Irish Council for Psychotherapy

Submission to CORU in response to the Public Consultation on Standards of Proficiency and Criteria for Education & Training Programmes for Psychotherapists

Submitted via email to: strategyandpolicy@coru.ie

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Summary

In this submission, we lay out the key concerns of ICP and its registrants in relation to the CORU proposals concerning the regulation of the profession of Psychotherapy in Ireland. In brief, we recommend the following:

1. The development of clarity around the nature of the work of psychotherapists, including the differentiation from counsellors;

2. The re-setting of the threshold level of training at Level 9;

3. The inclusion within the framing of training programmes of personal psychotherapy/personal psychotherapeutic experience.; and

4. The revisiting of details around direct observation of clinical practice within training.

As well as these concerns, we include details in relation to omissions, training criteria and proposed new proficiencies. We emphasise throughout this document our support for the development of a fully integrated training, a profession of psychotherapy whose distinct practice is properly recognised, and a public that is then in receipt of the safest and best service we can provide. This document should be read alongside our online submission.

Contents

1. Introduction

The Irish Council for Psychotherapy (ICP) is the national umbrella body for psychotherapy in Ireland, and a united group speaking on behalf of psychotherapists and psychotherapy training schools, which operate to rigorous standards of competence and professionalism. We represent the broadest range and greatest number of practitioners — more than 1,700 — and the major psychotherapeutic modalities in Ireland, as follows: Psychoanalytic Psychotherapy; Humanistic and Integrative Psychotherapy; Cognitive Behavioural Therapy; and Systemic Psychotherapy. We are very concerned that the current proposals would not protect either the public or the professional involved in the practice of psychotherapy. Like CORU, ICP's principal interest is that of public safety and we believe that regulation is central to public protection, professional trust and the evolution of the profession of psychotherapy in Ireland. It is due to our overarching concern for the safety of the public, as well as for the welfare of professionals in the field and for trainees in programmes, that ICP is making this submission.

This submission is based on an in-depth consultation of our professional members, undertaken specifically to inform our response to CORU's public consultation on psychotherapy. The ICP's members' consultation involved the formation of a working group; a survey of members' responses to the proposals, which had a very high level of engagement across the modalities; focus group meetings, where fuller discussions about concerns were possible; and a town hall meeting, where there was further scope for discussion of responses to the proposals. There has also been a high level of engagement from trainers on psychotherapy programmes across the country, who are in a particularly strong position to comment on the nature of training as envisaged in these proposals. A high level of engagement has been apparent throughout this process, and members have expressed their concerns very directly. This submission summarises these.

Members recognise the great amount of work that has been put into framing these proposals. While welcoming the move toward a regulation of the profession, and its recognition as a distinct profession, a high level of concern was apparent. Members have expressed shock at the proposals, as well as disappointment in relation to a perceived lack of recognition of the high standards already present in our training programmes. Members were particularly struck by the lack of differentiation made between psychotherapy and counselling here and the loss of what is distinctive in the practice of psychotherapists within the proposals. Our individual concerns are wide-ranging, including the entry level to training; the threshold level for registration; the lack of attention to clinical supervision and personal psychotherapeutic experience; demands that will reduce availability of suitable placement sites; and proposals for

direct observation of 100 hours of 'service user contact'. We believe that there are fundamental problems with the proposals, and we are recommending a re-thinking of these.

ICP believes the route to opening access to psychotherapy as a profession to more people, including people from diverse backgrounds, is not by lowering the minimum entry level to level 8. Rather, ICP believes the solution to ensure that all people have equal access to a sustained high level of training could be achieved by the provision of government-funded opportunities in education and training for people who want to undertake a postgraduate psychotherapy-specific degree.

2. Key Concerns of ICP

This section outlines key areas of concern, all of which are linked and interconnected. Our concerns relate to a wide variety of elements of what is proposed. Our key concerns are as follows:

2.1 Public Safety

As for CORU, our most important concern in responding to these proposals for the regulation of psychotherapy as a profession relates to the safety of the public. We do not believe that the level and nature of training envisaged here would provide the kind of psychotherapy practice that we recognise as vital within this role. We are concerned that the threshold level of training – namely at Level 8, with a lack of integration of clinical supervision and personal psychotherapeutic experience, and with the proficiencies as outlined – would not provide adequate protection for the public. Level 8 outcomes do not adequately equip a graduate to practise psychotherapy as the profession is more nuanced than level 8 proficiencies are designed to assess, and therefore pose a public safety issue for clients with complex issues, and for the therapists themselves. While a student may successfully complete an academic programme at Level 8, this is no assurance of their readiness to engage specifically in the work of psychotherapy, which demands a high level of emotional and interpersonal maturity, including a body of experience gained over late adolescence, emerging adulthood, and the early years of young adulthood. In this, we are also concerned for the welfare/wellbeing of trainees on programmes where there has not been due consideration to the impact of the training involved.

2.2 Lack of Definition of Psychotherapy and of Recognition of this as a Distinct Professional Activity

We are concerned that the current proposals do not adequately differentiate between the complexities of the work of a psychotherapist as compared with that of a counsellor, including matters relating to content and scope of practice. Despite the provision of two separate registers, the current proposals make very little differentiation between counselling and psychotherapy. This may be linked to contributions from those who do not see a difference between counselling and psychotherapy. We believe that it is important to have a clear definition of what psychotherapy involves as a practice in order that we can develop appropriate supports in training and beyond for this; and as a way also of having clarity for the public and for referrers, uncertain of the distinction between our fields, that we develop clear definitions of these two fields of practice, recognise them as separate professions, and move beyond the confusion that currently prevails. We think it is very important to recognise the distinctiveness of psychotherapy as a profession. This does not solely relate to a distinction between psychotherapy and counselling. It is also in relation to other forms of professional practice, including psychiatry and clinical/counselling psychology, where shorter term and focused interventions are central to that work. The distinctiveness of the work of psychotherapy is conveyed in the kind of language we use, and it is important that this appears in our framing of proficiencies, criteria, etc., so that the actual identity of our work is not erased. While we recognise the importance of a shared language to describe the overall parameters for thinking about training and practice, we see it as vital that the key values of the field of psychotherapy are expressed here within the language of this profession.

