



**Ag Rialáil Gairmithe Sláinte
agus Cúraim Shóisialaigh**

**Regulating Health +
Social Care Professionals**

Counsellors and Psychotherapists Registration Board

Consultation on:

- ***Standards of Proficiency for Counsellors***
- ***Standards of Proficiency for Psychotherapists***
- ***Criteria for Education and Training Programmes (Counsellors)***
- ***Criteria for Education and Training Programmes (Psychotherapists)***

Email/Written Responses to both consultations

Consultation Period: 4 September 2023 – 1 December 2023

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Feedback - Counselling & Psychotherapy
Date: Monday 18 September 2023 20:44:23

Dear CORU,

As a member of [REDACTED] I just wanted to give some feedback on the guidelines for registration.

I welcome the proposed policy to require a Level 8 Qualification to register as a Counsellor and or Psychotherapist. I hope that this will be applied across the board and that all professionals will be required to formally undertake at least a one year Top-Up to a Diploma program they may have undertaken previously. I don't believe that experience / time in the Profession is a substitute for the formal qualification. There needs to be a common standard of training that clients can expect in and from their therapists just as there would be in the medical profession. Otherwise, clients deserve to be told if their therapist has experience, a formal qualification or both. The amount of work, further study, further reflection, training and development that is undertaken to move to degree level is substantive and the depth of learning cannot simply be replaced by working longer from a lower qualification level. Therapists and clients alike will benefit from therapists undertaking the formal education to achieve Level 8.

I also welcome the ideas around Placement and Supervision. These ideas are hallmarks of really good training and development of therapists and will really benefit the quality of the therapy. Placements need to be better structured, resourced, supported and evaluated to ensure a common standard and quality for clients.

Furthermore, any therapist who has a degree in Counselling and Psychotherapy will clearly need to be able to advertise themselves as both a Counsellor and Psychotherapist. The Degree program they completed would have had the requisite emphasis on depth work to allow them to work deeply over a long time period with clients presenting with complex issues and needs as well as across shorter time periods and less complex issues. Such a program should also have involved a depth of self-reflection developed through experiencing therapy themselves while also completing a number of formal pieces of work and theses weaving theory and self-reflection together in an integrated way.

I really hope the work of CORU in this area will be completed soon to allow our profession to re-ground itself and finally encourage the development of a common formal standard across the profession like every other profession dealing with health and well-being of clients.

I believe our profession also needs to be able to raise our fees substantially as currently we are working at a loss, breaking even or barely making a profit. For self-care and ethical reasons mental health professionals should not be seeing a large number of clients further supporting the need to be able to charge much higher fees. However, for a lot of people to be able to afford Counselling and Psychotherapy they will need support from the Government both directly and via Health Insurance. Charities and HSE services have waiting lists that are far too long. Perhaps CORU can encourage the Government to support those receiving Therapy from Registered Professionals. Perhaps the Government can help also by helping Education bodies to provide the proper formal Top-Up programs that will be required to have a good supply of qualified therapists.

I welcome the difference the work of CORU will make to regularizing standards in the industry for everyone's benefit.

With kind regards,
[REDACTED]

Public Consultation: Psychotherapists - Standards Of Proficiency And Criteria For Education And Training Programmes For Psychotherapists

Public Consultation: Psychotherapists - Standards Of Proficiency And Criteria For Education And Training Programmes For Counsellors

This feedback is given from both the perspective on an accredited counsellor/psychotherapist and supervisor and as a tutor in a training college for counselling and psychotherapy. I am specifically involved in Clinical Practice. For reasons of practicality, I am limiting the feedback to a single page document.

General

- I completely agree with level 8 being the entry level to the register for both counsellors and psychotherapists.
- I find it extremely disturbing that personal therapy is not a requirement during training. In counselling and psychotherapy we are concerned with the client's (service user's) process and way of being in the world. If a trainee is not doing/has not done their own work, how can they sit with a client (service user) as a facilitator of change. This can be assessed on a continuous basis during training by observing the trainees, monitoring personal development, and regular meetings where there can be discussion around their process and growth.
- The documents appear to be tailored towards a full time course and do not appear to allow for part time courses primarily for mature students who may also be working full time, have families and most importantly have life experience.
- As a follow on from the point immediately above, the requirements around practice placements are not realistic.
- Throughout the documentation there appears to be an inference that counsellors/psychotherapists are 'clinicians' as opposed to practitioners.

Practice Placements

- On the assumption that trainees do not start their clinical practice before the end of Year 2 of training, the number of hours required are not practical or achievable in Years 3 and 4.
- Ethically, the number of client (service user) hours that a trainee does per month needs to be limited.
- Directly observed hours during placement is not practical in the context of adult learning where there is no 'block release' but rather a trainee doing a small number of hours each week.

Supervision

- The focus appears to be on 'case management' rather than supervision from a counselling and psychotherapy perspective which is more 'super-vision' – an additional perspective by someone who is more experienced in the field.
- In this context, supervision needs to be a mandatory requirement for all counsellors and psychotherapists throughout their professional lives.

Assessment/Diagnosis

- As counsellors/psychotherapists we do not assess or make diagnoses of mental health illness. Where we have concerns we refer to GP.
- As we are talking about trainees, the hope would be that as a result of placement screening, the clients (service users) referred to trainees would present with issues appropriate to their stage of professional development.





[REDACTED]

[REDACTED]

[REDACTED]



CORU Information -

- **The Standards of Proficiency** are the threshold, knowledge and skills required from graduates to enter the Register.

- **The Criteria for Education and Training Programmes** describe how an education provider facilitates and evaluates the achievement of the Standards of Proficiency of their graduates.

These standards set out the specific and detailed requirements that education and training programmes must meet to be approved by CORU.

CORU are inviting stakeholders to contribute to the discussion and to the draft standards being proposed.

Contribution and Feedback –

-  welcomes the proposed academic level of Level 8 for Counsellors and Psychotherapists as a minimum level of proficiency.

