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Editorial: *What works in practice?*

MARG LYNN

This issue is special. Its centerpiece is dedicated to honouring the life and work of Ian Murray who died on July 12th, 2011. We published Jan Richardson's moving tribute to him in the last issue of *Practice Reflexions* Vol 6. No 1, 2011. It was Ian who made *Practice Reflexions* possible by bringing together the (now) Australian Community Workers Association (ACWA) and Monash University (now) Community Welfare and Counselling staff, (we are all resignified now!), and developing the synergies to produce an important voice for the profession.

Ian was known to ACWA members and colleagues as a career-long advocate for the recognition of community service workers (by whatever title), those practitioners whose skills are often seen as second best to and by social workers and psychologists. It came as no surprise to us to discover that his last work, his magnum opus, was the creation of a very substantially researched argument to support his contention that the range of community service workers achieve as effective counseling outcomes as their more lengthily trained professional colleagues such as social workers, psychologists, psychiatrists. He takes this argument out of the realm of community service practitioners' frustrated conversations about inequity of recognition and reward to challenge a powerful discourse through rigorous research.

We publish here Ian's paper in full, with only some 'tidying up'. It is clearly different from the usual refereed paper in that its author was not able to respond to his critics and further develop the paper. We invited a number of writers to provide comment, and we are pleased to publish two responses, one a refereed paper from Sue Burney, Jo Brooker and Jane Fletcher, and the other a personal reflection from Margaret O'Brien (formerly MacMahon), who worked as an AIWCW (ACWA) colleague of Ian's and knew his advocacy well. We invite others who would like to formulate a response to Ian's paper, as either a refereed contribution, a note or a personal reflection, to write for the next issue of *Practice Reflexions*.

Sue Burney, Jo Brooker and Jane Fletcher respectfully challenge some of Ian's methodology, arguing that he concentrates on the many academic papers that support his argument rather than reviewing the whole field to reveal counter arguments, and further, that many of the studies need to make use of matched control groups to establish that 'apples are being compared with apples'. But the reader will be enlightened to find, nevertheless, the extent of research support for Ian's arguments, and the complexity of the search for evidence when much of the research is silent on

such matters as length of training. The authors agree with Ian that length of training is not demonstrated to necessarily correlate with better client outcomes, though they identify methodological limitations in Ian's argument that do not sustain evidence of better outcomes being achieved by lesser trained practitioners. They do support his claim that the therapeutic alliance may account for significant outcomes with clients, and that an effective alliance does not depend on length of training. Ultimately the authors make a fine contribution in naming areas where further systematic research is needed to validate Ian's claims; they do not ever suggest that such evidence may not be found. Their own, un-researched, practice experience supports many of Ian's contentions.

Margaret O'Brien writes from a background of deep practice and teaching experience, sound practice wisdom, and engagement with and observation of learners in the field. Her evidence is less scientific and more practical and conceptual. She reflects the title of one of the research texts that Ian draws on: Duncan and Miller's (1999) *The Heart and Soul of Change: What Works in Therapy*. 'What works' is at the heart of all good practice, and community welfare workers integrate their knowledge, values and skills to achieve the most successful and workable outcomes they can. What Ian was setting out to achieve was a bridge between the practice wisdom and localised research of most practitioners, and the rigorous knowledge that is created by scientific knowledge seekers. Such research needs to be informed by the parameters of practice, unblinkered by professional status categories and open to discovering some 'inconvenient truths' (for some) that lesser trained professionals are not only as effective, but perhaps even more effective in achieving successful outcomes with their clients, than their more lengthily trained colleagues. In attempting to build this bridge, Ian is to be judged by the knowledge frameworks on both sides of it. Burney, Brooker and Fletcher have sharpened the tools required to complete the bridge and have it standing firmly on both sides, recognised as sturdy, safe and open to two-way exchange. The implications of Ian's findings are profound if established, and even more importantly, if accepted by those with responsibility for acting on them: mental health professional bodies, universities, governments, non-government funding bodies, researchers and ultimately, practitioners and clients.

Two more papers are published in this issue that take us into the fields of community development and mental health. Wendy Mackenzie demonstrates a keen interest in democratic and civic principles, and the risk to their integrity that managerialism poses. She argues for local government to encourage the empowerment of its citizens through the adoption of participatory democracy, requiring education and changed practices, and a willingness to relinquish the neoliberal marketplace paradigm when dealing with their communities, especially in relation to the management and creative use of community halls.

Samuel Crinall provides very valuable insights for those working in the field of disability, where negative behaviours of clients have been reinforced through attention, in the absence of more functional behaviours having been learnt by clients or staff. The Ermha program could probably trace its genealogy to the individual psychologists Adler and Dreikurs, strong influences on parent education training, who saw that undue attention seeking was a 'mistaken goal' and could be addressed by establishing equality and cooperation, learnt through coming to understand logical or natural consequences of their behavior, within warm relationships. Applying this approach to challenging clients such as Ermha's has clearly been extremely effective and deserves to be known widely.

Some interesting papers are already waiting in the wings for publication next year, and it is our intention to pre-publish during the year, with a consolidated, editorialised issue at the end of the year. Look out for great papers to read in 2013, and please consider writing for us too, either responding to Ian Murray's paper, or on a topic of your passion, interest or concern. You will notice that the table of contents is identifying the state of origin of our writers. We would be very pleased for future issues to further demonstrate the national breadth of our contributors.

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Does the length of training determine the effectiveness of counselling practice?

IAN MURRAY

Abstract

The length of training has little to do with the outcomes of psychotherapy and counselling. Those with considerably less training are just as effective, or even more so, when compared to those with advanced specialised degrees, such as in psychotherapy, clinical psychology or social work. The publication of innumerable articles and studies over at least a forty-year period, often by research psychologists, supports this contention. This paper explores the evidence that concludes there is equivalence in effectiveness between paraprofessionals and professionals, and in some studies, evidence of superior client outcomes for paraprofessionals. The importance of the therapeutic alliance in determining outcomes for clients is underscored.

Keywords: counselling effectiveness, research studies in client outcomes, length of counselling training

Introduction

The length of training has little to do with the outcomes of psychotherapy and counselling. Those with considerably less training are just as effective, or even more so, when compared to those with advanced specialised degrees, such as in psychotherapy, clinical psychology or social work.

There is also considerable evidence that length of experience as a psychotherapist has little or no influence upon their effectiveness, but this aspect will not be further examined in this paper.

The reactions to such provocative and counter-intuitive statements have often been surprise, disbelief, and scorn, or outright dismissal, as not worth even considering; and this, despite the publication of innumerable articles and studies over at least a forty year period, often by research psychologists themselves. As Atkins and Christensen (2001: 129) conclude: 'if doctoral-level training - or even master's-level training - is unnecessary for effective mental health service delivery for particular disorders, then services can be provided at lower cost. Moreover, these kinds of findings could dramatically affect the role of the various mental

health professions'. Since the summary studies in 2001, evidence has continued to accumulate. These conclusions, are very pertinent to recent budget proposals with regard to the cost of mental health services in Australia, and should lead to greater recognition and employment for those with human services and community services training.

Purposes of this paper

The purposes of this paper, therefore, are to

1. Examine recent relevant studies regarding the influence of length of training on the effectiveness of psychotherapy
2. Provide a very brief critical summary of the 40 years of studies and meta-analysis of this issue, in order to review its context
3. Suggest possible reasons for the apparently counter-intuitive results
4. Discuss implications for current and future policy and funding regarding mental health policy, and
5. Suggest possible reasons for the apparent lack of attention to these results by mainstream researchers and by mental health policy

Methodology

A summary of studies and meta-analyses up until 2001 was undertaken, largely using the special issue of the journal *The Australian Psychologist* appearing in July that year. Original sources were consulted for most of these and for previous relevant journal articles. Some suggestions and limited critical comment are offered at this stage regarding some aspects.

Since 2001, a number of journals relevant to training, research and outcomes in psychotherapy and counselling have been accessed on line, using the perusal of individual issues of each journal, usually commencing at the beginning of 2005. Where necessary hard copies were retrieved from the University of Melbourne and other libraries in Melbourne. Time constraints meant that earlier issues could not be systematically scanned for relevance, but were individually consulted where articles in later issues referred to them. This search method was found to be superior to use of keywords in large databases, since the results were often voluminous (1500 + entries), and the prioritising mechanism was ineffective.

Clarification of concepts and definitions

Confusion over the concepts and definitions used in the literature interfered from the start with the proper examination of the issues, and limitations in scope had to be imposed (such as omission of much attention to length of experience) to reduce the work load and length of this article. Some attempt is now made at some important clarifications.

Psychotherapy and Counselling

Discussion both in Australia and overseas has focussed at times on the distinction (or not) between 'psychotherapy' and 'counselling'; and sometimes this includes overlaps with 'clinical psychology', 'therapy', 'psychiatry', and 'psychoanalysis' (Kanellakis and D'Aubyn 2010). The Psychotherapy and Counselling Federation of Australia (PACFA) suggests there is considerable overlap between the first two, but also recognises a focus of counselling to be more upon problem specific and life adjustment issues, while psychotherapy is more concerned with the restructuring of the personality or self (PACFA 2011). Schofield (2008) suggests that greater flexibility will be used in future with regard to these titles, as illustrated by the addition in 2000 of 'Psychotherapy' to the title of the association relevant to counselling in the UK, now the British Association for Counselling and Psychotherapy. The situation in the UK and in Europe seems to be in rapid change however (Mace, Rowlands, Evans, Schroder and Halstead 2009), and there are some who seem to bemoan the lack of a 'psychotherapy profession' which would override the separate therapeutic professions' concerns for market-share, and the pre-occupation 'to protect and enhance the economic interests and influence of their members' (Orlinsky 2009: 190). Abbott (1995) offers a similar trenchant criticism of social work.

There have been attempts (in Europe especially) to provide a definition of 'psychotherapy' which would be accepted as an over-arching profession for this form of intensive interpersonal helping, but without much success (Ginger 2009, Mace et al 2009). In fact the theoretical and 'political' stances taken by various associations in different countries seem to make the quest impractical (Ginger 2009, Mace 2009, Orlinsky 2009).

Ginger (2009) summarises the efforts by the European Association for Psychotherapy (EAP) to provide a private standardising body for psychotherapists. The EAP estimates there may be up to 120,000 professional psychotherapists in practice. The EAP has issued 5,500 European Certificates in Psychotherapy (ECP) in over 40 countries since 1991. To be eligible for the ECP, a three year degree in social science must be followed by a (usually part-time) four year qualification in a specialised psychotherapy modality qualification, and accredited by the EAP. No European government has provided official recognition of this endeavour, however, and Ginger agrees that political acceptance is a long way off.

‘Counselling’ can also be seen as a more generic term, of course, embracing specialities in such areas as employment and careers, rehabilitation, finances, pastoral work, etc.. Within this paper I am unable to address such issues further, and I must settle for an inadequate single term. Somewhat arbitrarily, I will use ‘psychotherapy’ as a generic term for all such practice.

Relationship between psychotherapy and other disciplines and professions

Many helping professions and occupations include psychotherapy (or ‘counselling’) of some sort in practice and in training. Nurses in Australia have had psychotherapy as part of their degree courses. Some professions have changed or narrowed their practice focus quite markedly within some contexts. Social work in the USA at the masters degree level has concentrated very much upon private fee-for-service.

‘Professionals’, paraprofessionals’ and human services work, community services/welfare work, etc.

This paper will not deal with definitions of a profession, although much of it will focus upon the (inappropriate) use of the term ‘paraprofessionals’ in some research. Many writers (see e.g. Mehr 1998, Neukrug 2000) prefer the term ‘entry-level profession’ or ‘beginning level professional’, supported by arguments about the true nature of professions being concerned with ethical services to clients. It is remarkable that in comparing psychiatry to psychotherapy, Ikkos and Mace (2009) emphasise the complex and fluid nature of professionalism, with a commitment to competence, integrity, morality, the promotion of the public good, and obligations to other professionals and to carers being prominent. Apart from a passing reference to written standards, training and its length is not mentioned at all. Perhaps within the medical context of psychiatry, lengthy training is just taken for granted.

The term ‘paraprofessionals’ is usually used in research studies from the USA to describe anyone without a professional qualification in psychotherapy, with a masters degree usually being designated the minimum ‘professional’ qualification. The kinds of qualification (and experience) which are included as ‘paraprofessional’ are the subject of substantial criticism, to be dealt with more fully below, but initially it should be noted that the use of the term is disputed by most of those to whom it is applied, including those within the long-standing Human Services profession in the USA (Mehr 1998), and various terms are used in Australia to cover the same occupational territory. ‘Human Services’ as a working discipline is not used much in Australia, but it has been used in the titles of some degree qualifications in this field (Murray 2007). The more generic terms used in Australia are ‘community services worker’, ‘community welfare worker’, ‘welfare worker’, ‘social and community services worker’, (Murray 2007). Also often included are somewhat more specialised occupations, such as youth worker, community development worker, aged care and disability care worker, but a large variety of lesser known and lesser trained occupations are also seen as part of the ‘social and community services industry’, with training mainly occurring via competency based

packages, within the VET sector at TAFE and private colleges, or within the workplace. Virtually all these courses at Certificate II level and above have some training in supportive counselling, involving role plays, videos, and group discussion and guidance.

Unfortunately, there is no well-acknowledged single generic term for these occupations and professions within Australia, and this seems to apply also to the UK and the rest of Europe, where the situation is complicated by the profession usually being translated as ‘social pedagogy’. This discipline has great overlaps with social work and community services work but includes the practice of psychotherapy. The overall situation therefore seems to mirror the lack of an over-arching term for the profession of psychotherapy.

I am similarly constrained to use the unsatisfactory term ‘paraprofessionals’ at relevant points in this paper, when the focus is upon research findings, even though I reject its implied meaning of ‘anti’ or ‘less than’ professional. A satisfactory term for workers who are not recognised as ‘professional, fully trained psychotherapists’ is still hard to find. It needs to be more neutral than ‘paraprofessional’ but still generic and inclusive of all those covered by the relevant research findings. The ‘lesser trained’, ‘low intensity’ psychotherapy (Orlinsky 2009), those with ‘limited training’ (Armstrong 2010), and the ‘minimally trained’ have each been used by some researchers, along with ‘paraprofessional’. I have chosen to use ‘limited training’ as the preferred term. What becomes significant in the discussion below, is a refined meaning attached to ‘limited’, ‘lesser’, and ‘minimal’ - just how minimal is minimal?