2.3 Lack of Attention to Developed Norms and Standards in the Profession and in Professional Training

We are concerned that a great deal of work has been conducted over many decades to develop a shape of training and practice in the field of psychotherapy nationally and internationally. These have been worked out very carefully and with a high level of negotiation between the key stakeholders. The emergent criteria for training at ICP and EAP (European Association of Psychotherapy) levels reflect that knowledge and experience of professionals in this field and are the outcome of a great deal of consideration. Current European requirements are for a 4-year psychotherapy-specific training, which follows on from an undergraduate degree (or equivalent) spanning at least 3 years. ICP believe that such a model would allow for a more appropriate threshold level for registration as a psychotherapist. Those entering psychotherapy training should already have a broad understanding of areas related

to psychotherapy – e.g., psychology, social studies, education – so that they have foundations in place for the advanced knowledge, skills and competence that are intrinsic to the practice of psychotherapy.

2.4 The Lack of Attention to Readiness to Engage in Psychotherapy Training

We are concerned that no attention is paid in the proposals concerning the assessment of readiness to engage in psychotherapy training. It seems important that this is examined explicitly, and the particular kinds of requirements that might ordinarily be in place to guide programmes in making decisions about entry stated clearly. We identify a risk here of the development of programmes that, in the absence of such guidance, may not consider this; the result of which may be the entry of people who are not prepared for this, outside of academic achievements. Emerging neuroscientific data points to the extension of adolescence into the mid-20s, suggesting that emotional, interpersonal, and social functioning is still very much in a state of development at this time. This is in line with observations made across these professions of the readiness of people to enter into this kind of work. Late-adolescent and emerging adult experience provides an important basis for this kind of work, but it is not a good time in which to be involved in such training itself. The emotional, interpersonal and social development of this time typically involves a great working through of experience. At this time, the demands of training in psychotherapy – particularly the emotional demands of this – would be damaging for trainees and, by extension, place clients at risk. We recognise the phenomenon, too, of the 'wounded healer', and that many people who have experienced a high level of difficulty in their lives are drawn to this kind of work. While, in the long term, this can be of value for the psychotherapist in training, it is important that there is a clear gap between the period of 'wounding' and the engagement in psychotherapy training. The current proposals do not recognise this.

2.5 Personal Therapy/Personal Psychotherapeutic Experience

We see an extremely concerning gap in including a need for engagement in personal psychotherapeutic experience within the training programme, both in the regulations and in the formulation of the proficiencies. The proposed proficiencies do not adequately present how personal learning from their own therapy process informs the practice of the psychotherapist and provides safety for the client. We view personal psychotherapeutic experience – in keeping with modality specifications – as integral to the training programme and confirmation of attendance would be required. Without such an integral/integrated requirement for this form of core support and formative experience, a programme would not have any real validity. For many of our modalities, personal psychotherapeutic experience or personal therapy/analysis lies at the very centre of the programme. Personal psychotherapeutic

experience ensures that the trainee psychotherapist is alert to aspects of themselves, for example blind spots, defence mechanisms and attachment styles, when they are working with a client, in order for them to know how to provide a safe, professional, effective way of working with a client. It is this that provides the trainee with the firmest grounding for doing this work, and it is also in this that the trainee develops a sense of the nature of the work they will do. Our own experience of a long-term therapeutic relationship provides a strong basis for our ethical practice in this field. Without this experience, members of the public who become our clients will not be met by the same level of openness, understanding, etc., as what is furnished by this kind of experience. We would like to have a requirement for personal psychotherapeutic experience mandated as part of the criteria for training, and/or have proficiencies included (both in Professional Development and in Professional Knowledge and Skills sections) that are directly linked to the contribution such engagement ensures for the student.

2.6 Entry Criteria for Training Programmes

We are concerned that there are currently no details here of expectations in relation to appropriate levels of personal maturity in entry criteria for training. Though we appreciate that this is being left to training programmes and professional bodies to decide, this would not provide a clear basis for ensuring an adequate decision-making process in this important area. This is an important concern for us as training programmes have evolved a well-thought through set of criteria for entry, which reflect the demands of training and the readiness of the applicant to meet these. Appropriate entry criteria in regard to prior academic achievements are addressed below.

2.7 Threshold Level for Entry onto Psychotherapy Register – Level 8 vs. Level 9

It is ICP's view that the knowledge, skills, and competences for psychotherapists to work safely with the public cannot be designed and delivered at a minimum entry level of level 8. Nor are the proposed threshold Standards of Proficiencies an adequate assessment level for graduates to safely carry out the demands, depth and complexity of the work of psychotherapy. ICP believes that a minimum threshold set at level 8 would not reflect the range and application of knowledge and skills required in order to practise safely. Psychotherapists, in the course of their work, are required to be able to meet and deal with very novel constructs of experience and this can have particular complexity, which requires psychotherapists to be able to engage in critical thinking. Critical thinking is a characteristic of training that includes an undergraduate degree plus a graduate/postgraduate psychotherapy-specific degree. ICP therefore proposes that the threshold level for entry to the register be set at level 9. See Appendix D.

2.8 Duration of Training

We are concerned that criteria in relation to the duration of training are omitted from the CORU drafts. We propose this might be addressed by a stipulation in regard to the duration of training as allowed for within Clause 25 of the Directive of the European Parliament and of the Council of 28th June 2018 on a proportionality test before adoption of new regulation of professions. It is our contention that a minimum period of 4 years' postgraduate study is required to provide adequate time for personal development and skills development prior to placement; allowing time to integrate learning, and facilitate a progressive approach to clinical practice.

2.9 Practice Placements, Clinical Practice and Clinical Supervision

We are very concerned that the proposals in relation to practice placements do not reflect best practice in our field. In the training of psychotherapists, it is vital that the roles of the clinical supervision and of the clinical supervisor are very carefully considered. A great deal of the developing understanding of the work of psychotherapy, its skills and the challenges that arise, are worked through within this relationship.

Placement Context and Supervision:

This is not a straightforward area, and it is one where different modalities currently have very different practices, and where there is also a variance between child/adolescent and adult programmes. There is agreement on the value of placement experience, including direct clinical practice, the exposure to clinical thinking and practice within a placement environment, and the learning around the roles of different professionals within a team in a setting. However, we are concerned by what we have heard so far in relation to what constitutes an acceptable 'placement setting' with regard to the availability of a psychotherapist on-site who would take on the role of supervisor. Clinical practice and how it is managed in psychotherapy training does not equate with the practice placement element in the training of other professionals; nor does the 'supervision' of such practice that we will address later in this submission. Many trainees complete their clinical practice in settings where there may not be other psychotherapists in situ (e.g., family resource centres, schools, charities, care and community settings). This practice has also resulted in the expansion of availability of psychotherapy in the community and the employment of graduates in settings where no psychotherapist was previously employed. Some students practise within more structured placement settings but may be there out of usual hours when all staff may not be on-site. Training providers are acutely aware of the shortage of placement sites available and the challenges that this presents. These challenges would become insurmountable should it be required that a psychotherapist be available on-site throughout placements. In addition, some mature students are already practising independently as psychologists,

counsellors, psychiatrists, etc., and are self-employed. We believe that they should be able to complete clinical practice, under the eye of the practice education team – including the external clinical supervisor, within this setting.

