The Maresfield Report on the Regulation of Psychotherapy in the UK

Arbours Association
Association for Group and Individual Psychotherapy
Association of Independent Psychotherapists
Association of Psychoanalysis Users
Cambridge Society for Psychotherapy
Centre for Freudian Analysis and Research
The College of Psychoanalysts-UK
The Guild of Psychotherapists
The Philadelphia Association
The Site for Contemporary Psychoanalysis

Glossary

ACP	Alliance for Counselling and Psychotherapy
APU	Association of Psychoanalysis Users
BACP	British Association for Counselling and Psychotherapy
BPC	British Psychoanalytic Council
CORP	Coalition Against Over-Regulation of Psychotherapy
CP-UK	The College of Psychoanalysts-UK
CPJA	Council for Psychoanalysis and Jungian Analysis
DSM	Diagnostic and Statistical Manual of Mental Disorders
HPC	Health Professions Council
IPN	Independent Practitioners Network
PFD	Practitioner Full Disclosure
SfH	Skills for Health
UKCP	United Kingdom Council for Psychotherapy

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Introduction

This report examines the proposed regulation of counselling and psychotherapy under the Health Professions Council. In 2007 the Government White Paper on 'Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century' gave the HPC the task of assessing the 'regulatory needs' of the talking therapies and whether 'its system is capable of accommodating them'. At that time, nearly all the counselling and psychotherapy organisations in the UK had agreed that HPC was not suited to regulate the talking therapies, and a variety of alternative models were discussed.

Since then, the field has been split into two camps: the groups and individuals who have concerns about HPC yet who do not wish to 'miss the boat', so accept the principle of HPC regulation, and those who maintain their original objections and continue to articulate critiques of HPC. Many of these organisations and individuals have made it clear that they would not register with HPC as this would involve not only a breach of professional ethics but a radical redefinition of the nature of psychotherapy itself.

This report details the arguments for and against HPC regulation, and sets out the history and context of the debate, with comparisons to the situation in Europe and internationally. It concludes that

- The HPC has not done what it was required to do, failing to conduct a proper assessment of the regulatory needs of the field and of its capacity to accommodate the talking therapies.
- The consultation process has been narrow and biased.
- The definition of psychotherapy arrived at by HPC is unacceptable to a large part of the field and will not help the public in making informed decisions about psychotherapy. Many forms of therapy do not consider themselves health professions and are based on highly disparate philosophies and approaches.
- Although there have been several projects to ensure that therapists are registered and subject to complaints procedures, Britain is the only European country which has aimed to regulate the actual content of therapy sessions.
- Although its complaints expenditure is the largest part of its budget, with £4.66m spent in 2009, only a tiny percentage of complaints from the public are heard each year. Of these, more than 70% are found to have no case to answer, compared with only 10% deemed to have no case to answer by one of the field's main regulatory bodies, the UKCP.
- For the past three years, HPC has consistently failed to process more than 30% of complaints received from the public, creating a growing backlog. Complaints take an average of at least one year to be heard, placing undue stress on all parties concerned.
- Where around 60% of complaints from the public are currently resolved by mediation in therapy organisations, HPC provides no mechanisms of mediation or informal process. Hearings take place in public, depriving the complainant of the confidentiality necessary to articulate details of a case.
- The alternative statutory model of Practitioner Full Disclosure (PFD) would better serve the public and the profession. It is less expensive than HPC, gives the public more web-based information about therapists, and is able to process a greater number of complaints.

This report is named after the home that Freud found in this country, when he was invited here in 1938: Maresfield Gardens. Britain's hospitality was appreciated by the founder of psychoanalysis, and there is a certain irony that today the UK is the only European country where the many and varied practices of psychotherapy inspired by Freud's work - as well as psychoanalysis itself - are directly threatened by the current proposals for HPC regulation.

Executive Summary

Since the 2007 White Paper, the Department of Health has given the Health Professions Council the task of assessing the regulatory needs of the talking therapies and its own suitability to regulate them. This brief, however, was understood as an imperative to regulate, with a resultant neglect of representations from the field and no questioning of the suitability of the HPC's own regulatory framework.

The Health Professions Order states that any profession to be regulated by HPC "must cover a discrete area of activity displaying some homogeneity". Counselling and psychotherapy constitute a diverse field and display little homogeneity. Many therapies do not consider themselves or advertise themselves as health professions. They focus on human relationships and not medical-style interventions with set outcomes or promises of cure. Unlike health professions, many therapies do not aim at removal of symptoms, but at an exploration of human life, understood in a variety of ways.

The consultation process initiated by the Department of Health was intended to assess the feasibility and suitability of state regulation through dialogue with all of the professional field. However, the consultation process became monopolised by a small number of people with a narrow view of talking therapy. This reliance on a small number of people with a set agenda has created the illusion that counselling and psychotherapy are a homogenous field. It has also meant the wholesale exclusion of professional groups and user groups.

The HPC has now adopted a definition of psychotherapy as the 'treatment' of 'mental disorder' which is unacceptable to many long-established traditions. Both practitioners and the public are ill-served by this conception of therapy, which introduces a considerable distortion regarding what may be expected from therapy. The definition is based on the theory used by a small number of therapies, yet any workable definition needs to be less theory-based, recognising the practice of long-established traditions and open to change as new developments in the field take place. Future therapies also risk being excluded for not fitting the HPC's definition.

The key issue in the regulation debate has been protection of the public. Therapists accept that their clients need the highest possible form of protection from inadequate and unethical practitioners. No therapy organisation or individual has argued against this principle. Indeed, therapists have consistently been open and active to strengthen the effectiveness of their current systems by all reasonable means. However, there is no research-based evidence suggesting that the client-group here is in the degree of danger that would justify being forced into a type of regulation that, in many respects, is unsuitable and unworkable for current professional practices.

Although HPC spends the largest part of its budget on dealing with complaints, it fails to hear more than 30% of cases, and a backlog has been growing consistently each year since 2005. In 2008-9, it spent 4.66m on complaints, 36% of its total budget, yet only 17 complaints from the public were deemed to have a case to answer. Each complaint thus cost £274,000. Complaints from the public were also consistently heard at a much slower rate than complaints from employers. More than 70% of complaints from the public were deemed to have no case to answer. In contrast, one of the field's main regulatory bodies - UKCP - found that only 10% of complaints from the public had no case to answer, and was able to use informal techniques of mediation to resolve nearly 60% of these cases at a fraction of the cost, with the other 40% dealt with by formal complaints processes.

The HPC complaints procedures are formal and adversarial. Most complaints in the field of the talking therapies, in contrast, are resolved by informal process and mediation. HPC gives no place to these processes, and thereby risks alienating potential complainants who do not wish to enter into such formal procedures, held in public with none of the confidentiality that a hearing may require. It also lacks the expertise to deal with the complexity of complaints in this field. The web-based model of Practitioner Full Disclosure offers a more efficient, balanced and cost-effective way of hearing complaints, as well as the necessary expertise.

HPC focus on two central issues regarding protection of the public: that any unscrupulous individual may set up a brass plate advertising their services as a therapist, and that, once struck off by a professional body, a therapist can simply continue to practise independently. Yet neither of these concerns is addressed by HPC regulation. HPC regulate professional titles not functions, so as long as the individual does not use a title protected by HPC, they can set up shop through use of any unprotected title: life coach, mentor, lifestyle consultant etc. As the BACP pointed out to the Department of Health: "the protection of a title, which is the main means by which statutory regulation operates, is proven to be ineffective: practitioners are able to re-title and re-brand themselves and continue working". The alternative model of Practitioner Full Disclosure, in contrast to HPC, does address these issues: anyone practising any form of therapy would have to disclose full details of their training and professional history. The public would thus be in a position to make an informed choice and could tell immediately if someone were not on the register.

The HPC brings with it mechanisms that may be suitable for professions allied to medicine, but which threaten the survival of the very essence of psychotherapy. Therapy is forced into a one-size-fits-all model of healthcare intervention, with its focus on outcomes and protocol-based procedures. HPC's current Standards of Proficiency for psychotherapy effectively exclude many of the most widely practised forms of therapy, which cannot be made to fit its framework. By marginalizing and even making illegal those forms of therapy which follow a different model, HPC regulation would deprive the public of their free choice of which therapists to consult.

In the short-term, we suggest that the process of forcing counselling and psychotherapy into the existing structure of HPC be halted. Instead, efforts should be made to improve existing professional arrangements and to ensure that these are properly implemented. In the long-term, we suggest reviewing the excellent work done by the Government in the past (Foster Report 1971, Sieghart Report 1978) and most specifically Lord Alderdice's Psychotherapy Bill (2000-1), all of which received significant support and approval from wide sections of the professions.

In the light of these reports and the research conducted to date on regulation of the talking therapies, we would recommend the development of a Practitioner Full Disclosure model of registration. This would involve the establishment of an independent body to administer a register of therapists, with the statutory requirement that anyone practising a therapy supply full details of training and professional history. The register would have its own complaints procedures sensitive to the particularity of the talking therapies. This would represent the most effective way to ensure public protection, avoid destroying long and honorable therapeutic traditions, and uphold the long and so far successful British tradition of cooperation between the professions and the law.

The Regulation Debate

The field of counselling and psychotherapy in the UK is rich and diverse, with several hundred different schools and orientations. Approaches to therapy differ enormously: some therapies focus on symptom-relief, some specifically avoid this; some aim at insight into unconscious phantasies, some reject the very notion of an unconscious; some try to bolster a patient's belief-system, some to undermine it; some encourage physical warmth, some proscribe this; some aim to get patients back to work, some do not. The range of practices is extraordinarily wide, and the public benefits from a choice as to this range of different approaches.

Since the early 1970s, the field has organized itself into a small number of umbrella organisations - UKCP, BACP, BPC - which have worked progressively on codes of ethics, practice and complaints procedures. There have been various attempts over the years to add a statutory framework to the field's own set of procedures, yet these have been consistently ignored or rejected by government. Nearly every practitioner currently working in the UK belongs to a professional association with codes of ethics, practice and complaints procedures, which is inspected periodically by its umbrella organisation. These codes were found by the UKCP-BACP mapping project, funded by the Department of Health, to fulfil or exceed HPC requirements.

This situation has not been especially controversial, yet calls for statutory regulation have been made by some therapists and lay people for the following reasons: there is nothing to stop any untrained person setting up a brass plate calling themselves a therapist; if a therapist is expelled from their professional organisation, there is nothing to stop them continuing to practise elsewhere; there are a small number of therapists who do not belong to any organisation and so are not subject to any agreed codes of ethics, practice and complaints procedures. These three factors are deemed to represent a significant risk to the public, which is the main reason given for statutory regulation.

The scare stories circulated to the media by HPC and by Witness, an advocacy group that the HPC works closely with and that has received significant funding from the DoH, serve to inflate the risks involved and confuse the relevant issues. No therapy organisation in the UK to date has shown any opposition to regulation. The question for them is whether HPC regulation is the best way to deal with these issues of protection of the public. HPC regulates professional titles, so if it regulated the title 'psychotherapist', it would be illegal for anyone to use this title without being HPC-registered. Likewise, being struck off the HPC register would make it illegal for someone to continue to offer their services as a psychotherapist. This seems to solve the issue of public protection, yet HPC regulation in fact fails to do so since the practitioner may simply set up shop using another title not regulated by HPC: life coach, therapist, life skills advisor, mentor etc. It thus fails to deal with the brass plate argument or the practising after expulsion issue.

Even if it were to close these loopholes by regulating functions and not simply titles, HPC regulation poses a number of very serious problems to the field of the talking therapies. It subscribes to outcome-based notions of health and wellbeing which are rejected by many schools of therapy, as well as redefining the actual concept of therapy itself. Therapy is defined as the correction or 'treatment' of developmental and psychological dysfunction via the application of a set of techniques to the patient. Yet many schools of therapy see their work as totally opposed to this model based on the health/illness framework. For them, therapy is a joint creative work, a collaborative effort to explore human life, with no manifest aims to 'correct' dysfunction or promote health.

The very notions of health, wellbeing, normality and dysfunction are rejected by many schools of therapy. These schools of therapy have a tradition of social critique, and distance themselves from the contemporary industry of 'wellbeing'. Terms like 'health' and 'wellbeing', they argue, often carry a political agenda in any given society, and the work of therapy has to go beyond them. Psychoanalysis, for example, has always aimed to subvert received forms of knowledge, and hence the current objection from most of the UK's psychoanalytic groups to subsume analysis into a framework which is based on received forms of knowledge and concepts which it has always rejected historically.

Given that the notions of health, wellbeing and illness run through HPC regulations, and influence its requirements regarding education and training, conduct, performance and the hearing of complaints, they naturally see HPC as unsuited to regulate their work. To construe therapy as a set of techniques to be applied to a patient, rather than as a relationship, an ongoing work between two people which can have no predictable outcomes or set goals, is to misunderstand its basic principles and ethics. HPC has redefined therapy though a medical lens which is not appropriate to the relationship-based paradigm of analysis and most forms of therapy.

HPC uses a model of health professions as service industries: a client pays an expert for a service, which they deliver. But for many schools of therapy, the service is actually provided by the patient. Like an artist's studio, the therapist provides a space where the patient can create something, following their own rhythm and logic. Therapy is thus not about the performance of any procedure. No outcome can be predicted in advance and so, contrary to the service industries, it is not self-evident which product the patient is paying for. This inherently risky work is clearly not served by pretending that its results and procedures are clear, predictable and transparent.

The most recent HPC Standards of Proficiency for Counselling and Psychotherapy testify to this misunderstanding of the therapeutic process. Therapists will have to:

- know how to operate equipment and minimise the risk of infection.
- know how to select appropriate hazard control and risk management, reduction or elimination techniques.
- have a knowledge of health, disease, disorder and dysfunction.
- be able to evaluate and implement intervention plans using recognised outcome measures.
- know when to use protective equipment.
- know how to formulate and deliver plans and strategies for meeting health and social care needs.
- understand the principles of quality control and quality assurance and conduct audits correspondingly.
- maintain an effective audit trail, participate in audit procedures and work towards continued improvement.
- be able to formulate specific and appropriate management plans including the setting of timescales.
- demonstrate a logical and systematic approach to problem solving and be able to initiate problem solving techniques.
- observe and record client's responses.
- be able to demonstrate effective and appropriate skills in communicating information, advice and instruction.
- understand the need to engage service users and carers in planning and evaluating the diagnostics, treatment and interventions to meet their needs and goals.
- understand the importance of maintaining their own health.
- know how to meet the needs of the client.

Where other European projects to regulate psychotherapy have specifically avoided imposing a set view of what therapy should consist of - emphasising instead registration and complaints procedures - HPC's framework is unique in Europe in actually prescribing rules and guidelines for the content of therapy sessions. The Standards have already

provoked astonishment abroad, and a petition largely from German and French doctors and psychiatrists has been established (See Bibliography for details).

The HPC Standards of Proficiency may be suitable for some health professions, but will change radically the framework of current psychotherapy practice. Many therapists do not see their work as involving set outcomes, or data gathering, or problem solving, or drafting management plans for the health of their patients, or applying possibly unacceptable systems of classification of 'disease' or 'dysfunction' (See the detailed critique of these standards in Appendix 3).

Where medical interventions may involve set outcomes which the patient could complain about if not achieved, many therapies are about the open-ended work done not by the therapist but by the patient him or herself. One could visit a therapist's office for years and not actually be doing a therapy, in the sense of being authentically engaged in an activity of self-exploration. Therapy, for many schools, is about what the patient manages to invent and construct in their encounters with the therapist, who does not apply the kind of protocol-based procedure envisaged by HPC.

Likewise, some schools of analysis and therapy hold that patterns of thought and behaviour that produce suffering in the patient derive from childhood responses to what is unknown and unpredictable in their caregivers. The compulsion to please others, for example, may have its roots in interactions with an erratic and unpredictable parent. Therapy will play out this situation, so that the therapist may behave in an erratic and unpredictable way, allowing an access to the process by which the patient's patterns of response were established. HPC's emphasis on clarity of communication and behaviour may fit a small group of therapies, but cannot subsume this latter model.

Many clinicians who do not subscribe to the healthcare model see their work as an exploration of the human condition, a journey in the same sense that becoming a Buddhist monk involves a long process of questioning one's life, ideals and expectations. Like a Buddhist training, this long process of psychotherapy cannot be identified with a set of techniques or procedures to be applied to a human being, but forms rather a strange kind of relationship which operates in unpredictable and unexpected ways. One cannot know what will happen in advance, and change often takes place through surprise, bafflement, shock and disappointment. HPC regulates professions within a framework which explicitly aims to remove these variables, and so it cannot accommodate those therapies which give a valued and central place to risk, shock and disappointment, seen as tools of growth and development.

A further and critical reason for the unsuitability of HPC as regulator lies in the field of ethics. Psychotherapy has, for the last 100 years, offered the patient a system of values freed from the moral judgments of social authorities. This has indisputably been the central characteristic of psychotherapy and what set it aside from the mental hygiene movement and from techniques of social engineering. Therapy provides a space for challenging received wisdom, social imperatives and norms of all kinds. Yet HPC regulation, for many schools of therapy, would involve the wholesale application of such norms to the therapeutic encounter. The therapist would have to become a 'health professional', whose practice must adhere to a moralistic and normative framework. Failing this, the practitioner would be struck off.

This tension between psychotherapeutic ethics and social morals is a crucial issue, yet it must not be misunderstood to suggest that therapists see their work as somehow beyond the law. All therapy organisations agree that rigorous codes of ethics and conduct must be in place, as well as complaints procedures. In the event of any instance of sexual assault or financial fraud, the criminal justice system should be appealed to. In line with international practice, in other cases, mediation and informal resolution of complaints are the first step, rather than automatic escalation of a complaint to the level of litigation.