Our concerns include -

- **No specific mention of personal therapy requirement in training.**
From the personal experiences of the tutors at  (all practicing therapists) and from their professional experience and their expertise and academic work as tutors - the consensus is, that personal development and self-awareness including robust self-examination and integration and trauma healing within personal therapy is crucial to work both as a counsellor and as a psychotherapist and is a necessity in protecting the public. The mandatory requirement of minimum personal therapy has always been significant in the formation of therapists since the beginning of the profession. Astrand and Sandell (2019) in their research and paper - *Influence of Personal Therapy on learning and development of Psychotherapeutic skills*, write that "As its ultimate purpose, personal therapy is assumed to benefit the quality of the therapist's clinical work and should, therefore, manifest itself in treatment outcomes". [Influence of personal therapy on learning and development of psychotherapeutic skills \(tandfonline.com\)](https://tandfonline.com)

Although courses can still implement requirement for personal therapy in training, lack of stating it by the regulator will create an opportunity for some courses to remove it to meet the demand for more affordable training. Our Clinical Practice Coordinator – a designated person with the college, employed to support the clinical work of our learners said “it is extremely disturbing that personal therapy is not a requirement during training. In counselling and psychotherapy, we are concerned with the client’s (service user’s) process and way of being in the world. If a trainee is not doing/has not done their own personal work, how can they sit with a client (service user) as a facilitator of change. This can be assessed on a continuous basis during training by observing the trainees, monitoring personal development, and regular meetings where there can be discussion around their process and growth.”

- **A different understanding of supervision in training.**

As per CORU definition:

Clinical supervision is understood and practised in the counselling and psychotherapy professions as a formal process of professional facilitated reflection on clinical practice and experience that contributes to individual development. In the context of practice placement arrangements as they are currently delivered in education and training programmes for the professions of counselling and psychotherapy, clinical supervision is a relationship established by a student with a clinical supervisor outside of the practice environment the student is working in.

- **On-site placement supervision required by CORU differs from clinical supervision in both its purpose and structure.**

On-site supervision required by CORU is a formal process between the trainee therapist, the practice placement supervisor, and the education provider. The CORU Registration Board does not stipulate in the drafts provided any requirements around student engagement in clinical supervision.

As founder and a course provider for past 13 years, an accredited counsellor/psychotherapist for nearly 30 years, and an educator and trainer for over 20 years, an accredited supervisor for almost 20 years, I would personally like to express my concerns and the concerns of our faculty team (all accredited and working therapists) at [REDACTED], about the lack of requirement for both in-house and external clinical supervision in training. My main concern is that the public will be at risk, trainees not having been clinically supervised by appropriately qualified supervisors.

The requirement for onsite supervision will be problematic for placements to comply with such requirement and it is not a realistic goal in my experience. I wonder if QQI

will approve these criteria as it would appear there may be conflict of interest and a lack of separateness and neutrality in assessment of trainee's work.

If CORU is there to protect the public then the undermining of clinical supervision/supervisors as the 'gatekeepers of the profession' minimises the importance of the professions and the depth of the work they engage with clients, and this will also apply post regulation.

There is no stipulation that clinical supervision should be maintained post training either to ensure standards, code of ethics, self-care, boundaries, CPD etc. CORU must take into consideration the culture and value of clinical supervision in Counselling and Psychotherapy and that clinical supervision is unique to these professions who continuously support members of the public who are struggling with mental health issues and deep emotional upset, unlike in any other profession in Ireland. In the words of our In-House Supervisor at [REDACTED] *"The focus appears to be on 'case management' rather than supervision from a counselling and psychotherapy perspective which is more 'super-vision' – an additional perspective by someone who is more experienced in the field."* and *"In this context, supervision needs to be a mandatory requirement for all counsellors and psychotherapists throughout their professional lives, thus safeguarding the public."*

As counsellors/psychotherapists we do not assess or make diagnoses of mental health illness. Where we have concerns, we refer to GP etc. As we are talking about trainees, the hope would be that because of placement screening, the clients (service users) referred to trainees would present with issues appropriate to their stage of professional development.

- Increase of placement hours

The Board's Decision



Counsellors	Psychotherapists
▪ 450 hours of practice placement education ▪ Minimum 300 hours in supervised service user contact ▪ 75 hours must be directly observed service user contact	▪ 500 hours of practice placement education ▪ Minimum 350 hours in supervised service user contact ▪ 100 hours must be directly observed service user contact

[REDACTED] expresses concerns over the proposed number of placement hours for both registers including the requirement for directly **observed service user hours**. Directly observed might

mean that clients and therapists would be recorded, which would create a risk of exploitation / data protection concerns, but also – clients might not want to be recorded or observed. As a course provider we see this as potentially a huge issue for placements to be able to comply with such requirement. Another way would be to have in the placements one-way mirrors – so the sessions can be observed live - this also would be seen as very difficult to implement for placements from the staffing / space perspective, also who is going to observe? Will they be qualified and experienced therapists? Who will pay them? Who will they report to? This is not possible in any placement that we are aware of – and because they take trainee therapists, are usually low-cost counselling centres/family resource centres – who are struggling with funding etc.