History of research studies

Findings about the relative lack of effectiveness of highly trained professional psychotherapists have been around for a long time. One of the earliest studies (Truax 1969) found that ‘non-professionals’ with 100 hours of counselling training performed only slightly less effectively than professionals, and considerably more effectively than clinical psychology graduate students, when dealing with 150 patients in hospital due to chronic schizophrenia. Earlier, Truax and Carkhuff (1967) stated that academic training at an advanced level actually correlated negatively with therapeutic effectiveness, and similar findings have been made since then, including the summary by Miller et al (2004) that at worst, the results of studies indicate that increases in training for most therapists actually decrease therapeutic effectiveness.

Following this controversial beginning, there were major reviews of studies of this issue by Durlak (1979), Hattie, Sharpley and Rogers (1984), Berman and Norton (1985), Stein and Lambert (1984 and 1995), Dush, Hirt and Schroeder (1989), Weisz, Weiss, Han, Granger and Morton (1995), culminating in a special issue of the *Australian Psychologist* in July 2001,

which included a comprehensive review of the previous reviews, entitled 'Is Professional Training Worth the Bother? A Review of the Impact of Psychotherapy Training on Client Outcome' (Atkins and Christensen, 2001). This article also included detailed summaries of significant criticism of the previous reviews, especially those offered by Nietzel and Fisher (1981) and by Berman and Norton (1985).

There can be no attempt here to provide an overview of all these articles and the sometimes fierce debates which broke out following the Durlak (1979) review - see instead the comprehensive analysis by Atkin and Christensen (2001) and other articles in the *Australian Psychologist* special issue (July 2001). However, some major conclusions stand out, despite methodological and statistical criticisms. Durlak (1979: 85) concluded that 'the central finding from these comparative studies is that the clinical outcomes that paraprofessionals achieve are equal to or significantly better than those obtained by professionals'. After criticism by Nietzel and Fisher (1981) - see below - Hattie, Sharpley and Rogers (1984) re-analysed the data in the studies using meta-analysis, including four additional recent studies, and concluded that 'paraprofessionals are at least as effective, and in many instances more effective, than professional counselors' (Hattie, Sharpley and Rogers 1984: 540). Berman and Norton (1985) were themselves critical of the Hattie et al (1984) studies and attempted to re-examine the studies using new methodology and statistical treatment, but found that neither paraprofessionals nor professionals displayed an advantage at the end of treatment or at follow up. They did find that professionals had better outcomes for brief therapy (up to 4 weeks duration), whereas paraprofessionals had better outcomes for longer treatment (over at least 12 weeks duration). Nonetheless, they concluded that trained and untrained therapists achieve comparable levels of improvement for different types of problems, treatments, and outcome measures (Berman and Norton 1985: 405).

Dush et al (1989) reviewed studies oriented to cognitive therapy, and found that those therapists with doctoral level training were linked to outcomes which were over seven times greater than therapists without graduate training. And yet Beutler and Kendall (1995) found that research evidence was not consistently supportive of the value of professional training, and some reviewers have concluded there is little correlation between levels of training and clinical efficacy. And Weisz et al (1995) did not find evidence for the effects of professional training for psychotherapists dealing with children and adolescents, although paraprofessionals seemed to have greater success with younger children, and overall paraprofessionals had better outcomes than graduate students or professional therapists.

The later review of 36 studies by Stein and Lambert (1995) offers perhaps the most unequivocal attempt at countering the main contention in this paper. Both client satisfaction and measures of outcomes favoured professionals, when fully assessed at the end of therapy, although when only measures completed by therapists at the end of therapy were reported,

there was no effect reported for training. (Nonetheless, this Stein and Lambert review has also been used to show evidence that non-psychological based health professionals (such as GPs and social workers) are able to deliver mental health treatment effectively (Richards, 2001). But Stein and Lambert (1995: 192) do conclude that 'it is clear that a modest but fairly consistent treatment effect size is associated with training level for a number of measures of client improvement'.

Since this Stein and Lambert (1995) review is the most quoted in rebutting these contentions (see, e.g. Helmes and Wilmoth 2002), it may be worthwhile examining the findings in more detail. Many of the studies surveyed compared professionally trained psychotherapists with other professionally trained ones, but at differing levels and duration of training; for example, those at masters degree level compared to those with PhDs, or interns at PhD level compared with experienced staff with PhDs. If quite small differences between those at PhD level (experienced therapists vs interns) found that length of training *did* indeed make a difference in outcomes, this could be seen as having little relevance to more general comparisons between professionals and so-called paraprofessionals, when the gap was much wider, and yet the paraprofessionals did just as well.

In fact, eight of the studies exhibited such a gap, involving those with BAs or less, and five of these found that the lesser trained had results as good or better than those with clinical PhDs with whom they were compared. Two of the other studies dealt with weight reduction and anticipatory nausea respectively, and therefore are more oriented to physical-based problems rather than those very often encountered in psychotherapy. The remaining study (of these eight) found higher drop-out rates for nurses, teachers, and other paraprofessionals, compared with psychologists and MA-level social workers. About half of the 36 studies were conducted at university counselling centres, with close supervision usually provided, which may have influenced results in sometimes unclear ways. In addition, almost all studies used extensively manualised treatments, with a likely inhibiting effect upon the working alliance development and maintenance. There was 'a tendency for therapists to become less approving and supportive, less optimistic, and more authoritative and defensive' (Stein and Lambert 1995: 194), and while more intellectually aware of the important processes within therapeutic sessions, they were actually providing a dose of 'disaffiliative communications' (Henry et al 1993).

Some other studies surveyed by Stein and Lambert found higher drop-out rates for the lesser trained, but they also report a meta-analysis of 125 studies by Wierbicki and Petri (1993, as cited in Stein and Lambert, 1995: 185) which found 'no correlation between dropping out and either years of experience or professional degree category,' and Stein and Lambert admit the significance of drop-out rates is itself unclear (Stein and Lambert, 1995: 193). They also speculate that a study which found better satisfaction ratings for first-year students than for

second-year students of family therapy may be because of ‘therapists’ growing preoccupation with therapy models and ‘technique’ at the expense of personal attributes such as warmth, spontaneity, etc.’ Stein and Lambert, 1995: 193).

Stein and Lambert (1995: 194) conclude that despite the supposedly ‘stronger (albeit indirect) evidence of the value of graduate training, given the enormous national investment ... it is quite remarkable that more compelling evidence is not available that demonstrates that graduate training directly relates to enhanced therapy outcomes.’ The more detailed analysis of their review undertaken above would seem to undermine their general conclusion about indirect positive evidence for training, as this applies to ‘paraprofessionals’ at least, and reinforces the view that the less intense concerns with theory and rigid scientific correlates of practice, and the more empathic, spontaneous, pragmatic and generic approach usually attributed to paraprofessionals and human services workers, explain their equivalent or superior outcomes with clients. The Therapeutic (or Working) Alliance may be the mechanism involved, as further examined below.

Main Findings from 2001

Therapeutic alliance

The Therapeutic Alliance between client and therapist (also known as the Working Alliance) has long been acknowledged as a crucial factor in determining outcomes in psychotherapy. The results of early studies by Horvath and Symonds (1991) and Orlinsky, Grawe and Parks (1994) (both as cited in Andrews 2001: 108) were confirmed by the summary handbook ‘What Works for Whom’ by Roth and Fonagy (2006), and Martin, Garske and Davis (2000). Up to 30% of the variance in outcomes is associated with the quality of the therapeutic alliance (Asay and Lambert, 1999). Andrews (2001) also points out that studies in the early 1990s associated with the National Institute of Mental Health Treatment of Depression Collaborative Research Program (TDCRP) had suggested the client’s perception of the therapist was crucial to the development of the therapeutic alliance.

One of the most ardent recent supporters of the importance of the therapeutic alliance is probably Barry Duncan (2010), who quotes its conceptualization by Hatcher and Barends (2006) as an all-encompassing framework for psychotherapy, transcending any specific therapist behaviour, and incorporating empathy and unconditional positive regard (Norcross 2010, as cited in Duncan 2010). Recent major studies include over 1000 findings supporting the association between a strong therapeutic alliance and positive outcome (Orlinsky, Ronnestad and Willutzki, 2004; see also Baldwin, Wampold and Imel, 2009; Anker, Owen, Duncan, and Sparks, 2010. Duncan (2010) concludes that the alliance is a force for change in itself, not merely a result of client improvement.

Despite this accumulation of evidence, at least one writer has been recently critical of several aspects of research on these alliance issues. Mick Cooper (2010) draws attention to the contention by Beutler et al (2004) that only 7-17% of the variance is attributable to the quality of the therapeutic relationship. For example, recent Swedish research revealed that about 15% of the variance in outcome correlated with the measures of the therapeutic alliance, but the writers still considered these results significant (Johannsson and Jansson, 2010). Cooper also mentions that the contribution of the client's perception of the therapist is probably the most important aspect of the relationship, and that the relative success of internet-based therapy and self-help manuals (Richards 2001) challenges the assumption that the therapeutic alliance need necessarily be person-to-person, at least for types of specialized stress. Kilfedder et al (2010) found that although patients preferred face-to-face counselling, outcomes for this, for telephone counselling, and for self-guided reading of a 176 page workbook, were equally effective regarding occupational stress management. In an earlier study, therapeutic alliance ratings were similar for email-based therapy compared to face-to-face therapy (Reynolds, D'Arcy, Stiles and Grohol 2006).

These objections aside, there seems to be growing evidence that the main findings regarding effectiveness of paraprofessionals compared to professionals are largely due to the quality of the therapeutic alliance. As early as 1979, the greater warmth and optimism of paraprofessionals has been suggested as a primary reason for this equivalence (Strupp and Hadley 1979, as cited by Atkins and Christensen 2001). Similarly, Thompson (1983) found a non-significant trend for paraprofessionals to exhibit greater warmth and empathy, and Atkins and Christensen (2001: 129) later speculate that 'if untrained paraprofessionals chosen for their warmth and empathy can generate client improvement as great as that obtained by trained professionals, the mechanism of change may be core, nonspecific conditions provided by therapists'. Such nonspecific or 'common factors' remained vague and relatively ignored for many years, and only in the last decade or so have they tended to gel into a focus on the therapeutic alliance. (A very recent study did re-confirm that only about 17% of interventions in both psychoanalytic and cognitive treatment were interventions specific to their respective theoretical frameworks (Roussos, Waizmann and Echbarne 2010)).

Unfortunately, it seems that efforts to train psychotherapists (over a one year clinical trial) in using the therapeutic relationship were not successful (Horvath 2001). 'The training not only failed to improve therapy outcome, but therapists' alliance also did not improve significantly as a result of intensive training' (Horvath 2001: 174). While extensive solutions involving student selection and supervision, personal therapy, and separation of research from the teaching of psychotherapy practice have been discussed (Horvath 2001, O'Donovan and Dyck 2001), there seems to be little evidence of these being systematically applied or researched.

As further discussed below, there is still a focus upon linking specific aspects of practice with how suitable they might be for paraprofessionals, in an effort to preserve the 'scientific/medical model' of matching specific conditions/problems with particular lengths (or kinds) of training.

Critique

The main early criticisms of the original findings by Durlak (1979), and later addressed by Hattie et al (1984) came from reviews by Nietzel and Fisher (1981) and Berman and Norton (1985). Nietzel and Fisher were concerned that such aspects as 1) characteristics of therapists (such as age), 2) specific therapies used, and 3) length of treatment, often varied between the two categories (paraprofessionals and professionals) with no attempt to control for these variables. Only 15 of the original 42 studies seemed to survive these confounding factors. More importantly, perhaps, was the confusion about definitions of the two categories, with graduate students considered to be professionals in 25% of the studies (Durlak 1979), but with a large (unspecified) number assumed to have no training in psychotherapy at all. This latter point is further complicated however, by the design of some studies which incorporated within the study sometimes very minimal training in either some form of general treatment (for depression, for example), or in a very specialized technique. In one study, eight therapists were trained 'at a workshop' (Strosahl, Hayes, Bergan and Romano 1998 in Nietzel and Fisher 1981). In another, both categories were trained 'at workshop', using manuals and weekly supervision (Bright, Baker and Neimeyer, 1999 in Nietzel and Fisher 1981).

After discarding the compromised studies, Nietzel and Fisher were left with only five that met methodological quality, but these tended to tentatively favour paraprofessionals, a disturbing result for traditional psychotherapy.

Studies that confounded therapist and type of therapy favoured paraprofessionals (Hattie et al 1984) but this tended to support the criticism by Nietzel and Fisher (1981). Berman and Norton (2005) drew out several other confounding factors, and reinforced the doubtful classifications for both paraprofessionals and professionals. Most studies in the reviews were not designed to investigate directly the relationship between training length and psychotherapy outcomes, and so details about qualifications and length of training for paraprofessionals were not even sought. An unknown number of studies, or even individual 'paraprofessionals' within other studies apparently had no directly relevant training at all, such as the Bright et al (1984) study which recruited paraprofessionals from self-help groups and support groups. Although that study found a trend for professionals to have better outcomes with cognitive-behavioural therapy (CBT), they conclude the two categories did not differ in outcomes using mutual support group therapy, and this mild support for professionals using CBT is supported by some other studies (Richards, 2001). Atkins and

Christensen (2001) comment that mutual support therapy may be well-suited for use by paraprofessionals.

‘What Works for Whom’ seems to have become the main approach to solving the confusion resulting from the surprising findings from 1979 onwards. There can be little doubt that lack of clearly categorised background data for paraprofessionals makes direct comparisons difficult, but it is by no means clear that such unknown variability negates the overall finding that such paraprofessionals obtain outcome results equivalent to or better than professionals, including those with specialised masters or PhD degrees.

Such variability may be illustrated by the case of a university lecturer who may obtain good outcome results after many years of informal counselling of students and consultation with colleagues, while having no formal psychotherapy qualifications himself. But this is no reason to discard such results from consideration, a priori.

Human services work

In contrast, many workers in the USA who would fit the paraprofessionals label used in these research studies, were being trained as Human Services workers, including two year associate degrees commencing in the 1960s, and 4 year Bachelor of Human Services being offered by the 1970s. Over 1000 training programs in human services were offered by 1975 (Mehr, 1998).