For some critics of traditional models of regulation, mediation and informal resolution are a profession's way of avoiding responsibility for mistakes and misconduct. Yet escalation

to the level of litigation and formal complaint may constitute barriers to real resolution of issues for those working within a non-healthcare model. For those therapies that are relationship-based, the parallel is less with HPC-regulated disciplines such as radiology or physiotherapy than with the introduction, encouraged by government, of mediation procedures as a first step when the divorce of a married couple is considered. Although this might seem surprising, it reflects more accurately the kind of problems some patients may experience in therapy - which, for many schools, is about re-living problematic relationships from the past – than the model of a failed medical intervention.

All of the above points have been made repeatedly to HPC by stakeholder groups, yet there has been no serious response to the issues raised. Rational debate is almost wholly absent, and the question of HPC regulation has been spun by HPC to give a picture of those therapists who oppose it as opposing any regulation of psychotherapy. As we have pointed out, this is by no means the case: the question is not 'no regulation' but 'the appropriate regulation', yet HPC has been unwilling to recognize this fact.

For these reasons, therapists and counsellors have been critical of the proposed HPC regulation of the field of the talking therapies. As well as criticism from many of the established groups, newly created organisations have been formed, brought together by serious concerns about HPC: The Alliance for Counselling and Psychotherapy and The Coalition Against Over-Regulation of Psychotherapy are two of the most vocal and active of these networks, and most of the UK's best-known therapists have added their names to the petitions that these groups have created. One of the results of the work of these groups has been to show that most practitioners in the UK are not aware of the detail of the current proposals. This report aims, in part, to make this information available to practitioners, as well as to patients, prospective patients and anyone concerned with the practice of psychotherapy in the UK.

Complaints and the Protection of the Public

Over the last twenty years, a variety of proposals have been made regarding the question of the regulation of counselling and psychotherapy. During this time, organisations such as the UKCP, BACP and BPC have developed rigorous codes of ethics and practice, as well as complaints procedures, designed to ensure maximum protection of the public. Complaints panels must include both professional and lay representation, and are inspected periodically by the umbrella organisation. The most obvious question here is to ask why these structures need be disassembled, after the long process of their elaboration.

There are three main reasons usually cited: to introduce uniformity into the field, so that all procedures are identical; to ensure that bias is not introduced into proceedings by practitioners protecting practitioners; to produce a substantial reduction in the threat of serious harm to the public.

The first of these issues is perhaps the least controversial. All organisations agree on the basic point that in cases of sexual misconduct or financial fraud there should be the involvement of the criminal justice system. Yet such cases are very rare, and most instances of complaint concern friction within organisations, between colleagues or between trainees and training body. Cases of serious violation of professional boundaries are sometimes blamed on lack of regulation, yet in nearly all documented cases the perpetrators broke current laws of the land and hence the appeal to the criminal justice system.

The key question here concerns those cases which are not clear-cut sexual misconduct or fraud, and this introduces the second issue of the possible collusion between practitioners to preserve their reputations. Although such complaints are rare, they must be taken seriously, and this is where the particularity of the talking therapies should be recognised. All forms of talking therapy involve the phenomenon of transference, the mobilisation of thoughts and ideas from our infancy and childhood which have been pushed out of consciousness. Love or hate, for example, are not always easy for us to bear: sexual love for a family member or hatred of a caregiver are unacceptable to us, and so become repressed or radically pushed out of our minds. This, at least, is what 100 years of therapy has agreed. During a therapy, these thoughts and feelings will become real, yet generally without the conscious knowledge of the patient. They will experience them as entirely real and objective in relation to their therapist.

Working this through is the long, difficult and painful work of therapy. The key factor is that it is precisely this working through that the work of therapy consists of, and the therapist must accept to be in the place of a target for all the hostile, negative and amorous projections of the patient. Of course, the therapist will not respond to them in the way that one might in everyday life, and this will in itself create new problems. If a patient falls in love with their therapist and the latter refuses to requite the love, this may generate acute feelings of reproach. By accepting the place of the target of the patient's projections, the therapist becomes the object of a very serious complaint: indeed, it is highly likely that any trauma or difficulty in the patient's past will become reactualised in the therapy. If the patient had an abusive parent, it is almost certain that the therapist will be experienced as abusive at some point in the treatment. This is what makes therapy both so difficult and so fruitful, when such transferences are worked through.

Working within a framework that encourages complaint will of course have an impact on what happens to the thoughts and feelings mobilised in a therapy. Every patient will

probably have a complaint in a long-term therapy, yet this will be worked through rather than shifted to a different and legalistic level. The danger of the current proposals is that they fail to recognise the phenomenon of transference, and risk channelling them not into the pathways of working through but into those of adversarial formal complaint. This may well be encouraged by those no win/no fee law firms currently developing the area of 'emotional harm' perpetrated by therapists and the well-known fact that insurance companies today prefer to settle complaints in this field out of court.

The mediation procedures currently employed by most therapy organisations help the complainant to consider whether the resolution of the complaint is best settled within or outside the therapeutic space. Lay persons may be involved in this part of the process, and if it should later move to a formal complaint must form part of the panel hearing the complaint. These lay persons ensure against practitioners protecting practitioners, and their own knowledge of the therapeutic process makes them sensitive to the variables relevant to the context of psychotherapy.

Complainants may often be wary of the difficult and stressful bureaucratic process involved in a formal hearing, and see mediation as a better option. Mind service users, for example, have expressed concerns about a 'paternalistic' complaints process which would discourage the formulation of complaints. HPC complaints hearings, likewise, may require that the complainant disclose their medicals records, something that no current complaints procedure used by UK therapy organisations requires. HPC hearings are also held in public, unlike any of the current formal hearings that take place in therapy organisations or their umbrella bodies, and it may be traumatising for the complainant to have to discuss intimate details of their therapy in a public space, in front of a gallery that usually includes journalists. HPC hearings may be suited for the investigation of medical-style interventions that go wrong, but do not constitute a safe space for the complainant to disclose the personal issues that will usually be at play in a psychotherapy complaint. HPC, unlike therapy organisations and their umbrella bodies, provides no alternative routes to resolve complaints in a fashion sensitive to the complainant's vulnerabilities.

This situation is made even more difficult by the HPC definition of a 'service user' as anyone who is affected by the practice of a registrant: relatives, carers and spouses thus become encompassed within the term 'service user'. It is well-known that someone doing a therapy may make important changes in their relationships with those close to them, and that such changes are not always welcomed by the other party: distancing, divorce or dispute are not always easily tolerated. HPC's framework would encourage complaints by those who believe that such changes are somehow the malign influence of the therapist, whatever the view of the patient him or herself. Even if the therapist is exonerated, great damage will be done by the time the complaint is heard.

In those cases where a formal complaint is made and upheld, proponents of HPC regulation argue that only their statutory framework will guarantee that the individual in question cease practising and hence cease to pose a danger to the public. The loophole here is that the individual may simply practise under another title – say, mentor or life coach - as long as they do not use the HPC-protected title of counsellor or psychotherapist. The Practitioner Full Disclosure model discussed below resolves this difficulty, as it involves the statutory requirement that any therapist provide full details of their qualifications and record to the Register. Failure to do so, and providing false information, would be a criminal offence.

Another significant issue here is the place of complaints within the market of available treatments. To pay money to a therapist you have to know what product you will receive, and hence, if you don't receive it, be able to complain. This is the position as stated by HPC. Now, a very small percentage of current therapies work within this model of offering a product. Most therapies, on the contrary, do not. For them, therapy is not a product to be applied but a relationship that develops between two people. One can never know what will happen to this relationship, how it will unfold or indeed what risks it may carry. Most therapies, likewise, do not claim to remove symptoms. Symptoms may disappear

during therapy, but this is not the cardinal goal. Rather, therapy involves an exploration of human life, a journey, and as such it cannot be easily shoehorned into the market-based model favoured by HPC.

This situation is rendered more complex by the fact that many therapies – and in particular psychoanalysis – aim specifically at disappointing or frustrating the expectations of the patient. If they expect one thing, the analyst must try to offer something else. The relation is based less on harmony than on discord. Contrary to the HPC requirement that the practitioner 'must meet the needs of the patient', psychoanalysis can only work if these needs are not met. According to many schools of psychoanalysis, this frustration will allow access to unconscious material. Through this process, the expectations and ideals of the patient can become clear and may then be challenged and undermined. Most of the time this does not occur through the analyst saying to the patient 'You expect this' or 'You are like this' but through the actual playing out of frustrations in the treatment. If the patient expects, for example, that the analyst is very moral or perhaps very immoral, the analyst may act in a way that reverses these expectations. Grasping these details of analytic work is crucial for situating potential complaints in their proper context and evaluating them.

The above points, however, should not be taken to support the absurd conclusion that therapists are never at fault. Yet they indicate that any body charged with hearing complaints about the talking therapies must be sensitive to the kind of dynamics involved in treatment, rather than the simplistic medical model of HPC. Faults occur in all human relationships – disappointments, frustrations, insensitivities, mistakes – and often generate strong feelings. Many forms of therapy not only recognise this but see it as an essential part of the therapy itself: the therapist's mistakes and failings are confronted and explored. Crucially, this takes place within the therapy, allowing the patient to engage with issues of uncertainty, risk and the unknown.

The danger of current HPC regulatory proposals is a movement away from work within the therapy to complaints heard in another space, thus blocking the working through of the therapist's failings as part of the therapeutic work. It is more logical to increase public information on this question, making it clear to the public what kinds of things may happen in a therapy. They may then engage or not depending on their own informed choice.

The objection might be made here: why this 'soft' approach to therapists? Surely if they are guilty of misconduct, they must be punished and struck off, thereby protecting the public. Yet the current system of complaints, with mediation as first step, is not soft in any way on serious issues of misconduct, as is made clear below in the section 'The Alternative Model'. Therapists do not wish to see dangerous and unscrupulous individuals putting patients at risk and bringing their field into disrepute. The problem is with all the other frameworks that the HPC brings with it.

The risk here is that with HPC regulation, therapists will no longer take on 'difficult' patients, those they believe might make a complaint given the culture of encouraging formal complaint. Likewise, in their own practice, they may start to find themselves following a model of 'defensive practice', already described by some arts therapist now regulated by HPC and by some medical professionals. The patient is seen first and foremost as a potential complainant, and therapeutic interventions carefully selected so as not to run the risk of displeasing them. The consequences for the patient here are clear: less chance of accessing a therapist and less possibility of therapeutic change due to the restrictive parameters of intervention. Therapy becomes a practice of risk-management where avoidance of complaint or litigation takes priority over authentic work with the patient.

The HPC model also fails to protect the public in another specific way. HPC advertising shows smart professionals holding out their HPC certificates to members of the public, with the message 'You can trust me, I'm HPC-registered'. Yet in fact, all of HPC

complaints hearings concern practitioners who were precisely HPC-registered. There is a certain danger in fostering the illusion that a certificate guarantees trustworthiness, a fact borne out by the actual history of complaints against HPC practitioners. Creating a culture in which trust and expertise are supposed to be guaranteed by a piece of paper will also arguably accentuate the prospective patient's suggestibility, and hence make them more vulnerable to potential abuse. An attitude of scepticism is far more likely to protect the patient, making them alert to possible boundary violations or, indeed, to the simple fact of poor practice. In contrast, the HPC approach risks fostering a false sense of security and suspension of critical judgement in the public.

An analysis of HPC complaints hearings – detailed in Appendix 2 below – brings out many of the problems discussed as well as indicating the inordinate expenditures involved. In 2008, HPC spent £3.76m on complaints, yet out of 108 allegations made by the public (25% of all allegations), HPC was only able to consider 63 cases in the year, leaving 45 allegations made by the public unconsidered. This builds up a massive backlog, and no doubt puts undue strain and stress on both complainants and those complained against. Only 18 (29%) of the 63 cases from the public that were considered were taken any further, with 45 deemed unfounded. The large part of the £3.76m was thus spent processing allegations from employers, the HPC itself, others within the profession and a small number from the police.

The situation was similar in 2007. £2.9m was spent on complaints, yet out of 78 allegations made by the public, HPC were only able to consider 34. Of these 34, only 12 were found to have a case to answer. 56% of the total allegations made by the public were not considered. Most of the allegations made by the public have not been heard within the year they were made, unlike in the majority of therapy organisations where complaints are dealt with usually within 4 to 5 months of being made. HPC's bureaucratic and slow handling of complaints generates a growing backlog of complaints. Each year since HPC was established, there have been 30% more allegations made than cases considered. The vast majority of these allegations are made by employers, the HPC itself or from those working within the field. The analysis in Appendix 2 shows that these complaints from employers are clearly prioritsed over complaints from members of the public, yet with registrants paying for hearings rather than employers.

A comparison with the current statistics held by UKCP for the handling of complaints is illuminating. It captures significantly more complaints than HPC. It deals with them more sensitively, using mediation and informal systems of resolution, with nearly 60% dealt with in a satisfactory way by informal processes of mediation. Crucially, it has a higher case to answer rate and a better response rate for complainants. Where HPC finds no case to answer in over 70% of complaints, UKCP found no case to answer in just over 10%. It is also better value for money, with costs nowhere near the HPC figure. See Appendix 2 for further details and comparisons.

These advantages characterise the PFD model for dealing with complaints, detailed below in the section 'The Alternative Model'. Unless the allegation concerns breach of existing laws, it is heard first of all at a local level, with an emphasis on giving the complainant access to informal systems of resolution. If this is not satisfactory to the complainant, it moves to the level of formal complaint, to be dealt with by the organisation to which the therapist in question belongs. Complaints not resolved at this level - which have to date been quite rare - are then passed on to the PFD complaints panel, which appoints an officer to investigate. Mediation and informal techniques of resolution are favoured as a first stage, although the panel may decide that there are grounds for formal complaint. Sanctions are decided on a case by case basis, and may include exclusion from the PFD register.

How HPC Regulation Will Affect The Public

HPC regulation risks impacting the public in a number of adverse ways. As the diverse field of therapies become constrained in the HPC model, members of the public will have less choice as to the kinds of therapies they can access. In particular, many patients choose a therapy precisely because it offers them something different from the framework of modern consumer society. Therapeutic ethics have, for the last 100 years, offered patients a system of values freed from the moral judgments of social authorities, yet now, these systems risk being reduced exactly to the moralistic view privileged by HPC. It is as if being a member of, say, the Socialist Workers Party would now only be legal if one had joined the BNP first.

Many therapies today do not accept the basic concepts of mental health, of wellbeing, of normality, or even of expertise. These concepts, they would argue, are part of a market-based vision of human life, and not the spiritual, ethical journey of a therapy. They are concepts in the service of a view of human life that many therapies aim to challenge. Some therapies may advocate those values, but many do not, and have historically been characterized by a critique of dominant concepts of health and lifestyle. Many patients seek out precisely these therapists, and HPC regulation would effectively render them obsolete. HPC have stated that they would in fact aim to phase out such forms of therapy from 2012, with the message to the public 'Don't use these people'.

Thus anyone who disagrees with the value-laden vision of human life and wellbeing advocated by HPC would be excluded from practice as a therapist. This would leave those members of the public who wished to begin a therapy with a therapist who was critical of the values of HPC without the possibility of help. Society at large would thus be deprived of a unique resource to help those who seek to deal with their suffering outside a narrow medical model of health and illness. Members of the public would no longer have the freedom to choose their therapist, a fact already brought up by user groups. They would have to select a practitioner from a list which only includes those who practise those forms of therapy compatible with HPC's framework.

Many schools of psychotherapy, likewise, have always been critical of received social policies and ways of framing human suffering. The new regulatory proposals would effectively be collapsing these schools of research and enquiry, with a real loss to the richness and diversity of a democratic society which has a duty to provide a space for alternative and non-conformist views of human life. The HPC-approved practitioner of the future can appear to be a person whose moral character has been officially sanctioned, yet this runs counter to therapeutic ethics which aim to put received morality into question.

To consider psychoanalysis, for example, as a quasi-medical treatment performed by a group of 'good characters' threatens to close down the space in which a very particular and valuable form of critical operation can take place, namely, the sustained self-examination which entails a re-appraisal of what is held to be true and good. This would constitute a grave loss to prospective patients as well as depriving the public of a certain kind of critical social practice which has had a long and fruitful history.

Many patients and prospective patients engage in therapies they know to be critical of socially-sanctioned value systems, and of particular importance for many is the question of diagnostic classification. The DSM system currently used in medical services in the UK is not accepted by many traditions of therapy or by many members of the public.

A member of the public may receive a diagnosis of some variety of 'mental illness' in psychiatric services, yet wish to pursue a therapy with someone they know to reject this system of classification. The new HPC proposals in fact subordinate any therapeutic work to a diagnosis made and communicated in what are clearly the terms of DSM. The therapist is then under the obligation to refer the patient on to the treatment deemed to work best for that diagnostic category, an imperative which would effectively shut down the possibility of the patient's working in a non-medicalised environment of their own choice.

HPC regulation would also involve a new definition of psychotherapy, as a set of techniques and procedures to be applied to a patient. Yet many psychotherapists would not recognise their work in this way. These future former psychotherapists, if they refuse to come under HPC regulation in order to keep their title, will have to find a different title for the therapeutic work they have been doing in many cases for a very long time. A person looking for psychotherapy as it used to be practiced (i.e. as a non-medical process of self-exploration and questioning) will experience more difficulty in finding the kind of person they can do this work with. The public will have to learn that they might not want a psychotherapist (in the new HPC sense) when they are looking for psychotherapy (in the current usage of the term).

Members of the public in therapy with an HPC-registered practitioner would have further difficulties in the event of a complaint. They might wish to use a process of mediation or informal discussion to resolve the issue in question, yet HPC provides no form of hearing apart from the formal and public complaints hearing. Members of the public will be less likely to engage with this adversarial and off-putting process, especially if their complaint clearly requires informal resolution.

Complainants involved in an HPC investigation may be required to disclose medical records, and, in addition to this, they will be forced to discuss sensitive issues and vulnerabilities in public. HPC hearings take place in front of a public gallery. This will almost certainly discourage potential complainants from pursuing their complaint. Comparison of HPC complaints hearings with those of therapy groups currently shows far more are processed in therapy groups than in HPC, and most of these use mediation and other resolution processes. HPC complaints take an average of at least one year to be heard, with more than 70% of complaints deemed 'no case to answer'. Members of the public will thus not receive the protection they merit via HPC procedures.