■■■■ offers a ■■■■ – trainee therapists are only approved to commence their clinical work end of year 2 and they have 2 years to complete 120 hours of clinical work, which in itself is a struggle for some, who are rearing families, working full time, engaging in personal therapy, attending in-house and external supervision as well as supervision sessions in their placement also. It is not possible to maintain a quality of life, provide a quality service to their client, and for us as a college to ensure quality and good practice over the pressure to complete the huge increase in hours requirement. This pressure and expectation will dilute the experience of quality and transformational learning and become a box to tick. This is not the essence, attitude, or value-based ethos of our training at ■■■■ or of many of the course providers we know. A Clinical Practice Coordinator at ■■■■ contributed *“Ethically, the number of client (service user) hours that a trainee does per month needs to be limited. Directly observed hours during placement is not practical in the context of adult learning where there is no ‘block release’ but rather a trainee doing a small number of hours each week.”*

- **Proficiencies designed for full time programmes not part time Counselling and Psychotherapy programmes.**

Another concern at ■■■■ is that generic proficiencies listed in the drafts are designed for full time education and based on other professions, not relevant to the training of Counsellors and Psychotherapists. Many of our adult learners (mostly 35-55 age group) have full time jobs and taking an internship style placement would not be an option for them. One of our Tutors stated, *“The documents appear to be tailored towards a full-time course and do not appear to allow for part time courses primarily for mature learners who may also be working full time, have families and most importantly have life experience.”* and *“the requirements around practice placements are not realistic. Throughout the documentation there appears to be an inference that counsellors/psychotherapists are ‘clinicians’ as opposed to practitioners.”*

At ■■■■ our contract with enrolled learners is that on completion of their training – they will be – competent, ethical, and compassionate practitioners (hence the need for personal therapy/personal development/clinical supervision and reasonable amount of counselling work with clients to qualify).

- **Other concerns from Stakeholders - our Tutors/practitioners in the field throughout Ireland, I think these sentiments are probably the most important voices in the discussion – The Therapists!**

Following sharing of information within our faculty team – these are some of the concerns voiced –

“I am really very concerned that the outcomes and CORU involvement may actually have the opposite effect than what was originally intended and instead, will really dilute the professional standards and subsequently anyone with basic enough qualifications will be allowed to practise (or be let loose on the vulnerable public).”

“It appears to me that CORU's proposals will dilute the profession into "well-meaning amateurs" instead of improving and implementing 'Gold Standard' psychotherapy that both therapist's and clients will really benefit from.”

“I am horrified at the lack of any mention of Supervision and personal therapy - the 2 absolutes that separate the mediocre/acceptable (and even bad!) therapists from the excellent ones! The best therapists I know are the ones who have gone deep into their own process and are more able to see, sense and feel into what is happening with the clients on so many levels. It enables us as therapists to tune into subtle layers and nuances that get missed otherwise. As Carl Roger's put it: our client's will only go as deep into their process as we have gone ourselves. We will unconsciously and consciously block and gate the client if we are not willing to go or have not gone deep into our own souls and selves.”

“I seriously question an individual's motive to become a therapist if they are not going to do that work with a therapist themselves. It feels quite ludicrous! How can any person sign up to train and become a therapist and expect clients to come and bare their souls in a therapy room but feel that they (the therapist's-in-training) are exempt from any need for doing it themselves!”

“There seems to be a lack of understanding about what the work and depth of counselling and psychotherapy entails, it is not like any other profession, work or training, you cannot tick a box, it is sitting with another human being at the level of working with core issues, the edge of despair, blocked trauma, facilitating hope, the therapist's use of self as an agent of change etc. etc. This profession is as old as time – the healer – the medicine man – the soul retriever.”

"It's completely incongruent on so many levels. I am flabbergasted by the piece about personal awareness/therapy. I truly understand and have lived the value and outcomes of good solid, deep psychotherapy which is why I then trained to become one myself. I make no secret of the fact that I continue to dip in and out of it in some shape, make or form whenever I feel the need to and always, my own client work develops a new lease of life when I do clear my own 'container'."

"I feel quite sad and concerned about a lot of the proposals and the gaps also."

- Submitted by

[REDACTED]

Stakeholder feedback for CORU consultation

Below please find my feedback and additional comments in relation to CORU draft Standards of Proficiency for Counsellors and Psychotherapists.

Draft Standards for Counsellors and Psychotherapists:

Safety and Quality (Counsellors)

- Counsellors are not qualified to diagnose clients, assessment tools are only relevant to inform counsellors of how best to work with the client i.e. appropriate modalities.
- There is solely an emphasis on evidence based practice incorporating solution focussed and goal orientated modalities. There is no mention of meeting clients where they are at and working with clients' lived experience which involves communicating an understanding of how client's experience their lives.
- There is no mention of the importance of the therapeutic relationship which is fundamental to the work. This involves the counsellor's ability to remain present to their clients at all times and to build trust and safety within the therapeutic relationship so that clients can explore their issues and concerns. Not all therapy requires a 'solution' or a 'goal' in order to help clients. Sometimes clients need a space where they will be held emotionally as they work through and express suppressed feelings.
- Counsellors have a duty of care to their clients and any potential child or vulnerable adult made known to the counsellor. However, they should not be held responsible for "those involved in their care".
- There is far too much emphasis on evaluative tools, performance/outcome measures and audits. This is potentially harmful and detrimental to clients' well-being. Many clients come to therapy because of low self-worth. This is usually connected to childhood experiences where unconditional love was not available to them. This can result in the client doing what is expected of them or being the 'good child' or 'good client' in order to be valued. Placing expectations on clients to 'improve' or 'feel better' could potentially trigger a conditioned response that could result in 1) clients pretending they are ok and/or 2) leaving therapy because if they are not improving, they may be left feeling that there is something inherently wrong with them. There is a very real and very worrying possibility of shaming clients and making them feel worse.
- Whilst counsellors work in the mental health sector, they are NOT medical practitioners and do not work in a medical/clinical setting so there should not be a onus on them to provide medical standards of sanitation.
- There is no mention of ongoing supervision (post qualification) which is essential to maintain professional standards and ethical practice.

