a bicultural perspective), the problem is that, at present, we have a monocultural regulatory system, under an inappropriate *Act*, administered by an unrepresentative Board. This particular Board is problematic in that it is particularly rigid in its interpretation of the *Act*; it is, compared with other "responsible authorities", particularly critical and parental in its tone and communication (see http://www.pbanz.org.nz/index.php?Home); it is not in partnership with the profession which conceived it; it publishes and communicates mis– and dis–information; it acts outside its authority; and is itself in breach of the *Act* [see Chapters 6 and 7].

In the light of these concerns (some of which pre–dated regulation and were predicted by Paul Bailey), a number of psychotherapists in this country, registered and unregistered, came together in 2010 to form a group both to resist and to challenge the apparent inevitability of regulation under the present legislation, system and regime; and to promote a pluralistic approach to regulation of psychotherapy — and, by implication, other helping activities/professions, such as counselling, art therapy, and music therapy, all of which are currently engaged in discussions about registration. The reader will have noticed the words "psychotherapists" and "unregistered" in the previous sentence. Of course, in the Orwellian — and Carollian — world of statutory registration and state regulation, there's no

such thing as an unregistered psychotherapist on the basis that, if you are not registered, you are not a psychotherapist: that is the logic of the statutory (and professional) protection of a particular term. The group that came together is a pluralistic group, including registered psychotherapists; "unregistered practitioners" (a term used by the Director–General of Health, 2009); and practitioners registered with other authorities: inspired by different traditions, different theoretical approaches, and different politics, and having different emphases in our concerns. What unites us, however, is an objection — and it is a conscientious one — to the imposition by the state and, in effect, only a few people, of a system of regulation:

- That was under–theorised, poorly argued (see MoH, 2003; and Chapter [8]), over–promoted, and insufficiently discussed.
- That did not address the nature of psychotherapy, or the particular context of psychotherapy in Aotearoa New Zealand.
- That makes no sense in terms of what psychotherapists know about human regulation.
- That, when presented as a unitary, and closed system, allows of no pluralism, autonomy, or alternatives.

Drawing on extensive and relevant literature, this book addresses these deficiencies:

1. By presenting and discussing the history (Chapters in Part [II]), and analysis and experiences (Chapters in Parts [II and III]) of the move to regulation and registration.
2. By presenting ideas about the context of the activity or profession of psychotherapy in Aotearoa New Zealand, with specific reference to *te Tiriti o Waitangi | the Treaty of Waitangi* (Chapters [1, 5, and 6), and to discussions about the nature of psychotherapy [Chapters 8, 11, 12, and 13] and counselling [Chapters 2, 14, and 15].
3. By understanding professional and political regulation in terms of the neuroscience of regulation [Chapter 13].
4. By offering an alternative of pluralism and self–regulation and co–regulation for psychotherapy [see Chapters 10 and 19].

As a number of us, together with others, have gathered together, we have talked, discussed, and read, including reading the *Act* , as well as a number

of documents published by the Ministry of Health on the subject (MoH, 2003, 2010a, 2010b, 2010c). What we have found is a Ministry that, by and large, is more open and pluralistic than is the "responsible authority" for psychotherapy, i.e. the Board. In the course of our working lives, in different sectors and fields, we have been at meetings at which statements have been made about regulation, registration, practice and the law, and, as a profession, we have been in receipt of communications from the Board, which are, simply, inaccurate. Another purpose in gathering together the material in this book has been to provide accurate information and access to sources of information. One example of this — and good news for pluralists — is contained in a recent document from the Ministry of Health (2010b):

> It should be noted that regulation under the *Act* does not prevent people who may be untrained from working in the area, ie, regulation will not prevent others from operating in the sector as long as they do not "hold themselves out to be a registered health professional". (p. 7)

The structure and contents of the book

The book is organised in three parts.

In Part I a number of chapters provide the background to and context of statutory regulation and state registration in Aotearoa New Zealand. Grant Dillon begins this in Chapter 1 [now 3] by taking us through the history of the NZAP's move towards the statutory registration of psychotherapists. The statutory regulation of psychotherapy and the state registration of psychotherapists always poses a problem for the relevant professional associations, which, ironically often have promoted such moves, as did the NZAP; and these problems — including those of authority, territory, identity, and relationship — is reflected in the history as well as in current debates within the NZAP and beyond, and in this book which, I hope, contributes to those debates both in this country and internationally. In Chapter [6] I review and critique the *HPCA Act 2003*, the legislation which ushered in a new era of regulated health professions in this country and new "responsible authorities" (RAs) i.e. the Boards and Councils of those professions regulated under the *Act* . In writing this chapter I was informed and inspired by Grant's initial research into the *Act* and I am grateful for his

early work and contribution to this chapter. In Chapter [5] Margaret Poutu Morice and Wiremu Woodard outline a number of objections to the *Act* and to registration from tangata whenua, and generously offer descriptions of overarching ethical values and principles derived from te Ao Māori which were originally compiled by Margaret and presented to an Ethics Committee Working Party formed at the request of the Board — which then rejected the work and, indeed, the gift. Margaret's work is an example of the practice and spirit of partnership, based on a Treaty relationship. The fact that this was rejected by an authority acting on behalf of the Crown is part of the problem that the Board has created in the field of psychotherapy — and is representative of a wider, social problem in this country. Chapter [4] comprises a dialogue, based on an exchange of e–mails, between Paul Bailey, the architect of state regulation and professional registration, and myself. I am particularly grateful that Paul agreed to participate in this dialogue and to publish our correspondence as I think it not only reveals some of the background to this recent history and his own motivations for pushing for the statutory regulation of psychotherapy and the state registration of psychotherapists, but also demonstrates the pluralistic approach of the book. In Chapter 9 Susan Shaw takes a broad, sociological perspective on regulation, and addresses and answers the questions "whence, why, how and whither" RAs and, in doing so, illuminates the roles that such authorities (Boards and Councils) take in the socialisation of people within a profession. She also makes the point that will be a relief for some: that such authorities are not inevitable — or permanent! Jonathan Fay follows this analysis [now co–authored in a new Chapter 7] by offering a specific critique of the authority that governs psychotherapy, the PBANZ.

Part II comprises seven chapters which offer different reflections on and responses to statutory regulation of psychotherapy and the state registration of psychotherapists. The first two chapters offer different and quite personal voices of response to registration. In Chapter [11] Evan Sherrard, a respected elder in our community, and an Honorary Life Member of the NZAP, offers a poignant account of his "uie" or "U– turn" with regard to registration — and Evan is not the only elder to have been shaken and disturbed by the Board's attitude to regulation and registration. One of the points Evan makes in his chapter is that, with the advent of regulation, the concept of "protection" shifted from being defined, discussed, and managed by psychotherapists as professionals to one defined and regulated by the

Act, and, in effect, by politicians and administrators. This is not only interesting, it also demonstrates why it is important for psychotherapists and psychotherapy practitioners to know what is defined and encompassed by the *Act* [see Chapters 5 and 6, and Appendix 3). [This is followed in a chapter by Susan Green who writes of her story of her journey and responses to the history — and, it is, arguably, a *his* story — of arguments for and against against regulation and registration.] Taking my inspiration from Freud's (1926/1959) paper on "The question of lay analysis", and drawing on the international literature, in Chapter [8], I review and critique the arguments for regulation and registration, and advance those against statutory regulation and state registration. The following three chapters in this Part take and develop different perspectives on the subject, informed by psychoanalysis, neuroscience, and eco–social justice, respectively. In Chapter [12] Jeremy Younger offers his particular "take" on the psychodynamics of regulation and reflects on why in this country there was so little (psycho)analysis of this move and proposal. In Chapter [13], Louise Embleton Tudor draws important and poignant analogies between regulation in terms of human development, informed by research in neuroscience, and the regulation of the state in the form of a responsible, regulatory authority. Reading this, it strikes me that, unless we want to give away the functions of our frontal cortex to any regulatory authority, as human beings and citizens, let alone those who are psychotherapists, we must resist such state regulation of our brains, bodies and beings. In Chapter [14] Sue Cornforth offers a critical perspective on regulation and registration informed by a deep commitment to eco–social justice. In the context of current discussions within NZAC and between NZAC and the government about registration, Sue's chapter is particularly timely. As a part of the wider project to stop and think about the issues raised by regulation and registration, Sue's chapter and, hopefully, the book as a whole, will contribute to offering the NZAC and other professional associations and bodies considering statutory regulation and state registration some foresight, based on the benefit of hindsight.

There are many forms or models of regulation (see Macleod & McSherry, 2007; and [Chapter 1]), a view that is both acknowledged and supported by the Ministry of Health (see Director–General of Health, 2009; MoH, 2010c). Three chapters in [the original] Part III focus on different models of regulation, registration, association, and organisation. In Chapter 10 Roy

Bowden outlines and reviews the NZAP's system of professional peer regulation and registration through application, supervision, and peer relationship, and, in doing so, emphasises that such professional and peer regulation and registration is based on knowledge through relationship, and that has provided professional safety and public protection over many years — and continues to do so. There are a number of forms of self– and peer regulation and organisation (see, for instance, House & Totton, 1997; and the Independent Practitioners' Network [IPN], 2010). Self–regulation and co–regulation is, of course, the way in which, as human beings, we organise ourselves. This has its roots in ancient wisdom traditions, and more recently in the work of Reich (1942/1973) and others; and is recognised by one of the RAs, the Osteopathic Council New Zealand (2010), which: "endorses the following philosophy and principles of osteopathic treatment [including that]: The body possesses self–regulatory mechanisms" [see also Chapter 13]. It is a pity that, at least at present, some RAs, including the current Psychotherapists' Board, do not endorse the self–regulatory mechanism of the professional "body". Nevertheless, it is perhaps significant that, having considered regulation under the *Act* (and also, perhaps, the experience of psychotherapy and psychotherapists), the NZAC is currently and seriously considering a model of self–regulation (see MoH, 2010c; NZAC, 2010). [In Chapter 14 Jonathan Fay outlines the recent history in this country of the developing critique of statutory regulation and state registration and, specifically, the story of the organisation of the Independently Registered Psychotherapists, now the Independently Registered Psychotherapy Practitioners (IRPP) (see www.irpp.org.nz). Chapter 15, written collectively by the Steering Group of the IRPP, offers some strategies for resistance and action, strategies which, as this book was going to press (in December 2010), were already showing signs that the tide is turning — towards freedom and pluralism. In many ways a published book is fixed at the moment of its publication; we hope to keep the ideas and arguments contained herein alive and updated not only through our actions and reprints but also by the development and use of the IRPP's website, to which the reader is referred for updates, news, and continuing debates and blogs.]

Having pushed for the statutory regulation of psychotherapy and the state registration of psychotherapists, the NZAP as an Association appears to be having second thoughts; now clearly supports a pluralistic approach to the practice of psychotherapy in Aotearoa New Zealand and supports both

registered and non–registered practitioners and members; and, rightly, is concerned about attacks on and harassment of its members by the Board. Speaking at the meeting of the Northern Branch of the NZAP in September 2010, Seán Manning, the President of the NZAP, said: "Those of us who are in favour of regulation and those of us who protest against regulation and registration — we all do psychotherapy". As the President of the NZAP — and as a colleague and friend with whom I enjoy the craic — I am particularly delighted that Seán agreed to my invitation for him to write the first of four Afterwords to this book [now Chapter 17], a commentary or response which, in its presence, if not all its content or tone, reflects pluralism. Although Seán says that he senses that he is the "opposition", I see him and his contribution as offering more of a counterpoint to the theme and variations of the main text. Whilst this book is particularly concerned with the situation in Aotearoa New Zealand, I am aware of the broader context of the struggle for freedom, pluralism and autonomy in psychotherapy and, more generally, in the psychological professions, and against statutory regulation which is taking place in a number of countries — see, in the UK, the IPN (http://i–p–n.org/); The Alliance of Counsellors and Psychotherapists Against State Regulation in the UK (see www.allianceforcandp.org); and the Coalition Against Over–Regulation of Psychotherapy (http://www.coregp.org/news.htm). Writing in 1927 about the question of lay analysis (a question stimulated by moves by American psycho–analysts to restrict analytic training to medical doctors), Freud (1927/1959) argued that this question should not be decided on practical considerations alone or on "local conditions" (in America). Similarly, the question of the regulation of psychotherapy and the registration of psychotherapists is an international one. For this reason I am also delighted to welcome two Afterwords from colleagues overseas: Denis Postle from the UK, and Anne Martin and Coinneach Shanks from Ireland [Chapter 17]. For many years Denis has been hugely active in what might genuinely be referred to as the "resistance movement" to the regulatory excesses of both the "psy" professions in the UK as well as the UK government itself. Denis is the author of many papers and some books on this area and has established and hosts the ipnosis and e–ipnosis website (http://ipnosis.postle.net). Anne Martin and Coinneach Shanks are based in Ireland and, like Denis, are participants in the Independent Practitioners Network: Anne in both London and Dublin, and Coinneach in Dublin. Both

these Afterwords offer us not only some comments on the book, but also an international perspective on our "local condition".

As this book is also intended for an international audience, Wiremu Woodard has kindly provided a Glossary [now *Appendix 1*] of terms in te reo Māori.

The research for and preparation of the book has also coincided with — and has both informed and been informed by — an intense period of political activity around the subject, and I have, at times, had a sense of having to surf the waves of a rapidly turning tide. Regarding the title of the book, I had had it in mind for some months; just as I was finishing this Introduction (in November 2010), I walked into a colleague's office at Auckland University of Technology (AUT), and saw a book on her table, titled *Turning the Tide*, edited by Peter Greener (2001). Peter Greener, who is a Senior Fellow at the Command and Staff College, New Zealand Defence Force, was previously the Head of School, School of Public Health & Psychosocial Studies [and now Adjunct Professor] — at AUT. Interestingly, and perhaps significantly, his book is about a new approach to conflict resolution. Clearly, there is disagreement and conflict within psychotherapy regarding regulation and registration; this books seeks to clarify the conflict, and, in the context of psychotherapy in Aotearoa New Zealand to prepare the ground for resolution through pluralism; [and so it seemed appropriate that the title of this book should echo that of Peter's].

I have been familiar with and involved in debates about professional regulation and registration for nearly 20 years and, although I am new to the debate in this country, I am nevertheless already aware of the heat that this debate — and even the argument for a pluralistic approach — generates. It is easy to characterise those of us who are stopping to think, and advocating the kind of pluralistic approach represented in the contributions in this book as "radical" or even "rebellious". Although, personally, I don't mind these particular attributions, I think that I and others are actually being rather conservative in that we are arguing for "conserving" certain traditions about the nature and purpose of psychotherapy; and, of course, in asserting our right to practice under the law, we are conserving the status quo (for further discussion of different traditions in psychotherapy, see Fay, 2008; Tudor, 2010).

ACKNOWLEDGEMENTS

Writing for and editing a book is not easy, and this particular project has both suffered and benefitted from the necessity of extremely tight deadlines. I am grateful to all the contributors not only for the quality of their contributions, but also for their forbearance of me fulfilling my editorial role, including hassling, and, of course, making final decisions; and I am especially appreciative of Seán, Denis, Anne, and Coinneach, who had the additional task of reading the whole book before writing their contributions as Afterwords [Chapter 17].

As an editor, whilst I am concerned to achieve (academic) rigour and consistency, for instance, with regard to writing, citations, referencing, and layout, I also support diversity, and I have sought to do this especially in this volume by honouring different expressions in different chapters, thus: different spellings of different references to and punctuation of "te Tiriti/the Treaty", "te Tiriti | the Treaty", and "the Treaty"; "state" and "State", etc., all of which carry different meanings.

As a contributor to any book I also edit, I am concerned that someone edits the editor and, in this case, I am most grateful to two colleagues at AUT: Dr Susan Shaw, Associate Dean (Undergraduate) [now Academic], for most ably fulfilling this important regulatory function, and to Associate [now full] Professor Kate Diesfeld, School of Psychosocial Studies and Director, National Centre for Health Law and Ethics, for her close reading of the text and especially Chapters [4, 6, and 8].

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In many ways, writing and editing are solitary activities; they are, nevertheless, also ones which require a lot of support, and benefit from a sense of community. As a relatively recent immigrant to the Land of the

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PART I

Recognition, regulation, and registration

Chapter 1

Recognition, regulation, and registration

Keith Tudor

In the literature and debates about professional regulation, various terms, especially regulation and registration are often conflated, and sometimes, deliberately so. In distinguishing and clarifying these two terms, I also refer to recognition (see Tudor, 2013). Broadly, recognition refers to the identification and acceptance of something, in this case, a profession, by an external authority, such as the public, or 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 trade or professional association or organisation. Of course, in the case in which statutory regulation simply requires a professional to be registered with a professional body (which supports professional self–regulation), there is a substantial overlap between the two terms. As a way of setting the scene for this book, in this introductory chapter, I elaborate these particular three "Rs", and offer a critical response to the criteria for statutory regulation as set out by the New Zealand Ministry of Health. As the original article on which some of this chapter is based first appeared in the *New Zealand*

Journal of Counselling, it also refers to the counselling profession and to counsellors, ‘though it is also applicable to other professions considering statutory and other forms of regulation.

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*, e.g., “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, problems with this argument.

The first is that, to a greater or lesser extent, it discounts both the standing and the independence that a profession already has. For instance, as an activity, counselling is already “recognised” by the general public and the media, and, in most countries, considerably more so than psychotherapy, which, generally, is much less known or understood. The word and concept “counsel” goes back some eight centuries; and, moreover, it fulfils the criteria of a “profession” in terms of most dictionary definitions of that word and concept. In this part of the world, “counsellors” 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. All human beings (and other animals) need recognition, and, 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 a — or, more problematically, the — external locus of evaluation of such recognition gives away the power of such evaluation, and suggests a certain lack of self–confidence and/or identity as a professional and a profession.

The second problem is that such recognition appears more reactive than proactive. Moves towards professional recognition through statutory regulation often appear to be motivated by reactions 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 or in part, on the basis that psychologists are registered; 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 Aotearoa New Zealand, 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)

Thirdly, for a profession to seek recognition by this means doesn't necessarily work. Eight years after the psychotherapy profession in Aotearoa New Zealand became regulated (by means of the registration of the title "psychotherapist" under the Act), on its website, Careers NZ (2017) rates the "Chances of getting a job as a psychotherapist [as] … poor due to limited recognition and funding in the public sector". This demonstrates that "recognition" depends more on political (policy) and economic decisions made at national and local levels, than on registration per se (see Tudor, 2017).

However, the fourth, and perhaps the greatest problem with the argument for such recognition in New Zealand, 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:

> **3. Purpose of Act**
> (1) The principal purpose of this Act is to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions.

It is not — and should not be or have been used as — a vehicle for a profession to gain recognition from the state, a point that, in 2010, drew a comment from the Ministry of Health (MoH, 2010c):

> 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). (p. 6)

Clearly, as far as the Ministry is concerned, statutory regulation should not be about seeking mana (authority or standing), 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 by 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 Manning, 2006; and Chapters 3 and 4 in this volume), 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 hoped for 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, over the past eight years, at any one time, between 10–20% of members of the NZAP have not registered with the "responsible authority" for psychotherapy (under the Act), i.e., the Psychotherapists Board of Aotearoa New Zealand (PBANZ, or "the Board"). Currently (at July 2017) this figure is 24%. (There are some members of the NZAP who are registered with other RAs such as the New Zealand Medical Council (n=5) and the New Zealand Psychologists Board (n=6); taking account also of the members of the New Zealand Association of Child and Adolescent Psychotherapists who are registered

with the Board (n=32), the total percentage of these two professional psychotherapy associations who are not registered is 22.6%.)

A further, related argument is that professional recognition through regulation under health legislation positions counselling and/or psychotherapy as a health profession, as distinct from being a profession (or professions) in its (their) own right, as is reflected in regulation under legislation specific to the profession, for instance, in Austria and Germany. While this association with health may be uncontentious for some, for others such close alignment with "health" is problematic for a number of reasons, especially as "health" so often actually means or refers to illness. In the Western world, health and health care are dominated by the medical paradigm; and health systems, policies, and practice in Aotearoa New Zealand are predominantly based on Western models of health at the expense of indigenous models of health, wellbeing, and dis–ease (see Pere, 1991/1997; Durie, 1994; and Chapter 5 in this volume).

REGULATION

There are a number of models of regulation or how rules are promulgated, monitored, and enforced, models which are summarised in Figure 1.1.

Figure 1.1. Models of regulation (based on Macleod & McSherry, 2007)

Least restrictive

⇓

Self–regulation (also known as *peer regulation*)
e.g., through voluntary membership of a professional organisation or group (see, for instance, Heron, 1997; Totton, 1997; New Zealand Association of Counsellors (NZAC), 2016)

⇓

Negative licensing or reverse registration
i.e., being allowed to practise unless listed on a register of practitioners ineligible to practise (see MoH, 2012)

⇓

Co–regulation
whereby members of a professional association are regulated by that association in conjunction with some other authority, usually government

⇓

Reservation of title
whereby a statutory registration authority reserves a professional title, e.g., "counsellor" or

"psychotherapist", for those eligible and approved to be registered (which is the system currently administered by the PBANZ)

⇓

Reservation of title and certain core practices
which restricts both title and some activities or practice, usually designated as "restricted activities"

⇓

Reservation of title and wholesale practice restriction
which restricts both title and an entire scope of practice to members of the registered profession and other specified registered health professions

⇓

Most restrictive

From this it is clear that in debates about regulation, a profession could 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 to external authorities, usually government, the regulation and state control of certain professionals and, increasingly, the regulation of the profession as a whole.

Practitioners thinking about statutory regulation should be clear that the reservation of title means precisely that: that the particular title is reserved for those practitioners who are registered; others may not use the title, or, more precisely, if they do, they risk prosecution. Currently, under the New Zealand *HPCA Act*, the registered 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. Within these, there are various sub–categories such as "interim psychotherapist" and "psychotherapist with child and adolescent specialism".

The protection of these titles — and the public — 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. (for a complete list of which see Chapter 6) — each of which has 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 (see Fay, 2011a, 2011b; Tudor, 2012; and Chapter 7), and my own research into the various scopes of practice determined by the RAs, 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, 2016, 2017).
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 in 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 1.1), and that some represent and others are clearly working towards the most restrictive model of reservation of title and wholescale practice restriction (see Tudor & Shaw, 2017).
d. That, once a title is regulated under the Act, the profession loses control over that scope or scopes, and, I suggest, to a greater or lesser extent, its identity

Given this, for those professionals and professions considering statutory regulation, it is worth noting that, while from a developmental, emotional, and social perspective, regulation is both necessary and important, for a profession statutory regulation is not necessarily desirable or inevitable. Most professions operate on the basis of some form of regulation, whether this is self–regulation, co–regulation, voluntary regulation, or statutory regulation. In New Zealand, 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 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).

Another concern for professions and professionals contemplating regulation is that once a profession gives away its regulatory authority and power to the state, it is virtually impossible to reclaim it. Despite the fact that the vast majority of the literature on the subject is sceptical about the statutory regulation of psychotherapy, and discusses and anticipates the problems encountered in the change from professional to statutory regulation, a number of psychotherapists in Aotearoa New Zealand have been surprised at just how the RA for psychotherapists has manifested its regulatory functions, This has included the 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 (11, s14(2)) (see Tudor, 2011a; and Chapter 7).
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 account of which, see Tudor, 2012; and Chapter 7).

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 (see Chapters 7, and 8).

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 (see PBANZ, 2012; and Chapter 7).

One major significance for a profession of regulation under legislation such as the *HPCA Act* is that it marks a profound shift away from self–regulation and autonomy for, in this case, psychotherapists and their professional bodies such as the NZAP and the NZACAP (see Chapters 3 and 11). Now, under s7 of the Act, a practitioner is held to be unqualified not through a lack of qualifications, experience or membership within a professional body, but through the absence of registration. Moreover, as there's no such thing as an unregistered psychotherapist (at least in the eye of the law), psychotherapy practitioners who choose not to be registered, are at risk of losing not only their professional title but also their identity.

The regulation of psychotherapy also marks a shift from what we might conceptualise as a psychosocial balance between trust and mistrust (see Erikson, 1959/1994), regulated by codes of ethics and practice and procedures with the profession, to a system based entirely on mistrust. For example, under s19 of the HPCA Act, an Authority can receive information from and question under oath any person it sees fit in considering a registration application; and, under s36, a practitioner with a valid annual practising certificate may be the subject of a competence review, without the need for any complaint. Whilst I accept that it is important to allow for proactive protection of people who are or are potentially vulnerable, the fact that the Act gives the power to an RA to review the competence of a practitioner "whether or not … there is reason to believe that a practitioner's competence may be deficient" (s36(4)) appears itself somewhat deficient.

The move from professional to state regulation represents a shift backwards from interrelationship and co–regulation (see Chapters 10 and 15) to a non relational, statutory regulation, and, thus, may be seen as a symptom of societal regression rather than progression (see Tudor, 2011b). For example, under s75 of the Act, whilst a practitioner who is the subject of a professional conduct committee must be told the membership of the committee, and is able to appeal it, the authority is under no obligation to respond to her/him!

The move from professional and free association with regulation and recognition by self, peers and supervisors to a system of statutory regulation managed by administrators, career Board members, and politicians also changes the relationship the place and role of professional associations and the relationship between its members and their association(s) (see Chapters 3 and 9).

This brief discussion of regulation has focused on some of the implications of regulatory policies and authorities, in effect, the politics of regulation. From a therapeutic perspective, there is a further aspect to this, which concerns the neuroscience of regulation, i.e., attachment, hierarchical organisation and homeostasis, co–regulation and self–regulation, self–esteem and gaze. These two aspects of regulation, the political and the neuroscientific, which have been brought together by Embleton Tudor (2011; Chapter 13 in this volume), challenge us to think about:

a. The psychological implications and impact of regulation — as Freud (1926/1959) put it: “the things that really matter — the possibilities in psycho–analysis for internal development — can never be affected by regulations and prohibitions.” (p. 250)
b. The personal implications of such regulation — i.e., both the personal motivations behind moves towards statutory regulation by another (the Other); and
c. The philosophical implications — for instance, about whether, as an operating philosophy and practice, such external regulation matches existing codes of ethics, for instance the values of the New Zealand Association of Counselling, 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)

It is questionable whether such statutory regulation reflects 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. Moreover, following Mowbray (1995), I suggest (in Chapter 8) that such regulation is harmful in that it encourages the view that we need to be — and can only be — regulated by an external other. In this context, it seems particularly ironic that psychologists and psychotherapists would chose to do this.

REGISTRATION

There are essentially two forms of registration: voluntary registration, that is, with a professional association; and state registration, that is, with some authority (board, council, ministry, or organisation) under legislation, which may be generic (health) or specific, for instance, to psychology, psychotherapy, and/or counselling.

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 1.1.

Reservation of title

While the title (chiropractor, dentist, etc.) is reserved, the practice is not; thus, currently in Aotearoa New Zealand, it is possible to practise psychotherapy without being a psychotherapist, as registration as a psychotherapist is not mandatory. As long as a practitioner does not represent themselves or "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. (see Chapter

19). From the history of counselling and psychotherapy in this country, and of the NZAP and its admissions process, it is clear that there are many members, for instance, 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, disproportionately restrict the freedom of expression and work–based rights to make a living.

Reservation of title and certain core practices

This (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 as well as 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 wholesale 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 others seeking registration with a similar "responsible authority".

Reservation of title and wholescale practice restriction

The final model as identified in Macleod and McSherry's (2007) taxonomy is the most restrictive in that it restricts both title and practice to registered practitioners only. This is very serious for the profession of psychotherapy internationally as some legislation restricts such practice to qualified psychologists and/or physicians (for instance, in Germany and Italy), thus closing the door on "lay" (i.e., non medical) psychotherapists (for further discussion of which see Chapter 8).

Principles and criteria for regulation and a critical response

In January 2010 the MoH issued a discussion document, entitled *How Do We Determine if Statutory Regulation is the Most Appropriate Way to Regulate Health Professions?* (MoH, (2010b), in which it outlined the "overriding principles" for regulation under the Act. They are that:

- the health services concerned pose a risk of harm to the public, or it is otherwise in the public interest that the health services be regulated as a health profession under the Act
- the profession delivers a health service as defined by the Act (where a health service means a service provided for the purpose of assessing, improving, protecting or managing the physical or mental health of individuals or groups of individuals) [and]
- regulation under the Act is the most appropriate means to regulate the profession. (p. 10)

It also proposed the application of "second–level criteria" based on those used in Australia (Council of Australian Governments, 2008). Here I discuss each one in turn; as they are progressive in that the subsequent one follow and are dependent on the previous ones, I address the first two in more detail.

Criterion 1. That the activities of the profession must pose a significant risk of harm to the health and safety of the public

They did — and do — not.

As the concept of "public protection" against "significant harm" is so crucial to the argument for regulation, both locally (see ss3(1) and 116(a)(i)

of the Act; MoH, 2010a) and more globally, and was crucial to the NZAP's argument for seeking statutory regulation, it is particularly important to examine this criterion (also see Chapters 3, 4, 6, 8, 10, and 15). In arguing the case for regulation under the HPCA Act any profession has to argue that it poses a significant risk to the public. Indeed, in a MoH (2007) document, under the heading "Statement of the Nature and Magnitide of the Problem and the Need for Government Action", the case is stated somewhat baldly:

> The New Zealand Association of Psychotherapists (NZAP) has applied for the inclusion of psychotherapy as a health profession under the Health Practitioners Competence Assurance Act 2003 (the Act) on the basis that it poses a risk of harm to the public. The NZAP has made the application on behalf of the profession.

Whilst this statement addressed this criterion, when we think about this more closely and critically, there is a certain irony in a profession such as psychotherapy, in effect, saying:

> "We're an important and significant profession, with a long and respectable history, and we are indeed a health profession, but our practitioners and our practices pose such a significant risk to the public, that, you, the state, need to protect our clients and citizens against us."

This strikes me as akin to seeking voluntary admission (to hospital) and regulation by another for fear of certain antisocial tendencies, a perspective (and a diagnosis) based on low self–esteem and poor self–control. The MoH's (2003) document outlining the *Proposal That Psychotherapy Become a Regulated Profession Under the Health Practitioners Competence Assurance Act 2003* cited from supporting material provided by the NZAP as evidence that the public is at risk of harm by the practice of psychotherapy. This comprised the following assertions:

1. That some psychotherapy has a negative effect, i.e., some clients get worse; negative effects are occurring extensively across modalities, diagnoses and treatment intervention.
2. That some clients, for example, clients with borderline personalities and schizophrenia, appear to be susceptible to worsening, especially

when treatment is aimed at breaking down/challenging habitual coping strategies and defences.
3. That there is a link between therapist attitudes and deterioration; dislike, disrespect and low empathy correlate with lack of improvement or negative change.

Thus, the NZAP was presenting the view that, because some clients get worse and others do not show improvement, and due to bad attitudes on the part of some therapists, the whole profession needed to be regulated (for further discussion of these assertions, see Chapter 8). As "evidence" goes, this offered a remarkably low level of evidence in support of the criterion that the activities of the profession of psychotherapy posed what the Ministry of Health referred to as a "significant" risk of harm to the health and safety of the New Zealand public such that the whole profession needs to be regulated by statute and the state. Moreover, even taking these assertions as facts, none of them can be remedied by registration.

Reading Paul Bailey's regular reports on occupational regulation in the NZAP *Newsletter* over the seven years 1999–2006, it is clear that officials in the MoH needed some persuading as to the risk of psychotherapy, i.e., the nature, frequency and severity of the potential risk; the likelihood of risk; and the nature, frequency and severity of harm to, or consequences for the public (see Director–General of Health, 2009). It is clear that the fact that psychotherapy is a regulated profession owes more to the determination of a small number of people (see Chapter 4) (and the lack of engagement in the debate amongst a larger number of people) and Paul Bailey's powers of persuasion, than a base of "evidence" from practice — and, as we know, there is no evidence to suggest that the state registration of psychotherapists or the statutory regulation of psychotherapy protects the public or ensures the competence of the practitioner (for details of which, see Chapter 8).

The later "Regulatory impact statement" (MoH, 2007) cited, presumably as evidence of "the nature and magnitude of the problem", two complaints in 2002/2003 to the Health and Disability Commissioner; claimed, without reference to any research or evidence, that "an estimated 80 percent of adverse events are not reported"; and went on to assert that: "The severity

of harm that could result from unsafe practice, including suicide or death of another party, is such that regulation of the profession is warranted."

Interestingly, in his contribution to Chapter 4 Bailey reveals that, for him, the argument that the regulation of psychotherapy was in the "public interest" (s115(1)(ii)) was more important than the argument that it would protect the public. This prioritisation of arguments, however, is problematic, given that, according to the Director–General of Health (2009):

> Where the focus of a proposal is more on the public interest than on the risk of harm, to accord with the principal purpose of the Act there must also be some significant health–related aspect of the work of the putative profession in which it is appropriate to be seeking to protect the health and safety of members of the public. (p. 61)

From my reading of the literature and, specifically, Bailey's reports in the NZAP *Newsletter*, as well as the special theme issue of the Newsletter on registration (Manning, 2006), it is clear that the "public protection" argument was not held as the central argument to regulation under the *HPCA Act*, but that the Act became a means to an end: of seeking professional status and parity. An MoH (2010c) document on statutory regulation specifically addressed such elision (see above).

Given all this, and coming at this as someone who was not involved in these discussions or the preparation of this "evidence" to the MoH, something felt wrong. The evidence presented appeared to be very thin, and the argument that psychotherapists were so dangerous that their clients needed protecting against them both circuitous and suspect — and, in terms of relationships between those in the profession, divisive. Then, in a discussion forum at the 2010 NZAP Conference held in Dunedin, in response to yet another difficult discussion about registration and regulation, Roz Broadmore, an ex President of the NZAP and, alongside Paul Bailey and Gordon Hewitt, a member of the NZAP's working party on registration, said simply and clearly: "We lied:". She named the cause of the tension in the room: that the NZAP had (in her words) lied to the government about the risk to clients of psychotherapy in order to achieve professional registration and regulation under the *HPCA Act*. While the majority in the profession had gone along

with this, wittingly or unwittingly, and now view this as history, others did — and still do — not agree with or support this strategy and basis for registration. Hearing this myself, I felt angry (that my professional association had both done and disavowed this), and sad (that this had caused so much — and, to some extent, still causes a degree of — tension between and amongst colleagues in the profession); but also relieved (that someone who had been there and centrally involved was, in effect, speaking truth to power). I refer to this for two reasons:

1. Because it did happen and it has caused tensions between colleagues, from which others can learn. I suggest that any colleagues and/or professional associations seeking state registration of psychotherapists and/or the statutory regulation of psychotherapy should do so with knowledge, understanding, integrity, and reflexivity — or suffer the consequences.
2. Because those of us who choose to live outside the specific law of the *HPCA Act* but fall within other legislation have to be particular clear about what we say about ourselves and our work. This has led to accusations from some colleagues about being disingenuous. This history demonstrates that the disingenuousness lies with those that sought registration at all costs, against the evidence, without due diligence, and without meeting due standards. In the first edition of this book, I quoted Bob Dylan's famous line "To live outside the law you must be honest" (Dylan, 1966) and whilst I still agree with this, I would also add that to live within the law and by a specific law, it is also important to be honest.

Criterion 2. Existing regulatory or other mechanisms fail to address health and safety issues

At the time of the Act (2003), the mechanism of membership to the NZAP had been successfully addressing health and safety issues for some 55 years. There was also — and still is — in existence the Code of Health and Disability Services Consumers' Rights, published and administered by the Health and Disability Commissioner (1996) (see Appendix 2). This Code affirms or "codifies" pre–existing consumer rights and corresponding provider responsibilities. It is an important and significant Code which applies to all "health care providers" irrespective of whether they are

registered or not — and yet, it was not referred to in any of the documentation regarding the regulation of psychotherapy (e.g., MoH, 2003, 2007). The rights encompassed by the Code are significant, especially those that deal with standards of care and informed choice for, as Sladden (2001) argued "these are central to an understanding of ethical and professional responsibilities". (p. 1) The Code, which is also published in te reo Māori and incorporates important Māori concepts, provides protection for the public, without taking away the responsibility of the profession. As Sladden put it:

> The Code is not, and should not be, the primary mechanism for the establishment of standards. Right 4 of the code in intended to provide a means by which standards set by other bodies can be enforced. Ultimately the responsibility for establishing and maintaining quality standards should lie with the relevant profession. (p. 5)

Criterion 3. Regulation is possible to implement for the profession in question

Yes — both prospectively in that the NZAP was already regulating the profession, and retrospectively in that statutory regulation has been implemented.

The consequences of the implementation, however, has, in my view, been problematic in that:

- There was no evidence or necessity for it;
- It was based on a lie, i.e., that psychotherapists were a significant risk to the public;
- It excluded — and continues to exclude — and marginalise certain practitioners, e.g., Māori, and elderly and retired colleagues;
- It undermined a well–established model of professional regulation (see Chapter 10); and
- It has been divisive.

Criterion 4. The benefits to the public of regulation clearly outweigh the potential negative impact of such regulation

They do not.

There has been no recorded, observable benefit to the public; in terms of public access to psychotherapy, the benefit (over the course of eight years since state registration) of only five additional psychotherapists working in New Zealand District Health Boards (see Tudor, 2017) does not outweigh the negative impact of regulation (see Chapter 8).

Criterion 5. It is otherwise in the public interest that the provision of health services be regulated as a profession

No.

There was and is no evidence that the regulation of psychotherapy was needed in terms of the public interest (see above, and Chapters 4, 6, and 8), or to support the provision of health services.

Having discussed the "3Rs" of recognition, registration and regulation, Chapter 2 considers and critiques the second aspect of the context of registration (and regulation) under the Act, the question of competence.

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Chapter 2

A competency mechanism

Nick Drury

This chapter offers a critical review of the dominant "competency mechanisms" recommended by the "psy" professions for professional development and public assurance. Although the New Zealand Association of Counsellors (NZAC) has voted against seeking registration under the *Health Practitioners Competence Assurance Act 2003*, it has advanced "competency mechanisms" similar to those developed by some of the other registered health professions. These mechanisms are a form of "panopticism", which has been subject to severe criticism by Foucault and other critical scholars. A review of the evidence shows that neither licensing nor panopticonian self–examination protects the public as intended. An alternative mechanism of routine outcome monitoring is therefore suggested that makes practitioners more directly accountable to their clients, rather than to a third party. This not only positions counselling more favourably, both economically and politically, but also resonates better with the emerging 4E–cognition paradigm, which promises to be ecologically more sound.

The New Zealand *Health Practitioners Competence Assurance Act 2003* calls for "mechanisms to ensure that health professionals are competent and fit to practise" (s3(1)). Criticising the mechanism developed by many health

professions, including the NZAC, of some form of regular self–examination, known as "panopticism", this chapter argues that public safety and assurance can be better achieved by transparent routine outcome monitoring. It will also show the emergence of a new paradigm in philosophy, politics, and cognitive science that suggests a sea change in how competency assurance might be achieved. The paper urges professional associations such as NZAC to adopt this change.

Historical context

Since the 1950s, membership of trades unions has been declining, with a shift from production to service industries accompanied by a growth in occupational regulation (Kleiner & Krueger, 2010). This has occurred against a backdrop of an accelerating institutional production of individualism, well–identified by Foucault in his early work (e.g., Foucault, 1980). Bauman (2007) has described our rapidly changing post–industrial society as "liquid modernity" as the neoliberal agenda has accelerated the individualising process by casting everyone as an entrepreneur, which, in turn, speeds up the market. As Foucault (2008) foresaw, increases in entrepreneurship or profit–driven market competition result in increased frictions, and this requires more judges to regulate the frictions (for further discussion of which, see Foucault (2008). Thus, risk management regulations have arisen to deal with these growing uncertainties (Beck, 1999; Power, 2007).

Occupational regulation, as an aspect of this, has increasingly shifted from minimally restrictive forms of peer membership to highly restrictive forms of licensing (or registration) where, in the "psy" disciplines — i.e., psychiatry, psychology, psychotherapy, psychoanalysis, as well as counselling, couple and family therapy, social work, etc. — titles and scopes of practice are prescribed and monitored in some manner (Macleod & McSherry, 2007). Across the board, "[o]ccupational licensing has been among the fastest growing labor market institutions in the United States since World War II." (Kleiner, 2015, p. 2)

This increasingly restrictive approach to occupational regulation would see neither Bill Gates nor Steve Jobs eligible for licensing as executives, as neither graduated from a university. On the basis of his education, Jay

Haley, a founder of family therapy and the journal Family Process, would not be eligible for registration (or licensing) in any of the "psy" professions today, and might struggle to gain membership in the NZAC. Research examining the relationship between therapeutic effectiveness and outcome that considers a variety of practitioner variables — including professional development, years of experience, and qualifications — shows there is no relationship (Chow, Miller, Seidel, Kane, Thornton, & Andrews, 2015; Malouff, 2012). However, despite a lack of empirical evidence, regulators continue to insist that competency assurance processes involving practitioner accountability for mandatory continuing education make them more effective and less likely to be harmful.

The claim that they will be less harmful stems from neoliberal risk management procedures, for, as Power (1999, 2007) demonstrates, practitioners are increasingly being judged on their adherence to a set of risk management rules. For example, a Royal College of Psychiatrists survey showed that most recommended "risk assessment" forms were seen as useless by psychiatrists, and primarily a form of defence "to protect the organisation" (Szmukler & Rose, 2013, p. 128). In Power's (2007) analysis, professional focus on clinical outcomes is being marginalised in favour of following defensible process, and, with this acceleration of managerialism, we are now witnessing a further shift from first–order risk (the safety of the client and others) to second–order risk, the reputational risk to the organisation or profession ("have they followed correct procedures?"). In medicine, this was seen in the increased funding to efficacy research, based on the risk management notion that accountability should shift to a practitioner's adherence to empirically–supported procedures (Chiappelli, Brant, & Cajulis, 2012).

However, although practitioner variables can be eliminated to a large degree in some physical health domains, the person of the therapist turns out to be the most important variable in mental health (Wampold & Imel, 2015). Indeed, mandating a specific treatment in mental health may actually do harm. Nevertheless, best–practice guideline committees threaten to excommunicate practitioners who fail to utilise empirically–supported treatments (Cooper, 2011; Prescott, 2013).

Further assaults on effectiveness in the name of efficacy (i.e., "best practice" procedures claims) came with the development of "core

competencies". The US Institute of Medicine (Greiner & Knebel, 2003) recommended five core competencies that all 21st–century health practitioners should be educated in as the "key skills" of the workforce. Various professional health institutions changed the number of core competencies — for example, the New Zealand Psychologists Board (NZPB) has nine (see NZPB, 2016), and these became the values against which health professionals began to be monitored and were required to self–monitor.

Although the US Institute of Medicine claimed that the "application of the competencies is not intended to be pejorative" (Greiner & Knebel, 2003, p. 49), practitioners may not share that view. Consistent with the paucity of evidence that such surveillance improves performance, it is noteworthy that wide variations in costs, quality, and effectiveness continue despite these efforts (Leifer, 2014; Yong, Saunders, & Olsen, 2010). Increasingly there are claims that it will take transparency of outcomes (of both practitioners and clinics/hospitals) and costs to bring about real quality improvement in healthcare (Henke, Kelsey, & Whately, 2011; Lamb, Smith, Weeks, & Queram, 2013). However, disclosing outcome variances has not been well received by some in the health field (Henke et al., 2011; Yong et al., 2010).

Many aspects of this history have been highlighted by other authors in this journal over the past decades (Cornforth, 2006; Crocket, 2013, 2014; McAlpine, 2011; Miller, 1994; Tudor, 2013). However, much of that conversation has been on the merits of state regulation versus self–regulation (via the professional association), without consideration that if the same mechanism is utilised, the difference might be moot. More recently, this conversation has begun to stress the importance of linking outcome monitoring to quality assurance (Crocket, 2013; Manthei, 2015), which fits well with the central argument of this paper: a need to move from process–based accountability to outcome–based accountability.

A PROTECTION RACKET?

Tudor (2016) has argued that overprotectiveness by the "Nanny state", such as we see in the state regulation of the psychotherapies, is an example of what Eric Berne (1964/1968) called a "protection racket" (a term from American slang referring to when Chicago gangsters sold phony insurance

policies). As early as 1974, Pfeffer concluded that occupational regulation in this form is not shown by empirical evidence to be in the interests of the consumers or the general public. Although we are led to believe that public outcries such as the Cartwright Inquiry or the Lake Alice adolescent unit scandal have driven the move to greater regulation, globally the initiative has more frequently come from within the professions themselves (Kleiner, 2006). Long ago, Carl Rogers (1973) noted that "tight professional standards do not, to more than a minimal degree, shut out the exploiters and the charlatans" (p. 383). Even Adam Smith (1776/2009) saw such endeavours as little more than a protection racket that claimed to protect the public but actually benefitted the guild. He said it was "impertinent" and "oppressive" for the lawmaker to "encroach upon the just liberty" of the workman and his [sic] employer to decide whom the employer employs, and that crafts lengthen the apprenticeship to ensure higher earnings (p. 91). Whether or not state regulators or professional guilds determine the length of the "apprenticeship" and the "core competencies" makes little difference to this argument about the effectiveness of the service the public receives. Smith had seen that medieval guilds were able to limit the number of individuals working in their industry and thus drive up prices; and all evidence shows that exactly the same is occurring with this resurgence of occupational guilds. The economist Milton Friedman noted the same with regard to the earliest licensed health practitioners (Friedman & Kuznets, 1945). He showed that doctors, who had been able to restrict the number of practitioners, had been able to drive up their incomes in the early part of the 20th century, in comparison to dentists, who had not restricted their numbers.

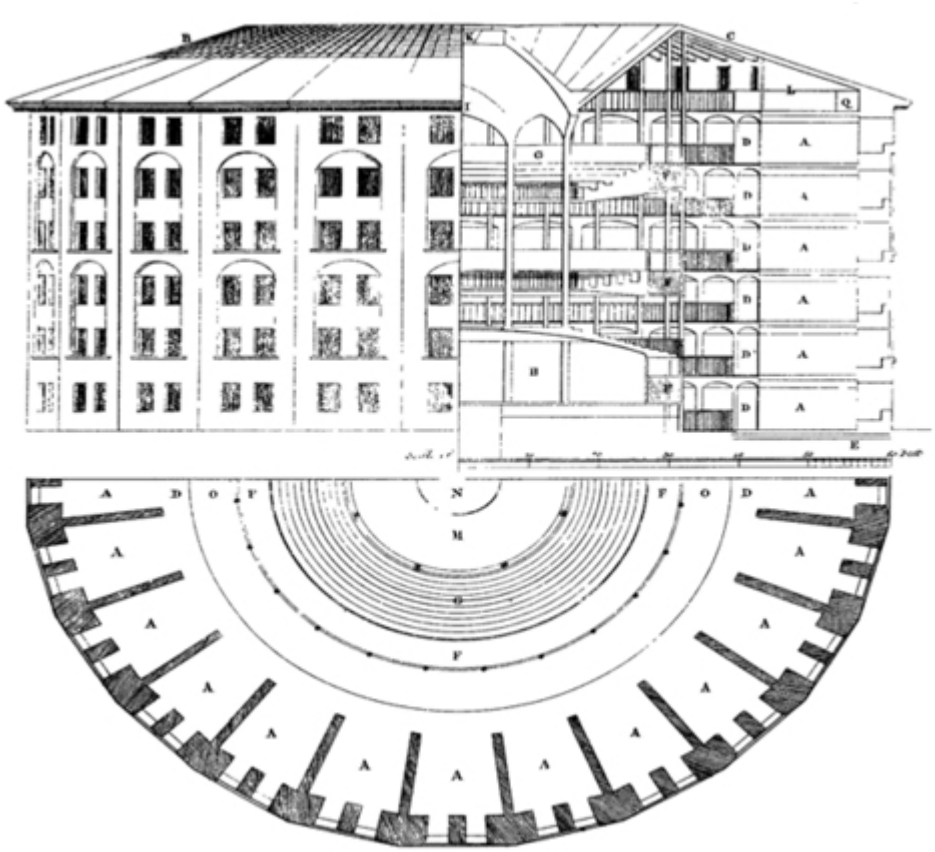
Kleiner (2015) has demonstrated that the price of services increased by at least 15% in the US through such restrictions, thus adding to the wealth disparity problem, which, in turn, is generating a lot of the social ills we are being called upon to address (Wilkinson & Pickett, 2009). Wealth disparity was at its lowest during the manufacturing era, as unions forced the sharing of profits. Kleiner and Krueger (2010) also identified the expansion of occupational regulation as a contributor to the neoliberal growth in wealth disparity. There is no compelling reason why it may be any different here in Aotearoa. As the NZAC's *Code of Ethics* (2016) calls upon us to "promote social justice" (5.2h), it is difficult to see how those of who are members can justify succumbing to the current dominant discourse on regulation.

Kleiner (2006) also argued that if more regulated professionals were making fewer mistakes because of ongoing competence programmes, their indemnity insurance would be lower — but there was no evidence that this was the case in any profession. Indeed, Kleiner found little in the way of evidence that the public is better protected by the greater regulation of numerous professions, including mandatory ongoing education requirements. Tudor (2011, p. 157) stated that there "are some eleven books (and many more papers) that have rebutted this assumption" that the recipients of "psy" services are better protected by licensing and regulation. Critics of licensing (e.g., Postle & House, 2009; Tudor, 2013) claim that those high–profile public scandals, such as the Cartwright Inquiry, are better dealt with through other legislative bodies such as the Human Rights Review Tribunal or the Health and Disability Commissioner, as they are usually system failures rather than individual practitioner failures. Many of these scandals could have been avoided through the transparency of practitioner and clinic outcomes (Henke et al., 2011; Lamb et al., 2013). Instead, there is a preoccupation with process regulation, which Power (1999, 2007), like many systems theorists, has argued is just another expression of the neoliberal agenda of greater individualisation and "responsibilization". Rather than recognising them by their fruits (Matthew 7:16), system failures are masked by undue attention to their processes.

Moving beyond panopticism

A significant reason for this flaw in our thinking, which causes us to focus on process rather than outcome, can be attributed to Cartesianism: the idea that we have a separate mind standing apart from life controlling it. For Foucault (1977), this way of thinking led to a sophisticated form of governance that he called "panopticism". The early 18th–century English architect and politician Jeremy Bentham designed a prison where the guard tower was such that the guards could look into the cell of each prisoner, but the prisoners could not observe the guards (see Figure 2.1) Bentham argued that since the prisoners never knew when they might be under surveillance, they would regulate themselves, and he considered this to be generalisable as the perfect metaphor for the governance of the whole population.

Figure 2.1. A design for a prison panopticon



Power (1999) claims that just such a governance process became a reality by late in the 19th century, as the management class entered the factories and used forms of panopticism to regulate deviations from the most economic behavioural norms. Foucault viewed this mechanism as having been so successful that it had created a self–surveilling society of "fabricated" docile subjects, monitoring ourselves for deviation from "normalizing judgements". These judgements are distributed in everyday conversation and institutional practices.

Western culture rationalised this loss of primary intersubjectivity when Hobbes (1651/1996) declared that the state of nature consists of a "war of every man against every man" (p. 88). Locke and Rousseau declared that we begin as blank slates (i.e., with no "primary intersubjectivity"), dissociated from each other and in need of an agreement or (social) contract to hold us together. Such social contract theories claim that we have

consented, either explicitly or tacitly, to surrender some freedoms in exchange for "a society of security" (Foucault, 2007, p. 11) — but such contracts are the very thing keeping this social neurosis alive, for they are premised on the assumption of our being separate.

As Tudor (2011) has noted, most indigenous traditions begin with our unity with each other, our innate sociality. In Māoridom we call this "whanaungatanga", our "us–ness" or "we–ness" if you like. In Zulu it is ubuntu; in Korean, "shimcheong" means to become one in flesh and spirit (Choi, Han, & Kim, 2007, p. 323). From the perspective of the Dreyfus' (1980) skill acquisition model, we might say that there was a stage of awkwardness as we learnt some particular social skill, but once mastered we should have returned to a state of unity, harmony, or resonance with others. However, due to the constant self–judgement of panopticism, we have become locked into a state of awkwardness. The social and ecological consequences are obviously now disastrous. Thus, panopticism is "diabolical" for it works against the generation of relationally responsive therapists (and people).

Competence and expertise

Are competence and expertise the same? Certainly, the skill acquisition model of the Dreyfus brothers indicates that mastery means achieving that state of "seamless" performance where the pilot is flying, and not the plane. The tool has become an extension of the master. Similarly, Polanyi (1974) saw competence defined by tacit rather than explicit knowledge, and that, like asking the millipede how it moved its 73rd leg, too much scrutiny destroys the skill. In the same vein, Wittgenstein attempted to show us that such "virtues" (skills) show themselves, or are revealed in performance, far more than anything we can say about them (Moyal–Sharrock, 2016). According to Alan Watts (1977), Taoists see the highest form of competence as a virtue called te, where "power is exercised without the use of force" (p. 121). He illustrated this by way of Chuang–tsu's story of Prince Wen's cook, who never needed to sharpen his knife in 19 years; instead of cutting or hacking at the meat, he allows his knife to find its way through the gaps in the meat, and when it comes to a piece of gristle or bone he allows it to slow down and find its way through the gaps there too. Prince Wen declares that from his cook he learns the way of life! A further

example is found in Aristotle's Nichomachean Ethics, where he suggests that heuristic devices such as epistemes (theoretical models, we might say today), technes (rules or techniques), and phronesis (practical wisdom, good judgement, or prudence) are used in the acquisition of a skill — but once the skill is learnt, these devices can be thrown away. It is in this respect that Keeney and colleagues have called psychotherapy a "performative art" (Keeney, Keeney, & Gibney, 2012, p. 62) We are seeking a mechanism that enhances our skill to become sharp and seamless.

The Dreyfus model of skill acquisition contrasts sharply with the more traditional Western thinking of Plato, Kant, and Chomsky (among others) who argue that "expertise" is the abstracting and internalisation of increasingly sophisticated rules. Chomsky (e.g., 1979) sees tacit knowledge not as performance knowledge ("know how") but as implicit rules that we are following but maybe not aware of. The metaphor of the computer is usually used in this paradigm of cognitive science, called "cognitivism", which suggests there are rules in our programming, awaiting discovery. From this traditional way of thinking we can see how we were led to pursue efficacy (rules) instead of effectiveness (expert performance). Cognitivism became the model used by neoliberal risk managers in the development of ritualised procedures (an algorithm of rules to follow) as a way of redistributing responsibility and reducing the anxiety of blame.

British nurses have been identified as early adapters to this transformation (Lees, Meyer, & Rafferty, 2013) — and, perhaps significantly, New Zealand nurses were the first group of nurses to be registered by statute (see Chapter 19). By having all nurses complete a set of procedural tasks for all patients on a ward, and fewer by one nurse for one patient, the nurse–patient relationship was transformed — into a caring–by–numbers approach. This drove research in health practice towards efficacy rather than effectiveness, which meant that accountability was assessed by the practitioner's adherence to "empirically supported procedures" or "best–practice guidelines" such as those issued by the UK National Institute for Health and Care Excellence (NHICE). Efficacy researchers wanted to eliminate the practitioner as a variable affecting outcome, and thus practitioners were deemed "competent" if they did it by the numbers. This no doubt had considerable appeal to some forms of factory management. However, as we have seen, in mental health the person of the therapist far exceeds any

method (Duncan, Miller, Wampold, & Hubble, 2010; Wampold & Imel, 2015). As such, we are ethically bound to resist this vision of "competence", as the interests of the client are secondary to the safety of the organisation.

It is also not difficult to see how the unexamined assumptions of cognitivism may have led the educators in our profession towards efficacy thinking. If competence is defined as conforming to best–practice standards and staying up to date with the newest treatment models, then there is opportunity to expand educational services to the profession. In a review of the outcome literature over the past 40 years, Scott Miller found that drop–out rates and numbers of clients getting better have not changed. He amusingly described this constant attendance at continuing education workshops as being like riding an exercise bike–working up a sweat but not getting anywhere (Thomas, 2014). To repeat, there is no evidence that continuing education improves effectiveness in mental health and addiction services, even if that claim can be made in some parts of mainstream medicine.

Fortunately, cognitivism has been superseded by the 4E–cognition paradigm in cognitive science (Menary, 2010; Noē, 2009; Varela, Thompson, & Rosh, 1991). The "4E[s]" stands for "enactive", "embedded", "embodied", and "extended", and represents the idea that, as we have more nerves going to the senses than from them, we are using our senses like a blind man with his cane, to remain attuned to the task at hand. Like the Dreyfus' learning model, when undertaking tasks that we've mastered, our attention (or "mind" if you like) flows around an extended circuit that includes objects in the world. In the now famous experiment, we are so at–one with counting the number of times the basketball players pass the ball that we don't notice the woman in the gorilla suit walk through them (Simons & Chabris, 1999). We are bodily embedded in the world — there's no Cartesian "self" standing apart from the activity — and most of the time (or the default position in this new paradigm is that) we are at one with the world. In therapy (and at other times in life), a conversation can take on a life of its own (Shotter, 2016). When competence is seen as mastery, it doesn't lie in knowing how we moved our 73rd leg; it lies in just moving it — effectively!

A MECHANISM FOR COMPETENCE AND ITS ENHANCEMENT

The argument then is that the pathway to competence is through effectiveness. Over the past 15 years or so, there has been a growing interest in client self–assessed outcome monitoring and management tools (Duncan & Reese, 2013). There is now an impressive array of empirical evidence that their use can lead to massive reductions in dropout rates as well as improved effectiveness rates for most counsellors (Duncan et al., 2010; Lambert, 2010). This evidence shows that services that utilise continuous feedback of client–reported outcomes (without clinician interpretation) can achieve levels of effectiveness that match or exceed those of clinical trials (Reese, Duncan, Bohanske, Owen, & Minami, 2014). Although a growing number of "psy" practitioners in Aotearoa New Zealand have adopted these tools, the impression among many of the agencies is that a stronger network of agencies and practitioners is required to ensure such tools benefit our community (Partnering for Outcomes Foundation Aotearoa, 2017). It is suggested that the NZAC could provide that network.

As things stand it can be claimed that members of the public are being put at risk, as they are being led to believe by the efficacy research rhetoric that if practitioners are adhering to "best practice" guidelines, and engaging in professional development activities to learn these methods, they will be receiving the best help available. Now while an empirically supported treatment may have achieved an 80% recovery rate in clinical trials, most "real world" agencies are only achieving a 15% recovery rate on average (Drury, 2014). This is due to a variety of factors, including that there are few pure "depressives" in the "real world", unlike the clients selected for clinical trials. Bohanske and Franczak (2010), who manage most of the mental health and substance abuse practitioners in Arizona, found that 80% of their practitioners showed remarkable improvements in their outcomes after routine outcome monitoring tools were introduced. As Sparks and colleagues (2011) commented, the use of these outcome management tools is in effect bringing clients to the front of the classroom as teachers of how to be more competent (effective) therapists. What we now term "professional development" activities move to a position secondary to this primary source of practitioner growth and improvement of practice.

As noted earlier, this is a shift from process–based accountability to outcome–based accountability; counsellors become more directly accountable to their clients. With growing emphasis on being transparent with the public (and referrers) regarding our outcomes, we are able to provide potential clients (and key stakeholders for that matter) with probably the most important informed–consent information most will want: not "are you doing it by the book?" but "how effective are you?" That is to say, the purpose of the *HPCA Act*, competence assurance, is shown by outcome rather than assessed by recipe compliance, for "the proof of the pudding is in the eating" (Duncan, 2010, p. 45). As Brown and Minami (2010) have argued, in a buyers' market, practitioners who offer outcome data have a better product to sell than those just offering "compliance" data.

During the past 15 years the development of outcome accountability, statistical techniques and computer programs have evolved, so it is now possible to generate trajectories of change on a session–by–session basis with which comparisons can be made of similar clients' progress from large databases of client change scores. Agencies, or professional organisations for that matter, can develop new outcome measures "on the trot", so to speak, allowing greater flexibility in making comparisons or dealing with specialist populations (Lambert et al., 2013). Through the use of what is called the Reliable Change Index (RCI) (Seidel & Miller, 2011), individual therapists can monitor not only their comparable effectiveness with colleagues, but also their own for different periods of the year or through their career; or they can compare their effectiveness on client variables such as gender, age, or a specialist population (Lambert, 2010).

Some have expressed concern that outcome measurement is vulnerable to "gaming" (Bevan & Hood, 2006; Hood, 2011; Mays, 2006; Saul, 2013). This is obviously considerably reduced when clients complete the outcome monitoring forms, rather than the clinicians. Nonetheless, it is a necessary consideration. If outcome management were administered by the NZAC, then a further check to the system would be to implement two– and five–year follow–ups of outcomes, as Seikkula and his team do in their work with psychosis (Seikkula et al., 2006). Although false advertising laws and our code of ethics would cover "falsified" results, this could be an aspect of our competency system.

Unlike current accountability systems, there would be no need to make outcome monitoring mandatory, only transparent. If professional bodies like NZAC were to encourage and disseminate outcome results, those who did not use outcome monitoring would stand out more clearly. Sparks and Duncan (2010) claim the research shows that outcome management raises the performance of the poorer performers, more than the better ones, giving all who use outcome management a market edge over those who do not. Thus, there is also an opportunity here for transparent outcome–monitoring practitioners to gain a better market position.

A POSSIBLE FUTURE POLITICS OF COUNSELLING

Tudor (2011, 2013) has argued that the proposition by some that we should adopt a form of professional regulation along the lines that other professions have chosen (i.e., registration and ongoing education) for fear of losing credibility can be considered not only a form of "group think" but also a form of professional and societal regression. As a result, he has called for a greater degree of differentiation of self to avoid being lulled into this position — but, from the perspective presented here, increases in secondary intersubjectivity and reduction in primary intersubjectivity are not wisdom.

Our task is to move away from institutional mechanisms that "fabricate" (Foucault, 1977) over–individuated selves, as panopticism does, and embrace practices that bring our primary intersubjectivity, and the ethics associated with it, to the fore. Our primary intersubjectivity is not something to be pathologised, as it might be in an over–individuated society. A recognition of this, as advocated by Bourdieu (2000), allows us to acknowledge our propensity to resonate with each other, and find ways of dealing with the risks of, say, conformity associated with being human.

In this vein, outcome measurement can be seen as having a conformity or preferred "group think" aspect when viewed as an expression of empowerment theory (Perkins & Zimmermann, 1995) and in what is being called the new "sharing economy" (Botsman & Rogers, 2010; Gansky, 2010). Empowerment politics has its roots in the civil rights movement of the 1960s, and found expression in the "psy" disciplines when Rappaport (1981) urged our professions to be "more a social movement than a profession". He argued that we needed to keep an eye on when we became

part of the problem (e.g., by fostering societal dependence as professional numbers grow, and disempowering the community from its own native skills) and thus doing what we can "to enhance the possibilities for people to control their own lives" (p. 15). One aspect of our political task is, as Robbins (2000) once expressed it, to put "ourselves out of business".

Empowerment suggests a move from a position of being society's professional "expert parents", instructing our "wards", to collaborators in strengths–based conversations (Saleebey, 1996). Indeed, it was the strengths–based conference organisers that brought Barry Duncan, who with Miller developed the Outcome Rating Scale (ORS), to Aotearoa in 2007 as part of our introduction to client–rated outcome management (D. Wood, personal communication, 2016). In essence, this is because the ORS can be read as a strengths assessment by clients as much as it can be read as a deficit assessment.

Outcome monitoring also resonates with the growing "sharing economy" phenomena seen in Airbnb, Uber, and the like. Although such businesses are not without their own ethical problems (Schor, 2014), Time magazine claims the sharing economy will change the world (Walsh, 2011). When Adam Smith (1776/2009) advocated for free market principles, he was being guided by the Scottish moral philosopher Hutcheson (1725/2004), who previously argued that authenticity binds us together better than calculated self–interest. Some advocates of the "sharing economy" (or "digital matching" or "collaborative consumption") claim that "dotcommunism" might achieve greater wealth equality, when Lenin and Mao couldn't, by encouraging greater market authenticity (Botsman & Rogers, 2010; Gansky, 2013; Lansley, 2016; Schor & Fitzmaurice, 2015; Tanz, 1999).

Here in Aotearoa, we have seen the growth of the NoCowboys website, which has recently begun listing some health professionals (NoCowboys, 2016). It would be preferable, I suspect, for most counsellors to have such a register administered and monitored by the professional association. If the association were to administer a client–rated outcome monitoring service, numerous ethical and pragmatic issues would need to be resolved. Counsellors obtaining high recovery rates would no doubt want their outcomes to be known publicly, but any restrictions they might have placed

on the choice of clients they saw would also need to be transparent. Other pertinent ethical and legal matters would need to be carefully considered.

Conclusion

The move to monitoring counsellors through some form of panopticism is not supported by empirical evidence, and represents the politics, philosophy, and cognitive style of a fading paradigm. A new paradigm is emerging in politics, economics, philosophy, and cognitive science that empowers community trust and our sense of a primary intersubjectivity ("whanaungatanga"). A central mechanism in the facilitation of this has been "digital matching"–feedback data on effectiveness. This article urges the adoption of this mechanism as the tool for ensuring professional competence and development.

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Public statutes

Health Practitioners Competence Assurance Act 2003.

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PART II

The background to the state registration of psychotherapists in Aotearoa New Zealand

Chapter 3

The road to registration: the New Zealand Association for Psychotherapy and its long search for identity and recognition through legislation

Grant Dillon

Psychotherapy is a registered profession in this country because of the New Zealand Association of Psychotherapists (NZAP). For almost sixty years the NZAP wished for, discussed and actively sought occupational and then professional registration for psychotherapy. However, it is debatable that the NZAP got the registration and regulation it wanted. As history often provides a window on the future, this chapter considers the history of the NZAP's search for identity and recognition through the statutory regulation of psychotherapy and the state registration of psychotherapists.

The image of registration surfaces throughout the history of the NZAP. In its papers, the quest for registration represents an embryonic search — at times for a professional and group identity, and at other times for external recognition and through it increased availability of psychotherapy in the public health sector. Often it was seen as a means of attaining and

maintaining adequate standards and safe practice in a profession that for the first forty years of the life of the NZAP, had no formal accredited training programmes. This can also be seen in the context of an early identification with the medical profession, which faded when this was no longer reciprocated; low practitioner numbers; anxiety about income, both for individual psychotherapists and for the Association; a perceived lack of status in relation to the "bigger brothers" in clinical psychology; and a developing desire to differentiate from counsellors.

The NZAP was founded in 1947. Three years later Ernest Beaglehole, a founding Fellow of the Association and Professor of Psychology at the University of New Zealand in Wellington, wrote in his book on Mental Health in New Zealand (1950) that those in authority (by whom he referred to the Minister of Health, the Health Department, and the New Zealand Branch of the British Medical Association) should give serious consideration to the possibility "to make provision in New Zealand for the training and State registration of lay psychotherapists and child guidance clinicians" (p. 105).

Beaglehole was motivated by concern both about the quality of psychotherapy as well as the (low) quantity of psychotherapists available. He noted that:

> at present there are probably no more than a dozen qualified medical psychologists and lay psychotherapists in private practice in the Dominion … we may safely say that New Zealand at the present time could absorb well over ten times as many psychotherapists as are at present available. (p. 41)

He concluded his book with a list of proposals for a Dominion mental hygiene movement, which included: "The establishment of a Psychotherapeutic Registration Board as part of the machinery of the present Medical Council to control the training and registration of lay psychotherapists" (p. 129). This concern for a medically–defined quality control was also reflected in the NZAP's 1947 Constitution, which stipulated that at least three of the seven Council members must be medically qualified (see Manchester & Manchester, 1996).

As the Association discussed support for a training course and a submission to the Department of Health for Social Security subsidy of psychotherapy in 1950, the Council resolved to seek Government recognition of the NZAP and registration of its members. This linking of official recognition of the NZAP with registration recurred in 1957 and 1958. What followed was a period of dynamic discussion about the criteria for admission to the NZAP, and tension between on the one hand a fear of low standards, and on the other of the perception of elitism, and the starvation of the profession by limiting recognition to trained medical professionals, and lay psychotherapists under medical supervision. Low membership numbers indicate that this narrowing of the base of the profession was a real cause for concern; in 1971 the Association's Annual General Meeting (AGM) attracted a mere seventeen members.

Further attempts to get Social Security benefit payments for psychotherapy continued through the 1960s. In 1970, the Medical Association of New Zealand rejected an appeal for affiliation from the NZAP. The Treasurer's report for that year put available funds at $39. In his President's report to the AGM, Dr Don Rountree said:

> The question is what are we asking to be recognised? If a department, professional body or the general public ask, what is a psychotherapist? What do they do? What training do we have? We don't have an answer … [Self–examination] raises the whole question of the present divergent, covert, unrecognised and unstandardised training experiences we as members have had and are having, with varying degree of opportunity for sharing and supervision of the internal travails associated with therapy. (Manchester & Manchester, 1996, pp. 50–51)

The struggle to develop an identity and to attract members led to a change of name in 1974, to the New Zealand Association of Psychotherapists, Counsellors and Behaviour Therapists, commonly known as the New Zealand Association of Psychological Therapists (NZAPT). By 1976, the NZAPT had written to the Ministers of Health, Social Welfare, Justice and Education, pointing out that there was "no specific training or registration in New Zealand for specialised counselling or psychotherapy", and that "there is no separate Government Occupational Class and Salary Scale for

specialised counselling and psychotherapy" (reported in Manchester & Manchester, 1996, p. 62); and asking that a Government working party be set up to take appropriate action. As the Association finally set out in the late 1970s to develop a standardised process for assessing applicants and make supervision mandatory for members, it also set up a permanent working party on registration. Interest was further stimulated by the introduction of the Psychologists Registration Bill in 1981.

The Association's ambivalence about its identity manifested in another name change in 1982 — to the New Zealand Association of Psychotherapists and Counsellors (see Chapter 19). Even this produced lengthy debate between those who saw a fundamental difference between the roles, and those who saw them as lying on a continuum. Through the mid 1980s, as a first code of ethics was formulated, an ethics committee formed and admissions and supervision requirements tightened, the Association first sought registration through the Medical and Dental Auxiliaries Bill 1982 (which was not proceeded with), and then through the Health Practitioners Bill 1984 (Manchester & Manchester, 1996). The deregulating stance of the fourth Labour Government (1984–1990) was having an impact.

Admission to the NZAP now required evidence of psychotherapeutic theoretical knowledge and practice. The Association took confidence from this evidence of identity and in 1988 changed its name again to the New Zealand Association of Psychotherapists (NZAP). This was also the year in which, for the first time, an NZAP handbook appeared with an operational definition of psychotherapy. The next year it issued its own first register, and sought affiliation to the Council of the New Zealand Medical Association.

At the AGM in 1990, it was unanimously resolved:

> That the NZAP write to the Minister of Health, asking that an Indicative Register be established of those recognised to practise as professional psychotherapists. Such recognition would be by virtue of their membership of NZAP or equivalent specialist psychotherapy training, or qualification acceptable to Council of NZAP. (quoted in Manchester & Manchester, 1996, p. 94)

From this we can see clearly that it was assumed that the NZAP would be the natural judge of membership, training, qualification, and registration.

Supervision and personal therapy requirements were strengthened; the NZAP added a Māori interpretation of its name and, in 1993, included reference to the Treaty of Waitangi in its objects. In hindsight, the gap in time between the NZAP's first moves toward registration and its acknowledgment of its responsibility to Māori seems significant as the lack of reference to the Treaty in the Health Practitioners Competence Assurance Act 2003 ("the Act"), the lack of consultation by the Psychotherapists' Board with Māori in the lead–up to registration, and the Association's failure to notice or address these problems, continue to haunt the NZAP.

Having focused much energy on developing admissions, supervision, ethics, complaints and publications, the Association was beginning to turn outward. It developed a public issues portfolio through the 1990s, and in 1997, as the NZAP celebrated its fiftieth anniversary, it supported Paul Bailey's attempts to have psychotherapy recognised as an Occupational Category (in the New Zealand Standard Classification of Occupations), which was achieved in 1999 (see Statistics New Zealand, 2001). At the AGM, Paul Bailey moved and Fay Danvers seconded the motion: "That this Association seek Occupational Registration through Parliamentary Regulation" (NZAP, 2000, p. 10). The minutes note that "Paul advised that this was a new motion" (p. 10); in fact it was a new motion, although not a new idea. When the motion was discussed at the AGM, questions about the consequences of such registration went unanswered and the motion was "carried". Bailey (2004c) reports that it was carried unanimously (and being somewhat surprised about this). However, having talked with a number of the 83 people who were there, it is clear that this was not unanimous, although there was a clear two thirds' majority; (NZAP does not as a matter of course distinguish the extent to which a motion is "carried"). Moreover, some present at the meeting (who voted in favour of the motion) perceived this as a vote to permit an exploration of the possibility of registration rather than a resounding vote in favour of it; and this was never brought back to an AGM for a more definitive and conclusive vote (R. Carson, personal communication, October, 2010). A working party appointed by Council, comprising Paul Bailey, Roz Broadmore and Gordon Hewitt, reported later that year that the registration process for health professionals was about to

be updated by the Ministry of Health (MoH). The NZAP Council gave the working party the mandate to attempt to have psychotherapy included in this. Bailey promoted the Health Practitioners Competence Assurance Bill 2002 strongly to the membership, and also encouraged them to ensure they kept informed and understood "the implications of this transfer of power, both the positive and the negative consequences of such a move. For, in this matter, if you leave your comments until you gain hindsight you may be too late" (Bailey, 2001, p. 31). He also said:

> Our prime task is to ensure that NZAP is delegated responsibility for the Register and is also well represented on the Board … Probably the most risky piece in this venture into regulation is that we will not know all the implications of our initiative until well after the event. (Bailey, 2000, pp. 16–17)

In support of his caution Bailey (2000) quoted Karl Figlio (2000), the Director of the Centre of Psychoanalytic Studies, University of Essex, writing in the British Journal of Psychotherapy about registration in the United Kingdom: "It is inevitable and must eventually be backed by statute ... [but] We need to explore the ramifications of professionalisation to ensure that registration does not deform the practice that it is meant to protect." (p, 333). Interestingly, and perhaps significantly, Bailey had omitted the sentence preceding this quote which read: "What I am sketching is the boot–strapping of a practice into a profession, in an environment that has been indifferent to it." Reading the complete article, it is clearl that Figlio was a harsher critic of state registration — and of the state's interpretation — than Bailey was presenting. Also, there was no ellipsis or "but" inbetween the last two sentences of the quote, additions which, again, alter the original meaning and intent of Figlio's argument.

In August 2002, Lesley King, then President of the NZAP, wrote:

> It may be that registration alone, or registration combined with membership of a professional body (not necessarily NZAP) would fulfil the professional requirement to practise. Instead of being the body psychotherapists need to belong to for professional credibility, we would be the association psychotherapists want to belong to. I wonder how that might

> affect our membership? How might it affect you personally? (p. 4)

King's was the first voice of doubt about unitary, state registration in the records of the NZAP.

