Academic/Research Article

# Is talk cheap? A review of health professional regulation in the context of an Irish register for counselling and psychotherapy

*By Claire Rountree*

**Introduction.**

The statutory registration of health and social care workers under CORU, Ireland's multi-profession health regulator, was initiated in 2007. Currently 11 health and social care professions are regulated, with psychology, and counselling & psychotherapy amongst the outstanding few (Coru.ie).

A 2017 public consultation on the counselling/psychotherapy specialism received over 70 submissions from practitioners, training, and quality bodies. Following the consultation, the Minister for Health announced a dual registration system for counsellors and psychotherapists (Dept. of Health, 2017).

At present, the education threshold for both professions is proposed at Level 8 undergraduate honours degree (Coru.ie) however there had been some expectation of an Undergraduate versus Master's Degree hierarchy, with psychotherapy being the higher qualification (O'Morain 2012).

The Irish Council for Psychotherapy (ICP) submission to the Minister in 2017 spoke to this point of hierarchy, equating psychotherapy with a higher status relative to counselling: "While professions such as … a doctor and a nurse are allied professions, there is nevertheless a clear distinction between them in terms of the scope of practice and preparation for such professions, which is clearly understood by the public" (ICP, 2017).

As the consultation process winds on, the specifics of entry pathway levels and content, and future scope of practice remain open. Some (e.g., Fallon, 2016) have questioned the social values placed upon 'academic' versus 'practice-based' trainings and questioned what, if any, distinctions in scope or practice exist between the titles. There has also debate around practical experience versus academic entry pathways (ICP, 2017, O'Morain, 2012) with varying requirements for students to complete counselling practice hours and personal therapy as part of their training.

This literature review set out to explore the international healthcare professional regulatory environment. The research question was; *what learnings might an Irish counselling and psychotherapy register take from international experiences?*

**Method**

An initial search was conducted in the Web of Science database, using the search term "regulating health professionals". The initial search yielded 1,676 results. Filters were applied at this stage to limit results to:

- Publications within the last decade (2012), and,
- Papers published in policy related journals.

This yielded 82 results which were manually scanned for relevance.

**Inclusion criteria:** 26 papers were retained for the review on the basis that they each:

- Discussed current or future regulation of at least one healthcare profession.
- Focused on a so-called "developed" national healthcare system.
- Were available in English.

**Data extraction:** Where the abstract met the inclusion criteria, the full article was included in the review. Bibliographic information (title, author, year, area of focus, study type, detailed information on topics) and key findings were recorded in an MS Excel spreadsheet.

**Analysis:** Once the full list was collated, topic headings were sorted and grouped into themes. Five inter-related topic cluster 'themes' were identified across papers. Papers were classified under main theme as follows (see Table 1): applying regulations, interprofessional relations, education and international mobility for health professionals.

The results will be discussed for each of these in turn in the results section, next.

## Results

### Theme 1: Applying Regulations

Different approaches to statutory regulation have emerged across jurisdictions due to policy legacies and cultural norms; in some it is the title that is regulated, and in others it is the scope i.e., activities that are subject to regulation.

***Table 1:*** *Main themes by number of papers in the review.*

| Main Theme | No. |
|---|---|
| **Applying Regulations** | **12** |
| • Traditional & Complementary Medicine | 4 |
| • Emerging professions (genetic counsellors/e-health) | 3 |
| • Midwives | 2 |
| • Evolution of regulation across jurisdictions (history) | 1 |
| **Interprofessional Relations** | **6** |
| • Oversight | 5 |
| • Professional misconduct | 3 |
| • Representative associations | 2 |
| **Education** | **3** |
| **International mobility** | **3** |

In many cases agencies have been constituted to regulate at a remove from both the regulated professions and the regulating state, and in some cases (as will the case with CORU in Ireland), in coordination across health professions (Leslie et al., 2021).

Doctors were the earliest regulated profession, and the most influential historically (Adams, 2020). The General Medical Counsel was established in the UK in 1958 following decades of negotiation.

Regulation has changed markedly in recent decades with a movement towards workforce sustainability, accountability, transparency, standardization, centralisation and efficiency. This has brought a shift away from the traditional model of self-regulation to a "regulated (self-) regulation", subject to greater external scrutiny and audit.

The main influencers for early healthcare legislation (exemplified by physicians) were the practitioners themselves, and state representatives (often 1 and the same). The losers tended to be the less trained or marginal practitioners. Over time, regulation of secondary professions (like nursing) aimed more to control, conferring fewer privileges, more limited scopes, and less self-regulation than the doctors had claimed.

**Traditional and Complementary Medicine (TCM).** Treatment of TCM within the wider health system highlights tensions between the dominant biomedical treatment model and sensitivity to people's cultural heritage and beliefs, and the difficulties inherent in regulating for diverse and fragmented therapies, some of which are not suited to centralised regularisation (Pokladnikova & Telec, 2020).