The Council for Standards in Human Service Education (CSHSE) has accredited over 100 programs, with most located in the eastern states. Many textbooks have been published to support study in these programs, and the National Organization for Human Services publishes the *Journal of Human Services*, as well as offering the Human Services – Board Certified Practitioner (HS-BCP) [tm] in 2010 (NOHS, 2011). No mention could be found in the reviews or individual studies under consideration for this present review of this entry-level profession of *human services work*, which includes such employment titles as: alcohol and drug abuse counsellor, intake interviewer, residential counsellor, case worker and coordinator, youth worker, crisis intervention counsellor (Mehr 1998, Orlinsky et al 2001: 141). Similar job titles are found among community services/welfare workers in Australia (Murray 2000, Morris 2001), and such workers with two year diplomas and three year degrees in community services/human services often perform the same work, and just as competently, as those with four or more years of training (such as social work) (AIWCW 2010, Murray 2000, Murray 2001). The term ‘human services work’ is little used in Australia, however, and indeed, in the USA ‘the human services movement and profession remain obscure to the general public and the allied professional community’ (Harris 1996: 23). This seems a likely explanation for its neglect in the current debate, but it seems a pity that a potential organising concept and structure is not used to help clarify problems emerging from the lack of background data in reviews involving ‘paraprofessionals’.

Other writers in this field have portrayed a more optimistic and challenging perspective. In a human services textbook, Schmolling et al. (1997: 388) note that ‘the responsibilities, knowledge, training, and competence of generalist human services workers have, from the workers’ point of view, increased to a level comparable to that of traditional professionals,’ and large numbers of the former and even some traditional professionals ‘believe strongly that many generalists outperform traditional professional workers’ The authors go on to suggest that these convictions give rise to strong feelings about the differences in pay, status, responsibilities and opportunities for advancement between human services generalists and traditional professionals.

Conclusions and speculations from the 2001 review in the *Australian Psychologist*

At this point it may be useful to draw attention to some of the statements made by reviewers of the literature, indicating numerous findings of equivalence between paraprofessionals and professionals in the outcomes of psychotherapy. Although many of the statements are cautiously phrased, and with due emphasis on caveats and exceptions, there can be no doubt about their overall significance.

‘The data [from all studies] up to this point have not shown an impact of experience and training in general, as evidenced by a therapist’s degree or years of experience’; and, ‘paraprofessionals have repeatedly demonstrated successful therapeutic change in clients, even when they have received no specific training in therapeutic procedures’ (Atkins and Christensen 2001: 128).

‘If untrained paraprofessionals chosen for their warmth and empathy can generate client improvement as great as that obtained by trained professionals, the mechanism of change may be core, nonspecific conditions provided by therapists’ (Atkins and Christensen 2001: 129).

For one methodologically rigorous study by Thompson, Gallagher, Nies and Epstein in 1983 (as cited in Atkins and Christensen, 2001) Atkins and Christensen (2001: 127) report ‘Overall, the results support previous findings about the efficacy of paraprofessionals’, while also recognizing that professionals had better success when assessed on some sub-scales of life satisfaction. Other studies have ‘found advantage ... in client retention, longer lasting effects, or greater impact on clients’ total functioning’ by professionals (Atkins and Christensen 2001: 128), and they hope that further research will find conditions which will suit each category of practitioners.

Atkins and Christensen (2001: 129) conclude that 'If doctoral-level training – or even masters-level training – is unnecessary for effective mental health service delivery for particular disorders, then services can be provided at lower cost. Moreover, these kind of findings could dramatically affect the role of the various mental health professions'. The emphasis on 'particular disorders' throughout discussion could be seen as a 'confounding factor' to the overall conclusions as quoted above.

Other articles in the special edition of *The Australian Psychologist* (2001) add further support. In the article by Henry Andrews (2001) *Back to Basics: Psychotherapy Is an Interpersonal Process* he claims that *only two studies show any training effects at all*. In one, traditional professionals were better with two specific types of child difficulties (Weisz, Weiss, Han, Granger, and Morton, 1995, as cited by Andrews, 2001), although according to Atkins and Christensen (2001: 124) Weisz et al. found paraprofessionals had better overall outcomes than graduate students or professional therapists. The other study was the Stein and Lambert (1995) review, already critically discussed above. Although acknowledging that one or two studies show more enduring effects from more highly trained therapists when they used a specific therapeutic system, Andrews concludes that:

'In general, paraprofessionals were as effective as doctoral-level psychologists' (Andrews 2001: 111), and 'apparently, many paraprofessionals can assist clients in an effective change process despite the absence of lengthy academic or clinical training' (Andrews 2001: 112). Earlier, Andrews (2000: 80) had stated that 'Scientist-practitioner psychologists have failed to demonstrate any outcome superiority compared with other professionals or paraprofessionals'.

Atkins and Christensen (2001: 123) acknowledge that earlier findings by Berman and Norton (1985) were difficult to believe for those who encountered them. They ask how it could be that those with no training could obtain similar results to those who had spent many years in acquiring skills as a psychotherapist.

In a comment on the debate, O'Donovan and Dyck (2002) mention that in the absence of any clear evidence for the overall effectiveness of training, any push for an increase in training length seems motivated mainly by maintaining and increasing the status and prestige of the psychology profession. They even question whether the profession of psychology deserves to be enhanced, in part because duration of education is confounded with quality of education.

New Findings (since 2002)

In the UK, various treatment and supportive programs have been recently set up which make use of those with 'minimal' training, and in some cases these workers have been compared with those with more training. One such study (Farrand, Confue, Byng and Shaw 2009) used 'guided self-help clinics, supported by paraprofessional mental health workers. This was found to be just as effective as when supported by an experienced mental health nurse – presumably identifiable as 'a professional'. In this comparison, the patients themselves conducted the 'treatment', and the comparison is with the nature of the supportive workers, with both groups having positive results.

The Leicester Counselling Centre is a typical generic, countywide, not-for-profit agency. It has provided one-to-one psychotherapeutic counselling for 25 years, offering weekly, hour long sessions for up to two years, hence helping to fill the gap between demands for psychotherapy from the UK National Health Service (NHS) and its supply (Moore, 2006). Over 70 volunteer counsellors were all provided with regular clinical supervision. Most referrals are made by NHS staff -- mainly GPs but also others such as psychiatrists, psychiatric nurses.

Some 45% of volunteer counsellors had previously completed certificates in counselling, and over two thirds had later achieved a diploma in counselling, with 6% having a masters degree in counselling. Many of them also had degrees or other qualifications, including teaching, nursing, or social work.

The outcomes for volunteer counsellors, using both therapist and client completed assessments, compared favourably with the Clinical Outcomes in Routine Evaluation System (CORE), a benchmark widely used for monitoring psychotherapy services across the UK. The study concludes that the kinds of services provided at Leicester were as complex, and just as effective as those provided by more formal psychotherapeutic services. These results counter the apparently widespread perception that only 'tea and sympathy' is offered to the 'worried well' at such facilities (Moore 2006: 221), and suggest that such voluntary staffed programs could be used more extensively and with confidence.

Although no direct comparison of length of training is possible from this study, those with only diploma qualifications perform as well as professionally recognized psychotherapists, and therefore the results tend to reinforce the contention in this paper that the lesser trained are as competent as those with much more extensive training.

As part of a special issue of the *European Journal of Psychotherapy and Counselling* in June 2009, Michael Rustin (2009) comments upon the article by Mace, Rowland and Evans (2009), pointing out that government experience with social work and teaching has raised

cautions about regulation, certification, and control as manifest in stringent curriculum prescription and assessment. He claims it was then not obvious that such centrally coordinated systems were superior to oversight by professional associations and occupational cultures. Other articles in this issue (e.g. Orlinsky 2009) together with the accumulated evidence in this paper that the lesser trained are just as effective as the highly trained, even for severe depression, raise doubts as to why there is a need for the IAPT (Improving Access to Psychological Therapies) two fold approach to therapy, based upon differences in intensity of therapy.

In a recent article, Cooper (2010) has asserted that there is little evidence to suggest that any particular type of personality or demographic characteristics are related to outcomes, and outcomes also do not appear strongly related to therapists' level of training, the amount of supervision they receive, and their personal development. Cooper believes that the quality of the therapeutic relationship is the main curative agent in psychotherapy, but he also offers challenges to this belief, as outlined above.

Another UK study (Buckley, Newman, Kellett and Beail, 2006) compared 60 clients treated by qualified and experienced clinical psychologists, with 60 treated by trainees (interns) at the same community based clinical psychology and health facility. Trainees had at least 90 minutes of supervision per week from a clinical psychologist with at least 2 years post-graduate experience. No significant difference was found between the two types of trainers when differences between pre and post clinical assessments were compared, and that less than 2% of variability in the outcome difference scores was linked to type of clinician (post-graduate vs trainee). Measures of clinical caseness, or meeting the criteria for a condition, showed the same lack of difference between the two types.

The authors conclude that the results 'appear to illustrate the relative clinical effectiveness of clinical psychology trainees' (Buckley et al 2006: 142), confirming early findings which tended to find no difference in outcomes between treatment by trained and untrained practitioners. However, they point out that the trainees in this study were matched by supervisors to suitable clients, with clients with 'enduring interpersonal problems' likely to be excluded. In addition, the trainees received intensive and formal supervision, as well as informal consultations with experienced staff and colleagues. The lack of follow-up assessment was unfortunate, and doubts about differences in experience, and overlaps between experience, expertise, and length of training, each illustrated limitations to the study. Buckley et al (2006) do recognize that the results could be used to support the importance of the therapeutic alliance. But they seem to suggest that the apparent equivalence of trainees with post-graduate psychotherapists can be accounted for by the amount and quality of supervision available to such trainees. It seems to this writer that while such factors must have some influence, not all the lack of difference in outcomes can be explained in this way.

In a study of outcomes in treatment of depression (Corney and Simpson 2005), those patients referred to eight highly trained counsellors (accredited by the British Association for Counselling and Psychotherapy) were compared with a control group receiving 'treatment as usual' from GPs, within nine practices in Derbyshire, over an average of six sessions per patient. The experimental group also continued to see their GPs, and about 25% of both groups took medication prescribed by GPs. There was significant improvement in both experimental and control groups in a 6 month follow up, but not between 6 months and a follow up at 12 months, and after 36 months the number of cases of clinical depression was very similar to the entry scores, on at least one measure. However, Corney and Simpson (2005: 138) found that 'at the 6-, 12-, and 36-month follow-up, there were no significant differences between the experimental and control groups on any of the outcome measures'. Severity of depression at initial assessment did not affect these overall results.

Although obviously not generally included as 'paraprofessionals', GPs in this study could be said to operate as such, when compared with the specialist psychotherapists in the experimental group, and so these findings can be said to support the contention that the lesser trained GPs (i.e., in psychotherapy/counselling) are just as effective as the professionally trained. The authors point out that treatment offered by GPs would differ considerably, but information was not available on just how much additional training participating GPs had in some form of counselling.

There have recently been much more comprehensive surveys of psychotherapy outcomes involving thousands of clients and hundreds of therapists, based upon Lambert's research group in the USA. As reported by Pilling (2008), a study by Brown, Lambert, Jones, and Minami (2005) found that the most effective 25% of therapists involved with over 1000 patients, had general improvement of 53%, which could not be related to diagnosis, length of treatment, or therapist training/experience. Another large study found that 7,500 patients seen by 149 therapists had over 100% better recovery rates (Okiishi, Lambert, Eggert, Nilesen and Dayton (2006) from the 25% most effective therapists. While attempting to develop clinical guidelines for various situations, these studies have highlighted the issue of therapist competence. But this concept has been subject to uncertainty and criticism, and the whole 'competency movement' was originally rejected by universities and some professions, when introduced to the Vocational, Educational and Training Sector (VET) in the late 1980s. More recently, government authorities in Australia have encouraged (or required) counselling competencies within relevant VET courses, including family mediation qualifications (King, O'Brien and Schofield 2008: 10).

Orlinsky (2009) has analysed results from a number of wide ranging studies focusing upon the effect of the therapist's professional discipline. Lorentzen, Ronnestad and Orlinsky (2008) (as cited in Orlinsky 2009) found that less than 1% of variance on the main effect could be

accounted for by professional discipline, in a study involving over 2500 psychotherapists. He surmises that these, (and other studies over a 60 year period of research), indicate it makes little difference in practice what kind of academic degree the therapist has obtained in order to be qualified to practice. He suggests that those trained in each of the traditional disciplines (such as medicine, social work, and psychology) may make important distinct contributions to their abilities to practice effectively, but equally each discipline might distort the overall effectiveness because of theoretical preferences inherent in their discipline. Orlinsky (2009) does not deal directly with the length of training in this article, and one cannot assume that length of training is directly linked to academic or professional discipline. However, it does seem reasonable to assume there will be some significant overlap. He notes that the well-respected *Bergin and Garfield Handbook of Psychotherapy and Behaviour Change* (5th edition) (Beutler et al 2004) remarked that few reviews found important direct effects of either professional discipline or amount of training on outcome, but that the type and amount of training confound the results in most studies.

The apparent primacy of non-specific, common factors over claims that any one treatment is better than any other, has been discussed since the 1930s, but by now is almost seen as an accepted truth by some writers (Duncan 2001, Miller et al 2004). This is the so-called ‘dodo effect’, named after the bird in *Alice in Wonderland*, who proclaimed that all had won a race and therefore all should get prizes. Beutler (2002) countered this conclusion, and studies by Benish, Imel and Wampold (2008) and Bisson, Elhers, Pilling, Turner, Matthews and Richards (2007) reach different conclusions about the issue, which cannot be further pursued here. However these studies do not seem to directly address the length of training issue, except perhaps for the assumption by Benish et al (2008) that a competent therapist held a masters level or equivalent qualification.