How HPC Regulation Will Affect Therapists

It is often claimed that HPC regulation will not affect the current practice of therapists in any significant way. They will be able to carry on their work as they have always done, unhindered by any new requirements or guidelines. However, HPC regulation will in fact have a significant impact not only in terms of individual practices but on the whole culture in which therapy takes place. Once therapy is reduced to an outcome-based model, complaints can be made either by the patient or by third parties (HPC defines 'service user' to include anyone affected by a registrant's practice: relatives, spouses etc) to the effect that the expected results have not been achieved.

Therapists will be less likely to take on difficult cases, and there is the risk that practice will become defensive: the therapist will be more concerned to avoid complaints than to foster growth and change in the individual. The patient will be seen more as a 'client of therapeutic services', and rigid rules of conduct will risk blocking creativity and surprise in the therapeutic encounter.

The most recent HPC Standards of Proficiency for Counselling and Psychotherapy testify to this misunderstanding of the therapeutic process. Therapists will have to:

- know how to operate equipment and minimise the risk of infection.
- know how to select appropriate hazard control and risk management, reduction or elimination techniques.
- have a knowledge of health, disease, disorder and dysfunction.
- be able to evaluate and implement intervention plans using recognised outcome measures.
- know how to use protective equipment.
- know how to formulate and deliver plans and strategies for meeting health and social care needs.
- understand the principles of quality control and quality assurance and conduct audits correspondingly.
- maintain an effective audit trail, participate in audit procedures and work towards continued improvement.
- be able to formulate specific and appropriate management plans including the setting of timescales.
- demonstrate a logical and systematic approach to problem solving and be able to initiate problem solving techniques.
- observe and record client's responses.
- be able to demonstrate effective and appropriate skills in communicating information, advice and instruction.
- understand the need to engage service users and carers in planning and evaluating the diagnostics, treatment and interventions to meet their needs and goals.
- understand the importance of maintaining their own health.
- know how to meet the needs of the client.

These Standards may be suitable for some health professions, but will change radically the framework of current psychotherapy practice. Many therapists do not see their work as involving set outcomes, or data gathering, or problem solving, or drafting management plans for the health of their patients, or applying possibly unacceptable systems of classification of 'disease' or 'dysfunction'. For some, likewise, communication may be oblique or allusive, rather than direct. The detailed commentary in Appendix 3 goes through the Standards of Proficiency one by one, pointing out their unsuitability to many forms of therapy.

Therapy, on the HPC model, risks becoming a stage on which the parties work together under the spotlight of a judge or examiner, perpetually concerned about 'doing the right thing' or satisfying guidelines and regulations. The very processes that the therapy may be aiming to free the patient from – a rigid and overbearing internalised examiner or judge – would thus become the framework of the therapy itself. These double standards can hardly be compatible with an authentic and ethical practice.

If HPC regulation were to take place, the practitioner will first of all need to provide a character reference from someone of 'good standing' who can vouch for their 'honesty and integrity'. They will then need to provide a health reference from a doctor who has known them for three years and who is registered with the GMC (charges for this to be paid by the applicant). Their health and 'character' may be considered by a Health and Character Panel, appointed by the HPC. Renewals forms will have to be submitted biennially. If they are not received, the practitioner will be removed from the register and unable to practice. To be re-admitted to the register there would be a charge of £191. Anyone not practicing for two years or more will have to re-apply to the register. The police will inform the HPC of any convictions the therapist may have prior to being on the register or while on the register

Assuming the role of an HPC-registered Health Professional will mean that the practitioner must meet their Standards of Conduct. The practitioner will be required to seek 'informed consent' from the 'service user', who will need to be told about the possible outcomes of the treatment. For most therapies this is clearly problematic, yet the obligation to determine outcome opens the gate to poorly founded complaints which may well be made by some unscrupulous individuals for financial gain. Law firms are currently developing the new area of 'emotional harm' caused by therapy, and insurance companies today are settling out of court to avoid excessive costs. If one well-paid expert witness can claim that the therapist didn't employ 'best-practice', refer the patient to a 'more-proven' therapy or that they caused emotional harm, insurers may well decide to settle. HPC complaints investigations, with their lack of sensitivity to the variables central to therapy, risk establishing the platform on which dubious legal action will then be taken.

This may then create a culture in which every aspect of the therapist's practice takes place within the shadow of potential litigation, a situation already reported by doctors and other professionals. Therapy becomes a risk-management procedure, with an ever-increasing number of health and safety regulations introduced, making authentic and creative practice effectively impossible. Teachers have also reported this redefining of their work over the last decade, and the growing number who retire for reasons of workplace-induced ill-health or despair should be sobering for those therapists who do not believe that HPC would affect their practice.

How the practitioner works will be determined by the HPC's Standards of Proficiency that reflect a particular and narrow notion of clinical practice (See Appendix 3). The current draft requirements state that relationships with service users are based on mutual respect and trust, an approach which makes no recognition of transference. Other requirements include the application of a theoretical model to the service user, the communication of empathy to the service user, keeping records using only acceptable terminology, to facilitate the service user's exploration of 'meaning' and to implement specific treatment methods for the symptoms of 'severe mental disorder'.

Many of these requirements impose a psychiatric framework on the work of therapy, as if a constituted medical knowledge were the point of reference for therapy. It is also clear that the formulation of these and other requirements imply that, in the event of a complaint, they will be used as benchmarks to assess a therapist's practice. HPC's requirement that therapists do not work outside their 'scope of practice' may seem reasonable, yet it risks imposing what HPC take to be received notions of what determines this scope. Classifications taken from psychiatry and which presuppose the concept of 'mental illness' would be likely to determine this, and the average case load of a therapist today would with great probability contain several instances where it was found that the

therapist was operating outside their 'scope of practice'.

Many therapists, of course, reject the vocabulary of 'mental health' and 'illness' and their own philosophy and ethics would render the HPC requirements nonsensical. The emphasis on the notions of 'health' and 'illness' means that there is a risk that patients all be fitted into diagnostic categories taken from psychiatry (DSM) and allocated the best 'evidence-based' treatment. If a therapist received a patient with, say, an anorexia, they will be obliged to tell them that the latest research shows that another form of therapy 'works better' and then to refer them on. If the patient decides to pursue the original therapy, the therapist risks litigation at a later date for not having referred the patient elsewhere. This may come from the patient themself or from their family. As pointed out above, insurance companies today are prone to settle out-of-court to avoid the costs of prolonged litigation, and the more that this becomes known, the more likely it is that some unscrupulous persons will engage in therapies just in order to pursue litigation for emotional harm at a later date.

Therapists would also be required to keep a 'portfolio' that demonstrates their CPD, how what they are doing in relation to professional development evidences how they meet all the standards set by the HPC, and how this benefits their patients. The therapist must demonstrate that they are taking up more than a 'form of learning', demonstrating that 'learning outcomes' have been of benefit to 'service delivery'. This outcome-based framework will not fit most forms of therapy, and risks coercing the therapist into a culture of duplicity, creating false rationalisations to appear reputable to HPC.

If a CPD portfolio is falsified, the therapist's Fitness to Practice will be investigated which can lead to being struck off the register. If the therapist is struck off the register, they cannot work as a practitioner for five years, and may then re-apply. Clinicians cannot call themselves psychotherapists unless they are on the register and they cannot be on the register if they are not practising. This is also highly problematic, as many therapies conceive training as involving first and foremost psychical change; that is why the main component of all training in psychotherapy is the therapist's own personal therapy. It then makes little sense to suppose that not practising puts the public at risk. The profound psychical change that personal therapy involves does not fit a knowledge and skills model where it would have to be updated to remain workable, as it would, for example, in medicine.

Regarding the issue of complaints, the HPC will inform the therapist's patients as to how to complain and what to complain about by way of a public advertising campaign. If a complaint is made, the therapist will be named and details will be made publicly available on the HPC website, prior to any investigation or hearing of that complaint. Hearing of complaints take place in public. If the therapist is found to be innocent of the charge, their reputation and livelihood may by now be gravely damaged. Allegations in proceedings to date hardly ever come from patients but mostly from NHS employers or colleagues. HPC may suspend or strike off practitioners for failures of 'personal conduct' which a court of law would not necessarily judge in the same way.

All of the above effects of HPC regulation risk creating a culture in which the therapist no longer acts authentically and creatively with the patient but rather feels they have to follow a manualised model in which the person one is working with is primarily a potential complainant and therapy a stage scrutinised by a third party. Defensive practice risks becoming the norm, with the therapist careful not to say anything that will displease the patient. Therapists may become like the employees of their patients in a business framework. To the extent that a patient may leave therapy at any time, they already are in a certain sense, but the new emphasis on a market-based model will transform this into a pattern where the therapist may feel forced to provide a product rather than engage in the risky and unpredictable relationship-based work that they have done historically. The culture of complaints, likewise, will foster more and more third party complaints, in which someone else feels damaged by a therapy, encouraged by no win/no fee law firms currently developing the new area of 'emotional harm' caused by therapy.

How HPC Regulation Will Affect Trainings

The UK network of psychotherapy, counselling and psychoanalytic organisations contains a wide range of trainings with different entry requirements, different systems of assessment and evaluation and radically different philosophies. This variety reflects different theories of human growth and change. With HPC regulation, all training programmes will have to meet HPC standards of education and training to ensure that they successfully deliver the Standards of Proficiency relevant to the modality in question. These Standards have been discussed in the previous section, and a detailed commentary on them may be found in Appendix 3 below.

The Standards suppose a largely medicalised model of healthcare intervention, inappropriate to the talking therapies, reducing them to the application of health 'management' procedures' and problem solving techniques. The person about to embark on a therapy is described more as a patient about to undergo surgery, with a team seeking out data on their case to be collated and discussed by a group of health professionals. The patient's participation as the main agent in the therapeutic process is completely ignored, to give a set of Standards that trainings will be obliged to deliver that change the very definition of therapy itself.

As well as teaching a radically different version of therapy, trainings will have to ensure that all the latest health and safety instructions are transmitted to trainees and members. The example of how such measures have increasingly affected teaching and social work illustrate what kind of stakes are at play here: aside from the absurdity of many of the regulations, trainings will have to outsource 'trainers' to teach trainees what are vaunted as the 'latest' developments that they need to know about.

The other key issue here is the question of personal therapy as the central variable of training. For many schools, the main element of any training in therapy or analysis is the person's own therapy or analysis. This is crucial since it explores the reasons why the person wished to become a therapist. By questioning the person's aims in wishing to work with human suffering, therapy hopefully allows the person to challenge their own motives. Indeed, deciding to give up one's aspirations to be a therapist is seen as a positive result by many schools of therapy and analysis. If there is a distinction between conscious and unconscious motivation, the conscious wish to 'be' a therapist must be explored and questioned.

This poses serious problems for any training which claims to offer a university-style approach to teaching and learning. For many schools, there can be no linear path through a training, and since one's own therapy is the central component of training, results can never be predicted in advance and, indeed, no standardised feedback can be given. Questions such as 'How am I progressing through the training?' make no sense according to these models. Accordingly, while maintaining rigorous assessment procedures should the trainee wish to apply for membership, they see their role as providing a space for the individual to critically reflect on the discipline, discuss clinical work, engage with new ideas and so forth.

The result of many therapies or analyses is certainly that the individual does take up a position as a therapist or analyst. But this is the effect of profound subjective changes at the psychic level and not of having learned any 'knowledge' or acquired any 'skills'. For many schools of analysis and therapy, taking up the position of clinician is like the scar of one's own psychic journey, defined and understood in different ways by different groups, but always in terms of the psychic work in their own therapy. Freud defined it as being able to forget anything that one 'knew' each time one saw a patient.

This view poses many problems for the HPC model, which relies on a linear, university-style model of knowledge acquisition, a model also adopted by Skills for Health in their NOS. On this model, one progresses through a course, learning more and acquiring new skills, receiving feedback that allows the trainee to know exactly where they are in the process. As the HPC Standards of Education documents spells out, trainings have to answer the question, 'How would you explain the overall programme and how a student progresses from day one to graduation?'.

The view of human knowledge here is very different from that of many schools of therapy and analysis, which believe that the result of one's own therapy must be a critical attitude to any kind of knowledge that claims to answer basic human questions. The HPC and SfH models effectively fail to recognise that the main component in a training, for many schools, is the personal therapy of the individual.

Once this fact is recognised, the whole idea of knowledge and skills and of student progression is put in question. The very concept of CPD also becomes problematic. Trainees don't graduate and then go on to improve themselves by learning more and updating their knowledge, since their own therapy or analysis will have taught them the vanity of human knowledge. If making the psychic journey that allows one to become a therapist involves, say, moving through one's Oedipus complex or one's depressive position, this can hardly be 'topped up' each year through CPD. CPD in fact supposes a notion of the self as a project for realisation of betterment, exactly the view of self rejected by many schools of therapy and analysis, which see it as based on a market-led vision of human life, where the individual must acquire/buy more attributes to make them an effective competitor in the marketplace.

HPC regulation would risk imposing this view on trainings which have been based for decades on a totally different view of human life, more in line with a Buddhist attitude to human knowledge and self than that of market-based visions. There is also the serious risk that HPC regulation will weaken the organisations in the field due to its policy of individual membership. Once one is HPC-registered, there would be no need to remain a member of one's own organisation. This would obviously have detrimental effects on trainings and may even lead to the collapse of institutions with a long and distinguished history. The very life of the profession risks being sapped by this centralising process.

There are also concerns about entry requirements. Many therapy organisations conduct extensive interviewing procedures which are based not on a set of formal requirements but the sense of the candidate as a human being. This time-honoured process allows many people who come from underprivileged backgrounds to enter therapy training organisations. Many will not have done an MA, and some will not have been through higher education, yet their qualities nonetheless make them well-suited to the field of therapeutic work. The rigid HPC set of formal requirements will result in the exclusion of these candidates, and effectively make therapy trainings open only to a small subset of the population (a privileged white middle class group). This was recognised by the Health Professions Council of British Columbia, which, after being approached by some stakeholder groups, concluded that its regulatory framework was not suitable for many of the groups under consideration, and would exclude potential trainees from trainings.

The HPC accreditation of trainings poses the further threat of introducing new parameters and coercing training courses to adopt particular models of the psyche or of what HPC consider to be 'best practice'. Notions of 'best practice' are widely used within HPC at present and are also found in their discussions of therapy and counselling, as if there was just one model of best practice. This relies generally on techniques that are inapplicable to the therapies, such as RCTs, and assumes that there is such a thing as "what is known", a phrase that appears in HPC generic standards.

As well as adopting a model of best practice that is rejected by most therapy and analytic organisations today, HPC ignores the fact that for many schools it is precisely moments of poor practice that may have crucial effects in a therapy. Engaging with the therapist's mistakes, blunders and insensitivities will play an important part in the therapeutic work

and allow it to move through critical periods. For many schools, realising that the therapist is human too and gets things wrong is essential in the process of engaging with the risks of life and undermining phantasies of expertise or omnipotence. There is likewise no such thing as a single and correct way to practise, a fact made obvious by recognising that most work is done not by the therapist but by the patient. Patients find very diverse ways of using the therapeutic space and each therapy will be tailored to these unique and individual details.

HPC regulation would thus have detrimental effects for trainings which are based on philosophies at odds with the HPC vision of what therapy is about. The meaning of psychotherapy would, for many organisations and traditions, be changed radically. HPC's medical-style model would restructure existing trainings, which would have to conform to the Standards of Proficiency established by HPC. The imposition of linear, university-style models of training would undermine the personal therapy-based paradigm currently dominant in the field where the focus is on psychical change rather than surface knowledge. It would also have detrimental effects for trainings which do in fact accept the HPC vision, by weakening their own membership bases.

The Alternative Model

We have seen above how the HPC model is not suited to the handling of the majority of complaints in counselling and psychotherapy, and how its framework will have detrimental effects on both the profession and on the public. A more robust alternative that would reinforce public protection and preserve the ethical codes of practitioners is the Practitioner Full Disclosure model, a version of which has already proved robust in Australia, Washington State and some other parts of the US.

PFD involves the establishment of an independent body to administer a web-based national database of practitioners, giving full details of their training, their affiliations, their school of therapy, as well as the codes and complaints procedures which they abide by and details of previous professional memberships. Rather than multiple databases – the current situation – PFD allows the public a simple and direct way of finding out about therapists. It would be a statutory requirement that any practitioner of a talking therapy would have to provide full details to the PFD register. Knowingly supplying false information would be a criminal offence.

This avoids the loopholes of HPC regulation, which, since it regulates titles not functions, could allow a practitioner who had been struck off their professional register to simply set up the next day under another title not regulated by HPC. PFD, on the contrary, would prevent this through its requirement that any practitioner of any form of therapy register, and include details of previous memberships and, if it were the case, exclusions. The HPC register, in contrast, as they admit, "does not provide a means by which members of the public can find further information about an individual's background, area of practice or (normally) any additional qualifications or experience".

