A critical evaluation of the revised SCoPEd Framework (July 2020)

By

Albertsen, M. and Shennan, T.

www.ukcounsellors.co.uk

Note: For ease of reading, all referencing of pages and individual criteria relate to the following 'SCoPEd Framework' document unless otherwise specified:

BACP, BPC, UKCP. (2020a). *SCoPEd Framework: A draft framework for the practice and education of counselling and psychotherapy*. Retrieved from https://www.bacp.co.uk/media/9178/scoped-draft-competency-framework-july-2020.pdf

This document has been produced by Counsellors Together UK and represents the views and contributions of its authors.

Summative statement

This document aims to provide a comprehensive review of the current iteration of the SCoPEd framework. The key issues remain the same as they were with its previous counterpart and those are as follows: The subscription to the medical model of distress. The elevation of psychotherapists at the expense of registered counsellors who are severely deskilled in key areas of their practice. Deskilled to such an extent it is difficult to argue they would be safe to practice at all. The inherent bias of the teams working on this framework and the widely challenged methodological flaws.

This newer iteration, which we meticulously evaluate, goes further in the restrictive nature of some key criteria. For example, the description of competencies being such that any work Accredited counsellors may currently get within the NHS would become untenable. It would be deemed unsafe. The NHS already explicitly states that unaccredited counsellors are unsafe to do one-to-one work with patients. An amendment to be inclusive of accredited counsellors in that would not be too far of a leap to make. This framework is resolute in its painting of a qualified counsellor being a static entity with no capacity to think for oneself across the spectrum of core competencies; including analysis and reflection of self, the client and the therapeutic relationship.

The accompanying methodological paper lacked a great deal of transparency and leaves as many questions unanswered as it answers. We discuss these areas and explore what changes could have improved the methodology and research up to this point.

This document then critically assesses whether the BACP, BPC and UKCP have met the aims they set out to achieve. The answer is it does not and where the framework may get close to meeting an aim, it falls short in profound ways. We then close with some recommendations for moving forward which include making adjustments for theoretical parity and truly consulting with members to discover what they want from this framework; if they want it.

Introducing the framework

The Scope of Practice and Education for the counselling and psychotherapy professions (SCoPEd) is an attempt by 3 voluntary membership bodies to build a competency framework detailing the minimum training requirements, competencies and practice standards within the field. It is limited to therapists who work with adults.

The first released iteration of this framework received a large amount of critique, some of which is laid out in the documents made available from the SCoPEd team. The points of critique are limited to being those that were acknowledged by the SCoPEd team; primarily through their consultation feedback. However, this was not the only channel that counselling professionals chose to air their feedback.

One of biggest acts of critique was the member resolution put forward by members of the BACP asking for the framework to be stopped in its current format (BACP, UKCP & BPC, 2018). Putting forward a resolution and succeeding in getting it passed would have resulted in a legally binding action. The framework would have had to be halted under the conditions laid out within that resolution. The resolution did not get passed through, not least because of some significant changes to the BACP governance processes that have hindered member voices (Albertsen, 2019).

At Counsellors' Together UK, a petition was created to ask for the resolution to be stopped in its current format (Albertsen & Shennan, 2019). This petition is still open to signatures and, at the time of writing, had amassed over 4000 signatures (approximately 6% of the total members of the SCoPEd organisations). In addition to these measures, the National Counselling Society sent and open letter to the BACP to ask for reconsideration of the project and outlined detailed critique of the change in positive re: whether counsellors are distinct from psychotherapists.

The newest iteration of the framework has not changed substantially enough for a change in the position statement that Counsellors' Together UK hold. As this document intends to highlight, there are still a large number of unaddressed and poorly addressed issues within this framework that are significant enough to require that the framework be strongly amended before the next iteration is published.

Methodology

The 'SCoPEd methodology update July 2020' (BACP et al., 2020b) outlines some of the processes and decisions made by the teams involved in the creation and update of this iteration of the SCoPEd framework. A decision matrix is shared but it lacks true transparency for some key decisions.

Early into the document a statement is made that the project lacks the requirement for an ethical review because, according to the BACP's *own* ethical guidelines for research, ethical reviews only apply to human data collection (BACP et al., 2020b, p.4). This is enough of a conflict of interest to prompt an independent ethical review by a panel not impacted by the outcome of the research. No conflicts are declared though.

Under the same ethical consideration, the following statement is made:

"Details of the professional body affiliations and theoretical orientations of both Technical Group (TG) and Expert Reference Group (ERG) are listed…" (BACP et al., 2020b, p.4).

The modalities declared included the vague (for the purposes of this project) title of integrative or pluralistic. Given that the framework places so much emphasis on training qualifications it may have been more apt to include a list the qualifications of the members involved. Where it is not immediately clear, a declaration should have been made of the modalities integrated for that qualification.

Why is this important? Because as this document will highlight, theoretical assumptions are made and linked to competencies that suggest a lack of awareness around modalities that are not psychodynamic/psychoanalytic. We already know that the teams were biased towards psychodynamic/psychoanalytic therapists due to their unequal distribution. If all the integrative therapists had a core modality that was also psychodynamic, this would have a grave impact on how well other modalities could be represented and potentially interpreted and understood.

It is also important because the framework is built upon the premise that academic attainment is correlated with therapeutic competence. If the TG and ERG are biased towards higher education, even masters, it goes some way to explaining why there is a clear blind spot and perhaps a lack of acceptance in understanding that many competencies can be achieved on a lower level course. The core competencies of therapeutic work are within relational work not within academic pursuits.

The member consultation was widely criticised for the bias of its questioning. An external market research company was recruited to conduct this consultation. A quantitative survey was developed to "assess the views of the members of the impact of the framework". Not the actual framework but perceived impact of it.

The questions put to members were as follows (BACP et al., 2020b, p.4):

Please consider the potential impact of the framework on the wider profession, as follows:

a) How will the framework impact on clients or patients being able to find the right kind of help to meet their needs?
b) How will the framework impact on employers being able to establish which counsellors and psychotherapists to employ in their services?
c) How will the framework impact on trainees in their understanding of the pathways open to them for core training with adults?
d) How will the framework impact on professional bodies being able to promote the skills and services of their members?

Members who responded we asked to respond using a 5-point scale ranging from 'the framework will make this aspect much harder' to 'the framework will make this much easier'. Members could select that they had no idea of the effect.

This is not true research into the need for a framework. This is a marketing and public relations exercise to assess the current perceptions of the framework. Results shared here indicate how they should be marketing the framework to get the most support and where they need to demonstrate the framework will make improvements (according to them). Yet, there was felt to be no need for an ethical review board?

Questions notably absent from this consultation:

e) How will the framework impact on clients' or patients' perception of my competence as a therapist?
f) How will the framework impact on my colleagues' view of what I do?
g) How will the framework impact training and funding for the modalities not preferred by the framework?
h) With my above responses in mind, do I believe the framework is a positive or negative change to the counselling and psychotherapy sector?

An open comment box was provided for members to give feedback.

A true consultation would have explored more than the perceptions of potential, and currently unevidenced, impacts. Where was the consultation on specific criteria? Counsellors Together UK conducted a survey alongside the consultation process where we asked respondents about their views on the framework and specific competencies outlined in that iteration. We had 487 respondents which amounted to an equivalent 6.9% (to 1dp) of the respondents to the SCoPEd consultation (7087 respondents).