Safety and Quality (Psychotherapists)

- There is no mention of attachment theory - a modality that is linked to childhood experience and how clients adapted to their environment. When there is an insecure attachment for a client, psycho-education can be of benefit. Attachment theory informs psychotherapists on how to use the therapeutic relationship as a means to renegotiate early childhood attachment so that the client can move into a more secure attachment style in their adult lives and in their adult relationships thereby leading to more healthy relationships and well-being.
- There is no mention of working existentially and the potential life stage crisis that many clients experience.
- Psychotherapists have a duty of care to their clients and any potential child or vulnerable adult made known to the counsellor. However, they should not be held responsible for "those involved in their care".
- There is far too much emphasis on evaluative tools, performance/outcome measures and audits. This is potentially harmful and detrimental to clients' well-being. Many clients come to therapy because of low self-worth, this is usually connected to childhood experiences where unconditional love was not available to them. This can result in the client doing what is expected of them or being the 'good child' or 'good client' in order to be valued. Placing expectations on clients to 'improve' or 'be feeling better' could potentially trigger a conditioned response that could result in 1) clients pretending they are ok and/or 2) leaving therapy because if they are not improving, they may be left feeling that there is something inherently wrong with them. There is a very real and very worrying possibility of shaming clients.
- Whilst psychotherapists work in the mental health sector, they are NOT medical practitioners and do not work in a medical/clinical setting so there should not be an onus on them to provide medical standards of sanitation.
- There is no mention of ongoing supervision (post qualification) which is essential to maintain professional standards and ethical practice.

Professional Knowledge and Skills (Counsellors and Psychotherapists):

- Reference is made to having an understanding of trauma and how it can impact clients and yet there is no mention of this under the education criteria.

Additional comments for consideration:

I think CORU would benefit from reading the EAP (European Association of Psychotherapy) standards of competency and ethical standards as a guideline. There is a lot of emphasis on evidence based practice and solution focused therapy with a requirement to provide 'proof' of change for clients in the current CORU draft standards. This could be harmful for clients because they may feel pressured into 'being better' than they are. Also there is no mention of psychodynamic, gestalt or existential approaches, or trauma training which are essential to working more deeply with clients. Just to note, the Irish Council for Psychotherapy standards and criteria are in line with EAP standards.

Yours sincerely

[Redacted signature]

Submission to Coru

On behalf of

[REDACTED]

Psychotherapist and Counsellor.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Psychotherapist and Counsellor and former trainer.

[REDACTED]

[REDACTED]

I want to begin by acknowledging the huge amount of work undertaken by Coru in putting together the proposal for registration of psychotherapists and counsellors.

I appreciate the opportunity to make a submission at this stage and welcome the openness shown by Coru to what is clearly a very complex and important area of professional development.

I care deeply about the profession of Psychotherapy. I have been practising as a psychotherapist for 25 years now. The development and progression of the profession is important to me. I want it to grow and expand in a way that stays true to its core principals and holds its ethical stance. Most importantly, I believe that the public deserve to have a good experience of being heard and understood as they confront their pain and frailty. It is from this position that I make the following comments:

Firstly, I want to say that I find the language in the presentation to be a bit liable to be misunderstood by the reader. I found the FAQ section of the Coru website to be much more accessible than the webinar presentation to psychotherapists and counsellors. I am curious as to why this language is being used as it is in my view prone to causing anxiety and concern among the profession.

The problem with trying to serve the public is I think that in most 'public services' pleasing the public is at the heart of the endeavour. The cliché that 'the customer is always right' for example. This kind of emphasis in psychotherapy needs to be addressed from the outset.

Neville Symington the renowned psychoanalyst states in his book 'the making of a psychotherapist'

"If your patient gets upset, it might be that the psychotherapist has made a mistake, been obtuse or insensitive... after a while, I found myself having to say the exact opposite. If the patient gets upset, it might be just that his/her psychotherapist has said something that is true but at the same time painful."

Therefore, it is imperative that Coru understand that the psychotherapist cannot just please the client. The task is to help the client with their particular dilemma or predicament at this stage of life. Without getting too complicated I think it is essential that Coru grasp that the psychotherapist must take on the disturbances of the client. If I were just to agree with the client and give the client what they want, I would be doing them a disservice.

Example: Client comes to see me.... Spends the session blaming their husband for being the problem. After some time, it strikes me that the dynamic between her and her husband is in fact complex and both people are contributing to the bad atmosphere at home.

If I were just to say to the client.. oh poor you... I am sorry you're enduring this... I would just be maintaining the relational dynamic that exists and no growth or development would or can occur.

Whilst, Coru see the public requiring protection and I absolutely agree with this focus, I also believe that the psychotherapist and counsellor requires protecting and safe guarding in order that they can do their work.

Taken from Coru website under FAQ section:

Direct observation refers to the amount of time **the assigned on-site supervisor directly observes a student in the practice of the profession**. Practice Education is an integral and central means through which a student is able to develop his or her professional proficiency towards being able to practice as an independent, autonomous practitioner. This determination of proficiency is made on the basis of the student's achievement of the standards of proficiency which are assessed during the course of a student's practice education.

Assigned on site supervisor..directly observes a student in the practice of the profession.

It is my understanding that best practice for the student to develop their skillfulness is through several components which ought to be part of a training course. Theory, self-reflection, client contact, supervision and assessment of the trainee by the team and their peers.

In the practice of psychotherapy and psychotherapy training it is very odd to think about an assigned onsite supervisor directly observing a student other than observation in the course of learning and in a group context.

The way Coru have phrased this requirement reminds me of a junior nurse being directly observed by her or his tutor. A training supervisor can get a real sense of what is happening in a session through a process recording or verbatims which are a key learning skill.

A qualified supervisor should be part of the training team of the training course in my view and not be outsourced privately by the training school which has become common practice in Ireland. By holding the Supervisor and Supervision of the trainee as a core component of the training of a psychotherapist and counsellor, assessment can more readily occur. It is

the responsibility of the training team in my view to assess readiness of the student to proceed to the next phase of training or not.

It is my view that the outsourcing of the Supervision component of training has led to a sectioning off of the essential skill of self-reflection necessary to the development of the psychotherapist and counsellor in training.

Once, the psychotherapist has been trained, their practice must of course contain supervision as it will be for the rest of their professional life. However, it is my view that 500 hours of supervised hours in training is too many hours. It is not too many when we take training hours and the two years post training ie pre accreditation.

It is normal and good practice for a student to begin slowly taking on clients. It is good practice that they do not exceed working with 3 clients over the last two years of training. Therefore, 3 clients in 40 week training year = 120. In two years, this amounts to 240 hours of supervised client hours up to qualification. The two years following training ie. Pre-accreditation – 240 hours plus more clients as the therapist develops.