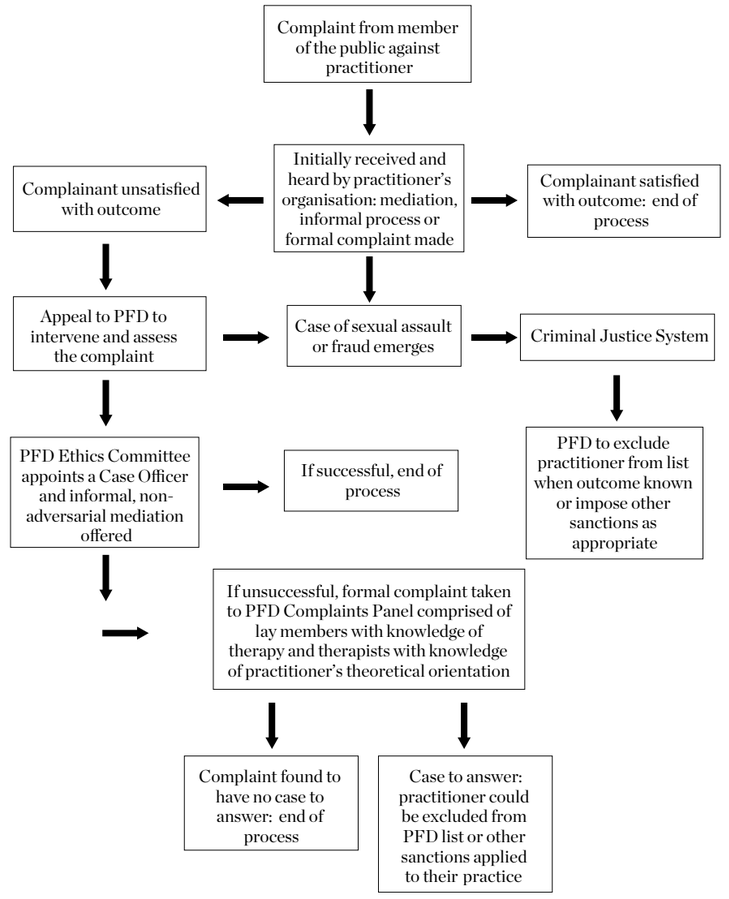
FPC thus avoids the 'brass plate' argument often cited in the regulation debate. Anyone, the argument goes, can set themselves up as a therapist simply by putting up a plate advertising their services. The PFD list deals with this neatly since it would immediately be clear to a member of the public whether the person they were considering seeing was on the list or not. A public information programme would at the same time inform the public of the variety of different therapeutic approaches, helping them to make an informed choice as to who to consult and alerting them to the potential risks and pitfalls of therapy. This model exists already in Canada and Australia, and allows members of the public to make their choice on the basis of full and accurate information.

Regarding the issue of complaints, in cases of sexual assault or financial fraud, the criminal justice system would be brought in, as it is currently in the UK and in other countries. For other complaints – which are in fact the vast majority in this field - if a complaint was not dealt with in a satisfactory way by the organisation handling it, the parties could appeal to have the case heard by the PFD panel, made up of lay persons with an experience of therapy as well as practitioners from the particular area of therapy which was in question. These would be handled in a non-adversarial way, with mediation a first step in the procedure, as it is in many other countries.

For each complaint, the PFD Ethics Committee would appoint a case officer, who would communicate with the complainant and establish the context of the complaint and its details. The complainant would be offered the possibilities of informal processes of mediation as a first stage. If this was not deemed satisfactory, formal complaint could be made, with the case officer and the Ethics Committee appointing a complaints panel to hear the case. This panel would be made up of lay people with a knowledge of therapy and practitioners with a knowledge of the particular orientation of work involved.

Judgements from these hearings could result in exclusion from the PFD list. However, in keeping with the ethics of counselling and psychotherapy, the possibility of human change would not be ruled out *a priori*, and so strategies and models of reflection and change would be considered by the parties involved. The complaints process could be represented as follows:

Alternative Model of Practitioner Full Disclosure (PFD)



The PFD model thus ensures protection of the public in a way that avoids gross interference with the ethics of the different schools of therapy. It does not attempt to shoehorn all therapies into one single model of 'Health Profession' but respects the diversity and difference between therapies, making the public aware of these and allowing a swift and efficient way of checking to see what the therapist's qualifications are.

The PFD administrative body would have an advantage over existing structures due to its independence from professional self-interest, through being one step removed, while at the same time drawing on areas of expertise from the field, being publicly accountable and, without the need for the vast administrative and legal structure of HPC. PFD allows for the creation of a robust and responsible body while at the same time preserving the unique identity and traditions of different therapeutic approaches. PFD would provide an overarching framework for the field with clear standards as well as a structure which is flexible enough to include schools of therapy with very different philosophies and views of the self.

Problems with the Consultation Process

The consultation process initiated by the Department of Health has followed two paths: that of the HPC and that of Skills for Health, charged with developing National Occupational Standards for psychotherapy. HPC were required to assess the 'regulatory needs' of the field and determine whether it was suited to accommodate it. Yet the fact that all the main therapy organisations rejected HPC as regulator was ignored, thereby foreclosing the question of 'regulatory needs'. The process at SfH has been just as controversial as that at HPC, and has resulted already in a number of formal complaints. Documents released under the Freedom of Information act, detailed below, show staff at SfH conspiring to lie to stakeholders. Both SfH and HPC have also failed to remain faithful to the original Department of Health remit to include representation from the breadth of the professional field and to respect the difference and diversity of the stakeholders concerned.

The HPC and SfH consultations give serious concern about the parity and transparency of the consultation process. They show both a failure to reflect the particular and differing nature of the psychotherapies in the mechanisms of regulation, and a hijacking of the process by a minority section of the profession to the exclusion of others. Re the crucial issue of complaints, there has been an over-reliance on the advocacy group Witness, which works closely with HPC and has received significant funding from the DoH.

Witness circulates stories to the media of abusive therapists and promotes the HPC as the solution to this, yet there have been questions as to the possible conflict of interest that may be involved in their approach, and the HPC's collaboration with Witness as opposed to actual user groups. According to Companies House, Witness has been in administration for some time now and there have been concerns that if funding were to be a key issue for their survival, and if the DoH and even HPC were funding this organisation, there is the risk that Witness may not be in the best position to articulate critiques of HPC.

Both HPC and SfH have failed to include a representative cross-section of the field in their consultation. The HPC's Professional Liaison Group, which deals with the talking therapies, was open to all stakeholders, yet membership was given almost exclusively to those who would not have a critical voice. Stakeholders involved in the regulation debate for decades were excluded, and HPC maintained a broadly disingenuous attitude throughout its meetings with stakeholders groups.

PLG meetings included such details as a member of HPC staff punching the air with joy when it was announced that the cost of making an appeal against HPC would rise for the party making the appeal, if unsuccessful, and a member of HPC staff circulating an inflammatory letter to stakeholders with allegations about a critic of HPC, and then refusing to circulate the response from the party concerned. The staff member admitted privately this had been a "mistake", yet HPC refused to acknowledge that anything untoward had occurred, despite the damage done by the circulation of the letter. Complaints to HPC's regulator, the CHRE, were not taken up due to the fact that CHRE decided that this was the action of HPC personnel, rather than HPC, and hence it could not be acted upon.

HPC, like SfH, have been working since at least 2007 on the proposed regulation of the talking therapies, yet their Chair could admit in late 2008 that as well as not knowing what transference was, he had no idea what psychoanalysis was either, despite the fact that

several explanatory documents had been received and acknowledged by HPC over that time. Documents from the field spelled out clearly the problems that not understanding the concept of transference posed for the HPC model.

Stakeholder groups continue to remind HPC of their main areas of concern, and their difficulties with HPC's handling of the consultation. From December 2008 to May 2009 there was a 'call for ideas' and stakeholder groups submitted detailed documents to HPC. The objections raised and the difficulties described are documented but were not acted upon or responded to. The process, for the stakeholder groups, was simply a formal show, to suggest that HPC had 'listened' to the field.

As for SfH, they appear to have failed to conduct the research they were briefed to carry out for themselves, relying almost exclusively on 'outsourcing' opinion about what is legitimate and what isn't: this meant effectively emailing one of a handful of 'experts' to ask if an academic or clinician that SfH had themselves invited to be part of the consultation process should in fact be 'invited'. These distortions to the consultation process – which are detailed below - have effectively ruled out a rational assessment of the feasibility and suitability of their project.

Problems with the Skills for Health Consultation

The consultation process initiated by the Department of Health was intended to assess the feasibility and suitability of state regulation through dialogue with all of the professional field. However, Skills for Health allowed their consultation to be monopolised by a very small number of people with both a narrow and restrictive view of psychotherapy and, arguably, a clear agenda to further their own particular brand of therapy which they endeavour to promote within the NHS.

The task of drafting psychodynamic/psychoanalytic competences was given by Skills for Health to Tony Roth and Steve Pilling, employees in the UCL Sub-Department of Clinical Health Psychology run by Peter Fonagy. Fonagy, in fact, chaired the Executive Group and the Strategy Group of the SfH project and also sits on the Reference Group, as well as sitting on the HPC Professional Liaison Group, charged with the regulation of the talking therapies. The influence of this highly controversial figure is thus unduly weighted in the consultation process. In one email disclosed under the Freedom of Information Act, Linda Hardy at SfH writes "I sort of feel I don't want to ask [Fonagy] everything".

Roth and Pilling, aside from having the link to Fonagy, are known for their work on CBT, a set of therapies which are totally at odds with psychoanalysis and most psychodynamic therapies. It is remarkable that the work was given to them rather than to one of the many university departments of psychoanalysis in the UK. It raises the question of how the UCL department managed to secure this contract.

This bias was continued in the composition of the project Expert Reference Group and the Modality Working Group, both of which were chaired by Anthony Bateman. Bateman is a close colleague of Fonagy and the two have co-authored a treatment manual for a form of therapy (MBT) which they endeavour to promote within the NHS. Fonagy is Director of the Anna Freud Centre, which holds courses on MBT in conjunction with the UCL Sub-Department of Clinical Health Psychology. These courses are held for those working in the NHS and generate revenue for the institution concerned. There is thus a line of economic benefit. The competences produced for psychodynamic/psychoanalytic therapy, many commentators have pointed out, fit MBT very well, but not other therapies.

A historical note is important here. Fonagy, Bateman and their colleagues are members of the British Psychoanalytic Council (BPC). The BPC is a network of organisations centred around the British Psychoanalytical Society, also known as the Institute of Psychoanalysis - of which Fonagy and Bateman are members - an organisation which for many years claimed to be the only psychoanalytic training body in the UK. They

repeatedly published statements that only their own members were psychoanalysts, and even wrote to newspapers claiming that those who pursued other psychoanalytic trainings were deceiving the public.

Over the years many other psychoanalytic organisations were established, attracting trainees who were not drawn to the Institute's practices, their theoretical orientations or the ethics of their selection procedures: gay trainees were not accepted until quite recently. Today, the majority of psychoanalytic practitioners in the UK belong to the psychoanalytic section of the UKCP, a fact which has been difficult for the Institute to accept. As the untenability of the Institute's position became clear, they moderated their claim to a monopoly, yet there is still a real tension between the Institute - and hence the BPC groups - and the other non-BPC psychoanalytic training organisations in the UK, most of which are in the UKCP. This is a major political factor in the current regulatory landscape which should not be underestimated.

The composition of the Expert Reference Group and the Modality Working Group was biased quite radically in favour of BPC - Fonagy and Bateman's organisation - with nearly all members coming from there. The list for the Psychodynamic Modality Group established on 16/10/07 consisted of 11 people, all of whom came from the BPC. Another list sent by SfH to Fonagy in January 2008 received the reply that it "goes slightly too far in the direction of UKCP", yet this list of 16 people included 2 from UKCP compared with 11 from BPC. UKCP, moreover, had pointed out to SfH in Jan 08 that it represented the majority of psychoanalytic practitioners in the UK.

Documents released under the Freedom of Information Act show how the lists for the work groups were made up almost exclusively of those from BPC and that, when other names of organisations or user groups that had actually been invited to participate were proposed or added to the lists by SfH, they mysteriously vanish. When further information on these disappearances was requested by The College of Psychoanalysts-UK under the Freedom of Information Act, SfH replied by sending hundreds of pages of irrelevant documents relating to the CBT groups and then claimed that they could not help further as they were only obliged by the Act to perform a certain number of hours work collating documents.

Some BPC groups may also have failed to inform their members of developments in the consultation process, with a handful of those on the relevant committees making claims for their membership without proper consultation. Nearly everyone involved in the SfH working groups either comes from BPC or the Fonagy UCL Department. In the list of PLG members that HPC have published, Fonagy's institution is listed as Skills for Health, a curious claim given he is not an employee of SfH and is in fact associated with the British Psychoanalytic Council, the same organisation as the person preceding him on the PLG list. If Fonagy's affiliation had been stated correctly, it would obviously have shown a bias in the PLG composition. HPC has not acted with transparency in this matter.

Fonagy, likewise, has been relied on in a wholly unprecedented way by SfH: in an email of 19.10.07, Linda Hardy of SfH writes re Fonagy "I sort of feel I don't want to ask him everything". Fonagy is a highly controversial figure in the world of psychoanalysis. He has advocated genetic testing as a guide to focus psychotherapy intervention and brain scanning to 'test' the results of psychodynamic work. He has termed the traditional neuroses 'disease processes' or 'weaknesses in brain function', and even encouraged brain scanning of two year old infants to determine whether psychotherapy intervention is necessary (as reported in The Times 12/5/07).

For many psychotherapists, these are extreme views, and it is therefore questionable why Fonagy has assumed such an influential and powerful role in the HPC and SfH consultation processes. Documents released under the Freedom of Information Act show Fonagy making incorrect and adversarial remarks about organisations in the field which are not questioned or checked by SfH. He puts in question the training standards of organisations critical of the consultation process with no substantiation, and SfH

make no effort to research or verify these allegations.

In September 2007 the UCL department apparently sent out a letter inviting participation in the expert reference group for psychodynamic therapy, yet this letter was not received by the psychotherapy organisations. It stated that the general framework would be that used for CBT, a fact which would have caused a great deal of protest in the profession had it been known. The methodology of the work is stated as "identifying manuals published in the UK, the US and elsewhere and building the framework from these sources". This would also have caused a great deal of protest in the field for the simple reason that there are no manuals of psychoanalysis, a fact which Fonagy himself points out in a minuted SfH meeting of 11/4/08. On 5/2/08, Roth and Pilling claim to have sourced "the psychoanalytic treatment manuals" for the criteria they have formulated, yet in the list supplied by them in May 2008 to accompany the NOS there are no psychoanalytic texts at all.

The result of the dominance of Fonagy and his colleagues in the consultation process has been the exclusion of other voices: professional groups and user groups have been excluded, despite initial inclusion in draft documents, and the Skills for Health team have even conspired to lie directly to an accredited therapist seeking representation in one of the work groups who had been invited to participate. Steven Richards, Chair of the British Society for Clinical Psychophysiology, contacted SfH on 18.10.07 requesting involvement in the cognitive and psychodynamic work groups. Linda Hardy of SfH writes to Rod Holland, who Fonagy had recommended to SfH to chair this group, on 25.10.07, that "We need not have him on the group if you are not happy - I'll rely on your superior knowledge of the therapies here!". This illustrates SfH's failure to conduct their research independently, leaving the process open to political manoeuvering. Holland writes that Richard's school of therapy "is at variance with most concepts of CBT", yet SfH do not assess this claim or even object to the exclusion of a diverse practice.

Hardy then writes to Richards on 29.10.07, "I contacted the chair of the group with your information and he feels that at this stage, with numbers on the group nearing capacity we really need to give the remaining few places to NHS employed practitioners as they are really underrepresented on the groups". In fact, it is because, as she writes to Marc Lyall of SfH two hours earlier on the same day, "Rod does not want this guy on the group. However I'm not sure what to say back to him - it's difficult when we invite people to show an interest and then tell them they can't join a group. I could say we are now seeking more NHS employed practitioners as they are under represented on the groups? [sic]".

When a Freedom of Information Act disclosure made these emails available to Richards, and he took them up with SfH, new correspondence was brought forward - not included in the initial disclosure - which it is quite possible and even likely that SfH has fabricated. The College of Psychoanalysts-UK has also written to SfH regarding an item of correspondence which they believe was falsified in order to cover themselves about another issue.

Other irregularities and contradictions in the consultation process are rife. On 1/10/07 Marc Lyall from SfH writes to Anthony Bateman asking him if he will chair the 'Psychodynamic Reference Group' when he has already been made chair in September by the UCL team of Roth-Piling. It appears that the Roth-Pilling decisions are just implemented by Lyall.

On 10/10/07 Marc Lyall emails Bateman and Fonagy the list of group members of the Psychodynamic Modality Group for them to review. Then on 16/10/07 the membership list is established. The list is of 11 people, all of whom come from one and the same political grouping (Institute of Psychoanalysis/BPC).

On 9/1/08 Marc Lyall of SfH writes to Bateman that "I am finding out which of the names...were nominated by UKCP and BACP..". yet if he was in charge of this part of the process it must have been known. It suggests that he just left it to Bateman, Fonagy and their team.

On 23/1/08 Lyall writes to Julia Carne, a stakeholder, that he has asked UKCP for nominations. He states that "Any list that you have seen. will be a list of nominations and does not represent the final membership of the group". Yet already in November 2007, SfH documents state: "Here is the membership list for the group".

On 25/1/08 Lyall writes to Prof. Darian Leader from The College of Psychoanalysts-UK; "I am of course aware that the list circulated is not representative of the organisations present within the field, something that we are looking to address". It is crucial, he writes, that the modality group "represents a cross section of the field" and that the list "has not been through the appropriate membership approval procedures".

25/1/08 Julia Carne's name is now on the list of the psychodynamic psychotherapy working group. Of the 20 people in the group listed here, 15 are from the same political grouping. Julia Carne's name then vanishes. Names of nearly all the other stakeholders not in BPC groups vanish.

19/3/08 CP-UK meet with Marc Lyall and Nadine Singh. They explain the politics of the analytic world, the distribution of analysts and emphasise yet again that the Fonagy-UCL group is not representative of the different analytic groups and orientations in the UK and that it does not speak for the majority of practitioners. They explain the debates around the question of evidence in psychotherapy, and send copies of articles and a bibliography requested by Lyall. They give him information about university departments and the BIOS centre at LSE where work critical of the UCL grouping takes place. The notes from this meeting are written up by Lyall and he confirms here and in a letter of 20/3/08 that representatives of CP-UK will be invited to join the Modality Working Group and that "these will be formally addressed by the Project Strategy Group at its next meeting".