Biomedicine is the Western medical tradition, taught in medical schools, that exercises a hegemonic narrative of legitimate medical care. A more holistic perspective is the common feature of many TCM practices where people are understood as simultaneously biological and social persons (Shuval & Averbuch, 2012).

The WHO formulated the Traditional Medicine Strategy 2014–2023 to strengthen the role TCM plays national public health systems (WHO, 2014). However, difficulties have been cited around education paths, public safety, scientific language, and English language usage, while there is an overarching expectation that TCM 'should' conform with western biomedicine standards (Care, Steel & Wardle, 2021; Palatchie et al., 2021).

Certification boards take an organisational role of Certification/CPD/advocacy in the absence of legal regulation (a la IACP/IAHIP etc in Ireland). Such organisation is voluntary and there is no external recourse for appealing complaints/discipline.

### Theme 2: Interprofessional Relations

Interprofessional relations might be considered an amalgamation of two essential questions for healthcare

planning; horizontally allocating resources as 'who does what', and vertically ordering hierarchies through, 'who says you have to'. (Schonfelder & Nilsen, 2016). Formal regulation is seen by practitioners of TCM and emerging professions as enhancing their professional status, and opening referral pathways (Care, Steel & Wardle, 2021; Lambert et al., 2022).

The concept of professional jurisdictions (Abbott, 1988, cited in Schonfelder & Nilsen, 2016) affords a framework for analysing power relations between professions and it addresses both these questions, categorising tasks as objective (technical) or subjective (culturally allocated). While objective tasks can be reallocated with relative ease, those perceived as more subjectively assigned tend to be much more hotly contested. For Abbott, nursing's emergence as a profession is seen to be result of a lost power struggle with the medical profession.

An example of the power dynamics at play between professional registration and interprofessional relations is illustrated in the Case Study example, below.

***Case Study:***

*Midwifery was regulated in 2000 in Manitoba. A separate role to nursing, midwifery provides a patient-centric alternative to medical care with favourable comparative outcomes. Until the 20th century midwives were the primary maternal authority, through informal community-based peri-natal care. They were relegated to the peripheries as the biomedical hospital and physician-based model gained dominance. Midwifery has been reborn over recent decades as bringing peri-natal care back into the hands of women (Mattison et al., 2020).*

*Over time, regulation of secondary professions (like nursing) aimed more to control, conferring fewer privileges, more limited scopes, and less self-regulation*

*(Adams, 2020)*

*Since 2000, collaboration between midwives and allied health professions has been fostered by employment contracts, co-location, and cooperative initiatives however hierarchy, excessive bureaucracy, and lack of understanding of the scope and context of practice by other HCP (especially, physicians) are barriers to interprofessional collaboration (Thiessen et al., 2016). Regulation is broadly welcomed by midwives and allied health professionals but interprofessional power struggles has been experienced as extremely challenging for the newly established profession (Thiessen et al., 2016).*

*Policy legacies, especially payment mechanisms that prioritise physician and hospital care, may also afford insight as to both why midwives are not better integrated, and the limitations to their scope and practice (Mattison et al., 2020).*

Parameters impacting on nurses interprofessional collaboration (Schonfelder & Nilsen, 2016) were education, the professional autonomy of nurses, level of professional hierarchy, adaptable scope of work, interdisciplinary teamwork and cooperation between services.

A similar set of eight factors were identified across three Australian regulated professions (Wiggins et al., 2023); education level, competency, professional identity, role confusion, legislation and regulatory policies, organisational structures, funding/remuneration, and professional-specific factors.

**Theme 3: Oversight**

An analysis of representative bodies by Paul et al. (2017) identified four governing rationales: two are founded in the public interest (developing and maintaining competence, protecting public safety), and two in the, opposing, interests of the professional class (managing resources for the membership, and advancing memberships' interests).

**Oversight - Role of representative organisations.** Representative organisations traditionally advocated on behalf of their memberships. The main influencers for early healthcare legislation (exemplified by physicians) were the practitioners themselves, and state representatives (often 1 and the same) (Adams, 2020).

Over time, regulation of secondary professions (like nursing) aimed more to control, conferring fewer privileges, more limited scopes, and less self-regulation (Adams, 2020). The losers tended to be the less trained or marginal practitioners. Professional status is an asset in negotiations such that high relative professional status is associated with state subsidised treatments, avoiding external regulation, and exerting a level of influence over other professions through referrals (Andersen, 2014).