When the Bill was introduced in June 2002, psychotherapy was not among the professions to be regulated. The working party lobbied the Select Committee hard to have it added. After a general election (in July 2002), with a radically different Committee, the lobbying began again. When the Bill passed into statute in September of that year, the NZAP turned to lobbying for psychotherapy to be included by Order in Council as soon as possible. Much was made of the potential risk to the public from unregulated practitioners, referring to harm caused earlier by therapists associated with the Centrepoint community, an untold chapter in the history of the NZAP and an important factor in the development of its internal checks and balances through the 1980s and 1990s (see Chapter 11). The MoH appeared somewhat diffident. A process had to be followed, submissions had to be called for, and even if regulation occurred, the Ministry preferred psychotherapy to be covered by an already existing authority, preferably the Psychologists Board (NZPB); a suggestion that excited neither the NZPB or the NZAP. At the 2003 AGM, John Gamby, a long–standing member of the Association, expressed reservations and asked if there was a contingency plan if the Association needed to extract itself from the process; Jonathan Fay also expressed concerns about registration leading to regulation (see NZAP, 2003).

Paul Bailey disagreed. The only alternative to state regulation was self–regulation, requiring an external, non–governmental body made up of psychotherapists and laypeople to regulate the register and complaints. It is not clear why self–regulation was not a preferred option; but Bailey (2004a) made his standpoint clear: "I believe that one of the main reasons a State regulates is to protect that which it deems valuable. I believe that Psychotherapy is valuable for New Zealand" (p. 29). Later, Bailey (2005) announced his intention to lobby for an initially reduced registration fee for members of the NZAP, given the many years of voluntary service and the small size of the profession, and for "seed funding" to help it in a new era. Implicit in these statements is a view of the State as a benevolent, loving

parent intent on fostering a special child. This view stands in marked contrast to an alternative reading of the state's relationship to the profession as expressed in the Act as the superego's relationship to the id, where psychotherapy, far from needing protecting by a benevolent regulating other (see Chapter 13) needs to be protected against by the state. No NZAP member responded in writing to Bailey's statement. In fact, detail of the content and debate about the implications of the Act are missing from the public records of the NZAP, from which it is impossible to know who in the NZAP had read the Act, and what those who had read the Act thought about it. Also absent from the records is any discussion of psychotherapeutic thinking about the internal forces driving this search for recognition (see Chapter 10, 12, and 13).

In the absence of "Why?" discussion turned to "What?" and "Who?" The NZAP Ethics and Professional Standards Committee worked on a scope of practice suitable to the Act, and names were suggested as possible nominees for a Board. It was imagined there would be five practitioner positions on such a Board; the Council ratified the nominations of five NZAP members, a number which was later revised to six. There was clearly a hope, even an expectation, that a psychotherapists' Board would hold a majority of NZAP nominees; one member, Sarah Calvert, said that, since it was a Ministerial requirement to appoint members of a professional body and the NZAP was the only such body, "the Minister will use our nominations" (reported in NZAP, 2005, p. 21). There was disquiet among Māori members and provisional members that the Association had not nominated a Māori psychotherapist for the Board, an embarrassingly unconscious oversight on the part of the NZAP.

The implications of registration and the inevitable loss of authority by the NZAP were still widely underestimated. Even Bailey (2004b) was not alert to this: "As N.Z.A.P. has both the expertise and the experience to conduct this assessment process, it is proposed that the Psychotherapy registration Board contract to N.Z.A.P. the assessment of readiness to practise psychotherapy" (p. 21).

Submissions on a proposal for occupational registration of psychotherapy closed in February 2005; another election (September 2005) intervened, and it was not until November that the Minister of Health approved it. For a further year the Ministry consulted on whether there would be a separate or

combined authority (see Manning, 2006b). Dr Lois Surgenor, the Chair of the NZPB, made an incendiary submission:

> The [Psychologists] Board notes the lack of academically–based training or reliance on evidence–based practice, the intent of psychotherapists to practise with some of the most vulnerable sectors of the public, and minimal emphasis in competencies related to diagnosing mental disorders ... psychotherapy currently includes far too many poorly trained, poorly educated, and simply unsafe practitioners. (cited in Manning, 2006a, p. 57)

A previously friendly relationship was ruptured; following the gratifying recognition by the Ministry, it was a bitter mirroring, and one which, paradoxically, aided the quest of the NZAP in its search for a separate Board.

In its submission on the form of the responsible Authority, the NZAP sought to preserve the Association's autonomous self–regulation on the basis of "if it isn't broke, don't fix it" (NZAP, 2006): in other words, the setting, maintaining and monitoring of standards should be left to the NZAP. The implicit paradox was that the NZAP had itself sought a fix through state regulation. A straw poll conducted at this time (reported in Manning, 2006b) revealed a mixture of hopes amongst members:

> I hope that it encourages recognition of psychotherapy … [registration] will possibly gain the respectability we seem to crave … I think we should go for registration as all the other health providers will be. If we don't, we lose credibility. (pp. 27–28)

but also fears:

> would it be any more effective than what we have now, especially in preventing harm to clients? ... We will lose freedoms that we can't appreciate now … I fear it will be costly and intrusive … I fear that costs will go up, that boards will dictate practice and that professional associations will become hobby groups .... (pp. 27, 29)

With a separate, stand–alone Authority confirmed, the reality dawned that it would not model its processes on those of the NZAP. Fifty one nominations for the Board were received, representing bioenergetics, gestalt therapy, Hakomi, Jungian analytic psychology, process–oriented psychotherapy, psychodrama, psychodynamic psychotherapy, psychosynthesis, transactional analysis, and child psychotherapists among other groups, as well as Auckland Family Counselling & Psychotherapy, the Hakanoa group, the New Zealand Association of Counselling, the NZAP, and other professional organisations. The NZAP also agreed to fund the establishment of the Board with a loan of $20,000 (see Manning, 2007b). When the Board was finally announced, a single NZAP nominee, Dr Andrew Duncan, was on the list (Manning, 2007a). The absence of Paul Bailey, the NZAP's architect of registration, was a shock. The Council imagined alternative futures, with the NZAP either embracing elitism by maintaining a higher bar than the Board would set, or aiming to be an umbrella group for a wide range of practitioners. These were difficult futures to hold in mind. At the same time, some Council members believed the Association might have registration, the issuing of annual practice certificates, and complaints processes devolved to it.

The Council was also caught between its support for registration, and its support for Waka Oranga, the runanga of Māori psychotherapists, in their refusal to register because of the Board's lack of consultation with Māori and the absence of a Māori scope of practice and kaupapa Māori pathway to registration.

In 2008 the NZAP Council sought input about its future from its members through a questionnaire. This outlined three possible forms of the NZAP: a continuation of the old structure; an Association open to registered and provisionally registered psychotherapists, with associate membership open to non–registered practitioners; or an Association similar to the second, with a senior practitioner category added. In response, 66% of those who responded favoured the second option, and 27% favoured the third (see Green, 2008). As compulsory registration came into force on 31st December 2008, the Association was — and still is — coming to terms with the consequences.

Between its founding in 1947 and the early 2000s, the NZAP invested heroic effort in developing its own identity through a Constitution, a

register, an admission process, supervision networks, a code of ethics, a complaints process, publications, meetings at conferences and in branches, and a relationship with its Treaty partner. The gaining of official recognition through registration paradoxically precipitated the loss of some of these aspects of its identity, and reduced the need for others. How the NZAP will identify itself in the post–regulation environment remains an unanswered and unfolding question.

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Chapter 4

Letters across "the Ditch": a trans–Tasman correspondence about recognition, regulation, and registration

Paul Bailey and Keith Tudor

This chapter is based on original correspondence in 2010 between Paul Bailey, who was (between 1999 and 2006) the prime mover within the New Zealand Association of Psychotherapy (NZAP) in seeking and obtaining from the government the inclusion of psychotherapy under the *Health Practitioners Competence Assurance Act 2003* ("the *Act*") (Minster of Health, 2007), and Keith Tudor, who has, for over twenty five years, been in favour of the freedom to practise, including professional regulation, and opposed to the statutory regulation of psychotherapy and the state registration of psychotherapists. The two of us had met briefly at the NZAP Conference in 2008 held in Waitangi and again in Napier before Keith emigrated from the United Kingdom (UK) to Aotearoa New Zealand and Paul moved to Australia, both crossing the Tasman Sea or "the Ditch" between the two countries in 2009. As Paul had been a significant figure in the profession and in this campaign, Keith was keen to correspond and dialogue with Paul, and to have his voice in this book. We began by Keith asking Paul some questions, to which he responded, to which Keith, in turn,

responded, and so on. We then engaged in a process of editing, and both agreed the final version of this chapter.

For this second edition, we agreed to reproduce our original dialogue and add a postscript.

The original correspondence (2010)

Keith: Firstly, Paul, thank you for your warm wishes for me finding my "place to stand" [turangawaewae] in my new land. It is a lovely turn of phrase, and a poignant one, given my critical "stance" on statutory regulation and state registration, and one which is, of course, relevant to our conversation. Thank you, too, for agreeing to publish the outcome of our e–mail correspondence. So, I guess we can start, and I'd like to begin with what your motivation was to seek statutory regulation for psychotherapy and state registration for psychotherapists.

Paul: I have no simple answer to offer. As you know, I swirled within the vortex of this question for nine years. Mostly, when I surfaced I found myself still advocating, albeit tentatively at times, for statutory registration to occur. Although you and others stand contrary to the outcome I sought, I appreciate you wondering what moved me to search out a protective body for the work we love. At first, I hesitated to respond so fully to your enquiry as I felt that I had already written (and spoken) on this theme for long enough. However, once I recalled the warmth of my initial meeting with you on the seafront of Napier a year or two ago, such reluctance dissolved. So here we are after the event and you could say "I told you so" and I could say "Wait and see, it's still such early days" and on and on, through each thesis and antithesis. And, at this point, old man Yeats (1918/2010) would step into the fray and would whisper to me: "We make out of the quarrel with others, rhetoric; but out of the quarrel with ourselves, poetry." Sure, much rhetoric I have uttered on this particularly subject over the years and heard as much against. Each outward voice resonated with one as strong within: no certainty ever, nor expectation that the end would be a celebration, simply a new beginning and the mourning of what had been lost.

Keith: I'm loath to interrupt you, especially as I enjoy poetry but, in the interests of dialogue, I will do by saying that I am surprised that you refer to the rhetoric against registration. From my reading of the debate here, including your article in *Forum* [The Journal of the New Zealand Association of Psychotherapists] (Bailey, 2004), there appears to have been very little argument, rhetorical or otherwise, which was critical of the moves to registration or regulation. Your reference to celebration and (versus) mourning also hints at a benefit versus cost analysis, which also seems to have been missing. Anyway, I interrupted.

Paul: No, I don't feel interrupted; rather, your comments allow me to feel more connected with you. And I can appreciate how you must have felt out of the loop regarding the local rhetoric, as what there was of dissent or critique was informal and, dare I say in hindsight, understated: barely a contrary voice was put into writing. You would have read the reports I offered to each AGM and Council meeting and what I wrote regularly for the NZAP Newsletter. However, much of these were on political progress or otherwise rather than in the form of debate. And, especially in those early years there was surprisingly little critical public debate on this matter, even in Council. As for the resounding silence to my writings back then, I suppose I read this as assent or disinterest.

So, back to your question regarding what moved me those long years through many a midnight and against the odds? What noble or dark aspect motivated me to stand before parliamentary select committees? It's too soon for me to really know or to discern whether the long — term outcome I had hoped and worked so hard for would be worth all the effort that I and so many others over the decades gave to this cause. Maybe in a generation or so we will know. For now, though, what doesn't work of the new is painfully apparent.

So, what did motivate me? Any glib rhetoric belies so complex a journey for any attempt to know intent is muddied by what we now know of the "readiness wave". In *A General Theory of Love*, Lewis, Amini and Lannon (2000) wrote that: "What we feel as the conscious spark of resolve ... proves to be an afterthought, not the majestic nexus of initiative we might imagine." (p. 29) They reported that:

“Recordings of encephalographic electrical waves show ... that a neuronal mandate for motion is under way: the so–called readiness wave ... Just where and how the early glimmers of intention coalesce ... remain beyond the ken of today’s science.” “The more we discover”, they conclude regarding intent, “the more we find that we do not know”. (p. 29)

Given this as a starting point, what can I now write, with any confidence, of what motivated me to seek protection for our profession? Yet I do offer you the following snippets from the storehouse of my own memory.

Motivation 1

I have a memory of reading, in the *NZAP Notes Towards a History: A Chronology of the First Fifty Years 1947–1997* (Manchester & Manchester, 1996), a statement by Ruth Manchester acknowledging that there were still some tasks that the Association had not completed, the prime one being the matter of statutory regulation. An Annual General Meeting of our pioneering Association had agreed on this direction back in the early 1950s. Yet, over the next four decades, little progress had been made.

In 1999, when the Labour Party was on the verge of becoming the new Government, I felt an impulse to pick up this baton from the ancestors, and to run with it. I felt that the time was riper than it had ever been in Aotearoa New Zealand for a Government to give serious consideration to this question. I spoke with colleagues. I spoke with friends. I read of what was happening with registration in Malta, Austria, the United States of America (USA), the UK, Australia, and France. I wanted the matter to be back on the political table, following 15 years of deregulation. I wanted there to be discussions within our Association and in the wider political sphere of where we stood and what we offer.

So, I made contact with the then Shadow Minister of Health, Annette King. She responded by acknowledging that, if or when her party won the election, she would ensure that the matter of psychotherapy and regulation would be re–opened for political debate. Some months later, as the new Minister of Health, she invited me to meet with staff in the Ministry of Health (the Ministry) to negotiate a path forward.

Keith: I am interested that you refer to regulation when the NZAP (and the Manchesters) tended to refer to registration. I think this elision is significant as the difference in terms is significant (see Introduction and Chapter 8).

Paul: Clearly you place more significance on this. I don't see it as an omission or an elision. Psychotherapy was already registered — what I would refer to as voluntary registration. The Association had been keeping a voluntary register probably since 1947. However, this voluntary register could not protect the public from those psychotherapists who choose not to be on such a voluntary register. What I read Ruth and Brian Manchester writing of was the statutory regulation of the profession, a state register of psychotherapists. Whether this would have been more wisely done under the current umbrella Act or under a separate Psychotherapy Act is a moot point.

Keith: I am also interested in the fact that, while you refer to a general interest in what was happening in other countries, you do not and did not refer to any of the critical views or literature on the subject or statutory regulation and state registration. No doubt we'll pick up on this later.

Paul: OK. I'll respond to this a little later and complete the matter of motivation first, if you like.

Keith: Yes, please.

Paul:

Motivation 2

As I sat, week by week and month by month, with men in the Hawke's Bay Medium Security Prison, listening to their stories, I was aware how many of them would benefit from what our profession offers. Yet, because Psychological Services was responsible for referrals, and cognitive behavioural therapy was the preferred mode of intervention, there was little chance, without regulation happening, for those in prison to gain ready access to our services. I was there simply to offer live supervision to the group facilitators since there was no local psychologist willing or able to do this. I felt sad about this.

Motivation 3

I was inspired by the energy and the patience and the rage I witnessed in tangata whenua over the decades from 1971. I watched as many Māori stood up. No longer were they willing to be so marginalised, so invisible, in Aotearoa. And I was touched by their grief. I heard in my heart what had already been lost. Enough was enough. I found access to my own courage as I witnessed theirs. They were fighting for the mana of their people. I was ready to stand alongside my colleagues for our profession, to ensure that the young men in prison and those men and women and children knocking on the door of state sector Mental Health Services could access us more easily. Idealistic though this was, I did feel this passion and I was moved to lobby for the State doors to open more easily for access to psychotherapy services.

Motivation 4

Despite neuroscience validating our work and attachment theory advocating for what we do, internationally pharmaceuticals and cognitive behavioural therapy (CBT) have continued to increase their staunch monopoly on mental health. I was motivated to make a stand in the corridors of parliament against the power of these two multinational juggernauts and to speak for the work our lineage offers.

Motivation 5

My professional education and experience, first and foremost, was as a psychotherapist. Yet, in the wider state sector including Corrections, there had been no place for our profession to stand. Unless I was a psychiatrist or a social worker or a nurse or a psychologist first, I could not be employed, even by Mental Health Services, to offer psychotherapy. Thus, I and most of us had been forced to work only in private practice. The few who were working in Government sector jobs did so under the guise of another profession. I was concerned with how the increasing marginalisation of our profession would lead to gradual extinction apart from ever–diminishing pockets of private work.

Motivation 6

I had been given much by belonging to our profession through the years of supervision and psychotherapy I had received. It was time to give something back. My sons were growing up and I had time and

energy to commit to such a cause. I was no longer a newcomer in the profession. I was becoming an elder. There was a job to do and I had the stamina, the patience and the will to take on the unfinished task.

Motivation 7

Having considered the matter of regulation for some time, I took this question to the Annual General Meeting of our Association [NZAP] in February 2000 to check if there was really any mandate for proceeding. To my surprise, the meeting agreed unanimously [Ed. — This is not accurate: the vote was not unanimous (see Chapter 3).] to go ahead.

Keith: My reading of the history — and that of others — was that, whilst this (2000) vote was on a motion "That this Association seek Occupational Registration through Parliamentary Regulation (NZAP, 2000, p. 10), votes in subsequent years (e.g. NZAP 2003, 2005) were to accept and adopt the Annual Report on the progress of occupational registration, and that there was never a final vote taken to sign up for statutory regulation under the *HPCA Act*. Did this come back to the members or to Council? Is this your understanding of events?

Paul: Yes, my understanding too was that I proposed the motion, that it was passed unanimously at that earlier AGM and that Council made the decision each step of the way, at each regular Council meeting, to continue pursuing inclusion in the *Health Practitioners Competence Assurance Bill* as it was called back then. Up until that point (the unanimous assent to the motion at the AGM), I had simply been attending to the ancestors, what they had wanted regarding regulation as well as my own concerns regarding the marginalisation of our profession and the limited access those in need have to our services. However, once the Association chose to validate this direction, I was charged with becoming the representative of my peers regarding this matter. I took this mandate seriously. I wrote regularly to colleagues through the Newsletter, through Council and felt that I was open to discuss this matter with anyone around the country who wanted to do so. For years I listened to concerns and felt my own. Yet, underneath, I felt the Association saying loudly and clearly that now was the time to take this stand, although I am well aware that the closer we came to the

reality of regulation happening, the more the voices of disquiet began. As T. S. Eliot (1925/1963) put it:

> *Between the idea*
> *And the reality*
> *Between the motion*
> *And the act*
> *Falls the Shadow.* (pp. 91–92)

Keith: So, let me come in here if I may. Perhaps I can summarise your motivations as: wanting to complete something (that had been started and dropped) (motivation 1); wanting to provide a service and access to a service (i.e., psychotherapy) for clients (motivations 2 and 3); wanting to get access to employment in the public sector for psychotherapists (motivation 5); wanting to break the monopoly of pharmaceuticals and CBT (motivation 4); and wanting to make a contribution (motivations 6 and 7). Would that be fair?

Paul: Yes.

Keith: What interests me about your motivations are that none of them were concerned with protecting the public which, as you're aware, is the central rationale for the regulation of health practitioners under the *Act*.

Paul: I was, at first, concerned with the matter of public protection. When I returned to Aotearoa New Zealand in 1982 as a psychotherapist, I quickly became aware of the considerable damage that many people had experienced here under the name of psychotherapy and the subsequent backlash to the profession. These events occurred particularly during the 1970s and early 1980s in Auckland (see Chapter 11). Clearly, there was a need for public protection. Psychologists had been regulated in 1981. Then it seemed possible that psychotherapists might have followed soon afterwards. However, at that very moment there was a dramatic turn of political events. In 1984, Roger Douglas, the Minister of Finance in the new David Lange Labour government, led the country speedily along the path of deregulation and the free market (of which more later). And for the

next 15 years there was no likelihood of further public consideration of the profession being regulated.

Keith: OK. So now I'd like to move on and ask you about your responses to the literature on regulation and registration. From what I've read of the debates here, and especially what you've written, I don't get a sense of much reference to the research on regulation and registration. In this age of "evidence–based practice" I'm especially interested how little "evidence" there is for regulation and registration. Were you aware, at the time, of the literature, especially from the USA and the UK that was — is — critical of statutory regulation and state registration and, if so, what were (are) your responses to it?

Paul: I'm surprised that you write that there is so little evidence for regulation and statutory registration. The evidence is strong and clear: the ever –increasing queue of professions seeking such regulation. Despite the distress and the dissatisfaction that the currently regulated health professions voice, I do not hear of medical practitioners or psychologists or occupational therapists or nurses or any currently regulated profession rallying vociferously to be deregulated. I hear them wanting the regulations to be changed not the fact that they are regulated. Back in 1999 when I commenced this journey, I read a range of writings, both for and against the regulation of psychotherapy. I read of the experiences and of the controversy not only in the UK and the USA but also in Australia, Austria, France and Malta. I think psychotherapy is still regulated in Austria and Malta. France had a strange arrangement in which, if I remember correctly, only medically–educated psychotherapists could be included under regulation. And, then, I considered the situation in Aotearoa New Zealand.

Keith: Excuse me. What were you reading in support of regulation and registration?

Paul: I'm not trying to avoid your question nor the debate. So, I'll describe here briefly my intellectual journey and where I found the support nationally and internationally for such regulation. As I indicated above, I did read the debate widely, especially at first from within the

United Kingdom regarding the regulation of psychotherapy and counselling. So, what did I read of support? From within the UK, I read how and why the UK Council of Psychotherapy at that time was advocating such a move; so, too, the British Association for Counselling and Psychotherapy. And then I read how and why other psychotherapy bodies, in countries such as Austria, France and Malta had decided to move to regulation. I read thoroughly the submissions from within currently regulated health professions in New Zealand of why they supported such regulation for their professions. At the invitation of the Ministry, I along with another NZAP member, attended the first "round table" meeting that the Ministry had called to seek approval for the new *Health Practitioners Competence Assurance Bill*. This was way back in 2000, I think, well before the *Act* was even drafted. So, two members of each already regulated health profession, as well as psychotherapists and, I think acupuncturists and maybe one or two others, were called to debate the merits or otherwise, in principle, of such proposed legislation. I remember clearly how, in the end, all the representatives of these health professions stated their support for this move. I noticed particularly how not one of those professions currently regulated was advocating for non regulation. Each group, for its own clearly articulated reasons, clearly supported regulation and registration.

Then I began reading the submissions that new health professions were submitting to the government, professions such as acupuncture, chiropractic, social work. Then, on behalf of the Association, I travelled to Australia to investigate first– hand how the different States there were responding to the issue of regulation and to speak at the inaugural conference of the Psychotherapy and Counselling Federation of Australia.

In the end, though, my intellectual travels took me to the core of the matter of regulation, which is why is it that throughout recent history many, if not most, health professions internationally seem to seek out and support statutory regulation? It seems that the significant advances in knowledge and the rapid growth of specialisation around the time of industrialisation led to the emergence of modern day professions. Very soon after the growth of these professions followed statutory

regulation. So, for example, in the UK, the *Medical Act* of 1858 regulated the medical profession. Why? The UK's General Medical Council (2010) is clear why: "to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine." So, too, those who argue in support of the regulation of the range of modern–day professions tend to advocate that it protects, promotes and maintains the health and safety of the community. It seems to me that at the centre of philosophical debates regarding regulation is the issue of individual rights versus government authority.

When is it time for a government to step in and when to hold back? In 1858, the UK Government took over the authority of the new profession of modern medicine. Some would argue that this stepped on or over individual rights. Yet, in the end, there seems to be popular support for this move. Keith, you state clearly that you stand for "freedom to practise". Yet, it seems to me that such freedom keeps psychotherapy marginalised. Professions that are not regulated are often disadvantaged and the people who wish to access these "freedom" services have difficulty accessing them because of cost. It seems to me that the modern concept of professionally regulated health care is to do with access to health professionals from a wide variety of fields and specialities. The path of deregulation seems to support the position of the user paying for the service. Thus a person has access to a health professional, including a psychotherapist, if s/he can afford to do so. The other way, supporting health regulation, is the way many governments around the world have established what has come to be called "universal health care". This is the attempt to provide equal access to services to every citizen by the State intervening in the freedom on which the "user pays" system is based.

So, the arguments I read and heard in favour of the regulation of psychotherapy were all to do with this philosophical and political question. Do we continue down the path of the user pays or do we allow State intervention with the intent of universal health care?

Keith: Well, we clearly disagree about philosophy but also about certain "facts". Firstly, and contrary to your statement, there is little international support for the state regulation of psychotherapy: most

countries in the world do not so regulate psychotherapy, counselling or other psychological therapies. Secondly, whilst the United Kingdom Council for Psychotherapy (UKCP) as an organisation always had state regulation as one of its aims, there have always been many dissenting voices within that broad church and, more recently, as you'll be aware, having looked at the way in which the UK government was proposing to regulate the psychological therapies, again on the basis of a medicalised view of therapy (see Health Professions Council, 2009), the UKCP has clearly turned away from such unitary regulation in favour of a pluralistic model.

Also, I think you conflate a number of arguments here. The first is that there is a difference in the motivation for regulation between governments and professions. Governments promote regulation principally for reasons of protection (of the public) and standardisation (both of which are represented by and in the *HPCA Act*), and also ideological hegemony, and political control. Professions often seek and argue for regulation on the basis of a certain self–interest, viewing regulation as enhancing their authority, status, and membership. The second conflation is around the argument for public access: you don't have to regulate a profession in order to make the service it offers more widely accessible; the state simply has to fund it — and, of course, it's interesting what the state chooses to fund.

Finally, your argument here (and, I think, generally) depends on viewing psychotherapy as a health profession and closely allied to other health professions and, in particular, those governed by the *Act*. I don't. Moreover, I think we need to be much more critical of the medicalisation of psychotherapy in all its manifestations, including its regulation.

Paul: Yes, clearly we do disagree on much of this. However, I do agree with you regarding being critical of any medicalisation of the practice of psychotherapy. In my view, psychotherapy seems to have emerged uniquely in each country in which it has taken root, for instance, the experience in the USA has been significantly different to how the profession arose in the UK; how Australia has governed psychotherapy is in contrast to Aotearoa New Zealand; nor have France and Malta developed frameworks for psychotherapy in the same way as Austria.

Although I did take heed of the forebodings from the UK, I gradually formed the view that politics happen differently in the Land of the Long White Cloud from countries on the other side of the world. There are three significant and exceptional qualities that gave me cause for hope that registration could happen differently here:

1. Firstly, the fact that New Zealand has te Tiriti o Waitangi as its founding document;
2. Secondly, that the NZAP has existed as the containing body for the profession since 1947; and
3. Thirdly, that since the country has such a small population, Members of Parliament are easy to contact and, thus, to lobby.

To expand — firstly, unlike Australia, the UK and the USA, the Treaty ensures, at least in principle, that tangata whenua are to be considered equally in the creation of any legislation. Thus, the statutory regulation of psychotherapy is required to take into consideration the likely impact and the benefit on the First Peoples. Any intervention ordered by the State that contravenes the principles of te Tiriti o Waitangi can be challenged. If the way that psychotherapy is governed, either by Statute or by the Board [the Psychotherapists Board of Aotearoa New Zealand (hereafter "the PBANZ" or "the Board")], breaches even the spirit of the founding document, both Māori and Pākehā could choose to rally in opposition.

Keith: So why choose to regulate the profession under a piece of legislation that doesn't refer to te Tiriti?

Paul: All legislation in Aotearoa New Zealand is now morally, if not yet legally, required to respond to the principles of the Treaty, whether specifically referred to or not. As you know, New Zealand does not have a constitution, well, not in the form of a unitary document. Rather it has an amalgam of customs and laws that are the basis of government. The Treaty is the country's founding document. Since the 1970s, and especially since 1975, with the establishment of the Waitangi Tribunal, the Treaty has been given much more significance by successive governments. The Tribunal's purpose is to honour the Treaty as a current and living document that is still relevant to the country. Of course I would have preferred the *Act* to articulate its

honouring of the Treaty rather than it being assumed. However, in my view, the *Act* is answerable to the Waitangi Tribunal and to whatever authority successive governments might put in its stead. However, I accept that honouring the Treaty and its principles is still one step short of being enshrined in legislation.

Keith: Whilst we agree about the importance of the Treaty, we disagree about the *Act* and the Treaty [see Chapters 5 and 6) and, again, about your strategy. It's taken the Board three years to come up with its policy statement about the treaty which (PBANZ, 2010) reads:

> The Board considers that the Treaty of Waitangi ('the Treaty') is an important part of the fabric of New Zealand society and affirms its commitment to implementing the Treaty in ways that are appropriate to the *Health Practitioners Competency Assurance Act 2003* ('the *Act*') under section 3 and 118 so far as this is possible within the constraints of the *Act*.

Given the caution and conservatism of this, I don't think the current Board would in any way see itself as answerable to the Waitangi Tribunal — though it might be interesting to test that!

Paul: Yes, I agree with your intent here. Back to what I was saying: my second point is that Aotearoa may be the only country in the world to have created, so early in its history, an umbrella professional Association that has been able to embrace psychotherapists of almost all persuasions. To have done this 63 years ago is remarkable. Of course, isolation and small numbers necessitated such a move. Still, the profession locally has borne the fruits of this history. At the time I was lobbying for registration, this fact is likely to have been a significant factor in convincing Members of Parliament and the Health Ministry that psychotherapy was mature enough to handle the implications of statutory registration. And now that the *Act* is a reality, such a unified body can use its collective strength to ensure that its voice continues to be heard by the State and through the Board as its appointed "authority".

Keith: I'm not sure that everyone would agree that the NZAP has been — or is — such a broad church as you make out and, indeed, I have heard that you yourself were concerned about the NZAP losing its (psychodynamic) depth in favour of encompassing a breadth of membership. More significantly, however, for our current argument, it seems a little strange to have promoted a form of regulation that relies for its checks and balances on the continued "collective strength" of a professional body such as the NZAP, as it were, to guard the guards.

Paul: Yes, that's true. I was at times concerned that quantity may have compromised quality. I was well aware that, throughout its history, the Association, probably like all organisations, has tended to ebb and flow on the matter of whom to include, whom to exclude. There were clearly times, like in the 1970s and early '80s, when it was a very broad church indeed, (and also included counsellors) that I was concerned that quality may have been compromised for quantity. And there were times, such as during the later '80s and into the '90s that entry standards were redefined. This was particularly so when the vote was taken to return the Association's name to its original 1947 title.

Regarding your second point about guarding the guards, I do think that guards do need guarding. The Association does guard not only its members and its own standards but also it does work to protect the public. And, now, its new task is also to guard the Board and to be guarded by the Board. However, the Association is only responsible within its mandate, which is from its voluntary membership. It has no jurisdiction outside its membership. Who is to protect the public and advocate for the public interest regarding the other psychotherapists who are not within the Association?

Thirdly, one of my more hopeful counter responses to the arguments against regulation was to do with some of the independent undercurrents evident in New Zealand political history. There is ample evidence that a small country with a relatively few politicians, all of whom are easily accessible to the public, can make decisions that are not only visionary but can also buck international trends. Whether I trust Members of Parliament or not was not the issue for me here; I was more persuaded by my trust in the people in such a small country

to be able to lobby parliamentarians successfully. Tangata whenua and Pākehā successfully lobbied for the formation of the Waitangi Tribunal. We persuaded the State to go nuclear–free. I trusted that if a statutory body is not doing its job in accordance with the spirit of the Treaty or in line with equitable standards, MPs can be persuaded to take heed of public concern about this. In this country (Aotearoa New Zealand) history offers some evidence that, if enough people speak out, as we did against sports tours with an apartheid nation, the government can be persuaded to listen. The same may not be so true in the US or the UK.

Keith: Your point about independence and lobbying is an interesting one and, given the current actions of the Board, one which I hope proves to be true. Whilst I'm all for independence and bucking trends, not all bucking is visionary and some of it is downright reactionary.

Paul: You can say that again!

Keith: Your point that Aotearoa New Zealand is a small country could equally support the argument that we did and do not need such a cumbersome regulatory Act and authority to regulate comparatively few practitioners.

Paul: Again, I agree with you. It's the word cumbersome that is the bother. The *Act* and the authority are unnecessarily cumbersome. I do not believe such a small country with such a healthy umbrella professional Association needs a cumbersome authority to regulate it. The public deserves protection and for its interests to be safeguarded, however, it does not need this to be duplicated if the voluntary system is currently working well. It can come in more potently if or when the voluntary bodies are not adequately caring for the public. However, I disagree with you regarding whether the public interests are being safeguarded with regard to psychotherapy. The way the public doors are and have been so barred to psychotherapy is not in the public interest.

Two other points I wish to make here. Firstly, I want to reflect, for a moment, on the even bigger picture. By the 1970s and certainly by the '80s, political life in most of the world was being dominated by the forces of economic globalisation. The Cold War was over, so too was

communism. The Berlin Wall was about to collapse. With no strong antithesis, the free market was extending itself. Aotearoa New Zealand was in the grip of this epidemic. Roger Douglas was its patron saint. Deregulation ruled OK. Regulation was seen as not only anti–individualistic but anti–the public good. There was no chance that any government would consider registering psychotherapy during this phase. Unchecked, rampant capitalistic impulses left so many people in the thrall of industrial consumerism. The power of the multi–national pharmaceutical industry and its vast marketing expertise was allowed to dominate mental health services, just as chemicals dominated the agricultural and horticultural services. Such collusive madness is now being challenged by an even greater force, the ecological crisis facing us all.

The world now, more than ever, needs clear visionary legislation that places ecological sustainability above short–term financial gain. Where does this fit in relation to the conversation you and I are having? It leads me to consider that, over and above the cumbersome nature of what is occurring with psychotherapy regulation right now, I see a bigger picture, a longer term view in which the public and the profession, via the wooden horse of regulation, is given significantly increased access to psychotherapy services.

Keith: I get the analysis, but I don't agree with your conclusion. Your image of the wooden horse is an interesting one. If you're referring to the Trojan horse, this makes regulation a trick which contains destructive forces (the hidden Greek soldiers). So, who or what is Troy? I love the Greek myths but let's move on.

Paul: Secondly, as I've just hinted at, I do not see, nor have I ever done, that the task of regulation and the role of the Psychotherapists' Board is only to protect the public. This is merely part of the story. The statute asks the Board to also consider the public interest. Section 116 of the *Act* states that:

> Before making a recommendation under section 115(1), the Minister must ... be satisfied of the following matters: either —

i. that the provision of the health services concerned poses a risk of harm to the public; or
ii. that it is otherwise in the public interest that the provision of health services be regulated as a profession under this *Act*.

I note that public interest is not defined and is, therefore, open to the interpretation of the Board. I also note that, in the *Act*, health service is defined not only in terms of assessing, protecting and managing, it is also about improving. Thus (s5) (Interpretation): "(1) In this Act, unless the context otherwise requires ... health service means a service provided for the purpose of assessing, improving, protecting, or managing the physical or mental health of individuals or groups of individuals".

Thus, I see that an equally important task of the *Act* and, therefore, of the Board is to ensure that psychotherapy is "otherwise in the public interest" and that "improving" psychotherapy services is part of its mandate. Having both tangata whenua and Pākehā in prisons without adequate access to the services of psychotherapy is not in the public interest; having so few psychotherapists employed within the public mental health system is definitely not in the public interest and is a failure to improve services; having the voice of psychotherapy so quiet in Children, Young Persons and their Families Services is also not in the public interest. The power and the benefit of the *Act*, despite all its flaws, is that it finally gives momentum to the public, deprived of this access for so long, the opportunity to call for state provision of psychotherapy services. The Board has a responsibility as well to advocate for the public interest in this matter and to improve services in this way. Not to do so, I believe, is a failing in its duty of care to the public.

Keith: Whilst I think this is an interesting point, I think you are being very optimistic in your aspirations. It is clear — from the *Act* itself; from documents published by the Ministry, including its webpage on the *Act* (see Ministry of Health, 2010); and, of course, the actions of the "responsible authority", in our case, the Psychotherapists' Board — that the key purpose of the *Act* is the protection of the public. Moreover, the section of the Act you cite (s115(1)(ii)) requires the Minister (not the Board) to be satisfied of the "public interest"

argument before the profession can be considered to be regulated, not after the event (see also Director–General of Health, 2009).

Paul: May I step in here again? I am being optimistic, that's true. Yet, I don't think that this is completely misplaced. Despite the Ministry's key purpose, the *Act* clearly does allow another purpose. This is the opening that I fought for: for the provision in legislation for psychotherapy to be considered in the public interest. I do think that psychotherapy and the growth of public sector psychotherapy is in the public interest.

Keith: Of course, prisoners and others who cannot afford it should have access to good, public psychotherapy services, but I haven't seen or heard of any evidence that, since psychotherapists have become registered, prisoners have any greater access to psychotherapists or that the public is on the streets demanding psychotherapy or, for that matter, that psychotherapists have any greater standing in the public sector health service, or equal pay with psychologists, etc.

As far as the Psychotherapists' Board is concerned, it has made its position quite clear: it is not interested in dialogue with the profession that gave birth to it; and not interested in advocating for psychotherapy; it is a purely a regulatory authority.

Paul: I had never considered that this legislation would alter the situation for the better immediately. I had seen this change as probably taking a whole generation for its positive effects to become apparent.

Keith: Wait a minute. Did you say "a whole generation?" Were other people, including the NZAP and its Council, let alone tangata whenua, aware that this was a long–term strategy?

Paul: This was and still is my view. I think legislation takes a long time to become effectively embodied within a culture. I say a generation and, of course, I don't really know. It may take longer. Did the Association and Council and tangata whenua know that this was a long–term strategy? I can't answer that. What I can say is that I have been loud and clear in my assertions all along that I believe this process of regulation will take a generation to be effective. This is my opinion

based on my view of history. Once the door was opened to the possibility of public sector psychotherapy, there would be still many hoops and committees to pass through. Yet, without the regulation, the profession would always be on the back foot in such negotiations and the public would continue to be disadvantaged.

Keith: I'm interested that you refer to the *Act* and "all its flaws". It sounds like we might agree that it has a lot. The provenance of the *Act* is entirely based in the medical model (see Chapter 6) and, in my view, has no redeeming features — so perhaps this is a good moment to ask you at what point did you (and others) begin to think about regulation under this *Act*, and whether you considered other models for regulation and registration?

Paul: A number of us, both within the NZAP and from outside, thought long and hard over this very question. We considered that there were two extreme models and a middle way.

On one extreme, we faced the possibility of a new Board succumbing to the seduction of "empire–building". In this model, Board members would likely become adversarial towards the profession, arguing that they were formed to serve the public and implying that the profession does not. They might begin to accrue unnecessary wealth and power to themselves. They might forget that the profession and the public are not, in fact, in any real opposition. They might forget that the profession has served and intends to continue to serve the public good. They might forget that the profession has not been interested in feathering its own nest and that it continues to be generous towards the values and the ideals that first inspired it to form. The Board might begin to justify holding more power than is warranted by viewing the profession as being self–serving and ignorant of matters of public good. It would model itself along the lines of a Judge within the judicial system, paying itself accordingly.

On the other extreme, we envisaged a "radical non–intervention" model. In this model, the new Board would adopt a hands–off approach. Board members would acknowledge that the profession, through its Associations and through Waka Oranga, was already beginning to do such a great job in serving the public good. The Board,

in a generous spirit of partnership, would celebrate the way the profession had taken up the challenge to protect the public, through its various committees, especially over recent decades. With regard to the thirteen functions that Section 118 of the *Act* delegates to its responsible authorities, and especially the tasks to do with protection of the public, it would humbly acknowledge how little it had left to do of this. In this model, fees for psychotherapists would be kept to a minimum. This would be a way of recognising that the public was already being well–protected by the ways in which the profession had developed its own gate–keeping. State intervention, in terms of public protection, would simply ratify this reality. In this model, Board members would see themselves as more akin to jurors than judges. In line with the practice of the jury system, in which the Court pays minimal expenses, so the members of the Board would pay themselves a minimal fee for their services. This would also serve as an indicator of partnership and solidarity with the profession of psychotherapists who had so generously governed the profession and cared for the public good, on a mainly voluntary basis, for over sixty years.

Moreover, the *Act* allows for such a non–interventional economic style. For instance, in s133 Application of fees, etc. "(3) There may be paid to members of each authority ... out of the funds of the authority, any remuneration (by way of fees, salary, or otherwise) and allowances and expenses that the authority from time to time determines." The point is that it is not the legislation itself that directs the amount of the fees. This is the Board's decision and, as such, the profession can keep on advocating, as vociferously as it likes, that it may not be in the best interests of the public for the Board to be paid its current amount because of the burden this places on the profession and consequently on the public. If the Board is to serve the public, high fees are contraindicated.

The middle ground models we saw as simply more moderate variations of these two polarities.

I was and still am a staunch advocate of the "radical non–intervention" model. If I had served on the Board, I would have rallied all my passionate powers of persuasion to have embodied this form of governance. I do not think it is too late. However, given that the

current Board seems to have so readily favoured the other extreme, I am aware that the task of shifting the centre of gravity of the governance of psychotherapy is now becoming more difficult. Yet, such challenges and resistances are the stuff of psychotherapists' lives. The same attitudes and values and interventions that we use in the consulting room, the same wisdom and courage and compassion, can be brought to bear on the State's protective arm. Simply to ask out loud "whom does the Board serve?" and "whom do we serve" may be a way, in time, beyond the current adversarial nonsense.

Keith: Well, thanks for your candour and advice, Paul! I have to say that you have both answered and not answered my question (p. 103 above). A number of points are, however, becoming clear(er):

- It is clear that you (and the others to whom you refer) were only looking within the framework of the *HPCA Act* and not, for instance, at the pluralistic model offered, for example, by the *Social Workers Registration Act 2003*
- Neither were you considering models of self–regulation. As you clearly extol the work that the NZAP had put in over the years (regarding public protection, admission, standards, partnership, etc.), I am still puzzled as to why you wanted to fix something that wasn't broken.
- It is clear that you have much more faith in the flexibility and responsiveness of the state and its "responsible authorities" than I do — a somewhat interesting role reversal for an old anarchist and an old socialist!
- Whilst I appreciate (and agree with) your analysis of the style of governance of the current Board, this makes bitter reading. I and others have better things to do than to fight the rigidity and excesses of the Board — and, as you're now in Queensland, we no longer have you to argue that the Board adopt your radical "non intervention" stance.

Paul: We did consider the possibility of a separate legislation for psychotherapy; however, the Minister and the Ministry ruled this out. The Ministry was and is clearly committed to a path of reducing the number of health profession regulations rather than increasing them.

The new legislation, in which psychotherapy was included, wiped out eleven existing Acts and replaced these with only one. The Association was involved in these early roundtable discussions with the eleven existing regulated health professions. At the time it seemed more appropriate to counsel for the profession to be included within health legislation rather than within social welfare or some other government department. However, these alternatives were considered.

Keith: OK, that answers my questions about other options and pathways. My own view is that, as "health" is so compromised by the dominance of the medical model, any "health" legislation is, in effect "medical legislation" (see Chapter 6).

Paul: OK. Regarding your third point about my faith in the state, I may not have been so clear in my early utterances, if this is the impression you are left with from what I have written. No, it is not the state as such that I have faith in, it is the people. It always has been where I put my faith, the power of the people to have the final say, regardless of how much hubris institutions and authorities may dare to gather to themselves. At times, though, I do notice that apathy rather than passion may be people's choice. Later, the voice of the people awakens again and change happens. This is what I trust.

So, finally, once more back to the question you asked about my motivation. Was it the seven noble statements above or were there other voices and other intentions directing my actions? Do I simply like a good fight in the political arena? Did my own ego run the show? Was I beginning to feel the empty–nest syndrome and need something to preoccupy my own grief at growing up? And why this cause? Clearly, though, I did believe and still do that we protect most as well as to create easy access to what we value most. I believe our work is worth standing up and fighting for. It deserves to be protected and accessed. You and I have no disagreement about this. The question is more to do with the way to protect and to increase access to psychotherapy. I suppose I had begun to lose faith that our profession in Aotearoa would have the strength or ability or determination to create greater access to our services for those who most need us. I wanted this to happen and I did not want to be a bystander witnessing

the demise of our lineage. Is the State and its Board a worthy protector of our work and will it ensure that those who most need psychotherapy have increased access to what we offer? Or is it the enemy, consciously or unconsciously, that will destroy what you and I both most value of the profession? History will decide. In the meantime, now that psychotherapy is in the State sector, psychotherapists will need to be even more staunch and more articulate about who we are and what we stand for and to ensure that even our protectors do not get in the way of the work.

Keith: This is really interesting. I am struck by your loss of faith in the profession (and, perhaps, your colleagues) with regard to increasing access to psychotherapy and, more broadly, to psychological therapies.

Paul: I'd like to jump in on that. I don't think it really was about so much my losing faith, at least not for long anyway, more accurately it would be that I was simply losing patience and felt that a more direct approach was needed if the public were ever going to be given greater access to psychotherapy. I was becoming intolerant of the user pays approach as being the dominant way psychotherapy was been delivered.

Keith: I guess I would link this to your earlier point (and motivation) about offering alternatives to CBT. My experience is that once the state gets its hands on a profession or a field such as psychotherapy, it tends to intervene. You'll be aware that in the UK the last Labour government was extolling CBT on the basis of an economic argument, advanced by Layard (2005), that brief CBT therapy would help people feel happier and that this would be measured (and afforded) by them coming off invalidity benefit (for a critique of which see House & Loewenthal, 2008; Tudor, 2008).

Paul: I share your misgiving about such superficial and inaccurate data offered only for financial purposes.

Keith: Your sentence about protectors not getting in the way of the work is particularly fascinating. I thought that the argument was that once

psychotherapy was a regulated health profession that psychotherapists would be and feel more equal with other health practitioners.

Paul: I don't think it ever was about feeling equal. I simply believed that there was and is unequal access to services for a profession that is not regulated.

Keith: It seems like you're saying that, once in the state sector, psychotherapists have more to do, as I see it:

1. To do the work; and
2. To (continue to) argue for psychotherapy (to be more staunch and articulate); and
3. To monitor our "protectors", presumably the state in the form of the Ministry of Health and the Board. Indeed, you predicted this in your article when you wrote (Bailey, 2004) that the profession does need to stay "strong and watchful" (p.37).

Whew! If this kind of statutory regulation is the answer, then it seems to me that we're asking the wrong question.

Paul: Yes, that's what I'm saying and have been saying all along. Regulation is not the end, it is the beginning. Once the wooden horse enters the city, then the political work begins in earnest. There is now much work to be done! We need those "protectors" to be guardians not only of the public but also of the profession because the profession is, in fact, now doing such great work already protecting the public. Once the Board accepts this reality, the issue of access becomes the key task.

Thank you, Keith, for giving me a chance to have my say.

To conclude, I want to wish you and my other colleagues in Aotearoa well. I have begun my new life in Queensland. I find that, even after only a year, I am at home here and am often happy. Interestingly, though, given what a warrior I have been for the cause of psychotherapy within Aotearoa, I have moved to a part of the world where psychotherapy is even more marginalised as a profession. I find, though, I do not have the fight left in me to yet be involved in the debate here. Instead, I am actively involved in my other professional passion, supervision. Paradoxically, although I cannot work for

Queensland Health as a psychotherapist, they have employed me and have given me State–wide responsibility to educate mental health staff on the art and craft of supervision. I am finding in this new work, somewhat to my relief, that I can stand for and can protect what I have most valued in psychotherapy.

Keith: I am pleased that you have found a home and work you enjoy. I hope you will forgive me, however, pointing out an irony that here, as a non registered practitioner, you would not be able to supervise other practitioners (unless the Board signed you off). Queensland Health is clearly more enlightened about experienced practitioners than is the current PBANZ.

Paul: No, I still need to be signed off by similar authorities here. I wouldn't want you to think that things were more enlightened here, for that is clearly not the case. And, I am registered here: I am on an Association's voluntary register of psychotherapists. It is simply that there is not a statutorily regulated register of psychotherapists in Australia as yet. There is still much work to happen in Queensland before either psychotherapy or supervision is acknowledged, honoured or valued appropriately.

Keith: I don't think we're going to agree about the necessity or the desirability of the statutory regulation of psychotherapy or the state registration of psychotherapists here, in Queensland, or anywhere else. I think it was ill–conceived and ill–considered and, as a result, those of us who care about freedom of assembly, association, and expression now have quite a fight on our hands. Nevertheless, I appreciate your willingness to engage in this correspondence. In terms both of the history of regulation, and with regard to the present and the future, I think it's been important to have your voice and contribution. At the beginning of our correspondence you quoted W. B. Yeats on quarrel, rhetoric and poetry. As much as I like Yeats, I'm more with Plato (380BCE/1955), who stated that: "there is an old quarrel between philosophy and poetry" (Book X, para. 607). Certainly there is a time — and season — for poetry, and for rhetoric; right now I think we need analysis and argument.

Best wishes, Keith.

Paul: And I would add the word "action" as well: "continued and persistent action" alongside your call for analysis and argument. Thank you again for this conversation.
And, again, I wish you well. Paul.

POSTSCRIPT (JANUARY 2017)

Keith: Paul, thank you for agreeing to revisit this exchange after some seven years. Perhaps we might begin with any further thoughts you have had in this time about the issue of registration and regulation and/or about our dialogue?

Paul: Thanks, Keith. I appreciate you giving me this opportunity to continue our conversation. Re–reading my earlier rambling responses to your questions regarding registration, regulation, the freedom to practise and the protection of the public, I want to pick up on three matters, in particular.

Firstly, I want to acknowledge how psychotherapy in the international context is experiencing such a steep political and cultural learning curve. Many countries are currently grappling with the cultural and political questions you raise in your book, as well as, of course, the ethical considerations. I cannot but be struck by the wide array of national responses. When I read the history of psychotherapy and its relation to the State in a country like the Czech Republic, how markedly different that story is to the situation in the United States. I see how Sweden (1985), Italy (1989), Austria (1990), Finland (1994), the Netherlands (1998), Germany (1999), France (2004), Slovakia (2004).[*Ed. — As a sub–speciality of psychology.*], New Zealand (2007), Switzerland (2013) have each recently answered in the affirmative the question as to whether to regulate psychotherapy by statute or not. And yet, even in these countries, what variety there is in the eventual texture and shape of each nation's regulation.

The other day I read how the Irish Council for Psychotherapy (ICP), representing 1,250 members, stated that it "is fully supportive of statutory registration of psychotherapists, and sees statutory registration as providing many advantages for patients and clients, the

professional psychotherapists themselves and employers." (ICP, 2015, p. 2) Further, it "urges timely action in advancing towards statutory registration" (p. 2). What the Irish government and the Irish Council of Psychotherapy will make of this political and cultural challenge will, in practice, in my view, be likely shaped much more by the interpretation of the few members of the regulatory board than by the State itself or even the profession.

Other countries, such as Australia, for a variety of historical and political reasons, have moved away from such immediate consideration. On this side of the Tasman, there is much more talk about a "best–practice self–regulation" model. As Margot Schofield (2008) wrote:

> The work undertaken by various professional associations to strengthen self–regulation for our professions are vital achievements which will position us well for future consultations around regulation options ... A high degree of self–regulation is required for a profession before statutory regulation processes are enacted. (p. 159)

So, it seems to me, that each country, as in the image of the blind men and the elephant, evaluates what ought to be the shape of psychotherapy and has negotiated registration accordingly.

My second response to our earlier dialogue is that I see that at the heart of the quest in Aotearoa New Zealand, at least my part in this quest, was an intent, with others, to find a way to increase people's access, more widely, more equitably, to psychotherapists. You called the first edition of this book *The Turning Tide*. What I experienced up until 1999 was more like "missing the boat". For I believed that the public, in terms of access, had been sorely disadvantaged by psychotherapists not being regulated back in 1982, when the opportunity had first presented itself. This failure left the field of psychotherapy, to a great extent, sidelined in the private sector, at the mercy of market forces and the long years of deregulation.

In 1999, the nature of the nation's politics was changing. For in that year the coalition government of Labour and the Alliance came into

political power, with Helen Clark as Prime Minister. The opportunity arose for the profession to begin a dialogue again between other interested parties and the State on how greater access to psychotherapy might best happen. This seemed the right moment to ensure that the profession did not miss the boat a second time for I perceived, accurately or inaccurately, that statutory regulation was a necessary precondition for greater access. I was well aware that the State and the Act that the State was proposing were more concerned with public protection. Yet, I did not and do not see these polarities as being mutually exclusive.

As I look back over the years since, I do not believe it was the politicians nor was it the Ministry of Health that has so adversely affected the workings of the Board. In the end, sadly, I believe it was the Board itself that chose to interpret the regulatory Act in the restrictive way it did. This, in my view, was not inevitable. The Board was appointed to hold the tension between public protection and the freedom of psychotherapists to practise psychotherapy well. I did not really foresee that the Board would overstep its mandate by seeming to ignore the interests and concerns that practitioners were voicing. I thought, in good faith, that the Board would be both more humble and respectful in its dealings with psychotherapists. I feel sad at the unnecessary hurt that the overstretching of the State's delegated control by the Board has wrought. It did not need to be so. At least in my view then and still now. Although, at times, I am not so sure.

And this prompts my third thought: who owns psychotherapy and who, in the end, has the power to define who can be a psychotherapist? In an international climate in which there is a wide variety of national responses to these basic questions, what is to happen when a practitioner wishes to move from one jurisdiction to another? This led me to reflect on the case of Heinrich Lanthaler. He was educated and registered as a psychotherapist in Austria, a country which legally recognises psychotherapy as an independent profession. When he moved to Italy in 2002 he applied to be included on the Italian statutory register. His application was refused because Italy allows only psychologists and medical practitioners to be legally registered as psychotherapists. He took the matter to Court and in 2008, the Italian

government “was forced to scrap a national law that contravened European legislation and the chambers of Italian psychologists were told to register Lanthaler as a psychotherapist in Italy” (Warnecke, 2010). I take heart from Heinrich Lanthaler’s experience in which his freedom to practise was not stifled, in the end, by a repressive interpretation of how the public needs to be protected.

Keith: Thanks for this, Paul. I’ll respond to each of the points you raise.

On the first point, clearly different countries (jurisdictions) have made and will make different decisions about regulation, based on complex factors: historical, cultural, political, organisational, and administrative, to name a few. As we know, the history of the organisation of psychology, counselling, psychoanalysis, and psychotherapy is complex, especially when professional associations organise internationally, across jurisdictions. This brings me to the case you cite in your third point (which I’ll address now), which was only able to be resolved because both Austria and Italy as member states in the European Union have, in effect, signed up to a higher, international system of legislation, which is not applicable in all countries. Thus, even though I am a qualified psychotherapist (and still voluntarily registered with the United Kingdom Council for Psychotherapy), the Board has made it clear that I should not refer to myself as a psychotherapist in this jurisdiction — and I don’t. As you may know, some years ago the Board suggested that any overseas psychotherapist working in New Zealand as a Visiting Educator should not refer to themselves as a Visiting Educator (see Chapter 7 for further details), a proposal that, after some work, some of us managed to influence the Board to modify.

I think you make a significant point when you say “Psychotherapy … will, in practice, … be likely shaped much more by the interpretation of the few members of the regulatory board than by the State itself or even the profession.” I think this is a key problem: that the adoption of statutory registration and state regulation shifts the responsibility for such registration and regulation from the profession and its representatives who, importantly, are answerable to the profession, to a small group of nominated and usually unelected members of the profession. Moreover, once colleagues become members of the Board,

they identify more with that “responsible authority” than their profession. The result is, in effect, a bureaucratisation of the professional — and, furthermore, taxation without representation. In my view — and now my experience — this is not only undemocratic but, given that the colleagues who serve on such regulatory bodies are by and large those who are strong advocates of regulation (and more regulation), is also dangerous. In this country, we now suffer from, as you put it, a “repressive interpretation of how the public needs to be protected”, with virtually no checks and balances.

You won’t be surprised that I am, of course, disappointed that the Irish Council of Psychotherapy has decided in favour of statutory registration, ’though I am glad to see that the Irish Department of Health (2016) is clear that “Regulation under the Health and Social Care Professionals Act 2005 is primarily by way of the statutory protection of professional titles rather than restricting scopes of practice.” By contrast, I am heartened by the recent vote of a substantial majority of members of the New Zealand Association of Counsellors in favour of professional self–regulation. After much discussion, which was informed by the literature as well as taking to members of the psychotherapy profession, they have decided to remain in charge of their own destiny.

It is on your second point that I think we most disagree. It is not accurate to say that psychotherapy was “deregulated”. The psychotherapy profession in Aotearoa has long been regulated: it has, to great effect, regulated itself, as the chapters by both Grant (Chapter 3) and Roy (Chapter 10) in this volume attest. The issue of public access to psychotherapy — about which I, too, am passionate — is not dependent on perception (yours or anyone else’s) or on statutory registration, but on political and economic will. If it were, then, potentially, there would be as many psychotherapists as psychologists in the public sector — and this is simply not the case. Moreover, the advent of state registration simply has not had the effect of any significant increase in the employment of psychotherapists in the public sector; in fact, recent research I conducted reveals a decrease in the number of generic psychotherapists employed in District Health Boards (DHBs) and no psychotherapists working in prisons under the

Department of Corrections (Tudor, 2017b). Such employment is a much more complex argument, one which relates to politicians' perception of and knowledge about practice and effect of psychotherapy; the differences in the respective history of psychology and psychotherapy with regard to research, and their respective relationship with the medical establishment and public health service; the power of the medical model; partiality in the funding of research; and much more. In short, I would say that your perception that the statutory regulation of psychotherapy was a necessary precondition for greater public access to psychotherapy was ill–informed (vis our previous discussion about how much of the literature you had read), ill–founded, and inaccurate. If the government wanted patients or consumers of the health service to have access to psychotherapy, it could simply make it so.

I appreciate your reflections with regard to the attitude and dealings of the Board, and especially your vision of its humble and respectful relationship with the profession, 'though, as I think I said in our original dialogue, I think you were somewhat naive with regard to the power of the state as expressed through the Board and other "responsible authorities", as you put, your "faith in the state" (p. 105). I agree that it would be better all round if they held a "right touch" or even a "light touch" perspective on regulation, in line with current international thinking on the subject (Professional Standards Authority, 2015) — and, even a light touch is nowhere near the model of "radical non intervention" you envisaged. Despite the Board's own view that it is only concerned with the protection of the public, all its decision have been characterised by a "heavy touch" that reveals a consistent pattern of moves to regulate more scopes or areas of practice (Visiting Educator, supervisor, and now educators and trainers). I was curious about your sentence "Although, at times, I am not so sure." Would you say more about this?

On your third point, it is clear that with statutory registration the title "psychotherapist" is "owned" by the state. It is equally clear that the term and practice of "psychotherapy" is not necessarily owned by the state. I note "not necessarily" as this depends on the legislation and the model of regulation that the legislation represents. As you know, in

some jurisdictions, psychotherapists are regulated by some form of health practitioners act, and in others, notably Austria and Germany, by a specific psychotherapy act. Broadly, the former is based on and concerned with title protection (state registration), the latter represents or allows for a broader restriction of practice (statutory regulation). Of course, the devil is in the detail, which is why — and I think we both agree on this — that it was important that every psychotherapist should have read the *Act* before voting on registration/regulation. Unfortunately, they didn't, and we have what we have; even more unfortunately we have at least one member of a recent configuration of the Board who, as she was joining the Board, quite openly said that she hadn't read the *Act* and that she didn't see a distinction between psychotherapist and psychotherapy!

Before I finish, I want to raise one point, which is about our original dialogue. I am particularly interested in this as our chapter is one that was referred to in both reviews of the book positively: "an elegant and mutually respectful piece of peer supervision" (Jenkins, see p. 394), and "a fascinating dialogue" (House, see p. 343). Yet, within the profession here, I have been criticised for "outing" your motivations, interrupting you, and, indeed, "humiliating" you. I should say that I have also had positive feedback that the dialogue was both informative and revealing — which I think was and is a good thing. Personally, I think the original dialogue, as well is this one (so far, at least!), was both robust and respectful, and that we both agreed both to the dialogue and to the final wording. I am clear that we disagree with each other about much of this; and I am clear that, at times, I have been both angry with you and somewhat despairing for myself and others about the legacy that you left here — and left us to deal with; but that, essentially, the argument is just that: an argument — and that argument helps to clarify things (see Tudor, 2016).

I'm interested in your thoughts about this, partly because I've experienced this debate as quite personal. I have been thinking, presenting, researching, and writing about professional regulation and registration for nearly 20 years, and yet when I and others presented these arguments in this country, especially in the early days (2009–2011), we were bullied by some colleagues as well as the Board — for

a certain period of time I myself was put under a lot of pressure to register because of my job as an academic (when there was no actual justification for doing so); and, since then, we have been personally attacked by some other colleagues as troublemakers and as presenting "academic" arguments (as if that were a bad thing). Perhaps more worryingly, however, many colleagues have stopped thinking and talking about this, and, specifically, what living in and practising psychotherapy in a post–registration landscape actually looks like.

Paul: Within our conversation, I, too, am struck by, no, touched by the personal between us; the way you and I are and have been so passionately active over the many years in the field of psychotherapy. Yet, I read the poignant ramifications in your words: "humiliating", "bullied", "attacked" and, so, I begin my response here.

I have not experienced you as humiliating me and I hope that I have not done so to you. Rather, despite or because of our ideological differences, I am grateful for the way you have invited me to reflect on my motivations for and perspectives on the actions I took an age ago. For these acts I am accountable and I like the way you have been "robust and respectful" in holding me to account. And I am sad, though, to read of the personal attacks on you, the cost of meddling in politics, of daring to speak "truth to power". Such are, as we both know, the inevitable consequences of shaking the status quo. And I want to let you know that I resonate with the following statement in your latest book, *Conscience and Critic* (Tudor, 2017a) in which you reveal:

> Whilst in some ways I have become psychologically and psychotherapeutically sophisticated, I also enjoy a certain freshness, even naivite, that derives from my idealism, which also fuels my interest in and commitment to action alongside reflection and I continue to be critical of psychotherapists who privilege and reify reflection at the expense of action, whether it be personal and/or social/political. (p. 10)

So, getting back to action in the political sphere, I accept that you and I have markedly different views on whether greater public access to

psychotherapists is dependent on statutory registration. It is such early days in the unfolding of this radical change, a change that is happening now or, at least, being reflected upon and debated, in a growing number of countries: "Cross–national differences in access mean", as David Pilgrim (2012) wrote, "that market–dominated health–care systems tend to exclude the poor from therapy" (p. 41). Whether the matter of title protection increases access in the longer term, only time will tell. What I am aware of, on this side of the Ditch and particularly here in Queensland, is that, because there is no statutory registration, psychotherapists who might wish to work as such are excluded not only from working as psychotherapists in the public sector but also from the Medicare scheme. However, those who have what are deemed the "core" degrees, namely, occupational therapy, social work, clinical psychology, medicine and mental health nursing, can practise as public sector and Medicare psychotherapists, even with minimal psychotherapy education and experience. This is not OK by me, not OK for the public, and not OK for those psychotherapists whose first profession is psychotherapy.

Naïve or not, when I look back, I remember being prompted to such decisive action whilst reading, of all things, the NZAP's *Code of Ethics (2008)*. I found the *Code* upholding values and virtues that I believe are essential to good practice. I was particularly activated by "Section 3:4 promote equity. Psychotherapists shall seek to improve social conditions through the fair and equitable distribution of community resources" and by "Section 3.6 encourage social debate. Psychotherapists shall encourage debate in the shaping of social policies and social institutions."

In 1999 in Aotearoa New Zealand neither the Association nor I seemed to be living actively enough into these particular aspirations. Whether the actions I and others took resulted in the right consequences or not, I believed strongly at the time that bold and decisive action was needed if the public and psychotherapists were to not "miss the boat" again. On a personal level, I was of an age within the profession in which my private practice was flourishing and I was not needing more work. Yet, I could foresee that, with the deliberate dismantling of the Welfare State that was occurring in Aotearoa New Zealand and the

rising gap between rich and poor, that within a generation the profession of psychotherapy was likely to become even further marginalised. I saw that this was not in the public interest. Nor was it in the best interests of the next generation of psychotherapists. For, as David Pilgrim (2009) argued, where the market model is dominant, this "ensures plurality on the supply side but limitations on the demand side. Demand is limited by the availability to pay and so the poor are excluded." (p. 41). This inequity demanded of me ethical action. "A decade or so on this trade–off between access and acceptability is central to debates about therapy in the public sphere." (ibid., p. 41).

Next I want to pick up on your statement that "it is clear that with statutory registration the title 'psychotherapist' is owned by the state." (p. 113) "Owned" is such an interesting and controversial word. If the anarchists say that no–one owns anything, the communists say the State owns everything, capitalists say ownership is an exchange based on commercial and legal norms, and Naomi Klein (2014), I and others ask what comes after communism and capitalism, then whose ideological rules rule with regard to what you call ownership? I think that, in practice, the jury is still well and truly out on the matter of who really owns being a psychotherapist. For it is clear that, in the 21st century, psychotherapy and psychoanalysis and counselling have each moved more actively into the political space, and each has much to say on ownership. Some years ago, Ann Casement edited a book titled *Who Owns Psychoanalysis?* (Casement, 2004). In his book, *Critical Thinking in Counselling and Psychotherapy*, Colin Feltham (2010) asked the question "who owns counselling?" and said "it looks like it has a proprietor" (p. 93). Yet who is the proprietor? In his chapter on "Psychotherapy and Psychoanalysis and the Problem of Ownership: An Effort at Resolution", Arnold Goldberg (2007) wrote:

> Ownership implies property, something that one has or holds. The powerful feeling of having something, or indeed someone, belonging to you, and the equally potent feeling that comes from belonging to another individual or group, makes the idea of ownership amenable to the tools and theories of a discipline devoted primarily to the mind. The

> relevance of such a study would reside in the arena of a better understanding of the meaning of ownership. (p. 83)

I do not see it as you see it. I do not see psychotherapists as being owned by the State. Although the Board is delegated the legal responsibility to determine who and who is not a psychotherapist, this gatekeeper role is not ownership. Maybe it is as John Steinbeck (1939/2015) wrote in *The Grapes of Wrath*: "That's what make it ours — being born on it, working on it, dying on it. That makes ownership, not a paper with numbers on it."

Responding briefly to your invitation to say more about "although, at times, I am not so sure". Simply, what I mean is that acting ethically is often complex, rarely so decisively right or wrong, and pursuing the ethics of equity and access is and has been fraught, for all the reasons we have already discussed and more. And, at times, I wonder whether I would have been wiser to wait longer before acting. As a character in Junot Diaz's (2007) novel, *The Brief Wondrous Life of Oscar Wao*, said: "It's never the changes we want that change everything."

Yet I did choose to act and in the way I did. And, although I am concerned that state regulation has or might move the profession in directions I cannot condone, I am surprised that you say that "in this country, we now suffer from ... virtually no checks and balances." (p. 112) This sounds like resignation or defeat. For, I believe, that there are checks and balances. I do not believe that the Board is or was ever meant to be the voice of psychotherapy in Aotearoa. The voice of psychotherapy lives in those who are actively engaged in the practice on both sides of "the couch". And. although psychotherapy lives in a world in which the Welfare State is being systematically dismantled, the challenge for us as psychotherapists and for the public is how to continue to give effective voice to the matter of equitable access to psychotherapy services whilst ensuring the plurality of such services.

Keith: Well, Paul, as ever there's a lot to pick up on in what you say, and I will respond to your points, albeit relatively briefly.

Firstly, I appreciate your personal comments as well as your reading of my own work. I also appreciate what you say about our dialogue and

agree that it has been both robust and respectful. I also agree that we are both passionate about psychotherapy. With regard to some of the responses I have had to this (and other equally robust and passionate debates), however, I wonder whether it is this precisely the passion that, for some people, evokes anxiety and misinterpretation? Yes, indeed, challenging the status quo comes at a cost.

Regarding public access to psychotherapy, clearly we are not going to agree. The facts simply do not support your view of or hope for psychotherapy in the public sector — in DHBs. Before registration there were 49 psychotherapists working in DHBs; currently there are 54, an increase of just five in eight years (and an increase that is entirely due to employment of a number of child and adolescent psychotherapists in two DHBs) (Tudor, 2017b); and, as I noted, none working in prisons. It's not as if the New Zealand government was simply waiting for psychotherapists to be registered so that it could employ them! Governments the world over will always tend to favour psychologists over psychotherapists (for a whole host of reasons) until psychotherapists argue their distinct(ive) contribution.

Part of this will be to reposition ourselves as "core", which would address a third point I want to pick up. I agree that psychotherapy, as a subject, a discipline, a practice, and a vocation and/or profession (see Tudor, 2018–in press), should be seen as core or central to life, but this would require something akin to a cultural revolution about how we as a society think and talk about psyche and therapia (healing). It would involve emotional literacy in the education system at all levels — and that's just the start!

Regarding your point about ownership — of course I don't think anyone "owns" psychotherapy but, as far as the title "psychotherapist" is concerned, you can't have it both ways. Your comments on this and the literature you cite and quote sound all very postmodern and deconstructivist: ownership is a construct; being a psychotherapist is part of who we are; we don't have to pay attention to (headed) paper with numbers on it; we don't have to give away our power; etc. Unfortunately, it isn't, we do, and we have. Moreover, you were the one who instigated a process that specifically gave away the title "psychotherapist" to the state. As you know, in New Zealand (and the

other countries to which you refer), unless a person meets certain criteria, governed by the relevant legislation and determined by a responsible authority (here, the Board), and pays a fee, they can no longer legally refer to themselves as a psychotherapist. In the context in which a person who isn't registered as a psychotherapist but refers to themselves or "holds themselves" to be a psychotherapist is liable to a $10,000 fine, how does the Board's "gatekeeper role" not constitute ownership? Again, I think you underestimate the power of the state — and, yes, I have to say that I wish you had waited longer before acting, not least so that I would have had these debates with you live and at a point when they might have helped inform the debate.

As far as the title "psychotherapist" is concerned, it is clear that the New Zealand state in effect owns the title; to borrow your metaphor, that particular boat has sailed, and, I, for one, have made my peace with that. I agree that the Board is not the voice of psychotherapy in this country, but it does govern the actions and voices of psychotherapists — again, we see that this distinction is an important one. What concerns me — and, from what you say, I think it would or should concern you — are the consistent attempts of the Board to govern the whole field (and voice) of psychotherapy, attempts which I have detailed and critiqued elsewhere (in this volume, see Chapter 7); and that psychotherapists (I would say most psychotherapists) are not concerned about this. That is, they are not concerned:

- About whether they can refer to an overseas colleague as a psychotherapist;
- That the Board approves (or disapproves of) their supervisor, and that the Board introduced this without consultation;
- About the fees the Board charges, which are now the second highest of all the responsible authorities under the *Act*;
- That the Board is proposing to restrict practice even further, with regard to those who can teach, supervise, and undertake personal therapy with psychotherapists in training;
- That Board has itself breached the *HPCA Act*; and/or
- That the Board doesn't take much notice of the profession (for further details on all of which see Chapter 7).

In response, I move between feeling indignant and energised, and, of course, defeated and resigned. Some, no doubt, would wish that I felt more defeated and resigned!

At the end of our first correspondence, you acknowledged that "the task of shifting the centre of gravity of the governance of psychotherapy governance is now becoming more difficult" (p. 104), but went on to comment that: "such challenges and resistances are the stuff of psychotherapists' lives" and reassured me/us here that "The same attitudes and values and interventions that we use in the consulting room, the same wisdom and courage and compassion, can be brought to bear on the State's protective arm." (p. 104) My response was — and still is — that we have better things to do, and there's certainly a lot in the field of psychotherapy that I am passionate and excited about. Responding to the latest nonsense of the Board isn't one of them. Over the past seven years things have got worse. Far from acknowledging the good work of the NZAP and of Waka Oranga as its Treaty partner — and it is significant that, to date, the only pathway to NZAP membership that the Board doesn't recognise is the He Ara Māori pathway that Waka Oranga instigated — the Board shows no sign of the generosity, celebration, humble acknowledgement, partnership, or solidarity, you hoped and suggested; and there are certainly no signs of the "radical non–intervention" model of governance to which you refer.

I guess I'll finish there. Again, my thanks for your willingness to engage in this. Whilst I don't have any plans to revisit this particular dialogue, I do wonder where psychotherapists and, of course, psychotherapy in Aotearoa New Zealand will be in seven years' time?

Best wishes, Keith.

Paul: Hello once more, Keith. I'll make a couple of very brief responses to two of the matters you highlighted and then conclude as well.

I was not trying to be postmodern or deconstructivist, rather I was simply intending to make the obvious point that the nature of ownership of a title, such as psychotherapist, is both politically and culturally fluid rather than fixed. Boards and board members come and go, as do governments. I believe that it is up to the profession to be

ethically responsible and, therefore, rigorously attentive to the ways the five psychotherapists and the two lay representatives on the Board interpret their particular defining powers and, in particular, how they chose to ratify practitioners as psychotherapists. Like you, I am appalled that the Board continues to exclude those who have travelled He Ara Māori pathway. Clearly and sadly, there is much more debate yet to be had about this crucial bi–cultural challenge — as there is too on this side of the Tasman Sea.

And this leads to the other comment that I wish to offer, which is an obvious one as well: that psychotherapy and psychotherapists live now more overtly in the political sphere as a result of statutory registration. How each psychotherapist lives into the values enshrined in the *Code of Ethics of the New Zealand Association of Psychotherapists*, especially Sections 3:4 and 3:6, is what I believe continues to lie at the heart of this important cultural and political shift, especially with regard to equity (see above).

And all that is left for me to say is thank you, Keith, and to let you know that I look forward to whatever contact you and I have into the future.

Public statutes

England and Wales

Medical Act 1858.

New Zealand

Health Practitioners Competence Assurance Act 2003.

Social Workers Registration Act 2003.

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Chapter 5

Māori psychotherapy and the *Health Practitioners' Competence Assurance Act 2003*

Na Margaret Poutu Morice (Te hapu o Tuwhakairiora, Te iwi o Ngati Porou), na Wiremu Woodard (Ngai Tuhoe), na Heather Came (Tangata Tiriti)

There are many similarities between the *Tohunga Suppression Act 1907* (*TSA*) and the *Health Practitioners Competence Assurance Act 2003* (the *HPCA Act*). Both Acts are prefaced on fear and invoke the holy grail of public protection. In the early 18th century (Common Era) the threat of rampaging infectious disease rationalised autocratic Crown responses and policy aimed at indigenous peoples. Ironically these diseases stemmed from colonization, not indigenous malpractice. At its heart the *TSA* was designed to undermine an indigenous position and superimpose a Western paradigm (Woodard, 2014). The *TSA* was, in part, specifically designed to suppress the uprising of Tuhoe prophet, Rua Kenana (Binney, Chaplin, & Wallace, 2011), legitimise his arrest, and authorise the subsequent destruction of the indigenous community at Maunga Pohatu in 1917.

Contemporary health policy needs to recognise that the multiple and systemic issues assailing indigenous peoples stem from social and cultural

phenomena which have their roots buried in historical colonial processes. Compulsory registration under the *HPCAA* for indigenous practitioners replicates colonising dynamics which exploit legitimised methods of control based on monocultural measures and punitive action.

Essentially both Crown Acts and actions operate to constrict and oppress the growth and practice of indigenous ontologies and subsequent methodologies. Therefore registration under a Crown authority is inherently problematic for indigenous practitioners. Arguably, resolution of the systemic issues facing indigenous peoples cannot be found within the very cultural/social organisms responsible for perpetrating the dysfunction of indigenous communities and psyche.