Somewhat earlier, a rather personal review and earnest reflection was published in *Psychotherapy in Australia* (Miller 2004). A shared taxi ride with those who had attended a presentation of a ‘new’ approach to PTSD sent Miller into despair, since it reinforced his growing perception that psychotherapy involved merely ‘a never ending list of ephemeral fads applied to unspecified problems with unpredictable outcomes for which rigorous training was required’ (Miller 2004: 45), and which ignored the accumulated research over many years. He characterized this internal crisis as a loss of faith in psychotherapy, although a year or so later he replaced this with ‘my faith was misplaced from the outset’ (Miller 2004: 51). Research had overturned his belief that favourable outcomes were the result of applying the right techniques and approaches to particular clients, and this was informed by ‘other studies showing little or no effect for training or experience on treatment outcome’ Miller 2004: 48). He ruefully pointed out that several reviews in 1992 of a well known clinic had discovered the most effective therapists were in fact graduate students! Later studies by Miller and his colleagues (Hubble, Duncan and Miller 1999; Miller, Duncan and Hubble 2004) found

significant differences in therapeutic outcome among psychotherapists with the same economic and cultural backgrounds, and the same level (length) of training. Despite intensive analysis of the data, no explanation for these results could be found. However, they were able to develop a simple within-session feedback mechanism, leading to an improvement in outcomes of 60% over a 6 month period, and refinements to this process have provided some hope for an eventual way through the morass of claims and counter-claims for the effectiveness of particular therapeutic approaches. Other researchers have found similar results (Ankar, Duncan and Sparks 2009, Robinson (2011).

Most of the studies mentioned above in the update of findings since 2002 have not directly addressed the relationship between length of training and outcomes of psychotherapy. Armstrong (2010) points out that the majority of studies were conducted in the 1970s and 1980s. They provoked great controversy, but new research on the issue was then sparse over the last two decades. Armstrong notes methodological criticisms of the original meta-analyses, and also the caveats and exceptional findings. For example, outcomes for paraprofessionals were better with longer duration treatment, but professionals achieved better outcomes with short duration therapy (Berman and Norton, 1985). But he also notes the later conclusions from the extensive review by Atkins and Christensen (2001) and a more recent one by den Boer, Wiersma, Russo and van den Bosch (2005) that ‘professional training and experience appear to contribute little to therapist effectiveness’ (Armstrong 2010: 23).

In a study of 118 clients using a voluntary agency in Scotland, Armstrong (2010) compared the effectiveness of minimally trained voluntary counsellors as measured by the Clinical Outcomes in Routine Evaluation Outcome Measures system (CORE-OM), with a benchmark established by the results of three studies examining professional psychotherapy in NHS primary care settings, and also using the CORE-OM. Although no details of level or length of training for the professionals were available, it was assumed these were fully trained professional counsellors, able to work as primary care counsellors, and requiring at least 450 hours of training (Bond 2002, cited in Armstrong 2010).

Results of the study indicated that professionals achieved about twice the effect attained by volunteer counsellors, and Armstrong (2010) suggests this challenges the general finding that paraprofessionals can achieve similar outcomes to professional psychotherapists. He is aware of the limitations to the study, especially regarding the use of benchmarks and the lack of data about the length of training of the professionals used as benchmarks. Other studies have indicated paraprofessionals are better at longer duration therapy, and since the average number of sessions in this study was only 4.6, then this might account for the relatively poor outcomes from paraprofessionals. Also, all of the 12 volunteer counsellors were trained in a 40-hour, highly structured solution-focused approach, and a rigid adherence to this may have compromised their effectiveness.

The strength of the therapeutic alliance has been shown to be an important factor in the effectiveness of psychotherapy, but in this study it seems the counselor was not given much of an opportunity to establish it. A more important criticism hinges on the meaning attached to 'minimally trained'. Although five volunteer counsellors (out of the 12) had certificate qualifications in counselling as well as the 40 hours of training provided by the agency, the amount of training was very minimal indeed. Some of the earlier summaries by Durlak (1979) and Atkins and Christensen (2001) have mentioned individual studies showed the effectiveness of those with similar very few hours of training (or no training at all), when compared with therapists with clinical masters or PhD qualifications. But whether the study by Armstrong (2010) could be said to counter these findings is doubtful, in view of the limitations of his study. Another possibly confounding factor is the definition of a 'professional qualification in counselling/psychotherapy (i.e. a diploma/masters degree)' adopted by Armstrong (2010: 23). A diploma qualification, even if preceded by a social science (etc) degree, and with only 450 hours of training (Bond 2002, as cited by Armstrong 2010) may still be seen as 'minimal', especially compared with the USA research which usually specifies at least a clinical masters degree as the minimum for a professional qualification.

This rare effort to offer a direct challenge to the accumulated research (and the thrust of this paper) on this issue of length of training compared to treatment outcome, seems to be basically flawed, mainly because of confusion about the very low levels of minimal training used for paraprofessionals, and the unknown but possibly also minimal levels assigned to professional psychotherapy. A more useful comparison might be between those with training over about two years (full-time) at diploma level (with or without a prior degree), and those with at least a specialized masters degree in psychotherapy, over at least five years duration.

In the most recent review of research evidence explored, there emerges a study by Nyman, Nafziger and Smith (2010) and summarized by Duncan (2010) as finding that it did not effect the outcome if the client was seen by a licensed doctoral-level counselor, a pre-doctoral intern, or a practicum student. (Duncan also maintains that experience does not seem to matter much, either, but this extension of the issue cannot be pursued in this paper). Training sites are often located at student mental health clinics within universities, with advantages of low costs to clients and closely supervised training for psychotherapists (Nyman et al 2010). Some training sites have adopted a multi-tiered approach to training, with licensed professional staff supervising pre-doctoral interns, who themselves supervised practicum students. The study by Nyman et al (2010) used the College Adjustment Scales, and the Outcome Questionnaire (as described by Nyman et al 2010) to examine whether improvement occurred in outcomes, regardless of counselor training level, and discovered that 'Clients in this study showed evidence of improvements in psychological functioning that were independent of the training level of their counselor' (Nyman et al 2010: 206). For both mean score data, and comparisons

of categories of client outcome (recovered, improved, deteriorated and unchanged), there were no differences in client outcomes according to counsellor training level, across a wide range of clinical assessments. In addition, termination rates did not differ, regardless of practitioner level. They caution that client-counsellor relationship factors such as client expectations and trust may mediate client outcomes, and that greater differences in client outcome might emerge if many more than the six sessions of counselling used in the study were used instead. (However, as already mentioned, some studies which did find outcome differences favoured those with limited training for longer duration treatment (Berman and Norton 1985).

Nyman and his colleagues reach what might be deemed a devastating conclusion. They begin by bemoaning the dearth of research investigating client outcomes across training levels, but unless they mean just studies relating to the use of trainees, this seems unjustified. There has been extensive attention to the issue over the last 30 years (and including the last decade), much of which is outlined in this paper. They then go on:

It may be that researchers are loathe to face the possibility that the extensive efforts involved in educating graduate students to become licensed professionals results in no observable differences in client outcome. However, in the interest of empirical enquiry, we urge professionals in the field to squarely face the possibility that counsellors-in-training may be as effective with clients as experienced counsellors (Nyman et al 2010: 208).

They also urge professionals to work more systematically to uncover the many moderating and mediating variables associated with client outcome and client-counsellor relationships.

Further Discussion

This final exhortation by Nyman et al (2010) seems to this writer to encapsulate the mainstream response to all of the counter-intuitive findings regarding this issue. Although there are no doubt genuine and valid methodological objections to aspects of the accumulated research, the vast majority of findings seem to confirm their validity, when applied to the real world of clinical practice. But from the early days of attempted refutation of the findings, the solution seems to have been to increase research efforts to delineate the kinds of clients, and/or the kinds of treatments, which are 'suitable' for those with limited training (i.e. 'paraprofessionals') to handle, rather than admitting their outcomes seem to apply regardless of the treatment methods employed, the diagnosis, and the severity of client affliction. In recognizing that the so-called 'common factors' are likely to be crucial to the surprising effectiveness of paraprofessionals, the earlier researchers tried to tease out and understand the most important of these, so that they could be used to enhance training of paraprofessionals

and further refine the kinds of clients and work suitable to them. Although still somewhat controversial (see Cooper 2010, Beutler 2002) the nature and strength of the therapeutic alliance seemed to be confirmed (by, for example, Duncan 2010) as the most important of these common factors, and was closely associated with positive outcomes in therapy. The motivation and expectations of the client are also seen as important, and contributing to the therapeutic alliance. Other client-oriented factors are the wider psycho-social situation of each client, such as unemployment, poverty, family disturbance and the like, traditionally part of the social work approach to psychotherapy for very many years.

As well as client factors, allegiance factors – the confidence therapists have in their chosen therapeutic modality – may be important (Robinson 2011). Such psychotherapists find confirmation in the sophistication, depth and comprehensiveness of the theoretical underpinnings, and the sense of integration of client assessment, theory, techniques, and a sense that they (therapists) have a reasonably clear understanding of where and how to go in therapy. (Even ‘faith’ gets a mention by some writers (Edwards, 2004)). While comforting, this self-assessment may have little to do with the reality, and most of the outcome success they encounter may be simply due to the mysterious mechanisms of the therapeutic alliance and other non-specific or ‘common’ factors (Personal communications, P. Langford; M, Safran 1996).

This kind of intensive, reflective approach seems to be behind the concept of *Healing Involvement* promoted by Duncan (2010) in supporting the work of Orlinsky and Ronnestad (2005), which had examined accounts of over 5000 psychotherapists as to how they developed professionally. The main components were the sense of theoretical breadth in the developing psychotherapist, a sense of career development, and the therapist’s sense of currently experienced growth. While providing a useful description of the progress of professional development in psychotherapy, the concept of Healing Involvement seems rather subjective, and the research conclusions showing effectiveness of those with limited training (or experience) do not seem to be dealt with.

Another practice-linked approach to why some psychotherapists developed superior expertise has used research from outside disciplines to show that hard work and intensive practice is the key, a process that has been labeled Deliberate Practice by Colvin and others (cited by Robinson 2011). But the detailed attempts by Miller et al (2004) to find some specific factors associated with expertise were unsuccessful, and it seems that at least some of those with limited training have exhibited such expertise. In any case this approach seems to have disadvantages in terms of the amount of motivation and commitment to work that is not inherently enjoyable, and in the short term, is not cost effective (Robinson 2011). The detailed study of how such experts deal with problems, rather like studying the moves of a chess grand-master (Robinson 2011), would also seem to be rather unproductive in general terms.

Other attempts to study 'exceptional helpers' (Edwards 2004), use qualitative methodology to highlight the various meanings attached to this term, and to the historical and social context of psychotherapy. She also praises the use of self-reflection upon the writings of such apparently 'expert' helpers. However one of her respondents uses such reflection to comment: 'If change emerges undirected...if [there is] no formal way of evaluating such changes and no formalized way of achieving them (theory), then our current years of training and hard won theory is useless' (Edwards, 2004: 24).

Attempts to study why the therapeutic alliance is so effective have not been very productive, and some early researchers (Strupp and Binder 1984, cited in Horvath 2001) have found that year long training designed to improve alliance-related skills just did not do so. Motivations for psychotherapists entering training may play a big part, especially where these involve unconscious factors, and/or a 'wounded healer' role (Nielsen 2010).

There have been other attempts to provide 'solutions' to the dilemma, including the systematic within-session feedback approach developed by Miller (2004), Miller, Duncan and Hubble (2004), (see also Anker et al, 2009), as outlined above. This pragmatic approach has had reportedly good results, but tends to side-step the main issue, since this technique seems to be fairly easy to learn and practice, and would not seem to need four to eight years of training at university, supervised by expensive doctoral level psychotherapists.

Hugh Crago (2011) has focused upon the content of training, in his series written for *Psychotherapy in Australia* entitled 'Straight Talk on Training'. He provides a comprehensive and insightful analysis, including ethical and theoretical issues regarding suitability of prospective psychotherapists, and whether selection processes should be paramount, or whether manifestly unsuitable candidates can be dealt with later, at greater cost in time and finances. While not addressing the issue of training length at this stage, his intensive and thoughtful attention to what might improve the process of training will be useful for many.

Accountability by psychotherapeutic service providers and the government bodies that legitimise and fund them has been increasingly important, especially in the current Australian context, where mental health funding has been a priority budget item. Reflecting this, professional accrediting bodies have demanded their members undertake lengthy training, 'although there is limited empirical evidence to strongly support the effectiveness of counselling training in the development of new counsellors' (Grafanaki 2010: 81).

Conclusion

This paper has extensively canvassed the evidence for length of training not being a determinant of outcomes in counselling, when comparing professional and ‘paraprofessional’ therapists. It frequently indicated that it was hard to ascertain exactly what qualifications the ‘paraprofessionals’ had, and most seemed to have little or no qualifications. There were often said to be too many other variables, including differences in experience. Much of the criticism of earlier studies and meta-analyses has focused on the lack of precise data about the length of training (and experience) of paraprofessionals, so that those with six to eight years of clinical experience are compared with those with either 40 hours of training, or those with a three or four year human services degree, or anything in between.

But these supposedly ‘confounding factors’ mentioned by many researchers do not really affect the overall results – that those with briefer training do just as well or better than those with many years of specific psychotherapy training. As Durlak (1979) pointed out in his response to such methodological criticism, the results were consistent, regardless of the quality of the individual studies. Most of the criticism of the findings seems bound to the ‘scientific’ model linking specific conditions with specific treatments, an important aspect of the Medical Model, which has been much criticized recently as being not sufficiently relevant to interpersonal practice.

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Ian Murray was a senior lecturer in human services at Monash University from 1976 to 1998, the national president of AIWCW from 1996 to 1998 and a member of the AIWCW national executive till 2009. He died in July 2011.

Editor's notes:

- 1. Every effort has been made to ensure the accuracy and completeness of the bibliography but the editor takes responsibility for any errors or omissions.*
- 2. Ian's stated intentions on pp 1-2 included discussion of funding and policy implications for mental health and suggestions of 'possible reasons for the apparent lack of attention to these results by mainstream researchers and by mental health policy'. While in the time he had to complete the paper, he managed only to imply the political, governmental, financial, educational and professional changes that would follow if these findings were fully accepted, it was decided by the editor to leave his aims intact to demonstrate the sweep of his intentions.*
- 3. We invite others who would like to formulate a response to Ian's paper, as either a refereed contribution, a note or a personal reflection, to write for the next issue of Practice Reflexions.*

Response to Ian Murray's Paper 'Does the length of training determine the effectiveness of counselling practice?'