Admission to training

Coru's decision to admit trainees as part of the normal university CAO process misses out on the unique profession of Psychotherapy and Counselling.

To practice as a psychotherapist, one must have **relevant life experience**.

The psychotherapist must also hold the capacity to **self-reflect** (rather than blame for example) – this component is crucial to the development of a psychotherapist and must be maintained to protect the public welfare as is stated by Coru as its objective.

The other criteria for admission to training in my experience as a trainer and interviewing candidates for admission to a training course center around how a person **understands their life experience** and how they relate to it. The **capacity for insight** is essential.

It is a huge disappointment to me to see that Coru will not put down a minimum age for admission to a psychotherapy and counselling training course. We know surely that the brain has not developed before the age of 23... how can we allow young adults to go through such a rigorous training

while they ought to be out living life and exploring who they are before undertaking such an intense and demanding course.

The **skill of assessment** is central to the work of the psychotherapist. The psychotherapist and counsellor must be able to assess what the client is presenting using both their theoretical framework and their understanding of the issue the client is presenting. Assessment is a key process in psychotherapy. It is a process not a page to be filled in on the first meeting. It is important that the psychotherapist must realise what their competence is and isn't. Knowing what they are able to offer and what they are not able to offer is crucial. Referring people to the right pair of hands is an important skill and one that should be encouraged and developed in the training of therapist and counsellor.

Supervision – I see that Coru are not emphasising the importance of working with a **qualified supervisor**. Psychotherapy cannot be practised without Supervision. It is impossible. The supervisor must be a psychotherapist. They also need to have undergone a training in supervision. At the moment to train in Supervision, the therapist must have at least five years practice behind them. I would say this is a minimum. The supervisor is essential to allow the therapist to reflect on their work and to assist the therapist clarify what belongs to them and what belongs to the client. The supervisor's primary aim is to help the client. Therefore, Coru should in my view support Supervision as best it can and to emphasise the importance of it.

Grandparenting

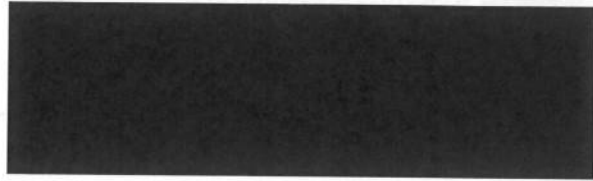
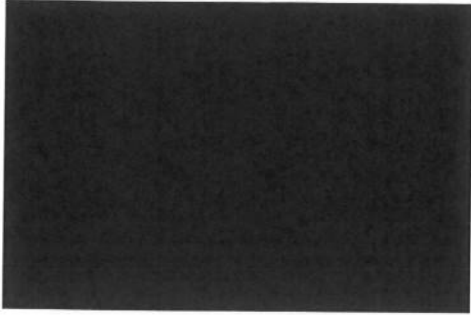
It is quite a number of years now that I have been hearing of Coru and its attempt to establish a register of psychotherapists and counsellors.

From the outset, my main concern has been my own capacity to continue practising as a psychotherapist. I would not qualify for the new standards being suggested for new practitioners to be registered. It is imperative in my view that the members who have 5 or more years of practice are given grandparenting status. This can be underwritten by the therapist's supervisor.

As I read through your document – the webinar presentation for psychotherapists, I see one of your concerns is how to make what's involved in the practice of psychotherapy and counselling accessible to the public. In my own reading and research for this submission, I came across the UKCP FAQs. I think it is very well put together with a good understanding of both what the psychotherapist can offer and what fears the public may feel in approaching a therapist.

[REDACTED]

[REDACTED]



SUBMISSION ON

CORU

***DRAFT STANDARDS OF PROFICIENCY AND
DRAFT CRITERIA FOR EDUCATION AND TRAINING PROGRAMMES
FOR COUNSELLORS AND PSYCHOTHERAPISTS.***

November 2023.

██████ welcomes regulation of the professions, and we appreciate the opportunity to provide our perspective through this consultation process.

In Part 1 of this submission we take a broad approach to the regulatory process, and note specific issues in relation to risk identification and management. We recognise the part that Training Providers must play in risk management, and also we identify areas of concern regarding significant risks that are both beyond the remit of Training Providers and are not currently being managed in the regulation process. We address, in particular, risks to clients and to service provision to clients. We suggest ways in which the risks could be managed. In particular, recognising the value of the information provision sessions by CORU to the professions of counselling and psychotherapy, we raise the possibility of similar information sessions being held for other key stakeholders, such as Service Providers (Placements). In Part 2 we identify discrete changes that could add to the effectiveness of the process of regulation of the profession.

PART 1. RISK IDENTIFICATION AND MANAGEMENT

Risks to Clients

It appears to us that some risks associated with the move to statutory regulation, in particular potential threats to clients and service provision to clients, have been neither identified nor managed. These risks are grounded in the specific context of therapy, which tends to deal with clients who may be at risk of harm to themselves or others, and family systems that can be highly conflictual, distressed, and fragile. Moreover, therapeutic services, particularly low cost services that focus on marginalised and vulnerable clients, are delivered to a great extent by students, including pre-accreditation counsellors and psychotherapists who will be equivalent to students under the CORU system outlined in the consultation documents. This model for service provision will change radically under CORU, and therefore it appears important that this change is managed in ways that prevent significant disruption to the therapeutic process, particularly where vulnerable clients are involved. Our proposals, outlined below, suggest adjustments that could decrease the risks to clients associated with the change to statutory regulation of the professions.

Any change to the student context of necessity impacts directly on their clients. In order to manage the risks to clients it would be useful to see consideration in the consultation process of client experience, risks to clients, and how disruption to clients will be managed. We consider that this is a significant omission from the current consultation documents. **Consequently we suggest that a further information / consultation period needs to be devoted to the management of risks to clients resulting from the transition from current regulatory systems to CORU regulation.** This additional period would allow specific risks to clients to be identified and mitigations to be put in place.