Genetic counselling is a relatively new healthcare profession, working clients to understand and manage testing and diagnoses for genetic conditions. Regulation in Australasia has involved a "significant cultural change" amongst genetic counsellors with a movement amongst representative bodies from mainly advocacy to implementing the self-regulatory process and ongoing socialization and communication of the protocols (Hoskins et al., 2021).

National medical associations have thus evolved beyond a representative, or advocacy function, to serve a regulatory function, within which quality is a key element (discussed next).

**Oversight – Misconduct.** Poor performance is often categorised as either impairment – substance abuse, illness or behavioural issues, or incompetence – a lack of knowledge or skills) (Weenink et al., 2014).

Power differentials between professions impact on how standards are applied across professions. Australian doctors were seen to be subject to less severe outcomes versus all other professions, but especially nurses, even for the same disciplinary issues (Millbank, 2016).

As the pendulum moves from self-regulation to more externally imposed standards, perceived unnecessarily strict interpretations are seen to undermine professional autonomy, and narrow scope of practice.

The situation described by Myburgh (2014) around chiropractors' experience with the newly established Danish National Board closely echoes that described by Irish pharmacists in response to a survey by Lynch et al. (2022) on their experiences of the revised regulatory context for community pharmacies. Pharmacists described a punitive implementation environment, with surprise inspections, and annual fitness to practice exams, "catching members out" on rules, rather than supporting them to meet raised standards.

**Theme 4: Education**

It appears that higher education levels contribute to higher professional autonomy and inter-disciplinary status (Schonfelder & Nilsen, 2016). This is not about the individual practitioner's training, but more about what is available

*The integration of international qualifications with local systems has been less than seamless*

*(Covell et. al., 2016)*

in the discipline; a profession with a doctoral or masters level qualification tends to have a higher status than one that ends at degree classification.

TCM practitioners expressed concern around unfair or unachievable (academic) qualifications being imposed or language requirements (Care Steel & Wardle, 2021). This speaks again to the homogenising impact of western biomedicine standards (Care, Steel & Wardle, 2021; Palatchie et al., 2021). Competency based education has been a prominent focus of reforms in wealthier nations. Such a programme would be derived from the competencies desired within the national health system, this makes them a potential 'vehicle' to integrate national and professional agendas.

It would require defining desired educational outcomes, developing individualized learning pathways, setting and assessing standards. The challenges associated lie in healthcare planning; identifying the community's health needs, defining the relevant competencies, developing (or leveraging the existing) educational systems to deliver the model, and assessing competence (Gruppen et al., 2012).

Mandated training for continuing professional development (CPD) is most effective when it is interactive, uses a variety of methods and involves multiple exposures over time. It should be focused on outcomes considered important by practitioners. Self-guided seems to be best (not externally set course requirements) (Main & Anderson, 2023). Revalidation requirements seem universally unpopular (Guillemin et al., 2013; Lynch et al., 2022; Myburgh, 2014).

The issue of poorly defined professional identity (Wiggins et al., 2023) speaks directly to the blurred boundaries and overlaps between different talk therapist functions. Clearly defined roles and education pathways, on the other hand, have potential to support career progression and mobility. This will ultimately support healthcare systems planning through broadening the recruitment pool.

**Theme 5: International mobility**

From the perspective of those charged with planning and managing healthcare systems, international health professionals represent an obvious solution to staffing problems however, the integration of international qualifications with local systems has been less than seamless (Covell et al., 2016). National standards for health professionals vary widely, as does the skills mix within and between professions and this lack of alignment impedes workers' mobility (Leslie et al., 2021).

Immigration had a significant influence on Canadian regulatory development in the mid-19th century when immigrant medical doctors from Scotland and Ireland, seeking to be recognised and accorded fairer entry, sought a greater voice in their own affairs. (Adams, 2020). However, a more recent Canadian systemic analysis (Paul et al., 2017) identified three often conflicting policy subsystems (immigration, education/regulation/licensure, and health system human resources) that challenge internationally educated health professionals seeking to join the Canadian workforce.

In keeping with their mandate to promote memberships interests, and conserve interests, Paul et al. (2017) suggest the representative

bodies charged with education/regulation/licensure may not be working to facilitate integration into the health workforce. Rather, they may also be, more or less actively, gatekeeping, controlling the labour supply in favour of its incumbent membership.

The interests of members may not be advanced by allowing internationally educated peers an easy entry route, and high entry requirements can be easily rationalised under public safety. While nationally educated professionals' interests may be served by restricting entry, on the other hand, healthcare workforce planning seeks to balance supply and demand to address regional needs with an appropriate mix of HCP while managing health costs.

**Discussion**

The challenge for regulators is prioritising public protection while ensuring access to the needed health workforce. While controlling what health care practitioners do through legislation can be "costly, time consuming and adversarial" (Wiggins et al., 2023) if at odds with professionals' self-interest, it can also provide clarity. In planning healthcare systems, policies should be cognisant of the "conditions and consequences of adjusting the skill mix between professions" as a hot button issue (Shonfelder & Nilsen, 2016).