Waka Oranga (Hall, Morice, & Wilson, 2012) is the national collective of Māori psychotherapists; its stand against the *HPCAA* and compulsory state registration is part of a wider indigenous collective action intended to disrupt Western assumptions of unambiguous power. This present contribution is the story of our struggle against the tyranny of cultural monopoly. It is dedicated to the many healers and indigenous practitioners who have been driven underground and, in spite of overwhelming pressure, have continued to work for the benefit of our peoples and communities (Mark & Lyons, 2010). This is a continuation of a monumental struggle to retain the right to name Indigenous realties.

Whaiwhai Tonu Matou, Ake, Ake, Ake!
We Will Fight on Forever and Ever!

[These words were spoken by Rewi Maniapoto (Ngati Paretekawa, Ngati Manipoto) when called upon to surrender at Orakau in 1864.]

It is now widely accepted that te Tiriti o Waitangi (te Tiriti) is the foundational document of this (colonial) nation (Healy, Huygens, & Murphy, 2102). te Tiriti provides a basis for bicultural relationships in Aotearoa New Zealand that are as relevant today as when it was first drafted in 1840, but, as the many struggles of the past 170 years attest, colonisation is a powerful status quo. The struggle for the recognition and acknowledgement of te Tiriti continues in contemporary post–colonial Aotearoa New Zealand society (Tahwai & Gray–Sharp, 2011). Each of the

Articles of the Treaty, separately and together, have been ignored, denied and contested. Nevertheless, they provide a framework in which power, responsibility, and resources could be more fairly and equitably distributed. te Tiriti o Waitangi forms the basis for a constructive bicultural partnership that has the potential to benefit all of the people of this land.

Viewed through the lens of te Tiriti, in the current political configuration, there cannot simply be one law of the land. If there is but one law, that law will inevitably be monocultural in its assumptions, its intentions, and its consequences, and thereby systematically disadvantage Māori. If we were to imagine an alternative, one that more closely aligns to the articles of te Tiriti, then every piece of statutory legislation would be evaluated according to its impact on and place within Te Ao Māori values and principles: law would co–exist with lore. Far from being difficult, time–consuming and seemingly repetitious, such a process would engage us in an aspirational and creative endeavour that would more immediately and consistently deliver tangible benefits to all New Zealanders. What this means is that all statutory legislation in Aotearoa New Zealand would be bilingual, bicultural, and emancipatory in intent. It would seek to uplift the people and to empower communities. It would support the exercise of local autonomy and local authority in the interests of local self–determination.

The relational concept of whanaungatanga provides a practical means for enacting decentralised and decentralising power and authority. The complex web of kinship and land–based relationships of whānau, hapū, and iwi that define the traditional social structure of Māori society, may be usefully applied to any person and all population groups within contemporary society (Marsden, 1992/2003). Furthermore, the concept of kaupapa whānau extends the values and principles of whanaungatanga beyond the boundaries of biological kinship to embrace communities of interest. In other words, the hierarchical (and patriarchal) authority of the Crown would be balanced by a broader based, local, grass–roots authority of people power that begins in small, intimate, face to face whānau relationships and extends outward to embrace progressively wider circles of influence that include larger communities with common interests. The Crown is repositioned as a governance body exercising kāwanatanga instead of imperial authority. In this frame, Crown authority and Indigenous authority share resources and decision–making powers. The Government governs by

providing consultation, liaison, oversight, mediation and dispute resolution to empowered communities. Democratic governance in a bicultural context is a complex relational matrix of social structure and function; it may not be systematic, it may be untidy and unpredictable, but it is neither chaotic nor destructive. Rather it has an organic life that arises directly out of and feeds back into the aspirations and needs of its people. It seeks balance and reciprocity in relationship and resembles at its heart, the whānau and family of origin.

What rangatiratanga actually means in practice is leadership from within rather than from without. Rangatira status is emergent and is bestowed by the people. Rangatira represent an empowered group, to whom they themselves belong and to whom they are accountable. Kotahitanga, in this context, oneness, describes an empowered group that is conscious of its own unity and carries a unified purpose and intention. Rangatiratanga is also exercised through kaitiakitanga. In this context, rangatira are guardians, a trustee, and a protector of group resources. In a culture that puts a high value on public speaking, a rangatira is also the person who can best articulate the sentiments of the people. Chiefly authority is both ascribed and achieved, but it is fundamentally not so much a matter of individual inheritance or democratic election as it is a consensually based authority that arises from and remains tied to and held within the context of group authority (Healy, Huygens, & Murphy, 2012).

Article I of the te Tiriti accepts Crown authority as a legitimate means of governing non–Māori (see Mutu, 2010). Crown authority is derived from the entire establishment of British law, and many of the values and principles of white, Western, European cultures. Democratic governance is founded upon broad and inclusive principles of fairness, respect, and dignity for all persons. Individual autonomy, enterprise and responsibility are all upheld, as is a recognised legal system. Private property and a system of income and property taxation designed to fund the common welfare of all, are all accepted in principle.

Article II of te Tiriti, however, reaffirms Māori customary rights and limits Crown authority (Mutu, 2010). The acceptance in principle of the arrival of the British people and way of life onto the shores of Aotearoa, does not abolish traditional Māori resources, mores, and ways of life. These are in fact, guaranteed and protected in Article II. Undisputed possession of

fisheries and forests, all precious taonga of a material and immaterial nature are to be retained. Article II means that whānau, hapū, and iwi all retain their self–determination in principle. The Crown accepts the chiefly authority of rangatira, which could — and should — in principle mean a partnership relationship in which there is Crown support for local and customary authority across all levels of whānau, hapū and iwi.

Article III (Mutu, 2010) establishes Māori as British citizens, legally entitled to equal treatment under the law, alongside all other British subjects.

Te Tiriti o Waitangi has been described as embodying the principles of protection, participation and partnership by the Crown (Royal Commission on Social Policy, 1987). A contemporary understanding of te Tiriti holds that, as the indigenous, non–dominant culture, Māori are promised protection from domination and being culturally overwhelmed by the Pākehā (white European New Zealand) majority, as well as equal opportunities to participate in mainstream society and freedom to meet their own cultural needs and pursue their own cultural customs. Finally, a bicultural partnership of mutual respect and care, established with due consideration for cultural differences and diversity, sharing power, resources, and leadership, supports the development of a vibrant multicultural society committed to fulfilling the shared aspirations, livelihoods and interests of its diverse population.

Māori psychotherapy viewed through the lens of te Tiriti

Viewed through the lens of te Tiriti, Māori psychotherapy would be actively encouraged to develop itself, both as a modern, Westernised approach to care for the psyche or soul, and as a contemporary indigenous social health care practice rooted in traditional Māori values, worldview and healing practices. The development of Māori psychotherapy requires nurture and protection, encouragement to join the psychotherapy mainstream as an equal participant and partner, as well as support to pursue a unique cultural agenda that would privilege Māori social health care needs and interests, which are distinct from Pākehā health care needs and interests (Morice, 2003).

The development of Māori psychotherapy has several different aspects. These include the development of Māori practice, for example kaupapa Māori theory and practice; the development of Māori practitioners through the recognition and development of Māori training programmes and practitioner networks, and the development of cultural competencies specific to Aotearoa New Zealand, both for Māori and non Māori (see Morice, 2003).

THE *HPCA ACT* VIEWED THROUGH THE LENS OF THE TREATY

Viewed through the lens of the te Tiriti, the *HPCAA* is a monocultural and colonising legislation. Written exclusively in English, without any reference to te Reo Māori, tangata whenua, Māori, Māori social and health concerns, needs or interests, the *HPCA Act* utterly fails to honour te Tiriti .

By enforcing a uniform standard of regulation and registration, the *Act* replicates the harmful actions of the Crown that have contributed to Māori marginalistion, social suffering and ill health for the past 170 years. Māori psychotherapists are understandably reluctant to join the mainstream of psychotherapy on these terms. Under this legislation, where a singular, lowest minimum professional standard is promoted as "inclusive" and "safe", tangata whenua are presumed to be fairly and equally served, alongside all others. This defies all social and health indices that clearly show Māori have been and continue to be comprehensively disadvantaged in access to appropriate and effective health care services (Durie, 1998; Marriott & Sim, 2014; Robson & Harris, 2007). In the face of alarming Māori health statistics, the now apparent deliberate omission of te Tiriti from this legislation appears to be a social justice and human rights issue.

With respect to the practice of Māori psychotherapy, in the light of te Tiriti, we would put several questions to the Crown and its representatives:

1. As the *HPCA Act* is a direct expression of the Crown authority referred to in Article I, what does kāwanatanga mean in this context? How does the Crown propose to offer effective governance to psychotherapy without imposing imperialistic policies and procedures?
2. As the rangatira authority referred to in Article II is a collective authority rather than an individual authority, how does the Crown propose to engage with the collective authority of Māori

psychotherapy, group to group? Where are the structures and processes by which this bi–lateral and bicultural relationship might be enacted?
3. With reference to Article III of the Treaty, how does the Crown propose to guarantee the equality of the Māori practitioner and the safety of the Māori public?
4. With reference to Article IV (the oral Article) how does the *HPCA* affirm wairuatanga?

We note that, despite the fact that these first three questions have been in the public domain for six years (i.e., since the publication of the first edition of this book), no–one, and not least the Ministry of Health or its responsible authority, the Psychotherapists Board of Aotearoa New Zealand (the PBANZ or, "the Board"), has responded to them.

Mana motuhake — Psychotherapy by and for Māori

In 2008 Waka Oranga, the collective voice of Māori psychotherapy in Aotearoa New Zealand, joined together with its te Tiriti/Treaty partner, the New Zealand Association of Psychotherapists (NZAP) to create a socially just, sustainable, long–term, Treaty–based bicultural partnership (Green & Tudor, et al., 2014). This partnership involved the creation of two designated Māori seats on the NZAP Executive Council. Both of the office holders in these two seats represent Waka Oranga, and are appointed by Waka Oranga's Māori members, not by the larger membership of the NZAP. In this way, and for the first time in the 60 year history of psychotherapy in Aotearoa New Zealand, the voice of Māori is heard and Māori practitioners are able to participate on our own terms. This new relationship opens up many creative possibilities for the development of a robust and effective psychotherapy that will better meet the needs of all the people of this land.

No such partnership has existed with the Psychotherapists' Board which is, in effect, the Crown registering authority specific to the practice of psychotherapy in Aotearoa New Zealand. As individuals, Māori practitioners of psychotherapy may choose to register with the Board. It is our right as qualified health professional individuals to do so. However, as the collective voice of Māori psychotherapy in Aotearoa New Zealand, Waka Oranga is compelled to defer registration and to resist overt and covert pressures to register until such time as there is a clear and coherent

Māori pathway to registration that is te Tiriti–based and fulfils the promise of indigenous practice in a bicultural society. It is in the best interest of public safety and the health and well–being of the people of Aotearoa New Zealand that these pathways be created without further delay.

The following descriptions of overarching ethical values and principles derived from te Ao Māori and based on previous work (Morice, 2003), were compiled by Margaret Poutu Morice and presented to an Ethics Committee Working Party which had been formed at the request of the Board, but which was not able to make use of them. They are reprinted here as examples of what is biculturally possible and also of Māori contributions that the Crown and its representatives have repeatedly failed to acknowledge or include.

Te Ao Māori ethical values and principles applicable to the practice of psychotherapy

1. Manaakitanga

Manaakitanga is the process whereby mana (power, authority) is translated into actions of generosity. Manaakitanga is founded on the recognition that when we uphold and elevate the mana of others, our own mana is upheld and elevated. When we are generous, respectful, hospitable, sensitive and receptive, we acknowledge others without diminishing ourselves. Psychotherapists offer their clients responsible caring. The psychotherapy relationship is invitational and inclusive. Through expressions of mutual respect, hospitality and generosity, psychotherapists aim to treat client's needs and feelings as having equal or greater importance than their own. This serves the basic purpose of the psychotherapy relationship, which is to benefit the other, to assist clients to re–establish and strengthen themselves through self–understanding and the experience of being understood.

2. Whanaungatanga

Whanaungatanga is the principle that binds individuals to the wider group and affirms the value of the collective. Whanaungatanga is the concept of being closely related and, just as importantly, the experience of being closely related to. Common to all definitions of whanaungatanga are the

concepts of connection, belonging and kinship that underpin the social organization of whānau, hapū and iwi. These include rights and reciprocal obligations consistent with being part of a collective. Loyalty and service to the group is regarded as loyalty and service to one's own extended self. Psychotherapists affirm the crucial importance of relationships and particularly family relationships to all human development. Psychotherapists believe that psychological maturity is achieved through the capacity for interdependence as well as independence. In their relationships with clients and others, psychotherapists seek contact, connection, mutuality, reciprocity, and intimacy.

3. Kotahitanga

Kotahitanga is the principle of unity, unity of purpose, intention and direction. It is demonstrated through the achievement of harmony and moving as one. The goal of kotahitanga is not uniformity, the erasure of difference or the production of identical views and opinion, but rather unanimity, the shared aims and identity of purpose.

Kotahitanga acknowledges and upholds individual differences but is inclusive rather than exclusive, affirming both … and rather than either/or solutions. Psychotherapists seek to engage in dialogue and achieve consensus through mutual understanding. Psychotherapists also strive to overcome the negative effects of domination, including overt coercion and violence and covert persuasion and influence.

4. Kaitiakitanga

A kaitiaki is a spiritual guardian, a trustee who holds responsibility for certain resources or domains. Kaitiakitanga embraces the spiritual and cultural guardianship of Te Ao Marama, a responsibility derived from whakapapa. Kaitiakitanga actively exercises responsibility in a manner beneficial to resources and the welfare of the people. Māori Marsden (1992/2003) stated: "Man is the conscious mind of Mother Earth and plays a vital part in the regulation of her life support systems and man's duty is to enhance and sustain those systems." Psychotherapists recognise the need for responsible care of natural and human resources and act as guardians and trustees of the resources of the inner world.

5. Rangatiratanga

Ranga means to weave, while tira refers to a group of people or stars. A rangatira is a leader who weaves the people together. Rangatiratanga is the expression of the attributes of a rangatira, particularly humility, leadership by example, generosity, altruism, diplomacy and knowledge put to beneficial use. Rangatiratanga also refers to sovereignty and self–determination and to the collective authority that regulated the social, political and economic life of traditional Māori society. Te Kawehau Hoskins (2001) stated: "Rangatira did not impose law, and only retained their mana and status through generous behaviour towards the people." (pp. 1920) Psychotherapists support the principle of sovereignty and self – determination for all persons and peoples. Psychotherapists also affirm that good authority demonstrates congruence and integrity and leads by example.

6. Wairuatanga

Wairua is "two waters": the physical and the spiritual. Wairuatanga recognises the spiritual existence parallel to and interwoven with physical existence. Wairuatanga is central to the everyday lives of Māori people and is integral to the way Māori view the world, expressed through the intimate connection of the people to maunga, awa, moana and marae and to tupuna and atua. These connections are affirmed through knowledge and understanding of Atua Māori and must be maintained and nourished in order to ensure wellness. Psychotherapists recognize the transpersonal dimension of human experience and its importance to the process of healing and being or becoming whole.

7. Tohungatanga

Tohungatanga refers to the role of the expert, a potential that resides in all of us. The tohunga is one who is adept in reading signs and symbols, in using and creating symbol sets that make sense of the world and help us to explore and explain the deeper realities of our life and the world around us. Psychotherapists develop expertise in noticing and interpreting the signs and symbols of personal meaning. Psychotherapists recognize that helping people interpret their lives helps them to discover, define and realise their full potential.

8. Ukaipō

Ukaipō refers to the experience of receiving mother's milk in the night; a metaphor for the nourishing that derives from unseen places and spaces. ūkaipō is associated with mana wahine and the bounteous nature of Mother Earth and also implies a reconnection to the true self that has the quality of revelation. Psychotherapists work to nourish clients in the most secret, dark and inaccessible parts of themselves.

Te kau tau — Ten years

Ten years after Waka Oranga was formed and six years after this chapter was first published we continue to be intrigued by NZAP's simultaneous establishment of a co–partnership with Waka Oranga and the divergent movement within the organisation towards Crown registration under the *HPCAA*.

Sadly, over these last ten years we have not observed any evidence/data supporting improved Māori health outcomes following the registration of psychotherapists under the *HPCAA*. In line with our initial critique we still believe that the *HPCAA* functions to tidy up legislative compliance across the health sector and continues to be a mechanism used to minimise risk for the government framed as reforms for "public safety".

The burden of disease, distress and trauma experienced by Māori individuals and whānau continues unaddressed. The cost to access psychotherapy services continues to rise and be out of reach for most Māori. The appropriate use of these services remain in question with a plethora of studies showing personally–mediated racism (Harris, et al., 2012) within the provision of clinical services with the New Zealand health system and institutional racism within the administration of the health system (Came, 2014).

Rather than increased bureaucratisation and state control, what is needed is investment in Māori–led solutions informed by mātauranga Māori and a real commitment to engage in decolonisation within the psychotherapy discipline. Western paradigms when imposed on indigenous people remain problematic. Rather than tinker with the *HPCAA* we would like see increased recognition and respect to Māori knowledge, experience and expertise as one would expect from one's Tiriti partner. Since 2007, a key

point of difference is the WAI 1040 (Waitangi Tribunal, 2014) Waitangi Tribunal ruling which finally acknowledged the Māori never ceded their sovereignty. The *HPCAA* does not accommodate this recognition by the Waitangi Tribunal.

Through tikanga Māori (Barlow, 2004) we have extensive checks and balances to maintain safety. The principles outlined by Margaret Morice (above) are as relevant today as they were when this article was first published. If we are concerned about public safety these principles have served Māori well for a millennium. Furthermore these holistic principles would be invaluable in guiding psychotherapy practice in this land.

In the absence of leadership from central government, the wero to our profession is to engage with the koha provided by Waka Oranga in relation to strengthening ethical practice. Ethical practice in Aotearoa involves engagement with te Tiriti o Waitangi and tikanga as the precursor to relationships (Hudson, Milne, Reynolds, Russell, & Smith, 2010). Waka Oranga continue to build on our original vision and kaupapa — to develop an indigenous home for psychotherapy in Aotearoa New Zealand. This means establishing clinical practice based on tikanga Maori and is reflective of the founding principles and the philosophical underpinnings in our constitution:

- To honour Atua, our people and our land.
- To honour te Tiriti o Waitangi in all our actions, thoughts and deeds.
- To uphold the Māori values and truths which are reflective of our kaupapa in our operational processes.
- To be advocates for social justice and change in Aotearoa New Zealand.
- To acknowledge the mana of all individuals and to act in a way that upholds the professional integrity both of our members and of Waka Oranga.
- To be conscious and self–reflective of our own values and the values of others.
- To acknowledge the diversity among Māori in Aotearoa New Zealand.
- To participate actively in the development of the whānau (extended family), hapū (sub tribe) and iwi (tribe), both personally and professionally.

- To promote actively the growth of an indigenous psychotherapy that reflects our values, beliefs and practices.
- To be committed to the development of professional practice through ongoing education, training, research, and networking.
- To contribute professional expertise to the development of indigenous psychotherapy policies, programmes and legislation that directly benefits whānau, hapū and iwi (Hall, Morice & Wilson, 2012, p. 15).

Ten years on from the formation of Waka Oranga (and psychotherapy registration under the HCPAA), we are still excited by these core principles. For us, these tikanga principles are an example of living ethical practice. Potentially, if we are willing to challenge our own cultural hegemony, these principles offer us the possibility of creating our own regulatory processes — the possibility to implement a set of dynamic creative principles based on ethical systems originating from within this land rather than defaulting to mindless centralised authority and control.

Public statutes

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Chapter 6

The Law is an Act!
The Health Practitioners Competence Assurance Act 2003

Keith Tudor

This chapter focuses on the legislation under which psychotherapists in Aotearoa New Zealand are registered and regulated. For this edition, I have edited and updated the original chapter, and whilst retaining most of the original structure, moved one part, on the work of the Psychotherapists Board of Aotearoa New Zealand ("the PBANZ" or "the Board"), to a separate chapter (Chapter 7).

The chapter, which analyses the significance and implications of the *Act* for psychotherapists and, more broadly, psychotherapy, begins with an introduction to the *Health Practitioners Competence Assurance Act 2003* (hereafter "the *HPCA Act*" or "the *Act*"), its origins and the nature of the legislation, including its (lack of) relationship with te Tiriti o Waitangi | the Treaty of Waitangi, a contract which is commonly referred to as New Zealand's founding document. The second part of the chapter examines the way that the *Act* allows for the concentration of power specifically with the Minister of Health and the "responsible authorities"; and the third part considers the two reviews of the *Act* that took place between 2007–2009

and 2012–2016. Reflecting on all of this, the fourth and final part of the chapter considers whether psychotherapists and psychotherapy are best served by the *Act*, and, indeed, by viewing themselves in this context as health practitioners, a discussion that offers some learning for other such practitioners considering or seeking statutory regulation.

THE *HPCA ACT*

The *HPCA Act* was passed by the New Zealand Parliament on 11th September 2003 and came fully into force when it received the Royal assent on 18th September the following year. Through the statutory regulation of certain health professions the *Act* provides a framework for state registration of specific health practitioners. When the *Act* came into force it incorporated thirteen medical professions and repealed a number of other Acts under which these health professions had been previously incorporated and regulated, and established initially fifteen "responsible authorities" (RAs) (in the form of Boards or Councils) (see Table 6.1).

Table 6.1. The Responsible Authorities under the HPCC Act 2003 and the number of practitioners registered with them 1

From 2003	**Number**
Chiropractic Board NZ (Te Poari Kaikorohiti o Aotearoa)	320
Dental Council NZ (Te Kaunihera Tiaki Niho o Aotearoa)	5,100
Dieticians Board NZ	641
Nursing Council NZ (Te Kaunihera Tapuho o Aotearoa)	55,289
The Medical Council NZ	15,864
Medical Sciences Council NZ (Te Kaunihera Putaiao Hauora o Aotearoa)	2667 [2]
Midwifery Council NZ	3,077 [3]
NZ Medical Radiation Technologists (Te Poari Ringa Hangarua I Raruke)	4,252
NZ Psychologists Board	2,861
Occupational Therapy Board NZ (Kaihaumanu Tūroro o Aotearoa)	2,294 [4]
Optometrists and Dispensing Opticians Board	718
Osteopathic Council of NZ	644
Pharmacy Council of NZ	300

Physiotherapy Board of NZ	4,665
Podiatrists Board of NZ	426
From 2008	
Psychotherapists Board of Aotearoa NZ	454

1, Figures as at July 2017 unless otherwise stated.
2, Reported in its 2015/2016 Annual Report (MLSB, 2016).
3, Reported in its 2015 Annual Report (MCNZ, 2015).
4, 2016 figures – from S. Ashworth (Registration Officer, OTBNZ), personal (e-mail) communication, 6th June, 2017.

Psychotherapy was not included in the scope of the original Act, but was included as a registered profession on 15 th October 2007 when, under Sections[ss] 9(1) and 9(3) of the *Act*, an Order in Council made five months earlier that year (on 21st May) on the recommendation of the Minister came into effect; and, under s120 of the *Act*, a Board was appointed (Minister of Health, 2007): the Psychotherapists Board of Aotearoa New Zealand (hereafter "the PBANZ" or "the Board"). To date, psychotherapy is the only profession to be included in the legislation since it was enacted.

While there is no doubt that the psychotherapy profession, in the form of New Zealand Association of Psychotherapists (NZAP), lobbied for regulation (see Chapters 1, and 3), it is equally clear:

- That, in the presentations and discussions about registration, there was little or no debate about the nature of the legislation under which the profession would be governed, and no distinction drawn between recognition, registration, and regulation.
- That, in the arguments presented for registration, there was a certain confusion between and conflation of the "public protection" argument and the "public interest" and the "professional interest" arguments.
- That no alternative models of regulation and/or registration were considered, such as models and processes of self– and/or peer regulation (see, for example, Heron, 1997; Totton, 1997), or the pluralistic and voluntary model enjoyed by social workers under legislation (see Social Workers Registration Board [SWRB], 2010, and p. 153 below).

- That the NZAP was — and is — not the only stakeholder with regard to psychotherapy in Aotearoa New Zealand, and that the interests of psychotherapists in other associations or groups were discounted, i.e., the New Zealand Association of Child and Adolescent Psychotherapists (NZACAP), the New Zealand Association of Counsellors (NZAC), and other associations; practitioners not working in the public health sector, i.e., in private practice and/or in organisations and/or industry (and not necessarily members of the associations named above); and, not least, tangata whenua (see also Chapter 5).
- That there was — and still is — widespread ignorance of the *Act* as a piece of legislation and, specifically, of the powers of the RAs i.e., the Boards and Councils, established under (s)115 of the *Act* (for a summary of the functions and powers of which see Appendix 3). This was something that was picked up in the "Summary of Submissions on the 2012 Review of the *HPCA Act*" (hereafter "Summary of Submissions …") (MoH, n.d.).

The *Act* was not uncontroversial and, indeed, was strenuously opposed by no less than the New Zealand Medical Association (NZMA) and the Association of Salaried Medical Specialists (ASMS), both of which bodies withdrew their support from this legislation. In 2003, Tricia Briscoe, then Chair of the New Zealand Medical Association, wrote:

> The NZMA and the ASMS have withdrawn their support [for the *Act*] … The NZMA believes the *Act* is a missed opportunity for improvements to medical practice and offers no assurance of further benefits to patients. It will increase political influence and bureaucratic involvement in the practice of medicine, with a consequent decrease in professional self–regulation.… The organisation of healthcare based on either state or corporate control imposes different goals and values than models structured on professionalism … the *Act* … will introduce untested concepts, undermine self–regulation, make quality assurance a highly bureaucratic process, and allow much greater levels of political interference into professional processes than before. Self–regulation is a cornerstone of medical practice, but the Minister of Health has removed the medical profession's right to

> elect some members to its regulatory authority…. The political agendas of governments and good healthcare that rests on medical ethical values do not always coincide. The professions must be autonomous in setting their ethical values and it is of huge concern that this *Act* legislates for statutory regulatory authorities appointed by the Government to set "standards of ethical conduct". (Briscoe, 2003, p. 1)

The *Act* is a significant piece of legislation that has specific and wide–ranging implications for the profession of psychotherapy and the practice of psychotherapists. It is often said that ignorance of the law is no defence or excuse and so, in preparation for writing this chapter, I have read the *Act* several times (and again for this edition), have consulted colleagues about it, and have taken legal advice about it and my reading of it. Interestingly and perhaps significantly, and despite Paul Bailey's urging, many proponents of registration and regulation haven't read the *Act*; indeed before she joined the PBANZ, one (now ex) member of the Board almost boasted that she hadn't read the *Act* and didn't see a distinction between "psychotherapist" and "psychotherapy"! I (still) encourage colleagues to read the *Act* and to engage with the reviews of the *Act* (of which the latest was in 2012). In the meantime, I offer this chapter as a contribution to understanding this particular piece of legislation under which, currently (July 2017), some 524 psychotherapists are registered. In this chapter I offer a critical commentary on key aspects of the *Act*, beginning with the nature of the legislation.

The nature of the legislation

The *Act* "provides a framework for the regulation of health practitioners to protect the public where there is a risk of harm from the practice of the profession" (MoH, 2010a). As such it is primarily and explicitly restrictive and prohibitive legislation (see s4(1)). It is also punitive and negative.

It provenance is entirely medical: it is based on the *Medical Practitioners Act 1995* (see Table 6.2) which, in turn, came into being as a result of the Cartwright Report (1988), which had raised concerns about the governance, accountability, and ethics of the medical profession. The *HPCA Act* was also, in part, a response to some of the findings of the Cull Report (Cull,

2001) which had reviewed processes concerning adverse medical events and, specifically, (then) current processes and timeliness of investigation(s) of certain medical practitioners; regulatory and institutional barriers that existed between the agencies which could impede the timely identification and investigation of adverse medical outcomes by medical practitioners; regulatory and institutional barriers to information–sharing between certain agencies; and any necessary improvements needed to allow easier patient access to complaint mechanisms. Based on 51 submissions, the report identified a number of problems with consumer complaints processes (mechanisms), including multiple investigations into the same events; and time delays in investigations, with and a certain anxiety (for both patients and professionals) resulting from such delays. Submissions agreed with the report in favour of amendments to the role of the Health and Disability Commissioner (H&DC); the H&DC's Office becoming the repository of complaints; and (14 to six) of having one disciplinary tribunal for all health professionals.

It is clear that the *Act* applies to "health" professions in that they are primarily concerned with health and illness and, by and large, inhabit the medical and allied sector. This is clear from the professions covered by the *Act* when it was enacted (see Table 6.1.), all of which are generally considered either "medical" professions or which ally themselves with medicine. The provenance of the *Act* is clear. As the MoH (2010a) stated on its website about the *Act*: "The HPCAA builds on the framework created by earlier legislation, in particular the Medical Practitioners Act 1995. All the major concepts of the Medical Practitioners Act 1995 have been carried forward into the HPCAA". It claimed these principles (presumably, the framework) had been "adjusted where necessary to generic terms to provide a framework that can apply to all health practitioners and not just doctors." However, reading the *Act*, it is apparent that this adjustment was a token one: the word "medical" still appears 136 times in the *HPCA Act* — and the word "therapeutic" is not mentioned once! Moreover, reading the *Medical Practitioners Act 1995* alongside the *HPCA Act 2003*, it is clear that they bear an uncanny resemblance (see example in Table 6.2).

Table 6.2. Comparing the Acts:
the clauses on confidentiality of information in the *Health Practitioners*

***Competence Assurance Act 2003* (s44) and the *Medical Practitioners Act 1995* (s65)**

44 Confidentiality of information

1. No person who examines any clinical records of any health practitioner under a requirement of a competence review, competence programme, or recertification programme may disclose any information (being information about any identifiable individual) obtained by that person as a result of that examination, except for 1 or more of the following purposes:
    a. for the purpose of making a report to the authority in relation to the health practitioner concerned:
    b. for the purposes of any criminal investigation or any criminal proceedings taken against that health practitioner:
    c. for the purpose of making the information available to the person to whom the information relates in any case where–
        i. the authority directs that the information be made available; or
        ii. the person requests access to the information.
2. Subsection (1)(c)(ii) does not affect the Privacy Act 1993.
3. Every person commits an offence and is liable on summary conviction to a fine not exceeding $10,000 who discloses any information in contravention of subsection (1).
4. No information, statement, or admission that is disclosed or made by any health practitioner in the course of, or for the purposes of satisfying the requirements of, any competence review, competence programme, or recertification programme and that relates to any conduct of that health practitioner (whether that conduct occurred before or during that review or programme)–
    a. may be used or disclosed for any purpose other than the purposes of that review or programme; or
    b. is admissible against that person, or any other person, in any proceedings in any court or before any person acting judicially.

65 Confidentiality of information

1. No person who examines any clinical records of any medical practitioner pursuant to a requirement of a competence programme or a recertification programme shall disclose any information (being information about any identifiable individual) obtained by that person as a result of that examination, except for 1 or more of the following purposes:
    a. For the purposes of making a report to the Council in relation to the medical practitioner concerned:
    b. For the purposes of any criminal investigation or any criminal proceedings taken against that practitioner:
    c. For the purpose of making the information available to the person to whom the information relates, in any case where–
        i. The Council directs that the information be made available; or
        ii. The person requests access to the information.

2. Every person commits an offence and is liable on summary conviction to a fine not exceeding $10,000 who discloses any information in contravention of subsection (1) of this section.
3. No information, statement, or admission that is disclosed or made by any medical practitioner in the course of, or for the purposes of satisfying the requirements of, any competence programme or recertification programme and that relates to any conduct of that medical practitioner (whether that conduct occurred before or during that programme)–

    a. (a) Shall be used or disclosed for any purpose other than the purposes of that programme;
    b. (b) Shall be admissible against that person, or any other person, in any proceedings in any court or before any person acting judicially.

The medical provenance of and influence of the *Act* can be seen in its definition of restricted activities and the implications of this for "psychosocial interventions". These "restricted activities" are defined as: certain surgical procedures; clinical procedures involved in the insertion and maintenance of certain orthodontic or oral appliances; prescribing certain nutrition where feed is through a tube, or certain ophthalmic appliances; and applying certain manipulative techniques to cervical spine joints. 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 Ministry of Health 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. In December 2009, Cabinet authorised the removal of this restricted activity, 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, 2007b), and as it impacts on the justification for the extent of the responsible authority's regulatory regime (see Chapter 1).

The *Act* aims to protect the public by restricting professional titles (see ss5, 7, and 27); by prohibiting practitioners from practice and certain activities (see ss4, 8 and 9); and by punishing practitioners who are incompetent, unfit to practice, or unable to perform their required functions by means of suspension (ss 4, 39, 43(1)(b), and 48). Furthermore, an RA can prescribe a

practitioner to complete a competence programme (s40) or a recertification programme (s41), and can vary their scope of practice (s43(1)(a)). As a piece of legislation it is based on a deficit model in that it does not define competence, fitness to practice or, for that matter, good practice except insofar as it legislates about incompetence or failure to meet "the required standards of competence" (s38), the "inability to perform required functions" (s48), and the (seven) factors that warrant discipline (s100) (see Chapter 8), about which the decisions of the Health Practitioners Disciplinary Tribunal (see http://www.hpdt.org.nz/) and case law provide interpretations. Despite its title, there is very little in or about the *Act* that is concerned with assuring competence (see Chapter 2. The initial Sections of Part 3 of the *Act*, "Competence, fitness to practice, and quality assurance", are all framed in terms of health practitioners who pose a risk of harm to the public.

On the issue of title, there appears to be widespread confusion in the profession — and not least, amongst the initial configurations of the PBANZ — about title and restriction (for clarification of which, see the taxonomy of models in Chapter 1). Fortunately, the government (in the form of the Director–General of Health [DGH], 2009) is clear that:

> The *Act* is largely based on certification of title rather than licensing of activity. It prohibits those who are not registered as health practitioners of a profession from claiming or implying to be practitioners of that profession. However, apart from a limited number of specified restricted activities where there is risk of serious or permanent harm, the *Act* does not prohibit unregistered people from performing activities that registered health practitioners perform. (p. 2, my emphasis)

The government was equally clear about the implications of this, pluralistic position: "This system leaves the public free to choose a registered practitioner, in which they have assurance of competence, or an unregistered provider, without any such assurance" (p. 4, my emphasis; see also Chapter 2). With regard to the regulation of psychotherapy, in its "Regulatory impact statement" written in June 2007, the MoH had acknowledged that: "It is possible that some people practising

psychotherapy may choose not to register and continue practising under a different title." (MoH, 2007)

Whether practitioners choose to be registered or not, there is a concern that the nature of this *Act* and any such regulatory piece of legislation, with its restrictions, prohibitions, sanctions, and general negativity, influences psychotherapists to practise restrictively, defensively and conservatively in order to minimise the possibility of disciplinary action (see Bollas & Sundelson, 1995; Mowbray, 1995; Clarkson & Murdin, 1996; and also Chapters in Part III.

The *Act* is not only restrictive in terms of limiting the use of certain regulated titles by practitioners, it also restricts practice — and, of course, this is the logic and purpose of such legislation. The practitioners defined as a "health practitioners" not only must not practise outside the scope of practice of the *Act*, but also must practise within the *Act*, including that s/he "performs that service in accordance with any conditions stated in his or her scope of practice" (s8(2)(b)), my emphasis). The implication of this is that practitioners should know all the conditions regarding her/his scope of practice contained in the *Act*, especially as ignorance or mistake of law is no defence (the Crimes Act 1961, s25). From a number of conversations I and others have had with colleagues, it is clear that probably the majority of psychotherapists in this country have not read or familiarised themselves with the *Act* and its terms, conditions and clauses — and, I suspect that this is true for psychotherapists in most jurisdictions (see also contributions in Chapter 17).

The *Act* embodies, as does all legislation, a distinction between that which is mandatory, indicated by the word "must", and that which is permissive, indicated by the word "may". Thus, the fact that RAs have certain powers under the *Act* (see Appendix 3) does not mean to say that they must use them, a point which is particularly pertinent when we consider how the PBANZ has sought to extend its influence, especially through extending the scope of practice of the psychotherapist, often justifying it as based on an assumed or perceived obligation (i.e., "must"). Along with the modal verb "can" (which expresses ability, possibility, probability, and permission), the use of the verbs, "must" and "may" in this context is not only of interest to linguists; the distinction between them is crucial to our understanding of the law and the implications for practice. In my experience of exchanges about

regulation and registration, people often misuse and misrepresent these words as when, for instance, people say: “You must be registered to practice.” This is not true. You “must” register with the Board if you want to call yourself a psychotherapist. If you are not a psychotherapist, of course, you still may — and, indeed, can — call yourself a psychotherapist, but there may, and, indeed, are likely to be consequences to that.

Beyond these particular broad concerns about the nature of the legislation by which psychotherapy has been regulated, there is a number of specific issues raised in and by the *Act*, specifically, the lack of reference to te Tiriti o Waitangi | the Treaty of Waitangi, and its centralisation of power (which I address in the next part).

Nullifying te Tiriti

As noted in the Introduction, the *Act* contains no reference to te Tiriti o Waitangi | the Treaty of Waitangi (hereafter “te Tiriti”), an omission which was justified at the time by the Ministry of Health (2003). This contention was based on Crown Law advice and on a Waitangi Tribunal (2001) finding in the Napier Hospital claim that the NZPHD Act 2000 makes adequate provision for Crown Treaty responsibilities in the health sector. The Napier Hospital claim was one made by Māori arguing that the downgrading of facilities and services at Napier Hospital by Healthcare Hawke’s Bay constituted a breach of te Tiriti (for further details of which, see Waitangi Tribunal, 2001). That the New Zealand Public Health and Disability Act 2000 — and, by association, the *HPCA Act* 2003 — make adequate provision for Māori is a sweeping statement with far–reaching consequences; is highly debatable; and, with reference to psychotherapy, is a claim which should be measured against the experience to date of certain failures of the Board regarding bicultural engagement (for discussion of which see Chapter 7).

Interestingly, in the context of discussions within the NZAP about a “stand–alone” or “blended” authority (originally, it was mooted, with the Psychologists’ Board), there was a hope, even an expectation, that such a smaller, stand–alone authority would adopt the NZAP’s support for and work on biculturalism (see Bailey, Quinn & Manning, 2006; and Chapter 7). However, whatever assessment and conclusions may be drawn about the

attitude of this particular RA towards te Tiriti, it is the *Act* that gives RAs the license to ignore it. At the same time, as a background component of the law in Aotearoa New Zealand, te Tiriti is used as a tool to interpret the *HPCA Act*. This being so, "the question is, therefore, whether silence equals a license to ignore" (K. Gledhill, personal [e–mail] communication, 8th July, 2017)

In its consideration of the *Act* with regard to te Tiriti, the NZAC's National Māori rōpū took a more critical view, concluding that: "Adopting an enhanced self–regulatory regime is more in line with a Tiriti o Waitangi based approach that would allow for developing structural equity for tangata whenua." (NZAC, 2016)

The centralisation of power and the power of centralisation

In voting for state registration of title under the *HPCA Act*, psychotherapists in effect gave away their sovereignty and, thereby centralised the power of decision–making with regard to the profession as it relates to certain professional regulation and the state registration of psychotherapists as health practitioners, not the field or discipline as a whole. Whilst some colleagues clearly favoured — and still favour — more widespread regulation than that of title (see the summary of models in Chapter 1), others did and do not. Even amongst those who voted for regulation, there were many who did not know, inform themselves, or find out about the *Act* and its scope; and some who did not imagine that the Board would take the power and control it has — or has attempted to exert — over the profession that set it in place, for instance, by extending the meaning of the word "practice" and, thereby, aiming to exclude non registered practitioners from research, policy–making, educating, and consultancy (PBANZ, 2008). As Baron–Lord John Action famously put it: "Power tends to corrupt, and absolute power corrupts absolutely", a point which, in the case of the RAs under the *Act* is exacerbated by the fact that they are only answerable to the Minister of Health. Significantly, the MoH's (2016) "Summary of Submissions …" reveals some concern from a number of submissions as to who regulates the regulators (see below).

The Act

The *Act* comprises some 227 section and eight schedules; it repeals schedules in 25 other Acts (see Schedule 7); and revokes 34 regulations (see Schedule 8); it amends clauses in 66 other Acts (see Schedule 4), and regulations in 40 other Acts (Schedule 6). It is a significant piece of legislation with wide–ranging powers including the power to issue a search warrant:

> in respect of an offence which has been or is suspected to have been committed against section 7 [claim to be a health practitioner] or section 9 [activities restricted to particular health practitioners] or which is believed to be intended to be committed against either section, even though the offence is not punishable by imprisonment (my emphasis). (s10(1))*
> [*The warrant is issued under the HPCA Act but by an "issuing officer" under the Search and Surveillance Act 2012, which refers to a judge or other authorised person, including Justices of the Peace and community magistrates, which, therefore, provides some check and balance with regard to this power.]

The idea — and reality — that authorities have the power to search someone's premises because someone (presumably on the Board) believes that someone intends to commit an offence under sections of the *Act* is, indeed, Orwellian. Given that most psychotherapists would consider themselves to be quite liberal with regard to social norms and mores, it also appears as somewhat strange that they would condone such a view and force.

There is also a sense that the *Act* gives responsible authorities permission to act above or beyond the law. Schedule 3 of the *Act* "Provisions applying to authorities" describes the information on which authorities (Boards) may act and, in a particularly notable section, states that: "Each authority must observe the rules of natural justice but, subject to that requirement, may receive as evidence any statement, document, information, or matter, whether or not it would be admissible in a court of law" (s2, my emphasis). This seems to indicate that hearsay and gossip could be considered by an authority — which leaves all practitioners vulnerable to such judgement, 'though the authorities remain governed by public law principles which

provide some protection, albeit that these principles are less strict than the rules of evidence.

The Minister of Health

Above the RAs lies the Ministry of Health and, specifically, the Minister of Health, who has a number of powers under the *Act*, including: the power to select authority (Board) members (s120), and members of the Health Practitioners Disciplinary Tribunal (s86); to call for an audit of the Authority (s124); to declare valid or to disqualify any quality assurance activity (s55); and to require the release to him/her of confidential information in reaching a decision: "Nothing in section 59 prohibits the disclosure of any information to the Minister, or to any person authorised by the Minister, for the purpose of enabling the Minister to decide whether or not to authorise the disclosure of the information under section 61." (s60(4)) While the appointment of Authority members is preceded by consultation, there is no requirement on the Minister to take this into account in selecting members; and, while there is provision for the election of at least one health practitioner member of an authority (s120(4)), this is not guaranteed. The Minister may also intervene to decide on resolving overlapping scopes of practice between different registered professions (ss127 & 128). This concentration of power in the hands of the Minister clearly leaves open the risk of actions taken for political as much as for administrative or clinical reasons ('though, again, this power is subject to public law control and so has to be exercised for one of the purposes of the *Act*), and of the selection of Board members for their political views — or regulatory proclivities.

The Minister appoints the Board members (see ss121, and 122). Indeed, one of the first signs that statutory regulation was no friend to the NZAP was that Paul Bailey, the architect of regulation and, as he put it, an advocate of a "light touch" to regulation (see Chapter 4), was not appointed to the Board. Under s120(2) of the *Act* the Board must include a majority of members who are health practitioners, and two or, depending on the numbers of members, three "laypersons". At the same time as not appointing Paul Bailey, the Minister appointed to one of the laypersons' positions a professional regulator.

The Responsible Authorities (RAs)

Under the *Act*, the RAs have wide–ranging powers and little accountability. For instance, in addition to the fees for registration and an Annual Practicing Certificate (see Chapter 7), an RA "may" add a disciplinary levy "of any amount that it thinks fit" to fund the costs of a professional conduct committee or Disciplinary Tribunal (s131). Other fines and disciplinary penalties that may be imposed under the *Act* include: a fine of not exceeding $30,000 for an offence of breaching s9(4) (a person stating or implying:

> that s/he is performing a restricted activity); a fine of up to $10,000 for failure to give evidence to a professional conduct committee (ss77–78) (which also requires court proceedings); and, if a Disciplinary Tribunal finds grounds on which a health practitioner may be disciplined (s100), a fine of up to $30,000 (s101(1)(e)) and costs (s101(1)(f)) — in addition to possible cancellation of registration (s101(1)(a)), suspension of registration (s101(1)(b)), or censure (s101(1)(d)). Appeal against such a finding (by reason of s106) must be made through the District Court or High Court, a staggeringly expensive prospect that leaves the decision in the hands of the judiciary, not in the hands of professional peers. We might well expect all this to lead to a large increase in professional indemnity insurance premiums and it is difficult to see how such greatly increased costs to the practitioner (and/or her/his employers) will encourage increased public access to psychotherapy.

Another example of the absolute power of RAs this is the absolute lack of transparency of their work. This is made clear in the latest review of the *Act* (MoH, n.d.) from which, amongst other things, I note:

a. That the public is unable to access information about an RA's decision;
b. That, as RAs are not Crown entities, they are not subject to the *Official Information Act 1982* and, therefore, to requests for information under that Act; and
c. That, in this country, there is no regulatory system or body for regulatory authorities (as there is, for instance, in the UK, in the form

of the Council for Health Care Regulators Excellence) — and, from the "Summary of Submissions …" document, it is clear that this is not being considered by the New Zealand government.

THE REVIEWS OF THE *ACT*

Section 171 of the *Act* requires the Director–General of Health to review the operation of the *Act* and consider whether any amendments to the *Act* are necessary or desirable. To date, there have been two reviews of the *Act*.

The first review (2007–2009)

The *Act* was reviewed through a process which began in October 2007 with a first phase of information gathering and analysis, a web–based survey (which elicited over 960 responses), and a commissioning of a literature review and report into best practice in health workforce legislation. This was followed by a second phase of workshops and draft recommendations; and a third phase of finalising recommendations and reporting to Parliament. The fourth and final phase involved further public consultation and final recommendations. The final report was published in June 2009 (DGH, 2009).

The review focused on the operation of the *Act* rather than "its underlying policy settings" (DGH, 2009, p. iii), which, it was noted, would be the subject of the subsequent review of the *Act* in 2012. For example, several submissions to the review queried whether the *Act* should be amended to include a reference to the Treaty of Waitangi. The Director–General's response was that this would involve consideration of the underlying policy settings of the *Act* and, therefore, be a part of the review in 2012.

According to the Director–General of Health (2009) "Overall, the review finds that the *Act* has been received positively by the sector and is operating as Parliament intended." (p. iii) He also noted that there were some areas in which the *Act* required clarification and recommended a number of minor legislative changes. In all, the Director–General made 37 recommendations.

Following the review, in January 2010 the MoH issued a discussion document, entitled How Do We Determine if Statutory Regulation is the Most Appropriate Way to Regulate Health Professions? (MoH, 2010c), in

which it outlined the "overriding principles" and the application of "second level criteria" for regulation under the *Act* (see Chapter 1, pp. 147–152).

The second review (2012–2016)

The second review began with the publication of a discussion document (MoH, 2012). Its executive summary set the parameters and the tone of the review: "The review will look at how *HPCA Act* is functioning within the wider health system and how it (or the broader regulatory environment) could be improved." (MoH, 2012, p. v) It claimed, 'though provided no references to the literature, that: "International trends in health occupational regulation point to a strengthening of consumer protection, standardisation of legislation and the design of institutions, and improving the performance of regulatory authorities", and set out four principles by which the *HPCA Act* would be assessed: future focus, consumer focus, safety focus, and cost effectiveness focus.

There was no reference to policy settings in the MoH's discussion document, let alone the "underlying policy settings" of the *Act*, a review of which the Ministry had previously promised; and there was no mention of te Tiriti | the Treaty. It did, however, identify certain principles which would guide the review, thus:

1. Regarding the focus on the future — that "A health occupational regulatory framework that supports workforce flexibility, working in multidisciplinary teams and clinically networked environments".
2. Regarding the focus on the consumer — that the operation of the *HPCA Act* is conducted in a way that is "accessible and transparent for consumers".
3. Regarding the focus on safety — that there is "A systems perspective that balances individual accountability with team and organisational accountabilities for the management of consumer safety".
4. Regarding the focus on cost effectiveness — that "The level of regulation is matched to the level of risk of harm to the public and ensures [that] value for money is maintained". (MoH, 2012, p. 3)

The Ministry gave two months for submissions. This was followed by public discussion on the draft findings (March and April 2013), and a final report which was due for release at the end of July 2013 (but which was not

released until 2017). With regard to the review itself, in my own submission, I commented that:

- There is no reference to this being a review of underlying policy settings;
- There is no reference to the previous submissions which referred to the te Tiriti;
- There is no reference to te Tiriti; and
- There is no justification of the four principles by which the *HPCA Act* will be assessed, or of the (limited) scope of the review. (MoH, 2013, p. 66)

There were only 145 submissions made to this review, a remarkable (and worrying) drop of 85% from the number of submissions to the 2009 review, a fact on which, perhaps unsurprisingly, the MoH did not comment either in it its "Summary of Submissions …" document (MoH, n.d.) or its "Regulatory Impact Statement" on the review (MoH, 2015).

From the "Summary of Submissions …" document (MoH, n.d., which is unpaginated), I note the following:

- With reference to workforce development — that "Using the *HPCA Act* as a lever to increase integration, teamwork and workforce flexibility was … Seen as likely to be minimally effective."
- With regard to education — that "There was some scepticism about the appropriateness of the *Act* directly addressing the need for a wider focus on the education of health professionals." (see Chapter 7)
- With regard to scopes of practice — that there appeared to be a high variability amongst the approach of RAs to scopes of practice "with some taking an approach that emphasises limiting harm and others focusing on optimising public benefit".
- With regard to the idea (which appeared in the MoH's 2012 discussion document) that RAs could have a role in health professionals' pastoral care — that "Almost all submissions addressing the issue rejected the notion that Responsible Authorities should be involved with such proactive pastoral care".
- With regard to the transparency of complaints process(es) — that, as RAs are autonomous in deciding what information to release to the public, this can lead to inconsistency.

- With regard to ensuring the safety of Māori — that: “It was of concern to a number of submitters that the first discussion document failed to address the omission of any reference in the *Act* to te Tiriti o Waitangi” and that RAs are not addressing alternative qualification pathways and scopes of practice. (see Chapters 5, and 7).
- With regard to consumer risk — that the current criteria “set too low a threshold for regulation” (of a profession under the *Act*).
- With regard to regulation of the regulators — that a number of submissions raised this and, somewhat unusually, the document notes the “frustration on the part of some practitioners with what they consider to be inappropriate policies and processes in the Responsible Authority that regulates them.”
- With regard to having elected professionals on the RAs — that “The wish to have elected members appears to arise out of a perception that the Responsible Authorities, as regulators, are not sufficiently accountable to the professions they regulate.”

On 15th December, 2016, the Minister of Health, Dr Jonathan Coleman, presented a document “Recommendations Arising from the 2012 Review of the *Health Practitioners Competence Assurance Act 2003*” (MoH, 2016) to the Cabinet Social Policy Committee, in which he stated that:

> As a result of the strategic review, I have concluded that the *Act* should be amended to require:
>
> i. regular performance reviews of responsible authorities
> ii. responsible authorities to provide information about decisions on practitioner practice and develop appropriate naming policies
> iii. responsible authorities to develop standards relating to integrated care, team work and inter–professional communications, to support integrated care
> iv. recognition of the importance of transparency, integrated patient–centred care, workforce flexibility and workforce planning
> v. responsible authorities to collect and provide additional workforce information and data to contribute to health workforce planning, subject to privacy requirements. (p. 1)

Again, in this document, there is no mention of te Tiriti | the Treaty.

Whilst I welcome the increasing concern with transparency, and specifically with regard to RAs providing more information about their decisions, I am concerned about the increasing drive to regulation and that this still leaves the practice of the many in the hands of the few.

Psychotherapy as a health profession and psychotherapists as health practitioners

The *HPCA Act 2003* was, of course, not a law written for psychotherapy or psychotherapists; it was a statute designed for health practitioners on the basis of a previous statute written for medical doctors. In my view, it was always going to be an implausible piece of legislation for what Freud (1937/1968) described as an "impossible profession" (see also Malcolm, 1981). This is not only my view, it was also the view of Anne Richardson, then a Senior Policy Advisor for the UK's Department of Health. In an address given 20 years ago, she made it clear then that psychotherapy and counselling could and should not come under statutory regulation as "there is no agreement here in the UK, or it would appear in Europe, about what exactly does or should constitute the activity of psychotherapists". She continued:

> There are no plans to regulate what after all we have to call an activity, rather than a title [by which] I mean psychotherapy is something that people do ... It's important to say it would be extremely difficult to regulate by statute something which is an activity like that. Could you imagine trying to write a law? It would be impossible. (Richardson, 1997)

From the two reviews of the *Act*, it is clear that the New Zealand government is driving an agenda of greater regulation, and, if anything, moving to bringing together the RAs under one unified authority (see MoH, 2016). Given the difficulty of combining psychotherapy and psychology under one RA, it is hard to see how this is going to work or to benefit psychotherapy.

Moreover, the relevance and impact of this health (medical) legislation has not be helped by the fact that the Psychotherapists' Board has, by and large,

tended to operate with a heavy rather than light or right touch (see Chapter 7).

Of all the authorities involved in the *Act*, the MoH is perhaps the most transparent, as:

- It is still open to a variety of forms of professional regulation: non regulation, professional regulation, and regulation by employers (see MoH, 2010a).
- It still recognises that unregistered persons (health care providers) can practice legitimately (see DGH, 2009).
- Its policy still challenges those professions seeking regulation for purposes of their own advancement (MoH, 2010c, 2015/16), and has clarified a number of issues, including the "risk of harm" criterion (see MoH, 2010c).

The logic of this pluralism and of the distinctions advanced in this chapter and elsewhere in the book are summarised in Chapter 19.

In this context — that is, the context described above (and, indeed, in the rest of the book) — it seems reasonable to raise the question of whether psychotherapists are best described and positioned as "health practitioners"; whether the profession is best regulated by the PBANZ; and, most importantly, whether the New Zealand public is best served by having psychotherapists as registered health practitioners under the current law or even an amended *HPCA Act*.

The *Act* states that its principal purpose is: "to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions." (s1(3)) This raises a number of concerns about the relationship of the *Act* to psychotherapy and psychotherapists, the first of which is the defining of psychotherapy as a health profession.

As an activity and a profession, psychotherapy is distinct from other professions allied to medicine, and there are significant problems when psychotherapy is defined as a "health profession" and associated — or solely associated — with "health" as a health practice (for a critique of which, see Postle & House, 2009; King & Moutsou, 2010; and Chapters 1, 8, 11, and 12; and for a defence of which, see Manning's contribution to

Chapter 17), and especially when, in effect, it is regulated under medical legislation. Historically, psychotherapy draws on a number of traditions, including healing, medicine, psychiatry, academia, lay practice, ministry, psychology, and social work (see Tudor, 2018–in press). To confine ourselves to one of these seems partial and, given the dominance of the (Western) medical, inequitable. The uncritical association of psychotherapy with medicine is epitomised in the over–reliance and overuse by psychotherapists of the *Diagnostic and Statistical Manual of Mental Disorders* (now in its 5th edition), an unscientific diagnostic categorisation authored by the American Psychiatric Association.

There are, of course, some psychotherapists and other professionals practicing psychotherapy who, as members of other professions such as psychology and psychiatry, may experience less distinction between their profession(s), their professional identity or identities, and their practice. At the same time, there are others with other backgrounds or identities, such as in and with indigenous health and social work, who may see themselves as health and/or social care practitioners but not in the sense of the medical model or the *HPCA Act*.

The fact that the *HPCA Act* is a piece of health (i.e., medical) legislation means that its language, terms and conditions are often somewhat alien to psychotherapists. For example, supervision is viewed very differently in most of the other health professions than it is amongst psychotherapists, usually in more of a remedial than a formative or supportive frame of reference. In optometry, for instance, the Optometrists & Dispensing Opticians Board (2010) generally only requires optometrists to have supervision if there is an identified concern about competence (or incompetence). Also, the sections of the *Act* that compromise practitioners' autonomy reveal an attitude to confidentiality that is unfamiliar to psychotherapists: under s42, a person authorised by an Authority may review any records, including client notes, held by another practitioner undergoing a competence review; and information gained in this way may be revealed to the authority, or to the client (s44); a practitioner who does not meet the authority's definition of a registered person or who is deemed to be working outside their scope of practice may be the subject of a search warrant (s10); and, during the hearing of sensitive evidence at a Health Practitioners Disciplinary Tribunal (HPDT), any member of the public may

be present (s97) — as the HPDT is a public hearing. A professional conduct committee (see ss71–83) may require any person to produce evidence (and failure to give evidence may incur a fine of up to $10,000 (ss77–78)); meanwhile, under s119 of the *Act*, Board members and employees are protected from criminal and civil liability for their work ('though this is a standard provision for those exercising quasi–judicial powers).

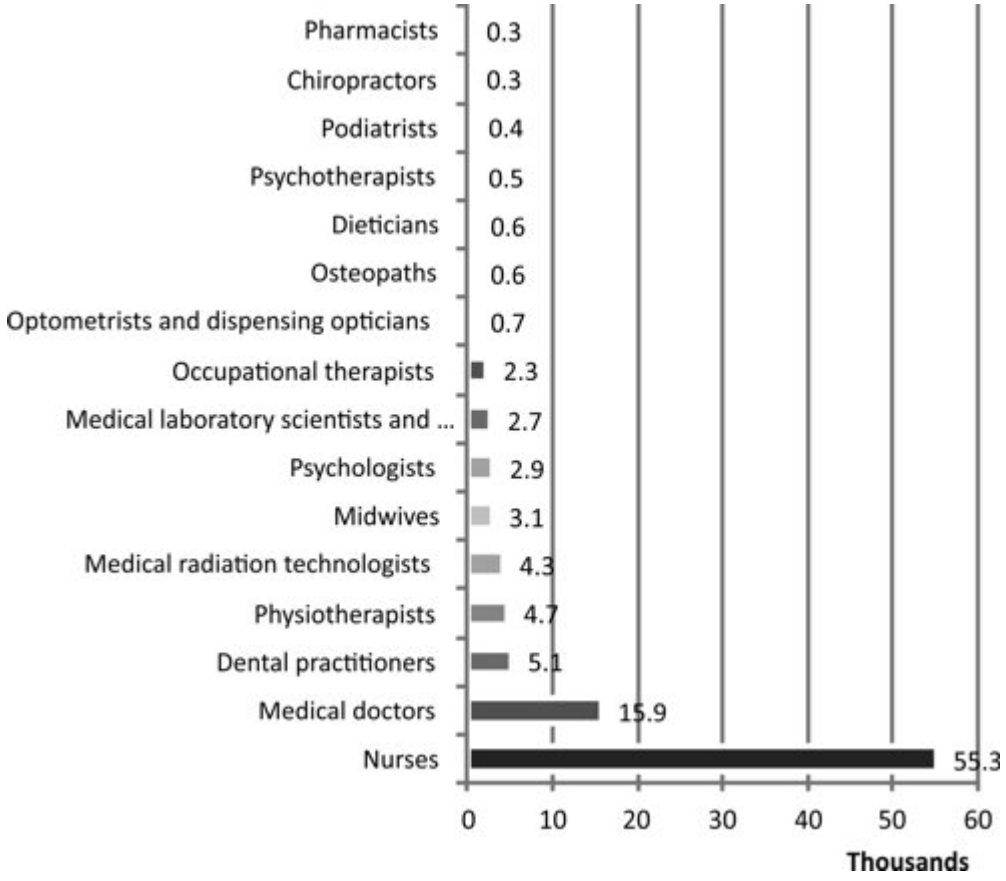
Some colleagues take the view that, as a profession, we are stuck with this particular legislation, and, by implication, this particular model of registration, and, consequently, any policy the Board publishes. We are not. It was — and still is — possible to maintain and develop parallel models (see, for instance, Totton, 1997; Fay, 2011). In terms of different models, the *Social Workers Registration Act 2003*, which was given assent on 9th April of that year, *some five months before* the *HPCA Act*, and which established a *voluntary* system of registration. The legislation introduced and protects the title "Registered Social Worker", but, significantly, also allows for an unregistered social worker still to call her/himself a "Social Worker" (see SWRB, 2010). The fact that psychotherapists sought registration with health (medical) professionals rather than with social work professionals appears significant in terms of where psychotherapists — or, at least, some colleagues — wanted and still want to situate the profession as a whole (see Chapter 4; and, for an alternative view see Manning's contribution to Chapter 17).

In his original rejoinder to this section of this chapter (in the original book), Manning (2011) chided me for questioning whether psychotherapy was best understood and organised as a health profession, given the dominance of "health" by medicine and the medical model. He presented the idea that medical model has been trying to get away from itself, at least since 1977 when Engle introduced the biopsychosocial model. I don't disagree with Manning's points about a more modern (or even postmodern) medicine that is more open to other wisdom and disciplines; to findings from developmental research into brains and behaviour; to an integrated and holistic mind–body perspective; and to being influenced by other professionals and professions. I do, however, disagree with and object to his cheap criticism that the arguments that I and others proposed (in addition to me, he originally cited Cornforth, Embleton Tudor, and Younger) as being

"a million miles away from real life" (Manning, 2011, p. 240). I object to this on two counts.

The first is that to claim that psychotherapy and health (i.e., medical) professions are engaged in a process of mutual and respectful co–influence is simply not true. It underestimates the power of the medical model and that fact that psychotherapy and psychotherapists are, in the bigger picture of the health professions, an extremely small percentage (see Figure 6.1), at 0.46%, less than a half of one percent.

Figure 6.1 New Zealand registered health professionals as a percentage of the whole registered workforce (2016 figures)



The second objection is one about the nature of argument, as I notice that when people make this kind of argument, they always privilege their own "real life", in this case Manning's consulting room) and ignore that we

critics are also practitioners — or, I should say, in the regulatory world that Manning subscribes and submits himself to, "healthcare providers". I disagree that the vision of medicine espoused in those or these pages is "immature and old–fashioned" (ibid., p. 240). In fact, neither I nor the other contributors to either the previous or this edition discuss medicine much. What I did and do discuss is the significance of the medical model and thinking, specifically on the *HPCA Act*, and the impact of an unexamined and uncritical acceptance of both the thinking and the *Act*.

Charles Dickens' Mr Bumble famously said: "If that's the Law, then the Law is an Ass" (Dickens, 1838/2003). While it looks like the *HPCA Act* is here to stay, 'though probably in some revised version, (see MoH, 2016), it is important to question its relevance to psychotherapy and, I would argue, to decide whether this particular law is an *Act* under which we want to continue to work and live, or whether it is an ass that we want to acknowledge as such and put out to pasture, so that we can move on to other and more appropriate ways of thinking about the practice, discipline, field and profession of psychotherapy and its regulation — and, most importantly, doing psychotherapy with clients.

Having discussed the *HPCA Act* itself, the next chapter considers the life and work of the RA under the *Act* for psychotherapists, the Psychotherapists Registration Board of Aotearoa New Zealand.

Public statutes

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Medical Practitioners Act 1995.

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Chapter 7

Responsible and irresponsible authority: the rise and fall(ibilties) of the Psychotherapists Registration Board of Aotearoa New Zealand

Keith Tudor and Jonathan Fay

Following on from the previous chapter about the *Health Practitioners Competence Assurance Act 2003* ("the *HPCA Act*" or "the *Act*"), this chapter focuses on the life and work of the Psychotherapists Board of Aotearoa New Zealand ("PBANZ" or "the Board"). The chapter comprises excerpts from two chapters in the previous edition, as well as material from other research and publications since 2011 (see Tudor, 2012a, 2012b, 2012c; 2015; Tudor & Duncan, 2012; Fay & Tudor, 2015; Tudor & Fay, 2015; Tudor & Shaw, 2016, 2017). As we take a critical stance on statutory regulation, this chapter takes a critical view of all "Responsible Authorities" (RAs) appointed under the *HPCA Act 2003* (see Tudor & Shaw, 2016, 2017). Here, we focus on the PBANZ specifically because it is the authority responsible for the registration of psychotherapists and especially because, by and large, it has been particularly zealous in its regulatory activities and its desire to extend the influence of its regulation.

While the New Zealand State through the Ministry of Health determines the parameters of the work of the RAs (see Chapter 6), and through the Minister of Health determines the appointment of people to the RAs, it is the RAs themselves who determine the rightness of touch with regard to how they regulate the professionals within their defined scope(s) of practice. Thus, any critique of a specific RA, in this case, the PBANZ, necessarily encompasses the RA as an entity, but also the work and approach of particular configurations of the Board. In this sense, our critique is both political and personal, that is, particular to the Board or Boards as, at any one time, this comprises a small number of individuals who make certain decisions — and who have choices about the decisions they make. Whilst people have a variety of motives to serve on such a Board or Council, it is reasonable to suggest that the people who put themselves forward to do so are a) supportive of the state registration of title; and b) more likely to be in favour of wider statutory regulation of the profession as a whole — in other words, at the more restrictive end of the spectrum of Macleod and McSherry (2007) models of regulation (see Chapter 1). We mention this point about the personal as well as the political as the debate about psychotherapy regulation here in Aotearoa New Zealand has, at times, become very personal, as a result of which, some colleagues on both — or all — sides of the debate have felt quite bruised (see also Chapter 4, pp. 114). Nevertheless, and especially in the context of ongoing discussions in a number of countries about psychotherapy regulation, we think it is important to present a view from a post–regulation landscape as often what is anticipated or even understood or agreed in advance is not what eventuates. As such, the chapter stands as a case study of the work of a specific RA, especially with regard to the concept and practice of "right–touch" regulation (Council for Healthcare Regulatory Excellence, 2010; Bilton & Clayton, 2013).

The chapter begins with some background to the establishment of the PBANZ, and some early concerns expressed by Jonathan as well as others about the approach of the initial Board. We then discuss the Board's approach to biculturalism, language, scopes of practice, and fees.

Background: the early years

It is fair to say that, by and large, psychotherapists welcomed the establishment of the Board as the embodiment of the achievement of state registration. Although this had been driven by Paul Bailey (see Chapter 4) and a majority of membership of the New Zealand Association of Psychotherapists (NZAP), a number of colleagues outside the NZAP also welcomed registration as an alternative to membership of the Association as the main player in the field. They were critical of the NZAP's privileging of psychoanalytic and psychodynamic thinking and practice, an historical tension which has been referred to as part of "turf tensions" within the NZAP over the years regarding modalities or theoretical orientations. The registration process as administered by the PBANZ was seen as being theoretically neutral and, therefore, more egalitarian. Currently, nearly 30% of registered psychotherapists are neither members of the NZAP or the New Zealand Association of Child and Adolescent Psychotherapists (NZACAP). However, this argument is only partially true. Whilst the criteria of the scope of practice "psychotherapist" have no particular theoretical requirements or implications, this is not true of the "psychotherapists scope of practice with child and adolescent psychotherapist specialism". In its document setting out the core clinical competencies for practitioners, the Board identifies certain competencies that distinguish practitioners registered in the specialism, all of which refer to psychoanalytic and psychodynamic theory and practice (PBANZ, 2010c). This, in effect, represents a theoretical specialism, which was entirely due to initial lobbying from the NZACAP and the continued influence of individual psychodynamic child and adolescent psychotherapists on the Board. As it stands, this scope of practice undermines the claim that the Board is theoretically neutral.

For its part, the NZAP had had just enough political knowledge and skill to lobby successfully for the formation of the Board, but not enough knowledge and skill to maintain any ability to steer the new RA, which, subsequently to its establishment, has shown itself to be an irresponsible or rogue authority as far as the profession is concerned, answerable to no one but itself and the Minister of Health. Apparently unwilling or unable to practise according to recognised psychotherapeutic norms and values, the PBANZ has also turned out to be of no help whatever with the important task of developing public psychotherapy services, which, at least according to Paul Bailey, was the main rationale for registration (see Chapter 4). In

fact, since registration, eight years ago, the overall number of registered psychotherapists has increased by a grand total of five (Tudor, 2017).

The PBANZ was established in September 2007. The Minister appointed five psychotherapists, 'though surprisingly — and perhaps significantly — not Paul Bailey, the architect of registration, and two laypersons, one of whom was a professional regulator …. The composition of the initial Board was highly significant in setting the tone of what developed subsequently. A year later, in September 2008, the Board stunned the psychotherapy community by opening for business with a $900.00 entry fee, then the second highest fee for registration and the Annual Practicing Certificate (APC) of all 16 RAs. On 29th November, 2007, Jonathan wrote to Roz Broadmore, the President of the NZAP emphasising the following points:

1. That the Board be strongly encouraged to forego or limit time–consuming and expensive regulatory activity, but instead focus on cost effective oversight, liaison and consultation.
2. That the Board be strongly encouraged to delegate the task of registration to each of its constituent professional psychotherapy organizations, who could then be empowered register their own members with Board oversight.
3. That the Board be strongly encouraged to avoid the morass of specialty registration but instead develop a variety of paths to registration that allowed practitioners to choose their own professional affiliation and develop the safety and competence of their practice within this chosen affiliation.
4. That the Board be strongly encouraged to recognize and respect the NZAP policies and procedures developed painstakingly over 60 years.
5. That the Board be strongly encouraged to self–identify as a low–budget, low–impact governance body in which Board members have fewer perks but also less work to do, as close collaboration with professional bodies and voluntary professional expertise relieves the Board of many time–consuming and expensive tasks. (Fay, 2007)

These five points were all aimed at shaping a Board that would collaborate with the NZAP in order to build a strong and responsive professional community that could effectively share the responsibility and task of keeping the public safe. The Board did none of these things — and,

perhaps, equally significantly, the NZAP Council did not push for this vision of a more co–operative and co–regulatory model.

By early 2008, it had already become obvious that PBANZ did not see collegiality or co–operation as relevant to its task. Purportedly on behalf of the "public", the Board had adopted an adversarial attitude towards psychotherapy and psychotherapists. In April 2008, Jonathan wrote to the NZAP's Council expressing his grave concerns about the shape that registration had already begun to take, and suggesting that the NZAP decline to join or support the Board's registration process (Fay, 2008a). Whilst the Council appreciated the sentiment, it felt that it was too far down the track to turn back, even though things were turning out far differently than had been envisioned. Several months later, Jonathan wrote to Council again with his concerns that the PBANZ was unready to assume power over the profession of psychotherapy and in fact posed a serious threat to public safety:

> ***Dear colleagues***
>
> The Board has with very little self–reflection taken the position of a stand–alone, imperial authority and this is already beginning to come back to haunt them and us. And make no mistake. They are not required to behave in this manner by the *Act*. The requirements for public safety would be far better met by a Board who understood their proper role as governance. This Board behaves like a Crown enterprise. By grossly overcharging for the annual practicing certificate, the Board has robbed our profession's funding base. They have also completely ignored NZAP's longstanding, honourable and effective history of protecting the public. The undermining effects of Board policies and procedures thus far have swiftly brought NZAP to the brink of abandoning both our admissions process and our complaints process. We simply cannot afford to persist in unpopular and expensive gate keeping activities without the money or the statutory authority to sustain these roles. But if we are to abandon our gate keeping roles, should we not seek some solid evidence that these critically important jobs will be adequately managed by others? ... We would naturally expect the Board's first priority to

> be one of defining the fundamental parameters within which psychotherapists will be expected to practise. Instead, we learn the Board has offered up a frivolous proposal to spend its time and our money organising a "road show" scheduled for January 2009 so it can promote itself to us with our own funds. What is urgently needed in place of this is a summit meeting between the Board and the Councils of NZAP, NZAC and NZACAP with a view to developing good working relationships. Until this meeting has actually taken place, I believe the NZAP Council should urge its members and provisional members in the strongest possible terms to delay their registration and withhold payment of their $900 pending resolution of these issues. (Fay, 2008b)

As there was insufficient time for Council to respond to this urgent matter, one week later, Jonathan wrote directly to the entire membership of the NZAP alerting it to the fact that, while the Board was about to open its register, it had set an incredibly high fee without any justification, and, at that stage, had no ethical code or complaints process! It had also decided not to require registered psychotherapists to be members of recognised professional organisations such as the NZAP, the NZACAP and/or the New Zealand Association of Counsellors, which, as Jonathan was envisaging it, would have been one way of ensuring a close or closer connection between the Board and the profession. In his letter, Jonathan also proposed a mass boycott of the registration process and payment of the registration fee until the Board agreed to hold a summit meeting with these associations to discuss a more collaborative relationship with regard to the structure and processes of registration.

Although most psychotherapists ignored this request, a small but significant proportion of members of the NZAP did not register as psychotherapists, as a result of which they received threatening letters from the Board (for a detailed account of this history, see Tudor, 2011). Writing two years later (in the first edition of this book, in 2011), we each noted that subsequent experience of the Board's approach to the profession only confirmed the Board's inability to stay in relationship with the profession that gave rise to it; to enact reciprocity or mutuality; either to allay the fears or address the concerns of psychotherapists; or to work to earn and deserve the trust of

psychotherapists, practitioners, or relevant health care providers (Fay, 2011; Tudor, 2011).

As with other RAs, the PBANZ knows how to amass and hold power, but not how to share power. In 2009, the Board entered into agreements to work collaboratively with Waka Oranga, the NZAP's Treaty partner, and Ngā Ao e Rua, a bicultural group of Māori and non Māori psychotherapists and health care providers, but then unilaterally broke these agreements, again without explanation. Despite repeated requests to the PBANZ on the part of both organisations that it give some account of their conduct, the Board refused to comment on this breach.

BICULTURALISM

As noted in the Introduction, the *Act* contains no reference to te Tiriti o Waitangi | the Treaty of Waitangi (hereafter "te Tiriti"), an omission which was justified at the time by the Ministry of Health (2003). This contention was based on Crown Law advice and on a Waitangi Tribunal (2001) finding in the Napier Hospital claim [*This was a claim made 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 of which see Waitangi Tribunal (2001).*] that the *New Zealand Public Health and Disability Act 2000* makes adequate provision for Crown Treaty responsibilities in the health sector. This is a sweeping statement with far–reaching consequences; is highly debatable, especially given the point made (in Chapter 6) regarding the role of te Tiriti in interpreting law; and, with reference to psychotherapy, is a claim which must be measured against the experience to date of the Board:

1. Failing to consult adequately with Māori psychotherapists in the lead–up to registration.
2. Neglecting, over three years (2008–2010), to agree on a Treaty policy (despite its claims to have one), and to have published it on its website. In September 2010, just a few days before the annual closing date for the renewal of practitioners' APCs, the Board put a statement on its website regarding the Treaty (which it was due to review in August 2012) (see PBANZ, 2010b). According to the relevant page on the

Board's website (PBANZ, 2016b), this has not been updated or reviewed.
3. Reneging on an agreement with Waka Oranga, the only runanga of Māori psychotherapists, to develop a Māori scope of practice and a kaupapa Māori pathway to registration (see Chapters 3 and 5).
4. Insisting on privileging the English language version of te Tiriti — contrary to the principle of *contra proferentum* (against the offerer), whereby the indigenous language version of a treaty takes preference over that written in the languages of the colonisers (Te Puni Kōkiri 2001/2002; United Nations, 2008).
5. Refusing to recognise the NZAP He Ara (Māori) pathway, significantly the only pathway to full membership of the NZAP which the Board does not recognise.