SUE BURNEY

JO BROOKER

JANE FLETCHER

First of all we would like to congratulate Ian Murray for raising this important and controversial issue and would like to pass on our sympathies in respect of his death to his family, friends and colleagues. It is a great pity that he was not able to complete his paper and address his last two aims.

Mental health issues are the largest single cause of disability in Australia accounting for 24% of the burden of disease and place a significant financial strain on the Australian health care system (Australian Bureau of Statistics, 2008). Therefore, understanding the minimal training needs of mental health workers to produce optimal client outcomes should inevitably lead to a containment of costs in this area (Atkins and Christensen, 2001). Another reason for addressing this issue is that it is important to determine the amount of training necessary for mental health care workers to achieve optimal outcomes so as to minimise the cost to clients for such services. This is all in the face of a decline in the volume of psychotherapy training in Australia, particularly in psychology (Voudouris and Hunter, 2011; Voudouris and Mrowinski, 2010).

Before we discuss our personal views on this topic we would firstly like to comment on the methodology used by Ian in his paper. We are of the opinion that it has not been adequate to answer his main argument. To provide convincing evidence that mental health paraprofessionals and professionals have similar client outcomes in psychotherapy we believe the search strategy should have been more rigorous. In fact, Ian's argument would have been more convincing if a systematic rather than an informal review had been undertaken. A systematic review entails the use of a process such as that outlined in the Transparent Reporting of Systematic Reviews and Analyses Statement (PRISMA) (2009). In this approach the search terms are clearly articulated, the sources (e.g., data bases, published and unpublished reports) provided, the inclusion and exclusion criteria of papers presented, and the number of papers accessed, included or eliminated, described. Given that such a process was not used, Ian could be accused of bias in the selection of the research papers included in his review. Further, we would disagree with his comment that 1500 papers were unwieldy in a review of this type. From our perspective this is not a large number of papers, and this number could have been quickly reduced by clearly articulating the search terms and inclusion and exclusion criteria prior to the start of the literature search.

On our review of the literature in this area we agree with Ian that there are many factors that need to be considered when determining client outcomes in psychotherapy. We are certainly in agreement that there is inconclusive evidence that length of training is directly related to client outcomes. However, moving to the main issue addressed in Ian's paper, the contention that paraprofessionals are able to achieve better outcomes in psychotherapy than professionals, there is no clear evidence of this. In fact the results are equivocal in many of the studies cited. Certainly, as Ian suggested, in the seminal meta-analytic paper by Durlak (1979), this conclusion was supported. In a number of subsequent studies (e.g., Akins and Christensen, 2001; Armstrong, 2010; Berman and Norton, 1985; Nietzel and Fisher, 1981), however, this contention was not supported. In one of the more recent studies cited by Ian, Nyman, Nafziger and Smith (2010) it was found that client outcome was much the same when clients were seen either by a licensed doctoral level counsellor, a pre-doctoral intern, or a practicum student. In our view these therapists are all professionals not paraprofessionals so we are not convinced the conclusions in this latest paper support Ian's argument.

We would certainly agree with Ian that variation in terminology regarding what constitutes a paraprofessional and professional makes a review in this area almost impossible. Further, comparing the training of mental health workers in Australia with that in other countries is fraught with difficulty given the considerable differences in the various educational systems. However, to ensure that Ian's research question about whether paraprofessionals and professionals in psychotherapy have similar client outcomes is answered we reiterate that a systematic approach could have been used. In such a review the inclusion/exclusion criteria would have been carefully considered at the outset, thus providing a clearer focus for the review. If such a search revealed no or few studies, then we could surmise that there was not sufficient evidence to answer the study question.

Another of our criticisms of Ian's paper is that most of the cited studies seem to be based on proxies for length of training. If carefully formulated research evidence is to be produced to support his contention, studies that explicitly record length of formal training, and then control for other relevant factors should be examined. Some of the factors that should be included are the amount, quality and relevance of continuing professional development training as well as the content of formal training. Other important issues to consider in such a review include the severity and type of mental health problems that are being addressed by mental health workers. For example, there is a vast difference in the skills and knowledge required to help a client manage an adjustment disorder versus major psychiatric illnesses such as schizophrenia. Furthermore, individual difference constructs such as personality, attitudes and life experiences of both client and the mental health worker will possibly have a substantial impact on outcomes of psychotherapy and these factors should be considered. Other important factors that should be controlled for in such studies are the sociodemographic profiles of clients and mental health workers, and the therapeutic paradigm in which the mental health worker practises. For example,

the degree of eclecticism and flexibility in the approach used by a mental health worker is known to impact on client outcomes in psychotherapy (Brooks-Harris, 2008).

Another concern about Ian's paper is that many of the citations included are quite dated. It would have been more pertinent to include papers examining changes in formal training course content over the last two decades. Apologising in advance for the many examples taken from psychology to illustrate our arguments, there have been major changes in the training of psychologists during this time. For example, master of psychology and doctor of psychology degrees by coursework that include 1000 hours and 1500 hours of clinical placement respectively were only introduced in Australia in the past 15 years. Prior to the introduction of such courses graduates in psychology with 'lengthy' training may have completed masters or PhD by research and been registered to practise with little or no practical experience included in these courses. However, PhD graduates in psychology are now required to undertake a field placement under supervision for one year (pro-rata) post-graduation before they can be registered as a psychologist with the Australian Health Professionals Regulation Authority (AHPRA).

In psychology the introduction of psychology masters and doctoral by coursework degrees in Australia has increased knowledge in specialist areas and provides a good example of how content of psychotherapy training may be more important than length of training. Using an example from our specialist area of practice, psycho-oncology, a cancer patient may find a psychologist with a health psychology qualification more helpful than a practitioner with a clinical psychology degree. Health psychologists are trained to assist clients who have mental health issues that are a direct cause of, or impacted by, physical health problems. A good example would be depression in a patient with cancer that might be caused by their diagnosis or the side effects of treatments such as chemotherapy and radiation. As a side issue, we would therefore refute Ian's claim that two of the studies referred to in his paper that dealt with weight reduction and anticipatory nausea (no references provided) were more oriented to physical-based problems rather than those very often encountered in oncology, as these are some of the very areas in which health psychologists can offer evidence-based psychotherapeutic interventions.

Given our professional view that it may be the content rather the length of psychotherapy training that provides for the best client outcomes, a study into the content of TAFE graduate certificates and diplomas in mental health, undergraduate degrees in counselling, psychology masters degrees by coursework, in social work, and other human services courses and client outcomes should be undertaken. The length, content and quality of the field placements, which are an integral aspect of training in all psychotherapy courses, also require careful scrutiny in terms of their ability to impact on client outcomes. We also believe that the amount, content and quality of ongoing continuing professional development post-graduation are probably more clinically useful concepts to examine rather than length of formal (institutional) training in terms of effectiveness of psychotherapy. Using psychology as an example once again, once registered with AHPRA all

psychologists must complete a minimum of 30 hours of continuing professional development (CPD) activities annually. This is mandatory if a psychologist is to maintain their registration. Further, if they also become a member of an Australian Psychological Society College they must complete an additional 30 CPD college points plus the base number of 30 required for membership. For each block of 30 hours a minimum of 10 hours must be 'peer consultation' and

10 hours must be 'active' CPD activities, which refers to training in which the psychologist must be engaged in activities such as role plays, case studies, and debates (AHPRA, 2012). This standard was enacted under the *Health Practitioner Regulation National Law* (2009) with approval taking effect from 1st July 2010. As we are not aware of contemporary studies with rigorous designs that have examined the effectiveness of ongoing professional development on client outcomes, we recommend that this be undertaken across all the disciplines mentioned in Ian's paper.

Another concern with Ian's paper is that it seems to consider the outcomes for clients in a single client to single mental health professional context. While we know that many mental health workers still practise in this context the trend in recent decades has been for multidisciplinary team involvement in the care of the client (e.g., General Practitioner, psychologist, social worker, psychiatrist) (Mitchell, Tieman and Shelby-James, 2008). Furthermore, many paraprofessionals work in conjunction with professionals, such that outcomes may best be considered as team outcomes. From our reading of Ian's paper it appears that this confounding factor has not been addressed in the studies reviewed.

While we have been very critical of Ian's review to date, we certainly agree that the strength of the therapeutic alliance should be considered a possible predictor of client outcome regardless of the health practitioner's training. This contention, however, should be subjected to careful research attention. Ian has cited a number of studies in which individual constructs such as warmth, optimism, and empathy were reported as responsible for positive outcomes from psychotherapy (e.g., Roussos, Waizmann and Echbarne, 2010; Strupp and Hadley, 1979; Thompson, Gallagher, Nies and Epstein, 1983). Ian has also quoted the conclusions of authors such as Schmolling et al. (1997) who were of the opinion that there are many paraprofessionals who outperform professional workers because of their strong therapeutic alliance. However, these studies do not appear to have strong scientific merit given the type of research designs used. The only way to be sure that the above conclusions are decisive factors in psychotherapy outcomes, more studies with baseline measures of therapeutic alliance and a comparison group composed of individuals who did not receive the particular psychotherapeutic intervention would need to be conducted.

Concluding Remarks

While we might agree with Ian's provocative statement that training length is not the key factor in determining the outcome of psychotherapy, and that therefore paraprofessionals and professionals achieve the same client outcomes in psychotherapy, our view is only from an uninformed standpoint based on our observations in the field. We therefore have no absolute evidence for making this claim. While Ian concluded that trained and untrained therapists achieve comparable levels of improvement, Berman and Norton (1985) after carefully reviewing the research evidence, found that it was not appropriate to compare the outcomes of the studies by professionals with those of paraprofessionals. This was because the mental health problems, treatments, and outcome

measures were not the same across the studies. In other words, Berman and Norton were not comparing 'apples with apples'. These are the very variables that need to be controlled for in a review of the evidence in this area. Therefore, the only way we will know if Ian is correct in his assertion, and that our informal view is sound, will be to undertake a systematic review of contemporary well-designed research studies that collect the necessary data. We therefore recommend that a more systematic approach to gathering the research evidence be undertaken, with more attention to the finer detail of the studies presented so that we are clear that the above concerns are taken into consideration. If the outcome of such a review supports Ian's contention that training length is not associated with client outcomes in psychotherapy then we will need to explore the factors that contribute to successful client outcomes that are inherent in some mental health training courses and/or in mental health workers using rigorous research designs. As a final comment we tend to agree with O'Donovan and Dyck (2002) who concluded that the push for an increase in training length in psychotherapy may largely be motivated by psychologists who wish to enhance the status and prestige of their profession. We are certainly not convinced that extending the length of training in our discipline will result in better client outcomes.

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Personal reflection on Ian Murray's Paper 'Does the length of training determine the effectiveness of counselling practice?'

MARGARET O'BRIEN

I first met Ian Murray in 1991 when I became a member of the Australian Institute of Welfare & Community Workers (AIWCW now ACWA). Over the ensuing years Ian and I worked closely together on many occasions, on a variety of issues, papers, projects and assessments in relation to the education and training of Welfare Workers. We were, in the beginning, mainly concerned with the new Associate Diploma of Community Welfare Work that was being delivered through the TAFE sector. This progressed over the years to higher education and also the overseas skills migration requirements for this sector of the Human Services Field. Many of our discussions centred round 'What makes a really good, effective worker?'

It was always his viewpoint that academic qualifications alone did not make an effective worker, that is, a person who was able to build relationship with a client that allowed a positive outcome for the client to eventuate. It came as no surprise to me that the over-riding aspect of this his latest, and sadly, his last paper has been focussed on research to prove his theory.

So what does make a really effective and competent practitioner in today's world of Human Service provision? To begin with we need to look at what competency really means.

Competency - The knowledge and the skill to apply it. Just what does this mean? For Ian, it meant a focus totally on the client which allowed the practitioner/worker to actually see the person. This allowed their problem or issue to be seen as totally unique to them, even though the problem or issue, itself, was common to many. The ability to develop this level of empathy for the individual demonstrates a true understanding of the human condition. It allows the practitioner/worker to assist the client in achieving a good outcome.

I am of the opinion that the research seems to bear out his viewpoint. Perhaps the lesser trained person who truly has developed the ability to:

- a. give, and demonstrate through their empathy
- b. the unconditional positive regard

- c. that is needed to see the real world situation
- d. rather than relying upon a theory book example

is the reason for some of the success data of the studies researched in this paper.

From my own teaching experience, both within the TAFE system and Higher Education levels, I have found that:

- a. the students who demonstrated the ability to build relationships with their clients during their practicum, and
- b. also the ability to interact positively in lively discussion, with both fellow students and educators, during their academic study times, in an effort to fully understand the issues under discussion

were the students, in general, who were more likely to determine the probability of good outcomes for clients in various real life situations. These students usually went on to become very good human service workers regardless of the level of study being undertaken.

I am aware that many generalist human service workers have undertaken the responsibilities of the traditional professionals, and demonstrated their knowledge and competence in the only way that matters. That is, positive outcomes for clients. As Ian has indicated in his paper, the benefits to the Industry at large could be huge if only we allowed ourselves to acknowledge the implications of the research that although particular knowledge of the human condition is needed:

- a. it does not necessarily mean that a person has to undergo lengthy training/education to provide beneficial services to people in need,
- b. or, to have in-depth knowledge, such as that required for example in the medical profession.
- c. So, unless they wish to specialise in a particular area, and depending on the area, even then lengthy academic training may not be necessary, and
- d. perhaps working within the Industry with a mentor would perhaps be a better option.

I tend therefore to agree with Ian's observations that the length of training time has no real influence on their effectiveness. The one proviso that I have is that the training/education should be accredited by the students' Professional Association in order to ensure that it has the depth and quality required. Once this is accepted, many more highly effective workers will be recognised for their worth, resulting in greater employment at the 'grass roots level' and beyond.

I would like to conclude this comment on Ian's paper by drawing attention to a particularly important sentence 'that those with briefer training do just as well or better than those with many years of specific psychotherapy training' (p 17). It would behove the Human Services Industry to look closely at WHY this is the case, and give some credence to the notion that 'the ability to build relationship is critical to the successful outcome' of any client/worker relationship. I believe Ian's research clearly demonstrates this fact and I am of the opinion that this, his last paper, will prove beneficial to the many people throughout Australia who provide a service in this Industry as well as to those who receive them.

Margaret O'Brien (formerly MacMahon) holds a Masters in Social Welfare Administration and Planning (UQ), is a former national president of AIWCW/ACWA and a long time community welfare worker and educator, now retired.