The initial framework created 3 groups: Qualified counsellor, Advanced Qualified Counsellor and Psychotherapist (BACP et al., 2018). In the first instance we asked respondents to indicate whether they felt they were a counsellor (46.4%), psychotherapist (5.4%) or both (48.3%). When asked if they felt there was a distinction between counselling and psychotherapy, only 35.5% believed there was. We then asked respondents to indicate whether they met the criteria for each of the competencies

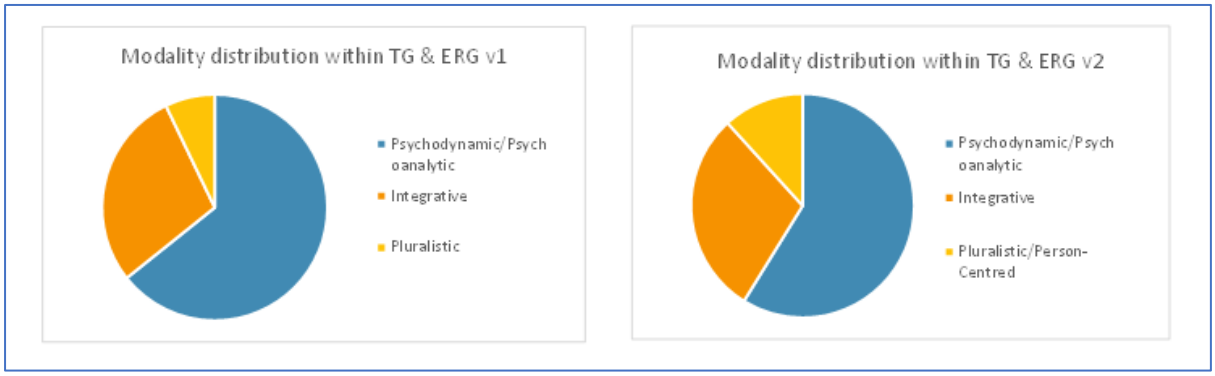
listed in the framework. Respondents felt there was very little discrepancy in who possessed the majority of the competencies. The key differences were areas not typically taught across all levels; or at all. These were working online and the ability to conduct a research project with the latter being an academic skill acquired through a higher education (Shennan & Albertsen, 2019).

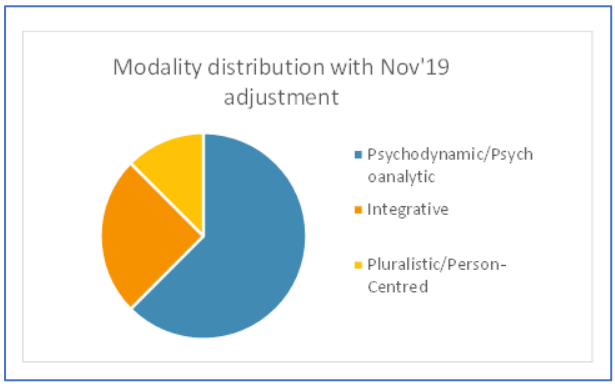
We decided to open a parallel consultation process because the framework was being marketed as mapping the current state of the sector yet there was also a lot of negative feedback stating the competencies deskilled counsellors. It was therefore important to explore this discrepancy.

Returning to the SCoPEd consultation process, there has never been a clear question asking whether members want this change.

The feedback it did manage to collect generated 7 themes (BACP et al., 2020b, p.6). One of which related to the ERG and the representation of modalities; namely, the lack of representation. Two members joined in August 2019 and one in September 2019. Their theoretical orientations were listed as one Integrative, one Person-centred/Pluralistic and one Psychoanalytic therapist but with the loss of an integrative therapist in November 2019, this meant that, in practice, the group only expanded by two members and the integrative orientation received no further representation.

If this seems like it does not actually address the critique in any way, that is because it does not. Here is what that hiring process did to the distribution of theoretical orientations:





There is one person in the ERG who defines themselves as person-centred and they also describe themselves as pluralistic.

The framework seeks to map the competencies of counsellors and psychotherapists both at the point of entry and those built up through experience. It is a claim woven into the foundation of the rationale of building the framework and yet it is one that is not met. There is no clear layout for competencies built up through experience or post-qualification.

There is also a disingenuous focus on 'gateways' that is suggestive of a true progression route. You can enter at virtually every single point without having completed the prior level. This is simply an academic hierarchy of entry points. You can choose to study at a higher level after you have qualified but this often means completing another course that is core-training rather than one that builds upon the counsellor or psychotherapist from the position of already being qualified. Therefore, the proposed "gateway" is actually a commitment to train for another 3-7 years via core training programmes.

The positive of this clear map lies solely at the feet of trainees or prospective trainees looking at what courses to do to become qualified. This potentially allows for greater autonomy in deciding which institute to train with and which level to train at.

However, there are points to highlight on this proposed training 'route'.

Accessibility (Disability): Counselling and psychotherapy training courses are not evenly distributed across the country. This immediately reduces accessibility on a logistical level for even able-bodied trainees. It also disproportionately impacts those with physical and mental disabilities who may have to try and navigate complex and long public transport journeys. Public transport is not equally accessible to people across the country and disabled people also experience this lack of provision the most. Even in London where there is a massive public transport network, it is challenging to get around the city if you are disabled or otherwise impaired.

Accessibility (Socioeconomic background): Cost is an important component that we need to keep discussing. All routes to counselling are costly but they become unthinkably costly as we progress towards 'Therapist C'. Some adding thousands onto the debt already accrued by the counsellors entering from the lower socioeconomic brackets (working class backgrounds, those with disabilities that have prevented stable work, those from ethnic minorities and those who come from severe poverty). An adjunct to cost is location of the courses available in relation to prospective students.

The Glass Ceiling (Cultural impacts on training aspirations): Whether it is widely acknowledged in academia or not, the class background of students and prospective students has the potential to have a large impact on the course choices those students make. These choices do not come from having varying standards of education or culturally different interests, but rather the socialised glass ceiling borne from the perception of we might achieve based on our background and the background of people like us. This could mean that someone does not even consider they could become a counsellor because they believe 'people like us' **cannot** be counsellors. More applicably to this framework, someone might not realise they can achieve success in higher education; even when all other barriers are removed. So, they do not look at degree level courses and they may struggle to believe they can achieve even at the diploma level.

We do not expect the creators of the framework to re-engineer the country's public transport system. Nor solve income inequalities and all of society's social injustices. We do, however, expect a clear acknowledgement of how creating a training hierarchy such as this, unfairly discriminates against those who cannot access these trainings for reasons mentioned above.

The vision of the framework

"If we can agree on a shared framework…we are in a stronger position to talk to external stakeholders about opportunities for all our members" (p.4).

Before anyone can critically assess and evaluate this statement, the aforementioned external stakeholders need to be disclosed. The industry cannot truly evaluate whether the framework is the appropriate solution for the 'problem' if we cannot know who is behind the problem and what criteria make up that problem. The process needs to be transparent. Transparency opens up the opportunity for a wider collaboration in championing the profession to these external stakeholders.

It is difficult to believe that the current version of this framework will open up opportunities for ALL their members though. Will the opportunities that members are missing out on will be paid opportunities or just more voluntary placements for Therapists A and B to 'gain experience' via these stakeholders? The framework for that is clearly laid out through stakeholders like place2be who offer voluntary placements to qualified counsellors as they 'gain experience' working in schools.

Still, the vision still wants to claim that the framework will produce paid employment. "We are confident the potential for this framework will be to maximise paid employment opportunities for members" (p.4).

Further in this document we will explore the potential for the exact opposite to occur and for counsellors to be locked out of employment and private practice but, for now, how do the team know this? What research have they done that such a framework would improve employment opportunities across all levels of competence? How does this framework differ from the informal system already in place which currently locks out counsellors not accredited by the BACP (or achieving equivalency where this is accepted) or those already meeting the criteria for Therapist 'C' level of the framework?

What is driving this confidence? Or is it just a hope?

Language is important. Saying they are confident infers clear knowledge of an outcome but in 2019 the BACP were still saying that they did not know what the outcome would be on the profession. This is clear by the supposition and hopes given in response to member questions. This statement would encompass the potential impact on the employability of counsellors and psychotherapists. The methodology paper that supplements this latest iteration of the framework gives no indication of how this confidence was found between the original version of the document and this one. Stating they hope the framework will provide employment might be less reassuring to members who are anxious of a large-scale restructuring of the profession; but it would be more honest.

Speaking of overstating the reach of the proposed framework:

"Through an agreed and embedded shared framework, we can distinguish all our highly trained and qualified members from people who take less ethical and robust trainings in a world where anyone can call themselves a counsellor or psychotherapist" (p.4).

This distinction already exists. It exists as an entry requirement to all membership bodies listed on the Professional Standards Authority Accredited Registers programme. It is also a marked distinction on a few other memberships not yet on that programme.

That being said, it will be interesting to see how this is achieved when there is so much ambiguity in the entry requirements to become a 'Therapist A'. Many of those criterions are listed as not specified or are worded in such a way, substandard trainings might argue they apply. This is explored in more depth in the section, 'Critical evaluation of the framework competency criteria'.