While the proposed number of hours of placement, 350 hours, is acceptable to us, we are concerned about the specification that this should be 'supervised' by an on-site psychotherapist. We would accept this criterion as long as the on-site 'supervisor' be replaced with a requirement for an assigned mentor/ placement manager who need not be a psychotherapist, as many other professionals could fulfil this role adequately in monitoring/assessing many of the placement objectives, and the balance are best assessed by the CLINICAL supervisor.

The following points underpin this:

1. The proposed framework for clinical practice, and placements, does not reflect current practice and would pose insurmountable difficulties for students, training providers, and placement sites.
2. The proposed model is not compatible with the model in practice in Ireland (or abroad) and appears to be drawn from that in place for professions where qualified practitioners already hold a responsibility to become a practice educator as part of their professional role within statutory agencies.
3. Current placement sites are not regularly in statutory agencies. They are often in voluntary agencies, charities, schools, resource centres, and a variety of small private agencies. Schools and childcare settings are also regularly used for placements for child and adolescent psychotherapists in training.
4. Many placement sites are staffed by volunteers, and by staff who would not be able or willing to provide the intensive on-site 'supervision' that is envisaged.
5. The current proposals do not seem to recognise, or else totally disregard, the high quality of level 9 psychotherapy training that currently exists in Ireland, the effectiveness of the clinical practice model in place, and the vital role that clinical supervisors play in the training and assessment of trainee psychotherapists.
6. On-site supervision as currently described cannot be held in any way comparable to the clinical supervision currently embedded in training courses.
7. The placement manager and/or mentors that are currently assigned to students on placements are not necessarily psychotherapists, do not engage with confidential relationships, and fulfil a valuable role that is not recognised in the draft criteria.

2.10 A Requirement for Direct Observation

There is a general agreement among ICP members that direct observation of client/therapist interaction would go against the philosophy and practice of psychotherapy, where the relational dynamics between therapist and client are central to the process and where the unconscious process is engaged with in an intentional way. This work relies on the absolute respect for the one-to-one relationship, conducted with well-articulated boundaries, and subject to the code of ethics for the profession. While a client may give consent to such practice, especially for a student providing free therapy or practising in a low-cost setting, there is a clear risk that such consent will not be freely given in that the client may feel obliged to agree to this, so as to avail of the service. This is a particularly crucial element for therapists working with children and/or adolescents, and for those working with particularly vulnerable clients.

Requiring 100 hours of direct observation would place an undue burden on services, students and clients, and would not lead to any commensurate benefit. Instead, it would pose a direct risk to the therapeutic alliance, the therapy process, and the confidentiality that is associated with safe, ethical practice. While it is possible for the student to be directly observed in other aspects of their practice placement, e.g., setting up the room, managing notes, participating with the team, etc., direct observation of the therapy session itself is problematic. Directly observing psychotherapy sessions compromises safety for the client, creates an artificial environment, reduces client trust, and impedes the development and maintenance of a therapeutic relationship. It also poses risks for the erosion of the professional experience that clients are currently offered; the centrality of confidentiality within the therapeutic relationship; the absolute need for psychotherapists to protect the highly sensitive information commonly shared by clients with their psychotherapist; our high ethical standards; and our obligations under GDPR legislation in regard to the use of personal data which is currently protected in regard to the very limited sharing of identifiable data.

We do not know of any other professions regulated by CORU that have requirements for ‘direct observation of service user contact’, and if any do exist, what ethical standards for protecting the client’s confidentiality are standard practice in those professions. Psychotherapy is a unique profession in which we deal with highly complex clients for a significant period of time in a confidential space. Contracting with psychotherapy clients includes making a clear agreement regarding confidentiality, including what is permissible in terms of the sharing of information with other members of the team (generally an absolute minimum), and the anonymised sharing of information with the clinical supervisor. Onsite supervision in placement settings could compromise this as the client may well be known to other members of the team who would not ordinarily be given access to the content of the client session.

Clinical supervision, as currently embedded in training programmes, is a far superior method of assessing the student's clinical practice to what is envisaged in the proposals. This may sometimes include the viewing of segments of clinical practice sessions, notes, etc., but the capacity to assess the student is not dependent on this. Clinical supervision is a critically important part of the training and clinical practice of the psychotherapist; it should be integral to the training programme, and criteria for this has been omitted from the draft. In psychotherapy training and practice, clinical supervision plays a very distinct role that is not mirrored in any other social care profession. It is a reflective space for the trainee and practitioner. It is a collaborative space, too, where ideas develop and in which the fuller process of working as a psychotherapist can be considered and developed. The failure to recognise this suggests a significant misunderstanding about the context in which ethical training and clinical practice occur. The clinical supervisor is an important member of the practice education team (or equivalent) and cannot be replaced by an on-site supervisor who may not be qualified as a clinical supervisor, even if trained by the training body to provide feedback on proficiencies. Each training course has distinct learning outcomes that can only be assessed by the clinical supervisor. Removing the current requirement for clinical supervision will inevitably lead to some training providers reducing or removing this component, and would result in a very unsafe environment for clients, students, and qualified psychotherapists.

2.11 Downgrading of the Profession of Psychotherapy

We are concerned that an enormous change in the nature of psychotherapy training and practice — what we see as a dramatic downgrading of this activity – is being pushed through very rapidly, and without sufficient discussion with key stakeholders. The proposed proficiencies have not been developed in relation to current norms in this field, including those that have evolved over decades of work by professional bodies. We are strongly concerned about the downgrading of the profession of psychotherapy within these proposals.

We understand that some of the motivation for CORU's recommendation to set the threshold level at undergraduate level is to support access to the professions. An alternative route to the development of psychotherapy training in an equitable manner, allowing for diversity and an equality of opportunity of entry in the field, would be through the funding of training programmes. This could be developed on the model already in existence for psychologists in Ireland — in clinical, counselling, and educational modalities.

2.12 Mobility between Jurisdictions, and Access to Employment Nationally and Internationally

We are concerned that the proposals in relation to minimum standards of training setting the threshold at Level 8 would leave registrants in a disadvantaged position vis-à-vis their standing among colleagues internationally and also the recognition of their qualification across Europe. Level 8 would put Ireland below the accepted standard in Europe, USA, and Canada. Graduates would be excluded from practice in other countries should they not have completed a postgraduate training that meets international standards. More locally, employers in Ireland such as the HSE and the Department of Education require applicants to hold relevant undergraduate degrees in addition to their psychotherapy qualification and accreditation. This suggests that they understand that the needs of clients are greater than the CORU proposed standards encompass.