Reclaiming the commons: participatory democracy and revitalising citizens' role in the management of community halls

WENDY MACKENZIE

Abstract

South American practices of participatory democracy have much to offer local government in NSW in re-invigorating community civic involvement in the management of community spaces. Barriers created by a restriction of representation and loss of democratic dialogue within a neo-liberal marketplace environment have constricted opportunities for local community democratic planning and management. The demands placed by new managerialism in one local government area in NSW with regards to the management of local community halls has resulted in loss of social capital and the disempowerment of local citizens. This article discusses proposals to educate for the revitalisation of local democratic conversation and citizen planning, and the adjustment of local government legislation to include participatory democratic processes, and it explores the possibility of participatory budgeting by the community through the current community halls management committees. The role of community development workers is to facilitate this process through supporting a changed paradigm which privileges the democratic over the market, the citizen over the consumer and validates the lived experience of community members in researching, identifying and managing issues which effect their lives.

Keywords: *participatory democracy, managerialism in local government, community development, local community halls.*

Introduction

A dynamic and exciting democratic renewal in South America through the vibrant growth of participatory democratic practices such as participatory budgeting, community councils and citizen education, has inspired citizens in the older representative democracies to review the role citizens could play in democratic processes. Influenced by the values of the Brazilian Paulo Freire, models of practice based in democratic dialogue, praxis, and transformation (Smith 2002) have strengthened civic engagement. Effective legislative reform in Venezuela and Brazil brought about the move from an ineffective and corrupted representative democracy to a new form of participatory democracy. This has resulted in a fundamental shift in citizens' participation in decision-making in these countries. In seeking to re-inspire

genuine participation by Australian citizens in their community, local government could adopt effective processes drawn from the South American experience to reinvigorate community involvement. In this way the dominance of representative forms of democracy can be challenged by using participatory democratic processes to educate local community about alternative, more empowering forms of democratic action.

Community participation

One area in which these processes could be applied is in the control and management of community infrastructure such as community halls. Community halls represent one of the most basic levels of community infrastructure. Traditionally the heart of small communities, the community hall continues to play a valid and affirming role in the life of local communities. How this asset is managed is critical in facilitating the empowerment of communities and in defining the quality of democratic engagement experienced by the residents.

In Newcastle Local Government Area (LGA), in the period 2009 to 2012, the management of local community halls has been under review. It is here at such a fundamental level that the choice between a restrictive representative form of democratic participation and the opportunity for a wider more participatory involvement by citizens is being debated. The role of the community worker in advocating for, and empowering, local community requires a deliberate choice to support the greater participation and civic involvement of residents, despite the challenges presented by managerialism and the neo-liberal political culture of the current times.

In exploring the difference between participatory democracy and representative democracy it is helpful to identify characteristics of each. Kenny defines participatory democracy to be ‘... where people do not elect others to represent them. People directly participate in and jointly control the decision-making processes’ (Kenny 2011:31). In this way the structures in South America such as participatory budgeting and Community Councils reinforce the involvement of citizens. By contrast, Australia has had a long history of representative democracy with entrenched systems of management. Kenny describes representative democracy in Australia as being ‘where people elect other people to represent them and make decisions on their behalf’ (Kenny 2011:31). One example of this is the election of citizens to Section 355 management committees (Section 355 (S355) committees under the NSW Local Government Act 1993) to represent residents in the management of community halls on behalf of local government in NSW. (In other Australian states the same structures are known by other identifiers, eg in Victoria, as Section 86 committees).

The representative government closest to the citizenry in Australia, like the South American experience, is local government. Local councils in Australia are elected:

to represent their local communities; to be a responsible and accountable sphere of democratic governance; to be a focus for community identity and civic spirit; to provide appropriate services to meet community need in an effective and efficient manner; and to facilitate and coordinate local efforts and resources in pursuit of community goals (Australian Local Government National General Assembly 1997, cited in Butler 2005).

This article explores some of the challenges for NSW local government in fulfilling their mandate to ‘coordinate local efforts and resources in pursuit of community goals’. The fiscal restraints, constriction of community representation and devaluing of community development roles within council are exacerbated by disengagement of local communities from civic participation. Butler notes that:

Local government cannot *facilitate and coordinate local efforts* without high levels of support and cooperation from communities (Butler 2005: 1).

Rebuilding community confidence and cooperation in democratic processes would require local governments in Australia to genuinely release control over both power and responsibility, and to trust local citizenry to effectively participate in genuine planning processes involved in the management of their local community. Through the development of participatory democratic practices in the management of local community halls the community can be re-engaged in the democratic process and empowered to implement their own vision on how this space can ‘be a focus for community identity and civic spirit’.

Barriers to participation

Prior to exploring practices of participatory democracy and the possibilities for application to the Australian political environment, it is worthwhile identifying some of the barriers that constrain community participation at a local government level.

One such barrier has been an actual constriction of representation at a local government level, as representative government has become diminished since the early 1990’s through council amalgamations. Ian Tiley, in discussing the structural reform of Australian local government, indicates that:

as a consequence of almost invariably forced amalgamations of local government in all Australian states, there has been a substantial reduction in the number of elected representatives (Tiley 2010: 24).

Tiley notes that ongoing local council amalgamations in the first decade of 21st century saw further reduction in the number of elected representatives from a total of 6636 councillors in 2003 to a total of 4970 in 2010 (Tiley 2010: 28). In discussing the tension in Australian local government between efficiency and democracy, Tiley concluded that the tension ‘has been resolved in favour of arguing for efficiency based on local council size’ (Tiley 2010: 24). The resulting pattern of local government representation is for larger geographical areas represented by fewer elected representatives.

One outcome of this new drive for amalgamation is that the increasing complexity of decisions made by Council are being reviewed by fewer councillors. This inevitably results in greater participation and control by managers vis-a-vis elected councillors in the advice provided to Council. This further degrades the possibilities of effective representative democracy at a local level and allows the predominance of new managerialism and neo-liberal ideologies to impact on local policies and practices, and raises barriers to participatory democracy by local citizens. In referring to this trend Kenny suggests that the ‘development of direct participatory democracy is constrained in the current political context in Australia, where it is deemed to be unwieldy, slow, ineffective and inefficient’ (Kenny 2006:31).

While I was working as Community Worker for Aged and Disability Services for Newcastle City Council between 2005-2011, the tension between democracy and efficiency was played out through a review process known as the Sustainability Review which was conducted using a Business Excellence Framework¹. Councillors were rightly concerned to review the economic balance sheet for Council as the 2009 Global Financial Crisis had adversely affected Council’s investments. However, prior to this, increased cost shifting by State and Federal entities, ageing infrastructure, a growth in responsibilities and community expectations, and a system of rate pegging² had effectively propelled Council into an economically unsustainable position for the future. Pressure on scarce economic resources had also raised barriers to participatory democracy where time spent empowering citizens to manage community issues was increasingly seen to be inefficient and a wasteful use of human resources. Newcastle City Council between 2009-2011 presented a snapshot of the effect of these processes on community participation in the management of community halls.

Different paradigms

As an outcome of the Business Excellence Framework Sustainability Review undertaken by the external consultants on behalf of Council in 2009, a recommendation was made that a Review of Community Halls be undertaken to assess future community needs and identify

¹ The Business Excellence Framework provides a systematic and structured process aimed at guiding development and improvement of management and leadership systems

² Rate pegging is a system that prevents Council increases land rates beyond a defined limit imposed by state governments.

current usage of facilities. Community Halls as described in the Landcom Community Centres Guidelines refer to

publicly owned facilities that provide space for local organisations and community groups to meet, and for a range of social programs, services and activities which address the social needs of a community (Landcom 2008:7).

An external consultant was selected to undertake this process which was supervised by a reference group of Council Managers from Finance, Planning and Life Services. However as the Review progressed, my perception was that the focus shifted away from identifying the future community needs for community halls, and ways to meet that need, to identifying poor performing community halls. Evaluations were undertaken using attendance, income, governance and an assessment of the age of the structure with the intention of removing, through sale or demolition, unviable or costly infrastructure, to be replaced by more centralised multi-purpose buildings. The underlying principle became that the existing halls needed to 'pay their way'.

However while these assessments were being undertaken the background to Council's acquisition of these community assets was not considered. As a result a more complete understanding of the significance of each public space and its role in creating a 'sense of place' for residents was not acknowledged, nor was the trust placed in local government by community members to value and preserve that heritage. The history of these halls furthermore indicates the gradual erosion of community participation and power in the management of these facilities. Historically some of the older halls had been established by citizen initiatives in the mid 20th century. For example the inner city Hamilton South Community Hall was established on a vacant block of land owned by the NSW Department of Housing in the 1970's after massive fundraising efforts by the tenants of the then recently established public housing estate. The hall has been in continuous use since that time. One tenant in describing these efforts in 2010 still maintained a strong sense of pride and ownership in the creation of the space.³ The West Wallsend Community Hall on the outskirts of Newcastle Local Government Area had a complex 70-year history with land and a building originally donated by Coal and Allied, a local mining company. Local residents, through the West Wallsend Progress Association maintained the building and recorded its rich cultural history of dances, marriages and playgroups. Management and control over the West Wallsend Community hall only devolved to Council in 2010 when the last remaining committee member became too ill to cope. The viability of both these halls awaits the outcomes of the review process.

³ Author's conversation with tenant Pat Dobson July 2010

Both the historical connections within community and the trust in local government contribute to the strength and resilience of local communities, the potential loss of connections and trust further erode the willingness of citizens to participate in relationships with local government.

The loss of these connections was further compounded by the affect of town planning on community. Expansive housing developments in 1980-2000 merged previously detached villages within the Local Government Area. Local boundaries and identities blurred as new residents settled into recently developed estates and older residents lost touch with their community networks. Gradually the care and control of the community space became a burden as the older residents became incapacitated or died and newer residents remained uninvolved. Lacking solid support from Council to regenerate the community governance of halls, the remaining local community members eventually transferred responsibility to council as the caretaker role became too burdensome.

A further impact on the understanding and recognition by local government of the ability of local community to maintain and manage their own facilities was the emergence of the new multipurpose complexes required to be built by developers under Section 94 and Section 94A of the NSW Environmental Planning and Assessment Act 1979. These complexes designed and built to fit in to the ambience of the new estates, began their life as a council asset and fitted neatly into a model that promoted centres as venues. By contrast the older citizen-developed centres seemed poorly utilised, required increasing maintenance and upgrading to meet current building standards, did not promote the scale of community use required to demonstrate efficiency, and required local government support with governance and management issues.

Tension between democracy and efficiency

It can be seen that the decision by council to resume control over facilities where governance has become an issue rather than support the community to reassert their democratic participation is a failure of community work and a choice that reinforced economic imperatives over democratic participation. In identifying the tension between democracy and efficiency Shaw and Martin (2000) comment that:

Social purposes may continue to dominate the professional discourse of community work practice, but economic objectives are increasingly applied to community development as policy. This is particularly significant when considering the changing relationship between community work, democracy and citizenship - as well as the crucial choices which have to be addressed in seeking to make the reconnections between them (Shaw and Martin 2000:407).

To reduce the barriers to a more participatory model of governance, appropriate community work would need to be undertaken to reclaim and reconnect citizens to their local space or 'commons'. The tensions between democracy and efficiency impact directly on local

communities as they have had a major influence on the ability of community members to continue to directly manage community halls through the delegated power Council has given them as Section 355 committees.

While the Review was being undertaken the local community were worried about the viability of their halls and expressed concerns that Council would sell off or take over the management of their facility. Three management models already used by Council included a lease in perpetuity for the four Senior Citizens Centres which paid an annual peppercorn fee of \$1.00 for the lease, seven halls managed through S355 Committees and two halls managed by lease through local Progress Associations. All committees had delegated responsibility for day-to-day hire of hall, managing the finances, hiring cleaners, gardeners, putting the garbage out and so on. Any excess funds were able to be allocated for improvements to the facility such as replacement of old whitegoods, installation of cupboards, polishing floors. In the case of S355 committees Management Committee members were nominated from the local community. Other organisations were incorporated in their own right and could use the income from the hire of the facility for maintenance and also for program costs such as outings for the Senior Citizens. Some of the centres were vital neighbourhood hubs, others were less utilised, however at the time of the review all halls were in some form of continuous use by local citizens.

Risk culture

My perception was that as the momentum of new managerialism gained ascendancy within the Council bureaucracy, Council officers from Auditing, Work, Health and Safety (WH&S) and Governance became more involved in the monitoring of community halls and the surveillance of community committees and facilities.

Kenny highlights these issues in her article 'Community Organisations and the Dance of Good and Bad Risk'. While her critique is aimed at the NGO sector it has relevance for local government.

The discourse on risk has been invoked as a rationale to support the introduction of a new culture of risk management in the workplace. This new culture is based on hierarchical management structures in which for the purpose of risk management, managers take responsibility for risk assessment and risk strategies and other workers are required to support their team leader in the interests of good risk management. This new culture is often identified as new managerialism (Kenny 2004: 327).

As a result of this culture, community hall committees were more and more accountable to Council, not only in auditing financial returns, but in managing risk through ongoing WH&S risk assessments, fire safety audits and safe food handling practices. While previous management models had turned a blind eye to community practices of the committee having

the neighbour clean the hall for \$50, or Dave, the chairperson climbing on the roof to clean the gutters, the cleaner's cupboard being a mess, and letting a small community group without appropriate insurance use the facility, current practices now saw these oversights as heinous breaches of probity and safety. Asset operators were directed by managers to ensure all facilities were managed within appropriate guidelines, further stressing the voluntary committees who were starting to feel that council no longer trusted their ability, or supported them in their capacity as managers of the facility.

Kenny refers to this phenomenon:

The discourse of risk is proving to be a useful legitimating tool for those in power. It normalises underlying control structures and helps mask contradictory policies and protocols established by governments and funding bodies. Risk management becomes a substitute for trust (Kenny 2004:329).

The Newcastle City Council Community Facilities Review continued to be delayed in its completion, however proposals based on the draft review were seeping into practice as the community committees started to collapse under the weight of these expectations, particularly as the Council Human Services Manager, who had directly supported the committees, had been removed by redundancy and restructure in late 2009 when the position was amalgamated with the Library Services Manager. This resulted in a huge portfolio to manage, placing unrealistic demands on the position, and disadvantaging the community committees.