Lyall asks in this letter; "Could you confirm what, if any, further action is reasonable for the Strategy Group to consider to remove the element of bias in the project..", yet then no further action is taken. CP-UK is excluded from meetings. On 3/4/08 Lyall writes to the College; "..I will get back to [sic] as soon as possible on the points you have made and the information you have provided." Yet no further correspondence ensues. SfH claim several months later to have asked two therapists in their work group to represent CP-UK, yet the therapists deny that this request was ever made, and CP-UK was never consulted.

03/ 09 The largest group of psychoanalytic psychotherapists in the UK (CPJA) unanimously approve report pointing out severe limitations to SfH NOS documents, and reject them as misrepresenting the work carried out by the vast majority of psychoanalytic psychotherapists. The report is sent to SfH. It is ignored.

04/09 SfH, ignoring the many critical responses to the NOS, issue briefing claiming NOS are applicable and accepted across the profession, in both NHS settings and private practise. The College of Psychoanalysts-UK publish response to the SfH briefing pointing out errors and misinformation. This is ignored.

07/09 HPC publish draft Standards of Proficiency for Psychotherapy and Counselling. These are greeted with critiques from a variety of organisations across the field. BACP encourage its membership to write to HPC to protest at the arbitrary and false differentiation of counselling and psychotherapy. The Standards would make many forms of therapy impossible to practise.

Appendix 1: The History

Debates around the possible state regulation of the talking therapies began in the UK in 1970 when, following a minor scandal associated with Scientology, representatives of a handful of psychology and psychotherapy organisations approached the DOH with the recommendation that Scientology be outlawed in order to protect the public. The subsequent developments are mapped out below:

1971 The Foster report is published concluding that there should be legislation to control psychotherapy in the UK.

1978 The Sieghart report recommends indicative (not functional) registration and the formation of a psychotherapy council.

1981 Graham Bright MP introduces the first psychotherapy bill which falls at the second reading in the House of Commons.

1983-89 Psychotherapy organisations meet annually in Rugby and form what is known as the Rugby Conference where the question of some form of regulation by the state and the formation of a voluntary register are discussed and planned.

1989 The United Kingdom Standing Conference for Psychotherapy is inaugurated based on the section module: therapy groups are divided into sections depending on their orientation.

1990 European debates lead to the formation of the European Association of Psychotherapy.

1992-3 The Standing Conference changes into the Council (UKCP) and produces the first voluntary national register for psychotherapy.

UKCP is later approached by the Council for the Professions Supplementary to Medicine (CPSM) with a view that it should join in with their application to effectively become the now HPC. This proposal is rejected, with the view psychotherapy was not a profession supplementary to medicine and would not benefit itself or the public by either being seen as a Health Profession or by becoming regulated by the Department of Health.

2000-1 Lord Alderdice introduces his Psychotherapy Bill which is rejected by the DoH, who announce that they are going to fit counselling and psychotherapy into the existing Health Profession Council (HPC). All stakeholder groups protest.

2004 In Brussels, the European Commission adds psychotherapy to the list of professions for which it issues Directives. Directives are used, inter alia, to standardise certain aspects of different professions throughout the European Community (EU), a process also misleadingly known as harmonisation. A major concern here is the practice, in some EU countries, to restrict training in psychotherapy to psychiatrists and/or those who hold a PhD in clinical psychology.

2005 Department of Health funds UKCP & BACP to scope training and practice of psychotherapy and counselling and to examine proposals for statutory regulation by HPC.

2006 All major stakeholder groups report to government that HPC is wholly inappropriate as regulator for psychology and psychotherapy. They propose instead the establishment of a Psychological Professions Council.

2007 Despite the recommendations of the reports from UKCP and BACP, the White Paper, 'Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century' charges HPC with exploring the regulatory needs of the field and its own suitability to regulate it.

February-March DH commissions Skills for Health (SfH) to develop National Occupational Standards (NOS) for psychotherapy, initially under three modalities.

May-June Without public tender or consultation SfH give contract for drawing up NOS for all modalities to University College London (UCL) Dept. of Clinical Health Psychology. Personnel in this department, arguably, may be said to have a vested financial interest in the outcome of the NOS: the directors of this department have developed a form of manualised psychotherapy to be used in the NHS. The department, jointly with the Anna Freud Centre, offers training courses in this treatment, specifically aimed at NHS personnel and Trusts.

June – October It is decided that the NOS will be based solely on manualised treatments which have undergone trials to demonstrate their efficacy. No other research evidence is admissible. This decision appears to have been taken by UCL Dept of Clinical Health and adopted by SfH. The research literature used is reviewed by the Expert Reference Group (ERG). SfH nominates Director of UCL Dept of Clinical Health as Chair, who invites selected colleagues on to it. Almost all of these work within the NHS and there are no psychoanalytic texts in the research material used. None are nominated by UKCP.

October-December UCL group start working up draft NOS for psychoanalytic/dynamic modality from this highly limited research. UCL group establish a biased list for 'Modality Working Group' (MWG) which will scrutinize draft NOS: significant controversy concerning how membership is formed.

December HPC publishes 'Counsellors and Psychotherapists - road map to their statutory regulation'. This document proceeds on the assumption that the current training standards, complaints procedures and regulatory frameworks of counselling and psychotherapy organisations (established by UKCP and BPC) are not adequate to protect the public. No risk assessment of the current situation is undertaken.

It assumes that all kinds of psychotherapy, including psychoanalysis, can be absorbed into the same framework without taking into account the many strands within the profession that argue cogently against this. Meetings between stakeholder groups and HPC produce no results, as if dialogue cannot take place.

2008 January SfH receive queries from several professional organisations concerning the membership of the psychotherapy working groups. SfH state that "the list circulated is not representative of the organisations present within the field".

2008 March Working party list confirmed, though UCL director says it "goes slightly too far in the direction of UKCP". Out of 16 people, 11 are from the same grouping as UCL director, with only 2 from UKCP. Stakeholders are excluded. No user groups are consulted, despite a statement in favour of this in original Strategy Group meeting in April 2007.

2008 April CP-UK writes to SfH under the Freedom of Information Act (FIA) asking for full disclosure of documents concerning the planning and formation of the Expert Reference Group (ERG) and the Modality Working Group (MWG).

2008 April-June Draft NOS worked on by MWG, published on SfH website. 450 detailed rules claiming to detail every aspect and stage of a psychoanalytic/psychodynamic treatment. UKCP reps describe them as wholly inaccurate for anything outside a very narrow manualised treatment within NHS type settings and not representative of psychoanalysis or dynamic psychotherapy.

2008 June onwards: SfH replies to The College of Psychoanalysts-UK FIA request with incomplete disclosure of documents requested. Extensive critique of the NOS from SfH produced by The Psychoanalytic Consortium. The section of the UKCP representing the psychoanalytic modality, the CPJA, and many individual training organisations have registered significant objections to the NOS, pointing out that they do not reflect the nature of psychoanalytic work. The following aspects of psychoanalytic work are contradicted by much of the content of the NOS:

- Psychoanalysis is based on transference and the idea that our conscious demands are moulded by unconscious desires
- Psychoanalytic work is not conducted on the basis of an expert doing something to the analysand in order to make them well (again)
- The analyst is not in receipt of knowledge about how the analysand should be and which they attempt to impart to the analysand.
- Neither the analysand nor the analyst can know in advance what it is that the analysand is struggling with. Through the analysis they can together recognize that they have stumbled upon an indication of it. The symptoms an analysand complains of indicate a now failing solution to an unconscious difficulty.
- The analyst will not know beforehand how the analysand will progress with their encounter with themselves, nor in what way their intentions with regard to their symptoms will change. So they will not be able to predict how the analysand will 'get better' nor how they will eventually measure the degree of the analysis' success
- Psychoanalytic work does not fit into a medical model of Health Care and psychoanalysis is not one of the Health Care Professions.

2008 June invite nominations from all psychotherapy organisations for the Professional Liaison Group (PLG): of 16 members a maximum of 6 will be from within the profession.

2008 August HPC issue 'Call for Ideas' requesting responses to 10 questions to assist the PLG in its deliberations on what recommendations to make to the HPC on the formation of the Register. Many of the responses to the HPC, now made public, point out the significant difficulties they and their members have, not with regulation but with the way that regulation is being undertaken. These focus on the fact that the framework being applied to the profession is in conflict with many of its fundamental premises.

2008 December Alliance for Counselling and Psychotherapy Against State Regulation formed to encourage debate about how protection of the public is not served by regulation by HPC : www.allianceforcandp.org

2008 December -**May 09** HPC sets up Professional Liaison Group to 'advise' on the suitability of the HPC regulating counselling and psychotherapy. The range of objections and difficulties with the project as detailed by responses to the HPC 'call for ideas' is distributed. Most of these are then ignored by the following proceedings.

2009 March HPC holds a stakeholder meeting in Manchester. Stakeholder groups endeavour to open up discussion of problems with HPC proposals.

2009 March The largest group of psychoanalytic psychotherapists in the UK (CPJA) unanimously approve report pointing out severe limitations to SfH NOS documents. The report sent to SfH

2009 April SfH issue briefing claiming NOS are applicable and accepted across the profession, in both NHS settings and private practise. The College of Psychoanalysts-UK publish response to SfH briefing pointing out errors and misinformation.

2009 May Coalition Against Over-Regulation of Psychotherapy formed. www.coregp.org

2009 May Opposition to regulation by HPC grows as greater understanding of the inadequacy of HPC to protect the public increases.

Appendix 2: HPC and the Handling of Complaints

The proposed regulation by the HPC is based on the premise that it will better protect the public than the current system of regulation which is carried out by organisations such as the UKCP and BACP, currently the major regulators for the psychotherapies. However, the HPC's own figures show that it deals with relatively few complaints from the public and costs an extraordinary amount of money in the process.

In 2008/09 it spent £4.66m, 36% of its total budget, on complaints yet this only included 78 allegations from the public. 58 of these were dismissed and only 17 complaints were found to have a case to answer. £4.66m for 17 complaints works out at £274,000 per complaint with a case to answer. This does not compare favourably with the existing system for dealing with complaints from the public in the field of the psychotherapies.

As well as proving poor value for money, over the last three years the HPC has consistently processed about 30% less complaints than the allegations it has received. Also, the allegations made by members of the public are processed less quickly than allegations from any other category of complainant. A backlog will be building up due to the unwieldy nature of the system and its failure to respond appropriately.

By comparison, the HPC does very well where complaints from employers are concerned. The majority of complaints received by HPC come from employers, and the HPC finds over 80% of these complaints have a case to answer. It also consistently processes a far greater proportion of the allegations made by employers.

So, far from protecting the public, the HPC upholds the interests of employers of the practitioners it registers, whilst being funded by registrants rather than their employers.

The HPC processes fewer complaints from the public than current organisations do, does it more expensively, and dismisses the majority of those it receives.

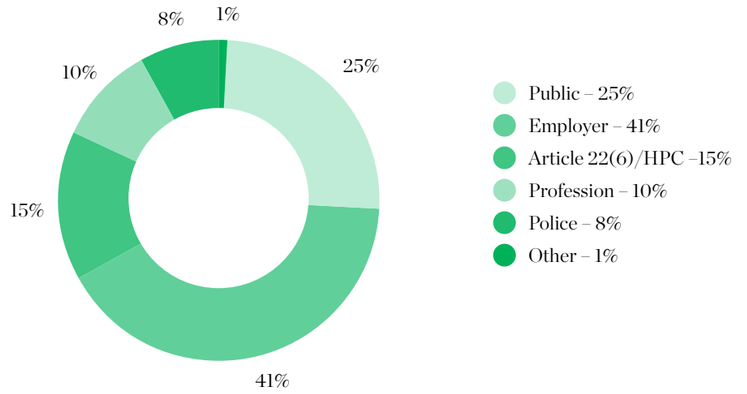
These conclusions are based on figures, outlined below, all of which are drawn from the following reports:

HPC Fitness to Practise Report, 2006/07
HPC Fitness to Practise Report, 2007/08
HPC (Draft) Fitness to Practise Report, 2008/09

HPC Annual Accounts, 2007
HPC Annual Accounts, 2008
HPC (draft) Annual Accounts, 2009

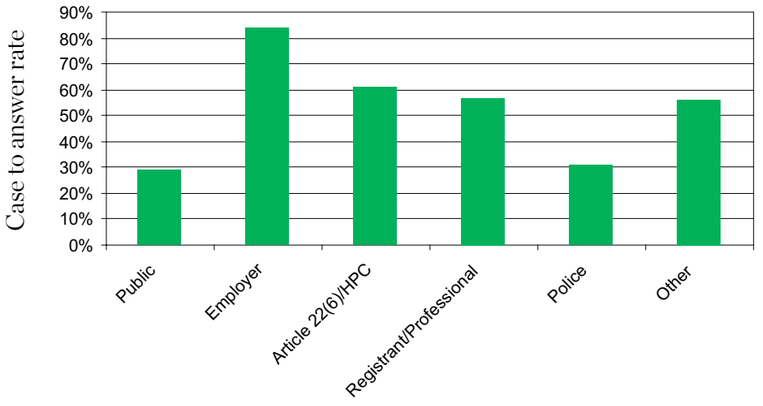
In 2007/08 the proportion of allegations from the public was only a quarter of all those made:

2008 breakdown of where the complaints come from



The proportion of allegations which the HPC considers to have a case to answer is very low for allegations made by the public, but high for those made by employers. The following chart compares the 'case to answer' rates for allegations made by different sectors in 2007/08:

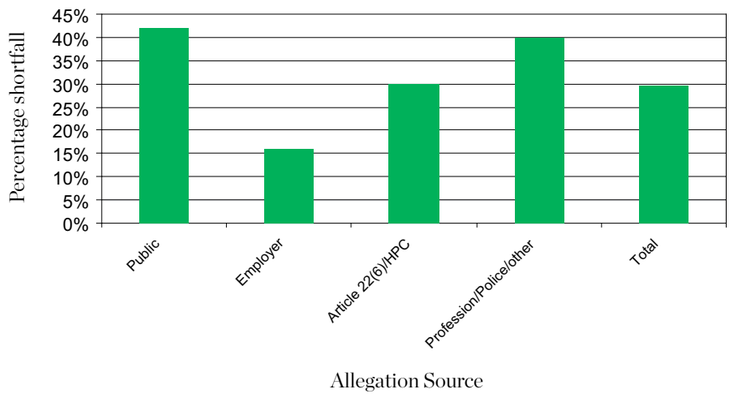
2008: Case to answer rate for allegations



The HPC is also processing, year on year, 30% less cases than there are allegations made. For example in 2007/08 there were a total of 424 allegations made, but only 299 were heard. That's a shortfall of 29.5%. This figure was similar for the previous year, and is 25% for 2008/09.

Again the public loses out because the shortfall in allegations processed is greater for allegations made by the public. The shortfall in cases processed following complaints made by employers is much smaller.

Percentage shortfall of allegations made/cases heard 2007/08



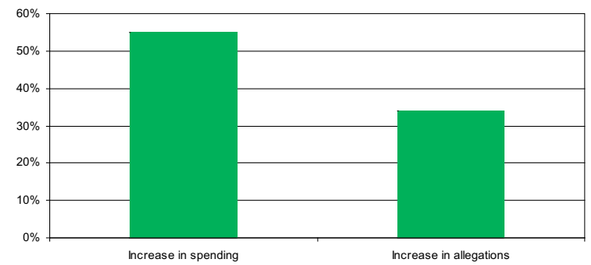
In 2007/08, 108 allegations were made by the public, but only 63 were heard: this is a shortfall of 40%, the highest out of all the categories. The Employers are much better served, with 143 cases heard out of 171 allegations made: only 16% shortfall.

Source of allegation	Total allegations made	Total allegations heard	% shortfall of allegations made to those heard
Public	108	63	42%
Employer	171	143	16%
Article 22(6)/HPC	63	44	30%
Profession/Police/other	82	49	40%
Total	424	299	29.5%

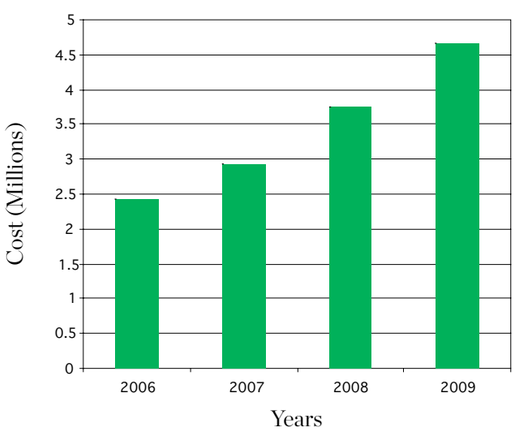
Rapidly-increasing cost of HPC Complaints hearings:

The cost of the HPC Fitness to Practise hearings is rising rapidly and steadily year on year, even though the number of complaints is not rising as rapidly. The following chart compares these figures rise since 2006:

2006-2008: Increase in number of allegations from public compared to increase in spending



The actual cost of the FTP hearings is rapidly rising also, now reaching £4.66m, 36% of the HPC's operational budget:



For **2007**, £2.9m is spent processing 70% of the total allegations, 24% of which arise from complaints from the public. This results in only 34 actual allegations from the public being considered in 2007; only 12 were found to have a case to answer.

So, for 2007, £2.9m to protect the public in just 12 cases to answer.

For 2008, £3.76m was the cost of protecting the public in 18 cases to answer.

For 2009, £4.66m was the cost of protecting the public in 17 cases to answer.