It must also be stated that it is heinous to co-opt the language of counsellors and psychotherapists decrying completely unethical trainings that exploit learners in order to sell this framework to them.

Not least because the framework itself does **nothing to address this issue**. It is not regulation of the profession nor the associated education system. But also, because this framework and the volunteerism linked to it is central to the exploitation of counsellors in our field (Shennan & Albertsen, 2019).

The final point on page 4: "[The framework] shows that professional bodies are working together in the interests of our clients and patients, rather than in our own organisation's interests."

The corresponding methodology paper explicitly outlines how the team excluded any potential evidence from other membership bodies and the whole framework is evidenced (in the large majority) from the archives of their own policies and frameworks to avoid losing 'methodological integrity'. The research scope of this project was explicitly limited to seeing how BACP, UKCP and BPC could bring their competencies together into a coherent framework. In which case it should be argued that this framework does not map the profession where it is at, at all. The remit remains within the limited scope of the three organising bodies. This is further evidenced in the methodology update when a substantial block of research undertaken outside of established BACP/UKCP/BPC literature is **excluded.** Including research that is more recently published than the majority of the evidence that was used. 23 bodies of work are excluded to maintain "methodological integrity."

This would be the same methodological integrity that lies behind this statement on p.45 of the methodology paper:

"We received additional feedback from the small group of [undeclared] critical readers which did not fall within the guideline of the questions asked and did not result in changes to the framework. We have therefore not included this feedback." Therefore, there is no way for people to critically evaluate whether the inclusion-exclusion criteria for deciding which comments were deemed actionable were suitably chosen. It is important to also re-highlight here that this statement follows multiple members complaining that the consultation survey was too biased and didn't allow for a 'true response' to be given. The absence of any transparency of the criteria the team were using to filter the data received, we cannot know if this bias was also applied at the analysis stage of their research.

Executive Summary

"Currently differentiation cannot be clearly defined by the titles that are being used by the three participating bodies" (p.5).

To translate: 'At some point in the future there will need to be a shared definition of counsellor and psychotherapist created, one that clearly differentiates between them so that we can make the roles fit our planned framework.' BACP, BPC and the UKCP have self-appointed themselves as the custodians of this task, whilst also downplaying that this will need to occur in the future. The framework providing ample, circular evidence that a clear differentiation is required.

Currently neither title is protected and if we were to continue down the route of now differentiating between counsellor and psychotherapist, a clear definition would indeed be required. Both for general understanding and for any future protection of these titles. However, such a monumental decision cannot be decided by only 3 organisations. This needs to be agreed upon using a much wider remit that includes but is not limited to; the other PSA registered membership bodies, organisations who centre protecting and supporting counsellors and psychotherapists at the core of

their work (i.e. Counsellors Together UK and the Psychotherapy and Counselling Union) and the biggest stakeholders in all of this; counsellors and psychotherapists themselves.

Changes to the SCoPEd framework

One of the biggest critiques to the first version of the framework was the unnecessary hierarchal nature of it. The explanation given for a large number of professionals (across academic training levels) believing this is a hierarchal framework is that we all must have been confused by the titles used in the original document. So, now, if 'A, B and C' are used then the hierarchy disappears and the noise from that critique will quieten down.

One of two things is happening:

1. BACP, BPC and UKCP recognise the danger of having the focus being on them creating a hierarchal system that diminishes counsellors whilst elevating psychotherapists based on the disseminated criteria that a majority psychoanalytical panel have chosen the distribution of. Thus, they now attempting to redirect the focus of their collective 60k members. Or…
2. The many people involved in a hugely significant project such as this, that looks to reshape our sector, are unable to understand the very basic definition of the word hierarchy. So simply changing the titles and not the structure of the framework means they believe it is a completely different set up.

Mapping

"For example, the terms 'conscious' and 'unconscious' have been used alongside the terms 'in awareness' and 'out of awareness' to ensure the widest possible understanding of these terms from different theoretical perspectives."

The original critique of the use of these terms was not formed due a lack of understanding of theoretical concepts. It was the elevation of one type of modality over all others. It should be noted at this point that the suggested terms are not interchangeable and this nuance is lost in trying to elevate this particular quality as an advanced skill. The person-centred approach is rooted in the present and what is within the conscious awareness of the client. It was created as the antithesis to analysis and supposition of what is not expressed by the client/patient; in part to address the power differentials in therapy.

Suggesting it is a lack of terminological and theoretical understanding that prompted this critique is insulting, especially when the original critique remains unaddressed. Working with a client's unconscious or 'out of awareness' processing should be an adjunct skill not a hierarchal one. This is true whichever theoretical model you follow and your professional conclusions on the use of the 'unconscious' or 'out of awareness' in therapeutic practice. This will be explored further under Theme 3; 3.12 later in this document.

Practice standards and training

The document mentions multiple times that feedback told them people felt the framework failed to account for post-qualifying experience. As mentioned earlier in this document, this is not addressed in this new version.

"…in the future, there could be other mechanisms for recognising post-qualifying training and experience" (p.10).

Not in the future; this needs to be now. A document which claims to map the profession as it is, fails to do so if it ignores the reality that the majority of the sector is built upon post-qualifying professional development and experience. Before this document can be finalised, counsellors and psychotherapists need to know exactly how the framework plans to quantify these CPD trainings.

Continuous professional development (CPD) is completely unregulated and lacks the robust processes that underline the Ofqual qualifications in the majority of the core training programmes. They vary widely in the quality of the content delivered and the quality of the method of delivery. To deliver a CPD training you do not need to have completed any training in teaching or delivering educational content.

This presents a major problem when mapping CPD onto this framework. How will they decide which CPD is good enough that it meets the requirements to allow a counsellor to move up a level of the framework? To say only CPD accredited by themselves is deemed worthy of this would be incredibly self-serving. It would also mean that low income counsellors are priced out, yet again, of achieving progression as courses claiming to be accredited by a membership body can set higher fees. Being an accredited course simply means the content and learning outcomes training providers claim to achieve have been signed off by that accrediting organisation. It says nothing about a trainer or tutor's ability to engage a learner and to impart that content in a way that is accessible for all types of learners. Very few trainings routinely provide multiple teaching modalities to account for different learning styles, learning difficulties and disabilities.

There is a risk that any employer aware of the lack of oversight in the CPD sector will simply state that Therapist 'B' or 'C' have achieved their status via the core training criteria over the CPD one.

This point also highlights a major flaw in focussing an educational framework upon the individual competencies of the learner and not the competencies and standards of the actual courses being delivered. If training can be delivered by tutors with no formalised teaching qualifications, it does not matter how robust the training programme looks on paper.

Critical evaluation of the framework competency criteria

Consolidated current training and practice requirements (BACP, BPC, UKCP)

The above flaw is never clearer than Therapist A having several points of 'non-specified' criteria for their minimum requirements. This framework, if it is to be applied, could be an opportunity to

specify that minimum criteria. The current framework is happy to continue to apply a hierarchy to the modalities counsellors and psychotherapists use but not happy to ask for basic, specific criteria to be met by counsellors at the lowest entry point – beyond being a full or part time course delivered in person at level 4 or above. A reality check is required here: it is not the degree and post graduate courses that are being challenged. Higher education is regulated in the UK as are diploma courses offered through legitimate further education colleges. Any core training offered outside of this remit is not regulated and students have to rely on membership bodies having robust accreditation processes and which do not value potential profits over the quality of training and the policies and implement of student support.

The fundamental question that will be on many counsellor's minds who have done training that did not meet the requirement of 450 tutor contact hours is, how can they progress into position 'B' without doing more core training?

The current situation is that you can complete a diploma with less than 450 tutor hours and 'add on' the hours you completed in *a lower level course*. For example, the average CPCAB course provides 420 tutor hours; falling short by 30 hours. It would be simple to ask CPCAB to stipulate this shortfall is removed for further iterations of a course but, instead, those students can still count their level 3 learning. The educational requirements for Therapist B align with BACP's individual accreditation process. A process that has been marketed as a gold standard for many years now and features as a minimum requirement in many job adverts. Yet by their own policies, some of these 'gold standard' counsellors will have lost 30 hours of teaching and discussions aimed at a cultivating a higher depth of understanding and critique than their level 3 will have been. It is a bizarre contradiction when this section of the framework explicitly hierarchises higher educational levels.