On the other hand, the absence of a defined scope, or mandated minimum education level, or minimum competency requirements, raises questions as to quality of care and patient safety.

**Oversight.** As the different roles of representative and accrediting organisations flex and adapt to meet a new regulatory context, the challenge of balancing rigidity and flexibility in healthcare regulation and implementation is apparent. Trust is essential, to avoid over-regulation. This should be a critical watch point for the counselling profession as regulation is; one, written, and; two, interpreted in practice.

**Interprofessional relations.**
With movements away from an institutional model towards individual rights-based care, and care in the community, integrative services are ever more in need. These require interprofessional collaboration where chronic, multi-morbid conditions, and mental health care and rehabilitation require a continuum of service from medical to social and daily living supports. This means moving beyond simple calculations of ratios of physicians to nurses; interprofessional relations between the professions indicate capacity for integrated service delivery.

The counsellor versus psychotherapist definition is an example of confused role identity, which acts as a barrier to collaborative interprofessional relations. This presents an immediate challenge for Irish representative bodies, and education providers, but it also challenges health systems globally to "define, differentiate, and demarcate" the roles (Wiggins et al., 2022).

**Mobility.** Restrictive criteria for internationally educated HCP suggest that representative bodies are prioritising their members' interests by limiting professional supply, in the face of demand for internationally qualified professionals from the health system and/or public. Such intra-professional conflicts of interest for self-regulating professional bodies ought not apply with an externally appointed body such as CORU in Ireland.

**Overall.** The issue of professions' relative self-interest speaks to an overarching theme of power and hierarchy that ran through much of this paper, which addresses the 'social values' question this paper set out to address. While clear scopes of practice and accessible entry pathways may seem self-evident public goods, enabling professional mobility, interprofessional collaboration, and career progress, reconciling these with existing interest groups is fraught with difficulty.

Taking the findings together for the question of education values, it appears clear that professions with higher qualification paths are valued more highly (Schonfelder & Nilsen, 2016). There are significant implications from professions' education ceiling in terms of its position in professional hierarchies, autonomy to practice, externally imposed discipline, interprofessional collaborative opportunities and governmental reimbursements. However, an over-emphasis on academic pathways risks marginalising skills and cohorts outside this dominant framework. Therefore, a higher education pathway with a strong competence element may offer the 'least worst' path.

**Study Strengths**

The analysis has reviewed a substantial body of evidence in relation to regulation of health professionals. Clear learnings from other professional and regional context have been gleaned for the Irish regulation of counselling and psychotherapy. The sub-questions around social values and education levels were also addressed.

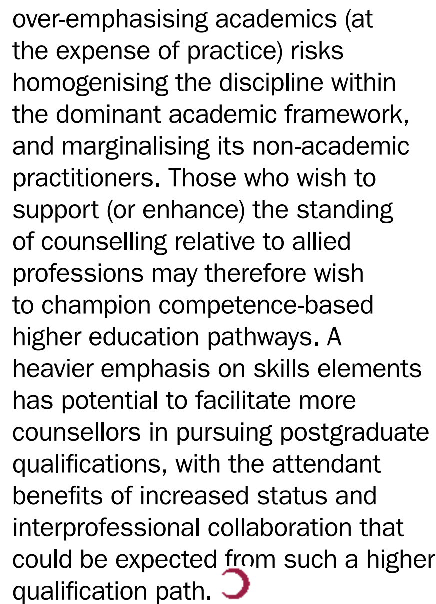
**Study Limitations**

The paper would have benefited from a more systematic, and more complete exploration of the literature (grey and different catalogues). The research and analysis was conducted by the author solo. A second researcher

would have added valuable quality control by cross-checking themes. The compiled omits other country's experience with counselling or psychotherapy regulations; search terms could have been supplemented to include more directly relevant experiences.

**Conclusion**

While clear scopes of practice and accessible entry pathways may seem self-evident goods, enabling professional mobility, interprofessional collaboration, and career progress, reconciling these with existing interest groups is fraught with difficulty. Clearly defined roles and education pathways, on the other hand, have potential to support career progression and mobility. However, over-emphasising academics (at the expense of practice) risks homogenising the discipline within the dominant academic framework, and marginalising its non-academic practitioners. Those who wish to support (or enhance) the standing of counselling relative to allied professions may therefore wish to champion competence-based higher education pathways. A heavier emphasis on skills elements has potential to facilitate more counsellors in pursuing postgraduate qualifications, with the attendant benefits of increased status and interprofessional collaboration that could be expected from such a higher qualification path.



*Appendices for this article are available on request to the Editor.*

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