An alternative method of managing community facilities was suggested that located them in the Facilities Management Section of Council with the halls treated like any other venue for hire. The staff position required would be financed by the income from the community halls. This process was in line with a 2009 benchmarking exercise of the management of communities' facilities undertaken by Newcastle City Council Life Services Section which indicated that larger NSW urban councils had shifted away from the traditional community management of facilities by constituted local community committees, to a more centralised management model that was based on management of risk and income productivity.

Citizens not consumers

Centralised control over community facilities effectively develops more barriers to participation by citizens, prevents community planning, management and development of local resources, and limits flexibility and citizen autonomy. The control is paternalistic and disempowering, access to the facility becomes increasingly difficult as bond payments, contracts and indemnity insurances limit local citizen participation in informal or ad hoc situations. In a very real sense, the community can meet together in a community facility only when approved by the local government officers. The sense of community ownership of public space has been extinguished. This does not have to be the case.

Within this contested environment community development workers are required to be vigilant about the invasion of ideologically-driven language used to describe preferred political agendas. The ubiquitous use of economic terminology to refer to citizens within the community services industry further reinforces the loss of substantive rights by community members. When citizens are reframed as consumers or customers, dialogue about rights is clearly restricted to that of market place exchange. Shaw and Martin refer to this issue:

If the space for progressive community work practice is to be regained, the role of community work itself must shift from that of turning citizens into consumers and customers to that of defining and defending democratic citizenship itself (Shaw and Martin 2000: 408).

It is in this context that the introduction of ideas and practices based in participatory democracy by community workers can effectively regain some of the integrity of citizen involvement in the management of public space and control over the solutions to local issues. It is incumbent on community workers to address the barriers to citizen participation through a range of strategies.

Enabling participation

In applying the ideas of participatory democracy to the management of community halls in the Australian context it could be beneficial to educate for understanding and participation, legislate for long-term protection, and devolve financial control to community groups.

Paulo Freire in *The Pedagogy of the Oppressed* highlighted the essential role of informal education in developing participatory democracy. In the South American experience, participatory democracy in many cases was supported from the Mayor's Office. In developing interest and support for initiatives promoting participatory democracy at a local council level in Australia, involvement and understanding by elected representatives would be crucial. Effective education of elected local government representatives and council staff could create a change in perspective that would challenge the hegemony of new managerialism and neo-liberal policies and create space to review existing structures more creatively.

Butler discusses some ways that local government can contribute to the development of social capital in local communities so that communities are more likely to participate in decision-making. Butler describes social capital as relating to:

The resources available within the community as consequence of networks of mutual support, reciprocity, trust and obligation and it can be accumulated as people interact with each other in a broad range of formal and informal settings (Butler 2005: 4).

Butler includes positive examples of community engagement and the building of social capital from local government in Victoria, one of which was the Township Development Tool Kit: Learning Towns in Action (Shire of Yarra Ranges and Mt Evelyn Township Improvement Committee 2002). Actions such as these by local government prepare the way for participatory democracy at a local level where citizens:

take part in identifying, articulating and presenting issues, policies and problems in their society and make decisions about the strategies to be used to overcome the problems (Kenny 2011: 31).

Increasing knowledge and practice examples of strength-based community development by social planning and community development workers in the community services industry also provide a rich source of collaborative practices which drawn on and develop local community strengths and assets.

Through this process the status of citizens as equal partners could be reinforced. Rather than seeing citizens as the problem, councillors and staff influenced by marketplace ideologies would have the opportunity to re-think the underpinning values that are driving democratically restrictive practices. Comparative examples of citizen participation, successful examples of alternative models and clear exploration of the impacts of policy using a quadruple bottom line⁴ could generate a more complex discussion of options than one based only on economic outcomes. By creating a space for reflection within local government the reversal of democratically restrictive practices is then more possible.

In the community, workers could pilot models of community participation in the management of community facilities through the introduction of some of the ideas of participatory democracy, for example the Community Councils model used in Brazil and Venezuela.⁵ Local S355 hall committee members could be encouraged to change their role from the current concept of a representative to that of a spokesperson for the local community.

Currently the S355 hall committees are required to hold Annual General Meetings and nominations are accepted for the positions on the committee, subject to Council approval. In practice it is difficult to find volunteers to participate on the committees, as the responsibility is perceived to be too onerous. Working *with* the community, rather than *for* the community, the unrelenting burden of the management could be shifted into a more positive and participatory model. Community workers would need to facilitate the development of different skills from the more formal management committee training that supports the

⁴ The quadruple bottom line refers to KPIs based on governance, economic, social and environment considerations

⁵ Community Councils are elected by local neighbourhood groups of 50-300 families. Community Councilpersons did not act as delegated representatives for the community rather they were described as spokespersons who could not act without community consensus (Fox and Leindecker 2009)

current infrastructure. This way it could be more likely that community members would participate in decision making, rather than leave the work to a few representatives.

The 'Building Rural Futures Through Co-operation: Study Circle Kit' developed by the Centre for Rural Communities, is an example of a skills-based resource using a strengths based approach (Sheil H: 1997). The study circle program creates a supportive environment that can encourage community members to become skilled in democratic interaction and to identify assets and areas of concern. The study circle kit also incorporates Freire's idea of praxis by including a practical process 'where action takes place from the identification of areas of concern' (Bruce 2006: 60).

A further example is the community Animation Project initiated by St Vincent De Paul in Claymore NSW in 2002 which is based in the Catholic Social Justice tradition and uses the concept of 'animation' as a method of involving residents in development practices. Animation principles and processes have been influenced by the work of Paulo Freire and Myles Horton along with experiences from the civil rights, popular education and community development movements.⁶ Animation focuses on creating autonomy and developing the resources of people so that they can gain the skills to affect their environment positively by coming together as equals to identify issues and address concerns. The outcomes for the people in Claymore have provided solid examples of both the transformative effects of the processes used and the very practical outcomes that have improved the quality of life for residents, such as the establishment of multiple independent management structures, the development of a community environment and the creation of business enterprises.

Projects such as these have led to a revitalised interest in collective decision-making in a range of community contexts through larger planning and discussion days in preference to the more familiar delegated authority used in the traditional management committee structure. This preference for inclusive research and planning processes has led to a shift in management structure as participants who have been involved in mapping out a path of action are more willing to contribute to the realisation of those plans. Innovative management practices can be seen in the community gardens movement where local groups establish formal or informal management structures specifically tailored to meet their needs. In applying these processes to S355 committees, could community workers revise the existing paradigm and encourage local S355 committees to meet every two months for a community consultation and barbecue rather than the tedium of a monthly meeting? Could committee members combine meetings with the playgroup or Zumba class so that it could be fun and interactive? Could social media be used to network with a broader community audience?

⁶ Further discussion of the Animation Project can be accessed through the Australian Institute of Family Studies' website Child Family Community Australia (www.aifs.gov.au/cfca) Promising Practice Profiles

Through the process of education and experimentation, barriers to participatory democratic processes can be reduced, the sometimes overwhelming force of neo-liberal ideology and managerialism can be challenged within local government, and alternatives can be explored and practised by the community.

To ensure long lasting change, legislative adjustments can further reinforce the primacy of democracy and citizenship over the marketplace. In NSW local government, the framework for participatory democracy may already exist with regards to the ability of council to delegate authority to S355 committees for the management of community halls through the Local Government Act 1993. It is this framework that has been under stress from the multiple demands of managerialism and loss of support and education for Council staff and community committees.

The NSW Local Government Act 1993 omits specific mention of the processes to be used by the S355 committees in the management of facilities, however multiple ideological, bureaucratic and economic factors have created barriers which have limited the possibilities of citizen participation. By including participatory practices in the statutory requirements of local government, the force of legislation would then provide some protection against the unpredictability of local politics and ensure participatory practices continue to exist over time.

In developing participatory democracy in Venezuela, legislation was used to articulate the rights of the local community to participate fully in decision-making. In Montevideo, Buenos Aires and Villa El Salvador participatory budgeting has been regulated and institutionalized by municipal resolutions, decrees or constitutions, while in Peru national laws on decentralisation and local government embed participatory democratic practices in the local communities (Cabannes 2004:40).

Currently the S355 committees of Council encompass a wide range of committees from large management committees handling substantial funds for specialised projects such as the Newcastle City Council Building Better Cities Management Committee which is responsible for millions of dollars, to the small local community halls whose income is in the thousands. Through amendments to the NSW Local Government Act 1993 the functions and role of committees that manage community halls could be further articulated so that they are treated as unique entities which provide active stewardship of the facilities, while ensuring full community participation in planning for and using the facilities, and controlling the allocation of funds attached to them. In this way a structure reflecting the possibilities of participatory democracy could be brought into being and sustained over time.

The statutory responsibilities of council are considered the primary authority for the actions and decisions made by the elected council and the administration. Once legislation has been

implemented, local government policies and practices would then be compelled to reflect the principles of increased participation by community in the planning, management and use of the community halls. The administrative burden imposed by Council could then also be mitigated by privileging social outcomes over economic; effectiveness measurements would reflect the changed paradigm.

The final aspect of developing participatory practices with local community management of community halls relates to resourcing community ideas by devolving financial control over hall income. Current practices provide for the management committees to hold in bank accounts the income from the hire of the hall on behalf of council. These funds can only be used to pay for utilities, cleaning, gardening and asset improvements. Active halls have increased income and improved facilities, inactive halls have less income, and the loss of income results in less maintenance, which can result in less usage and community disinterest. To encourage the use of community halls as vibrant community-controlled spaces, some income from the hire of the facility could be re-allocated by Council to participatory budgeting by the committee which could then articulate the community vision for the space. For example funds could be allocated to planning and development strategies which could result in citizen-initiated actions such as recreating barren land into a community garden, building a sand pit to encourage local mothers to use the hall, or painting a community mural on the walls of the hall by local youth. This would encourage further usage, increase community identification with the space and counteract the trend toward an increasingly barren environment, encouraged by utilitarian ideas of a neutral space for hire. The community hall has the potential to be the heart and soul of a community when integrated into the life of the community. The release of funds and introduction of participatory budgeting to develop community projects would nourish the visions of the community and increase greater understanding and involvement in participatory democracy.

The commitment to validating community control over community halls would require substantial re-thinking and adjustments to current trends. It would require Councils to moderate accountability and risk management expectations and embrace a more flexible approach to community needs based on increased trust in local citizenry to meet their own needs effectively and autonomously.

Conclusion

The prospect of democratic renewal offers particular challenges to policy makers, community workers and communities. The real question is whether politicians and policy makers will grasp the challenge of democratic renewal as a political process in which people in communities are regarded as critical allies and creative actors in the building of a new and

inclusive kind of democracy. Community workers are now in a strategic position to foster and sustain such an alliance. By creating one space where the community can develop the skills to achieve real participation through genuine management of their local community halls, planning at a grass roots level could be achievable, and in the process, community workers can become key agents in re-making the vital connections between community work, citizenship and democracy (Shaw and Martin 2000).

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The Ermha transitional dependence model of support: Increasing independence for people with a dual disability and high and complex support needs

SAMUEL CRINALL

Abstract

This article explores the Transitional Dependence Model (the Model) developed by Ermha to provide a diversely experienced and qualified workforce with a clearly defined and effective model of practice to assist them in the provision of support for people with a dual disability (an intellectual disability and co-occurring mental illness) who have high and complex support needs and are displaying behaviours of concern. The Model offers a simple and practical framework for engaging clients diagnosed with a dual disability in their journey to increased independence. The Model examines the practice implications of the understanding that for people with intellectual disability, behaviour can be used as a dominant form of communication, including in the communication of the symptoms of any mental illness that is present. The Model sees the relationship between the client and worker, or team, as central to the change process and explores the importance of consistency in supporting positive behaviour and an optimal personal identity.

Key words: *dual disability, complex support needs, positive behaviour change*

Introduction

Ermha Inc. (formerly Eastern Regions Mental Health Association) is a Psychiatric Disability Rehabilitation and Support Services (PDRSS) operating across Melbourne's South East and Western regions. Ermha was started by volunteers and carers almost 30 years ago and since then has grown to employ over 130 people and provide support to around 1200 people per year. Ermha has two main support divisions: 'General Services' which deliver, among other programs, traditional home based outreach, day program services and carer support. The other is Ermha's 'Specialist Services' whose core business is to provide psychosocial rehabilitation support to people who are experiencing a severe and enduring mental illness who have high and complex support needs, including those people who have been diagnosed with a dual disability.

Professional support workers for people with a dual disability who have high and complex support needs are often supplied through the PDRSS sector. This workforce is made up of people who come with an array of qualifications, some unqualified and all with varying degrees of industry experience. There is evidence and learning available in fields such as social work, psychology, social welfare, disability services, alcohol and other drugs and mental health relating to appropriate ways to support people displaying behaviours of concern, people experiencing a severe and enduring mental illness and people with an intellectual disability. There is not however, a functional and widely utilised, service model that draws the accumulated wisdom and knowledge of these fields together into a format and structure that, regardless of qualifications, training or education levels can be consistently and confidently applied by all workers and teams. Ermha has developed the Transitional Dependence Model in an attempt to provide such a model for their staff.

Considerations relating to providing support for people with a dual disability

The Transitional Dependence Model seeks environmental solutions by examining the often dynamic support patterns to identify how support teams and workers can participate in forming an environment that is conducive to strengthening personal identity and learning positive new behaviours by both clients and workers. The Model recognises the primary importance of the ‘alliance’ formed between a support worker, or team, and a client in bringing about positive change, and provides guidance and measurement of the efficacy of that relationship.

Also important to the foundations of the Model is that it does not accept diagnosis or disability as an explanation for behaviours of concern but looks at each behaviour individually in an attempt to determine what function it might be serving for the person. If the function can be located, then it is possible to provide alternative options for having that need met. As a practice, ‘applied behaviour analysis has been well established in the areas of autism, developmental disorder and intellectual disability,’ (Rahman et. al. 2010:213), though our observations as practitioners in the PDRSS sector is that it is not routine for community Non-Government Organisations (NGO’s) to engage in this process as a guide to decision making, and these are often the services providing many hours of support to people with high and complex support needs.