Specifically we have identified the following potential risks

First, we note a risk of disruption in therapeutic services to clients in the transition period between current regulation and CORU regulation, alongside a lack of clarity as to how continuity of service provision could be managed. During this change period there will be clients who are undergoing therapy, possibly for a considerable period of time, under the current regulatory system. Under CORU this system will change dramatically, for example through the cessation of the provision of therapeutic services by pre-accredited therapists. We note that any disruption to the current services provided

to clients risks significant human costs; indeed we would fear risk to life for the more vulnerable clients. No attempt has been made in the consultation process to ensure continuity of service for clients, or indeed to identify particular clients who may be at particular risk. We wonder who will be responsible for managing risks to these clients, and ensuring continuity of care. We suggest that this needs attention in the CORU consultation, at a minimum to allow service providers to identify and manage this risk. We appreciate the consultation is a public one, but in light of these potential risks to clients it may be useful if some attempt is made to provide information to and include specifically service users – clients – in the consultation. Clients will be substantially impacted by this process and we see no attempt to inform them of possible changes that might arise.

Second, we note concerns regarding risks of decreased availability of therapeutic services under CORU regulation. We are concerned that the training system envisaged by the consultation documents represents a significant change for placements that currently utilise students (including those identified as pre-accreditation) in providing therapeutic services to their clients. Many of these services operate in the charitable and voluntary sector, and/or with client designations such as abuse, trauma, suicidal and self-harm risk, migrant and refugee populations and so on. These services, as is evident from public media coverage, are stretched to their limits. We appreciate the consultation is a public one, but in light of these potential risks to clients it would be useful if some attempt is made to provide information to and include specifically placements as therapeutic service providers in the consultation. We note that no attention has been given in the consultation process to the specific inclusion of placement providers as a significant stakeholder. Any disruption to their services could impact significantly on their client populations, resulting even in the withdrawal of therapeutic care. As a profession we are well aware of the dangers this involves. **We suggest very strongly that CORU specifically considers the impact of regulation on the availability of services to clients, and works with therapeutic service providers to identify and manage risks.**

Risks to Students due to lack of timely, targeted information

Risks to students need to be identified and managed by training providers. A core part of this management is information provision to students, and this can only be done in the context of sufficient accurate information to allow providers to communicate risks to students. CORU has not provided an indicative timeline, and therefore providers are attempting to identify, manage and communicate risks to potential students in the absence of a key piece of information. Assessment and communication of risks with any accuracy cannot occur in the absence of a timeline, and this information is urgently needed for students who are considering beginning a programme in the next academic year. For example, students who begin a 4 year programme in September 2024 will require a minimum of 6 years prior to the closing of the Register to grandparenting in order to come within the grandparenting requirements. It is not possible for training providers to provide any degree of clear and accurate information to students about whether they will have sufficient time, and if so what courses of action they might need to take (such as not deferring or repeating a stage, or entering practice immediately after graduation). It is quite clear that students cannot make an informed decision about whether to begin a course that leads to professional recognition without an indicative timeline. **Consequently we strongly suggest that the duration of the run-in to grandparenting needs to allow a minimum period of six years between the publication of the final criteria with an indicative timetable, and the opening of the register for the two year transition period.**

Further we note that this uncertainty is already impacting on the profession. For therapeutic services to be available to clients there needs to be a steady throughput of students from entry to graduation. Already students are beginning to move away from the professions due to the uncertainty of the recognition field. This will inevitably impact on the availability of services to communities in Ireland, quite probably leaving the most needy and marginalised without any access, and we expect this to become increasingly problematic until clear information on timelines is produced by CORU. **Consequently we strongly suggest that CORU publishes an indicative timeline, or at a minimum a start date before which the opening of the register cannot happen, as soon as possible, and definitely before summer 2024 when enrolment to programmes will begin.**

PART 2. SPECIFIC PROPOSALS

Proposal 1. Clarification of the meaning of Practice Placement Hours On-site

Supervised service user contact is further specified, for example in the FAQs, as involving “a professional situated on-site in the placement setting”. The stipulation “on-site in a placement setting in the practice of the profession” needs to be clarified, specifically in relation to how “on-site” can be interpreted in a setting that provides therapy through distance means, such as online therapy. The manner in which “on-site” is used in the Criteria and FAQs could be taken to mean “face-to-face”, thereby excluding distance means of practising the profession. In the therapeutic professions the provision of services by distance means is both a growing area of expertise and a means by which access and quality can be increased. It is important that CORU regulations foster this welcome development by specifically including distance means of communication in service user practice, as well as in supervision and management.

Clarification is required to ensure that online provision is explicitly include in the criteria in relation to (i) online and hybrid placements where contact with clients and supervisory/managerial staff may be by distance means and (ii) remote working arrangements, where supervisors, managers and staff in a placement may carry out their responsibilities through distance means.

Therefore On-site hours should be clarified as meaning physically or virtually on a placement site.

This change should be brought through the documents to ensure that the following arrangements are specifically included in CORU requirements:

- (i) *Online Placements.* It is envisaged that a proportion of placements will require distance means of communication between students and service users, and students and supervisors / managers. We would expect that the proportion of online placements will reflect the current practice and demands of the profession. We note that this is required by criteria 2.3¹ and standard 5.27².

¹ Criteria 2.3 The number, duration and range of practice placements, and their position within the programme must reflect current practice and demands of the profession. They must be appropriate to facilitate translation of theory into practice and the achievement of the standards of proficiency”

² Standard “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.”

- (ii) *Remote working arrangements.* We note that remote working arrangements for managerial, supervisory, clinical and administrative staff in therapeutic services has increased substantially since COVID restrictions began, and this trend is likely to increase when the remote working arrangements requirements of The Work Life Balance and Miscellaneous Provisions Act 2023 are introduced later this year. Aside from the benefits to clients and the profession of remote arrangements, without clarity on the inclusion of distance means of communication as acceptable in a placement setting, training providers and placement may struggle to balance employee rights to remote working with their responsibilities in relation to student placements.