It is not the only contradiction to a framework claiming to provide some level of clarity and uniformity to the profession. Supervision, a cornerstone to the safe practice of counselling, is particularly vague. 'Therapist A' whom is presented as the least prepared for independent and organisational practice has the least specific requirements for supervision of all. This complete ambiguity is there despite, arguably, the most requirement for it; according to the competencies presented by the framework.

Supervision is not consistent across the levels of the framework either. UKCP have requirements that appear to be applied to whomever wants to apply them. Supervision-in-training training for Therapist C: "UKCP: usually 1:6 but not specified by all colleges." Post-qualification supervision for Therapist C: "UKCP: varies by modality but typically 1.5 hours per month". Therapist A who is a member of the BACP is told to maintain "appropriate" levels of supervision. What does this mean? Should they be meeting as much as accredited members? Should they be having more supervision because they need to build competence? Should they be having less because the kind of clients and the depth of work Therapist A is deemed competent enough to work with wouldn't require as much supervision? How would they measure appropriate?

Mandatory personal therapy is a controversial point for many in the sector. There is no clear reasoning for why an increase in *mandated* therapy is seen alongside higher competence. We know this is the view of those producing this document as competence distributions for qualities relating to Therapist A (and to some extent Therapist B) paint them as static figures unable to think for themselves and reflect upon situations sufficiently enough to be deemed a competence. Therapist C, with the highest rate of mandated therapy, is portrayed as the most reflexive and self-aware.

It should not need to be highlighted, but many people come to this profession having already accessed counselling and psychotherapy services. Many come to the profession having had years of therapy (with multiple modalities/therapists) because they have lived experience of the issues many clients are faced with. If hours of personal therapy correlate to heightened self-awareness to the extent it produces a higher level of professional competence, first, this needs clearly evidencing. This evidence may then produce a minimum figure that all therapists should have attained before qualification; such is the inferred importance. Second, is there evidence that mandated therapy is any more valuable than the therapy collected prior to training? If not, evidencing prior therapy should be sufficient to fulfil these criteria.

Personal therapy may not be mandatory at the BACP but many individual courses and/or placements **do** have a minimum requirement to be completed either prior to working with clients or during a specified timeframe alongside training.

Point of interest: The mapping doesn't include BACP Senior Accredited members meaning that whilst becoming individually accredited may move you from 'A' to 'B', being Senior Accredited creates no pathway between 'B' and 'C' without the specific training and education mapped for Therapist 'C'.

Theme 1: Professional framework

There has been little to change in this section from the previous published iteration.

Positives:

Removal of the inference that working with ethical dilemmas was only the purview of Therapist B and above.

Removal of the inference that Therapist A would be unable to critically evaluate their own work

Points to challenge:

Therapist A has the ability to "use team-working skills to work with others" (1.12) but not "take an active role as a member of a professional community and participate effectively in inter-professional and multi-agency approaches to mental health where appropriate" (1.12.a). Nor do they have the ability to "work in multidisciplinary teams with other professionals to maximise therapeutic outcomes" (1.12.b).

It is difficult to not read that as offensive. "Jane Doe has the ability to use team working skills to work with others" is reminiscent of a child's primary school report. Well done Jane, you have learnt to communicate with others and share ideas.

Beyond that, under what reality do counsellors working in an organisation not have to work within a multidisciplinary framework at some point or another? This is a core skill to being employable and competent regardless of academic attainment. It is also a relevant one to working in private practice with populations that require a multidisciplinary approach. For example, eating disorders or working with vulnerable adults in educational settings. The latter of which have also implemented counselling programmes with trainee placements. Is it these nuances that drive the reasoning behind also not addressing specialisation within the field? (BACP et. al., 2020b, p.26). It does allow

them to redirect pertinent critique by saying it relates to an area of specialism rather than holding applicability to all therapists.

Therapists A and B also lack the ability to "take an active role within the professional community locally and nationally. Be able to communicate effectively with other professionals in imparting information, advice, instruction and professional opinion" (1.12.c).

It almost feels like such a ridiculous (and hugely ironic) statement doesn't dignify a response here. All we need to say is that the success of even just our own group, Counsellors Together UK, proves how incorrect that is. We prompted the movement which has people understanding and talking about the exploitation rampant in our sector and we did so when the profession was heavily indoctrinated into the volunteering model. As the conversation spread and developed, more individuals and organisations have been able to make headway. The community behind Counsellors Together UK and our partners have shown themselves to be perfectly adept at simplifying complex concepts to others; including lay people. We continue to develop local and national pilot programmes to increase understanding of the counselling profession to the general public and to demystify counselling to employers and other professionals.

BACP (2019) released a video to say that after over 40 years of operation they still couldn't communicate what counselling is.

Theme 2: Assessment

The majority of the assessment section needs an overhaul.

Therapist is able to "make an assessment of the client's or patient's problems and suitability for therapy" (2.1) but is unable to make a "competent clinical assessment that is consistent with own therapeutic approach" (2.1.a)

This is an unnecessary distinction between Therapist A and B; if Therapist A lacks the ability to make a competent assessment of a client's suitability for therapy within their own theoretical training, they are incompetent to make an assessment full stop – what theoretical understanding and underpinning would they be working from in order to make that assessment? It would simply be unethical.

Only Therapist C has the ability to "conceptualise and (or) formulate ways of working with clients or patients with chronic and enduring mental health conditions" (2.1.b).

Does this criterion mean that BACP accredited counsellors will also no longer be able to work within NHS IAPT services? This framework states they don't have competency to work with the population of clients that goes into those services or, has it been forgotten how the majority of patients are allocated to statutory mental health services within the UK? Working in primary services is little guarantee that you will be working with shorter term, less pervasive mental health conditions. Patients are referred to IAPT in the first instance and then if, and only if, there are available slots within more complex care services, they are referred to them. The reality is that many patients circle IAPT short term interventions for years until they find help elsewhere, get discharged under dubious claims of lack of "engagement" or find themselves labelled with a personality disorder for still requiring help after low intensity support has been given. The latter of which does not guarantee that population will not still be kicked around primary services.

If the only option available to Therapist B is to "recognise more significant mental health symptoms and difficulties, and know when and how to refer on" (2.2.a) but they cannot work with those patients then the IAPT staff competencies document that (incorrectly) states unaccredited counsellors are unsafe to work 1-2-1 with patients should be expanded to include BACP accredited counsellors. Anything else would be ethically immoral and unworkable. This criterion reduces employability and is in direct conflict with one of the listed aims of the framework.

It is always extremely important to note that trauma correlates with chronic and enduring mental health conditions (i.e. severe mental distress). Mapping the competencies this way is still setting the profession firmly in the seat of pathologising distress and an attempt to reduce those who critique the medical model of distress from ever having contact with those populations. It reduces the right of clients and patients to have access to an individualised, holistic approach to their mental health, as championed by the independent Mental Health Taskforce in their 5 year-forward documentation (Mental Health Taskforce ,2016).

These competencies still frame emotional distress under medicalised terms and a medicalised framework. Given the very vocal protests surrounding this point, it seems remiss to not have it specifically addressed when the framework was looked at again. Does this fall within the cherry-picked feedback that the team chose?

This framework in its avoidance of outlining trainee competencies also fails to highlight how trainees with 0-100 client hours may be working with this level of distress. But the framework means that as soon as a trainee becomes Therapist A or B, they will not be able to work with trauma until they become Therapist C. This is clearly ridiculous and unworkable. It also lies in direct conflict with the actions taken by the BACP and other membership organisations when the UK experienced a health crisis this year.

The framework document has been finalised for another public consultation as we come out of a national lockdown due to a global pandemic. A period of time where qualified counsellors were encouraged to provide support to the public but especially key workers in an ongoing traumatic situation to potentially mitigate against the trauma of the pandemic. Despite evidence from other trauma events that early psychological intervention can be counter-productive. Nonetheless, multiple services popped up to provide teletherapy. Yet this document now tries to tell the profession that under normal circumstances, counsellors and accredited counsellors are not fit to work with trauma? Is this because we train under different modalities that may mean our understanding of human distress has not been formulated under the psychiatric diagnostic system? Since when did competence require ascribing to the ICD-11 (World Health Organisation, 2018)?