Interestingly, in the lead up to registration and in the context of discussions about a "stand–alone" or "blended" authority — originally, it was mooted, with the New Zealand Psychologists' Board (NZPB) — there was a hope, even an expectation, that a smaller, stand–alone authority would adopt the NZAP's support for and work on biculturalism. Writing on behalf of the NZAP Council, Bailey, Quinn & Manning (2006) put it thus:

> Access under the Treaty of Waitangi is best served by a stand–alone authority, in that the smaller the unit, the more flexible it can be in terms of biculturalism ... Our admission procedures, which we might hope will shape the criteria adopted by the authority, are flexible enough to accommodate indigenous method, belief and protocol. (p. 20)

Still now, over ten years later, in the light of the Board's reneging on various agreements with Waka Oranga, the NZAP's Treaty partner, and its general (in)activity with regard to biculturalism, this "hope" makes for somewhat bitter reading.

Language

One of the features of the PBANZ in its early days (especially 2007–2011) was its problematic use of language.

Given that the term "psychotherapist" is restricted, it was — and is — clear that the Board regulates the use of this particular word. The problem, however, is that it also tried to control the use of language and people's perceptions. In correspondence with one practitioner regarding some proposed wording about the practitioner's professional membership, the Registrar wrote: "I understand from you that this is not your intention however, the possible implication/perception still remains." (J. Manley personal [e–mail] communication, 3rd August 2010) This appeared to conflate if not equate implication, i.e., what might be implied (by the practitioner), with perception, i.e., what might be perceived (by the public). This not only contradicts phenomenological concepts of perception and reality, but also appears to extend the practitioner's responsibility for what s/he may imply to include anyone's potential perception of her/him. It also demonstrated a complete lack of appreciation of and respect for the experience, wisdom and intelligence of "the public" and potential client(s). This perspective is embodied in a phrase which the Board uses as a kind of test as to whether a practitioner is "holding themselves out to be a psychotherapist". Again, the Board's attack on phenomenology and any sensible use of the English language reveals its interest in extending its power. If someone is not a registered psychotherapist, not advertising her/himself to be a psychotherapist and, indeed, making it clear in all her/his statements that s/he is not a psychotherapist, then s/he is not a psychotherapist, even if s/he is practicing psychotherapy — a position that was confirmed in April 2010 by the Board's Registrar, Jacq Manley, when questioned about this at the NZAP Conference, held in Dunedin. However, it has appears that the Board not only holds and regulates the term "psychotherapist", but has also sought to determine and rule that particular practitioners are "holding themselves out" to be psychotherapists, even when they were or are not. At times, and, again, more previously than presently, the Board has appeared to be using Humpty Dumpty's approach to language, when he said to Alice in Wonderland: "When I say a word it means exactly what I want it to mean." (Carroll, 1865/2009).

Scopes of practice

Following its initial identification of and consultation with regard to scopes of practice (2007–2009), the PBANZ has consistently extended or tried to

extend the scope of practice and what is meant by the term "psychotherapist".

With regard to scopes of practice, all the RAs appointed under the *Act*, without exception, identify the care of patients/provision of a health or disability service as a scope of specified practitioners ("chiropractor", "dentist", "psychotherapist", etc.). In addition, there are a number of other scopes or roles that are mentioned by a number of RAs, including 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 fulfilling them. A small number of RAs, however, have made certain statements about these roles:

- The RAs for dentists and pharmacists acknowledge additional roles and assert that all of them influence public safety and, therefore, that they require anyone undertaking them to be a registered practitioner.
- The RAs for nurses and physiotherapists acknowledge other roles and the involvement of practitioners in them but only require practitioners undertaking these roles to be registered (and credentialed with an APC) if the role is in a context that may impact on public health and/or safety.
- The RA for psychotherapists stands alone in asserting that the other roles it identifies (research, policy making, educating, and consulting) require the person to be a registered practitioner — and without any explanation, justification, or consultation.

All RAs have wide–ranging powers (see Appendix 3) but only a few seek to extend the meaning of scopes of practice (which, essentially, is concerned with title protection) to the point where, in effect, the whole field of the profession is proscribed and regulated.

As far as the PBANZ is concerned, as has been noted, it has sought to extend their powers to regulate, specifically and significantly when it extended the definition of the practice of psychotherapy thus (PBANZ, 2008c, p. 3647): "Practice is not confined to clinical practice and encompasses all roles that a psychotherapist may assume such as client care, research, policy making, educating and consulting." This is a bizarre misuse of the term "practice" and is out of step with a number of other

related professions such as clinical psychology whose Board does not require educators or trainers to be registered practitioners with the exception of those educators or trainers on accredited courses or programmes who are teaching clinical practice or who are overseeing Intern Psychologists' placements, in which they would be expected to hold an APC.

An illustration of differences in the definitions and responses of the RAs towards scopes and roles of practitioners may be seen in comparing the Physiotherapy and Psychotherapy Boards. When (in December 2008) the Physiotherapy Board amended its original scope of practice it did so in a similar way to that of the Psychotherapists' Board had done earlier in the year (in September 2008) thus: "The practice of physiotherapy is not confined to clinical practice, and encompasses all roles that a physiotherapist may assume such as patient/client care, health management, research, policy making, educating and consulting" (PBANZ, 2008b, p. 5105). However, the Physiotherapists Board (2008) added a significant qualifier, that is, "*wherever there may be an issue of public health and safety*" (my emphasis). This allows physiotherapists to be managed, educated and consulted by non registered practitioners where there is no issue of public health and safety — as do the Boards/Councils for chiropractors, dieticians, medical auxiliaries, midwives, nurses, osteopaths; and podiatrists; and for occupational therapists, and optometrists (with regard to research, policy–making, consultation, and management); and medical practitioners (with regard to policy–making, consultation, and management) (for further comparative analysis of scopes of practice of the different RAs, see Tudor & Shaw, 2016). In this context it is hard to see how the Psychotherapists' Board continues to insist that, all managers, researchers, policy–makers, educators (trainers), and consultants have to be registered practitioners especially in the light of principles outlined by the Director–General of Health (2009) with regard to prescribing scopes of practice, principles which include: "defining scopes only as needed to protect public health and safety rather than responding to professional preferences ... [and] consulting widely and openly without predetermined positions, and carefully evaluating and responding to submissions" (p. 9).

The Board made this extension to its scopes in its response to the consultation (PBANZ, 2008b) and first published notice (in the *New*

Zealand Gazette) (PBANZ 2008b), 11 months after it was constituted. Under the *Act*, Authorities must specify scopes of practice and issue notices of such scopes (Section (s)11) — which it did. However, the *Act* also specifies certain provisions relating to s11, namely that "Before an authority publishes a notice under section 11 or section 12 or under this section, the authority must have consulted about its proposal for the contents of the notice" (s14(2)), and it must have consulted:

a. with persons who the authority considers are able to represent the views of health practitioners, or of classes of health practitioner, registered with the authority; and
b. with organisations–
   (i) that the authority considers will be affected by the proposal; or
   (ii) whose members the authority considers will be affected by the proposal.

This the Board did not do. Whilst the Board did consult about the proposed scopes: psychotherapist, psychotherapist with child and adolescent psychotherapist specialism, and interim psychotherapists (see PBANZ, 2008c), at no point in the time between October 2007 and September 2008 did the Board consult about its proposed extension of the definition of scopes of practice (or roles). Moreover, it added the phrase about the definition of practice — "Practice is not confined to clinical practice and encompasses all roles that a psychotherapist may assume such as client care, research, policy making, educating and consulting" (PBANZ, 2008a, as noted above) — on 18th June 2008, *after* the consultation. Therefore, by extending the scopes of practice in the way it did, the Board was — and still is — clearly in breach of the *Act*. Legal obligation, natural justice, professional courtesy, and common sense would require the Board to withdraw that part of its 2008 notice, and begin consultation about such scopes and roles. As it has transpired, that which the Board did not consult about in those early days has been far more encompassing and consequential than that about which the Board did consult.

In response to people questioning its extension of the scopes of practice, the Board has been disingenuous, arguing, at a meeting with the NZAP in February 2010, that its scopes of practice were "policy" and, therefore, that it did not have to consult about them! This was despite the fact that their

"note" about this was contrary to the explicit requirement (under Section 14(2) of the *Act*) on "responsible authorities" to consult with their respective professions about any proposed scopes of practice. In response to concerns expressed by the NZAP, the Board has been complacent, stating (in a letter to the NZAP's Council), that it was "satisfied" with the scopes of practice as they stood. It was only as a direct result of a complaint made in 2011 by the organisation of Independently Registered Psychotherapy Practitioners against the Board, through the New Zealand Parliament's Regulations Review Committee, that the Board, albeit reluctantly, agreed that it would consult the profession about its extended scopes of practice. In its letter to the Chair of Parliament's Regulations Review Committee (dated 9th March 2012), the Board, in the form of its Registrar, acknowledged that:

> with the benefit of hindsight, that it [the Board] could have sought further comments and undertaken further consultation on the "note" at issue ... [and] that it will ensure that its consultation process expressly covers the "note" in question to gauge views on its inclusion in a revised scope of practice. (p. 4)

This was a minor but significant victory for due process — and, we would argue, due analysis. However, the profession needs to remain watchful and, if necessary, consider using the complaints procedure offered by Parliament's Regulations Review Committee.

The Psychotherapists' Board is not alone in its desire to centralise power. In his report on the 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). In the light of the Board's distant and somewhat superior attitude to the profession, there has been some discussion about how "relational" the Board is or should be (see, for instance, Chapters 1 and 4). Whatever we think about this, the government, in the form of the Director–General of Health (2009) is clear that: "The *Act* is based on a system in which responsible authorities make decisions about professions. To function effectively, authorities must maintain the confidence and respect of the professions for which they are responsible" (p. 7) and, moreover, that "Authorities' success in engaging

and communicating with their professions should be a measure of their performance" (p. 8). Whilst different configurations of the PBANZ have been more or less open to engaging and communicating with the profession, there is very little evidence that they have taken any notice of consultation; and, since 2008, the Board has continued to extend its regulatory authority. Here, we discuss three examples.

THE CASE OF THE DISAPPROVED SUPERVISORS

Whilst the Board did not name the activity of "supervision" in the note it added in its original gazetted notice (PBANZ, 2008c), it has since, in effect, made this another scope of practice restricted to the title of "psychotherapist" by means of its changing policy on supervision.

At the end of July 2010 the Board put out a draft policy statement on psychotherapist supervision (see PBANZ, 2010a). In it the Board outlined its view of what supervisors would or should be and have: "1. A Registered psychotherapist in the scope of practice appropriate to the supervisee; A registered psychotherapist providing supervision must have a current APC or 2. A suitability qualified person, as agreed to by the Board." It went on to state that:

> A suitably qualified person will provide the Board with a CV outlining evidence of their competence in psychotherapy supervision either by qualification, professional development, skills and/or knowledge. At present the Board has no specific definition of a suitably qualified person *and the emphasis is on flexibility*. (my emphasis)

The Board gave six weeks for this consultation and feedback was due on or before 17th September. Then, after the initial consultation and following its meeting on 15th and 16th October 2010, the Board added the following note (published on its website on 4th November, 2010):

> Note. Practitioners who are providing supervision for psychotherapists, and who hold a qualification in psychotherapy that would allow or would have allowed them to register as a psychotherapist (under grandparenting), are considered by the

> Board to be holding themselves out to be a psychotherapist and will not normally be approved under this section unless they are registered and hold a current APC (see above). (PBANZ, 2010)

This statement made it clear:

a. That the Board does not wish to allow practitioners to practice as they have the right to do within the law, i.e., to choose to be "health care providers" as distinct from "health practitioners" (see Chapter 6), thereby restricting practitioners' freedom to practice and trade.
b. That the Board is restricting the choice registered practitioners have of who they engage as supervisors, a restriction which reflects a closed system and, in effect, promotes a kind of pyramid selling.
c. That the Board is setting itself up as the sole arbiter of what a practitioner is, implying and, again, collapsing the distinction between implication and perception.

This caveat was entirely reactive to and punitive of practitioners expressing their freedom to practice and autonomy of choice. It is also remarkable that a Board, comprising a majority of psychotherapists, could or would frame or agree to such a note which makes such assumptions about the "other" in terms of their presentation and identity; and positions itself not only as judge and jury but also as an active prosecutor in this case of practice and professional identity. At its final meeting of 2010 (5th & 6th December), the Board again amended its policy and removed this note.

This situation continued for a couple years. In 2012, the Board turned down applications from two experienced and senior practitioners (i.e., health care providers) to be considered as "approved supervisors", an approval they had applied for in order to continue supervising psychotherapists who were registered. One of reasons that the Board declined their applications was because, it wrote (in a letter to one of the applicants and, in the other case, in a letter to the applicant's supervisee) that: "the Board has adopted a position that it is unlikely to be appropriate to appoint an unregistered person as a supervisor in circumstances where that person has been, or appears to be, critical of regulation under the *HPCA Act*" (J. Manley, 2012). For some of us, this was an astonishing and very worrying response, which directly challenged only the supervisors' intellectual freedom, but also their

freedom to practice, both of which we would hope would be of concern to psychotherapists. The decision — and the lack of response from the profession — highlighted an important difference between colleagues: those who are pluralist (e.g., the two supervisors who were supporting their supervisees to be and remain registered); and those who are unilateralist (in that they, in effect, support a model of regulation that involves the reservation of title and wholescale practice restriction).

This particular decision was also noteworthy for the fact that the Board changed its "position" and policy on supervision during the process of these applications, thereby showing its contempt for due process.

The Board's current policy on supervision (PBANZ, 2016c) states that:

> Clinical psychotherapist supervision can be provided by either:
>
> 1. A registered psychotherapist with a current APC [annual practising certificate]; or
> 2. A health practitioner registered under the HPCAA with the current APC; approved by the Board as having sufficient psychotherapy training, knowledge, skills professional development.

This means that, in practice, the Board approves — or disapproves — a psychotherapist's choice of supervisor, and has restricted that choice to registered psychotherapists or other registered health practitioners — and has done so without consultation with the profession, in direct contravention of the *Act* (ss11 and 14(2)), which requires responsible authorities to consult on scopes of practice.

For some of us, all of this was — and still is — highly problematic. However, what is of greater concern is that the majority of the profession have not objected either to this restriction on their choice of supervisor, or to the fact that, in effect, the Board has extended the scope of practice of "psychotherapist" to include that of supervisor. Despite the fact that the Board has been challenged about its approach to scopes of practice, and agreed to consult (see below), it still expands scopes of practice and, thus, its sphere of influence, without appropriate consultation.

THE CASE OF THE "VISITING EDUCATOR"

Since the title "psychotherapist" has been protected, the Board has been concerned that no one who is not registered with the Board refers to themselves as a psychotherapist and, in its thinking, this extends to lecturers or educators visiting New Zealand who may be psychotherapists (registered or unregistered) in their own countries but who, by definition are not "psychotherapists" in New Zealand. In the two years immediately after coming into existence, the Board had taken issue with — and, indeed, threatened — individuals and organisations advertising overseas speakers in which they had included the word "psychotherapist" in their biographical details on the advert or flyer for a particular conference or event. In other words, whilst it was accurate and true to say that such a person was a psychotherapist, it was no longer legal to say so in New Zealand.

In August 2011, the Board put out a consultation document regarding a proposed new scope of practice for Visiting Educator (PBANZ, 2011). In order to ensure that applicants for registration in this special purpose scope of practice were fit for registration (in order to give a lecture or to do some training in New Zealand), the Board asserted that it must ensure that all such applicants were fit for registration under s16) of the *HPCA Act* (see Figure 7.1).

Figure 7.1. S16 of the *Health Practitioners Competence Assurance Act 2003*

No applicant for registration may be registered as a health practitioner of a health profession if –

a. he or she does not satisfy the responsible authority that he or she is able to communicate effectively for the purposes of practising within the scope of practice in respect of which the applicant seeks to be, or agrees to be, registered; or
b. he or she does not satisfy the responsible authority that his or her ability to communicate in and comprehend English is sufficient to protect the health and safety of the public; or
c. he or she has been convicted by any court in New Zealand or elsewhere of any offence punishable by imprisonment for a term of 3 months or longer, and he or she does not satisfy the responsible authority that, having regard to all the circumstances, including the time that has elapsed since the conviction, the offence does not reflect adversely on his or her fitness to practise as a health practitioner of that profession; or
d. the responsible authority is satisfied that the applicant is unable to perform the functions required for the practice of that profession because of some mental or physical condition; or

e. he or she is the subject of professional disciplinary proceedings in New Zealand or in another country, and the responsible authority believes on reasonable grounds that those proceedings reflect adversely on his or her fitness to practise as a health practitioner of that profession; or
f. he or she is under investigation, in New Zealand or in another country, in respect of any matter that may be the subject of professional disciplinary proceedings, and the responsible authority believes on reasonable grounds that that investigation reflects adversely on his or her fitness to practise as a health practitioner of that profession; or
g. he or she –
(i) is subject to an order of a professional disciplinary tribunal (whether in New Zealand or in another country) or to an order of an educational institution accredited under section 12(2)(a) or to an order of an authority or of a similar body in another country; and
(ii) does not satisfy the responsible authority that that order does not reflect adversely on his or her fitness to practise as a health practitioner of that profession; or
h. the responsible authority has reason to believe that the applicant may endanger the health or safety of members of the public.

In order to ensure that the applicant for the special scope of Visiting Educator met these mandatory criteria, the Board stated that it would require applicants to provide police checks; International English Language Testing System results (if applicable); and fitness to practise declarations. In addition to this, the Board would require:

- A certified copy of the first two pages of the applicant's passport;
- A Certificate of Good Standing (if they have previously practised in a country where there is compulsory registration or the equivalent);
- A copy of the applicant's curriculum vitae;
- Information on the course of instruction being provided by the applicant while in New Zealand;
- A certified copy of the applicant's qualification/s relevant to the course of instruction being provided in New Zealand; and
- A declaration from the applicant's sponsoring organisation or person confirming that the sponsor knows of no reason why the applicant should not be registered and that the applicant's credentials have been checked by the sponsor. (PBANZ, 2011)

These requirements, 18 in all, which the Board later claimed were "minimal registration requirements" (PBANZ, 2012) would have placed an intolerable burden on any overseas psychotherapist visiting and speaking as an educator/trainer and/or supervisor; and undue bureaucratic and financial

requirements on many hosting educational/training organisations. The likely result of the Board's proposals would have been that many overseas colleagues would simply have refused to visit or work on this basis. From discussions at the time with colleagues, including a number of those broadly in favour of registration, we gathered that most of the responses from the profession (by the due closing date) did not favour this proposed title; and, although (in March 2012), the indications from the Board were that it was still intending to impose certain conditions on such visiting educators, in the end it backed down, withdrew the proposed scope of practice, and, instead, drew up a statement about Visiting Psychotherapist Presenter/Educators "suggesting" that they and/or their hosts contact the Board with certain information regarding the name and qualifications of the presenter, the proposed topic of the presentation, and the limited period of the visit (i.e., less than 30 days), as well as confirmation that the visiting educator will not be undertaking clinical work with members of the public, and not claiming to be registered and New Zealand (PBANZ, 2012).

In the past five years, the Board has received just one notice from an organisation using a visiting psychotherapist educator (J. Manley, personal [e–mail] communication, 25th January, 2017). Nevertheless, as a result of this challenge, New Zealand hosts are able to introduce their guests by referring to themselves as psychotherapists, a point which is entirely consistent with the Māori concepts of kaitiakitanga, and manakitanga. We were thinking that this was a rare example of reason from the Board until we heard recently from an overseas colleague that he had been told by the organisation hosting him that he should not refer to himself as a psychotherapist. The struggle for common sense and common courtesy continues.

The case of the accreditation of training programmes and pathways

In 2015, the Board published a consultation document on a Tertiary Pathway, that is, a proposal to accredit training programmes. The proposal did not include any rationale for the accreditation of training programmes, and therefore, did not meet the criteria provided under Section 13 of the *Act*, i.e.,

a. That “the qualifications must be necessary to protect members of the public” — as no case has been made that the registration of psychotherapists protects the public, or that the accreditation of psychotherapy education and/or training programmes protects the public; and
b. That “the qualifications may not unnecessarily restrict the registration of persons as health practitioners” — as it may; and
c. That “the qualifications may not impose undue costs on health practitioners or the public” — as the costs involved have not been clarified and may well impose undue costs on health practitioners, i.e., training providers, students/trainees and potential students/trainees.

The consultation document clearly implied another extension to the Board’s scopes of practice to include that of educator, ’though this was not made explicit and, as such, (and as with the example of supervisor, noted above), did not meet the requirement for consultation under Section 14(2).

The document proposed certain further restrictions to practice, namely, that the personal psychotherapy of students/trainees would (have to be) be provided by a registered psychotherapist (PBANZ, 2015, Section 4.d)i.); that training clinical supervision would be provided by a registered psychotherapist (ibid., Section 5.c)); and that trainers and educators teaching specific content would need to be registered psychotherapists (ibid., Section 8.ii. and 8.vi.). In making such proposals, the Board offered no justification for them, again contrary to the principles outlined in Section 13 of the *Act*.

There were also issues with the document in terms of biculturalism, a lack of consultation with Māori, and a lack of detail about the cost to the providers of the proposed accreditation process. In short, the consultation document was a further manifestation of the Board’s regulatory mentality, and its refusal to engage with the literature regarding registration and regulation.

All the then current education and training providers responded to the consultation document; and, as most of us shared our responses with each, we knew that they were both extensive and critical. In 2016, the Board circulated a second draft of the consultation document, which had only two minor changes to the original document (PBANZ, 2016a). Again, for some

of us, this raised serious concerns as to the extent to which the Board is actually wanting and willing to take feedback from the profession. In a note to a colleague who was coordinating the second response from the only tertiary public sector provider in the country, Keith noted the following points:

1. From our own point of view and from discussions with colleagues, we know that many if not all of the tertiary training providers are very concerned about the Board's proposal to restrict the teaching of certain papers (i.e., clinical, and applied theory papers) as well as supervision to registered health practitioners. I note that the Board refers to registered practitioners rather than qualified, accredited, or registered educators, trainers, or supervisors. Given that this was a major focus of the feedback on the first draft, it is somewhat worrying (if not surprising) that the Board has simply reiterated its proposal about this and not altered it at all.
2. It seems to me that the Board is outside its brief. Part of the purpose of the *HPCA Act* is "for power to restrict specified activities to particular classes of health practitioner to protect members of the public from the risk of serious or permanent harm" (Section 3(2)(d). The question for the Board, then, is whether restricting teaching and supervising to registered health practitioners protects the public from the risk of serious or permanent harm. Given the lack of evidence that a registered practitioner is a better teacher or supervisor than a non registered practitioner, or that the students of a registered practitioner are themselves as practitioners safer than those students taught or supervised by a non registered practitioner, I don't think the Board has made the case for this restriction.
3. As the Board often defends its policies or decisions by citing those of other responsible authorities (RAs), it might worth noting what the New Zealand *Psychologists*' Board says. In its *Standards and Procedures for the Accreditation of Programmes and Schemes Leading to Registration as a Psychologist in Aotearoa New Zealand* (NZPB, 2016), the Board does not restrict teaching to registered health professionals. With regard to supervising staff in practica and internships, it uses the phrase "*Under normal circumstances* this will include registration within the relevant scope of practice" (Section 5.2,

my emphasis), a phrase which allows for some flexibility. In the light of the previous point, such a phrase seems both fair and reasonable and consistent with the requirements of the *HPCA Act* (*Section 13 Principles guiding the prescribing of qualifications*) that "the qualifications may not unnecessarily restrict the registration of persons as health practitioners" (Section 13(b)).

At this stage (August 2017), it appears highly unlikely that the Board will take any notice of any further feedback, and, thus, highly likely that it will publish and promote an accreditation of tertiary training programmes that will be unduly restrictive, again, contrary to the requirements of the *Act* (Section 13). If it does lighten its touch, then all well and good, and, no doubt, it will have the support of all New Zealand training providers. If it goes ahead with its current proposal, it remains to be seen what the response of the training providers will be. Some will seek accreditation up; others will not, and will close; yet others may not, and may or may not survive.

FEES

This *Act* has come at some cost to the profession, politically, professionally, ideologically, and, not least, financially. From its inception, the Board set high fees both for the initial registration and for the annual practising certificate (APC). Currently, amongst all the RAs, the Psychotherapists' Board sets the second highest fee for an APC, and the fourth highest total fees overall, ahead of dentists, doctors, and nurses, and nearly twice that for psychologists (who, by and large, earn more than psychotherapists). For comparative professional fees for registration and APCs, see Table 7.2.

Table 7.2. The respective fees for initial Registration (Reg'n) and Annual Practicing Certificates (APC) of the 17 RAs under the *HPCA Act*

Responsible authority	Fee ($) 2009/10		Fee ($) 2016/17		Increase from 2009/10	
Fee type	Reg'n	APC	Reg'n	APC	Reg'n	APC
Chiropractic Board of NZ	150	1100	153	1,124	2%	2.20%
Dental Council of NZ	350	748	535	1,001	53%	33.90%

Medical Council of NZ	425	640	400	757	-5.90%	18.40%
Medical Laboratory Science Board – Scientists	230	175	350	260	52.20%	48.60%
Medical Laboratory Science Board – Technicians	120	140	350	260	191.70%	85.70%
Medical Radiation Technologists Board	315	250	315	275	0%	10%
Midwifery Council of NZ	300	200	300	400	0%	100%
Nursing Council of NZ	750	96	1,000	110	33.30%	14.90%
NZ Dieticians Board	250	450	300	575	20%	27.80%
NZ Psychologists Board	232	400	185	479	-20.26	19.70%
Occupational Therapy Board of NZ	315	546	322	558	2.20%	2.20%
Optometrists and Dispensing Opticians Board	360	663	265	754	-26.40%	13.70%
Osteopathic Council of NZ	675	675	600	736	-11.1%	9.0%
Pharmacy Council of NZ	337	495	345	649	2.2%	31.1%
Physiotherapy Board of NZ	180	250	230	365	27.8%	46.12%
Podiatrists Board of NZ	370	800	378	992	2.2%	24%
Psychotherapists Board of Aotearoa New Zealand	281	956	400	850	42.2%	9.8%

It is hard — and, again, in the absence of information, harder — to understand how the Board justifies such a high fee for its APC, one which is over twice that which psychologists pay (who, by and large, earn more than psychotherapists); just under three times that which physiotherapists pay; just under four times that which medical radiation technologists pay; and over four times that which medical laboratory scientists and technicians pay. Totalling the fees received for the APC alone over the past eight years gives the PBANZ a levied amount of over $4,000.000!

To these fees an RA may add a disciplinary levy “of any amount that it thinks fit” to fund the costs of a professional conduct committee or Disciplinary Tribunal (s131). Other fines and disciplinary penalties that may be imposed under the *Act* include: a fine of not exceeding $30,000 for an offence under s9(4) (a person stating or implying that s/he is performing a restricted activity); a fine of up to $10,000 for failure to give evidence to a

professional conduct committee (ss77–78); and, if a Disciplinary Tribunal finds grounds on which a health practitioner may be disciplined (s100), a fine of up to $30,000 (s101(1)(e)) and costs (s101(1)(f)) — in addition to possible cancellation of registration (s101(1)(a)), suspension of registration (s101(1)(b)), or censure (s101(1)(d)). These fines go to the particular RA for the disciplinary offence (s133), but not for the criminal offences (s133(5)). Appeal against such a finding must be made through the District Court or High Court, a staggeringly expensive prospect that leaves the decision in the hands of the judiciary, not in the hands of professional peers. We might well expect all this to lead to a large increase in professional indemnity insurance premiums (against the costs of defending criminal or disciplinary proceedings) and it is difficult to see how such greatly increased costs to the practitioner (and her/his employers) will encourage increased public access to psychotherapy.

Concluding remarks

The Board has never addressed, at least publicly, the philosophical basis of its approach to regulation and, specifically, why its regulatory "touch" is particularly heavy. When presenting policies, it never justifies them with any reference to relevant research or literature. On occasions when it does offer some justification, it is often disingenuous; for instance, with regard to its note on the Visiting Educator, it claimed to be responding to colleagues who were concerned that if visitors described themselves as psychotherapists, they would be breaking the law, when, in fact, it was the Board that initiated some conversations with colleagues about notices and flyers in which colleagues were (correctly) referring to visitors by their overseas title and professional identity and status. When challenged about specific policies, and especially with regard to scopes of practice, the Board's stock responses are either that it is obliged to do (whatever it is proposing) under the *Act* — which it isn't (see Appendix 3); or that it, in doing so, it is in line with the other RAs — which it isn't (see Tudor & Shaw, 2016, 2017). Finally, and this is necessarily personal or particular, specific Board members have rarely addressed what might be perceived as conflicts of interest — for example, the fact that the "psychotherapists scope of practice with child and adolescent psychotherapist specialism" is restricted to psychoanalytic and psychodynamic practitioners was heavily

influenced by particular Board members who were (are) such practitioners and members of the NZACAP (which is a psychoanalytic/psychodynamic association); and the fact that the Board's policy on the accreditation of training has been driven by some trainers who are involved and invested in the very education/training programmes and courses that the Board is likely to accredit. As Shaw points out (in Chapter 9), in countries with relatively small populations and within relatively small professional groups, such conflicts are both a reality and a problem, and is another example of the problem of centralising power in the hands of a few.

Since its establishment 10 years ago, one of the issues with the Board has been its relationship with the profession and especially, 'though not exclusively, with the NZAP. As we have detailed elsewhere (Fay, 2011; Tudor, 2011, 2012a) and in this chapter, we consider that the Board has failed in its obligations both under the *Act* and as outlined in subsequent Ministry of Health (MoH) documents and reviews to "consult" the profession (see Chapter 6) — and, more importantly, to take notice of the consultation. Over the years some colleagues have argued that it is better to be "in relationship" with the Board. We think that this misunderstands the role of the Board and, in effect, attempts or wishes to make something personal out of what is fundamentally an administrative contract. Moreover, those colleagues who have said this have generally not followed through on this argument or wish, and clearly have had no impact on the Board's subsequent policies.

Whilst we recognise that the Board has governance of the title "psychotherapist" and of its registrants, we do not accept that it has sovereignty over the whole field, discipline, and profession that is psychotherapy. In that sense, it would do better to adopt a "light touch" approach to registration, and, in order to do that, to inform themselves about the research and literature regarding regulation, and specifically about psychotherapy regulation; and to consult more, more widely, and more openly i.e., to listen to and act on what the profession says. At present, all the members of the Board are appointed by the Minister of Health. Some RAs, e.g., the Nursing Council, have members who are elected by the profession; we suggest that within the current system, this is something that the psychotherapy profession could and should represent to the Board (see also MoH, n.d.).

Juvenal, the Roman poet, asked the question: "*Quis custodiet ipsos custodies*" ("*Who guards the guards?*"). In the first edition of this book, Keith suggested that, in response to the Board's activities, we needed to consider "Who regulates the regulators?" (Tudor, 2011). Both Paul Bailey and Jonathan had anticipated this: Bailey in 2004 coundelled that the profession would need to stay "strong and watchful" (p. 37); and, in 2005, Jonathan predicted that, as a result of registration, the work of the NZAP "will predictably shift to advising and collaborating with (or, if necessary, contesting) board policy" (p. 32) — and so it has proved and, sadly, will, no doubt, continue to prove. Interestingly, these concerns anticipated those in some of the submissions to the recent review of the *HPCA Act* (MoH, n.d.), and, from the government statement about the review, it is likely that one of the revisions of the *Act* will address this concern (see MoH, 2016).

Whatever the future holds for the profession of psychotherapy in Aotearoa New Zealand, we can only hope that the current PBANZ (and future configurations of it) will adopt what Paul Bailey envisaged as a "radical non–intervention" model of and approach to regulation (see Chapter 4) — and that we and others will continue to challenge it when it doesn't. Looking internationally, we hope this particular case study offers a cautionary tale to other psychotherapists who might be considering the statutory regulation of our practice and profession.

Public statutes

Health Practitioners Competence Assurance Act 2003.

Public Health and Disability Act 2000.

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PART III

Reflections on and responses to regulation and registration

Chapter 8

The question of regulation and registration

Keith Tudor

The two chapters in Part I of this book define the key terms of this critical enquiry: recognition, regulation, registration, and competence, as well as some distinctions between these terms. The chapters in Part II consider various aspects of the registration of psychotherapists, including (in Chapter 6) the nature of the *Health Practitioners Competence Assurance Act 2003* ("the *HPCA Act*" or "the *Act*"), and (in Chapter 7) the work of the Psychotherapists Board of Aotearoa New Zealand ("PBANZ" or "the Board"). As noted in Chapter 6, the *HPCA Act* is a restrictive piece of legislation. Its provisions, as outlined in Section (s)4, "prohibit persons who are not qualified to be registered as health practitioners of a profession from claiming or implying to be health practitioners of that profession", and restrict the provision of certain health services only to health practitioners who are permitted (by the legislation) to perform those activities. Just over 90 years ago, writing in response to moves to restrict the licensing of analysts to qualified medical practitioners and, thereby, to exclude lay analysts, Freud (1926/1959a) wrote that: "The reason for this restriction then becomes a matter for enquiry". (p. 183) This chapter, which has been revised for this edition, constitutes such an enquiry.

In the first part of the chapter, and drawing on philosophical perspectives, I discuss a number of assumptions which influence contemporary debates about the statutory regulation of psychotherapy and counselling, and the state registration of its practitioners; in the second part, I review and rebut the principal arguments for registration and regulation; and, in the third part of the chapter, I present and summarise the arguments against the state registration of psychotherapists and, more broadly, the statutory regulation of psychotherapy as a profession and a field.

Assertions, assumptions, and arguments

Most if not all of the "arguments" put forward in favour of statutory regulation and the state registration of psychotherapists, counsellors and other psychological therapists, such as art therapists and music therapists (who have sought to be included under the *Act*) — and, for that matter, of psychologists and other professionals already covered by the *Act* — are based on assertions and assumptions rather than substantial arguments. For example, in the article on which I draw for its useful taxonomy of models of regulation (Macleod & McSherry, 2007), the authors predicate their pro–regulatory stance on the assertion that "it is necessary to regulate all mental healthcare practitioners given the inherent power imbalance in the therapeutic relationship" (p. 46), a point and subject to which the authors do not return.

An assertion is a speech act in which something is claimed to hold or to be the case. Whilst simple assertions are less sound than robust arguments, from a philosophical perspective they are viewed as natural expressions of cognitive attitudes and, often, as having some "assertoric force" (see Frege, 1918/1980), and hence are important for revealing these attitudes, as well as the theories of knowledge and belief on which they rest. In logic, an assumption is the minor premise of a syllogism, a particular kind of three part argument, and, in general terms, refers to the basis of an argument, usually an unexamined basis or supposition. I refer to syllogisms as they are particularly relevant in examining persuasion as they include assumptions that many people accept but which allow false statements or often unspoken conclusions to appear to be true. Thus, for example, the assertion that professional regulation protects the public, when subjected to some logical analysis, appears thus:

The public are in need of protection,
Unregistered practitioners harm the public,
Therefore, registered practitioners protect the public.

In this syllogism, the first statement is a general statement, which outlines the major premise; the second is a specific statement of the minor premise; and the third statement is the conclusion based on the two premises.

One of my aims in writing this chapter six years ago was to expose and examine some of the assertions and underlying assumptions made about regulation and registration, in order to help move the debate from one based largely on fear, caution, conservatism, unexamined assumptions, and misinformation, to one characterised by more robust, logical arguments based on propositional statements, proof and evidence. In the discussions within the New Zealand Association of Psychotherapists (NZAP) about and leading up to registration and regulation, there was a distinct lack of informed or robust debate; it is clear that the members of the NZAP working party tasked to investigate the matter did not read the research or literature on the subject (see Chapters 3 and 4); and, from conversations I have had since 2009, it is also clear that those who at the time (from around 2004 through to 2009) were raising concerns and cautions felt discounted and, at one point "shouted down". Moreover, in the context of the zeitgeist and current hegemony of "evidence–based practice", and the concern of some of the proponents of regulation about the research evidence for the benefits of psychotherapy, it is somewhat ironic that the evidence–base for regulation and registration was — and remains — largely unexamined, and that much of the work and many of the policies of "responsible authorities" (Boards and Councils) under the *Act*, remain unexamined and unchallenged.

In a chapter published two years after his seminal book on the subject of registration, Mowbray (1997) identified four unassessed assumptions which underlie and perpetuate most "arguments" in favour of regulation and registration, which, here, I apply to the situation in Aotearoa New Zealand — then and now — and to which I add a fifth.

The assumption of inevitability

This assumption underpins and perpetuates the view that that statutory regulation and state registration is inevitable. This was the implicit

assumption from which Bailey (2004), the principal proponent of psychotherapy registration in this country, began his article about the history of registration, when he asked the reader (members of the NZAP) "what would happen if psychotherapy were not registered?" (p. 31) Apart from being an example of the confusion of registration (of title) with regulation (of the field/profession), this rhetorical question reflects a reactive and overadapted position on regulation and registration based on fear. As an "emotional system" (Panksepp, 1998), fear appeared much in evidence in the debate about registration, both from those who felt or feel they have to register (for fear of loss of title, position, status, and income), and from those who, in the early days, attempted to persuade others to register (often by means of fear–mongering about loss of title, position, etc.). Just as the first edition of this book was going to press (in December 2010), the Board was escalating such fear–mongering as it wrote to practitioners who had not paid their APC renewal fees threatening letters containing inaccurate information (for details of which see Tudor, 2011).

The assumption of necessity

There is an assumption that the incidence of harm arising from malpractice (or perceived harm or malpractice) is so great that it warrants the remedial action of statutory regulation. Indeed, it is the assumption of the Act, and it is the same assumption that led to the passing of the *Tohunga Suppression Act 1907* which outlawed traditional Māori health practices, and which was repealed just 55 years ago (in 1962) (see Woodard, 2014) — and is an assumption which needs to be tested. Interestingly, Freud (1929/1956) wrote in favour of "peasant healers". In its discussion document "How Do We Determine if Statutory Regulation is the Most Appropriate Way to Regulate Health Professions?" the MoH (2010b) made the point that, as outlined under (s)116 of the *Act*, the Minister has to be satisfied that either the provision of the (proposed) health services concerned "poses a risk of harm to the public" (s116(a)(i)), or "that it is otherwise in the public interest that the provision of health services be regulated as a profession under this *Act*" (s116(a)(i)) (for responses to which, see Chapter 1, and below).

The assumption of benefit

This refers to the assumptions that the statutory regulation and state registration of a group of practitioners or a profession a) protects the public; and b) is of benefit to the public; and, specifically, that a registered practitioner is more beneficial to her/his client than is a non registered practitioner. This reasoning, however, is flawed on two grounds: firstly, it presupposes that such regulation protects the public. As it does not, then this argument fails. Secondly, assuming that this assertion includes all registered practitioners (which, according to the logic of regulation, it should), then, even if a single non registered practitioner/provider benefits a member of the public, then this argument too fails. In philosophical logic, this is known as the fallacy of illicit process.

In the discussions within the NZAP, this assumption was promoted as a major argument for state registration by Paul Bailey (see Chapter 4) and others. In addition to this assumption being a philosophical fallacy, the evidence from recent research (Tudor, 2017) reveals that the registration of psychotherapists has been of very little benefit to the public.

The assumption of preference

The final assumption identified by Mowbray (1997) is predicated on the previous two assumptions (of necessity and benefit) and adds a further two, i.e., that a) there is an unmet need for public protection — which, in the case of the NZAP's argument was not proven and more generally is not proven (see pp. 196–198 below); and b) that the regulation of the particular activity or profession is the preferable way to meet this need — which is debatable.

If those in favour of state registration and statutory regulation were or are interested in logical argument, they should be arguing and providing robust evidence for the following:

1. That the practice of psychotherapy poses a risk of harm to the public; and
2. That this risk of harm is significant and evidential.
3. That psychotherapists could/can not satisfactorily regulate themselves;
4. That existing or previously existing regulatory or other mechanisms fail(ed) to address health and safety issues in any other way; and

5. That this problem (of risk) was unlikely to be solved in any other way or was/is inefficient or ineffective to solve in any other way.
6. That the state registration of psychotherapists and the wider statutory regulation of psychotherapy as a profession is of direct and evidential benefit to the public;
7. That this represents a minimum amount of intervention to solve the problem (of risk);
8. That the benefits of this intervention clearly outweigh the potential negative impact of such regulation, including that they exceed the costs; and
9. That it was/is in the public interest that practitioners providing psychotherapy services be regulated as a profession.
10. That this form of regulation under the *HPCA Act* or equivalent legislation was/is a preferred option to all others; and
11. That this warrants the state registration of psychotherapists and the statutory regulation of psychotherapy.

These statements form a series of logical propositions and steps, based in part on criteria and tests outlined by the Ministry of Health (2010b) in its discussion document on statutory regulation and health professions. I have not read or heard of any argument from any proponent of the state registration psychotherapists and the wider statutory regulation of psychotherapy come anywhere near addressing or fulfilling such logical requirements, either here in Aotearoa New Zealand or in others countries contemplating such regulation.

The assumption of irreversibility

To Mowbray's four assumptions, I add a fifth, which is relevant to those countries in which psychotherapy has been regulated by the state, as it has here in Aotearoa New Zealand, that is, the assumption that statutory regulation is irreversible.

Whilst registration of the title "psychotherapist" has taken place in a number of countries, and, depending on the legislation and how it is administered, the wider regulation of the profession, not all practitioners offering psychotherapy are registered or regulated or, according to the New Zealand Director–General of Health (2009) and the Ministry of Health

(MoH) (2010b), need to be. Furthermore, in New Zealand, the *HPCA Act* is under regular review (see Chapter 6), will certainly be amended, and could always be repealed. Currently, 25% of the membership of the New Zealand Association of Psychotherapists and the New Zealand Association of Child and Adolescent Psychotherapists are not registered; and the profession as a whole could decide to withdraw from state registration and further statutory regulation.

Regulation is a political issue with clear ideological undertones, and, as governments change, so, too, do their respective appetites for regulation. Moreover, as Crocket points out (in Chapter 15), since 2010, the (same) New Zealand government has changed its approach regulation of additional professions under the *HPCA Act*, and those that had applied for consideration — i.e., acupuncturists, anaesthetic technicians, clinical physiologists, counsellors, music therapists, speech language therapists, and western medical herbalists (MoH, 2010) — have been put on hold. Also, ideas about standards change and, as I note (in section 1.1, below), the MoH now has a different threshold of risk for considering such professions (MoH, 2010b), from which, it is clear that, if the NZAP were applying now for psychotherapy to be regulated under the *HPCA Act*, it would not be considered.

Just as governments change, so too, professions change, and the psychotherapy profession in any country in which it is regulated could decide to withdraw from it. In this country, we could follow our counselling colleagues in the New Zealand Association of Counsellors and (re–)establish NZAP's system of self–regulation — or adopt a mixed model of regulation as proposed by Crocket (see Chapter 15). We could also propose regulation, alongside some of the professions above, under a more relevant piece of legislation.

Founded on a lie (as noted in the Introduction), the state registration of psychotherapists and the wider regulation of psychotherapy in Aotearoa New Zealand lacks integrity; is irrelevant to a significant proportion of practitioners (health care providers), and especially those not working in the public health sector; has been divisive; and is not irreversible. Despite this, I think that is unlikely that the psychotherapy profession in Aotearoa New Zealand will reverse its decision, mainly because the majority of the profession don't care enough about it; like being able to refer to themselves

as registered psychotherapists (which, of course, is a tautology); and have settled into an easy acceptance of the status quo, whatever the Board proposes or enacts.

Nevertheless, it is important to acknowledge this assumption, partly to inform (and, hopefully, discourage) others, and to encourage the NZAP to acknowledge and preferably promote a pluralistic perspective on registration and regulation. At one level this is simply acknowledging the fact that the 20% of NZAP members who are not registered with the Board (or any other RA) are, in effect, regulated by the NZAP. The only people who would be against this would be those colleagues who are, in effect, unilateralist about registration and regulation, i.e., those who represent the most restrictive of Macleod and McSherry's (2007) models of regulation (see Chapter 1), a model, it should be noted, that is not represented by the *HPCA Act* (for further discussion and a summary of which see also Chapter 19).

The elaboration of these five assumptions is useful in exposing the basis of the argument — or, rather, the assumptions and assertions underlying the arguments in favour of regulation and registration, to which I now turn. In this and the third part of the chapter, I have numbered the sections and arguments, partly in acknowledgement of the tradition of philosophical logic on which this chapter draws and partly for ease of reference to the argument.

1. Arguments for regulation and registration — and rebuttals

1.1 That the practice of psychotherapy poses a significant risk of harm to the public

In its discussion document on statutory regulation, the Ministry of Health (2010b) commented that the risk of harm is a "low test", since any health service carries some risk if performed inadequately, and posed the question as to whether a profession must be involved in at least two of the following activities in order to establish a risk of harm:

- invasive procedures (such as cutting under the skin)
- clinical intervention with the potential for harm

- making decisions or exercising judgement which can substantially impact on patient health or welfare, including situations where individuals work autonomously, i.e. unsupervised by other health professionals.

Here we can see the medical provenance of these activities and criteria, and the medical influence on the concept of risk of harm. This stands in stark contrast to writers such as Freud (1926/1959a) who argued for the independence of (then) psycho–analysis and the comparative safety of analysis, compared with other, medical interventions. This is echoed by more recent surveys of research which suggest that, compared with medical and surgical procedures, psychotherapy and counselling have a large, positive effect (see Cooper, 2008).

In its analysis of submissions made in response to this discussion document, the Ministry of Health (2010c) reported that 42% of respondents agreed that a profession should be involved in at least two of these activities to warrant the assessment that the practice constitutes a risk of harm.

In its submission to the Ministry of Health, the NZAP defined this risk in the following terms:

1. That some psychotherapy has a negative effect, citing the fact that "some clients get worse"; and
2. That "some clients … appear to be susceptible to worsening".
3. That "there is a link between therapist attitudes and deterioration".
4. That some clients feel harmed by psychotherapy. This is explained with reference to a view that such harm is connected with the therapist's retreat to a theoretical position when challenged or questioned by a client; and with reference to a general statement which confirms the existence of unethical practice. (MoH, 2003)

The difference between the first two points is not made clear, and no citation, reference or evidence is given for the statement in point 3.

The NZAP then presented "some" (two) voices which "confirm the risk of harm by the practice of the profession", one of whom refers to the harm caused by poorly trained and supervised practitioners, and by inadequately trained practitioners; and other of whom reports the (one) example of a practitioner who claimed to have qualifications and a status that she did not

have. Both statements, which amount to just over 1,000 words, are entirely anecdotal; they contain no references to any published evidence, or debate, or literature review; and make unwarranted leaps of logic e.g., from the problem of poor or inadequate training and poor supervision to the "solution" of regulation. Neither in this submission or in any other published account:

- Was there any discussion about what constitutes harm.
- Was any distinction made between harm and relapse.
- Was any evidence advanced that there was a significant risk of harm to the patient/client from the practice of psychotherapy.
- Was there any discussion of when there is risk whether it can be demonstrated that this is a consequence of practitioner incompetence.
- Was there any comparison made between the risk of harm in psychotherapy with other activities for which no demand is made for regulation.
- Was any consideration given to the balance of the degree of harm which may occur set against the harm deriving from the institution of a regulatory system, a test required by the Ministry of Health (2010a).

The low level of argument in this submission for this "low test" is all too evident — and, given this, it is somewhat surprising (at least to this author) that this submission was not simply rejected out of hand.

A later statement about the impact of regulation, the MoH (2007) made it clear that "The objective of this proposal is to protect the health and safety of members of the public by providing mechanisms to ensure that psychotherapists are competent and fit to practise their profession" — but then does not refer to protection again!

There are three principal rebuttals of this argument about risk of harm:

a. That the practice of psychotherapy does not constitute a significant risk and, arguably, does not constitute such a risk in terms of the criteria or tests applied by the New Zealand MoH (2010b), which was clearly wanting to raise the level of the risk criterion for professions seeking to register under the *Act*.
b. That the practice of psychotherapy inevitably involves risk, a point that should be made clear to clients who can — and should — be more

trusted to assess the practitioner with whom they choose to work; and is a reality which is covered by the *Code of Health and Disability Services Consumers' Rights* ("the *Code*") (Health and Disability Commissioner [H&DC], 1996; see Appendix 2). However, neither the prediction or prevention of risk, or the repair of any harm caused is guaranteed by the state registration of practitioners but, rather, by good training and supervision (see Chapter 10); by certain qualities (see Freud, 1926/1959a); and by the practitioner being a decent human being, for which there is no guarantee through legislation or regulation.

c. That, whether or not psychotherapy constitutes a risk, as a society we make too much of risk and are becoming a risk averse society (see Gardner, 2009), based on and perpetuated by a culture of fear (see Furedi, 2002), which, from a psychosocial perspective we might consider challenging.

Striano (1988) described a number of ways in which psychotherapists actually can and do hurt or harm their clients: by mistakenly diagnosing symptoms of a physical illness as "psychological"; by subtle financial exploitation; by encouraging dependency; by entrapment in cult–like systems; by pathological labelling; by extreme passivity; by encouraging introspection at the expense of practical action in the world; and by compounding low self–esteem. It is unlikely that a conventional regulatory system would provide an effective means of responding to or protecting against these hurtful or harmful attitudes and experiences. Mowbray (1995) took this rebuttal further when he argued that regulatory and accrediting systems actually increase the risk of harm to the public as they promote a myth that the public can be protected against the difficulties of choice in this area of life, dynamics he referred to as a myth which is indicative of a process of "institutionalizing the transference" (p. 129). He continued:

> we have the very occupation which should know better pursuing the myth of accreditation ... and seeking "official recognition", statutory privilege and monopoly. By doing so transference would become institutionalized in the sense that the practitioner's status as "expert" would become endorsed by the state and his or her authority commensurately enhanced. Transference, and

> regression, are encouraged by anything that encourages you to "look up". (p. 130)

1.2 That such registration and regulation protect the public

This is perhaps the most common assertion about the benefit of registration and is predicated on and, therefore, follows from the previous argument. There is, however, no evidence to support this (see Gross, 1978; Hogan, 1979; Koocher, 1979; Alberding, Lauver & Patnoe, 1993; Mowbray, 1995; House, 2009), and, as outlined (p. 188 above), no logic to the argument:

> Regulatory systems are supposed to protect the public through certain mechanisms or functions, such as the establishment of entry requirements, disciplinary provisions and procedures; and/or the prevention of unlicensed practice. Here, these suppositions or assumptions are examined briefly.

1.2.1 By means of the establishment of entry requirements

This represents what in economics is referred to as a form of "input regulation" of a market for goods and services, and is intended to exclude the incompetent supplier (see Mowbray, 1995). However, this mechanism applies in the context of goods or services about which the consumer cannot be expected to know, for example, in a situation in which the body of knowledge involved is so specialised, obscure or arcane and, therefore, does not apply to a situation in which the service concerned involves the relationship between consumer and supplier. On this, Mowbray (1995) commented that:

> The rationales used to justify statutory regulation (e.g. specialist knowledge) also usually ensure that the regulatory mechanism is largely under the influence of the profession in question. Hence … a prevalent tendency is for entry requirements to be distorted in favour of the profession rather than in the interests of the public as a whole. (p. 80)

1.2.2 By means of the establishment of provisions for disciplining wayward registrants

It is suggested that the fact of regulation and registration, and the existence of mechanisms whereby practitioners can be disciplined, in itself protects the public. However, studies of disciplinary enforcement in the United States of America (USA) reveal that disciplinary action is extremely ineffective as a means of protecting the public (see Jervey, 1961; Hogan, 1979). Such mechanisms may make it easier to shut the stable door and even punish the horse, but only after it has bolted — and, presumably, if you can catch it! Moreover, it is doubtful that regulation does or can protect the public against bad character or human error. Indeed, it is rather obvious that registration clearly does not protect the public in respect of "bad character" in that the majority of practitioners who have been found to have abused clients have been registered. The fact, for example, that the British serial killer, Dr Harold Shipman, was registered with the British General Medical Council did not protect any of his over 200 victims from his lethal ministrations over some 27 years. In his foreword to Hogan's work Slovenko (1979) commented on the relationship between discipline and protection:

> In virtually every profession … disciplinary enforcement is virtually nonexistent. The little enforcement that is applied does not act as a deterrent and is often done to protect the reputation or economic interest of the group rather than protect the public from harm.

Furthermore, if most of the violations for which practitioners are disciplined are actionable under existing criminal and civil law, this makes such provisions redundant or superfluous (see Hogan, 1979; and p. 198 below). Set against this, however, is evidence from the Health Practitioners' Disciplinary Tribunal (2010) which suggests that most disciplinary actions are taken against various forms of professional misconduct, not crimes: in the seven year period from 2004 to 2010, of 138 guilty findings, 106 (77%) concerned professional misconduct and 32 (23%) criminal convictions.

1.2.3 By means of the empowerment of authorities to prevent unlicensed practice or use of title

The rationale for this is more to do with the protection of the profession than of the public; indeed, those most likely to complain about unregistered

practitioners are not members of the public but, rather, practitioners who are registered or who have a license and increasingly so at times when the profession is under usually economic threat (see Pfeffer, 1974; Rayack, 1975; Hogan, 1979). In Aotearoa New Zealand, and especially in the years 2009–2012, we experienced and saw colleagues reporting non registered colleagues to the PBANZ, and the Board pursuing and threatening unregistered health care providers, even though they were (and are) practising within the law. For a short period, there was a person who was contacting unregistered health care providers and trying to trap them into presenting themselves as psychotherapists.

As discussed in Chapter 6, there is an important distinction between unlicensed practice (which is permitted) and illegitimate claim to title (which is not), a distinction which the PBANZ did and does not appear to appreciate.

Insofar as the public can be protected against sharp practice, rogue traders, charlatans serial killers, or psychotherapists with bad "therapist attitudes", there are other effective mechanisms including:

- Existing legislation and codes — such as the *Consumer Guarentees Act 1993*, the *Health and Disability Commissioner Act 1994* and the *Code* (H&DC, 1996; also see Chapter 6), and the *Protected Disclosures Act 2000*.
- Common law duty of care — as enshrined in the *Code*, and fiduciary duty (see Ludbrook, 2012 for further details and case law); and claims for negligence, and personal injury.
- "Custom and practice" — such as the requirements and expectations of recognised good practice, and the requirements of existing professional associations, for instance, for training, personal therapy, qualification, experience, regular supervision and continuing professional development: all forms of internal, professional and peer regulation which protect the public (see Chapter 10).

With regard to "discipline", s100(1) of the *Act* sets out seven grounds for discipline:

1. Misconduct (that amounts to malpractice or negligence).

2. Misconduct (that has brought or is likely to bring discredit on the profession).
3. Conviction of an offence that reflects adversely on the practitioner's fitness to practice.
4. Practising without a certificate.
5. Practising outside the practitioner's scope of practice.
6. Failing to observe conditions on the scope of practice.
7. Breaching an order of the Tribunal.

The last four refer to "discipline" within the framework of the *Act*, but, if we consider the first three in terms of the NZAP's (2002) *Code of Ethics*, we can see that it covers such situations. The *Code of Ethics* is oriented to stewardship and public safety and structured with the following hierarchy of responsibilities: firstly, to clients (which includes point 1 above); secondly, to the practitioner her/himself, colleagues, and the profession (point 2); thirdly, to the wider community; and, fourthly, to employing institutions (and other authorities, including, the PBANZ). In terms of the NZAP's complaints process, the basic orientation is towards restorative rather than retributive justice, and to remedial education rather than punishment. Depending upon the severity of the misconduct, a practitioner might be prescribed a period of focal supervision with a report back to the Complaints Assessment Committee at its conclusion. If there is ill intent rather than honest mistake, as is clearly the case with sexual or financial exploitation, the member may be reported to the Health and Disability Commissioner (see the *Code* (H&DC, 1996)), and may be suspended or expelled from the Association, 'though in practice this has been the exception and not the rule. Other than Bert Potter and Centrepoint (see Chapter 11), the NZAP has had no cases where the profession was brought into public disrepute separately from a specific breach of its *Code of Ethic*s. A couple of issues regarding fitness to practice (point 3 above) have been appropriately and delicately handled by nominated senior members of the Association. Whilst practising without a certificate (point 4) has never been an issue as membership in the Association is entirely voluntary, members have been asked to correct ambiguous wording on their advertising.

In this case, some people argued — and, elsewhere, others argue — that psychotherapy should be regulated because other professions or trades are regulated (see section 1.5, pp. 203–204 below). However, with reference to

the "public protection" arguments, what this ignores is that the activity of psychotherapy is quite different from the professions with which it is often compared, for example:

- In terms of the authority and competence of those other professions to act without the client being fully involved, in that many medical procedures involve the health/medical practitioner treating the patient who, indeed, may be unconscious (see Brown & Mowbray, 1990).
- In terms of the emphasis in psychotherapy on and value of the quality of meeting or encounter between people (or encounter), which, in other forms of health care practice, may be incidental.
- With regard to its principle medium of and focus on the therapeutic relationship.
- With regard to its foundation on authenticity (see Totton, 1992; and Chapter 11).
- In terms of its purpose in helping people to move away from social norms and conformity, which is rarely the purpose of health care/medical treatment.

With regard to professions regulated under the *HPCA Act*, in terms of theory, origins, and practice, psychotherapy has little in common with any of the other professions apart from psychology, a point which might suggest that these two (and, possibly other practitioners of psychological, talking and creative therapies) would be more appropriately registered under a psychological practitioners Act.

It is clear that the state registration of health practitioners does not axiomatically protect the public, a point which Seán Manning (2010), then the President of the NZAP, acknowledged when he said that he accepted that there was not much evidence that statutory regulation protects anyone.

1.3 That registered/licensed practitioners are less harmful than those who are not registered

The logic of this argument relies on causation: that it is the fact that the practitioner is (or was) unregistered that causes or caused the harm and that this factor (of non registration) can be isolated as the sole cause and explanation of harm. Again, there is no evidence that this is the case in the field of psychotherapy (on which, see Bergin, 1966; Mays & Franks, 1985;

Striano, 1988); this argument simply is not proven (see British Association for Behavioural Psychotherapy, 1978; Mowbray, 1995, 1997). It is, nevertheless, a significant assertion and one that forms the basis for the justification of the registration of educators/trainers of psychotherapists (see Chapter 7).

This particular argument or assumption has always interested me as, even the most vigorous proponents of registration, when asked to recommend a colleague, will often go through a register and make comments about individuals, including why they would not recommend them and, in some cases, why they think they are unethical, harmful, abusive, and/or even mentally ill! Whether or not we participate in or condone this kind of informal assessment, it is common practice amongst colleagues in every profession. What is significant about it in the context of this current critical study is that it undermines the logic of registration as a reliable and agreed standard to which all regulated and registered practitioners could — and, arguably, should — subscribe, and/or "stand by" their colleagues. In other words, a registered psychotherapist who is convinced about state registration and/or statutory regulation should only recommend registered colleagues. If they recommend practitioners who are not registered, they undermine the logic of the exclusivity of state registration — and the reliability and exclusive standard of that registration/regulation. However, in reality, it is clear that neither qualification or certification, nor registration or regulation guarantee good practice, good practitioners, or automatic referrals. 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. (p. 283)

It is also significant that the debates about registration are conducted almost entirely without reference to or consultation with clients. For their part, clients do not appear prejudiced about registration. As Freud (1926/1959a) put it: "professional prejudices find no echo in them and that they are ready to accept a cure from whatever direction it is offered to them". (p. 245)

1.3.1 That registered/licensed practitioners are less harmful as educators/trainers than those who are not registered

When applied to educators and trainers, the argument that registered/licensed practitioners are less harmful than those who are not stretches causality to breaking point as it implies:

a. That any registered health practitioner is less harmful (presumably to the student/trainee) than an experienced, qualified and/or accredited educator/trainer; and
b. That, as a result of being educated/trained by the registered health practitioner, that the student/trainee is, thereby, a less harmful practitioner.

In the absence of evidence that clients of practitioners taught by unregistered health practitioner educators (who, of course, may be experienced, qualified, accredited and/or registered teachers/trainers), the requirement that psychotherapy educators must be registered health practitioners is prejudiced, political — and personal (see also section 2.4, below).

1.4 That the statutory regulation of psychotherapy leads to its greater acceptability and, therefore, to its greater availability to the public

Again these are common assertions or claims in the debate for regulation (see, for instance, Young, 1990) and, again, no hard evidence is advanced to support them. There are a number of strands to this assertion which concern acceptability, availability, and the public (interest).

1.4.1 With regard to its acceptability

For a title to be protected appears attractive: it and the professionals who can claim it become an accepted and acceptable part of the state system. However, this acceptance and incorporation into the public health system is not without its cost.

For some, “state psychotherapy” is a contradiction in terms. If psychotherapy is concerned with insight, understanding, awareness, autonomy, reflexivity, and intersubjectivity, it makes little sense that these outcomes are facilitated by someone who is regulated by statute and

ultimately answerable to the state through an "authority" such as the Board (see Parker & Revelli, 2008; Rogers, 2009; and Chapter 11). In the history of psychotherapy there are examples of where the state has controlled psychotherapy e.g., in Germany during the Third Reich (see Cocks, 1985); and of psychotherapists colluding with the state e.g., when American psychotherapists reported their communist clients to the USA Senate's Committee for Unamerican Activities (see Schwartz, 1999). Some colleagues, including Bailey (2004), argued that psychotherapy should be registered because the state favours registered professions, an argument which not only represents a state–centred perspective on psychotherapy as distinct from a client/patient–centred approach, but is also inaccurate, as is revealed by documents from the MoH (see, for instance, MoH, 2010b) which stated its openness to professional self–regulation and, in effect, to pluralism.

With regard to arguments about registration and regulation, the acceptability of psychotherapy is, without exception, linked to its location, provision, or proposed or supposed provision in the public sector. In Aotearoa New Zealand, this argument is somewhat undermined by the fact that 94% of generic psychotherapists work in the private sector (Tudor, 2017).

The acceptance of psychotherapy in the health sector, in West societies, is dominated by the medical model, the biomedical paradigm, and illness discourse. Despite Freud's (1926/1959a) arguments for lay analysis and his strong independent stance with regard to medicine — "For we do not consider it at all desirable for psycho–analysts to be swallowed up by medicine and to find its last resting–place in a text book of psychiatry under the heading 'Methods of Treatment' "(p. 248) — the medical model of diagnosis, treatment, and cure is dominant. This dominance has infiltrated psychotherapy and counselling training in much of which undue emphasis is given to medical/psychiatric diagnostic systems and thinking. In this regard, it is as if psychotherapy theory and practice is underconfident in its own distinct approach to psyche and therapy, and its own independent professional identity. There is a real danger that, in wanting to become accepted and acceptable, psychotherapy loses its identity, its own psychotherapeutic theories and practice, and becomes another profession allied — and subservient — to medicine, for a critique of which see

Sanders (2006). This argument also assumes that psychotherapy is best linked with other mainstream "health" professionals and professions rather than alternative and/or complementary health practice and practitioners or, indeed, other social care professionals and professions.

1.4.2 With regard to its availability

The notion that when psychotherapy is regulated by statute it becomes more available to the public is just that: a notion. It assumes a lot about how psychotherapy is understood and viewed by the state, its politicians, economists, managers, and administrators. This argument, in effect, places psychotherapy in the hands of the state — and the experience, certainly from the United Kingdom (UK) is that these are not gentle, caring, or respectful hands. Some forms of psychotherapy may become more available, but these tend to be the shorter forms of so–called "evidence–based" therapies, with the evidence, methodology, form and manualised treatment determined by the government. For example, in the UK, as a result of the "Layard agenda" (Layard, 2005), the government's initiative for Improving Access to Psychological Therapies (see www.iapt.nhs.uk) (note the plural) only regards and promotes cognitive behavioural therapy as the singular evidence–based talking therapy of choice — that is, the government's singular choice (for a critique of which see House & Loewenthal 2008; Tudor, 2008); and longer–term psychodynamic and humanistic psychotherapies are being marginalised. Recent research has demonstrated that the state registration of psychotherapists in Aotearoa New Zealand has not led to any significant increase in the availability of psychotherapy in the public sector (Tudor, 2017). Registration and regulation is no guarantor of greater public access to the plurality of psychotherapies. On the other hand, the decision of a politician or policy maker would have an impact on such availability.

1.4.3 With regard to the public interest

If these two previous assertions were true — that psychotherapy regulated by statute would be more acceptable and more available — then there might be an argument that regulation would be in the public interest. However, as the first two assertions are not proven, it is hard to see how the "public interest" arguments stands. Moreover, as Pfeffer (1974) put it:

> 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)

He 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 … [and] 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)

1.5 That state registration enhances the profession, especially with regard to other "health professions" and "health practitioners"

This is another common argument, often based on following the precedent of another profession or discipline, thus: psychologists are registered, so psychotherapists should be registered, and so on — and, indeed, this argument was made explicitly by some practitioners within the NZAP: "I think we should go for registration as all the other health providers will be. If we don't we lose credibility." (Smith quoted in Manning, 2006, p. 28) Of course this also creates an invidious domino effect whereby other disciplines then argue for registration on the basis that psychotherapists are registered, and so on. Whatever the merits of this argument (see below), the enhancement of the profession is clearly not the purpose of the *Act*, which is concerned with the protection of the public and not the enhancement of professions (see Chapter 6). Leaving aside (for a moment) the fact that this argument should not be used as an argument for state regulation, we may see that the argument is based on two assumptions: a) that psychotherapy is a "health profession"; and b) that psychotherapy should seek its enhancement, authority and credibility from the health care/illness sector with which it is best allied.

As to whether psychotherapy is a health profession

Whilst some psychotherapists do identify as health professionals, both in terms of the *Act* and, more broadly, the paradigm, the idea that psychotherapy is per se a health profession is debatable and, indeed, highly disputed (see, for example, Association of Independent Psychotherapists et al., 2009a, 2009b; Edwards, 2009; Gloster–Smith, 2009; Rogers, 2009). It may be common to describe psychotherapy as a health profession, but this in itself is not a sufficient argument and, in any, case, is only partial as it excludes those therapists not working in the health sector, for example, in industry, prisons, private practice, schools, etc. The predominant focus on health is perhaps even more surprising when we consider that the MoH (2007) document on the regulation of psychotherapy stated that (only) 5% of psychotherapy practitioners (then estimated at a total of 386 in the country) were then currently employed in the public health sector by District Health Boards (DHBs).

Even those psychotherapists who consider themselves to be "health practitioners" do not describe themselves in the same way as medical or other "health" practitioners. Many if not most psychotherapists have very different understandings and analyses of health, illness, treatment and cure than those in professions allied to medicine. Many psychotherapists promote insight, understanding, and even change, as distinct from "cure". Those within psychoanalytic and psychodynamic traditions tend to be more interested in helping patients or clients reconcile the ego with unconscious drives; behaviourists tend to be interested in changing behaviour; those in the humanistic tradition tend to think about client growth and creativity in terms of the fact that the organism tends to actualise. Despite the fact that psychoanalysts and psychodynamic psychotherapists still us the term "patient", for the most part, these traditions do not frame the client (or patient) in terms of the medical model. Freud (1927/1959b) himself was very clear that psycho–analysis was not a specialised branch of medicine:

> Psycho–analysis is a part of psychology; not of medical psychology in the old sense, not of the psychology of morbid processes, but simply of psychology. It is certainly not the whole of psychology, but its sub — structure and perhaps even its entire foundation. The possibility of its application to medical purposes

> must not lead us astray. Electricity and radiology also have their medical application, but the science to which they both belong is none the less physics. (p. 252)

If we define psychotherapy as a health profession in the context that, in effect, "health" is most commonly interpreted to refer to illness (see Tudor, 1996, 2004), and especially in the context of the *HPCA Act*, we run the risk of medicalising psychotherapy: both its practitioners and the field itself, and. By the same logic, if we do not seek to medicalise either distress (see Sanders, 2006), or the profession, we should not seek regulation as a health profession and, with it, the risk of pathologising our clients, and paying insufficient attention to human growth and potential. A serious risk for psychotherapists is that, over time, the framework of the *Act* may have a subtle but significant impact in influencing their thinking about their work and their clients through mimicking the medical model.

Significantly, the *Act* makes — or attempts to make — such debates redundant. As psychotherapists are defined under the *Act* as "health professionals", if a person who practises psychotherapy does not define her/himself as a health professional, s/he cannot refer to her/himself as a psychotherapist. Thus the *Act* represents and, literally, enacts a closed system, supported by a circular argument which limits professional identity, and a self–sealing doctrine (Riebel, 2000) of regulation which attempts to limit freedom of practice, expression, and thought. This argument has considerable practical significance in that, whilst unregistered "practitioners" must not claim or imply that they are "health practitioners" (see s4 of the *Act*), under the Health and Disability Commissioner *Act* 1994, they are "health care providers" and, thereby, covered by the *Code* (see H&DC, 1996) (see above).

In an interesting argument that links this critique directly to the role of regulatory "authorities" (Boards or Councils), Wampold (2001) argued that, as the medical model does not adequately explain the benefits of psychotherapy, any psychotherapist registration authority that is established under health legislation is inadequate (see also Association of Independent Psychotherapists et al., 2009b; Edwards, 2009; Rogers, 2009). Psychotherapy is a discipline independent from medicine. Freud (1929/1956) himself was clear about the "inherent value of psycho–analysis

and of its independence of its application to medicine" (p. 254), and favoured psycho–analysis being regarded as a branch of psychology. As Mowbray (1995) put it:

> a perspective that envisages psychotherapy as a treatment and cure business focusing on the illness or problem to be alleviated (i.e., a "medical model" activity) conflicts with a view of it as something primarily concerned with individual authenticity and uniqueness. (p. 14)

There is a parallel here with the argument nearly 100 years ago that psycho–analysts should be medical doctors and that it might damage an analyst's authority if the patient knows that s/he is not a doctor. Freud's (1926/1959a) response to this was to state that:

> For the patient, then, it is a matter of indifference whether the analyst is a doctor or not ... For him it is incomparably more important that the analyst should possess personal qualities that make him trustworthy, and that he should have acquired the knowledge and understanding as well as the experience which alone can make it possible for him to fulfil his task. (p. 244)

Manning (2011; Chapter 17 in this present volume) is somewhat scathing of this critique, arguing that medicine has been trying to get away from itself for some time and that psychotherapy (the couch) converges on and, presumably, has a positive influence on psychotherapy (the surgery). Ironically (in terms of Manning's accusation that the "academic arguments" of some of us writing in this book are "distant from everyday life in the therapy room" (p. 333), I suggest that his is the "unreal, idealist and naïve position. I see no convergence or dialogue between the dominant Western allopathic medical model and, say, homeopathic medicine, let alone indigenous medicine such as rongoā Māori" (see Durie, Potaka, Ratima, & Ratima, 1993). While psychotherapists give (undue) respect and attention to the Diagnostic and Statistical Manuals (of Mental Disorders) published by the American Psychiatric Association (APA), now in its fifth edition (APA, 2013), I don't see doctors expressing much interest in psychotherapeutic ways of describing symptoms, dis–ease or dis–order, or medical educators insisting that their students spend time studying empathy or

countertransference. In the context that psychotherapists in New Zealand form a small proportion (0.46%) of registered health (medical) professionals (see Table 6.1), (and of these only 54 are working in DHBs), I think it is Manning who is distinct from the everyday reality of the dominance of medicine and the medical model. (Of course, I recognise that not all of the other 99.54% of health professionals identify strongly with medicine and the medical model — there are critical psychologists, radical midwives, postmodern physiotherapists — and so on; these, nevertheless, reflect a small minority of health qua health professionals.)

As to whether psychotherapy should seek its enhancement, authority and credibility from the health care/illness sector

Assuming that the profession of psychotherapy should be seeking approval from other health practitioners, there is a question as to whether psychotherapists do or would get it. There is little evidence to suggest that, once psychotherapists are registered, they get more approval across the board from other health professions and professionals; greater access to employment, irrespective of theoretical orientation; equal pay, terms and conditions, commensurate with equivalent qualifications and training; or greater respect for their independent i.e., non medical discipline, perspectives, theories, and/or practice. It is a fact that some New Zealand DHBs employ psychotherapists — 'though only nine out of the 20 DHBs — but these Boards are not employing psychotherapists as a result of them being registered. The fact that a DHB may require a psychotherapist to be registered in order to employ them demonstrates the power of the medical model and managerialism, not of logic, or a concern for public safety.

Finally on this point, a subset of the argument that registration enhances the profession is that registration protects the practitioner. Apart from the fact, again, that the MoH does not support this as a valid argument in favour of registration (MoH, 2010b), there is no evidence to support this and, in any case, arguably, the practitioner is well enough protected by existing legislation which includes: the *Crimes Act 1960*, the *Trespass Act 1980*, the *Summary Offences Act 1981*, the *Domestic Violence Act 1995*, and the *Harassment Act 1997* (see Ludbrook, 2003); and by professional indemnity/liability insurance — which, contrary to the misinformation of the Board (see Tudor, 2011; Box 2.6), does not depend on a health care

practitioner being regulated. I have also heard the argument (assertion) that the *HPCA Act* protects the practitioner by limiting her or his financial liability to the maximum fine that can be imposed by a Health Practitioners' Disciplinary Tribunal. This is not true. Registered practitioners, who are subject to disciplinary action under the *Act*, are also subject to complaints to the Health and Disability Commission (see http://www.hdc.org.nz/) and, ultimately, to a Human Rights Review Tribunal and thus potentially liable to two sets of financial penalties.

In a general rebuttal of these assumptions and arguments in favour of registration, Mowbray (1997) suggested that, given that these arguments are not proven, to continue to argue for or to support regulation and registration, undermines the intellectual integrity and moral responsibility of those professions and professionals.

Having focused on the arguments for regulation and registration, I now turn to those arguments against regulation and registration — and for the freedom to practise.

2. Arguments against state registration and statutory regulation

There are many arguments against statutory regulation in general and against the statutory regulation of psychotherapy and the state registration of psychotherapists in particular. Here, I cluster these arguments under four main headings.

2.1 That such regulation and registration entail a nett harm

In the marketplace, the ancient warning, *caveat emptor* (let the buyer beware), reminded the customer to be mindful about her/his purchase. Freud (1926/1959a) cited this phrase in his discussion about the responsibility of the patient:

> Are the authorities so certain of the right path to salvation that they venture to prevent each man from trying "to be saved after his own fashion".[ ] And granted that many people if left to themselves run into danger and come to grief, would not the authorities do better carefully to mark the limits of the regions

> which are to be regarded as not to be trespassed upon, and for the rest, so far as possible, to allow human beings to be educated by experience and mutual influence? (p. 236)

It may be true that the public still needs protection from sharks and fraudsters, although, given the rise of consumer rights and the "rights culture", some have suggested that, these days, the warning should rather be caveat venditor (let the seller beware)! Whatever we think of the move to and mood of consumer rights, it has brought just that: a raft of legislation which gives rights to the consumer. For the wary client and potential complainant, there is a significant amount of legislation under which s/he can complain and seek redress (see, for instance, examples in section 1.2.3 above), in addition to being able to complain to the practitioner's professional association, organisation or group.

There are a number of arguments under this heading.

2.1.1 That the consumer needs protection from the harmful side-effects of registration or licensing

This is an argument that Hogan (1979) advanced, commenting that: "the preferred policy is to protect the public from harm in general, whether or not incurred by a practitioner. Such a policy requires an examination and weighing of the unintended and potentially deleterious side–effects of licensing." (p. 239) This certainly accords with the New Zealand MoH's (2010b) criteria, tests and balances with regard to professions seeking to be regulated. 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)

The identification of these negative "side–effects" is something which Mowbray (1995) viewed as "a very 'holistic' position that takes into account the overall balance of risk and benefit to the public rather than focusing on particular issues of risk in isolation" (p. 88), and is precisely the kind of cost–benefit analysis that should be undertaken by any profession seeking regulation under the *HPCA Act* or other such legislation.