3. Summary of ICP's Recommendations

What follows is a brief summary of some of ICP's key recommendations. We include more details in Appendices A, B and C, including revised wording and new proficiencies.

3.1 Recommendation 1: Criteria for Education and Training Programmes for Psychotherapists

Clause 25 of the Directive of the European Parliament and of the Council of 28th June 2018 provides for a **proportionality test** before adoption of new regulation of professions. This states:

"*Where relevant in view of the nature and the content of the measure being analysed, Member States should also take the following elements into account: the connection between* ***the scope of professional activities covered by a profession and the professional qualification required****; the* ***complexity of the tasks*** *in particular as regards* ***the level, the nature and the duration of the training or experience required;*** *the existence of different routes to obtain the professional qualification; whether the activities reserved to certain professionals can be shared with other professionals; and the degree of autonomy in exercising a regulated profession in particular where the activities relating to a regulated profession are pursued under the control and responsibility of a duly qualified professional*."

With regard to the scope and complexity of professional activities which comprise the role of a psychotherapist, we propose that this clause provides the means by which CORU might address ICP's concerns in regard to duration of training, clinical supervision, level of qualification, and personal psychotherapeutic experience.

Currently, European requirements, which ICP have adopted and that we promote, are for a 4-year psychotherapy-specific training (which follows on from an undergraduate degree spanning at least 3 years). The total duration of the training for ICP-accredited psychotherapists, and holders of the European Certificate in Psychotherapy, is 3,200 hours spread over a minimum of 7 years. The first 3 years of general training is in human sciences (medical, psychological, social, educational, etc.) or equivalence: estimated length = 1,800 hours.

A minimum requirement of 4 years of training in a specific modality applies = 1,400 hours, divided into:

1. 250 hours of personal psychotherapeutic experience, in individual or group setting.
2. 500-800 hours of theory or methodology, including psychopathology, in accordance with the usual standards of the modality.
3. 300-600 hours of clinical practice with clients/patients — either within a mental or social health setting, or equivalent — either with individual clients/patients, families or groups, under regular supervision. Even if this practice is not directly organised by the institute, it remains under its responsibility.
4. 150 hours of supervision of an effective clinical practice of the trainee.
5. Practice does not normally take place in the first 2 years of the training.

3.2 Recommendation 2: Criterion 1 — Threshold/Level of Qualifications for Entry to the Register

ICP recommends that:

1. The threshold minimum level of entry to the register of psychotherapists be a graduate/postgraduate psychotherapy-specific degree in addition to an undergraduate degree in human sciences (medical, psychological, social, educational, etc.). (Criterion 1.1.)
2. Minimum level of qualification for entry to the register to be set at Level 9 on the NFQ.
3. Duration of psychotherapy-specific training to span a minimum of 4 years.
4. Entry criteria for training to include a relevant undergraduate degree or equivalent.

This amendment would also require that proficiencies for the practice of psychotherapy be set at level 9 standards and that additional proficiencies be added as described in ICP's online submission (Appendix C) to address the higher educational level; clinical supervision as integral to the programme; and personal and professional growth and development arising from engagement in personal psychotherapeutic experience.

3.3 Recommendation 3: Criterion 2 — Practice Placements

This is related to Criterion 2.2 and its implementation. The following are our recommendations in relation to this:

1. That the requirement for 100 hours of directly observed service user contact be removed or significantly reduced.
2. That a minimum number of hours be set for direct engagement with clients engaging in the provision of psychotherapy.
3. That greater clarity be provided to ensure that the activities described as constituting service user contact for the 350-hour requirement match with any requirement for directly observed hours.
4. That the manner of implementing Criterion 2.2 be revised to ensure that:
    a. The title and role of the 'Placement Supervisor' be amended to that of Placement Manager or Mentor, and that criteria for their suitability be widened to include other professionals than psychotherapists who can provide professional support and guidance to the student, and provide feedback to the practice education team in regard to generic standards of proficiency achieved.
    b. That supervision in regard to direct contact with clients be provided by an external clinical supervisor, who need not be on-site, and who will assess profession-specific standards of proficiency and will communicate directly with the practice education team.

3.4 Recommendation 4: Criterion 2.10 and criterion 2.15 — Practice Placements

We recommend that each of these criteria — 2.10 and 2.15 — be amended to include the word 'clinical' before 'supervision'.

4. Conclusion

In conclusion, we would like to reiterate ICP's continued support for a process of regulating the profession of psychotherapy in Ireland, and we are keen to have a close involvement in informing those framing this about the nature of our profession and the associated processes of training best fitted to equip trainees to achieve this level. We recognise the body of work completed to date, and the good intent expressed here. However, we urge a fundamental rethinking of how the profession is understood and the level and form of training envisaged. We are very happy to engage with CORU in this process. As we have relayed above, in outlining our key concerns in relation to the CORU proposals, we are very strongly concerned about what is included here and what is excluded. We see great risks for the public, for prospective trainees and for the profession. We see a lowering of standards and a confusion of psychotherapy with counselling. Should the process proceed along these lines, this would be a significant backward step.

Appendix A: Comments and ICP Potential Revision to CORU Draft Proficiencies — Professional Knowledge and Skills

The following are potential revisions to CORU Draft Proficiencies. These are included to demonstrate some potential solutions but do not as yet represent the agreed position of the profession. ICP would very much welcome the opportunity to work closely with CORU to facilitate the revision of the proficiencies in consultation with our psychotherapist and psychotherapy training school members.