Another interesting point around the lockdown response is that there was no distinction between who should provide online therapy. It being an "unprecedented" event was used to bolster up the "do your bit" attitude. So, one might expect the framework to reflect that. It does not. Therapist A has the ability to "assess the risks for both parties specific to the online environment" (2.10) but not to "identify and respond to the interpersonal risks that are specific to working online as they impact on the therapeutic process or interaction with a client's or patient's presenting problems" (2.10a). Why is this distinction made? Interpersonal risks should be encompassed within generalised risks otherwise the risks are not fully and competently being assessed.

BACP suggest that they plan to assess members' mental health familiarisation and offer some form of educational training on this (BACP, 2020). This is a clear subscription to the medical model and the further legitimisation of the pathologisation of mental distress. Our profession already struggles to

not describe clients as a collection of symptoms; underlined by the plethora of training on how to work with various disorders and symptoms. The problem with such an approach is the risk of working with clients to resolve a symptom not its source. This is endemic to the medical model and encourages the fractured approach to mental healthcare we find in the statutory system in this country. It is also a contributing factor to people being shuffled around services only able to work on one symptom at a time.

Criterion 2.5 is marked as an aspirational criterion. That aspiration would be to "understand the core issues relating to the role of psychiatric drugs, dependence and withdrawal and the implications these have for clients or patients in therapy". This is a necessary aspiration and it is encouraging to see it placed as Therapist A competence. It would be disappointing if this was amended in the future as per the note made in the modalities update: "Extract high level competencies from APPG?" (BACP et al., 2020b, p.20). The stakeholders involved within the APPG would be disappointed to find their findings applied in a way to further pathologise clients or patients.

The issue is that the associated understanding to provide context and competence within this aspiration has been placed in columns B and C in the prior criteria (2.4). Therapist B: "Ability to critically appraise and conceptualise a range of symptoms of psychological distress, functioning and coping skills (with due understanding of cultural norms), during assessment and throughout therapy" (2.4.a). Therapist C: "Ability to understand the language and discourses around diagnosis, psychopathology and mental disorders" (2.4.b).

To be competent as a Therapist in criterion 2.5, therapists would need the competencies outlined within 2.4. Without that competence there is, first and foremost, no context for that information. You cannot have an understand the discourse around medication, including dependence and withdrawal, without including symptomology, diagnoses and psychopathology. Any training lacking in these components would create an unacceptable level of risk to clients. Therapists do not need to have a medical background or training in pharmacology but they would need enough understanding of symptoms to allow them to critically appraise those symptoms within a holistic approach. Without that knowledge, therapists risk colluding in a system that psychologises and pathologizes their physical responses to psychiatric medication.

An extension of any risk assessment and referral planning would be an understanding of the diagnoses associated with the medications/medicine classes that have higher risks of dependence and withdrawal. Further to that would then be an education in the types of side effects that can impact therapy or suitability for therapy.

Beyond the therapy room, professionals that lack this training and understanding can be vulnerable to extremist and exclusionary viewpoints that promote practices which perpetuate harm on either side on the conversation. For example, ignoring concerns and pushing drugs as a treatment irrespective of harms, or, pill shaming and anti-psychiatry views that have been known to decrease patient drug adherence in some people as well as influencing the stopping of medication without medical support structures in place. This is dangerous as some psychiatric meds need tapering to avoid harmful side effects from the chemical withdrawal. In short, you can't achieve criterion 2.5 without the ability to understand the context and history of psychiatric meds and associated harms; including the pervasive denial that withdrawal exists; and thus, criterion 2.4.b. This is not a competence skill possessed only by those who have achieved a level 7 qualification. But to be absolutely clear here. We are not suggesting that in response to this, the criterion of 2.5 should move into a different column. There is no evidence to suggest these concepts cannot be taught; or indeed added to a more comprehensive post-qualification assessment.

Back to the ability of a therapist to risk assess, in criteria 2.7 and 2.10 we find Therapist A still deskilled to the level of being unable to competently risk assess in any workable manner that means client work remains safe. It is like doing the hazard perception test to learn to drive and excluding the part of your learning where the teacher teaches you how to safely respond to those hazards. Any training on risk assessment should be also teaching risk management; any courses not doing that should not meet criteria for qualification.

Theme 3: Relationship

It is unclear why some of this criterion have been divided as they have and speaks more to the myths and stereotypes the people devising the framework appear to have about people who haven't gone into higher education.

For example, what evidence exists that only those with a level 7 qualification possess the "ability to communicate about the harm caused by discriminatory practices and aim to reduce insensitivity to power differentials within the therapeutic service provision, training and supervisory contexts" (3.3.b)?

This ignores the role of our individual experiences of privilege and discrimination in impacting our ability to recognise discrimination in any settings; irrespective of how many workplace trainings we may have on diversity and discrimination. Even this is limited by the unconscious biases we all have, the power differentials occurring within any team, our position within it and our prior experiences of speaking up/whistleblowing – and how this then impacts our ability to speak out against discrimination. Post graduate qualifications are not a buffer to this, nor do they possess the source of all knowledge of being able to detect issues. It is ridiculous to suggest otherwise.

Within the same criteria there is another unnecessary division to allow for special note to be made for the unconscious or 'out of awareness'. It is unclear why Therapist A is unable to work with things that may sit outside of the client's awareness (3.6.a). Does this mean Therapist A may never consider another point of view that the client may not have considered but would find therapeutically useful to consider? Or is this simply another point where the framework can infer that psychodynamic/psychoanalytical approaches are optimal?

Therapist A has the ability to "establish, sustain and develop the therapeutic relationship" (3.9) but not to "critically reflect upon the client's or patient's process within the therapeutic relationship" (3.9.a). Quite simply, how can A be achieved without B? How do you know you're establishing a relationship? How do you know it is developing? Certainly not from a vacuum of only our own experience of the relationship! This is a basic core skill required for therapy and supervision to be effective. Therefore, it is a skill for which the aptitude for should be assessed in all prospective trainees prior to entering a course which requires working with clients or patients.

Furthermore, criterion 3.10.a is a core, necessary skill for all professionals working with clients and patients. If a therapist is unable to contain and use their own responses to a client in a way that is therapeutic, are they safe to work with clients? It is not enough to simply note them. Too many people are harmed when "self-awareness" does not reach beyond that point of reflection. We (the sector) have heard from patients in various services who have been treated from poorly to criminally negligently because those in charge of their care acted and reacted in ways diametrically opposed to 'therapeutic'. Some therapists have and still do punish clients/patients when they believe the

clients/patients manipulate, anger or trigger them in any way. These behaviours are seen across the spectrum of roles in mental health and across the spectrum of educational levels attained by those staff.

It is also a core skill to maintain the level of self-awareness to recognise when you will not be able to use your responses in a therapeutic way and therefore should refer/refrain from working with that population. For example, knowing that your responses to sexual offenders would be harmful to the work – so not doing a placement with that population and also not denying them care if approached privately by maintaining a referral list.

Therapist A can "recognise and respond to difficulties or ruptures in the therapeutic relationship" (3.12) but remains apparently incapable of exploring with the client how these might be similar to other relationships the client has. Why? What evidence is there that this is missing? Therapist A and B also lack the ability to apply any understanding of things that are currently out of the client's realm of awareness (3.12.b). Again, why? Other than wanting to underline the unconscious as part of the psychoanalytic/psychodynamic training, what is the point of this distinction? Where is the evidence that A and B can't fathom the client might not recognise the similarities with the relationships discussed (or not discussed depending on the modality) within the therapeutic process?

Criteria 3.14 is another "spot the hazard but cannot work with it" criterion. Therapist A lacks the ability to analyse any difficulties that occur during the course of therapy which may lead to rupture or blocks in the process. What remains unclear is how, without the skills of analysis, Therapist A might select the interventions they are competent to use in order to respond to disagreements. Does Therapist A just keep trying random ones until one of them hit correctly? Or, more likely, do they analyse the situation and use their knowledge of the client in order to select the most appropriate interventions? Such as the ones most likely to succeed in order to minimise therapeutic blocks and ruptures through the client feeling unheard or, worse, coming to the conclusion therapy is not working because they are "too difficult to treat".