What we might refer to as other harmful "meta side–effects" include:

2.1.2 That psychotherapists take too much responsibility for clients

Freud (1926/1959a) put it thus:

> Let us allow patients themselves to discover that it is damaging to them to look for mental assistance to people who have not learnt how to give it. If we explain this to them and warn them against, we shall have spared ourselves the need to forbid it. (p. 236)

2.1.3 That regulation and registration create a false sense of security

It does this in a number of ways:

- By discounting the client's ability to be aware and to beware, a process that, according to Mowbray (1995), has the effect of institutionalising the transference (see section 1.1 above).
- By giving what House (1996/1997) referred to as the "illusion of policing" (see also House, 2003).
- By promoting a faith in registered practitioners which actually misleads the public (see Postle, 2007) and lulls them into a false sense of security ("S/he must be OK because s/he's registered") — and this despite the fact that the same practitioner might have been turned down for membership of a relevant professional association (see also 2.1.6 below).

2.1.4 That regulation leads to a regulatory culture in the field of therapy

Postle (2007) has described this as a "centralised monoculture of psychological regulation" (p. 236), which is based on a legalistic, managerial response to professional organisation and relationships which

seeks to standardise and simplify therapeutic experience and discourse (see House, 2009; and 2.2 below).

2.1.5 That regulation reinforces the status quo and closed systems

This is because the standards used to regulate the field tend to involve arbitrary, non evidence–based criteria that protect existing, conservative, and vested interests ("I'll accredit your course if you agree to accredit mine."). This is a particular problem in countries with relatively small populations (see Chapters 9, and 16).

2.1.6 That statutory regulation and state registration actually lowers professional standards

This has happened in a number of countries, including Aotearoa New Zealand, where the standards and entry requirements for full membership of the NZAP are higher and more demanding than are those for registration with the Board.

2.2 That regulation restricts and compromises therapeutic practice

There are a number of aspects to this.

2.2.1 That restriction of practice is a bad thing

Many would argue that restricting trade or practice is inherently bad and undesirable, morally, philosophically, economically, and politically; with regard to the field of psychotherapy and counselling both Mowbray (1995, 1997) and House (2009) have made this point. Freud (1926/1959a) himself was strongly against prohibition and restriction of practice: "If the prohibition were enacted, we should find ourselves in a position in which a number of people are prevented from carrying out an activity which one can safely feel convinced they can perform very well." (p. 234)

2.2.2 That regulation leads to defensive practice

In response to regulation and the presence of an "authority", in this case, the Board, and especially when it adopts a critical, parental tone (see Chapters 7 and 16), practitioners become more restrictive and defensive (see Bollas & Sundelson, 1995; Mowbray, 1995; Clarkson & Murdin, 1996). This tends

to ossify therapeutic practice (Hogan, 1979; House, 2009), and restricts creativity, diversity, and development of the field. In his paper in which he posed the question "Dare we do away with professionalism?", Rogers (1973, p. 382) identified a number of drawbacks to moves towards certification and licensure, one of which was that: "As soon as we set up criteria for certification ... the first and greatest effect is to freeze the profession in a past image. This is an inevitable result." (p. 382) More recently, Richardson (1997) commented:

> Another thing that militates against [statutory regulation] is the increasing evidence of the effectiveness of a variety of approaches which some people wouldn't call psychotherapy ... So if you were to regulate or legislate, you might stop that, prevent that diversity, and that would be unwelcome.

All this has a restrictive, constrictive and diminishing influence, which compromises creativity and development. Indeed, the Director–General of Health (2009) has shared this concern: "By over–regulating the health sector, the concern is that innovation will be stifled" (p. 27). By contrast, diverse, decentralised, deregulated, grass roots practice fosters creativity and development, and emergent order and self– regulation (see House & Totton, 1997; and Chapter 12, and 13). Also, regulation and regulations tend to have a conservatising influence on practice, and, indeed, on people, which compromises psychotherapy as a liberating, let alone "subversive activity" (see Embleton Tudor & Tudor, 1994; Hinshelwood, 1994; McWilliams, 2005; Postle, 2007; Pollard, 2009).

2.2.3 That regulation reduces access to the variety of therapies

With state regulation comes more state interference in the field of therapy, and, from the experience of a number of countries, including the USA and the UK, it is clear that, with moves towards licensing and state regulation, certain psychological therapies are privileged over others. Economic arguments in favour of short–term therapy, notably cognitive behavioural therapy (CBT), get conflated and confusion with arguments about the value of different theoretical approaches to therapy. A classic example of this is Layard (2005), who makes a sound economic argument for his "happiness" agenda, but one which does not address the relative benefit of different

theoretical approaches to therapy. Economic — and theoretical — arguments are justified with reference to "evidence–based practice", which is evidenced on the basis of particular research methodology, principally randomised controlled trials, which generally are not necessary appropriate for assessing and comparing different psychotherapeutic methods (see Freire, 2006; the Association of Independent Psychotherapists et al., 2009b; Pollard, 2009).

2.2.4That regulation is anti–therapeutic

The regulation of psychotherapy as a discipline and a profession is anti–therapeutic as it compromises the therapeutic space (Postle, 2007; Pollard, 2009; Rogers, 2009; and Chapter 12); and the purpose of therapy i.e., clients taking responsibility for what they create (Gloster–Smith, 2009) or co–create (see Tudor & Summers, 2014); and, in any case, is based on a false premise and illusion of attempting to control the therapeutic process and method (see Gloster–Smith, 2009).

2.3 That regulation restricts therapeutic thinking and thinking about therapy

In regulating an activity (discipline, profession or practice), the state in effect defines it in terms of what's in and what's out, what's allowed and allowable, what's disallowed and what's disavowed. By prescribing certain — and only certain — terms and conditions about nomenclature, practice and competencies, the state also in effect proscribes other forms of practice, and thinking about practice, as evidenced in s10 of the *Act* which describes the power to issue search warrants "in respect of an offence which has been or is suspected to have been committed against section 7 or section 9 or which is believed to be intended to be committed against either section" (s10, my emphasis). This Orwellian world of regulation based on mistrust, fear and paranoia makes it harder to think freely and independently or interdependently, and makes it more important to resist "Big Brother" and to insist on freedom to think and to practise. Panksepp (1998) noted that a human baby typically becomes enraged if its freedom is restricted simply by having its arms held by her or his sides, and wrote that: "throughout life anything which limits our freedom will be viewed as an irritant deserving our anger, contempt and revolutionary intent" (p. 189).

As the state takes such a partial, monocultural, one–dimensional, exclusive and excluding view of regulation and registration, it represents what House (2003, 2009) referred to as a "paradigm war" which represents differences and conflict in a number of areas, regarding:

- The nature of things (ontology) — which, according to Cox (1992/1996) "lies at the beginning of any enquiry". (p. 144) Thus, state regulation represents a particular way of viewing the nature of being (ignorant) and relationships between people (untrustworthy), for comment on and a contrast to which see Stewart–Harawira (2005).
- Human nature — regulation implies and is predicated on a particular and somewhat pessimistic model of human nature. Postle (2007) and the Association of Independent Psychotherapists et al. (2009a) suggested that this is one in which clients are viewed as "fallen" and, as such, incapable of assessing a potential practitioner/therapist. Equally, in this Judaeo–Christian theological model, the unregistered practitioner, being untrustworthy and full of sin or, at least the potential for sin, is also fallen. The good news (in this model) is that registration saves the practitioner from her/himself and, thereby, offers protection for the client and, more broadly, for the public.
- Knowledge (epistemology) — state regulation in effect privileges certain forms of knowledge, based on a medical view of health, and a managerial view of mediating relationships, and discounts or discriminates against other forms of knowledge such as those based on indigenous wisdom (see, for example, Urion, 1999; Stewart–Harawira, 2005), or critical epistemologies.
- Ways of doing things (methodology) — reading the *HPCA Act* 2003 makes this absolutely clear: it is regulatory piece of legislation based entirely on a Western medical model of health (i.e. illness) and management, i.e., managerialism (see Chapter 11). One of the drawbacks to "the urge toward professionalism", as Rogers (1973, p. 382) put it, was that it "builds up a rigid bureaucracy."

2.4 That regulation restricts the education and training of therapists and threatens academic freedom

The prescribed forms of knowledge and competencies outlined in such regulatory legislation, policies and procedures extend into the sphere of the

education and training of practitioners: the state regulation of practitioners is followed by the regulation of, or the attempt to regulate and register educators and trainers, researchers, policy–makers, and consultants (see PBANZ, 2008), and supervisors (for a detailed critique of which see Association of Independent Psychotherapists et al., 2009a; Edwards, 2009); Gloster–Smith, 2009; House, 2009; Postle, 2009; Rogers, 2009). The attempt to a standardise education and training flies in the face of most approaches to education (see, for example, Rogers, 1983); promotes exclusivity in training institutes/institutions (see Mowbray, 1995, 1997; Postle, 2007), and pyramid selling; and threatens academic freedom.

In Aotearoa New Zealand, academic freedom is enshrined in the Education *Act* 1989 (s161) as amended by the Education Amendment *Act* 1990. The purpose of a University is described in the Education *Act* 1990 (s4) which outlines the characteristics of universities, including that: "They are primarily concerned with more advanced learning, the principal aim being to develop intellectual independence" (s4(i)) and that: "They accept a role as critic and conscience of society." (s4(v)) However, since the PBANZ (2008) has extended the definition of the term "practice" such that it encompasses roles including educating, it is threatening the freedom of practitioners to be independent educators and trainers of psychotherapists. As Freud (1926/1959a) commented some 80 years ago: "Thus once again in our country a line of intellectual activity would be suppressed which is allowed to develop elsewhere." (p. 234) For further discussion of the implications of this, see Chapter 7.

Freud's argument in favour of lay analysis and lay analysts was based on his views about the nature of psycho–analysis, and from that, the knowledge that a person needs, which he described as "a great deal of psychology and a little biology or sexual science" (p. 218); and the personal qualities that s/he should possess, such as discretion and character, in order to be an analyst (and not the fact that that person is a medical doctor). He also argued that training should include "elements from the mental sciences, from psychology, the history of civilization and sociology, as well as from anatomy, biology and the study of evolution" (p. 252). To paraphrase Freud: registered psychotherapists have no historical claim to the sole possession of psychotherapy. He also placed great emphasis on training — "no one should practise analysis who has not acquired the right to do so by a

particular training" (p. 233) — and none on regulation or registration. In fact, he was clearly sceptical about regulation and, in his postscript to the paper on lay analysis, with reference to American colleagues passing a resolution against lay analysts, he commented (1927/1959a) that: "It is more or less equivalent to an attempt at repression." (p. 258)

Given the lack of evidence that clients are at significant risk from psychotherapists on any scale that warrants the cost of state regulation, and given the existence of contract law and consumer protection legislation, and of relevant and suitable professional organisations with frameworks of ethics, practice and competencies, the case for the state regulation of psychotherapy, including here in Aotearoa New Zealand is not proven. Such regulation is not only unnecessary and undesirable, it has also proved deleterious to the profession, the discipline, and its major professional Association, the NZAP (see Chapters 3, 10, 19; and Fay, 2011).

Public statutes

Consumer Guarantees Act 1993.

Crimes Act 1960.

Domestic Violence Act 1995.

Education Act 1989.

Education Amendment Act 1990.

Harassment Act 1997.

Health and Disability Commissioner Act 1994.

Health Practitioners Competence Assurance Act 2003.

Protected Disclosures Act 2000.

Summary Offences Act 1981.

Tohunga Suppression Act 1907.

Trespass Act 1980.

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Chapter 9

Whence, why, how, and whither? Responsible authorities under the *Health Practitioners Competence Assurance Act 2003*

Susan Shaw

The concept of having people within society designated as experts is not new and nor is the way in which groups of these experts define and manage their territory, and establish their position in relation to the general public or one another. The desire to define and manage professional groups is ancient and in some ways has changed little over time. Currently a prominent construct for defining and managing groups of health professional experts is the registration board. At best the registration of professionals creates a transparent model for assuring the public, managing practitioners and overseeing quality. At worst these agencies encourage territorialism, disenfranchise engagement within and amongst the professions and provide a protective space for ideas to be entrenched at the expense of reflection, critique and development. The concepts of socialisation and expertise are considered here as providing the machinery that delineates and privileges registration boards. The future of these boards and councils, as embodiments of "responsible authorities" under the *Health Practitioners*

Competence Assurance Act 2003 ("the *Act*"), as they currently exist, needs to be questioned and finding new ways of working and being requires appreciating these dynamics and formulating thoughtful and creative responses to them. This chapter presents a perspective on how such regulatory authorities (boards and councils) come to be and why they exist. It considers the whence, why and how of them with reference to the concepts of socialisation and expertise, and concludes with some suggestions as to what the future of such regulatory authorities might look like.

WHENCE REGULATORY AUTHORITIES?

A number of characteristics are associated with defining professional groups, particularly within the health disciplines. Professions are expected to hold a unique body of knowledge (that is both based on and generated by research), have a commitment to the good of the community, promote specific ethical and moral codes governing practice, value the notion of autonomy and have a model of preparation for practice based in higher education (Girard, 2005; Hoeve, Jansen, & Roodbol, 2014). Positioning the education of health practitioners within higher education has been part of a strategy in many nations to raise the profile of professional groups and enable them to attain status (Dent, & Whitehead, 2002).

Groups of professionals are afforded particular roles and powers by the societies of which they are a part (Waring, 2014).). Messages about the work of professions are constructed by the professions themselves as they define their role in relation to other groups and the wider social context. They also set their own rules for membership and establish how their boundaries are identified and patrolled. Professional interest groups (including societies, associations and registration boards) and educators construct these messages and provide these functions. In the process they define and protect the rituals, practices and specific values which underpin the development and identity of the profession (Langendyk, Hegazi, Cowin, Johnson, & Wilson, 2015).

Historically groups of people with similar expertise have congregated to protect their own interests and promote themselves. The resulting guilds enable their members to band together, forming a critical mass which is

then able to provide security and mutual aid for their members (Cruess, & Cruess, 2016). In recent history, securing legislation which names the profession has come to be seen as affording the ultimate status, and the groups are commonly formalised into registration boards.

Organised and named groups of health professionals within society may be viewed from two sociological perspectives. One of these is to see them as institutions of expertise which are benevolent, needed by society and exercising legitimate power. The other is to consider them as organisations which maintain their occupational control by developing esoteric knowledge which is then used to position and maintain their elite status (Abbott, 2014). There are both positive and negative elements and analyses of the groups that lead or manage professions. The members of registration boards and the practitioners who are impacted by them need to be mindful of these elements and to consider the positive and negative implications behind each of the key concepts involved. Compare this with Bailey's (2004) hope about "sailing smoothly and swiftly towards the relatively unknown implications of registration." (p. 35)

Why regulatory authorities exist

Registration boards and councils exist ostensibly to carry out a number of roles. While these may seem needed, and indeed self–evident, all of them harbour potentially problematic additional or even alter egos.

Protection

Messages about the need to protect the public in relation to health professionals and that registration boards are the appropriate mechanism for doing this are common and rarely questioned. These messages rely on a number of assumptions including that there is some inherent danger within health professional practice and that the public are unable to discern situations of risk and therefore need an agency to stand between them and practitioners. The reality of course is that professional registration boards are unable to prevent practitioners from behaving unsafely or dangerously if they choose to do so and, at best, will become engaged after the event (Marcovitch, 2015.). The highly charged concept of risk, inherent in the power dynamics between professionals and patients, does require some

attention, but mechanisms for responding to risk require that we investigate the rhetoric that the risk is significant. Beliefs that registration is the way to ameliorate risk and, therefore, that the public can be reassured are at best inaccurate, and at worst deceptive.

Defining the profession

Registration boards and councils are well placed to define and manage the boundary of, and territory occupied by professions (Dimond, 2003). They also have a role in raising the profile of, and promoting, the profession itself. The advantages of establishing and patrolling boundaries include making the roles of the group clear and, in so doing, providing some kind of map for those seeking to understand what the profession is able to offer. Disadvantages relate to the territory disputes that naturally occur. Within Aotearoa New Zealand scopes of practice within dentistry have been revised and republished in the *New Zealand Gazette* many times. This would appear to demonstrate how practitioners allied to dentistry such as hygienists and therapists are overseen by dentists, the more dominant group circumscribing the work of sub–groups.

One of the most striking examples of professions within Aoteaora New Zealand asserting boundaries under the HPCA legislation can be found in the list of "restricted activities", which, according to the *Act* may be declared by the Governor–General (Section 9(1)). These "restricted activities" may only be carried out by "particular health practitioners" (Section 9) for whom these activities are "permitted by his or her scope of practice". However, individual professions are not defined in relation to the various restricted activities. Table 9.1 below indicates which "particular professions" might be involved in each of the "restricted activities".

Table 9.1. List of "restricted activities" listed by the MoH (2017) and the "particular health professions" that they appear to involve

Restricted activity	Apparent "particular health practitioners"
Surgical or operative procedures below the gingival margin or the surface of the skin, mucous membranes or teeth.	Medicine – surgeons Oral health – dentists
Clinical procedures involved in the insertion	Oral health – dentists, clinical dental

and maintenance of fixed and removable orthodontic or oral and maxillofacial prosthetic appliances.	technicians, orthodontists Medicine – maxillofacial surgeons
Prescribing of enteral or parenteral nutrition where the feed is administered through a tube into the gut or central venous catheter.	Nutritionists
Prescribing of an ophthalmic appliance, optical appliance or ophthalmic medical device intended for remedial or cosmetic purposes or for the correction of a defect of sight.	Optometrists
Applying high velocity, low amplitude manipulative techniques to cervical spinal joints.	Chiropractors, Osteopaths, Physiotherapists

A further restricted activity — that of "performing a psychosocial intervention with an expectation of treating a serious mental illness without the approval of a registered health practitioner" — was identified but removed (for discussion of which, see Chapter 6).

Some of the largest professional groups covered by the *HPCA Act* do not feature in relation to any "restricted activity". Nursing is an obvious example and yet it is the largest health professional workforce in this country (see Chapter 19) and many others. Moreover, many practices which could reasonably be considered to carry significant risk if undertaken by practitioners who are not suitably qualified, such as delivering a baby, are not listed as restricted activities. The argument that more than one profession delivers babies (midwifery and medicine) does not hold as some of the restricted activities are carried out by more than one profession. It is, therefore, reasonable to suggest that the restricted activities denote sensitive territories that politically–motivated professional groups do not want to share. Designating practice boundaries in relation to risk serves a strategic purpose as it invokes legislation to restrict professional territory. The establishment of responsible authorities for individual professions creates clearly defined territories and boundaries. Such structures are likely to make the recommendations to address the need for integrated and interprofessional practice (Ministry of Health, 2016) difficult to enact.

The arbiter of expertise

The asserted (or legislatively conferred) role of professional registration boards requires consideration. While it may be palatable for a health profession registration board to assert some expertise in relation to health professional practice, the notion that they also have expertise in judging character, personality and standing, yet alone evaluating and accrediting educational agencies and programmes needs critique. There are other agencies arguably better equipped to carry out these functions and so the challenge of expertise, what constitutes it and how to defend and responsibly use it, remains. This critique directly addresses the notion of expertise and it is troubling that, as patients are increasingly being acknowledged as experts (Mawhinney, 2016), registration authorities (boards and councils) seem to find ways of increasing their sphere of influence.. Likewise, the expertise involved in accrediting educational programmes, conferring the status of various credentialing models and limiting the practice of registrants warrants interrogation. It may be legitimate for a registration board to circumscribe, bless and condone the practice of health professionals in some ways. It is questionable, however, whether or not they should be able to control registrants' ability to participate in roles other than practice, such as teaching or supervising within a practice–related subject area. Teaching is a discipline and field in its own right and in some jurisdictions has its own registration board, in which case the expertise in relation to monitoring teachers is held by another agency and may be better managed within that framework than by registration boards within the health professions.

POLITICAL AGENCY

The very existence of registration boards implies a political interest in the work of professions. While this may provide some kind of legitimisation to the professions it also poses the very real concern that the state will enjoy some form of reciprocity. The existence of a registration board constructs a mechanism for the state to communicate closely with the professional gatekeepers and potentially to influence practice and territory in direct relation to political will, social trends and resource agendas. It is rather a challenge to perceive registration boards as neutral given models by which their power is conferred and their existence funded and monitored. Impartiality is difficult to assure for any number of reasons. Within small

jurisdictions there is the very real risk that the profession may not be large enough to enable truly unbiased attention to the dynamics involved in the preparation and practice of professionals. For example, a small profession in a small nation with only a small number of accredited educational providers may find itself with members of the registration board involved directly in the design and delivery of the education, thereby lacking the standpoint of academic freedom from which to challenge and question.

These alter egos of protectionism, deception, redefinition and exclusion all contribute to the territorialism which further entrenches the apparent need for registration boards, and therefore how they come to be. The notion of the board becomes a self–perpetuating mechanism of control.

How regulatory authorities exist and function

Any number of mechanisms can be employed to control what people think and how they act. Regulatory authorities (in the form of registration boards and councils) appear to use the process of socialisation to limit and maintain membership or, more accurately, the practitioner's presence on their registers. Alongside this, they promulgate the notion of expertise to defend their right to exist and assert their elite status, thus embedding themselves within their respective professions. These two notions are considered here as the machinery that is engaged by registration boards in order to maintain the(ir) status quo.

Social machinery

Socialisation is the term used to describe the processes by which people learn and internalise the social values of a group of which they are, or wish to be members. The most overt socialisation within the health professions takes place during the process of usually undergraduate (or pre–registration) education and is an acknowledged, accepted and intentional part of the educational process (Bray, O'Brien, Kirton, Zubairu, & Christiansen, 2014). The experience of socialisation is arguably more complex for students who enter a course of study or profession as graduates. There are appear to be negative cultural issues for them to resolve but that they also have the personal skills to manage this (Stacey, Pollock, & Crawford, 2015). The socialisation process conveys to the student professional beliefs and

attitudes that are sanctioned by their chosen profession (Khalili, Orchard, Laschinger, & Farah, 2013). Exposure to role models in the clinical setting and planned interactions with one another, educators and patients are the primary mechanisms employed to acculturate students to the values (Lindeman, 2000), professional identity and attitudes (Wald, 2015) of the profession.

Socialisation occurs not only within disciplines, but also between disciplines; the history of nursing education provides some insight into this. The education of nurses initially developed within the limitations placed upon it by the medical profession. Evidence of the high profile of medicine within early nursing education is evident in even the most cursory analysis of documents outlining curricula. The emphasis placed on ensuring that nursing students learnt not to invade the professional territory of doctors (Bridges, 1990; Dixon, 1990) is a further example of these hierarchical values. Nursing has journeyed along a path of asserting its identity as a profession and is now accepted as such (Sabatino, Stievano, Rocco, Kallio, Pietila, & Kangasniemi, 2014), and much of this journey has focused on claiming the educational process of nursing back from medicine. There is also evidence that cultural changes are emerging in medicine as a result of the profession becoming more ethnically diverse (McKimm, Wilkinson, 2015). In some jurisdictions (such as New Zealand), registration boards or councils for nursing were amongst the first to appear, and it may be argued that this was related to its relationship with medicine, evidenced in the leadership of institutions and doctors' involvement in the education of nurses and midwives (Stojanovic, 2008). Of course, the move of nursing away from medicine did not eliminate socialisation, it simply reconstructed it from a medical basis into a nursing framework and, arguably, added to the messages about the role and place of nursing the additional dynamic of a group history of exploitation and oppression, which has been and to a certain still is perpetuated through internalised self–oppression of nursing and nurses. This history has some analogies with the role of psychotherapy and psychotherapists with regard to medicine and the medical model.

Having successfully qualified as a health professional the practitioner then negotiates a new world in which some form of recognition is required. This is in fact another site for socialisation to occur as new practitioners are inducted into the rules, rituals and language of professional culture

(MacArthur, Dailey, & Villagran, 2016; Schon, 1983). The socialisation of new members into a group is one of the ways in which professional culture is perpetuated, and mechanisms of social control, enshrined in rules, maintain the membership. Once qualified, practitioners continue to be influenced by role models within their profession, and subject to the social and political influences that surround their work and interaction with patients (Khalili, Orchard, Laschinger, & Farah, 2013). There are many ways in which organisations and professional groups socialise their members and those with whom they come into contact. The practice of peer review is one such obvious mechanism (Horsley & Thomas, 2003). The development and maintenance of elite vocabulary, rituals, limited membership and strictly perceived rules for belonging are fundamental to maintaining traditions amongst professional groups. Class and gender divisions are evident within some professions or sub–groups and further used to define and maintain territory (Hall, 2005). The military (Shulimson, 1996), law, and medicine (Hafferty & Light, 1995; Pringle, 1998), are examples of professional groups which highly value their culture, and which actively socialise their members. However, within the healthcare professions, the power to maintain authority, marginalise other knowledge and participate in surveillance is wielded in particularly powerful ways (Pryce, 2000). In Aotearoa New Zealand, the *Tohunga Suppression Act 1907* was a pertinent and shameful example of such power to marginalise and outlaw (see also Chapter 5). This power is apparent in analyses of architecture (Morrall & Hazelton, 2000) as much as it is evident in rituals of examination and treatment (Batalden et al., 2015), and even within the accepted dress codes (and uniforms) worn by professionals in any given setting. All of these activities serve to unite and identify professional groups, but also place barriers between practitioners and patients, who need more than just knowledge to counter power dynamics as they interact with professionals (Joseph–Williams, Elwyn, & Edwards, 2014).

The process of socialisation is invidious and begins before students enter professional education, demonstrated in the beliefs that they have about the role and status of their chosen profession. The process of socialisation during health professional education occurs as students are exposed to role models and contextual factors. Following graduation, practitioners are further socialised into the discipline by the rituals and traditions that the group defines for its members and uses as a mechanism to distinguish it

from other groups. Regulatory authorities need and promulgate socialisation by setting the rules for the profession and patrolling the boundaries that are evident to patients and practitioners. While this may be considered to be a relatively benevolent role as these authorities apparently oversee the professions, socialisation is used to maintain the status of such authorities (boards and councils) and to demand compliance from registrants. This context is fundamentally manipulative, self–serving and, arguably, a disrespectful way for an organisation to behave or for members to be treated.

Expertise: The machinery of self–promotion and patch protection

Expertise is highly valued in western societies and within healthcare could be considered as based on the assumption that, as a result of education, health professionals have more knowledge than the general public (Brown, McWilliam & Ward–Griffin, 2006; Illich, 1975; Wilson, 2001). This provides a paternalistic backdrop to professions, and casts the patient in the role of the passive recipient of care. Within this frame, the patient is expected to comply with the knowledge and expertise of the professional. However, the assumption that expertise about health and wellbeing is enshrined in the formally recognised education of health professionals is being called into question. An emerging response is that the personal experience that patients have of their health and disability is considered to constitute expertise in its own right. This is evident in discourses that present interactions between professionals and patients as a "meeting of experts" (Freeman, Horder, Howie & Hungin, 2002; Tuckett, Boulton, Olson & Williams, 1985). Such an approach requires that both the professional knowledge held by professionals and the lived experience of patients are seen as equally valid forms of expertise.

The concept of expertise no longer solely resides with professionals but is also attributed to patients. The continued articulation of indigenous dispossession, disenfranchisement, user and patients groups, the assertion of human and consumer rights, and pathways of redress, also inform this shift in the balance of power. Professions and, indeed, nations, that believe in and engage with their espoused appreciation of and commitment to partnership with indigenous colleagues and patients could demonstrate this by embracing the widest possible notions of expertise.

A progressive view is for patients and professionals to see their relationship as a partnership, based on respecting the expertise that they both bring (Brown et al., 2006; McQueen, 2000). Insincere attempts to appreciate the expertise of patients are easily recognised and are enormously counterproductive (Paterson, 2001). We should be mindful that there are risks in attributing expertise to patients as this may be used as a vehicle to blame patients for their predicament (they had knowledge and so they should have avoided this situation), or as an excuse which gives the state or the professional group the ability to absolve themselves of responsibility for providing care and support (Wilson, 2001). The approach of seeing patients as experts enables them to be engaged with health professionals as partners rather than subordinates. Traditional models of professional expertise are, in effect, challenged by active patients and need to be critically addressed by professionals and the professions themselves.

Whither regulatory authorities?

The substantial and self–perpetuating mythology of regulatory authorities (and specific registration boards and councils) demands attention, as does the machinery that is employed to retain the status of these agencies, both amongst the professional groups themselves and within the societies of which they are a part (see Chapter 7 for an attentive case study of one such authority). While there is a need to name and address some of the challenges inherent in the development and provision of healthcare, it is timely to question the assumptions, which, if anything, appear to be gaining credibility, that registration boards and councils are the appropriate tool for monitoring and patrolling professionals and professions. A critique of the existence of registration boards is necessary to illuminate what other frameworks may be worthy of exploration. New approaches may incorporate reference to collective approaches to engagement, philosophical stances and relationships with other agencies, including the state (for a discussion of which, see Chapter 15).

Collectivity refers to the way in which people organise themselves. We should not assume that in order to name, lead or promote a profession we must engage with regulatory authorities. There are many other models for groups of people to interact and organise themselves. There are many philosophical challenges inherent in the concept of a regulatory — and, in

the New Zealand context — responsible — authority, the most obvious of which relate to their management. Bureaucratic behaviour is the default position when "managing" groups of people. Registration boards and councils are likely to be established within modern democracies as primarily bureaucratic agencies that herd their registrants to jump through pre–determined hoops which apparently measure their competence and fitness to practice (for a critique of which see Chapter 2). Such registration boards and councils may be replaced by some other model of organisation that is able to meet the identified needs of the professions and this may be fundamentally organic and informal rather than state–constituted and bureaucratic.

Relationships with other agencies, including the state, require determined attention as, while they are often declared as normal, neutral or expected, they carry with them inherent power dynamics and potentially problematic lines of communication and reporting. For as long as registration boards and councils are, by definition, required to distinguish their profession and work from the role and function of other professions, they will be working against interprofessional engagement — and honest critique and innovation. Conversely, while they are necessarily required to interact with the state and be dependent on it for their existence (mandated in legislation and maintained by fees providing funding streams and entitlements), they are perpetuating a disproportionate power differential between the state and the profession.

Perhaps a valuing and progressive approach to the work of naming, leading and possibly governing professions could be built on the foundation of honest engagement within and beyond the profession. It would be appropriate to establish foundational concepts such as partnership and emancipation in the founding of such a new model. An organic model which acknowledged power dynamics and valued true dialogue would provide a sound basis for engagement between the professions and patients within the context of the wider society. Links to statutory agencies would be possible in order to manage complex situations of risk and unsafe behaviour, but the primary work of the professional organisation would be to reflect and grow rather than to approve, monitor and patrol.

There is a case for some rationalisation of the work currently attributed to regulatory authorities, and this could begin by identifying similar functions

across the professions such as police clearances for practice and the maintenance of lists of recognised practitioners. These functions are generic and could possibly be managed by a fairly generic agency which served the interests of a number of professions, ideally organised or clustered by sufficient common interests and shared values, but more specific than the general rubric of "health". The potential conflicts of interest across agencies and within small jurisdictions requires attention and it may be that some professions are represented or led across national boundaries so as to reduce risks of perceived or actual conflicts. Any change to the model of regulatory authorities that we have come to know will require determined effort, critical mass and the energy to navigate a critical path and a rocky journey.

Conclusion

Regulatory authorities are arguably mechanisms of dominance using the tools of socialisation and expertise to define and defend their existence. Our first port of call in considering the future of such authorities is to accept that there are other models for defining, promoting and ensuring the wellbeing of professions and those who engage with them either as practitioners or the public. It is not a given that this role is closely linked to the state, that it should exist in isolation from other groups or perspectives, or that it should wield wide powers. A further stop on this journey of reconsideration may be to ask what the fundamental role of such agencies should be and perhaps a refreshing approach may be to consider them as simply the framework that engages patients with the professional group in ways that enable meaningful dialogue. The journey to re–envisioning the organisations currently constructed as registration boards and councils will take a commitment to dialogue and risk–taking as there is a lot at stake for those perpetuating the status quo. Establishing a critical mass of people who think differently and who are united by not participating within the current model will take time and, ironically, may be more likely to happen in younger and smaller professions in the first instance where the risks of conflicts of interest are high and the sense of dissatisfaction is palpable.

Public statutes

Health Practitioners Competence Assurance Act 2003.

Tohunga Suppression Act 1907.

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Chapter 10

Regulation by association

A. Roy Bowden

Psychotherapists in Aotearoa are proud of the way the New Zealand Association of Psychotherapists (NZAP or the "Association") has always been an inclusive organisation. For seventy years practitioners have been accepted into the NZAP from a variety of disciplines. Membership of the NZAP includes those whose experience and training began in professions such as social work, counselling, psychology, general medical practice, psychiatry, nursing, church ministry, education, academia, indigenous environments and voluntary organisations.

There has never been one way to become a psychotherapist and the Association does not monitor or select training pathways. In some professions there is agreement as to how one enters the profession. The elements in training for those professions prepare practitioners for the career that lies ahead. In many ways it is easier to monitor professions where training is clearly defined and the nature of practice is agreed. In addition, competence can be tested against accepted norms and practice skills.

NZAP selection and assessment procedures which open doors into the profession have been built by drawing on professional insights from a variety of disciplines. These pathways, which include He Ara Māori,

eventually lead to a clear acknowledgement that candidates belong to an Association of highly skilled practitioners, are firmly held within a nurturing relationship. The process continues in a supervisory environment. The NZAP has been a pioneer in the constant monitoring of its members, and an acknowledged leader in the principles of accountability and responsibility.

The multi–disciplinary membership of the NZAP has enabled the Association to live through profound changes and periods of uncertainty. This has been achieved by honouring the importance of association, taking care of its members and providing professional care for clients. Whenever there has been uncertainty about purpose or identity, members have met face to face in specially–designed forums to discover the variety of personal reasons which form the foundations of tightly–held views. Practitioners in the Association have sometimes questioned the mainly psychotherapeutic approach to managing difference, and it is important to reflect that being therapeutic is not always the best way forward. However, an association of psychotherapists is bound to rely on processes that highlight individual feelings and thought patterns. Whenever the NZAP has made changes which have increased accountability, set new boundaries for practice, or defined ethics differently, members have engaged in vigorous debate. That is to be expected in an Association which consults its members carefully and allows for difference.

During the debates an important process has been built. Discussions about the nature of practice, how to keep clients safe and keep the soul of the therapist engaged have served as effective regulatory and monitoring procedures.

Decisions about the parameters of practice and the best way to serve the interests of clients have been agreed to after members have utilised opportunities to test their views against the opinions of others.

Regulation through association enhances compliance, creates energy for new pathways and settles any tension which may arise between colleagues and the NZAP Council. The establishment of the Psychotherapists (Registration) Board removed client access to two processes which had been keeping clients safe since the early 1990s:

1. The supervision of psychotherapists — which is the process that monitors the therapeutic relationship; and
2. The complaints process — which enables members of the public and psychotherapy colleagues to take action when therapists do not adhere to a code of ethics.

The Registration Board has taken control of these two safety procedures. Clients may well be at greater risk because safety measures are being managed at a distance without paying attention to the complex issues that the NZAP took into account every time there was a question about therapist competence or ethics. NZAP branches and supervision groups operated within an environment that created trust and shared information about matters being raised in supervision and the goals each therapist had for their own growth and development.

Keeping clients and therapists safe in supervision

Discussions about supervision, the way it was contracted and monitored and the way it enhanced clinical work had been a feature of the Association for many decades. Practitioners in the health professions are acutely aware that clients are not safe if the practitioner is unsafe. The NZAP requires intending and accredited members to be in a supervisory relationship with a health professional, preferably a trained psychotherapist. In 2010 the Psychotherapists Board published a supervision policy for consultation (see PBANZ, 2010b). It attends well to the qualifications required for being a supervisor of psychotherapists, makes allowance for allied health professionals to apply to be supervisors, and asks psychotherapists to comment on issues such as the regulation of supervision. However, there is no provision for the Board to monitor the quality of supervision or the processes which enhance professional practice. The Board has core clinical competencies (PBANZ, 2010a) which are clear guidelines for psychotherapists to adhere to when practising. The only way these competencies can be monitored successfully is by knowing what happens in supervision and being in close association with supervisors, and hence the importance of the development of an environment of trust in NZAP branches and supervisors' groups. My years as a foundation member of the Central Districts Supervision Group enabled me to be closely associated

with the work all my colleagues were doing in our region and gave me access to therapists who needed assistance with client work.

Unlike the NZAP, the Registration Board has no access to the relationship between supervisor and supervisee apart from the requirement to fill in a form on an annual basis. Discussions about supervision, the way it is contracted and monitored and the way it enhances clinical work have been a feature of the business of the association for many decades. Psychotherapy is about the facets of relationship on all levels and in many ways supervision mirrors the elements of psychotherapy with clients. The quality of supervision and the quality of the therapist's response to supervision cannot be monitored successfully by persons who do not have access to all the factors impinging on each supervisory arrangement.

The process is too tender, too challenging, too situation specific to be reviewed at a distance. There are many instances in the history of the Association where delicate facets of interpersonal disagreements were managed successfully because senior members of the Association were "in relationship" with therapists facing very complicated personal issues.

To some degree the Association has taken care of its members in an atmosphere not dissimilar to healthy family life. Observers may claim that there is a high probability that objectivity and clear boundaries may be at risk. Like many families, the NZAP has not always managed to make good progress around personal issues. However, my involvement in most aspects of the work of the Association since 1984 and experience of due process in the NZAP leads me to a significant conclusion. It is that being in relationship and holding creative tension within a close collegial atmosphere enhances practitioners and clients in ways that no ruling body can ever achieve. Association creates familiarity and familiarity adds a dimension to insights that no amount of authoritative objectivity will provide.

Over the years, supervisory reports included many aspects which did not go unnoticed by senior colleagues who read them and provided feedback. Supervision is also about professional training opportunities and reviewing performance. The dialogue pays attention to that which is personal alongside that which is professional. It has never been acceptable in the NZAP for supervisors and supervisees to provide a brief report stating they

are meeting successfully and keeping alert to the implications of professional practice.

If this valuable process is superseded by a body that observes from a distance and acts outside of relationship, supervision will become a practice based on compliance rather than professional growth. Supervision protects members of the public because the person of the therapist is constantly being reviewed. Supervisors need to be in close association with other supervisors because professional development is best achieved through debate and dialogue.

Attendance at supervision training courses provides knowledge and new insights but nothing can compare with challenges that come from being accountable to colleagues in a professional association. Senior colleagues in the NZAP have always been in the background offering support and perceptive insights as client work proceeds and the NZAP supervisors have always known they are not alone. If supervisors are merely accountable to an authoritative body that receives reports and relies on written assurances supervision is in danger of being a performed duty rather than a crucial element in client work. Interpersonal responses to transference and counter transference make waves which affect every person who is concerned about client progress and healing. This important process must be reviewed and held within procedures which have a history of commitment and trust. Clients are at risk if therapists, supervisors and colleagues are being monitored at a distance. A distant authoritative body cannot attend to risk factors generated within the therapeutic relationship and will not perceive dangers which may be on the horizon for clients.

The Registration Board registers therapists who have trained in a variety of modalities and generic training institutions. Client safety is monitored in each training organisation within a different context from that which exists in the NZAP. The psychotherapy Association is a professional body with a history of being primarily concerned for the best outcome for clients and has always tested the competence of provisional members against information pertaining to the way clients are being healed.

The NZAP embodies the only structure capable of ensuring the safety of clients and therapists because it keeps relationships as the primary focus. It attends to professional career and employment considerations well and

nurtures its members carefully, and client welfare is primary. Professional qualifications and experience provide entrée to the profession and to offering a supervision practice but the ongoing supervision environment can only be enhanced within an association where colleagues are accountable to each other face to face.

If supervision is assessed by providing evidence written on a form clients may sometimes be at risk from professionals who practice in isolation from other colleagues. Flexibility built into Registration Board policies permits allied professionals to supervise psychotherapists. This has also been the practice in the NZAP. When supervisors' groups received annual reports from NZAP members regarding their supervision arrangements the suitability of each chosen supervisor was discussed along with other issues surrounding supervision of the member.

On some occasions it was necessary to question the suitability of the supervision provided by an allied professional due to the nature of the work the NZAP member was doing. The Registration Board will not be able to monitor psychotherapists' supervision in this way. Detailed discussions in supervision groups sometimes lead to Association members being asked to attend to more professional development in instances where the nominated supervisor had not been aware this was necessary. These advantages will continue for members in the Association, but many psychotherapists in New Zealand will simply be able to furnish an annual report to the Registration Board without being subject to any intensive review of their practice. Safety for therapists and clients is now dependent on the commitment of a number of professional organisations whose status and right to control ethical and competent practice has been removed.

Protecting clients and therapists in a complaints process

The NZAP has been taking care of colleagues and clients in processes developed over nearly seven decades. The establishment of boundaries, ethics and professional competencies has been a continual feature of the work of the Association. In 1996 the Council approved its first *Code of Ethics*, although, from the inception of the NZAP in 1947, Council minutes record a number of discussions pertaining to aspects of ethical practice. Along the way, the *Code* has been subject to reviews as the mental health

environment changed and clients gained more insights into what to expect from therapy. Complaints from clients and complaints about colleagues have been always been assessed by referring to principles in the *Code of Ethics*.

An ethical code is always subject to interpretation. The wording is never clear enough to provide a basis for assessing complaints against members without a good knowledge of all the complexities in each situation. NZAP members who served on Complaints Assessment Committees and on the NZAP Council struggled on many occasions with the connections between intricate personal issues and behaviour which contravened best practice. The only way to find pathways leading to justice and protection for members of the public was to balance all the information and draw on privileged knowledge that comes from being "in association". Psychotherapists are trained to perceive that which is unconscious and name it without being definitive. These insights into what may or may not have happened consciously or unconsciously in any ethical circumstance are used to delay tendencies to make assumptions without due regard for that which is unknown. The NZAP has members skilled in managing situations where the *Code of Ethics* may have been disregarded. Over the years they have been careful to act within relationship rather than sit on a panel unaffected by the voices of those who have may have transgressed or those who may have been wronged. Psychotherapy is not a practice that can be monitored from the outside or judged at a distance.

The argument that ethics must be guarded by independent persons and processes has some validity. For example, psychotherapeutic practice can be reviewed by people trained to be objective, such as the legal profession, but their views are limited when complex unconscious influences are taken into account. Psychotherapy is about relationship. When client and therapist disagree or the relationship is broken by breaking boundaries, ignoring due process or failing to attend to crucial elements of therapy and safety, it is the relationship which is damaged. For members of the public affected by a therapist's non adherence to the *Code of Ethics* (NZAP, 2002), there has always been a need to attend to a wide range of emotional response as well as crucial human rights. The NZAP instituted process which held relationship at the centre while investigating the reasons for transgressing the *Code of Ethics*. If state registration is to guard successfully the interests

of clients and therapists it needs to act by being in close contact with complainants and respondents.

The establishment of a Board which is at a distance procedurally and assumes all therapists can be successfully addressed as a group creates resistance to relationship. The NZAP has always managed to guide, control and nurture therapists towards compliance by carefully monitoring individual relationships within the organisation.

For two years (2003–2004) I held the position of Complaints' Convenor within the NZAP. As the first contact for clients and colleagues who wished to lodge a complaint I was very conscious of being the voice of the Association with regard to the complaints process. The initial contact with both complainant and respondent gave rise to complex emotional responses and often set the tone for what followed. Once I had communicated with complainant and respondent, the Complaints' Assessment Committee received the material.

As well as following rigorous guidelines pertaining to my role, I disciplined myself to stay connected to all parties without appearing to be biased toward complainant or respondent. There is no doubt in my mind the role demanded all my skills as a therapist and, at times, highlighted my shortcomings. The Complaints Assessment Committee members were similarly charged with the responsibility to stay in relationship and act from their skills base, which took therapeutic process into account. Sometimes members of the NZAP sat on a hearing panel to listen to accounts from both complainant and respondent who were often represented by members of the legal profession. These highly accountable roles could not have been performed competently or fairly without special qualities which are the essence of therapeutic relationships. The next step in a serious complaint process was to ask the Council for a decision regarding guidelines or sanctions for the therapist respondent. During my time as a Council member (1991–2002), as President (1998–2000) and serving on hearing panels I was impressed with the atmosphere of sensitive justice for all concerned. Difficult decisions were made in the context of careful attention to the principles of healthy relationship. Complainants and respondents were not always pleased but sensitivity and commitment to personal care were always kept in view. This can only be achieved when people know

each other well, manage close and intense dialogue and stay true to the essence of effective association.

Now that the Registration Board has been established, the Executive Officer receives complaint material and summarises it for the Board to take action or pass the complaint to the Health and Disability Commissioner. There are psychotherapists on the Registration Board, some of whom belong to the NZAP, and the Association provides the names of psychotherapists to act as advisers to the Health and Disability Commissioner. They will have insights into complex relationship issues but they will not be "in relationship". The Board keeps reminding registered and non registered therapists that there are dire consequences if its directives are not adhered to. If complaints are referred into an environment focused on sanctions, complexities arising from within relationships will be ignored. The Registration Board inevitably acts as a distant authority and this diminishes empathy for and attention to intricate therapeutic detail with the result that fairness and objectivity are placed at risk.

Some registered practitioners belong to other psychotherapy associations and their clients are cared for under procedures allocated by those organisations. The NZAP is not the only professional body but its standing in the health field and its long experience with ethical issues means it could act on behalf of the Registration Board when it comes to complaints. The Board is charged with protection of the public but it does not make sense to override processes which have been put to the test by the NZAP over such a long period. No structured research project could have proven the efficacy of NZAP processes as clearly as its own historical accounts. The establishment of the Registration Board was based on the assumption members of the public were at risk from psychotherapists practicing in isolation. The isolation has not been overcome through the registration process as it currently possible to be a registered psychotherapist without belonging to a *psychotherapy* association. There was also discussion around the number of complaints that might ensue. NZAP records demonstrate that the number of complaints has decreased over the years, and this may well be due to the standard of care promoted by the NZAP. When it comes to the management of complaints from the public, distant authoritative process increases anxiety whereas cooperative facilitation improves service quality immensely.

For many years members of the public have had two avenues for complaints against therapists. Complaints could be forwarded to the NZAP or they could be forwarded directly to the office of the Health and Disability Commissioner. The NZAP process provided a procedure based on dialogue, which kept therapist and client in touch with progress and opinion. If this process was unsatisfactory for complainants they had the option of approaching the Health and Disability Commissioner (see http://www.hdc.org.nz/).

It is difficult to see how the establishment of a Registration Board which refers serious complaints straight to the Commissioner is providing members of the public with a safer environment. Most practising psychotherapists in New Zealand were members of the NZAP until the establishment of the Registration Board which enabled non members to apply for state registration. This step opened the door to psychotherapists with no affiliation to the solid history and ethics of the NZAP; moreover, their clients are restricted to one complaint system, which has a published flow chart, but no detailed process for complainants to follow (see PBANZ, 2010a). In addition, there are a number of practising psychotherapists not yet registered whose clients are restricted to the same complaint system, the details of which are not yet clear.

The NZAP is a partner under the Treaty of Waitangi with Waka Oranga, a tikanga Māori based organisation, whose members could ensure complaints were managed in accordance with cultural practice. The Association is committed to being in relationship with Māori and would have no difficulty working alongside Waka Oranga in this respect. The Registration Board web site assumes complainants will follow a process that makes no allowance for cultural difference and places many clients and therapists at risk. If the NZAP held the complaint process, cultural partnership would be preserved.

Protecting the future for clients and the profession

An effective solution to the dilemmas detailed in this chapter would be for the Registration Board to contract with NZAP and perhaps other professional associations to enable these organisations to manage their own quality control systems.

It is acknowledged that state registration is tied to demands and requirements beyond the Board's control and the *Health Practitioners Competence Assurance Act 2003* sets certain limits, but need not limit innovation. Psychotherapists know that most systems can be changed, given creative initiatives and commitment. The authority of the Registration Board would be enhanced if it trusted the NZAP to keep therapists and clients safe, advance knowledge and increase public confidence in the service therapists provide. So much could be achieved if Board members visited and reviewed Association processes, insisted on accountability and appreciated the elements which provide clients with assurance and quality. My experience as a social auditor taught me how helpful it is to monitor organisations with processes specially designed to broaden their vision and establish accountability securely. Professionals with a good knowledge of review procedures know how to act within relationship and enable organisations to follow their professional principles. Quality control does not have to be remote control nor does it have to rely on sanctions to gain cooperation. The Psychotherapists Registration Board could establish a cooperative environment by the Board contracting with the NZAP to re–establish procedures that keep everyone safe in a state controlled environment. Effective quality control is best achieved by implementing measures that have stood the test of time and placing them in the hands of those who know them well.

Currently (in 2017), the Registration Board is pursuing initiatives to build stronger relationships with the NZAP. It has taken some steps to acknowledge the importance of culturally based psychotherapy but it is yet to relinquish colonising processes. The Board was established in 2008 and in 2017 there is still no evidence to suggest client safety measures are enhanced beyond those practised by the NZAP. There is evidence that removing the quality focused monitoring which the NZAP used to employ enables therapists who are state registered (but not 'in association') to avoid close examination of their practices. The New Zealand Association of Counsellors has wisely chosen self–regulation. The Psychotherapists Registration Board would be well–advised to offer that option to NZAP.

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Chapter 11

Once was a psychotherapist

Evan M. Sherrard

I confess I have done a "Uie". In some circles doing a "uie" or a "u–turn" on a stand one has taken is considered a sign of unreliability, of inconsistency, of fickleness, and is used against one. So, for me to admit to having done a uie may be unwise. Given my strong support for statutory regulation and registration of psychotherapists since the late 1970s, it may appear somewhat ironic to have been invited to write this contribution. However, now that registration is here, I have turned full (or half) circle, and have huge concerns about State control of my life–long profession. Let me explain my early support and my present alarm which has lead to my u–turn.

Bad practice

The Psychotherapy and Hypnotherapy Institute of New Zealand, Inc

Back in the late 1970s in Auckland we had people setting up psychotherapy practices of doubtful quality. One such was the Psychotherapy and Hypnotherapy Institute of New Zealand, Inc. (PHINZ) which, while successfully offering "stop smoking" treatments, also sponsored a theory that, in private, all women push their new born children's heads and faces

against their perineum or vulva and all fathers make penile oral penetration of their newborn. Such behaviour is obviously repellent and socially taboo. The theory suggested that, in order to manage the conflict (between this theoretical perspective and the social taboo), all women and men consign any memory of their totally unacceptable actions to their deepest unconscious. This memory denial and suppression was claimed to be recoverable by hypnotherapy, and the social–emotional conflict resolvable by psychotherapy. Understandably, as this teaching in the PHINZ curriculum became known in increasingly wider circles beyond the Institute, it was viewed with repugnance. Some of those who found it difficult to dismiss it as nonsense became seriously disturbed and the media of the day began to report incidents of very distressed women. As a result, both hypnotherapy and psychotherapy got a bad press. In those days in New Zealand both counselling and psychotherapy were little understood or appreciated and were regarded as on the professional fringe. As members of the New Zealand Association of Psychotherapists and Counsellors, as it was then called (prior to it returning to the more exclusive New Zealand Association of Psychotherapists [NZAP] in 1987), we were struggling to gain respect, credibility and public acceptance. PHINZ did not help us.

Centrepoint

What is perhaps better generally remembered or known is Bert Potter's claim to be a psychotherapist. He claimed his whole Centrepoint enterprise was basically a residential psychotherapeutic community. To begin with, Potter's stated vision for the Shoreline Human Awareness Trust, the precursor to Centrepoint, won favourable response in many quarters, Dr Bill McLeod, Professor of Psychiatry at Auckland Medical School, being one. The supportive, accepting nature of the community and some of Potter's interventions produced beneficial outcomes for a number of individuals, and the vision seemed to be working. However, it was not long after the Centrepoint community was established on site in Albany in 1977 before reports came in which disturbed some NZAPCBT members. The ethic of confidentiality meant the concern was only shared in the most general of terms between those few who were privileged to learn at firsthand about some of the abusive activities. A full picture was not available. The victims were urged to make formal complaint but, in general, and for various reasons, they refused. To whom could these adults

complain? Potter refused to make himself accountable to anyone as he pursued his narcissistic course toward God–like status, and the engagement of adults in his treatment prescriptions was between consenting parties. It was only much later that the abuse of children emerged, which gave the police the right to take action.

One incident I recall was reported in the media at the time. It was the suicide of a young woman who was living in the community. From memory she left a note expressing her dismay and discouragement. At the time my interpretation, based on what I was hearing, was that Bert Potter had not chosen to favour her with his most potent therapeutic intervention to overcome her psychological barrier to full living, i.e. her sexual inhibitions, by taking her to bed. This interpretation was confirmed for me when Potter made his infamous response at a morning session at an annual NZAP conference held in Auckland, in the early/mid 1980s. Anxious to gain the support of the Southern members of the Association for urgent action on registration of the title "psychotherapist, we held a morning session for the membership which comprised a variety of people in Auckland calling themselves psychotherapists who were invited to explain their theory and practice. In those days anybody could hang out a shingle claiming to be a psychotherapist and many in Auckland were doing so. We wanted our Southern associates to appreciate what we were up against in Auckland and recognise the damage to our profession by people such as Bert Potter, who was one invited to speak. He showed his true colours and, with complete disregard for the impact he was having on conference members, explained his psychotherapeutic belief and practice of the benefits of sexual intercourse with clients. He was asked if this meant he had sexual activity with all women members of Centrepoint. A silence followed, during which he was goaded by one questioner about his silence, to which he replied that he was thinking if he could remember any with whom he had not had sex. Uproar followed in the lecture theatre and later. Powerless to do anything about Potter's offensive grandiosity, some Association members displaced their anger onto the conference arrangements committee. Our scheme backfired and we were roundly condemned for giving the likes of Potter a platform because, it was thought, the invitation implied that the Association was giving them endorsement.

Already, in 1983, it had been resolved that: “The Association affirms that sexual intercourse between counsellor/therapist and their clients/patients is incompatible with the clinical aims of this organisation” (quoted in Manchester & Manchester, 1996, p. 77). It was considered that we had no need to hear from Bert Potter in order to condemn his practice. However, the point we were seeking to make, that psychotherapy was gaining a bad name in Auckland and people were being damaged by its so–called practice, was side–tracked.

NZAP, REGULATION AND REGISTRATION

It was against this background that the need for registration of psychotherapists was a focus of attention within the NZAP for several years in the early 1980s. Some of the details can be followed in the Manchesters’ (1996) book about the *NZAP: Notes Towards a History: A Chronology of the First Fifty Years 1947–1997*. I cannot recall any major opposition to the perceived need for registration as protection for the public from highly suspect practice from self–claimed practitioners and professionals. Looking back, in those days, we presumed that registration would give a protection to the title “psychotherapist” and that only those registered would be able to use it. There would be protection from misrepresentation, just as doctors and nurses were protected from any unauthorised person using those titles. Registration would stop just anyone from hanging up their shingle. With registration would go a process of careful selection of those who could be registered; ongoing supervision as a means of ensuring accountability; a requirement for continuing professional development; and a mechanism for resolving complaints. It seemed a taken–for –granted assumption that registration was desirable and, at successive annual general meetings of the NZAP, progress towards this end was reported, and those working to implement it were supported and encouraged. We looked to the progress of the registration of psychologists for models of how to go about getting the appropriate legislation. We also considered that publishing a list of our membership could assist the public. One of our past Presidents, Dr Basil James, was made the Director of Mental Health, and was in a good position to assist and advise on the process. It was in this context that psychiatrist, Dr Robyn Hewland, President of the NZAP in 1986, through her networking and political skills, hoped she had the numbers in the House of

Representatives to introduce the necessary Bill for the registration of psychotherapists.

However, a radical change in the political climate in favour of the notion of the free market and the disestablishment of regulatory controls in general dashed those hopes. I remember the suggestion that dentistry would be deregulated, allowing the free market forces to determine the best dentists, and that consumers would avoid the worst as open competition revealed them. Although public outcry at this particular suggestion dissuaded politicians from such radical experimentation, the climate was against the introduction of any more controls. It was to be years before the introduction of the *Health Practitioners Competency Assurance Act 2003* ("the *HPCCA*" or "the *Act*") opened the door to fresh moves by the NZAP for registration. This *Act* "provides a framework for the regulation of health practitioners in order to protect the public where there is a risk of harm from the practice of the profession." (Ministry of Health [MoH], 2010) It was an *Act* which seemed to meet our concerns to protect the public from the risk of harm, but I did not see the fish hooks in this specific piece of legislation.

Problems with state registration

Notions of protection

So it was that the NZAP worked toward the establishment of registration for psychotherapists under the HPCAA and eventually this was achieved. However, I have been deeply dismayed and disappointed by what has eventuated. With the perspicacity of hindsight the situation is accurately described in the operative words in the above quotation: the *Act* provides a framework for the regulation of [psychotherapist] practitioners, a point which the MoH (2010) has acknowledged (see Chapter 6). What a framework it is turning out to be: cast–iron, inflexible, and totally regulatory of practitioner psychotherapists, based on patterns of regulations taken from sources quite outside our profession. It is a framework made by and for bureaucrats. It is based on the notion of protecting the public by regulating the practice of registered practitioners by bureaucratic administrators.

Back in the 1980s, within the Association, I believe that our notion of protecting the public was to use registration as a way of excluding unqualified practitioners damaging people. No doubt Potter would have kept up his enterprise to feed his narcissism but he would have had to limit his hat to that of a spiritual leader as he damaged people. I think there is a very important distinction in these two notions of protecting the public. The NZAP's concept of protecting the public was and, I think, still is based on trusting the professional (while accepting that a few are unreliable) . The state's notion of protecting the public, as enshrined in the *Act* is based on not trusting the professional. My first main intimation of this distrust was in the correspondence with the Registrar of the Psychotherapists Board of Aotearoa New Zealand ("the Board" or "the PBANZ") in the process of obtaining registration. Towards the end of each message there was a warning that if I was to do any of the activities defined in the scope of practice of psychotherapy without being registered or having an Annual Practicing Certificate (APC) I would be practicing outside the law. Having a big stick waved at me was outside the ethos and culture of the psychotherapy I had ever experienced. A new spirit was abroad.

Bureaucracy

The new spirit is the bureaucratisation of the administration of registration. It seems to me that a motivating drive with bureaucrats is the need to cover themselves from criticism. They are liable to the wrath of their political masters and to rage and condemnation from a disatisfied public. One way to avoid potential punishment is to do everything according to the rules and regulations. As I write this a perfect example presents itself, as reported by Rudman (2010). In 2007 the Charities Commission was set up with "the main purpose of improving the transparency and accountability of the charitable sector by registering and monitoring charitable organisations" (p. A11). I suppose this was to protect the public–tax payers from dubious charities seeking donations and a tax exempt status. What are the rules and definitions determining what constitute a charitable organisation entitling it to be registered? It turns out that in New Zealand this is governed by a British law enacted in 1601 known as the Statute of Elizabeth. This 400 year old law is used by the Charities Commission to judge what organisations in New Zealand in the 21st century are truly charitable and can be registered, and it seems the National Council of Women is ruled out

because (cited in Rudman, 2010, A11) its purposes are not sufficiently close "to the spirit and intent of those purposes listed in the preamble to the Statute of Elizabeth" according to Steve Brunton, the Commissions chief registrar. Interestingly, in the UK the list of purposes in that preamble has been brought up–to–date, and the National Council of Women would be a charity in that country, while here in New Zealand rules based on 400 year old definitions from another country are used to rule against along and well–established organisation. Can the Charities Commission be faulted? No. Are they to be admired? Yes. They are simply being bureaucrats.

My concern about the state having any sort of control over the practice of psychotherapy comes from my observation that state involvement means bureaucratisation. The whole system is set up by a bureaucracy: the MoH; and the registration Board has been established through the *Act* (Section 115) — by the MoH. This Board controls the practice of registered psychotherapy by administering the rules and regulations laid down under the *Act*. The Board comprises professional psychotherapists and lay members representing the public and are accountable to the Minister of Health. I know several of the professional members of the Board. I acted as a referee to one and supported others in their selection for membership and have talked intimately with them. They are wise, intelligent and experienced people, but they have become bureaucratised. The system does this to them.

My experience of becoming registered as a psychologist through a grandparenting process on the basis of my MA from the University of Michigan as an educational psychologist was very different. Then the New Zealand Psychologists' Board was relaxed and slow moving in getting the process up and running. They recognised they were introducing a new process and took it slowly to bring people on board, only gradually bringing in stricter requirements and regulations. I expected there would be this sort of gentle introduction to the transition of registering psychotherapists, with some degree of flexibility and allowance for special circumstances until such time as more uniformity was developed across the profession, with senior practitioners moving on, and younger ones coming in meeting all the newly introduced requirements. Times are different now, post *HPCAA*, with all the rules and regulations and definitions of scope of practice firmly in place from the outset, no transition needed or growing into what it means to

be registered, mechanistic not relational. I understand the Board has been and is instructed on what it can and cannot do, and what it must do in its functioning. There has been no growing into its role like the original Psychologists' Board, learning from experience what was needed to guide the practice of the profession. The Psychotherapists' Board, as the other "responsible authorities" established under the *Act*, must follow the directives of the Ministry. I assumed the members of the Board had been selected for their wisdom and competence to make decisions on the basis of case by case situations. An additional problem is the presence of career "lay" Board members (see Chapters 3, 7, and Tudor, 2011). But, no, I have learned that this function would create precedents and precedents must not be set because they can cause difficulty in the future. The Board appears to have no or little power of discretion, or the will to exercise what powers they do have and of being able to make allowances due to changing circumstances (see Chapter 2 and Appendix 1) . One size made in the *Act* has to fit all. The Board has been made aware that its members exist at the pleasure of the Minister. The Minister may at any time for any reason replace a Board member. Board members without any security of tenure are disempowered from acting autonomously and end up functioning bureaucratically. Members of the Board serve at the Minister's pleasure and, it seems that they are overly concerned about incurring the Minister's displeasure.

Culture clash

State power of control of this sort is inconsistent with the emancipatory purposes of psychotherapy. Psychotherapy aims to free people from the bondage of pathological psychodynamics and help them find autonomy and act with full awareness of their inner and outer world in healthy, socially appropriate, creative spontaneity in each circumstance. The system set up under the *HPCAA* for control of the practice of psychotherapy operates on bureaucratic values in a culture which seriously clash with the values and culture of the profession. The rigid ethos and culture of bureaucracy is antithetical to the living practice of therapy in which the therapist risks journeying on an unknown path to health with the client. The Ministry was founded on the medical model. In this approach, once a diagnosis of the bodily condition is established, and the normative treatment of choice is applied, any exception to this route must be carefully defended. This model

is not applicable to psychotherapy. Even if a definitive diagnosis can be made of a person's psycho –social condition, treatment outcome research indicates that it depends on the very idiosyncratic human quality of the interpersonal relationship established between therapist and client, and not on a normative set of treatment procedures. Psychotherapists must feel free to go on the journey to health along a path which suits them and their patient best, and not a route prescribed by an official authority — or "responsible authority". This clash of fundamental world views alarms me. It is no assurance that the politicians who pass Acts such as *HPCAA* tell us to have no fear because Ministry officials know the intent of the *Act* and, as public servants, they will administer it carefully. Such assurance was given by Prime Minister, Helen Clark at the time the Charities Commission was being set up, when alarm was sounded by the National Council of Women, that if they voiced opposition to Government policies and action it could mean the cutting of tax–free charity status. The assurance of politicians has been no safeguard for them. Here is a scenario. Is it possible that Ministry officials decide, as they have done in the UK, that cognitive behavioural therapy (CBT) is the preferred modality of treatment and must be included in all psychotherapists' repertoire of skills in order to be registered? In a recent conversation a senior, experienced practitioner was telling me of a referral he received from a GP in order to provide his patient with CBT. "You can do CBT?" he was asked. He gave an affirmative reply but suggested that, once having met the patient, his assessment might mean CBT was not the modality of choice, whereupon the GP declared that he was sending his patient for CBT or nothing. No doubt CBT is effective for many patients, but it is not a universal panacea. What if the Ministry gets to think like that GP over some particular approach to treatment, and requires it to become the norm? Is it too alarmist to fear the bureaucrats responsible for the practice of psychotherapy could ever get to act like those bureaucrats in the ACC over claims for assistance in cases of sexual abuse? Having seen the straws in the wind I do not think it is too alarmist, rather not alarmist enough.

ENDING

Thus I have made a complete u–turn over the statutory control of psychotherapy. I have registered as a psychotherapist with the PBANZ, but

I am no longer paying my APC fee. This means I am prohibited by law from indicating in any way that I am a psychotherapist. I am making the prohibition very clear, everywhere, today, by saying I am not a psychotherapist and I "once was a psychotherapist". Thus, I have made a u–turn, changing from advocating statutory registration to being opposed to it. I still strongly believe in the need for psychotherapists to be registered, that is, for them to have their names accepted for inclusion on a register of approved names which is available to the public. This register would be recognised by the state by some statutory or legislative means but not regulated by a statutory body like the MoH and its PBANZ. I think all psychotherapists should make themselves accountable for their professional practice, undertake regular supervision, and ongoing continuing education in their field. Such a process of registration requires management and this must not be done by a statutory agency for the reasons offered above.

Public statutes

Health Practitioners Competency Assurance Act 2003.

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Chapter 12

The baby and the bathwater: psychodynamic psychotherapy and regulation

Jeremy Younger

If the power structures of psychotherapy are totalitarian, how can our practice fail to be contaminated in significant measure by them? (Wilkinson, 1999) For the twenty years 1990–2010 I was a psychotherapist. Psychotherapy was what I was been doing. In this creative, fluid, postmodern world, where psychotherapy now lives and has its being, where the "meaning of a word", to quote Wittgenstein (1953), "is its use" (p. 43), I was, beyond all reasonable doubt, a psychotherapist.

Now (in 2011), however, because I believe statutory regulation and, therefore, state registration, is fundamentally antithetical to the very nature of psychodynamic psychotherapy, I am not willing to register with the Psychotherapists (Registration) Board of Aotearoa New Zealand ("the Board" or "the PBANZ"), and, therefore, can no longer refer to myself as a psychotherapist — at least, that is, according to the modernist, totalitarian dictates of the state which calls the tune. The Board is made up of people I don't know and haven't chosen; whose credentials I have no control over; and who stay resolutely and effectively out of relationship with me as the authority or body charged with the task of enforcing the state's decision that I am no longer a psychotherapist.

Of course the state has power to control things. It can chase me up, hound me, charge me, fine me, and, I suppose, handcuff me, imprison me, and even worse, but that in no way changes the naming and meaning of what I have been doing, nor my passion for what I have been — and am — doing. I may have to call myself something else till all this distractive bother blows over but, for the integrity of the work I do, for the good of my patients with whom I work, and for the love of my profession, I must protest. This is my duty to my patients who are presented with the claim that they will be kept safer if the psychotherapy profession is regulated by the state. It is my contention that this political process leaves me and my patients far from safe with little that I recognise of the risky, radical, relational matrix necessary for us to do our work together.
[The reader (and the Board) will note that, by using the pronoun "our", I am associating myself with being one of a number and a body of "psychotherapists"; however, both will also note that I have done so, in the past tense.]

While the bathwater of regulation swirls around and away, offering the illusion that all things psychotherapeutic are now safer, I am left fearful that the tender, tentative, wild, vulnerable (baby) nature of our work is all too likely to be washed down as well into the oblivion of political expediency.

Don't get me wrong, I have no problem with psychotherapy registration. As a member of the New Zealand Association of Psychotherapists (NZAP), I am already registered: our *Register*, published each year, publicly attests to this (see NZAP, 2010). It is here in the NZAP that I find my professional association and academy, made rich through history, scholarship, trust, and relationship. Each year we elect from among our peers, other psychotherapists, in whom we have confidence, and to whom we give a mandate to support, challenge, develop, and make safe for patients and practitioners the work that we do together. It is within this professional body, that, understands the nature of our work, that we have contracted for supervision, and developed and welcomed codes of ethics and practice, prepared with insight and care, to guard and guide our work as psychotherapists.

At the heart of this psychotherapy academy, I believe there is a constant imperative to think and wonder, psychotherapeutically, about the nature of our profession: about the nature of what we do, how we understand

authority and how we exercise it, especially in the face of the ubiquitous, defensive reactions in society to the dislocation of modernist fantasies of control and mastery. I am amazed how seldom this thinking and wondering seems to have happened. It is interesting and perhaps salutary to wonder why, as the state has been setting up this attempt at regulation, so little psychoanalytic or psychodynamic analysis of what is being attempted has taken place — with the notable exception of Parker and Revelli (2008). Instead it seems the therapy profession, unthinkingly and even unwittingly, welcomed it with open arms or at least acquiesced to it willingly — or so we are led to believe. Am I unduly paranoid when I continue to worry about the regulatory expectation to welcome the controlling eyes of the state into my consulting room? By desiring regulation, were we, as a profession, falling too easily on the sword of respectability instead of fighting for the countercultural freedom that I believe lies at the very core of my impossible profession? Yes. Why did we roll over, shake our legs in the air, and wag our tails at the thought of professional acceptance into the structures and strictures of the health care industry, when the one thing psychotherapy is not, for me at least, is a health care profession? Because we were compliant rather than dynamic. As King and Moutsou (2010) put it:

> The main reason for the protest is that state regulation of the profession is seen as incompatible with the nature of contemporary psychoanalytic practice, where the emphasis is not on treatment of an illness or symptoms, but rather on the establishing of a conversation with someone suffering from some form of distress. (p. 1)

In this chapter I look at some ways in which I think state regulation is antithetical to psychodynamic psychotherapy, especially as the latter is tentatively embracing the post — modern turn. Psychodynamic psychotherapy is for me a professional and confidential alliance entered into by client and therapist freely in which they make use of a variety of conscious and unconscious, relational processes such as transference and countertransference, free association, interpretation, metaphorical translation, conversation, reflection, fantasy, waiting and silence, to explore together the conscious and unconscious life of the client so as to gain greater understanding which may enable change.

The unconscious

First of all, psychodynamic psychotherapy works to bring the unconscious into consciousness through various processes: free association, dreams, jokes, slips of the tongue, automatism, (spontaneous verbal or motor behaviour) and then works with the divided (or fractured) structure of the patient that is thereby revealed. All psychotherapeutic modalities recognise the existence of transference, the movement of unconscious forces that shape the details of our lived, affective experience of other people and relationships. Transferences are a fundamental aspect of psychotherapeutic work. They are informative, analysed, interpreted and developed. They provide a rich, vibrant, difficult energy which cannot be managed, just worked with. The work with transference cannot be regulated, but it does inevitable and fundamentally shapes the experience both psychotherapist and patient have of the patient's reality.

The purpose of state regulation, we are told, is the protection of the public, that is, the patient. However, we have to ask what aspects of the patient do the regulators think need protecting against the psychotherapist? The subject posited by psychotherapy is split between conscious wishes, and demands, and unconscious desires, phantasies, and forces that might be quite opposed to the patient's conscious volition; conscious demands and unconscious desires rarely coincide. Many of the unconscious ideals and phantasies bring pleasure which the patient is loath to give up, despite the fact that this pleasure is often experienced consciously as pain and suffering. In working psychodynamically with such a patient the psychotherapist has to face the fact that the patient might be coming into therapy in order to restore or maintain his or her neurotic structure, which unconsciously they are committed to maintain. The job of the psychotherapist is to challenge and enable the alleviation of the neurosis itself. In a very real — and dynamic — sense, what the patient wants and what the psychotherapist offers are radically incompatible and, moreover, the individual can rarely give informed consent to an unknown and unmapped exploration. This view of and approach to psychotherapy challenges fundamentally the idea that the psychotherapist is a service provider in the way that other "health practitioners" may be.

Symptoms and dynamics

Psychodynamic psychotherapy, in contrast to medicine and to some other therapeutic approaches, does not work to remove symptoms, rather to access unconscious structures via an analysis of symptoms. Symptoms are information, a means of communicating, a gift to the work. Psychotherapy is the process of stumbling on hints where symptoms are recognised and shown to be failed but brave attempts to deal with unconscious demands, desires and difficulties. Psychodynamic work is never neat and tidy as symptoms are systematically removed; instead we have the messy untidiness of a risky exploration by patient and psychotherapist together into what cannot be known, or anticipated.

This untidiness and risk inherent in psychodynamic psychotherapy is in the relationship between patient and psychotherapist. If this relationship is regulated in order to (attempt to) make it safe, inevitably something creative is lost. To quote Leader (2008):

> We choose the clinician due to transferences; links and associations that will be unique to our own histories and that often select features that society may deem unsavoury. The clinician will be chosen because he is a womaniser, corrupt, feeble, a secret drinker, a tyrant, etc. It is nothing less than the exploration of these associations and details that will allow change and true analytic work, and so it makes no sense to sanitize the image of the clinician. (p. 211)

Given this particular way or working, which has more to do with understanding than cure, more to do with exploration than symptom removal, we can see that psychotherapy stands in stark opposition to medicine (see Freud, 1926/1959) and to "health" care and health services. Based as it is in the explorative relationship between patient and psychotherapist, and committed as it is to the unravelling and revealing of the unconscious that lies so forcefully hidden within every person's story, their history, their structure and their being, psychotherapy has far more about it that is redolent of art than science — and art cannot and should not be regulated. The very safety patients and psychotherapists crave and create both in the consulting room and in the relationship is not an end in itself, but, rather, provides a container in which both therapist and patient can risk

what is fundamentally unsafe, that is the exploration of the conscious and unconscious life of the patient.

The medical model of healing is that of the expert doing something to the patient: the surgeon operating, the GP prescribing. On the other hand the therapeutic art is, as Phillips (1995) has said, something very different, "a conversation between two people in which they have no idea what they are doing but know they don't want it to stop" (p. 42). The therapist is not in receipt or possession of knowledge which he or she tries to impart to the patient. If therapists are experts in anything, they are experts in not knowing and, in company with the patient, in wondering and musing, imagining and creating. These are activities that cannot be regulated or registered, any more than the works of Picasso or Mozart can be regulated, 'though they can be censored. There can be no expectation contained in the work of therapy; neither the therapist nor the patient can know in advance what the patient is wrestling with.

Therapy is less about cure and specific, measurable outcomes and more about understanding, where the therapist and the patient work together to create a discourse of understanding of and for the patient. Certainly, in doing so, change takes place, but it is change that cannot be planned, ordered or predicted. In this therapeutic process there is no measurement of success for either therapist or client.