Proposal 2: Include Case Presentation as a method of direct observation

We note the clear and useful description of direct observation given in the FAQs. We also note the value of laying out the methods of direct observation, as has occurred in response to the FAQ: “How can direct observation of a student be undertaken”. The variety of methods is particularly useful: Observation, co-therapy, two-way mirrors, transcription and recording.

However, we feel that one vital method of observation, used throughout the different modalities, is case presentation. This requires that a student not only presents a record of their case, but also includes conceptualisation and critique. It would be usual for case presentations to include a written analysis and transcript, thereby falling within the stated methods for direct observation, but presentations are particularly useful in that they allow a dialogue between the presenter and the audience. We consider that case presentation are vital as a separate and distinct mode of direct observation that contributes to assessment of achievement of competencies.

Some examples in journal format are available in the Sage Journal *Clinical Case Studies* <https://journals.sagepub.com/home/ccs>,

We therefore propose that Case Presentation is specifically included in the different methods of direct observation.

Proposal 3: Include team/ group hours in Direct Observation.

Direct observation by many of the methods mentioned in the FAQs occur in a team or group setting. For example, a team rather than just a supervisor observing behind a two way mirror is standard in family therapy; and case presentations / review of recordings frequently include both peers, who are participating in the presentation, and trainers/ supervisors, who are assessing the presentation. In such situations it is not only the presenting student that is being assessed in terms of achievement of professional competencies, it is also the peers who participate in the exercise. Therefore the teamwork involved in the presentation should be counted as hours for all students present. Otherwise, valuable assessments of competencies of students other than those presenting may not be possible.

We therefore propose that for each student their Hours of Direct Observation include time spent in a team observation setting, and that this is made explicit in the Criteria.

Proposal 4: Change location of definitions of crucial terms from FAQs to Glossary.

We note that currently crucial terms such as on-site and observed practice are defined in the FAQs. As the FAQs are evolving, and have no date or version control, these can change without any notice or notification. However, the meaning of on-site and observed practice are central to programme design and development, and therefore should be explicitly stated in the documents.

We propose that the most useful way to define key terms is to include within the glossary of terms of either the Criteria or Standards document. This should in particular include definitions and descriptions of on-site and observed practice

I wish to submit the following points to be taken into consideration by CORU on opening the register for Psychotherapists and Counsellors.

I would like to quote the following from the American Psychological Association as a way of introducing the value of psychotherapy and counselling to the public.

BE Wombold writes in the American Psychological Association Journal:

The first question is whether or not psychotherapy works. The answer is a resounding yes. The benefits of psychotherapy are clear: Those receiving psychotherapy achieve much better outcomes than they would have had they not received psychotherapy (Lambert, 2013; Wampold & Imel, 2015). Indeed, psychotherapy is more effective than many accepted but expensive medical practices, and is without aversive side effects.

In clinical trials, psychotherapy has been shown to be effective for the treatment of depression, anxiety, marital dissatisfaction, substance abuse, health problems (e.g., smoking, pain, eating disorders), obsessive-compulsive disorder, eating disorders, posttraumatic stress disorder, personality disorders, and sexual dysfunction, and with various populations, including children, adolescents, adults, and elders (Chambless et al., 1998; <https://www.div12.org/psychological-treatments>).

Psychotherapy stacks up well against medications for various mental disorders, most notably, depression and anxiety disorders, and is more enduring (i.e., less prone to relapse) and less resistant to additional courses of treatment (Hollon, 2016; Hollon, Stewart, & Strunk, 2006; Imel, Malterer, McKay, & Wampold, 2008).

Copyright American Psychological Association

1.

In so far as Psychotherapy is often called the 'Talking Therapy', it could be compared to how a lawyer might "talk" on behalf of a client in a court of law. Counselling is not just 'talking' but rather an informed, specific type of listening and conversation which highlights conscious and unconscious faulty beliefs, self-sabotaging behaviours, unused opportunities, and defensive patterns which contribute to layers of behaviour and thinking, leading to distress or anxiety in the client. This unique relationship is underpinned by unconditional respect, congruence, dignity and patience which eventually leads to trust and the possibility of challenge. It cannot be compared to the medical model of mental health treatment and is not readily understood by untrained and uneducated members of other professions.

I have grave reservations that CORU may not take into account the voice and concerns of Psychotherapists practising in Ireland and the importance of the learned theory which informs how psychotherapists "talk" to their client.

2.

A supervisor of psychotherapy has practised for five years before entering a post graduate course of up to two years of study to qualify. The aim of the supervisor is to enhance the learning and support a therapist by allowing the therapist to discuss their impressions and sense of their client. If there is an impasse in the therapy, a second opinion can sometimes unblock the direction of the therapy where the client has become stuck and cannot move forward. The supervisor tries to get a view of where the supervisee lacks clarity around what is going on for the client and in those cases may suggest or ask appropriate questions which helps the supervisee to ask questions or see what might not be clear for the client in terms of defensiveness, learned behaviour, conditioning or unconscious drives. The supervisor is trusted by the supervisee to gently challenge or advise on occasion. They would work as a team notwithstanding the fact that the supervisor has an ethical responsibility to ensure that the supervisee is working ethically him or herself.

I am under the impression that CORU see the role of the supervisor as that of superintendent and assessor rather than an ally and trusted educator.

3.

When therapists attend personal counselling, it allows for growth and wisdom of the therapist's own values, culture, perspectives and biases which they have learned from their own psychosocial environment. It is vitally important that the therapist can park these personal opinions when working with diverse and multi-cultural clients and be totally accepting of the client's perspective and almost walk in their shoes to capture what has led the client to this place and what they might do or think differently.

I am concerned that there will not be a value on a student of psychotherapy attending personal development counselling.

4.