Therapist A is able to communicate with clients about endings and work safely to complete them but is unable to "consider potential issues arising when ending therapy in light of the client's or patient's previous experience" (3.15.a). Seems unlikely that Therapist A would actually be able to end safely with all clients or patients if they cannot consider these potential issues. How would they manage the associated risks?

Theme 4: Knowledge and skills

Criterion 4.2 talks about skills typically built via academic study, though not exclusively. It is possible to learn this skill elsewhere and simply apply it. A degree or above provides a self-contained environment for doing this but it doesn't mean others lack it. Particularly those who have achieved higher education qualifications in other fields; the skill is transferable. The key things here are recognising prior educational attainment and how post-qualification skill development in this will be measured. This is important because the underlying inference is that counsellors lack the skill to truly work in an evidence-based manner as they lack the skills to critically appraise any research they are reviewing. This is untrue and potentially damaging to our profession.

The feedback given during the consultation highlighted the important point of not treating suicide and self-harm as one and the same. Thus, meaning that mean self-harm should be seen as a distinct phenomenon from suicide and suicidal ideation.

“I do not believe that linking ‘suicide and other self-harm’ is accurate nor helpful. Whilst an unsuccessful suicide attempt results in harm to oneself, this is very different from the coping mechanism that self-harm is generally used for” (BACP et al., 2020b, p.21).

The Technical Group advised that this was purely about risk assessment which meant they made the division of competence they did. Criterion 4.3 has split the knowledge and skill of working with suicidal or self-harming behaviours between A and B but Therapist A cannot work safely with suicide as they supposedly do not understand the “conflictual and paradoxical nature of suicidal ideation” (4.3.a). This is very basic knowledge. Training absent of this knowledge is unfit for purpose. A lack of this understanding also results in fear-based practice that overreacts to all ideation as an immediate risk thus unnecessarily risking therapeutic rupture. An additional risk of this response is that the client or patient gets flagged to services in a negative way that increases the likelihood they will be diagnosed with a personality disorder. An outcome we should avoid inflicting upon people.

What needs to be made clear here is how therapists can evidence they have received adequate training or developed adequate experience in suicide and self-harm. This training should be undertaken during core training but if not within a short period post-qualification. Suicidal risk and self-harm are not the exclusive remit of “mental health placements”. The Mental Health First Aid course should not be deemed adequate training in this despite it covering the topic of suicide. The course is not aimed at working with suicide or self-harm, only how to safely manage immediate risk as a lay person and then signpost to crisis or therapeutic services.

Criterion 4.6’s division appears to be superfluous. How can Therapist A select and use appropriate interventions if they are unable to explain or conceptualise why they are appropriate? Or indeed, why they might not be appropriate without modification. It suggests Therapist A simply plays a game of snap with a particular presentation and a list of possible interventions with no active thoughts happening on the part of the therapist. It is reminiscent of the Russian roulette inferred in 3.14.

Therapist A possesses the ability to “use skills and interventions for the benefit of the clients or patients, that are consistent with underlying theoretical knowledge” (4.7) but lacks the ability to “reflect upon the complex and sometimes contradictory information gained from clients or patients and coherently describe their present difficulties and the potential origins using a clear theoretical model or approach” (4.7.a). If this is not adequately taught to trainees so they can do this upon qualification then where do these trainees learn to reflect and consolidate their learning? How are these trainees passing their assignments and exams if they cannot demonstrate this skill that apparently only appears after 450 client hours? Where did the evidence for this claim come from?

Furthermore, only Therapist C is able to “understand the nature and purpose of therapy to evaluate and use theory to conceptualise how ‘unconscious’ or ‘out of awareness’ processes in both client or patient and therapist, may shape perceptions and experiences and influence the therapeutic process” (4.7.b). The real question is, what do Therapist A and Therapist B talk about in supervision? Apparently, it is not transference or counter-transference (or equivalencies in their theoretical model). What evidence is there that other modalities lack the ability to look beyond their own experiences and consider the client, themselves and the interaction of both as a whole for the therapeutic relationship and its progression? This is insulting and once again highlights the bias and misconceptions of the groups involved in the construction of this framework.

Therapist A finds themselves still stuck within their own mind for criterion 4.8 and unable to describe any philosophical assumptions that underpin theoretical understanding of identity culture, views and worldview (4.8.a). How does the framework propose that Therapist A developed their knowledge to understand themselves if not with some philosophical teachings? This understanding must occur in the same vacuum that prevents Therapist A and B integrating their knowledge of theory and research within the areas of diversity and equality into clinical practice (4.8.b). If this were true, how can Therapist A and B work within the legalities of discrimination and equality law? They cannot integrate their knowledge to do so. Why was this placed as a level 7/Therapist C competence?

Earlier in this document we highlighted how the framework infers that Therapist A is incompetent to work in an organisation because they lack the skills to work in a multidisciplinary manner. Criterion 4.11.a suggests they cannot work safely in private practice either because they lack the ability to "utilise audit and evaluation tools to monitor and maintain standards within practice settings".

Theme 5: Self-awareness and reflection

Therapist A lacks the ability to be "emotionally prepared for intense and complex work, which requires reflexivity, and which is potentially taxing for the therapist" (5.1.a) and also lacks the ability to "work with 'unconscious' and 'out of awareness processes" (5.1.b). Only Therapist C is able to "evidence reflexivity, self-awareness and the therapeutic use of self to work at depth in the therapeutic relationship and the therapeutic process" (5.1.c).

These are outright insulting. Where were these ideas plucked from? All counselling training has at least one module dedicated to self-awareness and self-development but it is an ongoing process through the whole training; even below level 4. Once again Therapist A is seen as a static figure who now not only thinks of themselves within a vacuum, they also lack the ability to do anything with any discoveries they learn about themselves because they lack reflexivity. It is a strange assumption as the entire training process requires a great deal of reflexivity in order to improve on skills being built. Despite this, the skill immediately disappears upon certification; only to pop back up at 450 client hours or completion of a masters.

As another example of being static, Therapist A is unable to "critically challenge their own identity, culture, values and worldview" (5.3.a). Where does this view come from? Or the one that suggests that Therapist A cannot review their own supervision arrangements to best respond to changes in need or requirement of ongoing practice (5.5.a)? It would be an opportunity ripe for abuse of power if only a supervisor could tell Therapist A when they could change supervisor.

Further thoughts

When the SCoPEd team market this framework as demonstrating the current 'state-of-play' in the sector, what they mean is the current situation within their own membership bodies. This should concern BACP counsellors and psychotherapists the most. As mentioned early in this document, the framework is being marketed as a way to combat the lack of regulation, "because anyone can call themselves a counsellor or psychotherapist." One might be forgiven then for thinking that this

framework would then offer some level of robustness to protect the public. But, if anything, it shows the glaring inconsistencies in BACP's registration processes. BACP are currently the largest membership organisation for counsellors and psychotherapists in the UK. Organisations look towards them to provide guidance and other membership organisations may look at them as a model to emulate. This affords them a considerable level of responsibility.

How do the requirements for 'Therapist A' demonstrate an attitude to robust practices and public protection? Too many of the requirements are 'not specified' and leave too much ambiguity even for trainees on courses accepted for registration. It means that course providers can set their own standards minimum standards which may or may not align with those expected for progressing through the membership levels within the BACP membership structure. It creates a situation whereby members are not on equal footing for accreditation but they *appear* to be to employers. Yet one therapist has applied all their learning hours through a level 4 or above course and another therapist may have used *multiple* courses to make up that shortfall; only one of which needs to meet the criteria that BACP does specify.

The decision to change position on whether a difference between counsellors and psychotherapists exist has been well documented elsewhere (Rogers, 2019). The conclusion that the SCoPEd framework makes, however, needs challenging once again. When the competencies are listed as they are, connected to the qualifications they are, they clearly state that psychotherapists and their approaches are better. If parity were the goal, there wouldn't be specifications related to those specific modalities. The framework places high value to the ability to work with diagnosis and the concept of unconscious and very little to the experiential processes within therapy except to the extent to which a therapist might critically analyse them. Furthermore, it assumes that the ability to critically analyse and reflect upon work lays heavily at the door of psychotherapy or 'Therapist C'. It appears as though there is a lack of ability to translate concepts beyond the bounds of psychoanalysis. This is disappointing and perhaps requires further reading on part of the TG and ERG.