CONFIDENTIALITY

All psychotherapeutic work is confidential. The work of psychotherapy is contained within the consulting room and the minds and memories of the patient and psychotherapist. How can confidentiality and regulatory registration sit together without compromising each other? What does confidentiality mean in a regulated profession? Here I think we find a fundamental clash between law and justice. Derrida (2002) wrote:

> Every time that something comes to pass or turns out well, every time we placidly apply a good rule to a particular case, to a correctly subsumed example, according to a determinant judgement, the law (perhaps and sometimes) finds itself accounted for, but one can be sure that justice does not. (p. 244)

His position is that law is calculable (which may be an expression of the limits of regulation), but justice is incalculable (which on the other hand may express the creative breadth of the psychodynamic). To be just one must follow the law (confidentiality is ubiquitous) but also, somewhat paradoxically, suspend it enough to reinvent it in each case (if we think psychodynamically, every case is a new decision about confidentiality). Free decisions demand that, every time, we go through the process of "undecidability" (Derrida 2002, p. 253). Goldberg (2007) put it succinctly:

> We should entertain the very promising thought that psychodynamics is a marvellous hybrid that lives by rules that it regularly reinvents. The struggles brought to analysis and therapy are not the kind that are solved by an effort to conform to some standard or principle carried and enforced by the analyst or the therapist. Such enforcement of a "law" is too easy. The real solution, one that may make a claim to a just and moral decision, comes about only by living through the painful state of uncertainty. However, this matter becomes more complicated still when we find ourselves looking through the lens of the unconsciously embedded guidelines, when we realize we live by words and ideas that are never spoken. (p. 20)

Regulation demands certainty, psychotherapy demands uncertainty. In psychotherapy rules only have power when they can be thought about by the patient and the psychotherapist together. Patients need to know that no – one else is in the consulting room making rules that can't be thought about, that for once in their lives there is a place where in the matrix of not knowing they can find their own discourses and have them valued, understood and respected. State regulation will never make this possible and, what is worse, guarantees that it will in future be impossible.

LANGUAGE

At the beginning of this chapter I wrote that we need to go back to fundamentals and consider the way that language lies at the heart of this discussion of state regulation. To find meaning it is necessary to look at how words are used and, therefore, how they function. If you want to describe and explore meaning as it relates to the particular discourse of the

NZAP or that of the Board, we have to look at how words are used in people's chatter.

In *The Structure of Scientific Revolutions*, Kuhn (1962) argued that science hasn't developed in a rational linear way, but rather that the history of science is a series of ruptures or "paradigms" which have repeatedly swept away the assumptions (the certainties) of previous scientific regimes. He argued that in science the illusion of continuity is created by the recurrence of terms or concepts that on careful examination are revealed to have very different and incompatible meanings from paradigm to paradigm. The language looks the same, the words may be the same, but on closer examination they are doing different, often opposite things in different contexts.

All this is about language and how it functions. We need, therefore, to look very carefully at language and the words we use because their meaning lies in their use. For psychotherapists, words are our stock in trade so that's why it's important to look at how psychotherapists talk to each other, to patients, and how people are trained in psychotherapy talking. Rather than relying on the myth of universal truths, as a profession we need to be far more subtle, creative and nuanced, and to find meaning in the use of our particular and fascinating discourse. A discourse is a system of possibilities, a language game, a possibility for knowledge, practice and power (see also Postle, 2010). A discourse is a set of rules around language that, within a particular and limited environment, be it science, therapy, sex, rugby, domestic life, train spotting, or state regulation, we identify and determine some statements as true or false and thus enable a map, a model, a classification system to be constructed to organise these statements.

These rules provide the necessary conditions for the formation of meaning and the exposure of nonsense, and within the discourse, and only within it, the production of truth. In this post–modern world, which psychodynamic theory seems so reluctant to embrace, truth is constructed, it is not universal: it is an effect of discursive rules and practices. A discourse itself in its entirety cannot be true or false, truth is always contextual and rule dependent, discourses' are always local and heterogeneous.

So as we put our brass plates on our doors and our graduate certificates on the walls, we psychotherapists mark out a domain within which we claim

authoritative or privileged knowledge, or at least the means to obtain it and judge it. Our work comes into being through language. Of course, this psychotherapy discourse relates to other discourses, be they science, medicine, ecology, politics, management, literature, religion, or the occult.

The history of psychotherapy is full of the strivings for therapy to position itself alongside other, particular and perhaps more acceptable and respectable discourses in the hope of gaining some authority and acceptance, but often with little generosity or reciprocity. There are often fierce battles for territory between professional discourses; we only have to think of a team meeting at a psychiatric hospital when the patient's therapist meets with psychiatrists, nurses, community workers, social workers, and administrators.

It is here that the accrediting institutions come in. These are the institutions, the academies that authenticate truth and meaning. Without them there is no psychotherapy theory, no clinical practice, no fees, no therapy community, and no profession. This is perilous territory to enter. There are many academies: some are contextual and local; some arise to protect and authorise particular ways of talking; some have been established in opposition to other discourses. The business of control and power is contentious and it's easy to enter a world of paranoid schizoid structures rather than explore together and learn to tolerate the dynamic flux of authority, accreditation and power. Starhawk (1990), the American psychotherapist, has offered a model of power, proposing three varieties:

- Power–from–within — In this psychotherapists seek to evoke, enhance and deepen the power–from–within of the patient. This is the power to survive, to recover, to flourish, to understand, to belong, to love and be loved.
- Power–with — This refers to co–operation, negotiation, parity, mutuality and sharing.
- Power–over — Power–over refers to a form of control that relies on bullying, coercion and domination with the necessary threat of force, sanctions and threat to ensure compliance, deference, obedience and subjugation. As Starhawk (1990) puts it: "Power–Over motivates through fear. Its systems instil fear and then offer hope of relief in return for compliance and obedience." (p. 53)

It would seem that it is in the power–over model that the force of the state is engaged through regulation in consolidating the psychotherapy profession. Psychotherapy is full of people who have challenged the psychotherapy institutions: those within are of course the most challenging, and because of this have often had to face expulsion or excommunication. We only have to think of Jung and Reich and Lacan. Life is never tidy or discrete, and neither is language: domains overlap, some seem contained within others and from time to time conversations within or between different domains reach inevitable impasses. All we can say then is that you have your say and I'll have mine. We also speak within many discourses at the same time and move from one to the other with ease or as often as not struggle without even knowing. So we move from the familial to the therapeutic to the sexual to the regulatory and, in each, position ourselves within a particular and distinct discourse. Occasionally we get it wrong!

It is my fear that psychodynamic psychotherapy will slowly lose its teeth and become adapted. If the culture of fear and protection has its way, psychotherapy will be sanitized and man–handled, with little space for unconscious processes or transference; it will be emptied of subjectivity, with no place for the embracing of what is unknown. We are not in the job of acquired knowledge but of putting all knowledge into question. However, with few exceptions, it is the very process of regulation that has not been sufficiently questioned from a psychodynamic perspective, and because of this the work of psychotherapists with their patients has been put at danger rather than protected from danger, the danger we see as the "baby" of this precious work is lost in the contaminated bathwater of regulation!

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Chapter 13

The neuroscience and politics of regulation

Louise Embleton Tudor

For many years, both as a psychotherapist and as a mother, I have been interested in and informed by attachment theory and neuroscience. On this basis, I have been intrigued by the fact that professional organisations and the state, when referring to the organisation of psychotherapy, use the term "regulation". In this chapter I explore the neuroscience and politics of regulation and draw analogies between the two. This subject, and the parallels between the world of human development and the world of human politics, is not only of professional and clinical interest, it also holds a personal interest. In terms of my own personal history I was generally under–regulated as an infant and over–regulated as a toddler and a child — in psychosocial terms probably the most common combination of parenting in the UK in the early and mid 1950s. Later, for ten years from my mid twenties to mid thirties, when I was working as a teacher, I became active as a trades unionist, which in many ways is concerned with mediating external regulations and regulation. The personal is indeed political — and, of course, the political is personal. We all have our own history of being regulated, both developmentally and socially/politically. In this contribution it is my intention to invite reflection on personal histories of regulation,

motivations for regulation, and the mechanisms of regulation in the context of state and professional regulation.

Four points inform my thinking about this subject:

- That regulation may be thought about in terms of hierarchical organisation and of balance or homeostasis.
- With regard to the regulation of psychotherapy, that it is framed predominantly in terms of external rules in the form of codes and competencies, and not in terms of self–regulation.
- That while the regulation of psychotherapists is an attempt to regulate an activity or a profession, the *manifestation* of this is to regulate people and thus I think it is more appropriate to think about regulation of psychotherapy in terms of balance or homeostasis between diverse forces.
- That when we talk about rules, regulation, codes of ethics and professional practice, and notions of competence, we are talking about the activity of society and government or, as the Ancient Greeks understood it, the polis, and hence I consider that it is impossible to discuss regulation and or registration without an understanding that it is political.

THE NEUROSCIENCE OF REGULATION

Every organism, from neuron to individual human being to a group of psychotherapists is dependent for its growth on interaction with others who share its defining characteristics. The need and ability to regulate, is an inherent capacity of all organisms. Macmurray, a philosopher who wrote two books on the form of the personal (Macmurray, 1957/1991, 1961/1991), conceived of the organism (1957/1991) “as a harmonious balancing of differences, and in its pure form, a tension of opposites” (p. 33). When I think about this I remember experiences at professional gatherings: a group, sometimes harmonious, sometimes in a state of tension, but a group–as–organism trying to accommodate its tensions in the form of differing needs and opinions.

In drawing the analogy between regulation in terms of human development and statutory regulation, here I discuss three aspects of development

informed by neuroscience: self–regulation, hierarchical organisation, and the importance of self–esteem and the carer's gaze.

Self–regulation

As with all organisms, human beings are constantly engaged in adjusting, responding and adapting to stimuli from the environment. This is an ongoing process, happening mostly without us being aware of the inner processes and changes taking place; although, as psychotherapists, we make it our business to engage consciously with these visceral clues to our changing states. Whoever we are, regulation is the stuff of everyday work and play, rest and activity and, of course, it is central to the way we experience ourselves and the way we engage with others.

In his book *Descartes' Error*, Damasio (1996) made the point that the overall function of the brain is to be informed about what goes on in the rest of the organism, within itself, and its surrounding environment, so that adjustments which ensure its survival and homeostasis may be made. Thus we are able to appraise the environment: to interpret signals; to categorise; and to decide whether to act or not, and, if so, whether to dance for joy, run for cover, choose a sword or a pen, compose a symphony, rock the baby — or rock the boat! Of course, this function also applies to a group such as a professional body and its capacity — or incapacity, competence or incompetence — to appraise the social environment for clues as to the degree of support for and threat to its integrity. This is a self–regulatory capacity which begins, albeit in a comparatively rudimentary way, at conception, and continues developing at the interface of genetics and experience. Genes serve as a template for the brain and provide structure and triggers for sensitive periods of development. Through a process called transcription, genes transform experience into neural material. The neuroscientist Cozolino (2002) put it thus: "through the biochemical alchemy of template and transcription genetics, experience becomes flesh, love takes material form and culture is transmitted from one generation to the next." (p. 6)

Hierarchical organisation

Thus a similar, also unspoken, transmission of the culture of a profession takes place between trainer and trainee, supervisor and supervisee, and

between more and less experienced colleagues, all of whom engage in a co–regulating relationship, with one person (trainee, supervisee) usually being more impressionable and vulnerable in such relationships than the other. Such relationships may be mutual but they are necessarily asymmetrical (see Aron, 1996). Indeed, hierarchical organisation is part of our humanity. The prefrontal cortex of the brain performs an inhibitory function over other functions. As Shore (1994) put it, the "higher cortical areas that act as a 'control centre'." (p. 139). Hofer (1984) also referred to the powers of restraint and executive function exerted by the pre–frontal cortex. The neuroendocrine system too is a hierarchy, with the higher centres regulating the lower ones. The analogy here is that a regulatory authority, such as the Psychotherapists Board of Aotearoa New Zealand ("the Board") acts on behalf of the state, as a "control centre" and performs the function of inhibition and restraint of an unregulated body of psychotherapists and, supposedly, protects the public from their unrestrained impulses.

However, the highest functions of the brain/body manifest effectively only in the context of a relationship which is mutual, attuned, playful, and reciprocal — and the point is that this relationship encourages hierarchical organisation in the child. Instructions, demands and requirements do not facilitate the development of higher brain function and smooth social exchange. In fact, the opposite is true. When a child does not have the opportunity to engage in the ups and downs of a reciprocally admiring relationship, with its inevitable ruptures and repairs, the development of self–regulatory processes is impaired and, usually, seriously so. Thus, if there is an absence of mutual admiration and regular, attuned, open and reciprocal and, even, playful relationship in the form of communication between, in this case the Psychotherapists' Board and psychotherapists, the "body" of psychotherapists is at risk of feeling at first anxious or mistrustful, then perhaps disengaged or cynical, and of becoming ultimately collapsed, passive, and even dissociated from their own management and organisation, including regulation and registration. Writing about her own experience of the process of regulation Green (2011) captures this sense of dissociation.

Thus, the self–regulatory, creative, communicative, and co–operative functions and the potential of psychotherapists as a group, with all our differences, are undermined by the existence of a board, representing the

state, whose joint purpose is "to protect the public", not to promote the growth and development of practitioners or of practice, and which is not accountable to the subjects of its gaze, the people who practice psychotherapy. Instead of a regulatory process which reflects human development, we have a "top down" attempt to regulate, in the sense of imposing rules, regulations, and requirements. From a neuroscientific perspective this form of organisation actually makes practitioners less safe as they have given over their ability to control themselves. This form of regulation and registration also and inevitably results in hierarchies of registrants, would–be registrants, and those who, by definition (of the state) are ineligible for and, therefore, excluded from registration. Furthermore, if the experience of other countries is anything to go by, this hierarchy is likely to evolve further to attempt to include formal processes for the recognition — and regulation — of trainers and supervisors (see also Chapters 7, 8 and 19). If more organisation of the activity or profession is needed, it would be more consistent, at least from a developmental point of view, to have a 'bottom up' development, parallel to a natural order of things, from simple to complex organisation: something which begins with self — regulation and co–regulation, and in this way facilitates the whole organism of psychotherapy, with all its diversity, to adapt to changes from within and from without.

We fail to engage actively at our peril. Neuroscientists say: "Use it or lose it", by which they mean that neurons which are not used eventually atrophy. Thus, if we rely on a powerful few, out of context of engaged, responsive and dialogic relationship, to determine the thorniest issues and to create rules for all of us, we undermine our self–determining nature as well as our abilities to engage actively with the ethical and moral issues relevant to practice. Much as the child is disregulated by lack of connection, there is a danger that, as a group of associates, we lose any cohesion, and become governed through division and apathy.

Self–esteem and gaze

The primary determinants of the success of a mother's attempt to influence her infant's autonomic regulation, and well– being are the state of her self–esteem and the qualities of her gaze. All else being well, confident and

proud mothers will generally produce confident children, with well–developed self–regulatory abilities.

Embryologically and anatomically, the eye is an extension of the brain. Variations in pupil dilation can produce up to a five–fold change in the amount of light reaching the retina, and open–eyed bright gaze elicits brightness (in both senses of the word), visible in the eyes of the child. We know that the caregiver's interest stimulates the child's interest: a direct brain–to–brain, right hemisphere to right hemisphere communication, operating independently of movement and behaviour. Conversely, "neutral" gaze, free of affect, elicits negative affect in infants (Tronick, Cohn & Shea, 1986). In slightly older children, and adults too, completely neutral or negative gaze results in a parasympathetic collapse, or shame, experienced as an intense uncomfortable awareness of the body and a desire to disappear or to not be seen. Thus, throughout life, gaze "acts as a hidden regulator" (Hofer, 1984, cited in Schore, 1994, p. 83). Subject to kindly interested attention we feel good about ourselves and we are motivated, whether at school, at work, in friendship or in love. When observed neutrally or negatively in those same settings and relationships, we feel demotivated, and at worst, frightened or angry. So we might — and, indeed, should — ask: with what sort of expression does the state and the Board appear to gaze on psychotherapy and psychotherapists?

If we feel threatened, we naturally seek to protect ourselves. If the experiences of other countries are anything to go by — and it is worth noting that most other countries do not regulate psychotherapy and psychotherapists — when registration arrives, so too do legalistic means of solving disputes and, in response, defensive practices (see Mowbray, 1985). In this situation, psychotherapists trust themselves — and others — less, and their clients even less than that. The greatest sacrifice is the creativity and flexibility needed to identify and to allow the usefulness to a *particular* client, at a *particular* time of an action which is unusual or exceptional to us, even one which breaks an unwritten rule. In such a climate, dogma develops e.g. "Never touch a client in any way" or "Always get the client to sign a contract" — and "This is what the contract should include". In this brave new world of registration, what place is there for authenticity, transparency, spontaneity and trust? Moreover, we run the risk of mirroring the very features of society which are problematic for many of our clients.

Further, we create a climate in which trainees and supervisees feel that they need to hide their mistakes, real and imagined, from their supervisors, and dare not explore their creative, critical or "out of the box" thinking.

Of course, this also applies to the relationship between the state and the Board. If the state "gazes" on the Board with indifference, then the Board is likely to feel unappreciated and defensive.

THE POLITICS OF REGULATION

In the first half of this chapter I have presented a necessarily brief exploration of some of the factors involved in the regulation of the human organism, and I drew some analogies and parallels with the regulation of psychotherapy. In the second half of the chapter, I argue that both forms of regulation are political. This becomes clear when we ask relevant questions, such as: "What is the purpose of regulation?", "What are the consequences of not being regulated or of de–regulation?" and, perhaps, most importantly, "What are the consequences of dys–regulation" Also: "What is our relationship with society?", "How do we balance all the relevant and significant factors?", and "Who knows best?"

I am aware that when some psychotherapists talk or write about therapy and politics, others turn off and say: "What has politics to do with me?" or "It's a waste of time, let's just discuss clinical work." When I hear these statements I hear something like: "I feel overwhelmed by the suffering and injustice in the world", "I feel powerless to change anything outside the consulting room" and maybe sometimes even: "I'm just too tired to listen to any more of people's experience." I have to say that there are times when I share all those reactions and sentiments. However, we would not exist as psychotherapists were it not for the vississitudes of our clients' lives, which, of course, result from a combination of social, economic and personal factors. Whether we label the causes of suffering as trauma or addiction, or as exploitation or oppression, most psychotherapists would agree that personal suffering has its origins not only in a psychodynamic but also in a psycho –social dynamic. What may be described as "relational" issues result just as much from prevailing ideologies about child–rearing and the social and economic realities affecting family and whānau, as much as from individual or intrapsychic factors. Furthermore, neither psychotherapy nor

psychotherapists exist in a vacuum: both are part of society or, as the Ancient Greeks had it, the polis. In this sense, psychotherapy is political because it exists and takes place in a polis or political and social context. Recent events regarding the Accident Compensation Corporation, and the response from many psychotherapists, bear out the sensitivity of many of us to the political nature of the context of psychotherapy. The regulation by the state of psychotherapy is, by definition, another political issue.

Proponents of the statutory regulation of psychotherapy and the state registration of psychotherapists generally cite two main reasons in favour of regulation and registration: firstly, that it is the best if not the only way to protect the public; and, secondly, that it affords psychotherapists the benefits of professional status. Here I address these reasons — or, more accurately — assumptions (see also Chapter 8).

The assumption that the regulation of psychotherapists protects the public

Such a position uncritically supposes that registered practitioners are less likely to abuse their clients than unregistered ones. There is no evidence for this, and there is evidence that registration does not eliminate abuse. The most extreme example of this is the most prolific serial killer the world has ever known, the UK GP Dr Harold Shipman, who murdered over 250 patients over two decades and is suspected of killing as many more — and at the time was registered with the UK's General Medical Council. Other examples of abusive but registered therapists are described in Masson's (1988/1989) book *Against Therapy* . Those of us who have been around a while have heard in our consulting rooms too many horror stories of distinguished psychiatrists, doctors, psychologists and therapists who have abused their patients' trust. As registration did not prevent it, is it likely to be the deciding factor in whether or not some registered psychotherapists are abusive. I think not. Asserting that there is "a huge amount of research" which shows that about 10% of all professionals abuse their clients sexually ('though not citing any of it), Pokorny (1998, p. 265) went on to suggest that: "the only constant index of the likelihood of a psychotherapist abusing a client sexually is to have been sexually abused during training, by one of the training staff." While sexual abuse during training may be an indicator of risk that the person may become a perpetrator, there is, however, no evidence that registration is an indicator of prevention.

Another problem with regulation is that while the existence of a register is intended to reassure the public, it can also provide a false sense of security: the public are likely to assume a level of safety which does not and cannot exist and which, therefore, makes the public's position less, not more safe. Mowbray (1985) called this situation an "institutionalizing of the transference" (p. 129). He argues that it is a myth that the public can be protected from the difficulties of choosing a psychotherapist and that registration encourages people to "look up to" and to defer to the state–approved expert, to lower their natural self– protective guard, and thus to be lulled into a false sense of security. Also, where psychotherapists are accorded higher status and authority by virtue of registration, it can become harder for people to complain and harder for the complaint to be seriously addressed. In the UK, I observed that, following a complaint and during the hearing of the complaint, the psychotherapist was effectively abandoned by the registering body, and that, during the process of hearing the complaint, the balance of power shifted significantly in favour of the client. Even when the outcome was favourable to the psychotherapist, their reputation, and sometimes their career, was affected.

The other side of this particular coin is that registration enhances the status of the registrant and encourages a self–view of an officially recognised expert, with all the authority implied in this. This is the direct opposite of how most of us say we want to represent ourselves in the psychotherapeutic relationship. It does nothing to promote a relationship between *different equals*, one within which clients can easily find or assert their own power — and, indeed, not have it taken away in the first place.

So to another frequent argument about protecting the public: that when someone seeks psychotherapy they may be too distressed and vulnerable to make a good decision about who can be trusted to help them. I accept that this is true — for a relatively small number of people whose functioning in the world might put them at risk in numerous ways. Of course, these might be the very people who might not think to consult a register. The majority of would–be patients and clients are mercifully not in such dire straits, and retain enough sense to ask around for recommendations, to ask some questions about and of their potential psychotherapist and to evaluate their own experience during the first meeting. To suggest that potential clients lack that ability even as they acknowledge a need for help, is to patronise

people, and to fall into the trap of equating vulnerability with weakness and deficiency. Schlutz (1979) argued that:

> In the present situation I rely on the State to tell me who is competent. I passively submit myself to a professional and if I don't like what he does, I sue him for malpractice. My role is inert and child–like. If I, as a consumer, know that I am responsible for selecting a counsellor, I am likely to assume a more responsible stance. In many cases the very act of being responsible will have a therapeutic effect. (p. 157)

The assumption that regulation and registration — and professionalisation — enhances psychotherapy and psychotherapists

While registration may enhance individual psychotherapists, in terms of status, employment, salary, etc., I am not sure that this is a sufficient reason to advocate or seek statutory regulation and state registration — and it is certainly not a sufficient enough reason for the Ministry of Health (2010) (see also Chapter 8) — and I am not sure it is worth what I and others regard as compromising the nature and purpose of psychotherapy (see, for example, Chapter 12).

House (2003) has argued that the success of therapy over the last decades is precisely because there has been no concerted effort to control it in relation to any agenda from the state. The array of modalities, philosophies, traditions, and techniques derived from all facets of human experience and creative and relational endeavour, all of which have influenced the field of psychotherapy, is part of its richness and part of the choice hitherto available to the public. Assurances to the public of psychotherapists having the *same* standards and training as each other and conforming to the same procedures — let alone health/medical "procedures" — are not only misleading but also undesirable. Were this to become true, by (no) virtue of the registration processes, we will have given away our individuality and our autonomy and, if this were to become the case, who or what may we be for ourselves, for our patients or clients, with a compromised individuality and autonomy? Issues of diversity and choice are especially pertinent here in Aotearoa New Zealand because our bicultural context and diverse population requires us as psychotherapists to be diverse — and to have

diverse psychotherapists (see Chapter 5). Compulsory registration and standardisation often result in the application of criteria which are irrelevant or not appropriate to the context of the development of a profession (see Chapter 9), groups or individuals The exclusion of Māori psychotherapists is particularly ironic in the context of our bicultural society and the common Treaty principle of partnership which, from our present perspective, we could understand as the perfect opportunity to *co– regulate*, in both senses of the word. Experience in other countries suggests that, as a "profession" becomes allied with the state, there is an intensification of state control with the result:

- That only certain forms of therapy are funded namely, cognitive behavioural therapies (see, for example, the UK's National Institute for Health and Clinical Excellence, 2007) and, that access for clients to a diversity of therapeutic modalities is decreased (see Tudor, 2008) — as is access to employment for a diversity of therapists.
- That short–term therapy is favoured over long or longer–term forms of therapy.
- That only certain forms and methodologies of research are accepted by the government on the basis of economics rather than "evidence" (see House & Loewenthal, 2008).

In state guidelines and contracts, we find the language of medicine and the market–place. Here is one example of many, from the Health Professions Council (HPC) (2009a) in the UK, and concerns the proposed requirement that psychotherapists and counsellors (HPC, 2009b): "be able to evaluate intervention plans using recognised outcome measures and revise plans as necessary with the service user" (p. 9). "Intervention plans" — do we all frame our work in this way or see the benefit of these? "Recognised outcome measures" — clearly not all psychotherapists work to these and, in any case, whose outcomes measures are recognised by whom? The Council also requires that psychotherapists and counsellors "understand the principles of quality control and quality assurance" (p. 9)! For a thorough and rigorous response to the HPC's proposals, see Postle and House (2009).

One apparent gain of state registration for psychotherapists, and one which is often cited, is that of greater recognition by statutory health services. My own thinking about this, and one which is informed only by my experience

in the UK, is that such "recognition" comes at too high a price. In the context of the public health sector, the onus is on the psychotherapist to accept her or his place in an organisation which privileges the medical model of mental illness and health, in a hierarchy which recognises psychiatry as the dominant discipline and psychiatrists as superior; and, generally, policies and procedures do not understand, support or reflect the nature of the psychotherapeutic relationship (see HPC, 2009a, 2009b).

I wonder and worry about the impact on psychotherapists if they become rooted in a competitive, exclusive and excluding, top–down hierarchical structure. From such a position, how can we foster in clients troubled by the impact of modern materialism the ability to resist, or to have integrity in dealing with wider cultural and market pressures? Such a position might also have a negative impact on our understanding of oppression and our relationship with the dispossessed and the excluded — with regard to colleagues as well as clients.

In 1942 Wilhelm Reich wrote of the process of professionalisation in psychoanalysis: "Slowly but surely it was cleansed of all Freud's achievements. Bringing psychoanalysis in line with the world ... took place inconspicuously at first ... [but gradually] Form eclipsed content; the organisation became more important than its task." (Reich, 1942/1973, p. 125)

Whither now?

As a gloriously disparate group, psychotherapists have created spaces to learn, to co– operate and sometimes to fight, in our established, but evolving, colleagial groups and free associations. I am curious about whether and how these could further evolve self–regulatory and peer–regulatory systems supportive of creative and responsible practice *and effective challenging* of irresponsible or unethical practice (see House & Totton, 1997). The task is whether we can achieve that delicate balance of being in the world, without necessarily being, in Reich's words, "in *line* with the world" (my emphasis).

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Chapter 14

Registering counselling's commitment to partnership, doing no harm, and eco–social justice

Sue Cornforth

Registration poses a serious challenge to counselling. It puts to the test counsellors' commitments to shared core values and organisational processes. It forces a re–consideration of both the wider context within which counselling is practised, and the specifics of practice. During what has been a long and arduous journey, counsellors are considering registration as both noun and verb: what will registration mean to them, and how can they best register their own interests, beliefs and commitments? This chapter focuses on debates within the New Zealand Association of Counsellors (NZAC), and locates registration within the multifocal, contradictory phenomenon of neo–liberal governmentality. It proposes that key features of this ethos, possessive individualism and performativity, are less than useful in addressing the more pressing problems of globalisation and climate change. It stresses the importance of counsellors registering their commitment to social justice, partnership, and doing no harm, if they are to hold fast to what it is to be a counsellor in an era of change.

With over 3,000 members NZAC is the largest professional body of counsellors in Aotearoa New Zealand. In 2007 it combined with several other counselling organisations to develop a joint proposal for registration. However, registration (as a noun) has proved to be somewhat divisive amongst counsellors, in particular amongst the NZAC membership, which has grappled long and hard with the possibilities of such a move. Although a recent Future Directions survey indicated that 70% of members and provisional members who responded would remain with NZAC should registration proceed, 5% responded that they would not renew their membership and the remaining 25% were unsure (Bocchino, 2010). Over time, there have been various strongly argued requests that the NZAC membership and Executive re–examine their approach to registration (e.g., Webb, 2007; Manthei, 2008). Throughout this ongoing debate, registration has been increasingly viewed by many members as inevitable, related to safeguarding the status of counselling, and ensuring future access to funding, even though it creates particular problems for particular groups: school guidance counsellors, who face the financial burden, and practical challenge, of double registration as both teachers and counsellors; those who work with limited or voluntary practices, who may not be able to afford the fee; trainees and educators who must cope with the increased cost and potential bureaucratisation of training and education requirements; and those who work with various indigenous or innovative approaches, whose philosophical positions might not be well understood, or compatible, with mainstream approaches. It is particularly challenging for the Māori membership who do not see a commitment to the Treaty of Waitangi foregrounded in the *Health Practitioners Competence Assurance Act 2003* ("the *HPCAA*" or "the *Act*"), under which registration was for some time sought (see Chapters 2, and 5). Furthermore, many counsellors cannot see that registration will be of any benefit to the clients whose interests they have at heart.

Given these associated concerns, which are not limited to counselling, or to counselling in this country, it is perhaps somewhat strange that so many professions have been persuaded to abandon the autonomy that used to be a professional indicator, instead subjecting themselves to government–appointed regulatory boards. It is common to locate this phenomenon within neo–liberal regimes of accountability that somewhat ironically accompany a political commitment to free–market economic theory. As

Larner (2000, p. 5) noted: “neo–liberalism” is the more widely used term amongst many counterparts such as “economic rationalism”, “monetarism”, “neo–conservatism”, “managerialism”, and “contractualism”. Neo–liberalism is a complex and contradictory beast and currently we are caught up in what Larner and Le Heron (2005) called the third phase of the neo–liberalising process in Aotearoa New Zealand. This third phase is characterised by a “new emphasis on performativity … a period of calculative practices unlike any we have comprehended before” (p. 858). While the complexity of the process may offer opportunities for resistance, it is useful to move beyond the political to the theoretical, in order to make sense of how neo–liberalism “draws us in”.

In order to make the interface of professional counselling and neoliberalism graspable, I follow several writers who have drawn on the Foucauldian concept of governmentality to discuss aspects of professional counselling practice (e.g., Besley, 2000; Bondi, 2005; Crocket, 2007). Foucault theorised that societies are no longer governed in a top–down manner, through state control (see, for example, Foucault, 1991). Rather, individual members of state play an active role in their own self–government, regulating themselves, as they are led to believe, “from the inside” (p.?). Various institutional processes, including the sort of knowledge that is considered acceptable, shape people into the sort of subjects that are considered desirable for the continuing of that society. The argument is laid out by Larner (2000), and owes much to the work of Rose (1989) who marked the role of the “psy” professions in producing and reinforcing this process of governmentality (as distinct from government). Briefly, the Welfare State, together with the concept of “service”, has been replaced by a new form of “government”: one that relies on various “technologies” such as audits, budgets, accountancy, rather than the top–down government. Thus, although neo –liberalism may mean less top–down government, it requires more effort from individual people in governing themselves, resulting in an increased workload and demands for leaner organisations. The derogative “nanny state”, used to refer to the earlier Welfare State, indicates the moral positioning that accompanies these socio/political changes, and their heavy reliance on developmental discourses: growth and individuation are given valence; care and nurturing are infantalised.

This new form of government is only made possible by replaying and reinforcing a version of subjectivity that foregrounds commitment to a certain concept of individualism. This individualism is the uniting factor that works to reinforce both a de–regulated free–market approach, and an ever increasing call for greater accountability. Rose (1989) stressed the role that ownership plays in this form of subjectivity, noting that this version of self is trapped with a text of "possessive individualism": it "owns" feelings, attributes, and dispositions; it enters the market as consumer in order to own more. Moral valence is given to continued and ongoing ownership as can be seen in the ideal of the life–long– learner and skill acquisition, with elisions being continually made in the advertising of other products. Bondi (2005) concluded: "the model of human subjectivity associated with neoliberal governmentality is deeply problematic, especially in its association with the production of highly individualised consumer–citizens" (p. 499).

The relational nature of counselling, together with partnership initiatives, and the recognition of the importance of connectedness as a criteria for wellbeing, sit at odds with the intensely individual focus of performativity and individual accountability. In 1996 Rose was already noting that although "the idea of 'the self' has entered a crisis that may well be irreversible" (p. 220), it is at the same time being reinforced by increasingly stringent regulatory practices. Registration is one such stringent regulatory practice, working to legitimise practitioners through the ownership of credentials, rather than the quality of practice, including relationship–building. And, although some might like to separate the "moral" prerequisite for ongoing self–development, training, and professional development from other forms of consumption, it has also been argued that " 'life–long learning' is now working as a vehicle for selling commodities and as a profitable commodity in itself … [a] headlong pursuit of relevance as defined by the Market" (Falk, as cited in McWilliam, 2002, p. 298). Comparing the self–development project to work done to develop Third World communities, McWilliam questioned the sorts of truths that we pay homage to, and which produce our professional subjectivities. The question is not learning per se — or, for clients, empowerment through acquisition of new self–knowledge, but rather the truth that frames them in terms of consumption, and acquisition of measurable outcomes, and then produces consumption as a form of morality. This is not an innocent or neutral discourse, as we can see when it is replayed on the global stage. We should

also note at this point, as did an American Psychological Association (APA) report on *Psychology and Global Climate Change* (APA, 2009) that the ideology of possession and consumption is a major cause of social and resource exploitation, and of environmental degradation, specifically culminating in disastrously rising levels of anthropogenic CO2, and subsequent climate change. This particular outcome also has far reaching implications for the commitments of counsellors and other professionals to doing no harm.

Not only is the "possessive individualism" of the neo–liberal subject problematic for counsellors, but its presumed autonomy has implications for "best practice" that are also troublesome for the profession. Bondi (2005) wrote: "as a form of governmentality, neoliberalism works by installing a concept of the human subject as an autonomous, individualised, self–directing, decision–making agent at the heart of policy making" (p. 499). The assumption that decisions are made after a rational consideration of neutral evidence — or that such evidence is possible — has been critiqued by many (e.g., Christians, 2000). This version of subjectivity allows policy–makers to justify their policies on the basis of so– called "evidence" based research, including decisions about what constitutes "best practice" for counsellors. Yet, "evidence often acts as a post hoc legitimisation of policy rather than genuinely informing it" (Lather, as cited in Clegg, 2005, p. 418), and research that is cost effective, quantitative, and marketable is research that will be funded. As a result, the neutrality of "evidence" is heavily contested, and through it the neo–liberal policies that it informs (e.g., Clegg, 2005). As Cooper (2008) noted: "the scientific method itself is not an assumption–free tool" (p. 5), and there are many problems in applying it to the caring rather than the curing professions (Curtis Jenkins, 2002). Counsellors have long been concerned about the privileging of the findings of "the modern gold standard in evidence–based health care … the randomised controlled trial (RCT)" (Curtis Jenkins, 2002, p. 199), over practice–based evidence — or, better, wisdom (e.g. Clark, Bondi, Carr, & Clegg, 2009). Cooper (2008) noted that, for counsellors:

> research is one very valuable source of information … but it is not seen as a privileged or superior fount of knowledge — theory, personal experiences, supervisory input and many other factors are all seen as having a role to play. (p. 5)

However, under registration, it is to be expected that both competence, and scope of practice, will be defined by evidence–based research directed to policy goals of so –called efficiency and cost effectiveness and measured by outcomes. This approach has already been shown to disadvantage the vulnerable client, and interfere with the ability to build meaningful relationships, since measurable outputs are more likely to be gained by avoiding "hopeless cases" (Smith, cited in Strathdee, 2004), as well as adversely affect the treatment of minority groups, some of whom are more likely to be given medication than therapy (Chantler, 2005).

These two key features of governmentality — possessive individuality, and restraints on practice imposed by the presumed autonomous authority of RCTs — are key features of registration. Both are troublesome to counselling practice and neither sit well with the ethical commitment inherent in NZAC membership. They pose problems especially for the counselling values of partnership, social justice, and doing no harm. They have particular implications for Treaty responsibilities. The current version of the NZAC *Code of Ethics* names six core values. The identification of these values is the result of many years of discussion and debate as the membership has grappled with the question of what it is to be a counsellor in Aotearoa New Zealand in the 21st Century. Counsellors are currently committed to six core values, namely: "Respect for human dignity; Partnership; Autonomy; Responsible caring; Personal integrity; and Social justice" (NZAC, 2002, p. 26). These six values are followed by nine principles which express the core values in action. The second of these foregrounds the commitment to "avoid doing harm", implicit in all the above values.

As part of a commitment to social justice, NZAC has grappled long and hard with the implications of the Treaty of Waitangi for counsellors and counselling. The 2002 version of the *Code of Ethics* ("the *Code*") introduced partnership as a core value, partially in embracing the principles of protection, participation, and partnership with Māori referred to in the introduction to the *Code* (see Winslade, 2002; Crocket, 2009), and partly in acknowledgement of the importance of respectful relationship. The concept of autonomous individuality — and an individualistic autonomy — is thus rendered problematic, and in any case is particularly problematic for Māori. As a result, in the revised 2002 *Code*, autonomy has been relegated from

first to third place, where it sits beneath a prior commitment to partnership (NZAC, 2002). This move was supported by an increasingly influential narrative influence in counselling, informed by social constructionism, and led by a group of academics at Waikato University, who were also influential in developing the revised *Code of Ethics* (NZAC, 2002). These are brave moves and situate counsellors in New Zealand differently from those in any other country. They move counselling beyond debates about sameness and difference and have real potential for a more respectful, sensitive, politically–aware, and relational form of ethics. The evolution of bicultural awareness in Aotearoa New Zealand has thus influenced thinking about social justice in this country, and enabled counsellors to make a unique contribution to international debates.

The context of these debates is not static, and counsellors are currently beginning to consider what a commitment to partnership and social justice, in order to avoid doing no harm, means in a globalised, environmentally challenged world. The ethical base–line of doing no harm is usually taken to be a professional prerequisite, although different professions may place different emphasis on its relationship to beneficence or "doing good". In the current environmental crisis, however, harm can no longer be limited to the immediate, or containable through questions of "who is the client". As Fisher (2009) noted, without reference to climate change, we now have wider "ethical obligations to all parties in every case, regardless of the number or nature of the relationships" (p. 1). Climate change, however, poses particular challenges in this respect, since the effects of possessive individualism place unfair burdens on the less affluent, on future generations, and on those at a distance. The discussion concerning counselling responsibilities is, as yet, in its initial stages, with the creation of a new Executive portfolio, but it witnesses the importance of ethics as ongoing praxis, rather than static code.

Counselling core values are central to counselling practice. Some even argue that since ethics and counselling both address issues of power, counselling is ethics in practice. Larner (1999), for example, wrote that "therapy proceeds through the deconstruction of power as the enactment of an ethical relationship to the other" (p. 46). Lowenthal and Snell (2000) further concluded that "ethics as practice is not in any way separate from psychotherapy. Rather, if ethics is defined as putting the other first, as

Levinas, the French phenomenological philosopher, defines it, then this is what all relationships should strive towards" (p. 23). The six core values can thus be said to re–present counselling in Aotearoa New Zealand. Thus the NZAC *Code* was presented as a framework for practice (NZAC, 2002), and is treated as a living document, inviting ongoing discussion and debate. It has undergone several revisions over the years, and the membership continues to be engaged in the ongoing challenge of locating counselling ethics within the local context of New Zealand culture and law, with particular reference to the Treaty of Waitangi. This ethical engagement is witnessed by contributions to the popular "Aunt Ethica" column in the *NZAC Newsletter*, *Counselling Today*, and recent NZAC sponsorship of two books, *Counselling and the Law* (Ludbrook, 2003, 2012) and *Ethics in Practice* (Crocket, Agee, & Cornforth, 2011). The NZAC (2002) *Code of Ethics* defined counselling thus: "counselling involves the formation of professional relationships based on ethical values and principles" (p. 26). This being the case, ethics must be central in the definition of counselling required during registration by the — or any — Act, and a major consideration in the definition of a scope of practice. However, according to a discursive analysis, conducted by the author, in which the *HPCA Act* was compared with the NZAC (2002) *Code of Ethics* (Cornforth, 2006), registration was found to be incompatible with NZAC's (2002) *Code*. The results of that investigation indicated that registration under the *HPCAA* could require significant rewriting of the current *Code*, and that NZAC and counsellors may have to:

> Revert to an ethic of beneficence; Abandon partnership as an ideal; Move further away from an ethic of social justice; Reinterpret responsible caring as being responsible to the *Act*, rather than to the client; Abandon integrity in favour of conformity; Remove reference to biological intervention and holistic practice; and Foreclose on options to accept environmental responsibility (Cornforth, 2006, p. 13).

If we view registration as a form of neo–liberal governmentality (see also Chapter 9), it becomes obvious that whatever code is accepted becomes an important technology for professional self–discipline, as mediated through the apparatus of governmentality. The terms of such a code, the values that

are considered acceptable, and the associated processes and practices that are deemed desirable, will shape counsellors into the sort of professional subjects that are considered suitable for the continuing of the counselling profession — by the government and its regulating authority. Moreover, it is possible to lose control of a well–thought out ethical code to a regulatory authority during the process of registration (see Fay, 2010, 2011). If this were to happen, counselling in this country would, in my view, radically alter, in order for the *Code* to be in line with the positions offered, and practices prescribed in the *Act*.

Several writers who are concerned about the effect of neo–liberal regimes on professional practice argue that we must use the inherent contradictions of neo–liberalism, working both with and against, positioning ourselves within the most effective strand of this complex discourse, in order to argue for the grounds on which we stand or fall (e.g., Larner, 2000; Bondi, 2005). Ironic juxtapositions are a characteristic of neo–liberalism, as Larner (2000) has pointed out, and we ignore them at our peril. Larner proposed that: "only by theorising neo–liberalism as a multi–vocal and contradictory phenomenon can we make visible the contestations and struggles that we are currently engaged in" (p. 21). Although common features are intense, consumer–driven individualism and restrictions on practice, viewing neoliberalism as a coherent policy not only reinforces its operation as a dominant, oppressive regime, but also glosses over the opportunities for resistance that are necessary if we are to live in more ethical relationship with each other. Noting that it was indeed a Labour government that introduced free market ideas to New Zealand, Bondi (2005) wrote: "neoliberalism has thus proved itself to be a flexible beast, capable of being marshalled in relation to both economic and social policies, and capable of hybridising with both authoritarian and social democratic ideas." (p. 499) The shifting sands of neoliberalism are already evident in the registration debate amongst counsellors, causing the President of NZAC to write in the NZAC Newsletter: "it is difficult to keep you up to date with the rapidly shifting issues around registration" (Bocchino, 2010, p. 15).

Many counsellors do position themselves as politically engaged, seeing subversive possibilities in the work they do. In so doing they draw on certain aspects of neo–liberalism to stake their claim. Winslade and Monk (2000), for example, drew on cost effectiveness to advocate for narrative

therapy as “powerful and brief”, whilst at the same time founding the politicising of their work within a theoretically well–supported Foucauldian interpretation of power (e.g., Winslade, 2005). Voluntary counsellors in Scotland had also found ways to resist buying in to the forms of subjectivity that are associated with the worst features of neoliberalism, i.e., being self–oriented and individualistic, and consumerism (Bondi, 2005). They did this by locating individual subjectivity within networks of relationships oriented to collective responsibility and political action. In this way, they worked with the neo–liberal concepts of autonomous choice and empowerment, whilst simultaneously resisting their individualistic interpretation. These counsellors had thus found ways to work both with and against systems of governance.

There are possibilities for NZAC counsellors in the ironic co–existence of partnership and accountability in the rhetoric of the current third stage of neoliberalism. Larner and Le Heron (2005) marked the major contradiction between collaboration and calculation that distinguishes this phase; between a “partnering ethos” (p. 851), and, simultaneously, regimes of accountability stricter than ever before; and posed the question “what happens when partnership meets performativity?” (p. 853). This is unknown territory, but its very indecipherable–ness offers opportunities which might be turned to advantage. Some of the more useful sub–strands in this rhetoric are emphasis on collaboration; on inter–disciplinary, trans–disciplinary, and cross –disciplinary work; on greater responsiveness to industry and community; and, in Aotearoa New Zealand, a greater commitment to raising outcomes for Māori. These are fruitful grounds for further embedding counselling in the concept of partnership.

There are several further reasons for making partnership the tumu or mooring pole of the counselling waka. The contemporary world is very different from the one in which the talking cures emerged, and the wider global and environmental context increasingly affects what might be thought of as the private space of counselling. It is becoming increasingly obvious that all peoples of the world are interrelated by way of their connection through economies and through shared use of our global commons. It is also predicted that increasing conflict will result from the unfair distribution of the benefits and burdens of resource exploitation, and the use of fossil fuels (Intergovernmental Panel on Climate Change [IPCC],

2007, 2014), and that collaborative initiatives will be needed (e.g., APA, 2009) . Indeed, unless international agreement can be reached, we may have no futures, professional or otherwise. Partnership, then, in the form of solidarity, has been heralded as the hope of a more socially just world. Benatar, Daar and Singer (2005) foregrounded the health challenges that affect everyone in the current globalised environment and write:

> The underlying basis for new threats to health, life, and security is our failure to adequately pursue the values that play an essential role in improving population health locally and globally … Foremost amongst these is solidarity — without it, we ignore distant indignities, violations of human rights, inequities, deprivation of freedom, undemocratic regimes, and damage to the environment. (p. 587)

Here "solidarity" is set against "individual freedom" or autonomy. In terms of the NZAC's (2002) *Code of Ethics*, solidarity more closely aligns with partnership, and is linked to an ethic of care by Sevenhuijsen (1998). Going further, many people argue that we must accept our partnership — our interrelationship and solidarity — with the natural world in order to prevent environmental catastrophe. This idea has been put forward by Māori (e.g., Selby, Moore & Mulholland, 2010), by ethicists (e.g., Jamieson, 2008), by ecopsychologists (e.g., Shepard, 1982), and by many others.

Whilst counsellors debate the pros and cons of registration in order to protect members of the public from "risk of harm", a far greater harm is already being inflicted through continuing business as usual. Our consumer–dependent lifestyles in the so called "developed" world are indubitably causing harm to those at a distance and to the planet itself (IPCC, 2007) as we speak. It is generally accepted amongst the scientific community that the people of the earth are facing a crises like no other in any previous time: anthropogenic rising levels of CO2 and subsequent climate change (IPCC, 2007). It is perhaps another irony of neo–liberal times that it is scientists who have brought to the fore the devastating effects of the unbridled use of the scientific method, and that the humanities are proving so slow in writing this concern into their agendas. Climate change, is life threatening. It is already affecting many clients and impacts on all our futures. It affects in particular the poorer peoples of the Third

World, both now and increasingly in the future, who lack access to resources that might enable them to escape or adapt. Climate change thus calls counsellors to re–engage with what they mean by individual autonomy, social justice, and non–maleficence, or doing no harm (Cornforth, 2008, 2009).

In my earlier analysis (Cornforth, 2006), I noted that a major redirection of counselling might be desirable, in the light of several challenges posed by the wider context within which counsellors operate: post–structural theorising, which challenges the ongoing viability of the bounded individual; climate change, which challenges our very existence; and registration, which turns the eye of surveillance inwards. I concluded by wondering if, by focusing on self–monitoring and the details of accountability, registration might limit the profession's ability to look outwards towards the bigger picture, in order to find creative solutions at a time when they are most needed. Since 2006, new alarming evidence has come from the scientific community (International Climate Conference, 2009) about the short time frame in which the peoples of the world have to make an adequate co–operative response in order to first stabilise, then lower, greenhouse gas emissions. Since climate change has delayed effects, some estimate that we have at the most five years before we pass certain tipping points beyond which recovery is no longer possible (e.g., Watson, 2009). The counselling profession has an important part to play addressing the psychological barriers to discussion, enabling people to make informed decisions about their futures, developing hopeful story lines, strengthening client's relationships with the natural world, and working co–operatively in various partnership projects.

When this chapter was first written (in 2011), registration was not a foregone conclusion; and, last year, the membership of the NZAC voted in favour of being a self–regulating profession. It is hoped that this well–considered and hard–won outcome will allow counsellors to retain their ethical commitment as outlined in their *Code* and this chapter, and to be engaged in a rigorous process of accountability. Larner's (2000) conclusion that neo–liberalism itself is a "more of an ethos than accomplishment" (p. 20), a "multifocal and contradictory phenomenon" (p. 21) with which we are continually engaged still stands. This being the case, it is crucially important that counsellors keep ethics at the forefront of their professional

interactions, reiterating those values that are the core markers of their profession, whilst continually extending their ethical vision in order to re–think what it is to be ethical practitioners who are also members of planet earth. If counsellors can continue to register their commitment to, and ongoing understanding of partnership, social justice, and to doing no harm, they may yet influence the direction of registration while at the same time contributing to the development of the profession, and playing a useful part in resolving environmental problems. This will be more effective if they remain cognisant of the opportunities offered by the different discourses that make up the master story of neo–liberalism, remembering that "to have control of definition is to have control of discourse" (Livingstone, as cited in Setten, 2006, p. 42). One could also argue that if counsellors fail to hold to these ethical positions, they have themselves de–registered their interest in counselling.

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Chapter 15

Recognition, regulation, registration: seeking the right touch

Alastair Crocket

More than a decade after the passage of the *Health Practitioners Competence Assurance Act* in 2003 ("the *HPCA Act*" or "the *Act*") it is undecided whether counselling will become a state–regulated profession. This focuses on three possible directions that the New Zealand Association of Counsellors (NZAC) and its members need to decide between: state–regulation; the current status quo as a self–managing organization; or a self–regulation approach with a measure of state approval. It argues that counsellors need to be pragmatic in deciding which to support since government policy considerations will influence the success of any direction we choose to take.

While much has happened in the three years since the initial publication of the original article on which this chapter is based (in 2014), little appears to have changed in the policy environment discussed here. The argument that self–regulation offers the appropriate level of accountability for counsellors and others in similar professions is still current. In late 2016, the NZAC

received a clear mandate from its membership to continue with the implementation of a self–regulation model.

Although the matter of state regulation of counselling was raised within the NZAC and its predecessor, the New Zealand Counselling and Guidance Association, from as early as the 1980s (see Hermansson, 1999), there was little prospect of counselling achieving that status during the 1980s and 1990s. Over the past decade however much attention has been focused on the possibility of state regulation. One catalyst for this focus arose from the 1988 Report on the Cervical Cancer Inquiry by Judge Sylvia Cartwright which raised questions about "governance, accountability and ethics" in the medical profession (Ministry of Health [MoH], 2009, p. 1), which, fifteen years later, led to the passage of the *HPCA Act 2003*. This *Act*, along with the *Social Workers Registration Act 2003* ("the *SWR Act*") focused attention on issues of professional regulation beyond those professions directly involved.

The *HPCA Act* replaced a series of acts that regulated individual health professions by authorizing profession–specific "responsible authorities" in the form of registration boards or councils. This *Act* also made it possible for health professions not already subject to state regulation to apply to the Ministry of Health ("MoH" or "the Ministry") to become regulated by the *Act*.

The passage of the *HPCA Act* and the *SWR Act* catalyzed the development of a coalition of counselling organisations, known as the Combined Counselling Associations of New Zealand (CCANZ) [*This included the NZAC, Auckland Transactional Analysis Training Institute, Australia and New Zealand Psychodrama Association, Creative Therapies Association of Aotearoa, the New Zealand Christian Counsellors Association, Relationship Services (which subsequently withdrew), and Te Whariki Tautoko.*] that actively canvassed regulation for the counselling profession under the aegis of the *HPCA Act*. The NZAC's National Executive took a leadership role within the CCANZ and sought a mandate for the pursuit of an application for *HPCA Act* registration. If the Association's response in the 1980s and 1990s to the possibility of registration had been ambivalence, both ambivalence and division have characterized the period since 2003.

It is now over a decade since the passage of the *HPCA* and *SWR* Acts and it is appropriate to reconsider a range of contemporary questions about professional regulation and registration. This article considers three current alternative frameworks for professional regulation, and the likely implications for counselling of each framework. These frameworks are:

- That counselling is registered under the *HPCA Act* (an option that is now unlikely for the foreseeable future).
- That counselling remains a self–managing profession (an option which avoids involvement with state regulation).
- That counselling becomes a self–regulating profession but with some form of external recognition (an option which might be seen as a third way).

COUNSELLING AS A REGULATED PROFESSION UNDER THE *HPCA ACT*

Key terms

The terms regulation and registration may appear to be used interchangeably at times but they have different meanings. The *HPCA Act* empowers sixteen responsible authorities to establish and maintain requirements that members of the professions that they regulate must observe. Responsible authorities have the following statutory responsibilities:

> [D]escribing their professions in terms of one or more scopes of practice with associated qualifications; registering and issuing annual practising certificates to practitioners who have shown continuing competence; reviewing and promoting ongoing competence; considering practitioners who may be unfit to practice; setting standards of clinical competence, cultural competence and ethical conduct; establishing professional conduct committees to investigate practitioners in certain circumstances. (MoH, 2010, p. 3)

These responsible authorities (boards and councils) maintain a register of professionals whom they have recognised as competent. Thus, reference is

often made to professional registration, although that is only one element of state regulation. The other activities of responsible authorities are intended to measure practitioner competence and take remedial action where a practitioner is considered not to have demonstrated sufficient competence.

Why seek State regulation?

Perhaps the primary interest of counsellors (see for example Shields, 2007) and psychotherapists (Bailey & Tudor, 2011; Chapter 4 in this volume) in gaining *HPCA Act* regulation has been an elevation of status and the possibility of access to wider employment prospects. However, the MoH (2010) stated that the primary rationale for state regulation is to limit the risk of harm to members of the public (see Figure 15.1).

Figure 15.1. Principles for HPCA Act regulation

The overriding principles for regulation under the Act are that:

- the health services concerned pose a risk of harm to the public, or it is otherwise in the public interest that the health services be regulated as a health profession under the Act.
- the profession delivers a health service as defined by the Act (where a health service means a service provided for the purpose of assessing, improving, protecting or managing the physical or mental health of individuals or groups of individuals).
- regulation under the Act is the most appropriate means to regulate the profession. (MoH, 2010, p. 10)

As well as the requirements that registration demands of professionals in relation to competence, it also confers some benefits. One benefit is the protection of title. All *HPCA Act* regulated professions have protection of title, which is the statutory restriction of the use of a title. As an example, only a person registered with the Psychotherapists Board of Aotearoa New Zealand is able to call him or herself a psychotherapist.

Another benefit is the definition of scopes of practice. Practitioners whose practice is regulated by the *HPCA Act* are both required to work within a scope of practice. A scope of practice offers a state–regulated practitioner a mandate to engage in the practices it describes. Some practices can be in

more than one profession's scope of practice. For example, a psychologist can practice psychotherapy but cannot describe himself or herself as a psychotherapist. Both psychologists and psychotherapists may practice counselling because it is in their scope of practice.

A third benefit is known as restriction of activity. In some cases registered professionals have an exclusive right to undertake particular activities. for example, particular tasks are reserved to surgeons and others to dentists. However, if the counselling profession were to be registered under the *HPCA Act*, counselling would not be restricted to registered counsellors because counselling already sits within the scopes of practice of other professions. While the regulation of counselling under the *HPCA Act* would protect the title of counsellor, it would not restrict the practice of counselling to registered counsellors.

An unlikely possibility? Reconsidering the policy signals

In preparing the article [on which this chapter is based] I re-read the the MoH documentation that I had first read four years ago, a review that led me to conclude that the achievement of *HPCA Act* registration is, at best, an unlikely possibility for the counselling profession.

The passage of the *HPCA Act* brought together 20 health professions regulated by 15 responsible authorities. After a concerted campaign, psychotherapy achieved regulation in 2007. Later that year the MoH began a review process of the *HPCA Act* which was reported to the Minister of Health in 2009 (MoH, 2009) and the recommendations in the report were opened for public consultation in 2010. These recommendations included new criteria to guide the Minister in deciding whether to grant registration to a profession (outlined in Figure 15.2).

Figure 15.2. Criteria for HPCA Act regulation

Criterion 1: The activities of the profession must pose a significant risk of harm to the health and safety of the public.

Criterion 2: Existing regulatory or other mechanisms fail to address health and safety issues.

Criterion 3: Regulation is possible to implement for the profession in question.

Criterion 4: Regulation is practical to implement for the profession in question.

Criterion 5: The benefits to the public of regulation clearly outweigh the potential negative impact of such regulation.

Criterion 6: It is otherwise in the public interest that the provision of health services be regulated as a profession. (MoH, 2010, p. 11)

In the new criteria for *HPCA Act* accreditation introduced in 2010, risk is framed in predominantly medicalised terms:

- to what extent does the practice of the profession involve the use of equipment, materials or processes which could cause a significant risk of harm to the health and safety of the public?
- to what extent may the failure of a professional to practice in particular ways (that is, follow certain procedures, observe certain standards, or attend to certain matters), result in a significant risk of harm to the health and safety of the public?
- are intrusive techniques used in the practice of the profession which can cause a significant risk of harm to the health and safety of the public?
- to what extent are dangerous substances used in the practice of the profession, with particular emphasis on pharmacological compounds, chemicals or radioactive substances?
- is there significant potential for the professional to cause damage to the environment or some wider risk of harm to the health and safety of the public?
- is there epidemiological or other data, (for example, coroners' cases, trend analysis, complaints) which demonstrates the risks that have been identified? (MoH, 2010, p. 12)

Many of these criteria are not relevant to counselling. The counselling profession could demonstrate a risk of harm to clients by reference to the work of the NZAC Ethics committee and findings of the Health and Disability Commission hearings (the last bullet point above). However, a further criterion would appear to negate that. This is that an application for *HPCA Act* registration needs to demonstrate that "existing regulatory or other mechanisms fail to address health and safety issues" (MoH, 2010, p.

11). In order to meet this criterion the NZAC would need to argue that its membership and ethics processes fail to act in the best interests of clients and that these interests would be better served by the work of a registration board.

In addition, both the Ministry and the government have been concerned about the high cost of regulation (MoH, 2009, 2012). The 2007 review specifically raised concerns about the high cost of registration for psychotherapists and the 2012 review was mostly focused on seeking to reduce costs of regulation by amalgamating either responsible authorities or common administrative functions. Further, another criterion introduced in the 2007 review asked if there was an alternative to *HPCA Act* regulation (MoH, 2009).

The 2010 report noted that seven "new" professions were in the process of application. These were: acupuncturists, anaesthetic technicians, clinical physiologists, counsellors, music therapists, speech language therapists, and western medical herbalists (MoH, 2010, p. 17). None of these professions has (yet) achieved *HPCA Act* registration, and indeed none is shown on the Ministry's website as having current applications lodged with the Ministry. It is worth considering whether the new selection criteria proposed in 2010 have stopped the progress of this group of professions towards state regulation. However the profession encompassing practitioners of traditional Chinese medicine is recorded as having applied for registration in 2011 and it is also noted that the outcome of this application has not yet been decided (MoH, n.d.). However, these new criteria did prompt a change in direction for counselling, as discussed later.

It is worth reviewing the policy signals in relation to *HPCA Act* regulation since 2003. The major outcome of the 2007 review was more demanding criteria for professions to meet if they were to be successful in achieving *HPCA Act* regulation. Since 2007 not one additional profession has achieved this status. Some would argue that since psychotherapy is State regulated then counselling should also be able to achieve that status. However counselling would now need to satisfy different criteria than psychotherapy did in 2007. Had an application for counselling been lodged in 2011, there is no guarantee that it would have been successful. The only "live" application for *HPCA Act* regulation lodged in that year (traditional Chinese medicine) has not yet been decided. It is worth noting that in the

UK art therapies have statutory registration while counselling and psychotherapy do not (Waller & Guthrie, 2013).

Within the "new" criteria published in 2010 there was an indication that alternatives to registration should be demonstrated to be unsatisfactory before *HPCA Act* regulation would be agreed. I discuss CCANZ's 2010 response to that policy signal later when I consider audited self–regulation. The 2012 review of the Act focused on the achievement of cost efficiencies among the responsible authorities.

The government's policy on the admission of "new" professions to the *HPCA Act* regulation may not be not explicitly spelled out. However, I suggest that the policy signals outlined above strongly indicate that, while *HPCA Act* regulation remains a theoretical possibility for counselling, it is an unlikely possibility. If the NZAC were to re–commit to achieving state regulation as a strategic goal, it may need to be prepared to work for this over many more years. Overseas experience indicates that the achievement of state regulation can be a very slow process. For example, in British Columbia the counselling profession has been seeking state regulation for at least 20 years (Martin, Turcotte, Matte, & Shepard, 2013). Counselling needs to accept that *HPCA Act* regulation may never be achieved.

Arguments against state regulation

From the moment when a move towards state regulation of counselling seemed possible there were strong voices arguing against this. In 2000 then president Sue Webb argued against external regulation:

> [The Association] probably best protects members' interests by instituting systems of regulation and accountability itself that enable these to develop within an appropriate counselling culture, rather than succumbing to outside intervention, which risks creating systems that contradict and undermine the purposes of counselling. (Webb, 2000, p. 309)

Some years later when NZAC's National Executive was preparing an application for *HPCA Act* regulation, some senior members raised strong arguments against the prospect of state regulation of counselling. At this time there was not just ambivalence about professional regulation but

significant differences of opinion within the association. Sue Cornforth (2006) made a discursive analysis of the NZAC *Code of Ethics* and the *HPCA Act* and concluded that registration under the *HPCA Act* "could threaten the core beliefs of counselling" (p. 12). Sue Webb again questioned registration at the time when a draft application for registration was available to members for comment. She raised a range of practical and philosophical questions and asserted:

> At present, the draft proposal reads as if counsellors need to beg entry into an elite club of illness professionals, with our beliefs and philosophy having been contorted and woven in with the language of illness, to make us look as if we fit. The document seems intent on conveying that we are a profession in critical need of external oversight, which we are not. (Webb, 2007, p. 39)

In the following year National Executive sent members a Special Newsletter on Registration. In response NZAC Life Member Bob Manthei wrote in *Counselling Today* "asking that NZAC reconsider its decision to go ahead with the application to register counselling under the *HPCA Act*" (Manthei, 2008, p. 21). He raised six points of objection including: the risk that non registered counsellors would simply describe their practice in another way (e.g., "therapist"); the problem of not being able to quantify any risk to members of the public from counsellors; the risk that the NZAC would become less viable if the cost of regulation meant registered counsellors could not afford two significant fees; and issues for Māori counsellors.

Recently in the NZAC journal, Keith Tudor (2013) revisited arguments against *HPCA Act* regulation cautioning counsellors to "be careful what [we] wish for". Keith's arguments against state regulation deserve careful consideration. At the heart of his critique of the prospect of registration is the argument that there is no evidence that registration would reduce risk to clients.

The achievement of state regulation would require two willing parties: the Minister of Health and the professions. The objections raised above (Webb, 2000, 2007; Cornforth, 2006; Manthei, 2008; Tudor, 2013) remain concerns

that counsellors would have to evaluate if the CCANZ were to persist with an application in the face of the policy analysis above.

Remaining a self–managing profession

In his argument against *HPCA Act* regulation Tudor (2013; see Chapter 1 in this volume) suggested that the NZAC and counselling are already sufficiently recognised. I think that this argument cannot be sustained. Previously I have argued that counselling needs some form of engagement with the state and to be able to effectively articulate itself within a policy environment dominated by New Right thinking (Crocket, 2013). The NZAC, as the strongest advocate for the profession of counselling, has been significantly challenged by the government's changes to policy or proposals to change policy in relation to the provision of state funded counselling.

As a member of National Executive, I have been aware of significant work undertaken within Executive portfolios in an endeavour to influence policy. Since 2009 the three policy areas that have required the most work are: the provision of Accident Compensation Commission (ACC) funding for sexual abuse counselling; the recent removal of Family Court funded counselling; and work to support school guidance counselling. The work undertaken in these three areas have been extensively reported in successive issues *Counselling Today*, NZAC's national newsletter for members. The achievement of recognition for the counselling profession is an ongoing, difficult task.

The pervasive reality of external influence

While Tudor's (2013) article makes a strong case against *HPCA Act* regulation for counselling, I disagree with his premise that if counselling remains self–managing that it would avoid state regulation. Although counsellors are not regulated under the *HPCA Act*, the NZAC and its members are not free from state regulation.

Most significantly, funders (the providers of financial provision for services) regulate individual counselling practice with their requirements or conditions for receiving funding. Most of the funding for counselling comes directly or indirectly from the government so the requirements of funders are effectively a form of regulation by one or another arm of the state.

There appears to be reluctance by District Health Boards (who are the major funders of health services in New Zealand) to fund contracts if the work is not to be carried out by an *HPCA Act* registered practitioner or an *SWR Act* registered social worker and this has effects for some NZAC members. There is anecdotal evidence of counselling graduates with Master's qualifications being advised to undertake social work or psychology qualifications not to develop skills, but to achieve professional registration.

A further regulation of counselling already in effect comes via the Health and Disability Commission (HDC). The HDC offers all receivers of health and disability services a *Code of Rights* (Health and Disability Commission, n.d.–b). A complaint against any practitioner offering a health or disability service may be investigated by the HDC and may be referred on to the Human Rights Review Tribunal (Ludbrook, 2012). A search of the HDC website (Health and Disability Commission, n.d.–a) shows that 16 investigations of complaints against counsellors or counselling practice have been completed. One investigation was referred on to the Human Rights Review Tribunal, which imposed penalties totaling $50,000 and costs of $11,250 as well as issuing a restraining order against the practitioner (*Decision 06HDC09325*, 2007). This hearing drew on the NZAC *Code of Ethics* to delineate counselling practice even though the practitioner, who described himself as a natural healer, was not a member of the NZAC and denied that he was offering counselling.

These two examples show how individual practitioners can be subject to regulation either through funding mechanisms or by the HDC's investigation of complaints about any "health service". More positively, it also shows that the Association's *Code of Ethics* may be recognised as being influential when counselling occurs, even if the practitioner is not an NZAC member.

The judiciary also has power to regulate NZAC's activities as a recent High Court decision shows. Any action by any organization is potentially subject to judicial review, which is a hearing where the processes employed to take decisions within an organization may be scrutinised by the High Court. A judicial review considered the validity of NZAC's complaints process when a member was not satisfied with the process and outcome of an Ethics Committee hearing of a complaint about her practice. The High Court

accepted that the process used by the NZAC Ethics Committee and the panel that conducted the hearing was appropriate (Sharman v NZAC, 2013). After reviewing and dismissing the grounds for judicial review Justice Winkelmann noted: "I exercise my discretion against the grant of relief. The decision of the Panel stands" (Winkelmann, 2013, paragraph 68). Implicit in this statement is the possibility that if the judge had not accepted that an adequate process was followed, or that the decision was consistent with the application of that process then she had the authority to require that NZAC amend its processes, or to rehear the original complaint. A "self–managing" profession is never going to be fully independent of the state, nor should it be.

Self–regulation in a partnership with the State: A third way?

Here I outline a third position that seeks to retain the benefits of being a self–managing profession and also seeks a form of state recognition of the effectiveness of NZAC as a self–regulating professional body. In this section I discuss two initiatives in relation to self–regulation, each of which is linked to state oversight. The first initiative refers to the opening of discussions in 2010 between the CCANZ and Health Workforce New Zealand about audited self–regulation. Health Workforce New Zealand is the arm of the Ministry of Health which oversees the *HPCA Act*. The second initiative is the development of an accredited voluntary registration regime in the United Kingdom. In 2013, the British Association of Counselling and Psychotherapy (BACP) became the first professional association in the UK to operate a voluntary register.

Neither of these approaches offers the same protection of title that the *HPCA Act* offers. However, as noted in the first part of this chapter, protection of title would not reserve the practice of counselling to counsellors. However, the approaches to self–regulation discussed here would have the effect of recognising the ability of a professional organisation to regulate its members using similar standards as *HPCA Act* responsible authorities do, and without requiring a duplication of membership and registration fees.

Audited self–regulation

Since 2010, the NZAC's position on registration has been influenced strongly by discussions on self–regulation. In that year, the MoH published a discussion paper (MoH, 2010) following the 2007 review of the *HPCA Act*. While this document set principles and criteria for the assessment of applications for registration, it also contained indications that the government was open to alternatives to registration. In the detail for the fourth criterion the MoH asked: "Is there an alternative to regulation under the *Act* that is practical to implement to limit any risk of harm posed by the profession, such as self–regulation or accreditation?" (p. 14)

The NZAC's National Executive considered that there was value in discussing self–regulation with the Ministry of Health and prepared a paper (Crocket, Bocchino, Begg, McGill, & McFelin, 2010) which was forwarded to the Ministry from the CCANZ. This paper proposed:

1. That the MoH might move to support a process of self–regulation. ***It is imperative that the standards and process of self–regulation need to be fully discussed as a collaborative endeavour between the profession and the MoH.***
2. That the Ministry would then promulgate a policy that such self–regulation is equivalent to statutory regulation.
3. And the Ministry would then ensure other ministries have policies to support the funding of health services provided by self–regulated professions.
4. That the Ministry would then ensure self regulating professional organizations have access to the same protection of title as that extended to currently registered professions. (p. 9, emphasis in original)

The Ministry responded with a paper (Health Workforce New Zealand, 2010) which proposed a self–regulation model sitting beside the *HPCA Act*. It was proposed that the adequacy of the organisation seeking self–regulation be established by an approved audit process. The benefits that the Ministry saw in the model it proposed were that an organisation would not need to satisfy the Ministry's risk threshold for registration under *HPCA Act*, and that the audit process would "provide formal recognition of a profession's ability to self–regulate" (p. 1), allow "approved organisations to promote themselves as approved self–regulators" (p. 1) and provide the

"public with a level of assurance about a profession's ability to self–regulate" (p. 1). The paper also noted that protection of title would not be possible outside the *HPCA Act*.

The NZAC's National Executive consulted with its members and received sufficient support to keep on exploring the initiative. However, in 2011, Health Workforce New Zealand announced that the review of the *HPCA Act* planned for 2012 had been brought forward and that no more discussions could be held on the proposal for audited self–regulation until the review was completed. Now [in the first half of 2014], the NZAC and the CCANZ do not have a clear understanding of the Ministry of Health's current position on audited self–regulation. It is not known if the Ministry of Health through Health Workforce New Zealand will re–engage with discussions about audited self–regulation or even whether an application for the registration of counselling would be received by the Ministry, let alone approved. Nonetheless, it is timely for the NZAC and the CCANZ to seek a resumption of discussions with Health Workforce New Zealand to pursue this initiative. UK experience points to the potential of such an approach to professional regulation.

The UK: "right–touch" regulation

Until 2010 it had been expected that the UK government would permit the registration of additional professions including counselling and psychotherapy. The path to voluntary self–regulation in the UK unfolded with a rapid change of policy between 2010 and 2011 following a change of government (Aldridge & Mulvey, 2013). As a result of this policy change state regulation has become reserved for professions which are perceived as presenting the greatest risk to service users. Professions that are assessed as presenting less risk are now able to apply to operate an accredited voluntary register. It appears that the UK's accredited voluntary registers fulfill a similar function to the audited self–regulation model that the CCANZ discussed with the Ministry of Health in 2010 and 2011.

The BACP was the first professional body to be accredited by the UK Government's Professional Standards Authority for Health and Social Care to operate an accredited voluntary register which its members could then apply to join (Aldridge & Mulvey, 2013). Accredited voluntary registers are

parallel to and different in some respects to state registration. The distinction between statutory and voluntary regulation is decided by a process called “right–touch regulation” (Bilton & Clayton, 2013). The principles of right–touch regulation are summarised in Figure 15.3.

Figure 15.3. The principles of right–touch regulation

- Identify the problem before attempting to prescribe a regulatory solution.
- Quantify the risks
  –It is not enough to identify that risks exist. Risk must also be quantified through a process of risk assessment. What measures are already in place to manage the risk?
- Get as close to the problem as possible.
  –Where and how does the problem occur? What is the cause of the risk? Problems are best solved close to where they occur — can this be achieved without involving distant national regulation?
- Focus on the outcome.
  –Stay focused on the outcome that needs to be achieved rather than being concerned with process. Focus on prioritizing patient safety rather than the interests of any particular professional group.
- Use regulation only when necessary.
  –Making changes to regulation, especially statutory regulation, can be a slow process, so regulation should only be used as a problem solver when other actions are unable to deliver the desired results. Build on existing approaches where possible.
- Keep it simple.
  –Avoiding unnecessary complexity will lead to a better functioning regulatory system. Where there is a choice between simple and complex solutions the simplest is likely to be the best.
- Check for unintended consequences.
  –It is inevitable that changes in policy and practice will have consequences for other parts of the system.
- Review and respond to change.
  –Regulators must not be seen as managing past crises while being ignorant of new evidence that should call for change. (based on Bilton & Cayton, 2013, p. 18)

Bilton and Clayton (2013) suggested that voluntary and statutory regulation are similar in that in both instances the professions involved are demonstrating a commitment to protecting the public by upholding the standards and codes linked to the relevant register. Membership of either type of register is publicly available information. However, being on a voluntary register is optional and being removed from such a register does

not prevent the practitioner from working. They note that, in the United Kingdom, a Disclosure and Barring Service does have the power to bar people from working with vulnerable people.

Finally Bilton and Clayton (2013) argued that the move to voluntary registers provides:

> [A] proportionate method to provide the public with assurance that voluntary register holders are upholding standards of practice for groups of workers for whom statutory regulation would be unnecessarily burdensome and expensive. The assured voluntary register scheme will help the sector to find the right touch for a wider range of health professionals and occupational groups. It will help consumers to exercise informed choice and distinguish practitioners committed to demonstrable high standards. (pp. 24–25)

Our sister organisation the BACP is rapidly developing experience of operating an accredited voluntary register. As NZAC considers the direction it wants to take it will be useful to apply the eight "right touch" principles (Bilton & Clayton, 2013) from the UK. Members need to consider which approach to regulation is most appropriately proportionate to the risk faced by clients. I suggest that the Ministry of Health's answer and that of many members will be some form of self–regulation.

CONCLUDING DISCUSSION

When the NZAC considers what it wants and needs from a regulatory regime, it is important that the discussion is informed by a realistic understanding of both what is desirable and what is possible. The three frameworks outlined above each involve the state, albeit in different ways. As Aldridge and Mulvey wrote: "whatever professions may want in terms of regulation, the power to decide ultimately rests with the government" (p. 1). What is possible may be influenced by the NZAC, but is unlikely to be finally decided by it. I have argued that *HPCA Act* regulation is unlikely and that to remain self–managing is insufficient.

The time frame is unlikely to be short. The current discussions about seeking *HPCA Act* registration have already spanned more than a decade.

The discussions between the CCANZ and Health Workforce New Zealand about audited self–regulation were very positive before they were adjourned by Health Workforce three years ago. It is likely that the CCANZ and/or the NZAC will need to initiate any resumption of these discussions.

When we achieve an outcome from these initiatives, it is unrealistic to expect it to reflect completely consistent policy. Just because psychotherapy achieved *HPCA Act* registration in 2007, it should not be expected that counselling could achieve the same. Since 2007, the policy signals have changed.

The NZAC needs to keep its own professional standards under review to ensure that these are seen as credible when viewed from outside. The standards set by the responsible authorities under the *HPCA Act* are likely to be a benchmark. The continued development of our own standards and processes will be a significant step towards some form of external audit or accreditation of our ability to regulate ourselves.