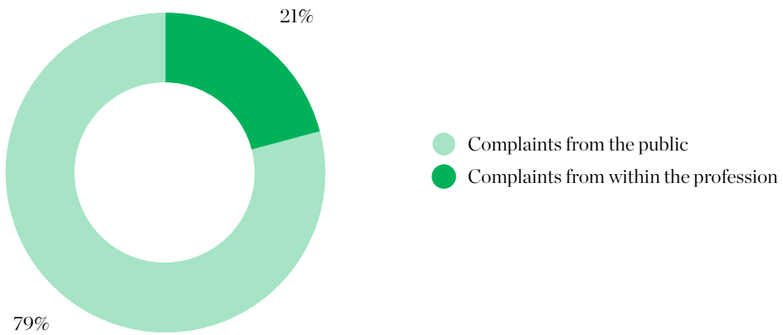
Comparison of UKCP Complaints

UKCP Member Organisations capture more complaints than HPC and manage them more sensitively: **The UKCP figure represents 0.35% vs the HPC's rate of 0.24% of registrants.**

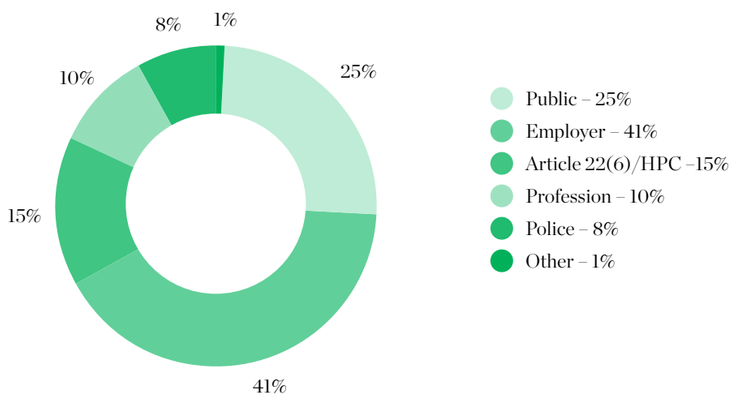
The current UKCP system of complaints is superior to that used by HPC in the following ways:

- it captures more complaints
- it deals with complaints more sensitively using mediation and informal systems
- it has higher case to answer rate: complainants are dealt with more sincerely
- it has a better response rate for complainants
- it offers better value for money: costs kept to a minimum

UKCP source of complaints

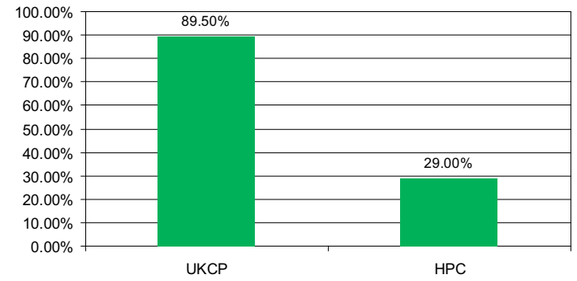


HPC source of complaints



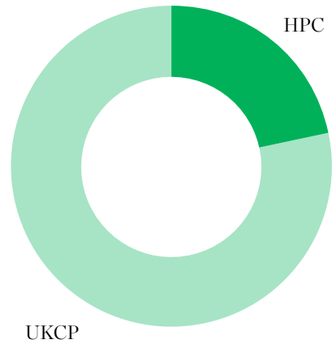
The UKCP has a much higher rate of finding that complaints from members of the public have a case to answer than the HPC:

UKCP vs HPC case to answer rates for complaints from public

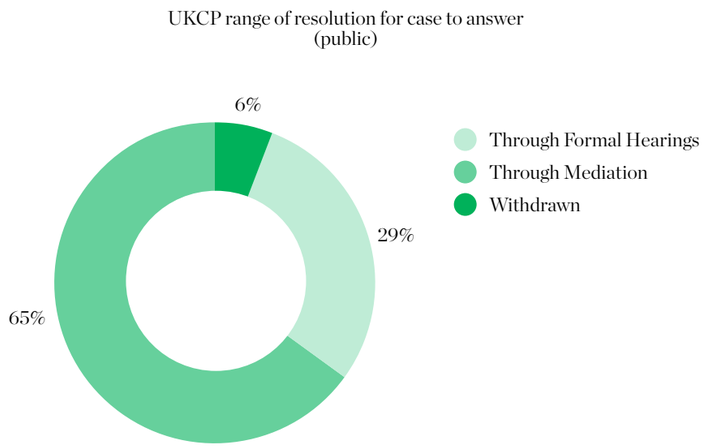


This information can also be shown in a pie chart to make the comparison clearer:

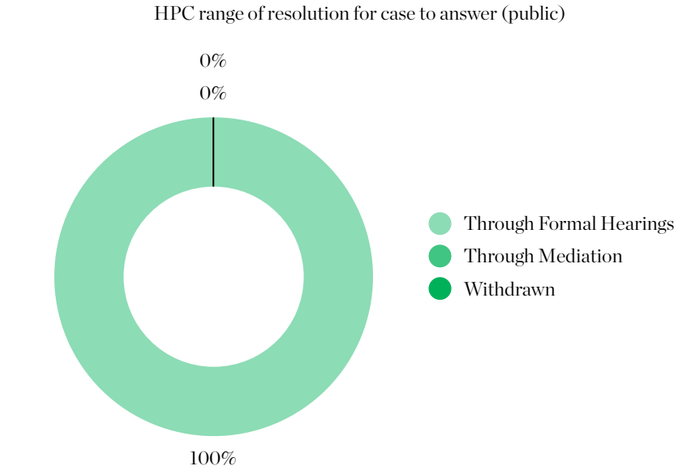
UKCP vs HPC case to answer rates for complaints from public:



The UKCP also has a range of methods for ensuring resolution of complaints to the satisfaction of the member of the public, the majority of which are done through mediation.



The HPC has only one method of dealing with complaints, this is expensive, adversarial, lacks any confidentiality and is often intimidating to the complainant:



From these statistics it seems clear that the claim of the HPC to be able to protect the public through the use of its complaints procedures and Fitness to Practise hearings is very misleading. The HPC spends a massive amount of money and delivers very little to the public. Most of its work is done at the behest of the employers of its registrants, or at the behest of other professional bodies. A tiny number of complaints by the public, in 2008/09 only 17 out of a total of 483, were upheld by HPC. Thus only 3.5% of the total allegations made were upheld by the HPC as valid complaints by the public. This constitutes 17 cases for £4.66m, a rate of £274k for each complaint.

Appendix 3: Response to the HPC Draft Standards of Proficiency for Psychotherapists and Counsellors

This text was drafted by the following organisations: Arbours Association, Association for Group and Individual Psychotherapy, Association of Independent Psychotherapists, Centre for Freudian Analysis and Research, The College of Psychoanalysts-UK, The Guild of Psychotherapists, The Philadelphia Association, The Site for Contemporary Psychoanalysis. It was sent to HPC and received no reply.

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Before providing comments on the individual standards of proficiency, it is important to make some general points which concern issues which recur repeatedly throughout this document.

1 The HPC standards have been drafted with hardly any thought as to the specificity of the talking therapies: there are references to the use of equipment, to infection control, and to the wearing of protective clothing. The fact that requirements that are obviously tailored to medical work within hospitals or NHS trusts feature so predominantly in the HPC standards begs the question of how much attention has been paid to the particularity of the talking therapies, despite the fact that the HPC has been exploring this field apparently for at least the last three years. Nearly all of the requirements would be highly controversial when applied to the talking therapies, although less so in relation to medical work carried out within the NHS.

2 The standards of proficiency presuppose a view of therapy which is contested by most major traditions in psychotherapy today. Therapy is seen as a procedure to be applied to a passive patient, and the standards suggest time and time again the image of a patient as an object being described, assessed, evaluated and acted on by a team of experts. This view completely ignores the central feature of psychotherapy: the fact that it involves a relationship between two parties, and that the main work of the therapy is conducted not by the therapist but by the patient. The patient is not a passive object who receives treatments and procedures from a therapist, but is rather the active agent in the process of therapy.

The standards repeatedly conceive the therapeutic process as the localised application of knowledge or skills to a patient rather than seeing the dynamical relations between patient and therapist as the central component of the work.

3 The standards repeatedly presuppose a view of the self which is not accepted by most of the main traditions in psychotherapy. The self is seen as a project to be realised, as if human beings were like faulty pieces of equipment that needed to be repaired and then continually upgraded. Psychotherapists have not been the only critics of this view of human life: philosophers and social theorists have observed and commented on this contemporary view of the self over the last three decades. On this view, the self must be continually improved and bettered, following both the old religious discourse about self improvement and the discourse applied to inanimate objects that are deemed to require continual upgrades (a well known principle of the modern economy). While there may be some therapists who adopt this view, the main traditions in psychotherapy do not see the self as something that needs perpetual improvement and bettering, but rather believe that therapy involves a recognition of the points of fracture, loss and disappointment that the new rhetoric of the self 'to be improved' tries to obscure. Growth and change are not about 'improving' or 'bettering oneself', but emerge as possibilities based on a recognition of often painful realities. Using the vocabulary of self improvement in the standards effectively makes therapists subject to the very principles that they are doing their best to challenge in their patients.

4 The standards repeatedly refer to procedures of audit, management and predetermined outcome. These terms may be applicable in most medical and business contexts, yet have little purchase for the main traditions of psychotherapy. These traditions see therapy as involving the fostering of a freedom in the patient from precisely these irrational forms of external 'audit' and 'management'. The HPC standards would thus force the therapist to do exactly what they are trying to get their patients to question and move away from. Clinically, this will produce therapists who constantly feel they are being watched, the private space of the therapy becoming the stage for an internalised judge or examiner. The consequences of this on therapeutic practice cannot be underestimated, and there is an irony here that many traditional descriptions of psychotherapy define it as the effort to free oneself from the internalised observer-judge that may be the cause of the patient's unhappiness.

Commentary on the Draft Standards

Please note that throughout this document, for the sake of convenience, we use the term 'patient' rather than 'client' or other terms used in different traditions of psychotherapy or counselling. It is not intended to imply a passive or medicalised position, but rather than of an active agent in the therapeutic process.

Point 1A.1

It is stated here that psychotherapists and counsellors must 'understand the need to respect, and so far as possible uphold, the rights, dignity, values and autonomy of every service user including their role in the diagnostic and therapeutic process and in maintaining health and wellbeing'. This requirement would not be accepted by a large number of practitioners. There is no reason why a therapist should respect the values of a 'service user', just as many therapists would not see it as their role to maintain the health and wellbeing of the patient, seeing this as in fact the responsibility of the patient. Many therapists do not see themselves as doctors or health professionals: they provide a space for a conversation about human life, rather than any kind of healthcare delivery. Similarly, many therapists would see it as a central part of the work to voice, on occasion, their own personal disagreement with the value systems of the patient. Should the Jewish therapist respect the values of the Nazi patient? The clash of value systems may in fact be a crucial instrument of change and development within a therapeutic practice. The references here to autonomy are also unclear, and may be problematic for those traditions which aim not to foster notions of autonomy in the patient, but on the contrary, to collapse them. It is also unclear what the references to the patient's role in the diagnostic and therapeutic process is meant to mean here.

1.6

Psychotherapists and counsellors are required here to 'understand their duty of care with regard to the legislation on safeguarding children, young people and vulnerable adults'. There is a question here of differentiating the duty of care of the healthcare professional and the responsibility of a therapist. Many therapists would believe that they certainly have a duty in relation to their clinical work, but this duty must be differentiated from the standard of notion of duty of care, especially when it concerns questions such as confidentiality.

1A.6

The requirement that psychotherapists and counsellors must be able 'to assess a situation, determine the nature and severity of the problem and call upon the required knowledge and experience to deal with the problem' would not be accepted by many therapists. They

would disagree with this medicalised conception of their work, which is based on the idea of localised intervention: a problem is defined and a procedure deployed to act on it. For the many schools of therapy which see their work as an open-ended conversation about the problems of human life, this requirement is entirely inappropriate. It suits more those therapies which seek concrete outcomes and solutions to problems. Many therapists, on the contrary, do not believe that they are in the problem-solving business. The danger here is that healthcare models of problems and solutions are used as a benchmark to both exclude and sanction alternative therapeutic approaches.

The requirement that psychotherapists and counsellors must 'be able to initiate resolution of problems', may be applicable to a small number of therapies but is largely antithetical to the practice and ethos of most forms of psychotherapy which are not focused on the resolution of problems and do not make any such claims to the public.

1A.7

The requirement that psychotherapists and counsellors must 'recognise the need for effective self management of work load and resources and be able to practice accordingly' may be applicable for staff working in organisations or NHS contexts but has nothing to do with the practice of psychotherapy

1A.8

The requirement that psychotherapists and counsellors 'understand the need for high standards of personal conduct' may be applicable to some therapists, but there are many traditions of therapy which highlight precisely the human nature of the therapist, and hence human weaknesses and failings. This is of course not to condone misconduct or breaches of professional boundary, but it is important as a part of the therapeutic process that the moral values of a society do not contaminate the individual value systems that can be fostered through the work of psychotherapy and counselling. The point has been made several times that psychotherapy has always offered a system of values freed from the moral judgments of recognised social authorities. Hence it makes no sense to apply these latter standards to those who undertake therapy and become therapists precisely in order to find something different.

The requirement that psychotherapists and counsellors 'understand the importance of maintaining their own health' is also inapplicable to the majority of schools of therapy. Therapists can drink, smoke and lead sedentary lifestyles just like anyone else. They do not have a duty to conform to any particular imperative of physical wellbeing obtaining in any particular historical period. Of course, if problems with their physical health make it impossible for them to practice, this is an altogether different question, one which all current codes of ethics and practice recognise and proscribe against.

The requirement that psychotherapists and counsellors 'understand both the need to keep skills and knowledge up to date and the importance of career long learning' may be applicable to some therapies but is at odds with many established traditions of psychotherapy which involve an engagement with the limits of knowledge. The idea of career long learning is part of the contemporary ideology of betterment or improvement of the self, as if the self is a project which must be realised, to allow one maximum satisfaction and efficacy in one's work. Many traditions of psychotherapy reject this view of the self, arguing that the work of therapy involves a recognition of human fracture and frustration, a recognition of the vanity of human knowledge and a profound scepticism as to the idea of a cumulative knowledge. The kind of knowledge operative in psychotherapy is unconscious knowledge rather than academic knowledge which can be simply and readily transmitted. Training in psychotherapy involves profound psychological change and it is this change that will allow the person to work with other people as a therapist. It is not about acquiring skills and knowledge, but rather about losing them, to open oneself up to another human being. The fact that this perspective is central to a large number of established traditions of psychotherapy must be recognised in any consideration of proposed standards of proficiency.

The requirement that psychotherapists and counsellors must be able to recognise 'their own distress and disturbance and be able to develop self care strategies' also supposes a view of the self antithetical to many traditions of psychotherapy. For these traditions, therapy is not about self care strategies, and the whole notion of self care has been the subject of sustained conceptual criticism. It supposes the contemporary ideology of management of the self rather than traditional views of a recognition and engagement with conflict, contradiction and fracture. The therapist here is once again put in the place of a kind of business manager whose job it is to pursue the work of risk management of the patient at the same time as a management and audit of the self. There may be some therapists who would subscribe to this view, but this is not a part of the relational person-centred version of psychotherapy that has been established in the UK for many years.

1B.1

The requirement that psychotherapists and counsellors 'understand the need to build and sustain professional relationships as both an independent practitioner and collaboratively as a member of a team' may well be applicable to some therapists working within the NHS but will not apply to many who work in private practice and who are clear about the importance of independence and, in some cases, not being part of a team. The internecine fighting between therapy groups over the last eighty years has meant that many therapists see it as a virtue not to work within a group and it is precisely this independence, even solitariness, that will attract certain patients to them rather than to other practitioners who work more closely within groups. This does not mean, of course, that the practitioner is not responsible and accountable for their work, but it means respecting the value of independence both for the therapist and for their patient.

The requirement that psychotherapists and counsellors 'understand the need to engage service users and carers in planning and evaluating the diagnostics, treatment and interventions to meet their needs and goals' may be applicable to a small number of therapies offering targeted interventions, but is not applicable to the majority of therapies which offer an open-ended exploration of human life and history. Planning and evaluating diagnostics, treatments and interventions is a medical paradigm that puts the patient in the position of an object, to whom a treatment is applied. Most therapies offer no set outcome and can make no honest promise about what will happen. Furthermore, many forms of psychotherapy aim specifically not to meet the needs and goals of the patient, with the idea that needs and goals are conscious phenomena, formulated as conscious demands, and if a distinction between conscious and unconscious thinking is recognised, the therapist has an ethical obligation to listen to the patient beyond their conscious wishes and demands. This is a fundamental feature of all psychoanalytic therapies, where the idea of meeting the patient's needs and goals makes absolutely no sense. The central ethical position of a psychoanalyst, according to the most widely practiced form of psychoanalysis, is the refusal of the analyst to meet the patient's demand.

1B.2

The requirement that psychotherapists and counsellors 'be able to contribute effectively to work undertaken as part of multidisciplinary team' may be applicable to certain therapists working in the NHS but has no application to most private practice therapy or counselling.

1B.3

The requirement that psychotherapists and counsellors must 'be able to demonstrate effective and appropriate skills in communicating information, advice, instruction and professional opinion to colleagues, service users, their relative and carers' may be applicable to certain health professionals but has little to do with the work of therapists and counsellors. There are many reasons for this. Confidentiality, for instance, means that clinicians do not broadcast their opinion, and, for most therapists, therapy is not about advice or instruction. As for communication skills, this may be important for some forms of therapy but is certainly inappropriate for others: a Freudian psychoanalyst,

for example, might remain totally silent and refuse to say anything for months or even years. The specificity and particularity of different traditions of talking therapy must be respected here and the public given the choice to pursue the form of therapy they consider appropriate, regardless of whether the therapist has communication skills or not. That is why the next requirement, that therapists and counsellors be able to communicate in English to Level 7 of the international English language testing system is absurd. There is no intrinsic reason why a therapist should have to speak any particular level of English: this may be for the obvious reason that the patients they receive would wish to speak in their own mother tongue, shared with the therapist, but also, and more fundamentally, because language is itself a psychological variable which will form part of the transference. If someone has been brought up by a parent who couldn't speak the language of the country they happened to be in, they may well seek out later in life a therapist who clearly has difficulty speaking a language. As long as the therapist does not claim to have standards of proficiency which they do not in fact possess, it is surely the choice of the patient who they wish to speak to. Insisting on a certain proficiency in English language removes that freedom of choice from members of the public.