Another critique made against the prior iteration of this framework was the pervasive deskilling of qualified counsellors and often to the point of rendering them unsafe to work (Shennan, 2019). This was and remains insulting. If the framework claims to provide clarity, this particular trend does nothing of the sort. Division of competencies does, in many places, actually reduce safety in the therapy room. It is not just an act of deskilling the current practitioners in Therapist A but it is an act that will trickle down into the competencies of trainees coming up the ranks by reducing the competencies they need to demonstrate before completing the qualification.

As some of the unsafe-to-safe competencies emerge between qualifying and 450 hours with clients, it is unclear how they appear. Does the burden of teaching them fall on employers and their managerial structures? Or does it fall onto the supervisors working with therapists but not directly *assessing* their practice the way a tutor or lecturer does during the course of training and the use of triads? The act of being able to write up what skills you may possess to demonstrate understanding (as is requested in the application to become accredited), whilst a useful reflective practice does not actually measure these competencies; only an aptitude in communicating them against marked criteria. If this were a robust enough practice in measuring practical skills, there would be no need to have any in-person assessment. One of the few consensuses across the field is that this is not the case. Given that former BACP chair made a statement to say that counsellors are "notoriously bad" at assessing their own efficacy (CPCAB, 2020), it seems bizarre to encourage a practice of subjective skills assessment when there is a ready-made assessment process within training courses across the levels.

Meeting its aims?

As mentioned earlier, there were four key questions put to members in the consultation process. We can infer that SCoPEd hopes to improve outcomes in these areas. How well does it do in that?

Aim 1: The framework will improve a client's or patient's ability to find a therapist best suited to their needs

From a client's perspective, there is **nothing** clarifying about this framework. It is jam packed with counselling jargon. As a client, I don't care how many hours of personal therapy my therapist has had or how much supervision they have. As a client, I may even feel suspicious and afraid of the supervision process and what that means for my privacy. Do I care if they have one type of qualification over another? Not so much. I do care about their specialisms and this framework doesn't talk about specialisms at all.

There are no focus groups asking what clients want demystifying and none following up to see if the framework achieves its goal in this area. It seems the independent market research company didn't feel conducting actual market research was necessary for this project. Or, maybe, they didn't have any remit to "conduct" the research beyond being the survey host? Regardless, there is no way to measure the success of this framework in this aim.

Aim 2: The framework will enable employers to establish which counsellors and psychotherapists to employ in their services

Specifically, what were employers misunderstanding? It is only BACP claiming to not be able to quantify the role of the counsellor. Individual counsellors are explaining their role to clients and their non-counselling colleagues every day; in those multidisciplinary teams the frameworks say the majority of counsellors have no competence to work in.

Aim 3: The framework will provide clarity for trainees wanting to understanding training pathways for core training.

This is perhaps the only aim the framework gets close to achieving and even then, it is flawed. There is a clearer path available to those who engage with higher education than those looking at further education colleges and training centres. It is not the graduates of higher education institutes that are having to justify their qualifications to employers against a backdrop of, "anyone can be a counsellor, you can get a diploma online for £30."

At the point when the majority of trainees are looking towards a course that allows them to qualify, the damage has sometimes already been done. We keep fearmongering with the idea of a person just signing up to a short-course on a whim and then behaving completely unethically. The rates of this occurring are unknown. The real risk is trainees being exploited as they meander an unclear and largely inaccessible field – accessibility being measured in the context of localised courses, reasonable fees and available placements. This contributes to people starting their training journey online. Sometimes the financial loss is small. A £30 course through an online coupon website is little outlay for most. However, for some, the realisation that their course is not fit for purpose succeeded building a substantial debt reaching into quadruple figures.

Aim 4: The framework will improve the ability of the professional bodies to promote the skills and services of their members

What is specifically so difficult about this that counselling can not be described in a way that shows competence to “stakeholders” without this arbitrary segregation of competencies based on the biases held within the SCoPEd development groups? Which professionals are we being compared to in order to require a competence that can be overlaid over theirs?

If there hasn’t been an ability to promote the profession and counselling developed and fine-tuned over the course of 40 years of operation (in BACP’s case), it seems unlikely that there has been a stumbling upon the magic solution. When we drill this down, what this is, is a failure to quantify counselling to service commissioners who cannot see beyond the medical model and have no interest of providing alternatives. This framework therefore fails on the aim of promoting the profession. It’s not a promotion of the profession, it is an act of seeing how the profession can be bent around an inflexible view of providing mental health “treatments”.

Suggestions going forward

A new start?

Some may argue that the issues with the methodology and, particularly the faults in ethical practice, mean that this project should halt and start again allowing for real transparency, ethical practice and genuine consultancy with ALL the stakeholders, not the selected ones. This has to include all the membership bodies listed on the PSA accredited registers programme. This framework has an impact on the industry that goes beyond the membership of the bodies writing it.

This option has some considerable downsides of its own; not least the amount of money that has already been funnelled into this project. Money that members have not been asked if they would like to be spent in this manner, so as a first priority, members should be asked if they want the project to continue. This should be asked irrespective of any decision of how and where to resume from.

If members choose to continue with this project, then there needs to be significant improvements to the methodology driving this.

Methodology

Independent roles need to be independent. It is possible to find a Chair from an adjunct profession who is not impacted by the decisions made in the production of this framework.

The theoretical bases of the TG and the ERG need to be equally distributed with full transparency of the modalities the members trained in. The qualifications level of these members should also be declared.

Given the known limitations of the Roth and Pilling methodology, there needs to be a thorough analysis of alternative methodologies for the structure of a competence framework. This analysis needs to include a consultation with representatives from other membership bodies and interested parties. As it was deemed to still maintain “methodological integrity” to plug gaps in Roth and

Pilling's methodology with select research and resources, there is an argument for the same approach to apply for a different model. A model that is felt to best represent the profession as it is.

Notably, research into the validity of competence frameworks found there were significant differences in how practitioners favoured competencies; favouring those from their own modality and eschewing those from others (Roth, 2014). More interestingly, the research found that practitioners were more likely to assign generic items as being characteristic to their own approach rather than others. This is pertinent because the TG and ERG will be subject to the same unconscious biases without a robust challenge to this. The modalities being distributed as they are does make a huge difference and being 2:1 psychoanalytic/psychodynamic doesn't leave much space for a robust challenge.

Address trainee standards

It is not enough to simply state that this framework is built for qualified counsellors and psychotherapists. There needs to be a consideration of what trainee competencies are essential for a trainee to be safe to work with the general public as a professional. In ignoring this set of criteria, there is little acknowledgement of the unsafe nature of some competencies in this framework. It is all very well to try and arbitrarily divide shared attributes into columns based on "good; better; best" but as we are working with the public during level 4 and above qualifications, there **is** a 4th column to be considered. Some competencies suggested in the framework do not allow for there to be a trainee level of competence. Anything less than 'A' would be unethical and unsafe.

If SCoPEd, or any alternative framework, would like to begin to address substandard qualifications, they need to address expected competencies upon entry to level 4 and above training courses.

In concluding, we sincerely hope that the BACP, UKCP and the BPC read this document in its entirety and take on board the issues that have been highlighted.