No	Current Proposed Wording	Comment and ICP Potential Revision
5.1	Know, understand and apply the key concepts of the domains of knowledge which are relevant to the profession and be able to work within a framework based upon established psychotherapeutic theory and practice.	Comment: Psychotherapists do not generally apply ideas – as may be done in an intervention in other professions, but rather draw on ideas, use ideas and integrate ideas, taking place consciously and unconsciously. Suggested revision: 'Know, understand and work with the key concepts of the domains of knowledge which are relevant to the profession and be able to work within a framework based upon established psychotherapeutic theory and practice.'
5.2	Demonstrate a critical understanding of relevant biological sciences, human development, social and behavioural sciences and other related sciences, together with a knowledge of health and wellbeing, disease, disorder and dysfunction.	Broadly accept.
5.3	Know and understand the principles and applications of scientific enquiry, including the evaluation of treatment/intervention efficacy, the research process and evidence-informed practice.	Comment: Graduates need to be able to critically appraise these principles and applications. While a knowledge of scientific method and thinking is important in our work, this requires more nuance when we are thinking of psychotherapeutic practice. While psychotherapy practice is evidence-informed – with much of the evidence arising from the clinical context, ideas of 'intervention efficacy', etc., do not fit with this work for most. Suggested revision: 'Demonstrate a knowledge of the principles and applications of scientific inquiry, including a critical evaluation of how we draw on research findings, as well as from practice-based evidence.' Suggested revision: 'Demonstrate an ability to complete their own specialised research project,

		systematic review or systematic case study, informed by extensive current understanding of therapeutic practice.'
5.4	Demonstrate skills in evidence-informed practice, including translation of theory, concepts and methods to clinical/professional practice.	Comment: In addition to the proficiency as currently stated, psychotherapists must also be skilled in their capacity to focus on the unconscious / out-of-awareness processes of both client and therapist, and utilise this in making complex decisions with regard to progress and deepen the therapeutic process. It would be good to reflect the two-way process of learning between experience and practice here, as this is particularly relevant to psychotherapy training and practice. This is in contrast to a one-way application of one to the other. This is the distinction between an intervention and a psychotherapy. Suggested revision: 'Demonstrate skills in the logic and practice of evidence-informed practice, evidence an ability to learn from clinical experience, and show in their work the use of theory in order to make sense of material arising within the practice.'
5.5	Be able to identify and understand the impact of organisational, community and societal structures, systems and culture on health and social care provision.	Suggested revision: 'Be able to identify and understand the impact of organisational, community and societal structures, systems and culture on psychotherapy practice.'
5.6	Demonstrate safe and effective implementation of practical, technical and clinical skills.	Suggested revision: 'Demonstrate safe and effective practical, technical, professional and clinical skills.'
5.7	Demonstrate ability to participate in or lead clinical, academic or practice-based research.	Suggested revision: 'Demonstrate autonomous research skills and the ability to engage in clinical, academic, or practice-based research and have a critical understanding of ethics in psychotherapy.'
5.8	Know the basic principles of effective teaching and learning, mentoring and supervision.	Broadly accept.
5.9	Be able to appraise the benefits, limitations and contraindications of differing psychotherapeutic approaches.	Comment: The idea that approaches have specific 'benefits, limitations and contraindications' may not fit here as well as in a medical context.

		Suggested revision: 'Demonstrate knowledge of different therapeutic approaches and what they seek to achieve.'
5.10	Be able to apply a chosen theoretical model to assess the service users' suitability for the type of therapy offered.	Suggested revision: 'Be able to apply a chosen theoretical model to assess the service users' readiness to engage in the type of therapy offered.'
5.11	Be able to work therapeutically with a wide range of presenting issues of varying degrees of complexity and severity, and across a wide range of diagnoses in order to facilitate service user insight and long-term change.	Suggested revision: 'Be able to work therapeutically with a wide range of presenting issues of varying degrees of complexity and severity, including those with enduring mental health conditions, and across a wide range of diagnoses to facilitate service user insight and long-term change.' Add additional proficiency: 'Understand the language around diagnosis, psychopathology and mental disorders within both medical model and social model frameworks.'
5.12	Be able to critically appraise current policies applicable to the work of their profession and the role of psychotherapy in the development and implementation of policy on health and social care on a national and international level.	Broadly accept.
5.13	Be able to reflect on the impact of the service user's experience, be able to demonstrate an understanding of their feelings and emotions and communicate that understanding in a non-judgemental manner.	Suggested revision: 'Be able to reflect on the impact of the service user's experience, to be able to relate in a meaningful manner to what a client is saying, and how they are in the work, and communicate understanding in a non-judgemental manner.'
5.14	Be able to review the therapeutic process and progress with the service user, and make adjustments in collaboration with the service user.	Suggested revision: 'Be able to review the therapeutic process and progress with the service user, and make adjustments in collaboration with the service user in accordance with the specific nature of the modality in which the psychotherapist practises.'
5.15	Be able to identify and critically evaluate how psychosocial factors may affect both the service user and the therapeutic process, and manage these in the therapeutic relationship.	Suggested revision: 'Be able to identify and critically evaluate how psychosocial factors may affect the service user, the psychotherapist and the

		therapeutic process, and manage these in the therapeutic relationship.'
5.16	Be able to critically appraise the theories of therapeutic relationships and be able to establish, build, maintain and conclude a long-term therapeutic relationship in a safe and ethical manner.	Suggested revisions – to make this into 2 proficiencies and add content: 1. 'Be able to critically appraise the theories of therapeutic relationships.' 2. 'Be able to establish, build, maintain and negotiate ending a long-term therapeutic relationship in a safe and ethical manner, including instances where the client has had negative experiences, including of endings or transitions, in the past, and demonstrate the capacity to repair ruptures or difficulties in the therapeutic relationship, including difficulties that stem from unconscious processes.'
5.17	Be able to use psychotherapeutic skills to build therapeutic relationships including the ability to demonstrate active listening skills.	Suggested revision: 'Be able to use modality-specific psychotherapeutic skills/practices to support the development of therapeutic relationships, including a capacity to listen attentively, both to conscious and unconscious communications, noticing and responding to emotional shifts occurring within the therapy session, with the aim of maintaining an appropriate level of emotional engagement.'
5.18	Be able to contract and re-contract with the service user during the therapeutic relationship, ensuring the therapeutic goals and each person's expectations and responsibilities are clear to all parties involved.	Suggested revision: 'Be able to contract and re-contract, according to the specific nature of the modality, with the service user during the therapeutic relationship, ensuring the therapeutic goals and each person's expectations and responsibilities are clear to all parties involved, while recognising that there are also aspects of the therapeutic relationship and the course of the work that are not fully conscious and develop over the course of the work.'
5.19	Be able to write concise, accurate and relevant reports which articulate and justify professional decisions made.	Suggested revision: 'Be able to accurately communicate relevant details regarding the client's therapeutic progress/process according to the specific modality and client group, and write concise, accurate and relevant notes/records which articulate and justify professional decisions made.'