Finally, counselling is not the only profession that might aspire to audited self–regulation. It is only one of seven professions that were some way through an application process for *HPCA Act* recognition in 2007. In the last seven years none of these groups has achieved that goal. The NZAC might seek collaborative relationships with these professional bodies to seek to develop a consistent approach to self–regulation that may be more persuasive to the Ministry of Health and other arms of government than the advocacy of any one individual profession.

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Chapter 16

Regulatory territories: rohe rather than walls

Susan Shaw

The regulation of health professionals has burgeoned across the world; is predicated on risk (Haines, Sutton, & Platania–Phung, 2008); and presented and promoted in terms of "protecting the public". Systems and processes for managing risk tend to develop from a foundation of defining jurisdictions — of professionals, of professions, and of geography: in short, various territories. However, it seems that tightly defining jurisdictions is as likely to be valued for limiting the risk to regulators themselves as much as to the public. It is also reasonable to believe that, in addition to a preoccupation with risk, global geopolitical contexts may influence the behaviour of regulators despite evidence that restrictive territories have the potential to impact negatively on professional practice. It is also plausible that these undercurrents conspire to construct adversarial dynamics between practitioners and those who regulate them.

My recent experiences of renewing three professional registrations in two areas of practice (teaching and nursing) over the last year has caused me to reflect on how these dynamics impact on professionals. Of the two registration renewals that were problematic one (in New Zealand) is with a regulatory authority that I am not obliged to register with, the other one is

with a United Kingdom regulator. Snapshots of these experiences are included to illustrate the lived experience of being a regulated practitioner who resides on — and, indeed, beyond the boundaries of the "territory" that these regulators patrol.

The Māori concept of rohe can be defined as "territory or boundaries of tribal groups" (Kearns, Moewaka–Barnes, & McCreanor, 2009, p. 123). Other definitions refer to these boundaries in terms of being theoretical or imagined and, within Aotearoa New Zealand, they are commonly understood in terms of trees (rather than walls) along the edge of a piece of land. This idea of marking territory in ways that are clearly understood (in order to be respected), without being severe and impermeable to people, is a good place from which to consider the limits placed around professionals.

The territory of risk

The recognition of practitioners occurs within historical, social and political contexts (see Chapters 1, and 3). Social and political imperatives appear across jurisdictions and, most recently, amidst a widespread increase in the perceived need to manage risk and protect the public (Lloyd–Bostock, & Hutter, 2008). This has led to an increase in legal frameworks and, in turn, very specific mandates for regulatory authorities to define practice and patrol the work of practitioners. There are commonalities between regulators of professional groups (especially those in the health and disability sector) across jurisdictions (Monteiro, 2015). Principles and expectations that inform the establishment and work of these regulators are similar, with an emphasis on public safety (Hale, Borys, & Adams, 2011), the remit to manage registration, to accredit educational programmes, and to deal with competency and the performance of practitioners. Whether such authorities can realistically impact on the practise of individuals in their daily work is highly questionable. If regulators are not able to influence practice and therefore assure patient safety then the reason for their existence is questionable. Given the emphasis on managing risk, it may be argued that risk identification and management is in fact their reason for existing as agencies, aside from any contribution they may make to wider society.

Risk has a high profile in justifications for the existence of regulators despite a very small proportion of (often recidivist) practitioners presenting the majority of the risk (Bismark, Spittal, Gurrin, Ward, & Studdert, 2013). This is constructed in heroic terms as regulators are responsible for "protecting the public". It has previously been argued that this is impossible as regulators cannot act pre–emptively to protect as it is individual practitioners who make decisions on any given day as to how they are going to engage with the public with whom they practise (Shaw, 2011). There are many cases of registered practitioners causing harm to people while they were registered, illustrating the nonsense of asserting that regulation of health professionals can be fundamentally protective.

At best regulators can work with, restrict or prevent individuals from practising, but this occurs after issues have arisen and the subsequent investigation and challenge. In reality, the ability to "protect" is only actively in place once harm or serious risk has already occurred and so the action can only be to prevent further substantial risk or harm. The power that regulators have to impose restrictions on practitioners may be seen as a deterrent to practise unsafely or unprofessionally and perhaps in some cases that may prevent some risk or harm (Allsop & Jones, 2006; Morrison & Benton, 2010) but it is unlikely to stop a determined individual acting as they choose. Moreover, as it is extreme acts by individuals that are often used to illustrate the need to regulate practitioners (Duncan, Thorne, & Rodney 2015), the argument for regulation is based on the fallacious argument reductio ad absurdum. It has been argued that processes of regulation, with their emphasis on managerial values and approaches, have the potential to negatively impact on the fundamental mission of health professions (e.g., nursing) which is to serve society (Duncan et al., 2015).

My experience last year of renewing my teaching registration (which I have held since the early 1990s) was particularly problematic and this seemed to relate to new and tighter descriptions and definitions of who is able to verify my identity and competence. The implementation of the *Vulnerable Children's Act 2016* (the *VCA*) obliged professional regulators to add additional steps into their revalidation/registration processes, including a verification of the applicant's identity. I found that when renewing my NZ nursing registration the Nursing Council of New Zealand did not have any difficulty with this and simply required that a Justice of the Peace or other

nominated individual complete a section on the usual annual recertification application form. However, I experienced significant challenges in relation to verifying my identity when renewing my New Zealand teaching registration.

The Education Council of New Zealand is charged with regulating the compulsory education sector; registered educators working in higher education are not required to be registered and this is probably why the list of people (defined according to roles, outlined on the instruction sheet) who could verify the applicant's identity was only relevant to primary or early childhood educators. Because the Dean of the university Faculty in which I work, who is my line manager, has signed off on my teaching competence on these applications for many years, it seemed logical that he would be able to verify my identity. However, because his role was not deemed to correspond with those outlined on the application form this caused a major crisis with my application. While published guidance about the *VCA* implies that my line manager and long–term employer with a role analogous to a school principal could verify my identity, the regulator could not cope with this. Ultimately they required that I meet with an educator (who I did not know) in order to have my identity verified, not on the basis that he knew me but apparently on the basis that he was "an approved" registrant. The regulator eventually provided me with an (outdated and inaccurate) list of named individuals who could verify who I was even though none of them knew me, the primary qualification being that they were already registered with, and known to, the regulator. As far as my competence was concerned my long–term employer/line manager was able to verify my practise, as he has for many years. The limited interpretation of the legal requirements for verifying identity seems to stem from a rule–bound and risk–adverse interpretation of the *VCA* and was particularly remarkable given that it was afforded more stringent attention than who could sign off on my professional competence. An additional irony was that the list of who could verify my identity was 'secret' — I was only sent it when I asked who these people were, demonstrating a rather glaring lack of transparency and accountability on behalf of the regulator.

Issues relating to identity may be constructed as risks but another analysis of risk may be that regulators are primarily concerned with risks to their own existence. These agencies are conceived and exist within a political

and legal framework in which they are mandated (and arguably, beholden) to governments which act as puppet–masters. The work of regulators is to define their territory and patrol the edges of it — which, thus, are more likely to be defined in terms of impermeable border walls rather than permeable boundaries or rohe, as walls are easier to see (and build) and, therefore, better at containing people.

Geographical territory

My own experience also included struggling to navigate definitions, systems and processes across borders. There are documented challenges with regard to practitioners gaining recognition across borders, which is highly problematic, given the significant flow of health professionals across the globe (Cheng, Spaling, & Song, 2013; Giblin, Lemermeyer, Cummings, Wang, & Kwan, 2016; Newton, Pillay, & Higginbottom, 2012). This movement of practitioners meets workforce requirements and includes rites of passage such as New Zealanders travelling overseas to visit and work early in their careers. My UK (nursing) registration has allowed me to live and practise there and, in addition to it having been very hard to secure in the 1990s (resulting in my reluctance to let it lapse), it provides me with the potential for professional flexibility. However, this time, there were many problems with renewing this registration, including that, despite my exhaustive portfolio of professional development activities, the confirmation of these online was only deemed compliant if the colleagues engaging in the reflective dialogue with me held their own UK nursing registration. This meant that the colleagues with whom I had had local and deep reflective conversations were afforded no regard because they did not have UK professional identity and status. A further irony was that the overall process (various sections of the portfolio and reflective discussions) required verification and that colleague did not need to be a registered nurse or anyone in the UK! The stock (usually automated and often patronising) responses to my attempts to address these anomalies included the assertion that I was not English and simply had no need for a UK registration anyway.

It was on one of the days which was a particularly low point in this administrative nightmare that the Brexit vote took place. I was kept updated throughout the day by the colleague in the UK who had agreed to be an

additional peer with whom I could have a reflective professional conversation. This meant that when uploading my renewal I could refer to her UK registration details, while effectively disregarding the reflective practice I had already undertaken with local colleagues. We talked as she sat up through the night with one eye on the Brexit vote results unfolding and this caused me to reflect that maybe my bureaucratic journey transcended others I had endured as a New Zealander living and working in the UK as a foreigner and which was, in fact, always impacted by a wider global political dynamic.

The Brexit vote heralded a new era in asserting jurisdictional territory and boundaries and indicated to the world that the UK saw itself as separate and sovereign. Arguably, it also involved a degree of racist elitism. Prior to the poll results in the UK referendum and the US presidential election, there were concerns that neoliberal political values were impacting health professionals and their practice (Duncan, Thorne & Rodney, 2015).

The other major geopolitical shock of 2016 was the election of Donald Trump as the President of the USA. While none of my professional registrations are with USA regulators, the recent re–emergence of nationalism seems to have cast me as a professional alien when trying to maintain my registration in a jurisdiction other than the one in which I was born, live, and work. Within this context there are many people who in addition to being professionally alienated are also culturally cast out.

Professional territory

One of the hallmarks of professional practice development in recent times has been an acknowledgement of the strength of interprofessional engagement. The identification of interprofessional learning and collaborative practice by the World Health Organization as imperatives for workforce development and service provision could be interpreted as a basis for regulators to work together within their jurisdictions and also across them. It has also been suggested that restrictive professional boundaries may increase the risk of professional misconduct as professions within a defined group may have a more relaxed approach to transgressions amongst their own group than others (Muzio, Faulconbridge, Gabbioneta, & Greenwood, 2016). However, regulators tend to work in isolation,

patrolling disciplinary boundaries and struggling to recognise that within the same jurisdiction they are probably developing systems and processes to meet the same requirements as fellow regulators. The advent of regulation can restrict meaningful engagement and the sharing of expertise across professional boundaries by either reducing practice to a generic set of standards or tightly prescribing territories (Adams, 2015; Reeves, Fox, & Hodges, 2009). Geographical boundaries can also be a mechanism for reducing interprofessional and intraprofessional engagement (Dower, Moore, & Langelier, 2013).

Extending engagement beyond sectors has many benefits including enabling critique of commonly accepted practices. In my recent experience all the regulatory authorities I am registered with emphasise reflective practice. This emphasis on reflection is common in the education of health professionals and professional development requirements but it does not follow that it has been found to be universally accepted as valuable and able to positively influence practice (Mann, Gordon, & MacLeod, 2009; McEvoy, Crilly, Young, Farrelly, & Lewis, 2016). Having a wider view of regulation and professional development may broaden current practice, providing opportunities for more relevant and appropriate definitions of practice and approaches to recognising and valuing it.

Considering a cultural perspective

The emphasis on risk and tight definitions of professions and processes for recognising and regulating them invariably dismisses a range of experience and expertise, practice and practitioners. If a truly cultural concept of nursing practice was appreciated by the UK regulator, it would not have insisted on an ethnocentric approach to renewing my registration. There are no grounds to believe that a reflective conversation with a (potentially) unknown colleague on the other side of the world would be more valuable than that which occurred with a local colleague and practitioner. A more respectful approach to bureaucratic processes would see less of an emphasis on electronically–generated interfaces to help real people address real questions. If there had not been so much global fear and distrust of people from other cultures during 2016 maybe my experiences would not have been so fraught.

People and therefore practitioners will continue to move between nations (Heale, & Rieck Buckley, 2015; Wismar, Maier, Glinos, Dussault, & Figueras, 2011). Fresh approaches to the regulation of health professionals may well serve a dual purpose of both "protecting" the public better while also treating practitioners with higher regard. Within Aotearoa New Zealand we should have the inside running on culturally relevant and respectful models for engaging with individuals and the wider community. We have a Treaty obligation to appreciate sovereignty and a good deal of discussion about ensuring we provide "for and with" tangata whenua (Māori as self–governing first people of the land).

Conclusion

Jurisdictions across the world are responding to perceptions of public risk by mandating regulatory agencies to oversee groups of practitioners. These agencies generally determine the processes they will use to "register" practitioners. However, there are questions about the very foundations of these regulators and their processes as the commonly cited expectation to "protect the public" cannot be enacted pre–emptively to prevent any practitioners from behaving inappropriately or incompetently.

Despite the power that practitioners feel wielded over them by regulators, one analysis may be that they are themselves little more than the machinery of the state to control and manage risk for legislators and governments. The power they wield as they interact with practitioners and the professions may be better directed to critiquing their role and contribution to the wider community and constructive and progressive relationships with their power masters. It is difficult to understand how the fundamental concern of public safety can be served by agencies that struggle to appreciate the wider sociopolitical context and lack an appreciation of the power dynamics they engineer.

While the concept of safety is problematic in relation to regulation the idea of protection can be constructed positively in relation to culture. Protection is closely associated with te Tiriti o Waitangi and should be valued in relation to caring for health and wellbeing. A new emphasis on culture could provide a fresh position from which to reconsider protection in relation to the regulation of health professionals, with an emphasis on

cultural appropriateness and wellbeing. Such an emphasis on culture could also be extended to the relationship between regulators and practitioners, conveying the value of respectful, transparent and accountable interaction.

If regulators were brave and creative enough they would work in ways that recognise and value cultural context along with regulatory structures. Such an approach has the potential to result in administrative processes that support practitioners to engage with registration and compliance requirements in ways that are nonracist and inclusive. We would do well to focus on an indigenous view of boundaries such as that of rohe rather than more imperialist concepts of solid border walls as we consider our similarities and differences and the provision of informed, appropriate and meaningful health care practice.

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Vulnerable Children's Act 2016.

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PART IV

Reflections on *The Turning Tide* and on seven years of state registration of psychotherapists in Aotearoa New Zealand

Chapter 17

Responses to *The Turning Tide* (2011)

Seán Manning, Anne Martin,
Denis Postle, and Coinneach Shanks

Psychological and social scientists

Anne Martin

Many of us are very depressed. There is a worldwide recession, the severity of which many of us have never experienced the like. Our jobs are being taken from us, our homes are being taken from us, and many of us are facing real hardship: our way of life is being taken from us. Everything seems troubled and off–balance, and we feel very threatened and afraid.

It is against this background that the wish for regulation, which has been around, at least in theory, since the early 1980s, has begun to thrive in practice. In a situation where many therapists seem to be chasing few available clients, competition for these clients seems to have become cutthroat: in itself an uncivilised and demeaning situation. Groups with vested interests have formed and seek to monopolise the field, each insisting that their particular therapy and their particular way of doing it is the only way; and they do their best to get rid of the rest. Well, the "rest" have at last begun to realise this and, some few years ago, begun to fight

back. Much wonderful literature has already been produced, which attempts to deal with these issues (see references in Chapter 8), and this book is an important addition to this literature. This volume sensitively and surely explains fully why, all around the world, psychotherapists have found regulation controversial and impossible to implement satisfactorily; and the book feels as if it has been put together most sincerely, enthusiastically and dedicatedly, and in a way in which the individuality of each author is well respected.

I love the dedication: it is inspirational, as is the book, and we need inspiration at this time. As to the book itself, I couldn't agree more with Grant Dillon (in Chapter 3) about the psychological reasons for the need for registration. I agree that it is all about the need to establish individual and collective identity, recognition and validation. This is particularly so in Ireland, a country only relatively recently independent of "Great Britain", and with an underlying sense of inferiority which, in my opinion, at least, it frequently hides with reaction formation behaviour. The issues causing these phenomena really belong not to the statute books but to the consulting room. I was especially interested in Chapter 5, illustrating Māori traditions of mutual respect, which serves as a reminder of the unchangeable principles on which psychotherapy itself was founded and what psychotherapy was originally all about. Of course, to use the concept of protection and the word "protected" about "psychotherapist" is a nonsense. The word — and, indeed, the psychotherapist — has been appropriated by the "regulationists", who are playing "Pirates", and, one might say, colonisers. In fact, the term psychotherapy has been stolen from the founders of our traditions — Freud, Jung, Rogers and so on — who bequeathed to us their precious legacies, which belong to us all. One of my colleagues, speaking of the objections to some of the larger professional bodies' methods of operation called it "a money–making racket". I'd go further and declare it to be "a protection racket"! I do wonder about the motivations — and of course the psychodynamics and the Shadow — of the regulationists who seem to have an obsession with interfering with and trying to regulate space in which they (should) have no place (see Page, 1999), and wonder whether they seek regulation in order to satisfy their own unanalysed issues around recognition, validation, and respectability.

Of all the chapters, I found Susan Green's (Green, 2011) deeply worrying and disturbing. In what is a courageous contribution, she acknowledges that many therapists have taken things they don't understand on trust; have "a high degree of obedience"; have put off thinking about the issues until it was too late; and have allowed themselves to be intimidated and bullied. It seems to me that she is reporting and reflecting on an unconscious collusion between those who wish to control and those who wish to be obedient and controlled; and that we need to be exploring the inner meaning and significance of regulation, as do Jeremy Younger (in Chapter 12) and Louise Embleton Tudor (in Chapter 13) — and there is far more to do. Even Susan's report of "confusion" strikes me as describing a defence against anxiety, pain, and taking responsibility. That those who conform and are obedient and/or confused are qualified therapists, whose work is to help others with their lives and responsibilities, makes me wonder about the role and effect of training and personal therapy. Does psychotherapy training and training analysis or therapy teach us to dance like marionettes to the tunes of professional associations and training bodies, or does it help us find our own voices? So much for us being trusted caretakers of Jung's concept of individuation! Susan's worry about getting involved in any political sense also reflects what I find in Ireland. I feel shocked and appalled at all of this and also at the reluctance I find in Ireland to read what is probably the equivalent of the *Health Practitioners Competence Assurance Act*, i.e., the *Health and Social Care Professionals Act 2005*. If practitioners did read it, they would find that the whole content and style of what they themselves do not like about their professional bodies has already been enshrined in the *Act*, which is just now waiting to gobble up all the analysts, psychotherapists and counsellors, too. There is always something more important to think about than getting to grips with these issues, such as the lack of work, family problems, illness, or whatever, and, at present in Ireland, we are in the worst recession since the 1940s and '50s. Also, like Susan and other practitioners, people are — or have been — scared. Just the other day [in 2010], I found out from a practitioner who is newly qualified and accredited (with one of the major professional bodies in Ireland), and a recent participant in the Independent Practitioners' Network (IPN) Dublin, that she didn't know that she could be barred from practising if she doesn't register. If she doesn't know, then probably many others of the membership don't, either (and that might explain, at least in part, why I am finding it

quite hard to find takers for the IPN in Dublin). The fear factor even extends to practitioners being scared stiff of being found out to be attending IPN meetings and of the retribution of their training institutes and professional associations, although I would question the professionalism of such associations. One colleague said to me: “Ireland is a small country and we have little experience of diversity”; and another reflected: “Many, if not most of us have been so crushed in childhood, that it is hard or impossible to stand up and say ‘No’ ”. I understand the fear, but am appalled at the ignorance, and have to ask the question “Why?” Is information being withheld from these people? Are people trained in conformity? I trained in London in the early ’80s, and we were talking then about the possibility of regulation and what it could or would mean. Even then we knew that we could be barred from registered practice if we didn’t tick all the boxes — and hence the importance of independent networking.

This is a well–organised, greatly readable, and important book, and is an object–lesson for psychotherapists in countries who do not have statutory regulation and are perhaps working towards it. In this, I also appreciate the trouble that Keith Tudor (as editor and a contributor) and other contributors have taken to define terms. This is helpful for others at different stages of struggle. Although the book is specific to New Zealand, there are astonishing parallels in the issues reported and faced there with those others of us in Ireland facing the same and similar issues, although these parallels are maybe not so astonishing when we consider that we are dealing with human nature and archetypes. I hope that, together, united, we can expose the tyranny, dictatorship, oppression and regimentation into conformity and uniformity the regulationists would wreak on us all in order to satisfy their own needs for recognition, validation and respectability, and replace it with something infinitely more sensible and humane. All the chapters spoke to me in different ways. Other than the ones I have mentioned I particularly appreciate Sue Shaw’s (Chapter 9) on socialisation. In my view, if we’re not social scientists, we’re missing something.

This book excites me! Why? Because regulation or the threat of it and its implications and effects have, all over the world, bothered us, suffocated, crushed and depressed us, made us miserably anxious, made us forget our roots (and our routes!), tyrannised, oppressed, intimidated and demeaned us, divided and ruled us all, and isolated each one of us. Fear and darkness

surround us. In this context, comes this book, a book which places these problems clearly in a historical as well as a psychological context. In doing so, it details what is a clash of basic psychotherapeutic absolutes and values based on freedom with the rigid, impersonal, arrogant, and bureaucratic principles of regimentation by fear, coercion and exclusion. This book shines a very bright light on the wrongs and the sham/e of statutory regulation; recalls us; unites us in mind, place and action; reminds us of who we are, and of our sheer humanity and morality; creates hope and optimism and the possibility of wholeness and healing; and reminds us that, even post regulation, it's never too late to resist and change things — if we work towards them courageously and faithfully.

I especially recommend close reading of Chapters 8 [Green, 2011], and 15 [Independently Registered Psychotherapy Practitioners, 2011] and their expositions of how to set about opposition to statutory regulation. This book is especially significant as many health professions in New Zealand are in a "post regulation" state; and so, for those of us who are still in a state of "pre regulation", the book is an important message from the future. It is clear that a number of colleagues in New Zealand are unhappy with what they have created, and that regulation has not brought what they had hoped. I heartily applaud all the contributors to this great book! Well said! Well written! Well done, and thank you so much!

Public statutes

Ireland

Health and Social Care Professionals Act 2005.

New Zealand

Health Practitioners Competence Assurance Act 2003.

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A HISTORY OF STRUGGLE AND TENSION

DENIS POSTLE

This is a richly diverse book, a history of the struggle and tension implicit in resistance to integration of the psychological therapies into the New Zealand state. I was interested to discover the notable lack of enthusiasm for the government's regulatory framework and how it points to the possibility of an exodus, and the development and adoption of alternative forms of governance. In these pages, this mix of tasks, awakenings and testimony intriguingly mirrors much of the ebb and flow, but mostly flow, of the incoming tide of regulation of the psychological therapies in the UK.

As a humanistic psychologist trained and educated in the human potential tradition I have long been marginal to the disputes in the UK about whether psychotherapy is equivalent to counselling and whether state regulation will protect clients. But marginality brings with it some freedoms, freedom from undue deference and loyalty, and the possibility of speaking truth to power that others deep in professionalization may find difficult.

This marginality has provided a perspective that has brought into sharp focus the harmful effect that state regulation would have on the legitimacy of my 25 years of personal and professional development work. In 1997 Emmy van Deurzen, the then Chair of the United Kingdom Council for Psychotherapy (UKCP), gave a speech on the regulation of psychopractice in which she outlined her view of certain practitioners as weeds to be uprooted:

> When a garden has been very fertile and has been left to itself for a long period of time it is overgrown. Sprawling plants obscure each other's light and deprive each other of nutrients. It is then necessary to cut the plants back, quite drastically and carefully select the ones that one wishes to encourage and make room for, at the same time as uprooting those plants considered to be weeds. (cited in Postle, 2006a, p. 37)

This kicked off a decade of reporting, polemic, research, and vernacular history published and archived on the eIpnosis website (http://ipnosis.postle.net/) that I maintain. To date [in 2011] I have published around 200,000 words, many of them by writers other than myself; a book (Postle 2006b) contains the first five years of this production, and a second volume is on the way [now published — Postle (2012)].

In pondering what I could most usefully contribute from this experience to the present highly nuanced and comprehensive account of a state regulation debate in the Southern hemisphere, I was aware that I am even more marginal to events in New Zealand than in the UK. What would be helpful or informative? I thought I'd try to put together some generic gleanings from the last ten years of opposing UK moves towards state regulation of the psychological therapies: resistance to what I have come to see as attempts to "domesticate" therapists, or as one psychoanalyst put it, to encourage their "self–mutilation" (Oakley 2008).

Governance of psychotherapy by state edict introduces a chronic ethical incongruence into practice. Therapeutic alliances with our clients are surely based on love, which I would define as seeking the flourishing of the other, and where duress or coercion is anathema. State regulation as envisaged in the UK and now in New Zealand, tends to be framed as a legally enforced catechism of "musts", "shoulds", and "oughts", surveillance and audit; manifestations of a belief that the subjectivities of therapeutic relationships can, and should be, subject to social control. Duress–free love in the workroom, enforcement and alienation in the regulatory governance. Isn't this a way of manufacturing ethical incongruity?

At a minimum such incongruence leads to defensive practice and false compliance (Gladstone 2008). How could this fail to contaminate therapeutic work? And why is it so widely accepted? Over the last decade, study of the power relations of psychotherapy and counselling institutions in the UK points to a convincing explanation. There seems to be a widespread ethos about power relations; one that is shaped by a belief that dominance and corresponding subordination are righteous and inevitable (Scott, 1990; Starhawk, 1990). Both state enforcers and compliant practitioners appear to share this formative cultural imperative. Yes, it is discreetly veiled, and yes, individuals enthralled by it are acting from the best of intentions.

As if this were not enough to raise doubts about the value of state incursions into the psychological therapies there is more. Statutory insistence that practitioners sign up to state–defined forms of practice compromises what to many of us seems a very important aspect of psycho–practice: its counter cultural posture of reflection and critique.

There are many more reasons for ensuring that the state does not infiltrate the psyche. I want to mention two that are related to the topic of this book. Firstly, that many people who show up seeking therapy have suffered harm that is a consequence of some form of the dominance/subordination behaviour, such as abuse and bullying. If this is echoed in the professional governance isn't this likely inhibit our perception of the power relations that are being presented? Secondly, is it not the case that most therapist abuse can be traced to some form of duress or coercion in the work with clients? We may immediately recognize gross abuse or exploitation but less easily the harm arising from the unwitting imposition of a personal world view, or work coloured by a practitioner's disappointment or cynicism.

A subterranean belief that domination and subordination are natural and inevitable, has seemed to contribute a surprising amount of bullying, duress, and coercion to psychotherapeutic governance in the UK, leading some sectors to seek to embrace even the extreme form of it represented by the Health Professions Council. Confronting the grip of this trance has seemed to be an essential contribution to keeping UK psychological therapies from, literally, capture by the state.

This is not to argue for an ethical free–for–all but to recognize, alongside the cultural turbulence that resistance entails, some yardsticks or benchmarks might be essential if we are to migrate to a non–state form of governance, one that seeks to hold ethical congruence, and in which, for instance, elements of therapeutic practice that support facilitation and negotiation and that honour the unpredictability of therapeutic encounters are valued. As I mentioned earlier, one yardstick is to value love. When dominance is present, love goes absent; as Carl Jung (2001) observed: "Where love rules, there is no will to power, and where power predominates, love is lacking. The one is the shadow of the other" (p. 87). Another yardstick that seems essential for the necessary flushing out of hidden agendas of coercion and duress is to move, wherever and however possible, to peer governance. People will say "Oh no, the psychological

therapies are too big for that" (although perhaps less so in countries with relatively small populations). My response is to argue that, with modern social communications, substantial networks of small, local groups of practitioners can hold peer governance very successfully. This is not to deny the value of hierarchies of experience and expertise, only to argue that they be embedded in peer review and peer governance.

Resistance to capture of the psychological therapies by the state evokes troublingly ambiguous attitudes. Many practitioners are likely to think "I don't like the sound of it but something has to be done", or "I'll lose my job if I don't sign up". Some will resolve this through false compliance, for some others, conscientious objection will drive exodus. The strong version of this departure promises to be the generation of new, ethically uncompromised forms of practice and governance, echoing perhaps what Carl Rogers achieved in the formation of counselling. This book resonates with the vibrant creativity that such a development requires and which paradoxically, resistance to oppression tends to evoke.

All of which takes us to a further if as yet embryonic necessity: the need for new naming and, possibly, a variety of new namings, ways of differentiating our work from those practitioners who seem happy with compromised ethics, or who face life choices that take them unwillingly into state regulated practice (see Postle, 2010a). A choice I have made has been to move to declaring what I offer is "human condition work".

Another related necessity is to let go of the notion of "*regulation*" altogether and move to "*civic accountability*". As you may see from the previous references, *regulation* is intrinsically a "power over", dominance form of governance. Under it, in UK regulatory plans still on the table, governance of the psychotherapies will be externalized in a tick box culture of audit, surveillance, standards, proficiencies and "fitness to practice" catechisms.

Civic accountability is a collective name for the task of holding "duty of care" and other ethical obligations to clients. It points to a combination of refereeing and public disclosure of statements about who I am, my background as a practitioner, what I offer, and how this is embedded in peer support and challenge, including how to complain and get redress in the event of a dispute with me. In 2003 I published a proposal for a "Practitioner Full Disclosure List" (see Postle 2006c) that embodies this

"client–side" information. An updated version of the proposal is being piloted in Bristol UK, by a group Counsellors and Psychotherapists in Private Practice. Through favouring governance that honours the whole range of the mêtis/aural/relational/embodied nature of practitioner/client relationships, *civic accountability* also upholds diversity in the psychological therapies. In the UK, for the past 15 years, the Independent Practitioners Network (IPN) (see http://i–p–n.org/) has provided a lived experience for me that has shaped and supported the critique that I have outlined here. The IPN has a long track record of implementing a non–hierarchical, peer to peer form of governance for psychological therapists. While it is onerous in its demands on time and commitment, it seems more than adequate to the task of holding practitioners in a process of support and challenge in ways that minimize ethical violations.

I'll conclude with a current research topic, a bird's eye view of what promises to be a helpful revaluation of the roles of the state and market and thus governance issues in the psychological therapies. I believe there has been a missing perspective The emergence of an international "Commons" movement, endorsed in 2009 by the award of a Nobel Prize to one of its principal exponents, economist Elinor Ostrom, has drawn attention to our shared resources:

An epoch in modern history has ended. The growth imperative of market capitalism is evidently endangering the ecosystem. Confidence in governments as reliable stewards of people's interests has been shaken. Therefore, a new path forward is coming into focus: the commons! The commons is about reclaiming, sharing and self– governing resources that belong to everyone. As a form of governance it is defending traditional or building new social and institutional systems for managing our resources — water and land, knowledge and seeds, genes and the atmosphere — based on the principles of equity and sustainability. The commons is a practical means for re–inventing society in ways that markets and governments are unable or unwilling to entertain. Commons does not mean resources alone are centre stage, of higher importance are the relationships among us, the commoners, our ways of commoning! (International Commons, 2010)

If we widen the scope of our political civic and psychological awareness does this not reveal a "*psychological commons*" (Postle, 2010b), a domain of relationship, insight and know–how which actually belongs to everyone?

A preliminary perspective for a psychological commons shows it as a landscape populated with the vernacular psychological knowhow of ethnic, employment, business, family and school peer groups; pharmaceutical science; groupings of "professions": psychiatry, psychology, psychotherapy, psychoanalysis, counselling; pastoral care, coaching; mentoring, heritage religion; self–help groups such as twelve step programmes and survivor groups; co– counselling, infant massage and spiritual counselling; media, print, broadcasting and the internet.

This abundant psychological knowhow is articulated through celebrity and women's magazines, newspapers, TV, and daily conversation. The fruits of professional psychological enquiry are also abundant, with hundreds of thousands of books, articles and conferences but are subject to artificial scarcity through mostly being available via professional channels. A psychological commons would facilitate open dissemination of ways and means for human condition survival, recovery and flourishing. From this perspective, schools or accrediting bodies who sign off or register practitioners as qualified "professionals", experts in a modality or a sector of psychological work, are making enclosures in this psychological commons, professional gated communities that, however well– intentioned, are also discriminative, often over–academicized and at least in the UK, unhelpfully rivalrous, and rife with tribal loyalties, fiefdoms and patronage. Through their construction and maintenance of "professions", they tend to impose an artificial scarcity on the psychological commons that is otherwise richly abundant.

What of the psycho–practitioners who choose to stay out of the gated communities of state regulation — but are necessarily held in viable forms of *civic accountability* governance? What tasks might they have? I hope they will find a role through which to expand political awareness of the ubiquity of domination; to honour the global as well as the local dimensions of our psychological heritage; to make what we know more freely available, to make ourselves as practitioners more freely available; to give voice to the value of love in this work we love, and take steps to help find a home for it in a psychological commons. An ambitious vision of possibilities, but the diligence, care and commitment that writing, editing and publishing this book has entailed seems likely to uphold such vision and commons as a trajectory for some sectors of psychotherapy in New Zealand.

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SPEAKING FREELY

COINNEACH SHANKS

I found that having the scope to speak freely in this response was a pleasure — and a complete antithesis of the current pro–registration discourse in psychotherapy. I appreciate that freedom because it cuts against the grain of "registration fever", and is all the more important since, in many areas, feelings of fearfulness exist that go against the successful organisation of an alternative form that would sit better with the spirit of psychotherapy — and, as psychotherapists, we must surely speak of our heartfelt feelings in

this initiative. What feelings did I have in response to the diverse array of essays contained in this book? My own feeling was one of constriction — and in further examining this I decided it was a bit like being strangled. I was a breech birth and narrowly avoided death — and to this day I cannot abide a tightly knotted tie, because I feel strangled. I get the same feeling from what I see as the process and repercussions of state registration and hence the same reaction too much of the contents of what is being reported and discussed this book: I can't breathe.

Across the range of essays, the genuine lived experience of the psychotherapist came across in a vibrant way. It represented a thorough–going diversity that is authentic compared to the artificial bolt–on diversity promoted by the modern state. The work of psychotherapists is a long way from the artificial partnerships beloved of the governments. These, in my opinion, are a grim parody of the mutual autonomy of the therapeutic alliance. The manner in which diversity (one of the shibboleths of the modern state) is played out is likely to arouse strong feelings. In many ways the concept of diversity invoked by the state "renders the question anodyne" and therefore tensions arise that are demonstrated in Margaret Poutu Morice and Wiremu Woodard's contribution (Chapter 5). Also, it is clear, as Susan Green suggests (Green, 2011), that the state in no significant way encourages ordinary people into the ranks of the professions. I myself have seen working class trainees opting out of psychotherapy training, simply due to lack of funds. Compulsory registration inevitably adds another financial barrier through which broad participation and hence input is lost.

At the root of the matter is the claim that through state registration the consumer will be protected, a claim that brutally undermines the client's independence. The client is reduced to a consumer selecting a commodity — and who, therefore, should be protected. As Evan Sherrard points out (in Chapter 11), the state distrusts psychotherapy professionals. Why would this be? Would it be because through encouraging the autonomy of individuals, psychotherapists threaten state hegemony? Marx (1867/1975) commented that capital suffuses every object. He was referring to relationships that psychotherapist quietly subvert (see also Marx, 1975). We would have to go a considerable distance to find such a self–reflective and mutually aware dyad than psychotherapist and client. The state seeks to compromise this and, as Keith Tudor suggests (in Chapter 8), prefers to

thrust us into measurable forms such as cognitive psychology. Whilst the latter is often practicable, it can too often, in the hands of the medical profession, provide little more than a conformity patch. Does the state want individuated citizens or functioning cogs in a machine?

The book also gives us a very good sense of "Oh no! What have we done?" I like Evan Sherrard's description (in Chapter 11) of his "*Uie*", which coincides with some experiences in my own psychotherapeutic collective. I am a Jungian and so naturally the relationship between the individual and the collective is of great importance to me. The collective structure of associations built in good faith by psychotherapists can turn into a blunt instrument. Some individuals who helped to initiate it now recoil in horror from their own creation, but it is to post–Freudian Christopher Bollas that I turn to obtain some purchase on the psychosis haunting our collective's approach to state registration. The place where I live and work has been seized by a dreadful conformity. At the core of what Bollas (1987) describes a "normotic illness" (p. 5) is a drive to be "normal" in a manner that privileges objectivity at the expense of subjectivity. In consequence, the haste to be acceptable (registered) has numbed our subjectivity. We are merely manufactured products amongst others in "the object world". So the collective psychotherapeutic self is happy to make itself an object in this object world, because it is reassuring: "Well that's the way things are nowadays, all professions are regulated" (something of Bailey's argument in Chapter 4). Our professional collective, having found it easier to be "objective" in a world of data, facts and "evidence–based" criteria, lost touch with its subjectivity. It is a sad state of affairs that often our profession appears unable to develop a full sense of self. So a sense of self has to be borrowed, constructed elsewhere by a state registration body. This particular self, of course, has no unconscious and hence no shadow. That is all abandoned in favour of "progress".

I am pleased that this book seeks to redress this state of affairs. Colleagues in Aotearoa New Zealand have given us a case study elaborating the possibilities of the reversal of an inappropriate process that is ultimately destructive for our work.

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THE OPPOSITION

SEÁN MANNING

I have been invited by the editor to update the chapter I wrote in response to the first edition of this book. At that point I was responding to the other contributors. On this occasion, not having seen the text of the second edition, I will simply put the contrary case as I see it, further informed by experience during the intervening years. I am the opposition, or a representative of it — it is expected that I will counter the central argument of the book. I support the idea that psychotherapy should be a registered health profession alongside medicine, nursing, psychology and so on — 13 professions in all, including psychotherapy.

I will begin as I did in the first edition, by acknowledging the integrity, passion, and scholarship of the other contributors. They were experienced by some, at the time of the first edition's publication, as a group of unruly malcontents. I do not, and never have, subscribed to that view. Discontent among such a group of writers as this should be taken seriously. Even while I was at the centre of things, as president of the New Zealand Association of Psychotherapists, a role that I relinquished in 2013, I hope I tried to understand the conditions that disturb contentment among good citizens, for it is often the task of good citizens to disturb the peace. As Thomas Jefferson is rumoured to have said "Eternal vigilance is the price of liberty– power is ever stealing from the many to the few…. The hand entrusted with power becomes … the necessary enemy of the people."

In this spirit, Keith Tudor's efforts in the publication of these volumes must be welcomed. As an expression of opposition to state regulation the book works well.

Naturally among scholars, the contributors do not always agree with each other, but they do set out a wonderful array of arguments opposed to the current system of regulation of psychotherapy. The Psychotherapists Registration Board of Aotearoa New Zealand (the "Board") was, at the time of the publication of the first edition in 2011, and possibly has been since, harassing and authoritarian. Their world was described as Orwellian, one dimensional, incompetent, and inappropriate. There were, and presumably still are, calls for the repeal of the *Health Practitioners Competence Assurance Act 2003* ("the *Act*") or at least for psychotherapy to be removed from it.

My job here, as I see it, is to listen to arguments that oppose mine, not just to defend my position, but to listen carefully and respond, an exercise not unlike the practice of psychotherapy.

Insufficient debate

One theme illustrated very well is the insufficiency of debate about regulation, including the debate within the New Zealand Association of Psychotherapists (NZAP), the largest professional organisation in the country explicitly for psychotherapists, who sought registration on and off over a 60–year period.

Further, there still is widespread ignorance of this piece of legislation. There is no doubt that psychotherapists have been culpable in setting up a system that at least some of them would regret. That there were many incidents of delinquency over a long period of time which self–regulation had failed to cope with, as described eloquently by Evan Sherrard (in Chapter 11), is not an excuse for poor preparedness.

Unattractiveness to Māori

Another excellent aspect of this volume is an explication of why the current system of regulation is unattractive to Māori, indeed it seems designed not only to discourage Māori psychotherapists from registering, but to drive them away from the profession entirely.

Article 2 of the Treaty would protect customary rights. Article 3 would demand consultation. However, the *Act* contains no mention of it, because the Treaty is seen by the Ministry of Health as being adequately dealt with

as far as Crown entities in health are concerned, in the *Health and Disabilities Act 2000*. The problem is that the Psychotherapists Board does not see itself as a Crown entity, and has a legal opinion to back that up. There are no distinctly Māori routes to registration and there is no recognition of Māori practice. The comparatively large fee (see Chapter 7) adds to the forces deterring Māori practitioners from registering.

The Board's aggressive style of communication changed some minds

In Chapter 11, the late Evan Sherrard details how the Centrepoint scandal and the conviction of the leader of that community for child sex offences influenced the move toward registration, a development that would "stop just anyone hanging up their shingle" (p. 247). He then describes how he changed his mind from advocating statutory registration to being opposed to it. He describes "a framework made by and for bureaucrats … based on the notion of protecting the public by regulating the practice of registered practitioners by bureaucratic administrators." (p. 248); and writes about the Board's style of correspondence: "Towards the end of each message there was a warning … Having a big stick waved at me was outside the ethos and culture of the psychotherapy I had ever experienced. A new spirit was abroad." (p. 249)

An empathic stance is not reflected

One disturbing aspect of the story of registration is that this approach — of understanding that those who represent the other side of an argument always have something worth listening to — has often not been extended back. I cannot count the number of times, in relation to registration, I have thought, "Oh, for Christ's sake ..." (This is a primitive exclamation as I have not been a Christian since I was a child.)

Since I left the centre of things, I am unsure of how the regulating authority — aka "The Board" is seen. There have been many changes of personnel in the past six years. Certainly the aggressive position that the Board sometimes took was intensely alienating. Back then, the Board was described in very disparaging terms quite routinely by people who in relation to other topics would habitually practise a listening and responding

stance. In the argument over registration this is a casualty. *They* are unreasonable, so *we* don't have to be.

So far I am in agreement with the other contributors to this volume. While there are other points of meeting in what follows, from this point I am more or less critical of the anti–regulation arguments.

The use of psychological or psychodynamic terms and theories to explain political events

Omnipotence is a natural consequence of mastery. We learn to explain human experience and behaviour in individuals and to some extent in families thus to alleviate suffering, so we naturally tend to explain social and political phenomena in the same frameworks. This is a mistake. We extend ourselves beyond the limits of our competence here — using psychodynamic constructs to explain political phenomena is a parlour game, not to be taken too seriously. When we hear of "the regulating function of the mother's gaze" compared with state regulation (as Louise Embleton Tudor does in Chapter 13), we stretch a metaphor too far.

It may be that psychotherapists had a fantasy of the Board as a good parent, but it was never intended to be so. The *Act sets* up a Responsible Authority — the Board — not to protect psychotherapists, but to protect the public *from* psychotherapists. No doubt when psychotherapists were seeking registration they had in mind that it would be good for the profession, and it may indeed turn out to be so in some ways. Thus it is tempting to interpret disappointment with an unsympathetic authority as a response to rejection by a bad mother, but psychotherapists are not children; we have all had a lot of therapy and our emotions are not regulated by a parental government entity. We cannot reasonably claim the Board or the *Act* as the cause of our dysregulation. Human groups do not behave like individuals. The development of societies does not parallel the development of individuals. The oppression of an individual more often than not produces fragmentation — even when there is also heroism, it is accompanied by splitting — while totalitarian government reliably gives rise to originality, courage, individuation and intelligent resistance. This book is a good example of such a response to perceived totalitarianism, but its arguments are weakened by psychodynamic approaches that confuse human developmental and political processes.

Who should do the regulating?

At times those who object to registration of psychotherapy appear to be objecting to the Board's function in *certifying* psychotherapists, as opposed to regulating them. Certifying is an act that acknowledges competence, but, as one writer correctly points out, certification, usually conferred by an institution, is not the *same* as competence, which can only be confirmed by a consumer, or, failing that, by peers in an ongoing way. Thus, self–regulation by peers is considered by many to be the best option. In fact, it is hard to find anyone who is opposed to regulation per se. Most seem to accept that there is no such thing as an unregulated environment, but would argue about who should do the regulating.

There is no evidence that regulation protects anyone

This seems to be true — I am aware of no evidence that regulation actually protects anyone. That includes regulation of any kind, whether self–regulation or state control. The major professional organisation for psychotherapists in New Zealand, the New Zealand Association of Psychotherapists (NZAP), has been proud of its low rate of complaints in comparison to other organisations, and this has become a claim that self–regulation works better than state regulation. I have never seen any comparative figures to justify that claim. If the rate of complaints against psychotherapists is in fact low, it might be simply because selection and training are on the whole of a good standard, or it may be that nicer people are attracted to psychotherapy, or it may be a complete illusion.

However, the lack of evidence in its favour does not mean that we should abandon regulation. All psychotherapists that I have met agree that there should be some behavioural rules. No–one objects to there being a code of ethics, or to procedures to deal with exploitation. It is just very difficult to design a study to assess the effect of regulation. We do have social experiments like Zimbardo's simulated prison, which suggest that unrestrained power leads to abuses (Zimbardo, 1971), and there are a number of real life histories to support that conclusion. We tend to be in agreement that oversight is desirable, that a completely unregulated environment is dangerous. The question is how, not whether.

Are certain therapies privileged by state regulation?

Several writers in both editions of this book allude to the idea that that regulation limits practice. It is suggested that regulation creates a climate in which trainees and supervisees feel that they need to hide their mistakes, real and imagined and cannot explore their creative, critical thinking. In the context of the impact of medicine on psychotherapy, it is suggested that longer–term psychodynamic and humanistic psychotherapies are marginalised. There is an argument against the dominance of evidence–based practice, which by its nature mainly supports short–term interventions, as they are simply easier and cheaper to research. (Fonagy, Roth & Higgitt, 2005; Leichsenring, 2005; Leichsenring & Rabung, 2008)

This is somehow linked to registration, but the argument does not hold up against, if I may be permitted to quote it, evidence. The regulating authority, aka the Board, accepts psychoanalysis alongside transactional analysis, gestalt, and psychodrama. There is no privileging of short–term models in the process of regulating psychotherapy, and besides, the evidence increasingly supports the efficacy of humanistic (Truax & Carkhuff, 1967), psychodynamic psychotherapy and psychoanalysis (Schedler, 2010, 2010b). The problem is not that regulation privileges certain therapies, but that funding mechanisms do, unsurprisingly. Psychotherapists have a responsibility to convince funders otherwise, and small successes are evident in this — for instance, the Accident Compensation Corporation (ACC) now accepts long–term therapy, with 30 sessions funded at a time, given an assessment that justifies it. Moreover, funders are much more likely to listen to registered health professional than to non–registered, unregulated practitioners.

We are in a similar position to that confronting clinical psychology 30 years or so ago. Instead of complaining passively about funding systems not recognising psychodynamic therapy, the profession might consider learning from our more scientifically–inclined colleagues.

If one compares the New Zealand situation to that pertaining in Australia, which in theory more resembles what is sought by those opposed to registration, we find quite a lot to be alarmed about. In Australia there is no state regulation of psychotherapy or counselling, the field being dominated

by psychiatrists and psychologists. However, look more closely and one finds the field competitively dominated by medicine — even the psychologists must have a referral and a treatment plan designed by a doctor. There is virtually no funding for psychotherapy — it relies entirely on the ability of the client to pay. In New Zealand, where psychiatry, psychology, and psychotherapy are all registered health professions, psychotherapists can do assessments and provide treatments recognised by funding agencies such as ACC. We can be, and are, employed by District Health Boards; we can sign documents recognised by Work and Income New Zealand, the national benefits agency; we are consulted and referred to by the child protection agency, the Corrections Department, the Ministry of Justice, etc., etc.

But yes, some therapies are preferenced by regulation. There are always preferences. Humanistic and psychoanalytic therapies are preferred over spiritual healing, aromatherapy and iridology, and for good reason. If regulation gives psychotherapy an edge in credibility, so much the better.

Is psychotherapy a health profession?

In this book much is made of the notion that psychotherapy is actually not a health profession. A while back, before registration of psychotherapists began, a psychotherapist friend of mine, concerned with what, if any, regulations, governed the way a psychotherapist's records are kept, approached the Ministry of Health, asking if there were guidelines. The response was unequivocal — psychotherapists are health professionals; our records are defined as health information, and, therefore, the twelve rules of the *Health Information Privacy Code* (Privacy Commissioner, 1994) apply. I have never heard a psychotherapist object to this idea. The *Code* is routinely taught in all training courses as a standard for the treatment of client information.

The *HPCA Act* is thought by some to be biased toward medicine, incorporating thirteen professions which are either medical professions or which ally themselves with medicine. This list includes psychology, which is pertinent to this argument. A comparison of statements on confidentiality in the *HPCA Act* and in the old *Medical Practitioners' Act 1995*, which was replaced by the *HPCA Act* 2003, will find that the two are almost identical (see Table 6.2). This is also taken to be evidence that everyone regulated

under the *Act* is chained to a medical model, rather than that it is simply a very good statement on confidentiality.

The fact that psychotherapists sought registration with health professionals rather than with social work professionals appears significant in terms of where psychotherapists want to situate the profession. Freud is invoked, having suggested in his discussion on lay analysis that psychoanalysis should not be regarded as part of medicine, but actually as a branch of psychology.

These arguments are weak and contradictory. Psychology, which Freud recommended as a companion to psychoanalysis, is itself registered under the *HPCA Act* as a health profession. Psychoanalysis is only one form of psychotherapy, and it began largely among medical practitioners, of which Freud was one, and the idea that psychotherapy should be registered under the same *Act* as social work is hardly an argument against regulation. It is said that social workers have a choice, but this is an illusion — to work in government–funded agencies, they must be registered.

Besides, what exactly is wrong with being identified as a medical–style profession? If (and it's quite a big "if") the public see psychotherapy as similar in some way to medicine, I am not sure what that would change. What the public might see is that one professional is registered and another not. The fine distinctions involved in distancing ourselves from medicine (and it is not clear to this writer that that is a good idea), are largely matters that concern members of the profession, and not even all of them. It does not change what we do in the slightest.

Since 1977 when psychiatrist Engel introduced the "biopsychosocial model" in an article in Science, the "medical model" has been trying to get away from itself. The notion of "disease" underlying what seems to be the understanding of the medical model in these pages is now quite archaic, at least in psychiatry, neurology, genetics, pain management, cardiology and epidemiology, where holistic approaches involving interactions between biochemistry, social conditions and subjectivity are common if not *de rigueur*. Rosenfield (1992), Damasio (1994, 1999, 2003), LeDoux (1996, 2002), Schore (1999, 2003), Siegel (1999), Edelman and Tononi (2000), Cozolino (2002, 2004, 2006), and Solomon and Siegel (2003) all come at subjectivity, affect, consciousness, attachment and emotion from a

combination of biochemical and neurological observation, and consulting room experience. In thus applying a medical model to matters of concern to psychotherapists, they accumulate a considerable weight of evidence for what we do. It would seem that the couch and the surgery have been encroaching on each other's territory, even *converging*, for some time now.

Perhaps psychotherapy is not about cure

For some, cure is not central to psychotherapy, which is about exploration, not comfort. For some, the aim of psychotherapy and counselling (for those who do not distinguish the two) is solidarity, partnership, or political engagement as opposed to individual freedom or autonomy. Authenticity and uniqueness are preferenced over feeling better.

There is no problem with these ideas. They are faultless academic arguments, if they seem at times somewhat distant from everyday life in the therapy room. The great majority of psychotherapy clients come because they seek freedom from anxiety, depression, posttraumatic symptoms, destructive relationships, violence, addiction, and other behavioural, affective and cognitive subjectivities that are ruining the quality of their lives. They are driven to seek us out because they cannot stand their own thoughts or feelings, or are driven to despair by their relationships, their drinking, or their violence. This is very much about health, and we work alongside health professionals of all colours to try to improve that health, so that people can sleep a little, drink less, smile more, lose or gain weight, improve their relationships. Generally they know what they want, at least in general terms. This may well include the development of authenticity, uniqueness, partnership and solidarity, which may be signs of health, or may be health–creating, or may be by–products of health, or a road to health, but it is a search for health that brings clients to us, and which defines us as a health profession.

Paradoxically, if we suggest that we know better than our clients when they come seeking health, we are guilty of the same arrogance of which we accuse our medical colleagues. Only in our own minds do we have our own identity. We define ourselves only in part. We are also defined by the interaction of a matrix of constructs, including those of government, the Board, other professions, and in large part, those of our patients.

In real life, sometimes we are opposed to medicine, sometimes allied with it. We are certainly more similar than different. Our codes of ethics, our attitude towards people and our desire for wholeness, integration and harmony are almost identical.

In the world of this book (at least its first edition), however, these ideas are sinister. Association with medicine means being regulated, not only alongside medicine, but almost as though by medicine, and that will stymie all the good subversive work towards authenticity, responsibility and understanding of the unconscious, replacing it with symptom relief. We are redefined by the *Act* as a kind of psychotherapeutic paracetamol.

But what if the opposite is just as true, that medicine continues to be — as it undoubtedly has been — influenced by psychotherapy? What if their ruthless pursuit of symptoms has become infected by curiosity about what is really going on? In the 1930s the psychoanalyst Balint Mihály, later known as Michael Balint, emigrated from Budapest to Manchester, England. Between then and his death in 1970 he had, and continues to have, a profound effect on General Practice medicine. Balint groups still thrive all over the world. The Balint Society, which has its own journal, exists, according to its website, "to help general practitioners towards a better understanding of the emotional content of the doctor–patient relationship" (Balint Society, 2017). The vision of medicine espoused in these pages seems therefore immature and old–fashioned.

Psychotherapy is like social work

Another view that comes up in the text is that we should be more like social work than medicine. When I was a young idealistic social worker running around West Belfast in the early 1970s, we believed that psychodynamics were phenomena created by social forces. Whether we were nice middle–class people helping the poor or communists who saw capital as the source of evil, we all attributed the enormous difficulties we encountered to social forces. It was the environment that created the mind. Psychoanalysis, which, in the early twentieth century, had an enormous influence on social work literature and method, had failed completely, had done horrendous damage in encouraging the separation of infants from their parents, based on the commonly–held notion that infants did not attach until several months old. The satirical newsletter *Case Con* never let an issue go by

without lampooning the therapists. I have never worked in an environment so implacably opposed to psychotherapy. We may like their legislation, as it gives them a choice over whether to register, but why on earth would they want to be associated with us? I don't hear social workers making overtures.

The HPCA Act is flawed

There is little to question about this — everyone who has studied the *Act* agrees that it is problematic. The New Zealand Medical Association is quoted thus:

> NZMA believes the *Act* is a missed opportunity for improvements to medical practice and offers no assurance of further benefits to patients. It will increase political influence and bureaucratic involvement in the practice of medicine, with a consequent decrease in professional self–regulation. (Richardson, 1997, cited in Chapter 6)

Briefly, its concerns were that the profession has no right to elect members to its regulatory authority, leaving any responsible authority open to political as opposed to professional agendas, and that government appointed bodies are not the best vehicles to be setting ethical standards.

More seriously, the *Act* contains no mention of the Treaty of Waitangi, and no Māori path to registration, thus alienating Māori psychotherapists. The effect is to marginalise the organisation representing Māori psychotherapy — Waka Oranga. It is a provocation, and the decision of many Māori psychotherapists not to register or to protest in other ways is an inevitable consequence.

The *Act*, as is common with state regulation, is draconian. Practitioners are subject to competence review without the need for any complaint, and a practitioner who is the subject of a professional conduct committee must be told the membership of the committee, and is able to appeal it, but the authority is under no obligation to respond. That the Board has adopted a "high trust" model for auditing practitioners — a simple journalling tool recording profession development is sufficient, much less than that required of any other health profession, or, for that matter, of social work — does not remove these misgivings about the *Act*.

A weaker argument is the comparison with the 1907 *Tohunga Suppression Act*, which was indeed a blatantly oppressive piece of legislation. However, a closer look reveals that the two are not so similar. The *Tohunga Suppression Act* had one clear purpose, as debates in Parliament at the time clearly illustrate: to enable the arrest of the political leader and prophet Rua Kenana, whose community at Maungapōhatu was just a bit too successful for a people who were considered a "lost race". It is a brutally brief document of only four clauses, and was assisted by a lethal outbreak of influenza and, truth be told, the practices of some charlatans claiming tōhunha status, which had led to some unnecessary deaths.

It was shameful period in our history, alienating to Māori, but the link to the *HPCA Act* is weak. The argument romances old ways of doing things. Rua Kenana was undoubtedly a charismatic and successful leader with a sophisticated vision of decolonisation. His Maungapōhatu community was so economically viable that it frightened the colonial government. It is also true that unlicensed practitioners were engaged in fraudulent practices in an era when indigenous people were dying in large numbers. Rua was a threat to this — his community was a response to the dilemma of the colonised. His very effectiveness was the problem. Māori suffered more from influenza than Pākehā because of their social conditions, not because indigenous practices were denied them. The problem that Rua created for the government was that he was improving on those conditions.

Even so, compared to today, the era was a brutal one, as is illustrated in Vincent Ward's 2008 documentary movie, *The Rain of the Children*, and the government's response was typical of the brutality of the time. The *HPCA Act*, while it is a stunningly stupid piece of alienating bureaucratic reductionism and an example of government which still has at its heart a secret desire for assimilation, is not deliberately aimed at the arrest of revolutionaries and will probably not result in a military assault on our homes, which is what happened at Maungapōhatu, and, in an eerie repetition in October 2007, at Ruatoki. The comparison between those two events is valid. The comparison the *HPCA Act* and the *Tohunga Suppression Act* is not.

The Board

This is possibly the most difficult area of argument, as the anger of practitioners who are marginalised or forced to pay high fees (the Annual Practising Certificate fee currently (in 2011) stands at over $600, reduced from an initial $900) tends to find fault and only fault in the operations of the Psychotherapists Board.

Looking back over the first 10 years of the Board's operation, it seems clear that the first Board behaved in a way that was often offensive, culturally insensitive and authoritarian to the point of bullying. There was no engagement with indigenous people and what consultation did occur seemed ineffective. In his chapter, Evan Sherrard illustrates the response of a conscientious practitioner who, never having done anything wrong, feels threatened with legal action.

Since then, the Board have adopted a policy under the Treaty of Waitangi, consultation has become a regular feature, and a "high trust" model has been adopted for auditing practitioners. Arguably, this book, and the work of the practitioners who have contributed to it have influenced this softening of the Board's approach to its task. Also, there have been many changes of personnel and the profession has been active in seeking and promoting people who apply to go on the Board, including lay members such as the late Paraire Huata, who had a profound influence in humanising the Board's processes, and in bringing an indigenous perspective to bear on their deliberations.

Now the opposite dynamic seems to hold true. At many, or most consultations offered recently by the Board, they have outnumbered the practitioners who have turned up to the meeting. The Board are having difficulty finding a profession with whom to consult, and this apathy is dangerous, as the Jefferson/Berry quote at the start of this chapter emphasises. The Board still work under the *Act*, and the latter is still problematic. The present more discursive atmosphere can be a phase. Other Boards under the same *Act* — for instance the New Zealand Medical and Nursing Councils and the Psychologists' Board, are much more authoritarian in their interpretation of their job and it requires constant vigilance to hold the Psychotherapists Board to their current consultative approach.

Does self–regulation work better?

There are good reasons to believe that it does. It is certainly a kinder, more flexible, a gentler and more private system. Under the NZAP's complaints procedure, for instance, a complaints convener will contact the complainant to discuss what they want. Complainants often seem to want to be listened to, to have their concerns understood and passed on, but not to make a formal complaint, and not to hurt anyone. Such flexibility is not usually available with statutory regulation. I cannot say that it is not possible, because I believe it is, but it cannot be depended upon.

These are valid arguments for self–regulation, but they are infused with romantic nostalgia. Those who criticise the fact of regulation also rail against a lowering of standards as a consequence — it is thought to be easier to get registered, for instance, than to get the NZAP's Advanced Certificate of Practice, the ACP, which was the outcome of the membership process before registration.

Curiously though, the voluntarily regulated ACP process has *narrowed* the field of psychotherapy. The NZAP has espoused a "broad church" policy, but, in fact, the requirements of each candidate have become increasingly similar. It is the Board's criteria that, paradoxically, have created a broad church among registered psychotherapists, both members and non–members of the NZAP, as it (the Board) accepts a greater range of qualifications than was the case with the professional organisation. Now that the NZAP, the professional organisation, accepts anyone registered with the Board as a member, a development that I am proud of, having proposed the motion at the 2009 AGM in Christchurch, it has, *as an indirect by–product of registration*, incorporated a much greater variety of approaches than its old membership process allowed.

Nostalgic idealisation ignores the many who did not belong because they felt excluded by the perceived exclusivity of the system, or chose to belong to the more accepting New Zealand Association of Counsellors (NZAC). At the time registration was introduced, a survey of NZAC members suggested that there were as many identifying as psychotherapists among their ranks as the total practising membership of the NZAP (Bocchino, 2007; Chapter 19).

The self–regulating mechanism of the NZAP, so lauded in the chapters of this book, has come in for almost exactly the same criticism as the state

regulating system currently in place. As to bureaucratisation, in September 1950 the NZAP Council minutes note: “The president then went on to speak of disaffection in the Association with the attitude of the Council, and of the danger of a Soviet system and a Politburo developing.” (quoted in Manchester & Manchester, 1996, p. 28).

What can be said for self–regulation is that at least there was a choice — one could go with the NZAP, the NZAC, the Jungians, the gestalt therapists, the psychodramatists, the transactional analysts, and so on — and what can be said against this is that people of dubious training and questionable practice could get away with not belonging anywhere. Even within the fold, the system was ineffective. Perhaps the worse failure of self–regulation among psychotherapists was the Centrepoint scandal, where a member of the NZAP was found guilty of the systematic sexual abuse of children over a period of years. Lots of people knew; no–one seemed able to do anything about it.

Between the lines of this text, the weakneses of self–regulation regularly appear. The rivalry between institutes and organisations, the power–based hierarchies of trainees, candidates, junior and senior members, the eligible and the ineligible. It is arguable that many of the luminaries of our profession — Freud, Jung, Lacan, Horney, Reich — were people excluded from self–regulating guilds. Strangely, this authoritarian regulation so abhorred by the authors of this book, would have let them all in.

It is true that all of the previously credentialing organisations emphasised relationship and collegiality, personal development, as well as certification, and that the current regulating system which demands that psychotherapists have 120 hours of personal therapy cannot examine the quality of that development in the same way. This, for me, is perhaps the best argument for self–regulation that we can look at the person as well as the paper credentials. In a way, the combination of statutory regulation and self–regulation achieved by those who are registered and also belong to a professional organisation may achieve the best of both worlds.

Does regulation help the profession?

Yes, very simply, it does. It takes time, but recognition of psychotherapy as a health profession is gaining ground. We can do assessments for funders

like the ACC; we give non–government agencies credibility when they are being audited and are seeking contracts to provide services; we can work with the child protection agency, Child, Youth and Family Services; our testimony is taken seriously in court, including by the coroner.

I recall when I was a psychiatric social worker listening to the recently–registered psychologists complain that they were not taken seriously, specifically by psychiatry. Forty years later, psychotherapists are complaining that psychologists are taken more seriously than psychotherapy. It takes time. Evidence must be produced (something, incidentally, at which psychologists have excelled), and it is steadily accumulating.

Conclusion

The case is not simple but, on balance, there are advantages to state regulation. Despite arguments to the contrary, there is already evidence that the profession of psychotherapy is better accepted since registration came into effect.

Although some of the contributors to this book would keep psychotherapy outside of mainstream services, its acceptance within is improving. The idea that psychotherapy has far more about it that is redolent of art than science, has a lovely ring to it, and I hope it is true, but it is hardly an argument against regulation. Besides, the same claim is made for medicine. For instance:

> The practice of modern medicine is the application of science, the ideal of which has the objective of value–neutral truth. The reality is different: practice varies widely between and within national medical communities. Neither evidence from randomised controlled trials nor observational methods can dictate action in particular circumstances. Their conclusions are applied by value judgments that may be impossible to specify in "focal particulars". Herein lies the art which is integral to the practice of medicine as applied science. (Saunders, 2000, p. 18)

For this writer, Tudor puts the case against regulation most eloquently, with another reference to Freud: "by good training and supervision, ... by certain

qualities (see Freud, 1929/1956), and by the practitioner being a decent human being, for which there is no guarantee through legislation or regulation." (Chapter 8, p. 195)

However, the *caveat emptor* world into which Tudor invites us, where clients are responsible for the outcome of their experience, and the best responsible practitioners can do is to warn against charlatanism, but not to provide any consequence for it, is not palatable. His assertion that criminal and civil law are adequate protection against bad practice do not fit with experience. Most people will not press charges, and if they do, the one with the most money usually wins. In that alternative, anything goes.

Regulation is an irritant, that is true. The paperwork, the racism implicit in the *Act*, the high fees, the sometimes aggressive language of regulating authorities, these things are annoying, but not as much as the unrestricted practice of the fringe healers: the layers on of hands; the "abundance" therapists; the sexual reorientation therapists; the aura readers and energy manipulators; the positive thinkers; the perpetuators of the fraudulent "law of attraction", from Mary Baker Eddy to Rhonda Byrne. They are *really* annoying. Regulation, by comparison, is benign.

Public statutes

Health Practitioners Competence Assurance Act 2003.

Medical Practitioners' Act 1995.

Tohunga Suppression Act 1907.

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Chapter 18

Reviews of *The Turning Tide* (2011)

Richard House and Robert Jenkins

REVIEW (2011, UPDATED 2017)

Richard House

> [S]tatutory regulation of psychotherapy and the state registration of psychotherapists represent a battle for the minds and the hearts of psychotherapists, and for the soul of "soul healing". (Tudor, 2011/2017, p. 365)
> [*For ease of reference, all page numbers where the citations refer to chapters in the previous printed edition, have been changed so as to refer to the 2017 printed edition.]*

> There has never been one way to become a psychotherapist. (Bowden, 2011/2017, p. 235)

> The values of psychotherapy themselves demand that we become more socially active and socially activist, that we actively search for creative alternatives to rigid and coercive management

> systems that ... lack a social conscience or any grounding in spiritual and ecological awareness. (Fay, 2011a, p. 201)

This book has very considerable relevance to the continuing arguments both in Britain and internationally about the auditing, accountability and the regulation of the psychological therapies. At the outset I should declare an interest and a bias, in that I have campaigned for many years in the UK, both politically and in academic writings, against the statutory and state regulation of the psychological therapies. In 2010 in Britain, those activists in the Alliance for Counselling and Psychotherapy (see goo.gl/q6XJqN) (including myself) who were strongly critical of the drive to state–regulation counselling and psychotherapy had a famous if highly improbable victory in our anti–regulation campaign, when the then new coalition government of 2010 decided to drop the previous Labour government's well–advanced plans for regulating the psychological therapies via the UK Health Professions Council. The full history of this victory has yet to be written; but if the regulation spectre should return at any time (and sadly, there's always a possibility that it might in the current era of Late Modernity), then perhaps the Alliance will do what Keith Tudor has usefully done in this book, and chronicle in detail the ongoing struggles against alien audit culture values and practices colonising our field. More on this later.

There exists a considerable literature, dating from the late 1970s, which has consistently challenged the alleged beneficence of the state and statutory regulation of counselling and psychotherapy (just some of which is referenced below). What is unique about the book under review is that it gives us a blow–by–blow account of what happens when regulation takes effect, in this case, in Aotearoa New Zealand, where regulation took place in 2008. To the largely theoretical arguments and arguments from rationality, represented in the literature to date, we now have actual empirical data, much of it reported in this book, about what *actually happens* to the field of therapy after regulation. As such, this book is — and should be — salutary reading for everyone, pro and anti– regulation, who has a stake or an interest in the "psy" regulation question.

The Turning Tide, then, details the history of moves towards the statutory regulation of psychotherapy and the associated state registration of

psychotherapists in Aotearoa New Zealand (ANZ). There are substantive and detailed critiques of the *Health Practitioners Competence Assurance Act 2003* ("the *Act*", the statutory vehicle for the regulation of a number of health professions), and the activity of the "responsible authority" for psychotherapy. Arguments for and against regulation and registration are clearly set out in the book, as is the important distinction between title regulation and the licence to practise. Part of the book's importance lies in its reclaiming of a pluralistic perspective on therapy practice, and practical alternatives for healthcare providers practising psychotherapy are explored.

This book is probably the latest addition to a burgeoning collection of books dedicated to the theme of therapy professionalization, all of which have argued strongly against the state or statutory regulation of the field (e.g., Bates & House, 2003; House, 2003, 2010; King & Moutsou, 2010; Mowbray, 1995; Parker & Revelli, 2008; Postle, 2007, 2012; Postle & House, 2009), and without a single published text to date making a systematic case for such regulation — and this despite repeated calls by the critics of regulation for the pro regulators to do so. A deafening and highly indicative silence, perhaps.

The book under review was [originally] divided into three parts. In Part [now II], six chapters provide the background and context of regulation and registration in ANZ, with Chapter 3 (by Grant Dillon) examining the history of the move of the New Zealand Association for Psychotherapy (NZAP) towards statutory registration. Chapter 4 consists of a fascinating dialogue between the book's editor, Keith Tudor, and the architect of regulation and registration, Paul Bailey. In Chapter 5 Margaret Pouta Morice and Wiremu Woodard present challenges to the *Act* originating from tangata whenua (people of the land), with ethical values and principles derived from te ao Māori (the Māori world) that were originally presented to an Ethics Committee Working Party convened by the regulation Board but which were subsequently rejected. In Chapter 6 Keith Tudor looks critically at the *Act*, which prefigured a new era of regulated health professions in the country. Another chapter offers a critique of the Psychotherapists' Board of Aotearoa New Zealand ("the PBANZ Board") [present Chapter 7); and another [Chapter 9], on sociological perspectives on regulation (Susan Shaw).

Part [III] contains a number of chapters on “Reflections on and Responses to Regulation and Registration”. Two chapters, by Evan Sherrard (Chapter 11) [and Susan Green (Green, 2011)] offer personal responses to registration while, in Chapter 8, Tudor himself looks in detail at arguments for and against regulation and registration. Jeremy Younger’s chapter (Chapter 12) explores the psychodynamics of regulation and why there was so little analysis of the dynamics of regulation in the profession, and Louise Embleton Tudor’s chapter (Chapter 13) looks at some neuroscientific analogies for regulation. In Chapter 14, Sue Cornforth exposes regulation to a searching critique from an eco–social justice perspective that explicitly foregrounds the left–critique of neo–liberalism and globalisation — a critique that is arguably even more relevant today (2017) than when the book first appeared..

In Part[s] III [and IV] chapters look at different models of regulation, registration, association and organisation. In Chapter 10 Roy Bowden reviews NZAP’s system of professional peer regulation and registration, based as it is on knowledge through relationship. [In other chapters, Jonathan Fay outlines the recent history of a developing critique in the country, focusing in particular on the organization of the Independently Registered Psychotherapy Practitioners (IRPP) (Fay, 2011a). Finally, a collectively authored Chapter 15, written by the IRPP’s Steering Group, suggests some strategies for resistance and action, in a move towards pluralism and freedom (IRPP, 2011).] There are also several appendices, including three afterwords: three appreciative commentaries from the UK Independent Practitioners’ Network (IPN) participants Denis Postle, and Irish IPN participants Anne Martin and Coinneach Shanks, and a fourth one from Seán Manning, Past President of the NZAP (see present Chapter 17). Rich and suitably diverse fare indeed.

I was especially drawn to Chapters 4, 8, 9, 10, 11 [and those in the original edition by Fay (2011a) and the IRPP Steering Group, 2011]. In Bailey and Tudor’s dialogue, we read (from Keith Tudor) that “there is little international support for the state regulation of psychotherapy: most countries in the world do not so regulate” (pp. 95–96), statement that is still true, six years on; that there is a common but fallacious conflation/elision between regulation and registration; that if one wants to make a service more widely available, regulation is by no means essential, only state

funding is; that, outrageously, the Psychotherapists' Board is not interested in any dialogue with the profession; and, most poignantly, that "once the state gets its hands on a profession or a field such as psychotherapy, it tends to intervene" (p. 106) — an example of what James C. Scott (1999) terms "seeing like a state". In his chapter Evan Sherrard also writes of the regulatory framework's bureaucratic values which "seriously clash with the values and culture of the profession. The rigid ethos and culture of bureaucracy is antithetical to the living practice of therapy" (p. 251) — with the Ministry (of Health) founded on the medical model, which is inappropriate for psychotherapy (see Mowbray, 1995; Aho, 2008; Hansen, 2007).

Tudor's substantial and erudite Chapter [8] lies at the heart of the book. He points out the irony of the lack of any evidence base for regulation and registration in this age of "evidence–based practice" (p. 189) (see Bohart & House, 2008; House & Bohart, 2008, new editions of which are due to be published in 2018); and he further shows how, over the course of some 115 years of psychotherapy, "advances in the training and supervision of psychotherapists have been adequately addressed outside regulatory schemes" (Tudor, 2011, p. 134). We also read how there simply exists no evidence that lack of registration is a causal factor in client harm — a point made repeatedly in much of the anti–regulation literature; and that medical model values and practices have started to infiltrate therapy trainings (see House, 2012), with the way in which the Act functions, severely limiting practitioner identity.

Jeremy Younger's brief chapter [12] on psychodynamic psychotherapy and regulation is a gem of a chapter, and a vital contribution to the critical literature on regulation. For him, the great concern is that dynamic therapy will "lose its teeth" as a result of state regulation, with therapy sanitized and man–handled ... with little space for unconscious processes ... emptied of subjectivity, with no place for the embracing of what is unknown ... [and] the "baby" of this precious work [being] lost in the contaminated bathwater of regulation. (p. 261)

In her chapter, Embleton Tudor writes of how legalistic means for solving disputes generate defensive practices, with the result that that "gloriously disparate group" (p. 272), i.e., psychotherapists, trust themselves less, and "The greatest sacrifice is the creativity and flexibility needed to identify and

to allow the usefulness to a *particular* client at a *particular* time of an action which is unusual or exceptional" (p. 267, original italics). This is an absolutely key Winnicottian point that those who "see like a state" seem incapable of understanding, and it cannot be repeated often enough. Embleton Tudor quotes soberingly Wilhelm Reich's poignant, telltale view that in the process of the professionalization of psychoanalysis, "Form eclipsed content; [and] the organization became more important than its task" (Reich, 1942/1973, quoted on p. 272).

There are the inevitable occasional typos and some unevenness in the [original] book, which is pretty much inevitable and unavoidable in a complex and lengthy, self–published book. Yet what for me is most valuable about *The Turning Tide*, apart from its clear and diverse range of contributions, is that it reveals in all its gory detail just what can happen to the field of the psychological therapies when state regulation, and all that goes with it, is uncritically and undemocratically imposed on the field. To give just one chilling example, we read (on p. 197) of how some therapists are reporting their (unregistered) colleagues to the Board, which is then pursuing and threatening them, even though they are practising within the law. If this book had been available in the UK a few years earlier, it might well have saved us much, if not all of the angst and trauma of being dragged by both government and professionalizing practitioners to the very brink of regulation under the UK Health Professions Council, until the UK coalition government of 2010 saw sense and, at the eleventh hour, dropped "psy" regulation.

More generally, in relation to the literature on professionalization and regulation, even accounting for the fact that it is commonly easier to challenge than it is to write in support of the conventional wisdom, the dramatic lack of balance in the literature addressing the crucial arguments in this book is surely symptomatic of something very important. When looked at in any conceivable way, the extant literature on the professionalization of the psychological therapies comes out unambiguously and resoundingly against the supposed beneficence of the kinds of professionalizing developments and political manoeuvrings, often driven by economic and institutional interests, that still, alas, strive to dominate the field in a number of countries. This welcome book makes a

significant contribution to flushing out such power–and–interest–driven processes, wherever they manifest.