References

Albertsen, M. (2019). *CTUK Response to the BACP 'scrap SCoPEd' members' resolution result*. Retrieved from https://ukcounsellors.co.uk/ctuk-response-to-the-bacp-scrap-scoped-members-resolution-result-2019/

Albertsen, M. & Radway-Bright, E. (2019). *Initial response to BACP re: SCoPEd project*. Retrieved from https://ukcounsellors.co.uk/initial-response-to-bacp-scoped-project/

Albertsen, M. & Shennan, T. (2019). We are asking BACP to scrap the SCoPEd project. Retrieved from https://www.change.org/p/british-association-for-counselling-and-psychotherapy-we-are-asking-bacp-to-scrap-the-scoped-project

BACP. (2019). SCoPEd: Answers to members' questions. Retrieved from https://www.bacp.co.uk/news/news-from-bacp/2019/31-may-scoped-answers-to-members-questions/

BACP. (2019, June 19). *Fiona Ballantine Dykes talks about SCoPEd*. Retrieved from https://youtu.be/QCwPkEx4L7Y

BACP. (2020). *FAQs about SCoPEd*. Retrieved from https://www.bacp.co.uk/about-us/advancing-the-profession/scoped/scoped-faqs/

BACP, BPC, UKCP. (2018). SCoPEd: A draft framework for the practice and education of counselling and psychotherapy (November 2018). Retrieved from https://www.bacp.co.uk/media/5161/scoped-competency-framework.pdf

BACP, BPC, UKCP. (2020a). *SCoPEd Framework: A draft framework for the practice and education of counselling and psychotherapy*. Retrieved from https://www.bacp.co.uk/media/9178/scoped-draft-competency-framework-july-2020.pdf

BACP, BPC, UKCP. (2020b). *SCoPEd Methodology Update: Framework Iteration Three: Response to Member and Stakeholder Consultation (July 2020).* Retrieved from https://www.bacp.co.uk/media/9118/scoped-methodology-update-july-2020.pdf

CPCAB. (2020, July 15). An introduction to counselling research (1/3): Why is research important. Retrieved from https://www.youtube.com/watch?v=rdBUpHHzrRY&t=2s

Mental Health Taskforce. (2016). *The Five Year Forward for Mental Health*. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFVfinal.pdf

National Counselling Society. (2019). *SCoPEd: An open letter to BACP by the National Counselling Society.* Retrieved from https://www.nationalcounsellingsociety.org/assets/uploads/docs/scoped_open_letter_to_bacp_wv.pdf

Partners for Counselling and Psychotherapy

Rogers, A. (2019). *Maps, languages & lost continents: Person-centred therapy and the scoped project*. Retrieved from https://allianceblogs.wordpress.com/2019/07/31/maps-person-centred-therapy-scoped/

Roth, A. D. (2015) Are competence frameworks fit for practice? Examining the validity of competence frameworks for CBT, psychodynamic, and humanistic therapies. *Psychotherapy Research*, 25(4), 460-472. DOI: 10.1080/10503307.2014.906763

Shennan, T. (2019). *Why I'm seconding the #scrapSCoPEd resolution*. Retrieved from https://ukcounsellors.co.uk/why-im-seconding-the-scrapscoped-resolution/

Shennan, T. & Albertsen, M. (2019). SCoPEd: Reducing the scope of client choice? Exploring the potential impact on counsellor populations and the models, theories and therapeutic

interventions available to clients. Retrieved from https://ukcounsellors.co.uk/scoped-reducing-the-scope-of-client-choice/

World Health Organization. (2018). *International classification of diseases for mortality and morbidity statistics* (11th Revision). Retrieved from https://icd.who.int/browse11/l-m/en

Appendices

Appendix 1: SCoPEd Resolution

Summary

It is proposed that the BACP discontinue their association with the SCoPEd project, which portrays counsellors as less competent than psychotherapists and questions their capacity for independent judgement. Furthermore, we propose that any future move towards developing a competency framework must be undertaken with member-consultation from the outset.

Explanatory Statement

We propose that BACP discontinue their association with the controversial SCoPEd project, and that any future move to develop a competency framework should be undertaken with member-consultation from the outset.

Communication with members has been poor, and many members are unhappy with the way the research has been conducted. The joint project between BACP, UKCP and BPC was developed without any initial member-consultation. The majority of the expert reference group are psychoanalyst/psychodynamic therapists, and several modalities are unrepresented, including person-centred therapy.

The tiered system presented in the project favours trainings associated with two of the bodies involved with the project – UKCP and BPC. While the authors of this resolution do not suggest any impropriety from researchers, we suggest the absence of declarations of potential conflicts of interest is a serious ethical limitation of the research.

The SCoPEd framework places counsellors and psychotherapists on a competency continuum which deskills counsellors, and is not reflective of the ways in which members work in reality.

Claims that SCoPEd will provide clarity for clients, therapists and other stakeholders are called into question by members who report feeling confused by the project. The SCoPEd team have said the terms ‘counsellor’ and ‘psychotherapist’ are not titles, while presumably the evidence they draw upon in the research would use these terms as titles.

BACP have said that the tiers are ‘entry points’, yet ‘Advanced Counsellor’ is only attainable for the vast majority of members through accreditation or equivalent post-qualification experience, which is not an entry point. Facebook chats and Therapy Today articles appear to have only obfuscated further. Members are concerned about what SCoPEd means for the future, because the BACP are not providing clarity about this.

Additionally, concerns have been expressed about the use of medicalised language in the framework, which does not reflect the diversity of modalities and therapeutic approaches amongst members. This comes as movement to challenge the medicalisation of distress gains traction in the field (See: Power Threat Meaning Framework, Johnstone and Boyle, 2018).

If this resolution is successful, the BACP will discontinue its association with the SCoPEd project. This will mean that the tiered framework will not be implemented for BACP members, and the BACP will

not spend members' fees and resources on its further development or implementation. The authors of this resolution propose that this is in the interests of the organisation, its members and clients.

If this resolution is unsuccessful, we do not know what this will mean for the future of the BACP or the profession. At the very least, it is likely that courses leading to UKCP and BPC membership will be seen as preferable from the perspective of new students, employers and perhaps even insurers, since SCoPEd declares therapists entering the profession with those qualifications to possess higher competencies around assessment, ethics, ruptures, unconscious processes and more. The authors suggest that these propositions are damaging, do not reflect the realities of training and practice, and are based on flawed research.

Appendix 2: Scrap SCoPEd public petition

We believe that the proposed SCoPEd project by BACP, UKCP and BPC creates a hierarchy between counsellors and psychotherapists and is detrimental to the progression of the counselling profession. As members of BACP we ask that the SCoPEd program is stopped with immediate affect.

This project is not representative of BACP members. BACP states in their literature that they have 12 members only on the project panel, only 2 of which are humanistic therapists and the majority of which (7) are psychoanalytic. How can this panel represent the BACP membership? We would ask that BACP consider how this framework is exploitative to its members by promoting such hierarchy. How can a project such as SCoPEd which is being developed without representation of the majority of your membership offer a fair representation of knowledge, skills and attitudes which is what you state you aim to be measuring, when the panel is so deeply rooted in psychoanalytic theory?

If this framework was to be implemented the majority of change would be for BACP members only. UKCP and BPC members would remain largely unaffected. The main change is that there will be 'qualified counsellors' and 'advanced counsellors' within BACP, with psychotherapists (at the top). Regarding the changes for BACP members, they'd fall into either the 'qualified counsellor' or 'advanced counsellor' categories. BACP members may choose to be psychotherapists if they undergo personal therapy and meet other criteria. However, most members would predominantly fall into the first two categories. In those two categories the only thing separating 'qualified counsellors' and 'advanced counsellors' is accreditation. There is no other criteria to separate them. So those who cannot or who choose not to become accredited stay as 'qualified counsellors' and are not classed as advanced regardless of experience and training.

We would like to reiterate to BACP that Accreditation is supposed to be a voluntary process. Once qualified, counsellors are deemed fit and competent to practice. Accreditation is a process [which] members can opt to take. In not doing so they should not be penalised by being ranked below those who have chosen to do so. In reality 'qualified counsellors' could be more highly qualified, experienced and skilled than those with the title of 'advanced counsellor.'

Regarding public confusion, BACP have proposed a set of standards that confuse members of its own membership body, never mind the public. Such an exercise undertaken without consultation with your members only serves to enhance confusion. In alienating members from this process, you take away our voice and do not seek to represent but rather to dictate to us. You have failed to consult properly with your members. You say that as of January 2019 you are beginning a consultation process with your members. However, this is a consultation process that you are rolling out near completion of the project! BACP members should have been consulted from the outset. This is not a democratic process and we feel the process you have undertaken reflects and highlights the hierarchy system in place within BACP, who operate from the top down. What we have is a membership body making decisions on behalf of its members in a way which is not membership led, but rather a reflection of the hierarchal system of titles you seem to be proposing for your members.

Therefore, we don't believe that the proposed framework reflects your membership, but reflects the agenda of those who sit on the panel.

We ask BACP to end the SCoPEd project.

By Maria Albertsen and Tara Shennan

On behalf of Counsellors Together UK