5.20	Be able to reflect on and critically analyse the factors that influence therapeutic boundaries and the dynamics of the therapeutic relationship between the psychotherapist and service user.	Suggested revisions – to make this into 2 proficiencies for clarity: 1. 'Be able to reflect on and critically analyse the factors that influence the development/observance of therapeutic boundaries between the psychotherapist and service user.' 2. 'Be able to reflect on and critically analyse the dynamics of the therapeutic relationship between the psychotherapist and service user.'
5.21	Be able to recognise personal emotional responses, vicarious trauma and the need to develop effective self-care strategies and burnout prevention.	This may need some revision to reflect psychotherapy-specific practice.
5.22	Be able to maintain professional and ethical boundaries with service users and be able to identify and manage any associated challenges.	Suggested revision: 'Be able to maintain professional and ethical boundaries with service users and be able to identify and manage any associated challenges, including seeking supervisory assistance in relation to threats to boundaries.'
5.23	Be able to practise therapy that is within psychotherapist's level of skill, knowledge and professional judgement.	Suggested revision: 'Be able to practise therapy that is within psychotherapist's level of skill, knowledge and professional judgement; identify areas for which one has insufficient educational and supervised clinical training and not engage in work in this instance.'
5.24	Be able to critically reflect on conscious and unconscious dynamics in the therapeutic process and be able to manage their personal involvement in, and contribution to, the process of psychotherapy.	Suggested Revision: 'Be able to critically reflect on conscious and unconscious dynamics in the therapeutic process, must be competent to make informed clinical decisions based on these reflections, and be able to manage their personal involvement in, and contribution to, the process of psychotherapy.'
5.25	Be able to critically reflect on conscious and unconscious dynamics in supervision and be able to manage their personal involvement in, and contribution to, the process of supervision.	Suggested Revision: 'Be able to develop an ability to identify and reflect on conscious and unconscious dynamics in supervision and be able to manage their personal involvement in, and contribution to, the process of clinical supervision.'
5.26	Be able to articulate the parameters and value of clinical supervision and demonstrate the ability to	Suggested revision: 'Be able to articulate the parameters, importance and value of clinical

	utilise supervision to assist in practice review and in areas for development.	supervision, and demonstrate the ability to utilise clinical supervision to assist in practice review and in areas for development.' Additional Proposed Proficiency: 'Engage in appropriate ratios of clinical supervision to clinical practice, and demonstrate a commitment to continuing in this post-training.'
5.27	Be able to demonstrate skill in the technologies and communication methods required for the delivery of therapy in a virtual setting, and be able to apply these therapeutically and safely while protecting service user privacy and confidentiality.	Comment: We are uncertain about whether this should be included as a core part of training or as a part of post-qualifying CPD. As there are many competing elements in training – academic, personal psychotherapeutic practice, clinical supervision — this may not be a priority. Suggested revision: 'Be able to consider the use of technology in the conduct of psychotherapy, the adjustments that this kind of work involves, and the impact that this has on the nature and quality of the practice of psychotherapy.'
5.28	Be able to identify, distinguish and critically evaluate the level and impact of trauma on psychological functioning, and be able to work therapeutically with service users who have experienced trauma.	Suggested revision: 'Be able to identify, distinguish, and critically evaluate the level and impact of trauma on psychological functioning, and be able to work therapeutically with service users who have experienced trauma and/or are experiencing significant psychological distress.'
5.29	Be able to identify potential risk for suicide, self-harm or harm to others and implement early management, supporting the immediate safety of the service user, and make referrals for additional treatment.	Comment: Though it may not be the intention, this seems to imply that suicidal risk will lead to the termination of this work and the referral to someone else who would take this up. In many instances, it is important that this work continue, and that whatever contacts are made and supports sought following such an assessment of risk go alongside the continuing psychotherapeutic work (apart from in situations where this is assessed to not be possible or beneficial). Suggested revision: 'Be able to identify potential risk for suicide, self-harm or harm to others; implement early management, supporting the immediate safety of the service user; make referrals for additional treatment where indicated; and demonstrate competence in making complex judgements about ongoing work with high-risk clients.'

5.30	Be able to demonstrate knowledge of crisis intervention and prevention and be able to work with people in crisis for improved outcomes.	Broadly accept
5.31	Have a critical awareness of the need for organisation and resource management for practice.	Broadly accept
5.32	Be able to demonstrate an understanding of the impact of pharmacological use and history on psychological functioning and recognise potential implications for service users	Broadly accept

Appendix B

Identified Omissions and Proposed New Proficiencies

Proposed New Standards of Proficiency: Domain 5 — Professional Knowledge and Skills

1. Be able to recognise the importance of maintaining professional and ethical boundaries within the practitioner-service user relationship.

2. Demonstrate a deep sensitivity to the impact of one's own history and family of origin on recurring patterns of behaviour, interpersonal relationships and of the process of change in oneself and in others, leading to a developed capacity to understand connections between their own family experiences and their therapeutic work.

3. Assess critically, and in light of their own reflective processes and in response to feedback from others including clinical supervisors, make plans to improve their own knowledge, skills and competencies in working at the forefront of the field of psychotherapy.

4. Reflect critically on the personal process of self and client, professional practice matters and therapeutic use of self within psychotherapeutic relationships, including relationships with complex and vulnerable clients.

5. Demonstrate a commitment to engage in CPD to maintain and enhance proficiency in knowledge, skills and competence in the psychotherapy field, including novel and emerging techniques and theories.

6. Use appropriate psychotherapy frameworks and advanced clinical judgement to refer onwards, or formulate and implement personalised plans for psychotherapeutic interventions, informed by specialist knowledge, including responding to new and novel circumstances.

7. Advanced skills in managing a psychotherapy practice within contexts of ambiguity, uncertainty and unfamiliarity, including effectively, e.g., setting up practice, managing referrals, intake procedures, clinical governance, record keeping, storage of files, report writing, and working within relevant guidelines.

8. Apply advanced reflection skills to complex matters, act effectively and autonomously in managing complex cases, and make appropriate use of interpersonal and organisational resources for personal and professional support.

Proposed Amendments to Standards of Proficiency: Domain 5 — Professional Knowledge and Skills, with proposed amendment underlined:

5.3. Know, understand and critically appraise the principles and applications of scientific enquiry, including the evaluation of treatment/intervention efficacy, the research process and evidence-informed practice.

5.6. Demonstrate safe and effective implementation of practical, technical and clinical, and professional skills.

5.7. Demonstrate ability to participate in, and conduct or lead clinical, academic or practice-based research and have a critical understanding of ethics in research.

Identified Omission Re Standards of Proficiency: Domain 2 — Communication, Collaborative Practice and Teamworking

Omission: Insufficient references to developmental considerations necessary (both age and stage of development) when engaging with children, adolescents and other vulnerable clients. Also, more is needed regarding inter-agency and multidisciplinary team work.

Proposed Amendments to Standards of Proficiency: Domain 2 — Communication, Collaborative Practice and Teamworking, with proposed amendment underlined:

2.2 'Be able to modify and adapt communication methods and styles, including verbal and non-verbal methods to suit the individual service users considering issues of language, age, developmental stage, culture, beliefs and health and/or social care needs.'