The many other requirements in this section involve basic misunderstandings about language, presupposing the dated and much criticised view that language is simply a medium of communication. For most traditions of psychotherapy, as well as for the human sciences in general, language is less a medium of communication than in itself a body which has effects: the act of saying something in itself may produce change and the performative aspects of language have been well studied.

The requirement in this section that psychotherapists and counsellors 'recognise that relationships with service users should be based on mutual respect and trust' would not be accepted by all schools of therapy and it is precisely, in some cases, a lack of respect and trust that will generate the development and the dynamic of the therapeutic work. There is no intrinsic reason why a patient should trust a therapist, and indeed, it has often been argued that in an ideal world the patient's attitude should be one of sustained scepticism. It is well known that unconditional trust is the best possible framework for the abuse of power and the violation of professional boundaries. There is also no intrinsic reason why a therapist should automatically respect the patient, even if they may learn to respect them as the therapy progresses. To make it a rule that one human being should respect another is an arbitrary imperative: should the Jewish therapist automatically respect the Nazi patient for example? Note that this does not mean that a therapist should in any way mistreat a patient, an entirely different matter which is codified against in all current codes of ethics and practice of psychotherapists.

The requirement that psychotherapists and counsellors be 'able to communicate appropriately and effectively with other professionals about the client and propose therapeutic work' may be applicable to some therapists in NHS contexts but, even then, it raises serious questions of confidentiality. We find here yet again the view that runs thorough all the HPC's standards of proficiency that the patient is an object about whom therapists and other 'professionals' may have a discourse. The characteristic of most established psychotherapy traditions is to treat the patient as a subject and not an object. The fact that this kind of requirement keeps on emerging in the HPC standards shows the centrality of the medical model which underlies it: a group of people discuss a human being as an object of medical style interventions to be applied to them. In contrast, for most traditions of psychotherapy, the patient is an active subject with an active engagement in the work they undertake. The main work in the therapy, after all, is performed not by the therapist but by the patient.

1B.4

The requirement that psychotherapists and counsellors 'understand the need for effective communication throughout the care of the service user' begs the question of whether the therapist subscribes to the notion of communication and what theory of efficacy is assumed. The Freudian's complete silence, for example, may be felt as an effective communication by one patient but as a total lack of communication by another.

The therapist him or herself may likewise not feel that they are in the business of communication: they may well see their work as allowing the creation of a space in which the patient can hear themselves in a new way. It is thus not a question of communicating information or knowledge to the patient. Many therapists would also see the idea of communicating information to the patient as constituting a form of suggestion and hence consolidating the place of the therapist as a kind of master in the therapy, a situation which most therapists would want to avoid.

2

The requirement that psychotherapists and counsellors 'be able to build, maintain and end therapeutic relationships with clients' might seem natural enough, but it once again supposes a model of therapy as something that is applied to the patient, rather than seeing therapy as the work done by the patient. It is really the work of the patient to build, maintain and end the therapeutic relationship, although the therapist will no doubt work to facilitate this to the best of their ability. This asymmetry is another feature that is consistently ignored and unrepresented in HPC's standards of proficiency, which see therapy as a set of techniques to be applied to a patient rather than an active work performed by a patient. How, after all, can a therapist be able to end relationships with clients? A moment's reflection on this requirement shows its absurdity: if therapy is a relationship between two people with all the complexities and emotions of any passionate human relationship, it would be as if a requirement were imposed on human beings in their love relationships that they be able to end them competently. There are no rules for ending a human relationship, and to pretend that there are is pure charlatanism. Rather, what is particular to psychotherapy is precisely the fact that the difficulties, the horror, the pain and the complexity of endings actually form a part of the therapeutic work, rather than being a skill to be applied to it.

2A.1

The requirement that psychotherapists and counsellors 'be able to gather appropriate information' may be applicable to some health professionals working in the NHS but has little to do with most practices of psychotherapy and counselling, which are not about the gathering of information.

2A.2

The requirement that psychotherapists and counsellors 'be able to select and use appropriate assessment techniques' may be applicable to some therapists who work within a particular diagnostic paradigm, but there are many traditions of psychotherapy which use alternative models, in particular those which see therapy as simply a human conversation. Such therapies specifically aim to avoid the objectification of a patient through 'assessing' them. This point would apply to the following requirement, that psychotherapists and counsellors 'be able to undertake and record a thorough, sensitive and detailed assessment, using appropriate techniques and equipment'. It is remarkable that this latter phrase has been included in HPC's generic standards for psychotherapists and counsellors: even the most cursory review of the field would remind the HPC that psychotherapists and counsellors do not use equipment.

The next requirement obliges psychotherapists and counsellors to 'be able to devise a strategy and conduct and record the assessment process that is consistent with the theoretical approach, setting and client group'. This may apply to some therapies but certainly does not fit the many traditions of psychotherapy that do not subscribe to the idea of an objectifying assessment and also do not accept the principle of recording and the reduction of the patient to a written record. There are also many therapists who do not accept the idea that there is such a thing as a 'client group': rather they work with each unique individual who approaches them. When one starts to make client groups out of individuals, one necessarily imposes what some may see as arbitrary classificatory structures, something which is specifically contested by certain traditions in psychotherapy which see their work as attending to specificity and uniqueness rather than inclusion in groups and classificatory schema.

The next requirement that psychotherapists and counselors 'be able to observe and record client's responses and assess the implication for therapeutic work' is problematic not only in terms of the issue of recording but also as it neglects the fact that responses can be constructed retroactively and so may only 'be observed' years later within the context of the therapeutic process. Once again the HPC standards of proficiency suppose the idea of the patient as the passive unchanging recipient of therapeutic knowledge: in other words, someone who is talked about and thought about, rather than someone whose own activity constitutes the main part of the therapeutic work.

2A.3

The requirement that psychotherapists and counsellors 'be able to undertake or arrange investigations as appropriate' is clearly inapplicable to the field of the talking therapies although it may have purchase within the work of an NHS health professional.

2A.4

The requirement that psychotherapists and counsellors 'be able to analyse and critically evaluate the information collected' is clearly inapplicable to the work of the talking therapies, showing once again the view of the patient as an organism rather than a human participant in a person-centred therapeutic process. Hardly any forms of psychotherapy would see their work as involving the collection of information, although this is of course exactly what characterises some aspects of the medical model of healthcare delivery. In therapy, the therapist does not collect information about the patient and then use it to apply a procedure to a patient. Rather, there is an ongoing dialectical relation grounded in speech, which is of course radically different from information.

The next section is entitled 'Formulation and delivery of plans and strategies for meeting health and social care needs'. The very title of this section is indicative of HPC's failure to understand the basis of most forms of talking therapy, which do not involve the delivery of plans and strategies, just as they do not involve meeting health and social care needs of patients. These paradigms belong to a medical model of health care in which a team are treating a patient with targeted intervention such as the administration of a surgical procedure, a treatment via pharmaceuticals or other forms of medical and quasi-medical process. Most psychotherapists would fail to recognise their work in the requirement that they are there to meet the health and social care needs of their patients. And in fact, most would probably see the particularity of their work as offering precisely something which did not fit within the health and social care paradigm. Trying to fit their work into this paradigm not only does an injustice to this work and to the work of many patients in therapy, but would also have detrimental effects on trainings which, as the PLG report makes clear, will have to formulate teaching to fit these standards of proficiency.

2B.1

The requirement that psychotherapists and counsellors 'be able to use research, reasoning and problem solving skills to determine appropriate action' may be appropriate for a minority of cognitive-based therapies but is at odds with most traditions of psychotherapy which do not see their work in terms of problem solving skills and do not aim to formulate specific actions to respond to specific problems.

The next requirement that psychotherapists and counsellors 'be able to engage in evidence based practice, evaluate practice systematically, and participate in audit procedures' is once again entirely inappropriate for many forms of psychotherapy, which eschew the rhetoric of evidence based practice and believe that its ubiquity today is based on profoundly flawed premises. There is now a large literature critiquing the notion of evidence based practice and many traditions in psychotherapy see it as of the utmost importance to distance their work from the rhetoric of evidence based research, which of course carries the danger that - once inappropriate research 'shows' that one method of treatment is 'best practice' for a particular symptom - that other forms of therapy be excluded, thus depriving patients of the choice of working with the therapeutic process

they choose. Many schools of psychotherapy, likewise, would not accept the notion of audit procedures, a practice linked to management and to the world of business or managed health care rather than to the individual and creative conversation about human life that constitutes the stuff of many forms of psychotherapy.

The requirement that psychotherapists and counsellors be able to 'demonstrate a logical and systematic approach to problem solving' once again supposes that therapists are in the business of problem solving. As we have noted several times above, there may be some forms of therapy that do but in general this is not the case.

2B.2

The requirement that psychotherapists and counsellors 'be able to change their practice as needed to take account of new developments' in the area of 'knowledge and skills' is applicable to a medical based model but not to the majority of forms of psychotherapy where the large part of the work is done by the patient, facilitated by the psychotherapist. In medicine, a doctor may learn that a drug being prescribed is harmful and may then cease to prescribe it. This would be an example of a new development informing a practice, but knowledge in psychotherapy is different from knowledge in medicine. The 'new developments' that matter in the therapy will be those that come from the patient rather than from the therapist.

The following requirement that psychotherapists and counsellors 'be able to demonstrate a level of skill in the use of information technology appropriate to their practice' is absurd and may apply to some health professionals working in the NHS but has nothing whatsoever to do with psychotherapy and counselling.

The requirement that psychotherapists and counsellors 'be able to recognise when further therapy work is inappropriate or unlikely to be helpful' is problematic as the articulation of such a view to a patient may have catastrophic effects. Although the issues here are clearly complex, it seems likely that the formulation of this requirement is based on a medical model in which a team is responsible for the health of a patient. It also opens up the obvious question of third party complaints, as there must be tens of thousands of spouses and family members of people in therapy across the country who are convinced that the therapy that their loved one is undertaking is inappropriate and unhelpful. This is an everyday situation which therapists and counsellors are familiar with, and the particular formulation of the 'standard of proficiency' here runs the risk of implying that there are objective, externally verifiable standards of whether a therapeutic work is inappropriate or unhelpful.

The requirement that psychotherapists and counsellors 'be able to make informed judgments on complex issues in the absence of complete information' is one of the most absurd in all of the standards of proficiency. It is obviously just taken from a medical model where information may be necessary about health issues prior to the prescription of a drug or surgery. In a psychotherapy, how can information ever be complete? What sort of fantasy would either the patient or therapist have if they believed in the idea of complete information?

2B.3

The requirement that psychotherapists and counsellors 'be able to formulate specific and appropriate management plans including the setting of timescales' may be suited to some staff working within NHS contexts but has little to do with the open-ended work of psychotherapy which often does not have a time limit and which eschews the very idea of a 'management plan'. Since it is never possible to predict in advance what will happen in the therapy, it is clearly absurd to believe one could formulate 'specific and appropriate management plans'. While this may have a sense in the context of a targeted health care intervention, it has little to do with the talking therapies, many of which specifically reject the concept of the 'management' of human beings. These therapies differentiate themselves from practices associated with social engineering.

2B.4

The requirement that psychotherapists and counsellors 'be able to conduct appropriate diagnostic or monitoring procedures, treatments, therapy or other actions carefully and skilfully' may be appropriate for a laboratory technician but not for most forms of psychotherapy. Psychotherapy does not involve the application of a procedure or treatment to a patient but is the work created by a patient, facilitated by a therapist. Very few forms of therapy involve the application of any procedure, and it is often argued that those that do in effect disqualify themselves as psychotherapies for that very reason. As noted above, many forms of therapy, likewise, would not accept the notion of diagnostic or 'monitoring procedures'. As for the reference to skills, there may be some therapists who pride themselves on performing their work skillfully, yet there are many others who give a central place to blunder, error, failing and any of the other difficulties which constitute human life. For many therapists, it is an engagement with these failings that a large part of the work of therapy is about. This would involve a questioning of ideals of both autonomy and mastery and fantasies of one's own self image as a skilful 'expert'.

The requirement that psychotherapists and counsellors 'understand the need to maintain the safety of both service users and those involved in their care' has a very limited application for psychotherapy. The primary responsibility of the therapist is not to ensure the health of their patient but simply, for many clinicians, to allow a conversation to take place. They would obviously need to ensure that there is an appropriate fire exit from their office and that there are no dangerous obstacles which might put the client in danger of slipping or falling in the consulting room, but beyond this, most traditions of psychotherapy see the maintaining of health as a personal responsibility of the patient rather than being a duty that the therapist must take on for them.

The requirement that psychotherapists and counsellors 'be able to establish an effective, collaborative working relationship with a client' is inapplicable to most forms of psychotherapy since, for many psychotherapy traditions, psychotherapy is not something that one person applies to another, but is rather a property of the relationship between two people. Given this, it is hardly a requirement for the psychotherapist to establish an effective collaborative relationship, since a large part of this work will come from the patient. The parallel is obviously in terms of everyday relationships between people. Whether a relationship works or not does not depend on one person but on both.

The requirement that psychotherapists and counsellors 'be able to enable and work with expression of client emotion' is problematic in that there are different theories about what constitutes emotion and whether, indeed, there is any difference between emotion and the expression of emotion. There is a vast literature on this question. Some traditions of psychotherapy do not place great value on the expression of emotion, arguing instead that what matters are the unconscious thought processes underpinning emotions, which in themselves may be misleading. Other therapies do place a great emphasis on the release of emotion, but there is no consensus view on either the nature or place of emotion in the field of psychotherapy.

The requirement that psychotherapists and counsellors 'be able to communicate empathic understanding to clients' would be rejected by many traditions of psychotherapy which hold that empathy with a patient is a sign that something has gone wrong in the therapeutic process. For these traditions, there must be a certain distance established between the therapist and the patient, and, most importantly, the therapist must recognise that they can never know exactly what is going on in the patient's mind and certainly can never claim to understand their experiences. For these traditions in psychotherapy, listening may be sympathetic and attentive but is not empathic, which would imply that the internal states of the patient are accessible and shared by the therapist. This may be experienced by the patient as a gross intrusion and a denial of the singularity of their own experience. Other traditions and therapies do of course emphasise the importance of empathy. There is no consensus on this issue in the field.

The requirement that psychotherapists and counsellors 'be able to initiate and manage

first and subsequent counselling/psychotherapy sessions by developing rapport and trust' is inapplicable to many traditions of psychotherapy. For example, the Freudian who sits there in silence may not be aiming to actively develop rapport and trust with a patient, even though rapport and trust may result from the resolute maintaining of this silence. Many traditions of psychotherapy would also argue that if the therapist actively tries to make the patient trust him or her, there is something wrong with the therapeutic process. Trust should not be an automatic property of the relationship, but will rather depend on transference issues. If a patient systematically mistrusts their therapist, the reasons for this may be explored. This would be very different from the therapist trying to make themselves trusted, which can only be a symptom of the instability of their own position.

The requirement that psychotherapists and counsellors 'be able to respect and take into account the client's capacity for self determination' is problematic given the fact that many traditions of psychotherapy see the very concept of self determination as in question. For many traditions, autonomy and self determination are fictions, often with a political agenda. For these traditions, what matters would be to explore the structures that determine the lived experience of the patient and, at the end of the therapy, it may become clear to the patient that there are profound limits to any supposed autonomy or self determination.

The requirement that psychotherapists and counsellors 'be able to work with both the explicit and implicit aspects of the therapeutic relationship' is mystifying: it is unclear what exactly this might mean.

2B.5

The requirement that psychotherapists and counsellors 'be able to keep accurate, legible records and recognise the need to handle these records and all other information with applicable legislation, protocol and guidelines' may be applicable to those working in the NHS and for most health professionals, but is at odds with many traditions in psychotherapy. Freud and most other subsequent psychoanalytic thinkers advised against record keeping, arguing that it blocks the spontaneity of unconscious communication between patient and analyst. It is also widely recognised that record keeping may simply serve as a way to block the therapist's anxiety, and that they would be better served by discussing the relevant issues in their own personal therapy or supervision.

The requirement that psychotherapists and counsellors 'understand the need to use only accepted terminology in making records' is absurd, as it implies that there is such a thing as accepted terminology in the field of the talking therapies: would the terminology include 'shadow', 'jouissance' 'plane of identification', 'matheme' etc? The danger here, as elsewhere, is that therapists will gradually begin to not only document but also think about their own practice through the eyes of someone they think is watching them, be this benevolent or malign. The moment that therapy becomes experienced in these terms, as if taking place on a stage for a third party to monitor, it ceases to be true psychotherapy and perpetuates the very dynamic that the therapy itself may be trying to free the patient from.

2C.1

The requirement that psychotherapists and counsellors 'be able to monitor and review the ongoing effectiveness of planned activity and modify it accordingly' is at odds with many traditions of psychotherapy which do not plan intervention or activity, seeing therapy rather as an ongoing, creative and unpredictably unfolding conversation. It is not a question of formulating and applying specific procedures which can be monitored and checked.

The requirement that psychotherapists and counsellors 'be able to gather information, including qualitative and quantitative data, that helps to evaluate the responses of service users to their care' may be applicable to some health professionals but is at odds with

most traditions of psychotherapy, which do not seek to gather information or to perform procedures of evaluation.

The requirement that psychotherapists and counsellors 'be able to evaluate intervention plans using recognised outcome measures and revise the plans as necessary in conjunction with the service user' may be applicable for some health professionals but has absolutely no application to most forms of psychotherapy. Most forms of psychotherapy do not involve the establishment of intervention plans that are then applied to the patient as the recipient of a procedure, and in most psychotherapies there is no notion of 'recognised outcome measures'. It is often argued that the difference between psychotherapy and mental hygiene is precisely this: that in mental hygiene the therapist knows what is best in advance for the patient and tries to implement this. In psychotherapy, on the contrary, the psychotherapist listens to what the patient has to say.