Currently, diagnosis of mental illness is a subjective interpretation, made by a qualified professional seeking to elicit the necessary symptoms required to meet the set criteria outlined in Diagnostic and Statistical Manual (DSM) IV (Bennett 2008:4). The investigation and assessment leaves diagnosis as an interpretation, rather than something concrete and

indisputable (ibid). Because of this space for interpretation, ‘many psychiatrists... regard all unusual behaviours in people with an intellectual disability as part of the disability itself rather than seeking alternative diagnostic hypotheses,’ (ibid) resulting in underdiagnoses and treatment of mental illness for people with intellectual disability (ibid).

In addition to the challenges of appropriate diagnosis leading to appropriate medication, many treatments for mental illness are focused on psychotherapeutic interventions that utilise dialogue and abstract and detailed concepts as a way to influence a person’s perceptions, feelings, behaviours and thoughts. As behaviour is often a dominant form of communication for people with intellectual disability, this makes psychotherapeutic approaches that prioritise verbal dialogue, not as useful. Utilising behaviour as a communication method (or engaging in a ‘behavioural dialogue’) with someone can be much more time consuming than verbal dialogue and this can be a role that appropriately trained and supervised support workers can fulfil.

Confronting crisis

At Ermha, it has been our observation as practitioners that the level of disturbance in the behaviour of some people with a dual disability has often led to services adopting a management plan of ‘abate and maintain’. Some of the people with a dual disability who we have supported present regularly in crisis and are violent towards themselves and others. Our intuitive responses to these presentations can be to ‘do whatever it takes’ to calm the situation down.

Unfortunately, when these episodes of crisis and de-escalation become the prevailing form of interaction, our unexamined responses have a propensity to result in the unintended function of supporting the concerning behaviours to continue. This is because we are teaching clients to be in crisis as a way to receive service –we participate in forming a cycle of crises. The result is clients becoming dependent on the service and dependent on these episodes of crisis as a means to have their immediate needs met. Support provision has to remain the same or increase and there is often little change in, or a worsening of, the person’s presentation over time.

The Transitional Dependence Model

The Transitional Dependence Model of support was developed by Ermha as a response to this cycle of crises and has one overarching goal of support: *to increase independence*. The Model does this by providing workers with a defined framework for examining how *their* behaviour

affects the long-term behaviours of the clients who they support. The Model offers a method for workers to provide support in a way that encourages independence and positive behaviour change, for clients (and workers).

The Model is not concerned with ways to control clients or manipulate their behaviour, it utilises behaviourism as a way to examine *our* behaviour as workers. We identified this as important through our reflections on the need to participate in a purposeful way with this client group and to actively support them in their processes of transformation, and that starts with our behaviour and the environments that we jointly create with our clients.

The Model also uses the principles of reflective practice and provides workers with a simple guide to lead their reflection, the questions that are central to these practices are:

- Will this response support positive behaviour change?
- Will this response support the strengthening of a positive personal identity?
- Is this response repeatable and therefore able to be consistent over time?

These three questions make up what the Model refers to as the ‘Decision Matrix’, a reliable and procedural approach to decision-making that guides our support practice. These questions were arrived at through the realisation that behaviour of concern is often enacted in the first instance because there is an unmet need, and subsequently, because:

- It has been learnt through a schedule of reinforcement (it achieves the desired response);
- Of personal identity (‘I am a frustrated person,’ ‘I am an aggressive person’) or;
- There is an emotional disturbance based on a lack of consistency in one’s environment (often in one’s support provision).

In order to be effective, the ‘guided reflective practices’ of the Model must occur everywhere: through informal conversations around the office, in structured client reviews, in formal supervision, in private reflection. The goal of these ‘guided reflective practices’ is to continually ask: ‘under what circumstances does this person behave appropriately and how can we participate in the creation of that environment?’

The Model does not advocate the removal of things - it cannot be used to hide behind as in refusing to provide someone comfort and support in times of crisis because of the risk of reinforcing ‘bad’ behaviour. Rather, the Transitional Dependence Model looks at what can be *added* in order to enhance a person’s quality of life. The Model looks for opportunities to celebrate a client’s efforts and introduce easier, more appropriate ways for meeting fundamental needs.

Applying the Model

Ally (pseudonym)

Ally has been a client of Ermha for 2 years. Prior to being referred to Ermha, Ally had been receiving 24 hours of support each day for many years, delivered in a community setting. Ally had difficult and turbulent relationships with her support team. Ally regularly engaged in self-harm, risky, promiscuous sexual activity and had a routine of presenting at the Emergency Department feigning illness and seizures.

In the case of Ally, one of the first behaviours (and least confronting for Ally and staff) that the Model supported her to address was the regular presentations at the Emergency Department. Historically, the approach that had been taken when Ally asked to go to the hospital was to try and convince Ally that she may not need a trip to the Emergency Department and then when she insisted, to take her there and sit and wait with her at the request of the Emergency Staff. The first step of the Model was to expose the current support pattern to the 'Decision Matrix,' asking:

- Is this response supporting positive behaviour change?
- Is this response supporting the strengthening of a positive personal identity?
- Is this response repeatable and therefore able to be consistent over time?

The answers were: no, no and no.

In terms of supporting positive behaviour, engaging in a disagreement with Ally about her needs and then supporting a situation where Ally was seeking to elicit unilateral support and attention for feigned conditions, while offering no opportunities for the trialling of new behaviours was not considered to be supporting positive behaviour change. Through the process of 'guided reflective practice' the team proposed that Ally, through the responses of the staff, was being encouraged to utilise her strategy of initiating a visit to the Emergency Department in two situations: the first, when she was not getting the social attention that she desired from the staff, and the second, when she was not enjoying her environment at home either due to boredom or frustration and wanted to 'escape.'

In respect to the formation of personal identity, participating in the establishment of an environment in which someone grows to perceive themselves as 'chaotic' or 'dependent' is not going to support the formation or maintenance of a positive personal identity. Ally was moved to initiate the strategy of visiting the Emergency Department out of a desire for social

attention (or escape); she was then confronted with the subtle frustrations of her support staff and the hospital staff, these interactions negatively affecting her personal identity.

The response is also not repeatable and therefore not able to be consistent over time; the Emergency Department while they were warm and supportive the first time/s that Ally presented, were growing weary of the regular presentations and becoming less and less accommodating. The Emergency Department maintaining their warmth and support is not something that is able to remain consistent over time due to their demanding workload. This adds layers of confusion for Ally as she decodes the behavioural messages of rejection and neglect.

The 'no' responses to these questions result in the Transitional Dependence Model rejecting the idea of supporting the current strategy. This is the engine of the Model and key to its innovation. It provides a way to quickly assess the appropriateness of a response. This is often an ability that experienced workers have developed and what the Model is trying to do is provide a framework to explain and teach appropriate ways to work, while people build experience and their theoretical foundations to practice. It also provides reassurance to more experienced workers, and provides an answer to those sometimes seemingly endless conversations we can have with ourselves that begin with the question, 'was that the right thing to do?'

When Ally was referred to Ermha, the first condition that we placed on accepting the referral was to refuse to provide 24 hours of support. Ermha insisted that Ally needed her own space and times of the day where she was able to exercise her choice and full autonomy. Supporting what has been found in many fields (Hasenfeld 1987:469), the Model sees the relationship between the client and the worker/s as the agent of change. We refer to a high quality, professional, robust, genuine 'alliance' relationship as 'being in a space of change' with a client.

If Ally perceived support staff as 'supervisors' who were with her for 24 hours a day, entering a 'space of change' was not going to be possible. It was imperative to support Ally's freedom and draw attention to her control over her environment; leaving when she asked us to (either verbally or through her behaviour), asking her how she would like to spend her time and by not reprimanding her for her decisions or their outcomes. Another important part of developing the relationship and entering a 'space of change' was to pay attention to opportunities for Ally to teach staff things, for her to offer staff something, rather than communicating through our behaviour that the relationship was unilateral, with Ally as a passive recipient of care and support with nothing of value to offer in return.

As the Ermha staff and Ally entered a 'space of change' the staff utilised The Decision Matrix to explore the viability of possible strategies to address Ally's regular presentations at the Emergency Department. The Model identified the following response as the most appropriate:

- Ensure that Ally's home was somewhere that she felt safe, supported and validated; somewhere she enjoyed spending time
- Ensure that Ally felt in control of her home and accommodate her verbal or behavioural requests for 'alone time'
- Agree to drive Ally to the Emergency Department when she requested it
- Drop Ally at the Emergency Department (rather than go in and wait with her)
- Drive to collect Ally when she was ready to be picked up
- Be respectful and polite, but draw Ally's attention to the choice she had made, with a comment like, 'Oh it was a real shame that you had to go to the hospital, we were looking forward to spending the night watching movies with you. Oh well, you can't control when you're sick and need a doctor I suppose.'

This response draws Ally's attention to her choice and provides her an opportunity to assess a current behaviour and consider changing it for a more positive one. It also communicates that she is valued and supported and this contributes to a positive identity for Ally. In Ermha's circumstance, the response was also repeatable and able to be consistent over time, as we had the resources required and staff who were prepared to commit to, and follow, the same plan.

The existing behavioural pattern may continue for a while, but by introducing an easier, more effective way to have needs met, we are seeking to provide environments where people can try new behaviours and increase their own quality of life.

A diminishing model of support

The Transitional Dependence Model of support is a diminishing model of support: there is a planned, structured and regular reduction in support provision as a client of the service increases their independence. This is of vital importance to the success of this approach. Often a breakdown in the effectiveness of support occurs when services provide a positive and engaging environment for a while and when things start to relax and break down through familiarity. Having structured and planned reductions in support provides people with opportunities to trial their new patterns of behaviour, to interact with their communities and to develop or maintain lifelong support networks while providing support staff with regular milestones. The Transitional Dependence Model is a vehicle for change, but it has to be purposeful and monitored, otherwise we are in danger of ending up with dependence, rather than 'transitional dependence' and the negative cycle continues.

Preliminary outcomes

This approach has repeatedly proved successful and can be recently exemplified in Ermha's dual disability program that currently supports ten clients in the Barwon Region through Individual Support Package (ISP) funding. In its first two years of operation, Ermha's Barwon service, under the Management of Giuseppe Prestia and Direction of Alf Francett, has supported dramatic reductions in required support hours. While each support package began at a different time over the two year period and each had a different number of allocated hours at its beginning, internal data reflects that the average allocated hours at package commencement was 32.5 per week. The average support hours now required to support the same group of clients is 23.2 per week, a reduction of around 30%. Reductions in support like this correlate with increases in quality of life for the clients supported and serve as an indication of increasing independence and time spent engaged with community.

In conclusion

The core of the Transitional Dependence Model is to examine the environments that we jointly create with the people we support and by examining and improving these environments we assist clients to increase their quality of life through actively participating in their own behavioural transformation, while increasing their independence and sense of positive identity.

Ally now receives 8 hours of support per day, and while she will likely continue to require some support, she has started a stable romantic relationship and is no longer engaging in risky, promiscuous sexual activity or presenting at the Emergency Department and her self-harming has dramatically reduced.

Under the guidance of Alf Francett, Ermha's Specialist Services have been using the principles of the Transitional Dependence Model for many years. Over the past 18 months, Christine Thornton-Gaylard, Giuseppe Prestia and Samuel Crinall have been working to formally articulate the Model. Ermha are currently preparing for a pilot research study on the efficacy of The Transitional Dependence Model for working with people with a dual disability who have high and complex support needs. If you would like further information, please contact Ermha's Service Development Unit on 1300 ermha1 or via reception@ermha.org

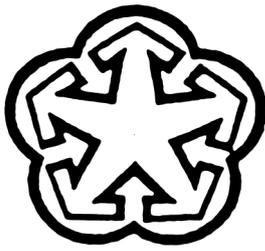
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For those of you who haven't come across the (New) Community Quarterly yet, let me start with a bit of history. ***Community Quarterly*** started in 1983 by ***People's Projects***, a publishing project of Employment Working Effectively Inc. It appeared during the heyday of government attempts to use community development as a strategy to enlist the efforts of activists, volunteers and '*true-believers in the bottom-up approach*' to assist with addressing problems like unemployment (especially amongst young people), multicultural work, environmental involvement, etc. It kept going for seventeen years as the only specialist community development journal in Australia, mostly produced by volunteers, totalling 51 issues. Fading energy and the virtual destruction of community development programs under the conservative governments of the 90s led to its suspension in 2000.

In 2002, a collective of people based at or associated with the Borderlands Cooperative, relaunched the journal as the ***New Community Quarterly***.

We start from the premise that the '*development of community*' is something our world, our nation, our local sites and places and we as individuals need fundamentally if we are to survive as a species with a sense of dignity, justice and responsibility. The journal aims to promote education and to stimulate discussion about theories and practices of community development, to foster a sense of community through the establishment of networks of community activists, practitioners and learners in Australia and Oceania. Each of the four yearly issues includes (refereed and non-refereed) contributions to a set theme, a section with other refereed articles related to community development-at-large, network news – local, state-wide and national as well as international, and news about relevant happenings across the world, including new books, conferences and other events, important news in the political and economic realms, poetry, letters, etc.

We finished publishing the first and second issues in our volume *ten* (again, we're a bit late...) and the third issue is at present being edited and will – hopefully – come out before the end of the year. Issue four will then appear in early 2013. The themes of all issues which have appeared since 2003 (as well as those having appeared in our predecessor journal, the *Community Quarterly*, from 1983 till 2000) are on our website, www.newcq.org.

The issues for the year 2013 are planned as follows: #1 ***Conflict resolution, peace and restorative justice: the contribution of Community Development***; #2 ***Community Development, Indigenous peoples and post-colonialism: what have we learned and achieved post-Mabo?*** #3 ***Community-based economics: a review of initiatives***; #4 ***Community Development in rural, regional and remote areas***.

We strongly believe that *all* community and welfare workers should be – at least – interested in community development theories and practices – even if their job description makes no reference to it. People are always already members of a community and it is imperative that (future) community sector workers become aware of what could be meant by the concept and the reality covered by it.

A full-year 'regular' subscription is \$65 - for a total of over 280 pages of reading per year!!! Students and low-income subscribers pay \$35 and organisations at present pay \$120 per year. As an incentive for members of the ACWA, we keep the regular price for next year at \$55, hoping that many of you may decide to join about 500 subscribers across Australia (and help us increase numbers so that we can do a better job at what we do).

Jacques Boulet, editor