2.13 'Understand the need to build and sustain professional relationships as both an independent practitioner and collaboratively as a member of a team, including inter-agency and multidisciplinary teams with other professionals to enhance therapeutic outcomes.'

Rationale for proposed 2.2 and 2.13 amendments: To more accurately reflect the actual practice of the psychotherapist.

Identified Omission Re Standards of Proficiencies: Domain 4 — Professional Development

Omission: The whole Professional Development proficiencies section is weakened in that it does not address the central and critical role of the psychotherapist's engagement in clinical supervision, at appropriate ratios, both during and after training. Neither does it consider the central role that engagement in personal psychotherapeutic experience plays in the professional development of the psychotherapist.

Proposed New Standards of Proficiency: Domain 4 — Professional Development

We propose that at least 2 more proficiencies be added to Professional Development proficiencies to ensure the continued mandatory engagement in clinical supervision and personal psychotherapeutic experience that is currently part of the psychotherapy profession in Ireland, and throughout Europe, and is associated with safe, ethical, and professional practice.

Rationale: Without embedding requirements for personal therapy and clinical supervision, there is a risk of the loss of both of these elements from some training programme (and we have already heard of plans in this direction from other providers) and the consequent diminished competency of graduates and increased risk to the public.

Appendix C: Profession-Specific Criteria for Education and Training Programmes

(a) Criterion 1: Level of Qualifications for Entry to the Register

No	Current Proposed Wording	ICP Comment
1.1 Q.56 - 57	The minimum level of qualification for entry to the register is Level 8 on the National	The ICP does not see this as the correct minimum level of qualification for entry to the register; we are of the firm belief that threshold level should be set at a minimum of Level 9. We recognise that Level 8 programmes often provide a basis for other professions, as well as a strong basis for postgraduate study, and we

		believe than an undergraduate degree, in the health or social sciences, should continue to form part of the entry requirements for a postgraduate psychotherapy specific training. The requirement for entry criteria to include holding a relevant undergraduate degree is embedded in the European Association for Psychotherapy (EAP) definition of psychotherapy, and is recognised internationally as best practice. We are concerned that the CORU proposals have an incorrect, implicit assumption about the nature of the work of psychotherapy that understandably leads to proposals about what kind of training may be appropriate for this kind of activity. Psychotherapy is really a fluid engagement rather than a set of interventions, as seems to be assumed here. While the documents acknowledge the therapeutic relationship, and include statements around conscious and unconscious processes, the full significance of this is not apparent in most of the proficiencies that are outlined. The proficiencies are more in keeping with an intervention-oriented approach, including those that involve specific programmes responding to particular kinds of diagnostic categories. In essence, they are framed in undergraduate terms that would not allow for assessment of students at the threshold level at which we expect them to practice in the interests of public safety. **These criteria do not recognise the highly complex work in which psychotherapists engage with highly vulnerable clients.** **Level 8 would put Ireland below the accepted standard in Europe, USA and Canada. Free movement to other jurisdictions is also a consideration; graduates would be excluded from practice in other countries should they not have completed a postgraduate training that meets international standards.** More locally, employers in Ireland such as the HSE and the Dept of Education require applicants to hold relevant undergraduate degrees in addition to their psychotherapy qualification and accreditation. This suggests that they understand that the needs of clients are greater than the CORU proposed standards encompass. At level 8, Ireland would be adopting the lowest standards for regulation of psychotherapists to date — no other country that has regulated the profession has considered an undergraduate degree to be appropriate as a level of training. It would be ironical if, in the name of 'public safety',

		Ireland was to adopt standards that are lower than current self-regulating bodies and employers require. We understand that the proportionality assessments are a key aspect for CORU Registration Boards and that this directive requires the Boards to balance considerations regarding access to the profession with considerations on public interest, health, and safety. To conclude, we do not believe that an undergraduate degree would protect the public: instead it would reduce the level of protection currently afforded by professional bodies within the ICP and by the employment standards currently set by agencies such as the HSE and the Department of Education.

(b) Criterion 2: Practice Placements

No	Current Proposed Wording	ICP Comment
2.1	Practice placements must be integral to the programme.	Agree
2.2(a) Q.58 - 59	The programme must ensure that each student completes 500 hours.	**This is an area where different modalities have currently very different practices, and where there is also a variance between child/adolescent and adult programmes. There is apparent agreement on the value of placement experience, including a level of direct clinical contact, the exposure to clinical thinking and practice within a placement environment, and the learning around the roles of different professionals within a team in a setting.** However, we are concerned by what we have heard so far in regards what constitutes an acceptable 'placement setting'. Clinical practice and how it is managed does not equate with the practice placement element in the training of other professionals. Neither does the 'supervision' of such practice. Many trainees complete their clinical practice in settings where there may not be other psychotherapist in situ (e.g., family resource centres, schools, care settings). This practice has also resulted in the expansion of availability of psychotherapy in the community and the employment of graduates in settings where no psychotherapist was previously employed. Some students practice within more structured placement settings but may be there out of usual hours when all staff may not be on-site.

		In addition, some mature students are already practising independently as psychologists, counsellors, psychiatrists, etc., and are self-employed. They should be able to complete clinical practice, under the eye of the practice education team – including clinical supervisor, within this setting. We would urge that we think of two kinds of settings here, both of which are a part of the training programme – 1. A placement setting in which a trainee can develop an understanding of how services operate, the nature of presenting difficulties, the range of services available, professional activities, relationships, forms of communication, etc.; and 2. The location of the supervised practice and/or of the clinical supervisor. We believe that thought must be put into this area, and the practical working out of this would require close consultation with the different modalities.
2.2(b) Q.60 - 61	Criterion 2.2 Of the 500 hours of practice placement a student must complete, 350 hours must be supervised service user contact experience.	The number of hours, 350 hours, is fine EXCEPT for the specification that this should be 'supervised' by an on-site psychotherapist. We would accept this criterion as long as the on-site 'supervisor' be replaced with a requirement for an assigned mentor who need not be a psychotherapist as many other professionals could fulfil this role adequately in monitoring/ assessing many of the placement objectives, and the balance are best assessed by the CLINICAL supervisor. The following points underpin this: 1. The proposed framework for clinical practice, and placements, does not reflect current practice and would pose insurmountable difficulties for students, training providers, and placement sites. 2. The proposed model is not compatible with the model in practice in Ireland (or abroad) and appears to be drawn from that in place for professions where qualified practitioners already hold a responsibility to become a practice educator as part of their professional role within statutory agencies. 3. Current placement sites are not regularly in statutory agencies, they are often in voluntary agencies, charities, schools, resource centres and a variety of small private agencies. Schools and childcare settings are also regularly used for placements for child and adolescent psychotherapists in training.