The requirement that psychotherapists and counsellors 'recognise the need to monitor and evaluate the quality of practice and the value of contributing to the generation of data for quality assurance and improvement programmes' is totally inapplicable to the field of psychotherapy. This is not just due to the problems with the idea of 'monitoring and evaluating' that we have discussed above, but gives the therapist the role of a bureaucrat, with the task of managing the patient rather than that of a partner in a dialogue accompanying the patient on their journey. The notion of 'quality assurance' is anathema to those traditions of psychotherapy that are not based on a business model of service provision, and the notion of an 'improvement programme' also belongs to a modern ideology of the self which most of the major traditions in psychotherapy eschew.

The requirement that psychotherapists and counsellors 'be able to make reasoned decisions to initiate, continue, modify or cease treatment for the use of techniques or procedures, and record the decision and reasoning appropriately' is at odds with most forms of psychotherapy which do not use techniques or procedures, and once again, this requirement begs the question of why every clinical decision would need to be recorded and explained. This would create a mindset in which everything the therapist did would only make sense given an observing eye that would be judging their action. This form of internalised authority may be useful in techniques such as policing but runs counter to the major traditions in psychotherapy which are about freeing oneself from the tyranny of internalised forms of irrational authority.

The requirement that psychotherapists and counsellors 'be able to help clients to reflect on their process [progress?] of therapy' is certainly applicable to many forms of psychotherapy today, but it is equally incompatible with many other forms of contemporary practice. Some forms of psychotherapy involve a continued focusing on the relation between the patient and the therapist, whereas other forms aim to open up a space beyond the consulting room and to subordinate the therapeutic process to these other variables. There is thus no consensus view on the importance or necessity of making patients reflect on the therapeutic process. This point applies to the following requirements that the therapist 'review and evaluate' their work with the patient. For many forms of therapy, it is technically a mistake to bring things back to the relation between the two parties, following one version of the object relations tradition.

The requirement that psychotherapists and counsellors 'be able to evaluate the therapeutic work in collaboration with the client' supposes once again that there is some kind of external position from which the work of therapy can be assessed and evaluated, rather than seeing it as an organic, unfolding and open-ended process. Since this process is constituted by the relation between the patient and the therapist, neither is able to abstract themselves from it to give an 'objective view' or evaluation.

2C.2

The requirement that psychotherapists and counsellors 'be able to audit, reflect on and review practice' would be acceptable if it was limited to the verb 'reflect on'.

Psychotherapists do not audit their practice although no doubt those who work in business or in some forms of healthcare delivery might wish to do so.

The requirement that psychotherapists and counsellors 'understand the principles of quality control and quality assurance' may be applicable to business contexts and some forms of healthcare but is largely inapplicable to most traditions in psychotherapy which do not use the conceptual vocabulary of quality control or quality assurance. The key to these traditions is precisely the fact that they offer a space outside the market place, one in which human beings are not seen as 'resources'. Most traditions of psychotherapy do not view human life as a series of business-style transactions and they do not use business vocabulary to describe human beings.

The requirement that psychotherapists and counsellors 'be aware of the role of audit and review in quality management including quality control, quality assurance and the use of appropriate outcome measures' is absurd and inapplicable for the reasons outlined above. As has been repeated, these concepts are at odds with the ethics of most forms of psychotherapy, which likewise, do not have a notion of 'outcome measures'.

The requirement that psychotherapists and counsellors 'be able to maintain an effective audit trail and work towards continued improvement' is totally inappropriate for most forms of psychotherapy, although it may be appropriate for business contexts. Likewise, many of the major traditions in psychotherapy do not believe in the modern ideology of 'continual improvement' but rather aim to give a place to the central experiences of disappointment and frustration that lie at the heart of human life. It is precisely the wellbeing industry promotes the idea of 'continual improvement', often in order to sell products to the public. Most forms of psychotherapy, on the contrary, are characterised by their refusal to enter into this form of transaction, and do not make promises to the public about results or endeavour to sell products.

The requirement that psychotherapists and counsellors 'be able to crtically reflect on the use of self in the therapeutic process and engage in supervision in order to improve practice' may be applicable to some forms of therapy today, but would be at odds with many traditions of therapy which do not see the self as a tool to be used in the therapeutic process, or even as any fixed entity. There are also several traditions of psychotherapy which are critical of the very notion of the 'self' and, for those who do accept it, it is not always seen as a variable that can itself be the object of reflection: this would once again suppose that the therapist could abstract themself from 'themself', precisely the kind of dissociation that the HPC framework is designed to foster. As regards supervision, although all traditions of psychotherapy give a central place to the practice of supervision, there is no general agreement that the role of supervision improves practice.

3A.1

The requirement that psychotherapists and counsellors 'understand the structure and function of the human body, relevant to their practice, together with knowledge of health, disease, disorder and dysfunction' may be applicable to those working in the medical field but has little to do with most forms of psychotherapy. There are some forms of therapy which do involve a focus on the body, yet these may presuppose different models of structure and function from those presupposed by mainstream medicine. Likewise, many traditions in psychotherapy do not accept the concept of health, disease, disorder and dysfunction as applied to psychological matters.

The requirement that psychotherapists and counsellors 'be aware of the principles and application of scientific enquiry, including the evaluation of treatment efficacy and the research process' is not unreasonable in the field of the talking therapies, but there is the serious danger here that it would involve a limited conception of scientific enquiry, efficacy and research. HPC and Skills for Health, for example, have very limited and monolithic notions of these variables, foreclosing completely the rich tradition in history and philosophy of science that has been developed in this country over the last hundred

years. There is a grave risk that fashionable notions of scientific enquiry, efficacy and research are used as benchmarks to evaluate therapeutic practice, rather than themselves being the object of critical enquiry in the tradition of work in the history and philosophy of science.

The requirement that psychotherapists and counsellors 'understand the typical presentations of severe mental disorder' is at odds with many traditions of psychotherapy which are critical of the very notion of mental disorder. There is the risk here that psychiatric notions of mental disorder are used as a benchmark in the evaluation of therapeutic practices when these practices may either reject classificatory systems or use alternate classificatory systems to those of psychiatrists. For example, there is massive disagreement as to the clinical signs of non-triggered psychosis and different traditions will have radically different views as to what these signs might consist of. These concerns apply to the following requirement that psychotherapists and counsellors 'understand methods of diagnosis of severe mental disorder.... and be able to conduct appropriate diagnostic procedures'.

The requirement that counsellors 'understand theories and research on mental health and wellbeing and obstacles to wellbeing and be able to use these to facilitate the client's development' might be applicable to some forms of counselling but not to those which are critical of the notion of wellbeing, which is effectively the market place today for selling products to the public. The appearance of the term here under the rubric of 'counsellors' only shows a certain disrespect to the important work that counsellors do, as if the counsellors were just concerned with wellbeing and the therapists were doing something different.

3A.2

The requirement that psychotherapists and counsellors 'select or modify approaches to meet the needs of an individual, group or community', may be applicable to a small range of therapies but is at odds with those major traditions of psychotherapy which do not see the work of therapy as involving meeting anyone's needs. Many forms of therapy involve a questioning of what the patient feels they want and the needs that the patient presents are, in these traditions, taken as symptoms which need deciphering rather than 'meeting'. In psychoanalysis, for example, the central ethical position of the analyst involves the sustained refusal to meet the needs of the patient.

3A.3

The requirement that psychotherapists and counsellors 'be aware of applicable health and safety legislation and any relevant safety policies and procedures in force in the workplace, such as incident reporting, and be able to act in accordance with these' is obviously applicable to those working in NHS contexts but hardly for therapies conducted in private practice beyond the most obvious measures taken to ensure that the consulting room does not contain hazardous objects or, have a slippery floor, or any craters into which the patient might fall.

The requirement that psychotherapists and counsellors 'be able to select appropriate hazard control and risk management, reduction or elimination techniques' is likewise inapplicable to most private practice psychotherapy contexts, just as is the requirement that they 'be able to select appropriate protective equipment and use it correctly'.

The next requirement regarding 'hazard control and particularly infection control' is obviously inapplicable to the talking therapies. It is extraordinary that these latter requirements have been included in such an important document, after the HPC has been supposed to have been thinking about the field of talking therapies for at least three years now.

Appendix 4: Response to PLG report July 2009

This text was drafted by the following organisations: Arbours Association, Association for Group and Individual Psychotherapy, Association of Independent Psychotherapists, Centre for Freudian Analysis and Research, The College of Psychoanalysts-UK, The Guild of Psychotherapists, The Philadelphia Association, The Site for Contemporary Psychoanalysis. It was sent to HPC and received no reply.

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Before detailing specific comments on the report by the HPC Professional Liaison Group on the proposed statutory regulation of psychotherapists and counsellors, it is helpful to make some general points about the report and the draft standards of proficiency which are attached to it. All of these general points have been made repeatedly in meetings with the HPC as well as in written correspondence over the last three years:

1 The Government White Paper on Trust, Assurance and Safety had given the Health Professions Council the task of assessing the 'regulatory needs' of the field and 'ensuring that its system is capable of accommodating them'. These two briefs have simply not been met by the HPC consultation or by the work of the PLG. There has been both an absence of sustained rational debate on the central issues and an exclusion of critical voices, a fact which has been brought to the attention of HPC and of MPs repeatedly.

2 Many practitioners of talking therapies do not see their work as constituting in any way a health profession, and their traditions have been critical of the received notions of health, illness and wellbeing that the HPC consultation and the PLG report take as given. Despite the fact that this point has been made innumerable times, it is not reflected in either the content of the report or the standards of proficiency.

3 The view of therapy presupposed in many parts of the report and in the standards of proficiency is at odds with many traditions of therapy over the last century. Therapy is not conceived as an intervention to be applied to a patient, but rather as an activity which the patient him or herself engages in, facilitated by the therapist. It is thus not a question of the transmission of knowledge or skills from one party to another, just as it is not in any way comparable with a medical style intervention such as the administration of a drug or any other form of predetermined procedure.

4 The report and the standards of proficiency presuppose a concept of self that is radically rejected by many schools of psychotherapy. This is the modern idea that the self is reducible to a set of skills and competencies which must be forever improved. On this model, the human being is seen as a business which has to better itself, making it an ever more viable competitor in the marketplace. Although there may be some therapists who subscribe to this view, it is totally opposed to many therapeutic traditions which base the very work of therapy on a critique of socially accepted notions of selfhood. For these therapies, the self is not there to be 'improved' or 'bettered', but rather to allow its history to be explored, and its fractures, frustrations and disappointments to be recognised. The growth and change that may follow do not constitute an 'improvement' or 'bettering', as this would suggest a normative view of what people should be. The standards of proficiency thus presuppose the very idea of self that thousands of therapists work every day to undermine in their practice. There is thus both a contradiction and an absurdity in trying to force therapists to frame their work within standards of proficiency that uphold the very values that the therapeutic process aims to put in question.

Comments on HPC Draft Document on the Statutory Regulation of Psychotherapists and Counsellors.

Page 6

The constitution of the PLG is described here as including "individuals representing professional bodies, education and training providers, a qualification awarding body and organisations representing the interests of service users". It is not pointed out that the choice of the 17 members rigorously excluded all those who had critical views of HPC regulation who had been nominated by their organisations or who had nominated themselves for the PLG. It was thus a highly biased collection of individuals, which also excluded the service user group the Association of Psychoanalysis Users. Instead HPC chose the advocacy group Witness, which is funded partly by the Department of Health and which has worked closely with HPC. It is also incorrect to state that the PLG included "organisations" representing service users, as there was only one, if Witness can be so described.

Page 7

The report states that 'the responses to the [HPC's] Call for Ideas informed the discussion and recommendations of the PLG'. In fact there has been a remarkable failure to respond to any of the critical responses to the Call for Ideas aside from noting which groups had made which points in a previous HPC document. After this cosmetic registering of some criticisms, HPC has failed to respond in any detailed or serious way to the points made in response to the Call for Ideas. It was pointed out several times to the HPC that the PLG meetings had failed to include adequate discussion of the majority of the points that had been made.

Paragraph 19 and 20 refer to the stakeholder events held in Manchester in March 2009. There is no mention of the criticisms made of the HPC project there or of the HPC's refusal to hold a further meeting in response to the request from stakeholders and members of the public who attended and saw an absence of any engagement with the points that were made. The Manchester event was simply there as an airbrushing exercise to create the false impression that HPC had 'listened'.

Page 8

Paragraph 26 It is stated that 'the role of the PLG was to discuss and make recommendations about how psychotherapists and counsellors might be regulated in light of the conclusions in the White Paper'. Yet the White Paper had required the HPC to assess the 'regulatory needs' of the field and whether it was suited to 'accommodate' this field. Neither of these crucial questions was in fact taken up in any sustained or serious way by the PLG meetings, the minutes of which are publicly available.

Page 29

Voluntary registers to be considered for transfer to HPC require that members demonstrate a commitment to CPD. Although many therapists would accept this idea, there are also important traditions in psychoanalysis and psychotherapy which do not accept the idea of CPD. Becoming an analyst or therapist, according to these traditions, involves profound psychological change which is not the result of knowledge or anything that can be taught in a course or learning environment. Such change can be more accurately compared to losing a limb than to memorising a handbook of information. For these traditions, that is what allows the person to then be open to working with the unconscious of other people. Given this view, it makes little sense to argue that the practitioners need to update their knowledge and skills on an annual basis. This would be like making the person prove on an annual basis that their limb hadn't miraculously re-grown. These traditions also hold that the result of any serious analysis or therapy is a questioning of the vanity of human knowledge. This is completely at odds with the modern mentality of CPD in which an 'expert' is brought in to dispense the latest

knowledge to those who wish to better or improve themselves. Psychoanalysis and many forms of psychotherapy do not have a cumulative model of knowledge, but rather sees the loss of knowledge as decisive. Freud, for example, said that the analyst must forget everything they know each time they see a patient. Taking this seriously, CPD would involve ensuring that the practitioner is able to not know anything. The paradoxes of this form of assessment are also well known, with clinicians feeling that they have to prove themselves to some external authority: This, indeed, is exactly the kind of dynamic that many forms of therapy aim to collapse.

Page 32

Point 9 Here, and at several other places in the document, there is a reference to clinicians only being able to practice 'in those fields in which they have appropriate education, training and experience'. On the surface this may seem a very reasonable obligation, but it introduces important political factors which have an impact on how the fields are defined for which such education, training and experience are relevant. There is a very real danger here that models of diagnosis and categorisation of human distress – such as that provided by DSM – will be used here as benchmarks, despite the fact that many traditions in psychoanalysis and psychotherapy have their own classificatory systems which disagree with those of DSM, or indeed, which object to the very notion of the classification of human beings into groups through the process of dividing them via external symptoms. The danger is that notions prevalent in modern healthcare, such as 'best practice', 'evidence based research' and 'mental illness' will be used uncritically in order to tell therapists who they can and cannot work with.

Page 35

The document states that if a registrant's competence is called into question, the 'standards of proficiency set by HPC are taken into account in deciding whether any action is necessary'. Since the standards of proficiency proposed are so dramatically incompatible with many long established traditions in psychotherapy, it puts registrants at great risk of having their practices adversely affected by the application of frameworks which are unsuited to assess or evaluate them.

Page 36

There are several paragraphs here which state the requirements of certain standards of proficiency in English language to enable a therapist or counsellor to be able to practice. This is a rather absurd requirement as there is no intrinsic reason why a therapist should have to speak a certain level of English: this may be for the obvious reason that the patients they receive would wish to speak in their own mother tongue, shared with the therapist which is not English but also, and more fundamentally, because language is itself a psychological variable which will form part of the transference. If someone has been brought up by a parent who couldn't speak the language of the country they happen to be in they may well seek out later in life a therapist who clearly has difficulty speaking a language. As long as the therapist does not claim to have standards of proficiency which they do not in fact possess it is surely the choice of the patient who they wish to speak to. Insisting on a certain proficiency in English language removes that freedom of choice from members of the public.

Bibliography

Web References

www.coregp.org
Website of Coalition Against Over-Regulation of Psychotherapy.
www.psychoanalysis-cpuk.org
Website of The College of Psychoanalysts-UK, see Latest News.
www.psychoanalyticconsortium.org
Website of The Psychoanalytic Consortium.
www.allianceforcandp.org
Website of The Alliance for Counselling and Psychotherapy.
www.psyreg.co.uk
Website offering information on the regulation question.
www.petitiononline.com/statereg/petition.html
Petition signed by clinicians opposed to HPC regulation.
www.snppsy.org
Website of the Syndicat National des Practiciens en Psychothérapie.
praxismzw@web.de
European petititon against HPC regulation.
http://ipnosis.postle.net
Website of information and opinion about HPC regulation.
http://hpcwatchdog.blogspot.com
Monitors the operations of HPC.
www.health.vic.gov.au/pracreg/psychotherapy.htm
Australian consultation on regulation of therapies
www.doh.wa.gov/hsqa/sunrise/2001/mentalhealth.doc
Mental Health Counsellors Sunrise Review, Washington State Department of Health, January 2001.

Books

Marie-Noël Godet,
'Des Psychothérapeutes d'État à l'État Thérapeutique', Paris, L'Harmattan, 2009.
Daniel Hogan,
'The Regulation of Psychotherapists', 4 Vols, Cambridge, Mass, 1979.
Richard House and Nick Totton eds,
'Implausible Professions: Arguments for Pluralism and Autonomy in Psychotherapy and Counselling', London, 1997.
Richard Mowbray,
'The Case Against Psychotherapy Regsitration', London, 1995.
Ian Parker and Simona Revelli eds,
'Psychoanalytic Practice and State Regulation', London, Karnac, 2007.
Denis Postle,
'Regulating the Psychological Therapies: From Taxonomy to Taxidermy', Ross-on-Wye, 2007.
Nikolas Rose,
'Governing the Soul', London, Routledge, 1989.
Bruce Wampold,
'The Great Psychotherapy Debate: Models, Methods and Findings', London, 2001.