Addendum

Five years on from the original publication of this book, its continued relevance to the conjuncture in which we find ourselves should be obvious. Notwithstanding all of the countervailing evidence that a control–oriented, audit–obsessed accountability culture is the death–knell of creative therapy practice and innovation (e.g. Bohart and House, 2008; House, 2012, 2016), the State seems determined in many cases to cling on for dear life to the discredited view that therapy and counselling practice is somehow enhanced by a manic armamentarium of controls, auditing and regulation. Yet as all good therapists know, where there is the desire to control there is always an inability to trust, and fear — and worse, almost always unprocessed fear. We will need to keep returning to the arguments in this excellent book, until the *Zeitgeist* finally shifts and we can stop worrying about our field being engulfed by the alien and alienating values of the audit culture (Power, 1997; Strathern, 2000).

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REVIEW (2012)

Robert Jenkins

> "I must be one of the first Chairs in 10 years who is confident in saying that statutory regulation won't be happening on my patch." (Amanda Hawkins, newly elected Chair of BACP, in *Therapy Today*, December 2011).

This statement by the Chair of the UK's foremost professional association for counsellors and psychotherapists represents nothing less than a *volte–face* and begs many questions as to what finally persuaded this key player of the regulation game so resolutely to reverse its previous policy on statutory regulation. It is hoped that the book reviewed in this article provides, albeit retrospectively and speculatively, some of the answers.

The Turning Tide, edited by Keith Tudor, is a collection of writing by therapists and others from Aotearoa New Zealand. The version of the title appearing on the back cover is "Turning the Tide". Perhaps this is an editorial slip (as is conceivably the substitution of the word "patch" for "watch" in the above quote from the BACP Chair), or perhaps it's a nod to the increasing numbers of practitioners who have in recent years begun to reflect more critically on the political questions behind the assurances of their professional associations and to act more independently of them.

In the UK, certainly, there has been a move away from a view of statutory regulation as the tide coming in and of its opponents as pitiable victims of a Canute–like delusion, and towards a view of a landscape that can be reclaimed from harmful elements by those who ultimately have the greatest stake in it — therapists and clients. It is mindful action in the form of a sustained and arguably successful campaign by practitioners concerned to protect therapeutic relationships, and it has stemmed what would have been a surge of bureaucratisation by the Health Professions Council, likely followed by a backwash of homogenisation, the combined effects of which

could have seriously limited diversity of approach and freedom of choice in UK therapy practice. It is now possible to focus on further improving existing voluntary frameworks that are reasonably congruent with, rather than fundamentally inimical to, the values of psychotherapy.

Tudor's anthology takes as its backdrop the post–registration scene in Aotearoa New Zealand where, since the application in 2006 to psychotherapy of the *Health Practitioners Competence Assurance Act 2003*, only those psychotherapists who register with the Psychotherapist Registration Board (of Aotearoa New Zealand) may refer to themselves as such. Yet this book is concerned with much more than this particular time, territory or topic. The wave made by state regulation at this juncture in the era of neo–liberal democracy in Aotearoa New Zealand is essentially the same wave that has already washed or will yet wash over many other territories. The undercurrents driving the wave — "public protection", "evidence–based treatments", "value for money in the market–place" — are the same undercurrents. Nobody can afford to ignore that psychotherapy is situated within a political eco–system that influences and is influenced by all its constituent players, however they may think or act. Thus the contributions in this book will resonate with and be relevant to any and all therapy practitioners, on whichever shore they find themselves, and whatever the state of the tide there.

The parallels in Grant Dillon's chapter [3] on the steps toward registration taken by the New Zealand Association of Psychotherapists (NZAP) with those taken by the corresponding UK bodies are striking — and unsurprising. There is the same sense of yearning for acceptance by a "higher power", the same dearth of psychotherapeutic understanding of the potential for "institutionalising of the transference" (Mowbray, 1995, p. 127), the same sense of inevitability, coupled with the same "Hurry Up" lest the regulation train leave without its passengers. There is the same disregard in relevant meetings of basic democratic processes or of the need for evidence that the proposed regulation would have the intended effect, the same misrepresentation and manipulation of memberships in the service of the same vested interests and out–dated ideologies and, to judge from the muted or non–existent reaction from rank and file psychotherapists affected, the same blind trust in their organisational officials that "everything would be fine".

When the legislative *Bill* first appeared in June 2002 in New Zealand, psychotherapists were not included as "relevant health professionals" at all. What happened between then and the charging of the first registration fees in 2008, a period that included two changes of government but no change in policy, differs from recent UK experience. The NZAP continued determinedly lobbying for registration, going so far as to insist on inclusion, which was effected by an Order in Council (equivalent to the UK's Privy Council Order granting the Health Professions Council the "right" to capture psychotherapy in the UK). There was no concerted objection such as that initiated in the UK by the Alliance for Counselling and Psychotherapy. Indeed, most of the resistance came from successive Ministers of Health and select committees, who preferred psychotherapy to continue regulating itself. One voice of objection was that of NZAP Council Member Jonathan Fay, whose chapter "Whence and Whither" the Psychotherapists Registration Board?' (Fay, 2011b) [revised as present Chapter 7] recounts his singular attempts to rally resistance to the NZAP's drive to set up a regulatory authority, a process he likens to the sorcerer leaving his workshop in the charge of his hapless apprentice, the current Psychotherapists Board as it transpired. His case study complements the chapter [9] by Susan Shaw which critically addresses the whys and wherefores of registration bodies generally, reflecting that they often seem to end up exercising their powers of dominance largely to justify their own existence.

The prime mover in the NZAP for registration was Paul Bailey and one of the most absorbing chapters is the email dialogue between him and Tudor, the inclusion of which is just one testament to the pluralist stance aimed for in the book. This comes across as an elegant and mutually respectful piece of peer supervision with Tudor eliciting Bailey's thinking and rationale for statutory regulation and Bailey stating his "motivations". It leaves the impression of Bailey as stuck in a creepy symbiosis both with the "founding fathers" of New Zealand psychotherapy and what the tides of the 1940s were telling them, and with the New Zealand state, whom, as Dillon remarks (p. 82), Bailey appears to have idealised as "a benevolent loving parent intent on fostering a special child".

Tudor's chapter "The Law is an Act!" [present Chapter 6] is a thorough deconstruction of the ideology behind the legislation, a close examination

of its provisions and incisive critique of its potential unintended consequences. Those familiar with how corresponding UK legislation is enacted by the HPC will be struck — though, again, unsurprised — by the similarities with respect to underlying principles, range of bureaucratic powers, and operational inequities. Like the HPC in the UK, the Psychotherapists Board of Aotearoa New Zealand appears oblivious of any need to regulate itself. Thus, it may act against a person "who holds themselves out to be a psychotherapist" (i.e., without duly registering, and thereby "misleading the public"), while opponents of the *Act* are powerless to insist that a Board member who is actually an expert on regulation yet "holding themselves out to be a lay person" on said Board might equally be deemed to be misleading the public. In a further chapter, "The Question of Regulation and Registration" (Chapter 8), Tudor debunks a number of assumptions underlying the contemporary debate on these issues, reviews the principal arguments for and against regulation and registration, and offers reflections on the debates as they relate to proposals for alternatives and action against statutory regulation as now implemented in Aotearoa New Zealand. This clear and comprehensive commentary on the issue provides an indispensable compilation of antitheses to the complex web of ulterior transactions that has both seduced and intimidated so many psychotherapists and thereby sustained the game of state regulation for so long.

[Susan Green's chapter offering "An Ordinary View" of registration (Green, 2011) reminded me of the myriad voices that emerged in the UK in the weeks around the Alliance's first conference (in 2009) of therapists who had suddenly realised that the move to state regulation involved much more than they were personally prepared to countenance. In Susan Green's case, as she freely admits, awakening came late. Her honest and unpretentious sharing of her confusion and scare, and the personal learnings she gained from her experiences with the registration process touched me.]

Sue Cornforth, a previous Chair of the New Zealand Association of Counsellors, offers the sort of eco–political and philosophical perspective on registration that might once have fuelled Susan Green's scare. It discusses how the roles, values and responsibilities of counselling and psychotherapy in the wider world are currently threatened, and posits how as therapists we might maintain these in the face of the bureaucratic tick–

box cultures increasingly relied upon by governments in neoliberal democracies. In support of her argument, Cornforth cites the Foucauldian perspectives of Larner (2000) and Bondi (2005), both of whose studies of neo–liberal subjectivities point up their essentially hybridising and often self–contradictory discourses. Tellingly, she admits that, as they negotiate the shifting tides of the regulation and registration debates, therapists too sometimes buy into the same ideology of self–governance. Obvious examples are the pressure felt by many inherently relational therapists to add cognitive behavioural therapy to their tool–kit, or to adapt to a research methodology that might be more clearly 'heard' from within the prevailing normative paradigm. We might also wonder about the mixed motives of those colleagues co–opted by the HPC onto its Professional Liaison Group, set up for the purpose, apparently, of considering the views on statutory regulation of concerned "stakeholders".

No review of Tudor's excellent collection would be complete without reference to the Māori perspectives that permeate it. Readers who have not visited Aotearoa New Zealand might be generally aware of the contributions of indigenous cultures to all forms of healing but perhaps not specifically those of tangata whenua, whose ethical principles (see Chapter 5) have influenced much Pākehā [white] therapy practice. Margaret Poutu Morice, Wiremu Woodard [and, now, Heather Came's] chapter offers an account of the sidelining of Māori views on psychotherapies by the regulators.

To New Zealanders, such attitudes raise wider issues around contemporary interpretations of the principles of the Treaty of Waitangi and the current trend to overlook the rights to inclusion of indigenous cultural perspectives and their embodiment, where relevant, in law.

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Chapter 19

Taking the current: working and living in a post–regulation landscape

Keith Tudor

There is a tide in the affairs of men.
Which, taken at the flood, leads on to fortune;
Omitted, all the voyage of their life
Is bound in shallows and in miseries.
On such a full sea are we now afloat,
And we must take the current when it serves,
Or lose our ventures.

(Shakespeare, *Julius Caesar*, Act 4, scene 3, lines 218–224)

THE LANDSCAPE

Psychotherapy — literally, "soul–healing", from psyche (soul) and therapia (healing) — has been practiced for centuries before the first modern reference to the term, which dates back to 1811 when Johann Heinroth was appointed the first Professor of Psychic (Psycho) Therapy (at the University of Leipzig, Germany). As a practice and a discipline, psychotherapy has

been influenced by healing traditions, medicine, psychiatry, academia, lay practice and the consumer movement, ministry, psychology, and social work (see Tudor, 2018–in press) — which is one reason why I argue for the pluralism in psychotherapy and against any moves to unilateralism and to its medicalisation (see Chapter 8).

Historically, the practice of psychotherapy in Aotearoa New Zealand has been one which has embraced pluralism — with regard to different theoretical modalities/orientations, as well as forms of practice — and is one that, especially over the past 10 years has, to a greater or lesser extent, been engaged in important and significant discussions about the impact that living in a bicultural nation has on and in psychotherapy (see, for instance, Bowden, 2001).

At a certain point in the development of any practice, its practitioners tend to come together and form trade and/or professional associations. According to Caplow (1966), this represents the first step towards professionalisation. These associations generally regulate themselves and their members, and may then either be regulated or seek some form of external regulation. In New Zealand, with regard to the health professions referred to in this book, this is summarised in Table 19.1.

Table 19.1. New Zealand health professions: registration and association

Profession	Professional Association	Registered by Statute	Professional Association
Medicine		*Medical Practitioners Act 1867*	1886 New Zealand Medical Association
Dentistry		*Dentists Act 1880*	1905 New Zealand Dental Association
Pharmacy		*Pharmacy Act 1880*	1881 Pharmaceutical Society of New Zealand
Physiotherapy	1894 Society of Trained Masseurs	*Masseurs (Registration) Act 1920* *Physiotherapy Act 1949*	1950 The New Zealand Society of Physiotherapists
Nursing		*Nurses Registration Act 1901*	1905 Wellington Private Nurses' Association
Midwifery		*Midwives Act 1904*	1905 Wellington Private Nurses' Association

			1989 New Zealand College of Midwives
Chiropractic	1922 NZ Chiropractors' Association	*Chiropractors Act 1960*	
Optometry		*Opticians Act 1928*	1930 New Zealand Association of Optometrists 1952 Association of Dispensing Opticians of New Zealand
Medical Laboratory Science	1946 NZ Institute for Medical Laboratory Science	*Medical Auxiliaries Act 1966*	
Psychology	1947 British Psychological Society NZ Branch 1967 NZ Psychological Society	*Psychologists Act 1981*	
Psychotherapy	1947 NZ Association of Psychotherapy	*Health Practitioners Competence Assurance Act 2003 (in 2008)*	
Nutrition Dietetics	1949 NZ Dietetic Association		
Occupational Therapy		*Occupational Therapy Act 1949*	1949 The New Zealand Registered Association of Occupational Therapy
Medical Radiation Technology	1959 NZ Institute of Medical Radiation Technology	*Medical Auxiliaries Act 1966*	
Podiatry		*Medical Auxiliaries Act 1966*	1968 (Chiropody) Medical Auxiliaries Act 1980 New Zealand Society of Podiatrists
Osteopathy	1973 The NZ Register of Osteopaths (later the Osteopathic Society of NZ)	*New Zealand Register of Osteopaths Incorporated Act 1978*	

From this, it may be seen that some professions were registered under legislation before the development of their professional associations (i.e., medicine, dentistry, pharmacy, physiotherapy, nursing, midwifery, optometry, podiatry, and occupational therapy), while others formed professional associations before they were — or applied to be — regulated

by statute (i.e., chiropractic, medical laboratory science, psychology, psychotherapy, dietetics, and medical radiation technolog, and osteopathy). The information in Table 19.1 also reveals that, of this second group, psychotherapists were self–regulated for the longest period of time, i.e., 60 years (see Chapters 1 and 10), followed by chiropractors (38 years) and psychologists (34 years).

The second step towards professionalisation identified by Caplow involves changing the association's name so as to reduce its identification with any occupations considered of lower status. Two examples of this are: the founding of the New Zealand Society of Physiotherapists in 1950, to distinguish themselves from masseurs, and following regulatory legislation; and with regard to the New Zealand Association of Psychotherapy (NZAP), which, interestingly, has changed its nominal identity over the years, thus:

1947. New Zealand Association of Psychotherapy

1974. The New Zealand Association of Psychotherapists, Counsellors and Behaviour Therapists (Incorporated)

1981. The New Zealand Association of Psychotherapists and Counsellors (Incorporated)

1987. The New Zealand Association of Psychotherapists (Inc).

It is clear, however, both here in New Zealand and internationally, that there is a great degree of overlap between the practice and the professions of psychotherapy; counselling; and psychology, and, within this, specifically, counselling psychology. It is also clear that individual practitioners make choices about the practice and the association(s) with which they identify. For instance, for these historical as well as a number of other reasons, there is a significant number of members of the New Zealand Association of Counsellors (NZAC) who identify with psychotherapy, primarily, it appears, through their training (Bocchino, 2007). Moreover, comparing the different registers and membership lists of the relevant organisations reveals that 69 members of the NZAC are registered with the Psychotherapists Board of Aotearoa New Zealand ("the Board" or "the PBANZ"), 31 of whom are also members of the NZAP. This means that 38 members of the NZAC identify and, by virtue of their training are eligible to be registered

as psychotherapists, but do not identify with either of the two professional psychotherapy associations, i.e., the NZAP or the New Zealand Association of Child and Adolescent Psychotherapists (NZACAP). The results of looking at this in relation to theoretical orientation are summarised in Table 19.2.

Table 19.2. Members of the NZAC who are Registered with the PBANZ

Qualification	Numbers
Psychosynthesis	9
Gestalt	8
Eclectic psychotherapy[1]	7
Child and adolescent psychotherapy	3
Psychodynamic psychotherapy[2]	3
Psychodrama	2
Transactional analysis	2
Bioenergetics	1
Undesignated	3
Total	*38*

1. These are from Auckland Institute of Technology (1989–1999), when its core theoretical model was more eclectic.
2. These are from Auckland University of Technology where, from 2000 to 2011, the core theoretical model of its training was psychodynamic. (From 2012, it has been and is now more broadly relational.)

To some extent this represents what has been a widespread critique of the NZAP for being too psychodynamic, and of its submissions' procedures for being theoretically biased, although many would acknowledge that, in recent years this has changed, and, perhaps not least, as a result of the statutory regulation of psychotherapy.

Finally, the following three figures (Fig. 19.1–19.3) offer a visual representation of the current professional landscape with regard to psychotherapy in Aotearoa New Zealand in what is, in effect, the fourth of Caplow's stages of professionalisation, i.e., (statutory) regulation.

Figure 19.1. The relationship between NZAP membership and psychotherapists registered with the PBANZ

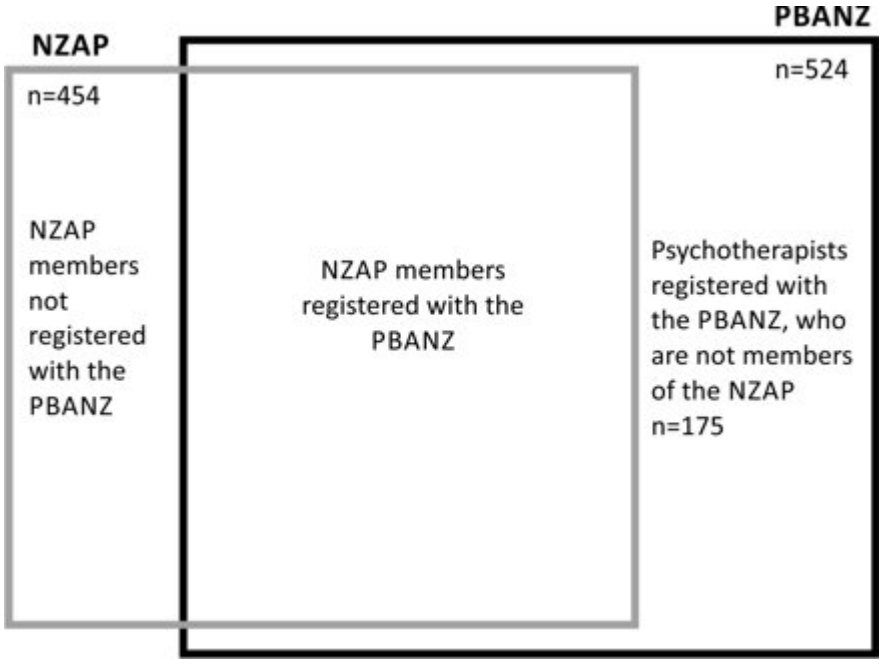


Figure 19.2. The relationship between NZAP and NZACAP membership and psychotherapists registered with RAs

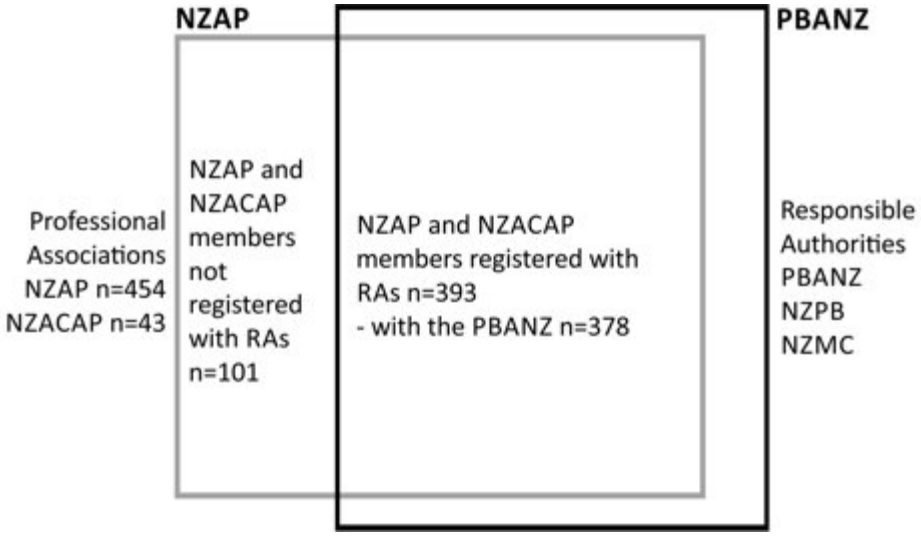
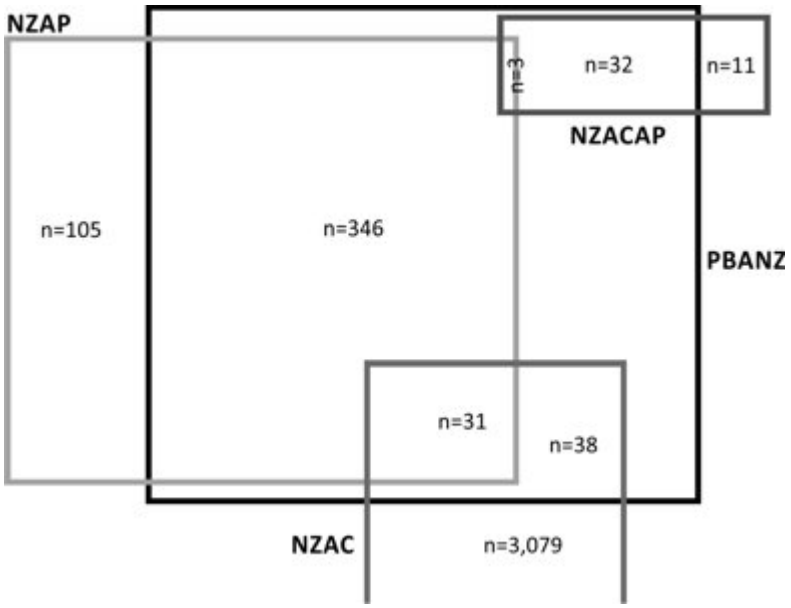


Figure 19.3. The relationship between the PBANZ and the professional associations: the NZAP, the NZACAP, and the NZAC



WORKING

Despite this pluralistic landscape, some psychotherapists find pluralism difficult, both practically and politically. One colleague put it thus: "If you walk and talk like a psychotherapist, then you're a psychotherapist", the implication being that anyone who practices psychotherapy should register as a psychotherapist. However, the legal reality in this country (and others in which there is similar legislation) is that if someone is not registered — and, on a personal note, in New Zealand, I do not refer to myself as or hold myself out to be a psychotherapist (and, indeed, take particular care not to do so) — then, de facto, I am not a psychotherapist. If colleagues want a more restrictive model, i.e., one that restricts practice as well as protects title (see Macleod & McSherry, 2007; and Chapter 10), then they should argue for it — and, in my view, should do so politically, not personally. In the meantime, in our pluralistic landscape, there are legitimate options for practice and for professionals (as summarised in Table 19.3).

Table 19.3. Options for practitioners: Pluralism in practice

Unregistered Provider	Registered Practitioner

Title	Analyst, Counsellor, Family therapist, Kaiwhakaruruhau | Wahine Māori social and mental health care provider, Psychodramatist, Transactional Analyst, Traumatologist, Counsellor, Minister, etc.	Psychotherapist, Psychotherapist with child and adolescent specialism,Interim psychotherapist
Overall description	Health care provider	Health practitioner
Practice	Analysis, bioenergetics, child and adolescent psychotherapy, counselling, couples therapy, family therapy, gestalt therapy, psychoanalysis, psychodrama, psychotherapy, transactional analysis, trauma therapy, etc. Consultancy, education, research, supervision, training, etc.	
Governance	Code of Health and Disability Services Consumers' Rights (Health & Disability Commissioner, 1996), Other laws (see Chapter 8)	Code of Health and Disability Services Consumers' Rights (Health & Disability Commissioner, 1996), Health Practitioners Competence Assurance Act 2003, Other laws (see Chapter 8)
Public accountability in law	To the Health & Disability Commissioner, To the public under law	To the PBANZ, To the Health & Disability Commissioner, To the public under law
Professional accountability and association	Aotearoa New Zealand Transactional Analysis Association, Australian and New Zealand Psychodrama Association, Australian and New Zealand Society of Jungian Analysts, Gestalt Institute of New Zealand, Independent Practitioners' Network, International Institute for Bioenergetic Analysis, International Transactional Analysis Association, NZAC, NZAP, NZACAP, New Zealand Christian Counsellors Association, Psychosynthesis Aotearoa New Zealand, Waka Oranga, etc., etc.	
Professional accountability	Through supervision, training, membership of professional associations, and, through them, adherence to codes or frameworks of ethics, and of professional practice, and complaints procedures.	

LIVING

Within the profession of psychotherapy in Aotearoa New Zealand, clearly there are different views about the history, the purpose, the benefits, the desirability of and, overall, the advantages and disadvantages of the state registration of title and the statutory regulation of practice. Moreover, because there was not a well–informed debate, or 100% agreement within

the profession regarding the move to state registration, this makes both working and living in our post–registration landscape more complex.

As a result, what has emerged in the last decade is, in effect, a number of different groupings, which, following Macleod and McSherry's (2007) taxonomy, are noted from those who represent the least restrictive to the most restrictive approaches to registration and regulation.

1. Those health care providers who are not registered as psychotherapists but who provide and continue to provide psychotherapy, which, as has been well–established (see Chapters 1, 6, and 8), is entirely legal. This group includes some radicals and activists, both Māori and non Māori who are, as it were, on the front line of the debate with regard to the state control and regulation of psychotherapy in Aotearoa New Zealand, and more broadly, about professionalisation of psychotherapy both locally (nationally) and internationally; as well as some less active, and retired or retiring psychotherapists. This group numbers some 90 members of the NZAP and 11 members of the NZACAP, with others in other professions (ministry, social work, etc.), some of whom were active in establishing the organisation of the Independently Registered Psychotherapy Practitioners (IRPP) (see Fay, 2011; IRPP, 2011). Colleagues in this grouping subscribe to the first three models in Macleod and McSherry's (2007) taxonomy.
2. Those psychotherapists who are registered only because they have to be, for instance, in order to be employed, but who essentially disagree with state registration, and the operation of the Board, and, over the years, have been concerned about some of the behaviour of the Board, especially its lack of consultation with and distance from the profession, as well as its treatment of certain, highly respected colleagues. In my experience, this group relates more to the professional association of which they are members than to the Board.
3. Those psychotherapists who essentially agree with state registration, but not necessarily the extension of statutory regulation, and who also agree with pluralism, at least intellectually, either from a philosophical and/or a social/political perspective point.
   These two groupings, both of which reflect the fourth of Macleod and McSherry's (2007) models, are particularly important in challenging the Board *as registered psychotherapists*. A few colleagues in this

group have served on the Board and generally take a "light–touch" approach to regulation (see Chapters 1, 4, and 15).

4. Those psychotherapists who are absolutely convinced of the validity of the state registration of psychotherapists, and the statutory regulation of psychotherapy, and who would extend such regulation to include either core practices or wholesale practice restriction, and thus represent the fifth and sixth models in Macleod and McSherry's (2007) taxonomy. Members of this group disagree with anyone practising psychotherapy who is not a psychotherapist, and, thus, are, in effect, unilateralsts, as they disagree with pluralism in a post–registration landscape. It is this group who would agree with the extension of scopes of practice, and the "heavy touch" regulatory regime of the Board. It is from this group that, over the years, most of the Board members are drawn, 'though currently this appears to be changing. It is also this group who, in my experience, and with a few exceptions are the least familiar with the international literature on registration and regulation, and, indeed, the details of the *HPCA Act* itself.

From this, it is clear that the arguments about registration and regulation, and professionalisation, would only be of interest to members of the first three groups, 'though it is also true to note that most psychotherapists in Aotearoa New Zealand in groups 2 and 3 above do not care much about the debate about regulation and registration — or, indeed, the distinction between the two — let alone about actively defending and promoting pluralistic practice.

Some, especially those involved with engaging overseas educators and trainers, for instance, in organising conferences and workshops, might appreciate being able to introduce an overseas colleague as a psychotherapist without worrying about being fined — and the fact that they can do so is a direct result of those of us who lobbied the Board about its proposed restrictive conditions on such visiting educators (see Chapter 7). However, the considerable majority of psychotherapists do not appear to be at all disturbed by the fact that the state approves or disapproves their supervisors, and there is no evidence that there is any movement on the part of psychotherapists to lobby the Board on this. Similarly, with regard to the proposal that the state in effect approves or disapproves the educators or trainers of psychotherapists, outside the relatively small number of training

providers, there is little sense that the profession is interested in or concerned about the Board's proposals (see Chapter 7).

When it comes to being active about these arguments and issues, many colleagues in these groups, and particularly within the NZAP, appear, for various reasons, somewhat reluctant, preferring to be or to try to stay "in relationship with the Board". This desire is fuelled by personal histories and relationships, and relies on the conviction of the principal proponent of recognition through state registration, Paul Bailey (see Chapter 4), who argued, at least within the NZAP, that the Board would comprise people who were "Not 'them' but 'us'." Unfortunately, this view conflates and confuses personal and political spheres, and fails to distinguish between a psycho–analysis (of personal and group dynamics and relationships) and a political analysis of the state and its systems, including its regulatory regimes. The Board has, at times, actively contributed to this confusion: its professional members arguing, when under pressure, that they were originally nominated by various groups within the profession and, at other times, asserting that now they do not "represent" the profession.

In terms of the freedom to practice, in a post–regulatory society such as New Zealand, professional practice is, by definition, certainly more restricted and thus, from a pluralistic perspective, there has certainly been more ebb than flow. Despite all this, as has been noted, a significant number of us in Aotearoa New Zealand continue to critique and resist further state intervention and regulation in and of the field of psychotherapy, and remain staunch advocates of pluralism in the practice of psychotherapy. Despite receiving certain criticism and sometimes personalised attacks, those of us who are more active and "out" about our position (in practice and theory) and previously or currently identified with the organisation of Independently Registered Psychotherapy Practitioners are heartened by the response to our stance from a number of people:

a. Other colleagues in the first group (above) who approach us privately and thank us for our continuing support of them.
b. Colleagues, specifically new immigrants, students/trainees, and supervisees, who make contact with us in order to find out about registration and regulation, and different pathways to qualification and registration, for whom we act as a kind of advisory clearinghouse.

c. Colleagues from outside the profession of psychotherapy, notably, counsellors who have studied the experience of the psychotherapy community and had thorough and informed debates about registration and regulation (see Chapters 2, 14, and 15).
d. Colleagues overseas who have been or are engaged in these debates and who are interested to learn from the "New Zealand example" (see Chapters 17 and 18).

Reflections and actions

> Integrity depends on clear ... processing of internal dialogues by the uncontaminated Adult, and clear insight into the subversive nature of those social institutions that impair authentic encounters between individuals. Hence strengthening the Adult promotes integrity. (Berne, 1966, p. 306)

Traditionally, psychotherapy, and especially psychoanalytic and psychodynamic psychotherapy, has prioritised reflection over action. However, just as there is a time for reflection, there is a time for action, and a time for integrating the two in active reflection — and reflective action. Here, by way of a conclusion to this particular contribution and volume, I offer a few overall reflections on the debates about regulation and registration. My own action is partly represented by this book; partly by my participation in a network, now an organisation of colleagues in favour of pluralism in the organisation of psychotherapy and of genuine partnership with colleagues and clients.

As I have reflected on and written this contribution, five points particularly strike me:

- That the strong alliance in favour of pluralism and autonomy in psychotherapy (see House & Totton, 1997) and against the state registration of psychological therapists and the statutory regulation of psychological therapies crosses theoretical orientations, a situation which, both in the UK and here in Aotearoa New Zealand, has especially and specifically brought together psychoanalytic, psychodynamic, and humanistic psychotherapists and practitioners. This range of analysis is represented in the literature that is critical of

moves to registration and regulation (see especially House & Totton, 1997; Postle & House, 2009) and, more generally, of the professionalisation of the activity of psychotherapy and counselling — see Rogers (1973), House and Totton (1997), Parker (1999), House (2003, 2009).

- That the debate has by and large shifted from one which is represented by those who are viewed as being on the margins of the profession to involving the majority. In the UK, being critical of and even opposed to state regulation, especially in the context of the Health and Care Professions Council (HCPC, see http://hpc-uk.org/) is now mainstream (see Postle & House, 2009). This came to fruition in the UK in 2009 when Professor Andrew Samuels, a Jungian analyst and writer, stood for the position of Chair of the United Kingdom Council for Psychotherapy on an anti–HPC regulation and pro pluralism platform — and won by 66% of the votes cast which, in turn, represented 63% of the electorate of some 6,000 voluntarily registered psychotherapists. This movement is also supported by a number of petitions against regulation — see, for instance, http://www.petitiononline.com/statereg/petition.html, which (in 2011) had nearly 3,000 signatories. In Aotearoa New Zealand, although being opposed to the statutory regulation of psychotherapy and the state registration of psychotherapy is still a minority view, it is a significant minority, and there appears to be a majority in favour of pluralism.
- That there was no equivalent great debate here in Aotearoa New Zealand regarding regulation and registration, and that the initiative in favour of registration was led by a very small group of psychotherapists within the NZAP. To my knowledge only one article has been published in this country on this subject, by Bailey in 2004; in 2006 a special theme issue of the *NZAP Newsletter* (Manning, 2006) was devoted to the subject of registration. In a further comment, which is particularly interestingly in the light of subsequent events, especially with regard to the conduct of the Psychotherapists' Board, Bailey (2004) wrote that: “we seemed to be sailing smoothly and swiftly towards the *relatively unknown implications* of registration” (p. 35, my emphasis). This statement appears both naive and somewhat disingenuous as it ignores the fact that many of these implications

were known at the time (see Introduction, and Chapter 4). In his article, Bailey (2004) referred neither to any of the then books on the subject — i.e., Hogan (1979), Dawes (1994), Mowbray (1995), House and Totton (1997), and Wampold (2001) — or, indeed, to any professional literature or research about registration or regulation.

- That, in debates about the subject of state registration and statutory regulation, people consistently underestimate the power of the state and its organs such as "responsible authorities" (professional registration Boards or Councils), which tend to take on the power invested in them and to distance themselves from the profession they regulate and seek to govern rather than serve. In his article, Bailey (2004) stated that psychotherapy in Aotearoa New Zealand is at "a stage where an active dialogue with the State, in the form of registration, is appropriate" (p. 37) and went on to hope that: "The State may show itself to be as benign". He concluded that: "At this point in history, I am willing to trust the State as benign, provided the profession stays strong and watchful. I hope history proves my belief to be well–founded." It is clear from subsequent and recent events that the (capitalised and reified) State, in the form of the Psychotherapists' Board, is not interested in an active, relational dialogue with the profession; and that it is interested in extending its regulatory powers — and, therefore, that the profession needs to be stronger, more watchful, and more critical. Neither history nor the present is on Bailey's side.
- That the arguments in favour of external, statutory regulation seem to reflect a certain lack of confidence in the profession or activity of psychotherapy. This is especially reflected in those colleagues who see psychotherapy as a part of the health (i.e., medical) establishment and a profession so closely allied to health, that some ape the medical model with regard to "diagnosis", "treatment" and "cure" of "patients". Presumably these colleagues disagree with Freud (1929/1956) "On the question of lay analysis", but, worse, don't appear to have confidence (or trust) that psychotherapy is a distinct psychosocial discipline with its own ways of understanding, conceptualising and working with people. Along with this, there seems to be a lack of confidence (and, again, trust) in the associations of psychotherapy and the well–established structures and processes of

professional regulation (see Chapter 10). The spectre of the unregulated charlatan hanging out her or his shingle seems to loom large in the minds or fantasies of those in favour of regulation and leads to proposals for more restrictions on practice, thinking, and scopes or roles of associated practice. The reactions — and they are reactions — of the regulators to question, debate, pluralism, and alternatives suggests a certain anxiety about and fear of freedom (see Reich, 1933/1972; Fromm, 1942/1960), as a result of which regulation becomes a defence against anxiety (see Menzies Lyth, 1959/1988). In his paper "The question of lay analysis" Freud (1926/1959) took the reader and the figure of an "Impartial Person" through an introduction to psycho–analysis in which he elucidated the nature of psycho–analysis and, on that basis, argued that psycho–analysts did not need to be medical doctors. Ultimately, one's position on regulation and registration will be based on one's philosophy and values about the person and, crucially, one's definition and understanding of psychotherapy. In this sense the state registration of psychotherapists and the statutory regulation of psychotherapy and the represents a battle for the minds and hearts of psychotherapists, and for the soul of "soul healing".

Taking the current

Taking this particular current — of being against the state registration of psychotherapists and the statutory regulation of psychotherapy, and being for professional pluralism in Aotearoa New Zealand — has certainly not led to the fortune referred to by Shakespeare's Brutus. Rather, it has involved awkwardness, disagreements, and disputes; and, at worst, bullying, threats of being reported to the Board and, even an attempts of entrapment — at one point in 2011/2012, I was contacted by a number of non–registered colleagues who had been approached by the same person who, purporting to be a potential client, clearly had an agenda of trying to entrap them into saying that they were psychotherapists. Colleagues and friends have fallen out, and a number of us have had sleepless nights, and a lot of work. Nevertheless, taking this current stance has also led to a "a full sea": becoming closer with some colleagues, becoming friends with others, and meeting still other colleagues who I and others would not necessarily have

met; further research; engagement in other psycho–political projects; and, I would say, a certain liveliness in the intellectual life of the psychotherapy community. On this last point I particularly want to acknowledge the engagement of my colleague and friend Seán Manning (see Chapter 17). He and I consistently and constantly disagree with each other (about registration and other matters), but I appreciate that he not only stays in relationship but also acknowledges the value of the research, the debate, and the "opposition".

The questioning of statutory regulation and state registration is neither popular nor pragmatic: it is a political, intellectual, and principled position of opposition to state intervention in and ultimately control over the practice of psychotherapy. If we — psychotherapists and others involved in the therapy of psyche or soul healing — value the freedom to practice, free association, and the freedom of association, then, I would argue, that we can do no other than to take this current or, indeed, lose the venture of psychotherapy itself.

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Appendix 1

Glossary

Na Wiremu Woodard (Ngai Tuhoe)

This glossary is intended to encourage the reader into further research and investigation rather than to translate concepts and thoughts of an indigenous language into definitive English meanings. The references given here are not an exhaustive collection; instead they provide a stepping–stone onto further ground.

(te) Ao Māori — the Māori world — see Walker (1987, 1990), Durie (1995, 2001), and Ihimaera, 1998).

(te) Ao Marama — the world of light.

(te) Ao Pākehā — the world of Pākehā.

Aotearoa — the Land of the Long White Cloud; originally used to refer to the North Island, now generally taken to refer to the whole country; its use together with "New Zealand" represents a bicultural perspective.

Atua — divine or supernatural entity.

Atua Māori — a distinct contrast with a monotheistic Christian God.

awa — river.

Crown — the British Crown.

Crown authority — the symbolic representation of monarchical British imperial power in British colonies — see Walker (1987), and Stewart–Harawira (2005).

hapū — to be pregnant; denotes a system of kinship defined around shared whakapapa; shared blood connections.

iwi — bone; strength; denotes a system of kinship defined around whakapapa connections that share the same genealogical body: "where my 'bones' are from".

kaitiaki — a spiritual guardian, a trustee.

kaitiakitanga — guardianship (see Marsden & Henare, 1992).

kapa haka — traditional dance; contemporary dance and performing arts.

kaupapa Māori theory — transformative and emancipatory theory based on kaupapa Māori principles — see G. H. Smith (1997), L. Smith (1999), Cram (2001), and Bishop (2005).

kaupapa whanāu — indigenous Māori family systems.

kawanatanga — transliteration of "government" (see Durie, 1998a).

kohanga reo — language "nest" pertaining to Māori community initiatives of the 1970s to revive te reo Māori (see G. H. Smith, 2003).

kotahitanga — oneness; the principle of unity; guardianship (see Cox, 1993).

kura kaupapa — Māori total immersion education and language school, which grew out of the te kohanga reo initiative.

mana — power; authority; self–concept; e.g. "to mana ake" denotes unique personal qualities bestowed and recognised by the collective — see Metge (1986), Pere (1988), and Durie (2001).

manaakitanga — the process whereby mana is translated into actions of generosity (see Morice, 2003).

mana motuhake — autonomy; empowerment (see Hill, 2009).

mana wahine — absolute female authority (see Pihama, 2001).

Māori — the first peoples of Aotearoa, who identify generally with their iwi; Māori is a general term referring to the indigenous peoples of Aotearoa; as a term it was created by colonialism (see Durie, 1995).

marae — a complex of buildings designed to facilitate a broad range of community activities and ritual (see Tauroa & Tauroa, 2009).

maunga — mountain. moana — ocean.

Ngā Ao e Rua — a national group of psychotherapists, based in Auckland; which explores concepts of belonging in Aotearoa/New Zealand; consists of two groups te Ao Māori and te Ao Pākehā.

Pākehā — generally taken to refer to white, New Zealand born people of European (mainly British) descent; sometimes used to refer to all non Māori (see King, 1985, 1999).

ranga — to weave.

rangatira — guardian/s; trustee/s; protector/s of resources; a leader who weaves people together.

rangatiratanga — sovereignty (see Melbourne, 1998, Morice, 2003).

(te) reo (Māori) — the Māori language.

roopu (rōpū) — group.

tangata whenua — commonly translated into English as “people of the land”; this translation, however, still highlights the distance inherent in the Western paradigm between “Man” (and I use the masculine noun to emphasise again the culture categorisation that is a part of the Western world view) and “nature”. Although the words “of the” bring the relationship closer, there is still a separation. In the indigenous

psyche there is no differentiation, and a closer translation might be "people/land": whenua is self and self is whenua (for further accounts of the relationship between the land and indigenous psyche, see Durie, 2003, 2005; Park, 2003, 2006).

taonga — treasure, something prized.

tikanga Māori — social precepts originating from an indigenous kaupapa Māori frame of reference (see Barlow, 1998).

tikanga Pākehā — social precepts originating from a Western frame of reference. tira — a group of people or of stars.

(Te) Tiriti o Waitangi — The Treaty of Waitangi, signed at Waitangi on 6th February 1840, and widely regarded as the founding document of the nation — see Orange (2004), Belgrave, Kawharu & Williams (2005).

tohunga — learned person; practitioner of Māori medicine; priest.

tohungatanga — the role of the expert.

tumu — pole. tupuna — ancestor.

ūkaipō — home; place of the experience of receiving mother's milk in the night.

wairua — two waters: the physical and the spiritual.

wairuatanga — the realisation of "wairua" (see Pere, 1988).

waka — canoe.

Waka Oranga — life bearing principle(s); a Māori psychotherapists' collective. wānanga — forum or discussion.

whakapapa — to earth; refers to genealogy; being grounded in our earth Mother Papatūanuku.

whānau — birth; also denotes family, and family members.

whānaungatanga — the concept of being closely related; also alludes to the practice of inclusion, fostering, nurturing, and developing a sense of

belonging (see Morice, 2003).

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Appendix 2

Code of Health and Disability Services Consumers' Rights (New Zealand Health & Disability Commissioner, 1996)

The *Code* makes a distinction between consumers, who have rights, and providers who have duties. Every consumer has the rights in the Code; and every (health care) provider is subject to the duties in the Code. Every provider must take action a) to inform consumers of their rights; and b) to enable consumers to exercise their rights. There are 10 rights identified in the *Code*.

1. To be treated with respect.
   Kia manaakitia koe hei tangata.
2. To be treated fairly without pressure or discrimination.
   Kia manaakitia koe, kia kaua koe e tāmia e wai rānei, kia kaua hoki e tūkinotia e te kaikiri o te tangata.
3. The right to dignity and independence.
   Kia hāpainga tō rangatiratanga, me tō mana motuhake.
4. To receive a quality service and to be treated with care and skill.
   Kia taea e koe ngā ratonga whai tikanga, ā, kia tika te taurima i a koe, me te teitei o ngā pūkenga o te hunga manaaki i a koe.
5. To be given information that you can understand in a way that helps you communicate with the person providing the service.

Kia tae katoa mai ngā kōrero ki mua i tō aroaro mā roto i tētahi huarahi whakamōhio ngāwari ki te whakarongo, kia tino taea ai tō kōrerorero tahi ki te kaiwhakahaere o taua ratonga.

6. To be given the information you need to know about your health or disability; the service being provided and the names and roles of the staff; as well as information about any tests and procedures you need and any test results. In New Zealand, people are encouraged to ask questions and to ask for more information to help them understand what is going on.
   Kia tino tae ake ngā kōrero whai pānga ki mua i a koe mō tō hauora me tō hauatanga; te āhua o te ratonga e horahia ana, ngā ingoa me ngā tūranga o ngā kaimahi, me ngā kōrero katoa mō ngā whakamātautau me ngā whakahaere e tika ana mōu, me ngā hua aua whakamātautau ina puta ake ana. I Aotearoa nei, e whakamanawatia ana ngā tāngata kia patapatai, kia inoi hoki ki ētahi atu kōrero kia mōhio ai rātou he aha te aha.
7. To make your own decision about your care, and to change your mind.
   Kia riro māu anō e whakatau ngā tikanga tiaki i a koe, kia huri hoki koe i tō whakatau, kia haere ki huarahi kē.
8. To have a support person with you at most times.
   Kia noho mai he kaitautoko i tō taha i te nuinga o te wā.
9. To have all these rights apply if you are asked to take part in a research study or teaching session for training staff.
   Kia pā tonu ēnei mōtika katoa, ki te inoia koe kia uru ki tētahi rangahautanga, ki tētahi wāhanga whakangungu kaimahi rānei.
10. The right to complain and have your complaint taken seriously.
    Kia āhei koe te whakatakoto whakapae, ā, kia āta tirohia hoki tō whakapae.

Appendix 3

The functions, powers, and obligations of Responsible Authorities under the *Health Practitioners Competence Assurance Act 2003*

Keith Tudor

Under the *Health Practitioners Competence Assurance Act 2003* (hereafter "the *Act*") the "authority" means "a body corporate appointed, by or under this *Act*, as the body that is, in accordance with this *Act*, responsible for the registration and oversight of practitioners of a particular health profession." (Section [s]5(1)) The *Act* gives the responsible authority (RA), in the case of psychotherapists, the Psychotherapists Board of Aotearoa New Zealand ("the PBANZ" or "the Board"), certain functions, and authority or powers. These are wide–ranging and far–reaching, and have serious consequences for practitioners and serious implications for the profession (as discussed in a number of chapters in the book). The functions, authority and powers of the RAs, for instance, the PBANZ are also misunderstood, misinterpreted and, to some extent, misrepresented, and there is some concern in the psychotherapy profession that the Board has overreached itself, especially with regard to its extension of scopes of practice or roles (see PBANZ, 2008; and Chapter 7).

This Appendix sets out some details of the remit of RAs under the *Act*. The first part sets out the functions of the RAs, as described in s118 of the *Act*. The powers of the Board, as with any RA, derive from these functions; the second part of the Appendix summarises particular powers that the Board has, and gives the reference to the relevant section/s of the *Act*. In law, a distinction is made between permissive and mandatory legislation: the former gives powers which are optional or discretionary; the latter refers to legislation and powers which require people or authorities to do something. Linguistically, the difference is expressed in terms of what legislation allows for, i.e., what people or, in this case, an Authority "may" do, and what it "must" do.

It is important to know that the various entities and people identified and governed in the *Act*: the health practitioner; the Board; the Registrar; the Minister; the Health and Disability Commissioner; the professional conduct committee; and the Health Practitioners Disciplinary Tribunal: all "must" do certain things and, in some cases, "must not" do other things, and also "may" do certain things and, therefore, may or need not do other things. As there appears to be some confusion about what the Board "must", "may" and need to do, the third part of the Appendix notes what RAs are required to do, again with references to the relevant sections of the *Act*; the rest of what they "may" do is optional.

THE FUNCTIONS OF AUTHORITIES (S118)

The *Act* identifies fourteen functions of Authorities appointed in respect of a health profession:

a. to prescribe the qualifications required for scopes of practice within the profession, and, for that purpose, to accredit and monitor educational institutions and degrees, courses of studies, or programmes:
b. to authorise the registration of health practitioners under this *Act*, and to maintain registers:
c. to consider applications for annual practising certificates:
d. to review and promote the competence of health practitioners:
e. to recognise, accredit, and set programmes to ensure the ongoing competence of health practitioners:

f. to receive and act on information from health practitioners, employers, and the Health and Disability Commissioner about the competence of health practitioners:
g. to notify employers, the Accident Compensation Corporation, the Director–General of Health, and the Health and Disability Commissioner that the practice of a health practitioner may pose a risk of harm to the public:
h. to consider the cases of health practitioners who may be unable to perform the functions required for the practice of the profession:
i. to set standards of clinical competence, cultural competence, and ethical conduct to be observed by health practitioners of the profession:
j. to liaise with other authorities appointed under this *Act* about matters of common interest:
k. to promote education and training in the profession:
l. to promote public awareness of the responsibilities of the authority:
m. to exercise and perform any other functions, powers, and duties that are conferred or imposed on it by or under this *Act* or any other enactment.

The powers of RAs

These include the power:

1. To issue current practising certificates (s8(1); see also §s26–33), and to suspend such certificates (ss39 and 48).
2. To require or order examination, assessment or competence review (§s8(3)(c), 9(5)(c)).
3. To prescribe qualifications (s12).
4. To register practitioners (s15).
5. To decide an applicant's fitness for registration (s16).
6. To obtain information about an application for registration (s19), including:

    a. Receiving any information from the applicant or any other person; and
    b. For the purpose of questioning the applicant or any other person, to administer an oath. (s19(2))

7. To require, in circumstances where an authorisation of a scope of practice requires the inclusion in the scope of a condition of supervision, a practitioner's supervisor/s to "report to the authority at intervals specified by the authority (whether generally or in relation to any particular case or class or case) on ... the performance of the applicant". (s23(a))
8. To change a practitioner's scope of practice.
9. To review the competence of a practitioner (s36 and s37) and, in this context, may require the practitioner to undertake a competence programme (s38(1)(a)); to sit an examination or undertake an assessment (s38(1)(c)); or to be counselled or otherwise assisted (s38(1)(d)); and may include (unspecified) conditions in the practitioner's scope of practice (s38(1)(b). An RA has the power to review the competence of a practitioner who holds a current practising certificate "whether or not — (a) there is reason to believe that the practitioner's competence may be deficient". (s36(4), my emphasis)
10. To set or recognise competence programmes (s40) and recertification programmes (s41). Such programmes may require the practitioner to pass any examinations or assessments, or both; to complete a period of practical training; to complete a period of practical experience; to undertake a course of instruction; to permit another health practitioner specified by the authority to examine the clinical records of the health practitioner in relation to his or her clients and, in the case of recertification programmes, "any or all of his or her relations with other health practitioners" (s41(3)(d)(ii)) and "any or all of the clinical records of the practitioner in relation to his or her patients or clients". (s41(3)(d)(iii))
11. To order a health practitioner to have a medical examination (s49). If the Board considers that a health practitioner is unable to perform her/his required functions because of some mental of physical condition, it may require her/him: "to submit himself or herself for examination or testing by a medical practitioner." (s49(1)) In the context of orders regarding or limiting the restoration of membership, a Disciplinary Tribunal (s84–86) also has powers to impose conditions that the person undergo: "(i) any specified medical examination and treatment; or (ii) any specified psychological or psychiatric examination, counselling, or therapy". (s102(2)(b))

12. To appoint a professional conduct committee which, in turn, has wide–ranging powers (see ss71–83), including the power:

    a. To regulate its procedure "as it thinks fit" (s72(1)); and
    b. To receive as evidence "any statement, document, information, or matter that, in its opinion, may assist it to deal effectively with the subject of its investigation, whether or not that statement, document, information, or matter would be admissible in a court of law." (s72(1), my emphasis)

13. To prescribe fees (s130(1)) in respect of an application for registration; an addition or alteration to the register; the issue of a practising certificate; the issue of any other certificate; the supply of a copy of any entry in the register; inspection of the register; the supply of any documents other than certificates of registration; examinations; and "any other matter that relates to anything the authority is required to do in order to carry out its functions." (s130(1)(i))
14. To "impose" (in the wording of the *Act* s131):
    on every health practitioner registered with the authority a disciplinary levy of any amount that it thinks fit for the purpose of funding the costs arising out of–

    a. the appointment of, and any investigation by, any professional conduct committee; and
    b. proceedings of the Tribunal.

What the Board is mandated or obliged to do

This section is based on a search of the *Act* with regard to what the Board "must" do.

With regard to scopes of practice

1. It must specify one or more scopes of practice — and publish these in the *New Zealand Gazette* (s11).
2. It must consult about its proposal for scopes of practice and qualifications before publishing a notice under s11 (re scopes) or s12 (re qualification) (s14(2)); and ensure that an up–to–date version of each notice that the authority has published under these Sections is:

a. available on the Internet; and
b. available at the office of the authority during business hours, so that members of the public may–

    i. inspect the notice free of charge; or
    ii. obtain a photocopy of the notice for a reasonable fee. (s14(3))

With regard to qualifications

3. It must prescribe qualifications (s12) — and, in doing so, must be guided by the following principles (s13):

    a. the qualifications must be necessary to protect members of the public; and
    b. the qualifications may not unnecessarily restrict the registration of persons as health practitioners; and
    c. the qualifications may not impose undue costs on health practitioners or on the public.

With regard to monitoring educational institutions

4. If it accredits an educational institution, then it must monitor that educational institution (s12(4)).

With regard to applications for registration of an annual practising certificate

5. It must review the Registrar's decision regarding applications for registration of health practitioners and authorisations of scopes of practice and must either confirm or revoke that decision (s17(5)(a)), and do so with regard to applications for annual practising certificates (s26(5)(a)).
6. It must consider a duly completed application for registration or for a change in the authorisation of an existing scope of practice as soon as reasonably practicable after receiving it. (s19(1))
7. It must advise the applicant about the identity of other persons that it may question (about their application) and the nature of the questions. (s19(3))

8. It must inform the applicant that it proposes to depart from the indicated scope of practise or to decline the application (s20) and, if so, inform the health practitioner concerned in writing why any information including in the application is (considered) false or misleading (s27(4)(a)), and give the health practitioner a reasonable opportunity to make written submission and to be heard on the question (s27(4)(b)).
9. It must promptly consider an application for an annual practising certificate that the Registrar submits to the authority (s28(1)) and, if the authority proposes to decline an application for an annual practising certificate, or to include or vary conditions in the health practitioner's scope of practice, it must give the applicant:

    a. a notice containing enough particulars to inform the applicant clearly of the substance of the grounds on which the authority proposes to decline the application, or to include or vary any conditions; and
    b. a copy of any information on which the authority relies in proposing to decline the application, or to include or vary any conditions; and
    c. a reasonable opportunity to make written submissions and be heard, either personally or by his or her representative, in respect of the application. (s28(2))

With regard to competence, fitness to practise, and quality assurance (Part 3 of the Act)

10. It must notify certain persons of risk to harm to public (s35) (i.e. the Accident Compensation Corporation, the Director–General of Health, the Health and Disability Commissioner, and any person who, to the knowledge of the authority, is the employer of the health practitioner — and

    If, after giving notice under this section in respect of a health practitioner, the authority forms the view that the practice of the health practitioner never posed, or no longer poses, a risk of harm to the public, the authority must promptly notify every recipient of the notice under this section of the current position in respect of the health practitioner. (s35(3))

In the context of reviewing a health practitioner's competence

11. It must make inquiries into, and may review, the competence of a health practitioner who is registered with the authority and who holds a current practising certificate (s36(1), and, "In conducting a review under this section, the authority must consider whether, in the authority's opinion, the health practitioner's practice of the profession meets the required standard of competence" (s36(5)
12. It must give the health practitioner under review–

    a. a notice containing sufficient particulars to inform that health practitioner clearly of the substance of the grounds (if any) on which the authority has decided to carry out the review; and
    b. information relevant to his or her competence that is in the possession of the authority; and
    c. a reasonable opportunity to make written submissions and be heard on the matter, either personally or by his or her representative.

13. If, after conducting a review under s36, the authority has reason to believe that a health practitioner fails to meet the required standard of competence, it must make one or more of the following orders:

    a. that the health practitioner undertake a competence programme:
    b. that 1 or more conditions be included in the health practitioner's scope of practice:
    c. that the health practitioner sit an examination or undertake an assessment specified in the order:
    d. that the health practitioner be counselled or assisted by 1 or more nominated persons. (s38(1))

14. 14.If the authority proposes to make an order under s43(1) (re unsatisfactory results of competence programme or recertification programme), it must give to the health practitioner concerned–

    a. a notice stating–

        i. why the authority proposes to make the order; and
        ii. that he or she has a reasonable opportunity to make written submissions and to be heard on the matter, either personally

or by his or her representative; and

b. a copy of any information on which the authority is relying in proposing to make the order.

15. Before giving a notice under s49 (power to order a medical examination) this section, the authority must endeavour to consult with the health practitioner about the medical practitioner who is to conduct the examination or test. (s49(3)
16. If the authority has received a report in respect of the health practitioner (s50(1)) it must consider the report (if any) and all the relevant circumstances of the case. (s50(2))

With regard to complaints, and discipline (Part 4 of the Act)

17. Whenever the responsible authority receives a complaint alleging that the practice or conduct of a health practitioner has affected a health consumer, the authority must promptly forward the complaint to the Health and Disability Commissioner. (s64(1))
18. When the Health and Disability Commissioner refers a complaint to the responsible authority, the authority must promptly assess the complaint and consider, in light of the nature and circumstances of the complaint, the action or actions that the authority should take to respond to the complaint. (s65(1))
19. Regarding the referral of complaints and notices of conviction to professional conduct committee, if the responsible authority decides to refer a complaint to a professional conduct committee, it must do so as soon as practicable after it makes that decision (s68(1)), and when a notice of conviction is given to the authority, it must, as soon as reasonably practicable after receiving the notice, refer the notice to a professional conduct committee (s68(2).
20. Regarding the interim suspension of practising certificate pending prosecution or investigation, the authority must revoke an order under s69(2) as soon as practicable after–

a. the authority is satisfied that the appropriateness of the practitioner's conduct in his or her professional capacity is no longer in doubt; or

b. the criminal proceeding on which the practitioner's suspension is based is disposed of otherwise than by his or her conviction; or
c. if the criminal proceeding on which the practitioner's suspension is based results in his or her conviction, the authority is satisfied that no disciplinary action is to be taken or continued in respect of that conviction under the Health and Disability Commissioner *Act* 1994 or under this *Act*; or
d. if the investigation on which the practitioner's suspension is based has been completed, the authority is satisfied that the practitioner will not be charged as a result of the investigation.

... and must ensure that the practitioner is notified as soon as practicable. (s69(4))

21. Regarding professional conduct committees, the authority must appoint one of the members of each professional conduct committee to preside at the meetings of the committee. (s71(3))
22. Regarding information to be given to practitioner and complainant, within fourteen working days after a matter concerning a health practitioner is referred to a professional conduct committee, the authority must ensure–

    a. that the health practitioner is given written notice of–

        i. the particulars of the matter; and
        ii. the membership or intended membership of the professional conduct committee that is to consider the matter; and

    b. in the case of a complaint, that the complainant is given written notice of the membership or intended membership of the professional conduct committee that is to consider the matter. (s74(1))

    ... and, as soon as reasonably practicable after a further matter concerning a health practitioner is referred to a professional conduct committee under s68(4), the authority must ensure that the health practitioner is given written notice of the particulars of the further matter. (s74(2)

23. Regarding requested changes in membership of professional conduct committee, if within five working days after being informed of the membership or intended membership of the professional conduct committee that is to consider a matter about a health practitioner, the practitioner or, in the case of a complaint, the complainant may give the authority concerned notice– (a) requesting that any or all of the members or intended members not be appointed as, or not act as, members of that committee; and (b) stating the reasons for the request, the authority– (a) must have regard to the request; but (b) need not comply with it. (s75(2)

With regard to the Health Practitioners Disciplinary Tribunal

24. Regarding the resourcing of Tribunal and nomination of executive officers, each authority appointed in respect of a profession must nominate one person who is to be the Tribunal's executive officer for the purpose of proceedings brought against health practitioners of that profession. (s104(2))
25. Before an authority nominates a person under s104, subsection (2), the authority must consult the chairperson of the Tribunal. (s104(4))

Structures and administration (Part 6 of the Act)

26. In the context of the Minister giving directions to resolve dispute, every authority must comply with any directions given. (s128(5))
27. Regarding fees and levy, each authority must ensure that an up–to–date version of each notice that the authority has published under ss130 or 131 is–

    a. available on the Internet; and
    b. available at the office of the authority during business hours, so that members of the public may–

        i. inspect the notice free of charge; or
        ii. obtain a photocopy of the notice for a reasonable fee. (s132(4))

28. As soon as practicable after the end of each financial year, each authority must deliver to the Minister a report on the operation of the

authority during that financial year, and every report to the Minister must include the audited financial statements of the authority for that financial year. (s134(1))

29. Each authority must maintain a register of the health practitioners registered with the authority. (s136)
30. Regarding removal of qualifications, or cancellation of registration, overseas.
    The authority must take all reasonably practicable steps to ensure that the health practitioner is given–

    a. written notice containing sufficient detail to inform him or her clearly of the substance of the grounds on which the authority has decided to carry out the review; and
    b. any information in the authority's possession relating to the cancellation, suspension, or removal concerned; and
    c. a reasonable opportunity to make written submissions and be heard on the matter, either personally or by his or her representative. (s147(2)

31. Each authority must appoint a Registrar and may appoint one or more Deputy Registrars. (s151(1))
32. Regarding publication of orders,
    If a court makes an order under this *Act* in respect of a health practitioner, the authority with which the health practitioner is or was registered must publish, in any publication the court directs, a notice stating–

    a. the effect of the order; and
    b. the name of the health practitioner; and
    c. a summary of the proceedings in which the order was made. (s157(3))

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PAUL BAILEY — Pablo Picasso once said that "The meaning of life is to find our gift. The purpose of life is to give it away". Paul was perhaps fortunate to discover his talent for psychotherapy early. For forty years or more he has been honing this gift in order to give it to others, session by session. He was born in Aotearoa New Zealand and studied under the guidance of his profession's elders in London and in his homeland. He has found much happiness and much to challenge him in a life of service to psychotherapy. A father of four sons and a

grandfather of three grandsons, he now lives and continues his work in Australia.

A. ROY BOWDEN is a former president of the New Zealand Association of Psychotherapists (1998-2000) and the New Zealand representative on the Board of the World Council for Psychotherapy (1998-2017). Roy was a Senior Lecturer in Social Work at Massey University, Head of Health Sciences and Counselling degree programmes at the Wellington Institute of Technology and a trainer of counsellors and therapists in a number of settings. Roy was on the NZAP Council for eleven years, served as Complaints Convenor, on the Ethics Committee and as an NZAP supervisor and, in 2015, he was awarded "Te Tohu o Te Pihi" by Waka Oranga and the NZAP for cultural advocacy. Roy has been a clergyman, an associate therapist in a community psychiatric centre, and a national trainer for Relationships Aotearoa and the director of a Family Counselling Centre. Roy established the first private psychotherapy practice in Manawatu (1987-1999) and is currently co-director of Mana Consultancy in Plimmerton.

HEATHER CAME is a seventh generation Pākehā New Zealander who grew up on Ngātiwai land. She has worked for nearly 25 years in health promotion, public health and/or Māori health and has a long involvement in social justice activism. Heather is a founding member and co-chair of STIR: Stop Institutional Racism, a fellow of the Health Promotion Forum, co-chair of the Auckland branch of the Public Health Association, and an active member of Tāmaki Tiriti Workers. She currently embraces life as an activist scholar. She is a Senior Lecturer based in the Taupua Waiora Māori Health Research Centre within Auckland University of Technology.

SUE CORNFORTH, Associate Professor, is now retired, but remains a Research Associate with the Faculty of Humanities and Social Sciences, Victoria University of Wellington, New Zealand. Her research interests are ethics, Higher Education and education for sustainability. She enjoys working with poststructural frameworks.

ALISTAIR CROCKET has recently retired after almost two decades teaching counselling at the Waikato Institute of Technology in Hamilton. He was a member of the National Executive of the New Zealand Association of Counsellors (NZAC) for several terms between 1989 and 2015. In 2016 he was elected to Life Membership of the NZAC.

GRANT DILLON practises psychotherapy and supervision in Tamaki Makaurau (Auckland).

NICK DRURY is a counsellor, psychologist, and supervisor, based in Herne Bay, Auckland. He has been a practicing therapist for nearly four decades, with a strong interest in philosophy and sociology, as well as the "psy" disciplines. He has a diploma in clinical psychology, and a passion for Wittgenstein and Zen. In the past decade, his academic interests have been focused on how we might recognise, appreciate, and develop further, what Merleau-Ponty calls our "primary intersubjectivity", or intuitive direct relating with each other and the world. For therapists, this encourages us to be more relationally responsive and present to our clients, dissolving the need for treatment plans, models of treatment, and other intellectual encumbrances. He sees this as an essential step in our path to what Bateson called an "ecology of mind".

LOUISE EMBLETON TUDOR trained and qualified in psychotherapy in the 1980s in the UK. In 1993, with Keith Tudor, she co-founded Temenos in Sheffield, an organisation which offered training in psychotherapy & counselling from Diploma to Master's level and, for 17 years, was one of its Directors. She is the author of some 20 professional papers. Her interests include power, authority, politics, and culture in psychotherapy and supervision; and neuroscience and the regulation and dysregulation of the human organism, especially as manifested in trauma and somatisation. She works as a psychotherapist an independent practice in Auckland.

DR JONATHAN FAY was born in Madison, Wisconsin and raised in the green mountains of Vermont. He is a Senior Lecturer at Auckland University of Technology and currently Head of Clinical Services in

the School of Public Health and Psychosocial Studies. He originally trained as a clinical psychologist at Duke University in Durham, North Carolina and was for several years a psychiatric unit chief at Elmcrest Hospital in Portland, Connecticut. He has practised psychotherapy for 39 years in the United States and Aotearoa New Zealand. He is a Registered Psychologist, a Member of the New Zealand Association of Psychotherapists (NZAP), and a recipient of NZAP's Distinguished Service Award. He is married to Margaret Poutu Morice. They have three adult children.

RICHARD HOUSE, PhD, C. Psychol., is an educational consultant and a left-green political campaigner, based in Stroud, UK, committed to Jeremy Corbyn's political project. Formerly a practising counsellor-therapist, senior university lecturer in Early Childhood (Winchester University) and in psychotherapy (Roehampton University) and former co-editor of Self and Society journal, Richard co-founded the Independent Practitioners Network (1994), the Alliance for Counselling and Psychotherapy (formed in 2007 to de-rail the UK State's drive to state-regulate the psychological therapies), and several early childhood campaigns. Richard is author or editor of twelve books, including (with co-editors David Kalisch and Jennifer Maidman) *Humanistic Psychology: Current Trends and Future Prospects* (Routledge, 2017); *Too Much, Too Soon? Early Learning and the Erosion of Childhood* (Hawthorn, 2011), *In, Against and Beyond Therapy* (PCCS, 2010), and (with co-editor Del Loewenthal) *Against and For CBT* (PCCS Books, 2008). A trained Steiner teacher and childhood campaigner, in 2006, 2007, 2011 and 2016 Richard co-organised four influential multiple-signatory press letters on the state of childhood in modern culture. He loves John McLaughlin's Mahavishnu Orchestra, and trying (and, to date, failing – though "failing better") to work less hard.

ROBERT JENKINS spent his career in various education and mental wealth roles, culminating in independent practice, from which he retired in 2014. He maintains an academic interest in the therapy world, and a respectful distance from it.

SEÁN MANNING, MSc, DipSW, DipGrad, MNZAP, TSTA, Registered Psychotherapist, is a psychotherapist in a therapeutic community in Dunedin with a small private practice. His academic and professional background is in psychology and social work. Raised in Belfast, Northern Ireland, he has lived in Aotearoa New Zealand since 1975. He is 65 years old and has three grown up children and one grandchild. He is a former member of the Board of the International Transactional Analysis Association, and of the Training & Certification Council of Transactional Analysts Inc, was until recently Chair of Ethics for the Western Pacific Association for Transactional Analysis, and is the current president of the New Zealand Association of Psychotherapists instead of having a social life. His almost adequate command of Māori language is still a lot better than his command of Irish. His addiction to collecting stringed musical instruments is almost under control and his ability to play them is just enough to get him into a series of unsuccessful Irish bands. He is intensely interested in how psychotherapy works, what happens in the human brain as a result. He has authored a report summarizing the effectiveness of psychotherapy and a number of papers on antisocial behaviour and the unconscious. Confessing to being sometimes unreasonable and impatient, he is passionate about this profession, its place, its meaning and its future in our society.

ANNE MARTIN trained in individual and group psychodynamic training with a Jungian bias, in London from 1981. According to Jungian typology, I am a feeling type, with auxiliary function intuition. On my course I was assaulted by my first therapist — with dire consequences. I could see which way things were moving, also with regard to regulation, and so “diversified”, in order not to have all my eggs in one basket, and also because there is more to therapy than psychodynamism only! I am also trained in relationship and psychosexual counselling, hypnotherapy, metaphor therapy (à la David Grove), stress management, and neurolinguistic programming, and am happily eclectic every day! Despite the assault, I am passionately against statutory regulation. I have found my psychotherapy “home” with the Independent Practitioners’ Network (though, sadly, this no longer exists in Dublin); and am also a member of The Alliance for

Counselling and Psychotherapy Against Regulation. I am the daughter of two Jungian psychotherapists, and took psychotherapy in with my mother's milk! For me, it is not a job, but a way of life, and I will leave the field rather than register.

MARGARET POUTU MORICE is an indigenous New Zealander, from the Hapu o Tuwhakairiora and Te Iwi o Ngati Porou. After raising three children, she completed her Master of Health Science (Psychotherapy) at Auckland University of Technology (AUT), and has worked in a variety of public mental health settings, with a focus on the development of an indigenous psychotherapy. She is currently employed as a Clinical Educator supporting students in the generic psychotherapy programme at AUT. She holds membership in the New Zealand Association of Counsellors (NZAC) and New Zealand Association of Psychotherapists (NZAP), and is a founding member of Waka Oranga, the National Collective of Maori Psychotherapy Practitioners and NZAP's Treaty partner.

DENIS POSTLE — After two decades as a broadcast documentary film-maker, Denis Postle accumulated the education, training and experience to become a groupwork facilitator and trainer, and later a humanistic psychology practitioner, coach, mentor, and supervisor. He has studied and chronicled the professionalisation of the psychological therapies for more than a decade. A founder participant in the Independent Practitioners Network (IPN), he sees IPN as exemplifying his core values of experiential inquiry, working from love, and demonstrating that long term civic accountability for psycho-practitioners can be structured through cooperative non-hierarchical organisations.

COINNEACH SHANKS — Now retired, Coinneach was a Jungian psychotherapist, working in Dublin, Ireland. Originally from Scotland, he trained as a sociologist at Middlesex University (1970-1976), and has a Masters in Deviancy. Following a career as a social research consultant, and a period working in development in Central America, Coinneach retrained as a psychotherapist. Coinneach's period making short films and documentaries in the UK film industry prompted him to create a blog which links his own photographic images with

symbols, dreams, memories and reflections. This led to a highly successful photo-story blog, much influenced by Jung and Freud. He is co-author (with Camilla Galli de Bino) of Equal to the Future (Northern Ireland Voluntary Trust, 1997), a photo essay on Northern Ireland youth during the peace process. He now writes about animation, cinema and jazz.

SUSAN SHAW, BN, MEd Admin (Hons), EdD, Dip Tchg, RN, PFHEA, has a background in education and health care having originally qualified as a primary school teacher and then a nurse. She joined Auckland Institute of Technology, now Auckland University of Technology (AUT) in 1992, where she has held various academic leadership roles. Her commitment and contribution to educational practice been recognised with the award this year of a Principal Fellowship from the Higher Education Academy (UK). She has maintained clinical interest and practice in the areas of disability and palliative care, along with research interests in chronicity as it is experienced by patients and health professionals. She has co-edited five textbooks with Oxford University Press and continues to teach undergraduate and postgraduate students. Susan is currently the Associate Dean (Academic) in the Faculty of Health and Environmental Sciences, and a Director of the National Centre for Interprofessional Education and Collaborative Practice at AUT.

EVAN SHERRARD wrote for the first edition of this book — “I’ve always been passionate about helping to relieve people’s distress. I started my people-helping career as a Minister with a focus on pastoral care. My core sense of identity is that of a healer/therapist. To become the best I could be required a long sequence of training and education, here and overseas, obtaining university degrees and qualifications. I am still actively learning. I am eclectic and eccentric (off centre and toward the edge). Discipline and rigour has been important to me as I explored several different approaches to the practices of therapy I have incorporated. Accountability and supervision are crucial in my discipline. A core belief I hold is that giving and receiving therapy must be pleasurable, even fun-filled, to be effective. Of course, it is a serious journey associated with pain, but it must be accompanied with laughter and humour. In following this path I have achieved much and

been privileged to pioneer several significant new ventures. Sharing my learning with others is one of my greatest joys. Today, because of the new limiting regulations, I do not practice psychotherapy anymore, but I continue to provide pastoral care therapy." Evan died on 21st October 2015.

HAARE WILLIAMS writes — "I was the cherished grandchild of two caring grandparents who nurtured me in a whare raupo". Haare was born in Gisborne and brought up on the remote shores of the Ohiwa. Of Te Aitanga–a–Mahaki, Rongowhakaata and Tuhoe tribes, he was nourished in the Ringatu Church of which he is a registered elder. Teaching in primary and secondary schools he later lectured at Ardmore Teachers College, and Auckland Teachers College before doing a stint as a Research Fellow at Waikato University. Into broadcasting for 11 years, Haare later pioneered Māori Radio as the General Manager of Aotearoa Radio. He has worked closely with iwi claimant communities collecting and preparing iwi oral testimonies for presentation before courts and the Waitangi Tribunal. Haare has worked on recording and archiving the oral histories of Aotearoa New Zealand, hence his work as a facilitator for oral histories workshops with iwi together with The New Zealand Libraries. Haare has published his poetry, was a judge for the Watties Book Awards, and has held five solo art exhibitions. He was an Executive Director of the New Zealand 1990 Commission especially responsible for waka construction and their assembly at Waitangi for the 1990 Sesquicentennial. Haare was a two-term city councillor in Papakura. For five years, Haare held the position of Pae Arahi (Director), at UNITEC, before he set up a joint venture with South Seas Film and Television School in Birkenhead for the training of students with competency in te reo and tikanga. He is currently working with the new Auckland Council. Haare concludes: "Poetry and art, for me, is like the cadence and rhythm of the cicada."

WIREMU WOODARD is Tuhoe and an Indigenous therapist, father of four, activist, environmentalist, sometimes contemporary dancer and artist. Wiremu is committed to reducing health disparities for Māori and promoting social justice. He currently works in community practice at Kereru and teaches on the psychotherapy and counselling

programmes at Auckland University of Technology. Wiremu is a founding member of Waka Oranga, a group of dynamic Indigenous Māori practitioners committed to emancipatory freedom.

JEREMY YOUNGER has been an Anglican Priest for over forty years. Twenty five years ago he trained in London as a Neo-Reichian Holistic Therapist, and, until his recent retirement, worked in Auckland, New Zealand, where he still lives.