		4. Many placement sites are staffed by volunteers, and by staff who would not be able or willing to provide the intensive on-site 'supervision' that is envisaged. 5. The current proposals do not seem to recognise, or else totally disregard, the high quality of level 9 psychotherapy training that currently exists in Ireland, the effectiveness of the clinical practice model in place, and the vital role that clinical supervisors play in the training and assessment of trainee psychotherapists. 6. On-site supervision as currently described cannot be held in any way comparable to the clinical supervision currently embedded in training courses. 7. The mentors that are currently assigned to students on placements are not necessarily psychotherapists, do not engage with confidential relationships, and fulfil a valuable role that is not recognised in the draft criteria.
2.2(c) Q62 - 63	Criterion 2.2 Of the 350 hours of supervised service user contact experience, 100 hours must be directly observed service user contact.	Direct observation would go against the philosophy and practice of psychotherapy where the relational dynamics between therapist and client is central to the process and where the unconscious process is engaged with in an intentional way. This work relies on the absolute respect for the one-to-one relationship, conducted with well-articulated boundaries and subject to the code of ethics for the profession. Requiring 100 hours of direct observation would place undue burdens on services, students, and clients, and would not lead to any commensurate benefit. Instead it would pose a direct risk to the therapeutic alliance, the therapy process, and the confidentiality that is associated with safe, ethical practice. Directly observing psychotherapy sessions compromises safety for the client, creates an artificial environment, reduces client trust, and impedes the development and maintenance of a therapeutic relationship. It also poses risks for the erosion of the professional experience that clients are currently offered, the centrality of confidentiality within the therapeutic relationship, and the absolute need for psychotherapists to protect the highly sensitive information commonly shared by clients with their psychotherapist; our high ethical standards, and our obligations under GDPR legislation in regard to the use of personal data which is currently protected in regard to the very limited sharing of identifiable data.

		Contracting with psychotherapy clients includes making a clear agreement re confidentiality, including what is permissible in terms of sharing information with other members of the team (generally an absolute minimum), and the anonymised sharing of information with the clinical supervisor. On-site supervision in placement settings could compromise this as the client may well be known to other members of the team who would not ordinarily be given access to the content of the client session. To be clear, clinical supervision, as currently embedded in training programmes, is a far superior method of assession the student's clinical practice. This may sometimes include the viewing of segments of clinical practice sessions, notes, etc., but the capacity to assess the student is not dependent on this. The clinical supervisor is an important member of the practice education team and cannot be replaced by on on-site supervisor who may not be qualified as a clinical supervisor, even if trained by the training body to provide feedback on proficiencies. Each training course has distinct learning outcomes that can only be assessed by the clinical supervisor. Removing the need for clinical supervision will inevitably lead to some training providers reducing or removing this component. We do not know of any other professions, regulated by CORU that have requirements for 'direct observation of service user contact', and if any do exist, what ethical standards for protecting the client's confidentiality are standard practice in those professions. Psychotherapy is a unique profession in which we deal with highly complex clients for a significant period of time in a confidential space. It is possible for the student to be directly observed in other aspects of their practice placement, e.g., setting up room, managing notes, participating with the team, etc.

Appendix D: NFQ 'Level 9 Indicators' and the relevance of this to psychotherapy training as it currently conducted on programmes recognised by ICP

CATEGORY	LEVEL 9 INDICATORS	PSYCHOTHERAPY PROFESSION
Knowledge – Breadth:	'A systematic understanding of knowledge, at, or informed by, the forefront of a field of learning.'	This is very much in keeping with the role of the psychotherapist who, operating autonomously, is required to remain informed to the highest levels. Students access primary sources, current commentaries and critiques.
Knowledge – Kind:	'A critical awareness of current problems and/or new insights, generally informed by the forefront of a field of learning.'	The work of psychotherapy involves an ongoing critical awareness of the development of practice in the field. The idea of 'critical awareness' is key to this work, and it would be very difficult to adequately engage in this work without this capacity and ongoing activity. Some of this is related to the developmental realities of the psychotherapist in training also, and it is difficult to have this 'critical awareness' – or the kind required by this field – without the level of emotional maturity connected with adult engagement.
Know-How and Skill – Range	'Demonstrate a range of standard and specialised research or equivalent tools and techniques of enquiry.'	The overall level of skills required of a psychotherapist who is working within a therapeutic relationship, and responding to conscious and unconscious processes, is very high. The level of responsiveness that the psychotherapist is required to have necessitates the development of a very wide and deep knowledge base.
Know-How and Skill – Selectivity	'Select from complex and advanced skills across a field of learning: develop new skills to a high level, including novel and emerging techniques.'	Psychotherapy responds to changes within our societies and across our cultures, and psychotherapists respond in relation to these changes as well as to the unique presenting reality of the client.
Competence – Context:	'Act in a wide and often unpredictable variety of professional levels and ill-defined contexts.'	The work of psychotherapy is often ill-defined. We work with people who, whether they have a diagnosis of not, present with ill-defined problems. As psychotherapists, this is something that is core to our work; we adapt our practice to

		meet the particular individual and idiosyncratic psychological reality of our client. This brings us into many different states of mind and ways of being, while, at the same time, we are managing the boundaries of our work.
Competence – Role:	'Take significant responsibility for the work of individuals and groups; lead and initiate activity.'	As psychotherapists currently work primarily in private practice, with the assistance of ongoing clinical supervision, they take full responsibility for their work with individuals or groups, depending on modality. They are generally not parts of multi-disciplinary teams. It is likely that psychotherapists will continue to work primarily outside of services and training should reflect this.
Competence – Learning to Learn:	'Learn to self-evaluate and take responsibility for continuing academic/ professional development.'	This is a core element of psychotherapy practice. There has been a long-term recognition of this as involving ongoing academic and professional development, with practitioners being expected to engage in this very actively. Unlike where the work of a profession involves the repetition of particular interventions, psychotherapists must learn from experience – as well as from academic and professional developments – so as to sustain a highly varied and changing nature of work.
***Competence -Insight*:**	'Scrutinise and reflect on social norms and relationships and act to change them.'	Psychotherapy as a profession has been strongly engaged in the wide social sphere, based on what we meet in long-term work with clients. Psychotherapists get to meet changes in social norms within the lives of their clients and have a responsibility – when the opportunity arises – to bring this to wider attention, engaging in debates around change.