It seems to be too late to object to a separation of the titles of "Counsellor" and "Psychotherapist" however I would like to register my objection to this division and pose the question "When does counselling become psychotherapy and psychotherapy become counselling?" It has been researched and proven that academic achievement has little to do with outcomes for clients and the therapeutic relationship between counsellor and client is a vital factor in successful resolutions. There has never been a definitive definition offered of the two titles and most countries agree that they are one and the same. Another consideration is that the general public use the terminology "I am going to counselling" or "I am looking for a counsellor" because there is a lack of understanding around the roles of psychiatrist, psychologist and psychotherapist. The public will look at the register of counsellors to find a counsellor and the psychotherapist will be at a loss because of the titles.

I believe the separation of the two titles reflect the lack of research and understanding of the profession by the powers who have designated the two distinct titles.

5.

My last concern is the lack of time spent by CORU interfacing with actual therapists working in Ireland currently. I believe there has been too much time devoted to regulatory bodies and colleges which often are the same people with the same agenda. For example, the current Leas Cathairleach of IACP is also on the board of one of the largest course providers in the country. There is a danger of conflict of interest, given that a good number of people who have been appointed to inform CORU are also involved with low -cost counselling funded by the HSE and therefore profit driven as opposed to therapists working on the coal face of the Irish mental health landscape. The exploitation of therapists who have had no alternative other than working free to get their accreditation hours is testament to how we have been treated in the past and that system continues today. Therapists have no choice but to seek accreditation from the regulatory bodies and pay exorbitant membership fees in order to purchase insurance and find paid employment in the HSE or other counselling organisations.

6. VAT.

Statutory Instrument No. 170 of 2nd July 2018 designates psychotherapists and counsellors as a regulated profession and establishes the Counsellors and Psychotherapists Registration Board. Professional counselling psychotherapy provided by persons registered on this board are exempt from VAT from the date of registration. However because this Counsellors and Psychotherapists Registration Board is still not open to registrants, therapists are continuing to pay an extra tax not required by other health professionals.

This is unfair to therapists and also the public who are paying for private services and unable to claim back in the usual manner.

[REDACTED]

Overall, I did not have any questions or comments apart from the issues below.

SoP for counsellors:

- The domain 5. **Professional Knowledge and Skills**: items 11, 12, 13, 15, 16, 19, 22, 30 and maybe some more use the term counselling or therapeutic relationship (it is also an issue for some other items that may be using terms like psychological functioning [e.g., 25] or mental health [e.g., 23] or psychosocial [e.g., 24], exploring trauma therapeutically [e.g., 26], etc. – given that the standards of proficiency also relate to the scope of practice how do these SoP relate to the SoP for psychologists, e.g., counselling, clinical, or educational psychologists?

Other comments SoP Counsellors:

- 5.26 Be aware of the potential for harm to the service user in exploring trauma therapeutically, understand the need to refer on and be able to identify suitable referral pathways. – could that be explained? - Exploring trauma is quite a mainstream approach to reprocessing trauma.

SoP Psychotherapist:

- Similarly like with the counsellors, the SoP for psychotherapists in the domain 5 **Professional Knowledge and Skills** refer to the terminology that overlaps with what will likely be covered in the SoP for psychologists (e.g., clinical, counselling). This includes for instance the items 1 ('psychotherapeutic theory and practice'), 9 ('the benefits, limitations and contraindications of differing psychotherapeutic approaches'), 11 ('to work therapeutically with a wide range of presenting issues of varying degrees of complexity and severity, and across a wide range of diagnoses'), 12 ('the role of psychotherapy'), 14, 15, 16, 18, 20, 24 (references to therapeutic process and therapeutic relationship), 17 (psychotherapeutic skills), 23, 27 (therapy), 24 (psychotherapy), 28, 32 (psychological functioning)
- So the question is, given that psychologists also offer counselling and psychotherapy which will be reflected in their SoP how would the two/three scope of practices overlap/complement each other? I do not see a problem with it, if it is not going to be prohibitive for any of the professions.

Other comments SoP Psychotherapists:

- 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 (not all approaches psychotherapy approaches see insight as central) and long-term change (well this is quite ambitious given what we know about change accomplished by psychotherapy).
- 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. – these (underlined) concepts are central only to psychodynamic and related psychotherapists – not central to humanistic or cognitive-behavioural
- 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. – these (underlined) concepts are central only psychodynamic psychotherapists – not central to humanistic or cognitive-behavioural

Criteria for Education and Training Programmes

- One of the documents (e-book "CPRB Public Consultation 2023 Criteria for education and training programmes) suggests that so far the only clear difference between the counsellors and psychotherapists education is 450 hours of practice placement education vs. 500 hours of practice placement education (and a corresponding difference in the hours of supervision

and direct observation). The difference is 50 hours. Which extra skills will psychotherapist learn in that time comparing to counsellor and will that difference remain the same for the duration of their career/practice?

- I also saw in the FAQ a rationale for the difference in the hours for counsellors and psychotherapists and the reference to the SoPs of the two professions. I see that this the rationale for the difference in the hours and an example:
 - Firstly just an observation about the example, it is very difficult to see the difference in the wording of 5.11 (in the SoP for psychotherapists) and 5.9 (in the SoP for counsellors). It is also not clear how it relates to the extra 50 hrs (would they allow to accomplish this difference [which is very difficult to see] and would that difference be meaningful during the course of the career? Also, in terms of 5.11 SoP for Psychotherapists – not all therapies focus on 'insight' it is really a psychodynamic terminology. The long-term change that can be achieved is more aspirational than an empirically confirmed. The psychotherapist also needs to recognize the limits of their competence and refer as appropriate (as suggested in 5.9 of the SoP for Counsellors).

Secondly, the practice of what is referred to as the profession of counsellor and the profession of psychotherapists is constantly undergoing changes and often these two are seen interchangeably (by public, professional/academic/research literature). Obviously, the registration board made its decision on the basis of research, but anecdotally I am not sure whether the statement in the FAQ (see below in italics) is fully accurate and/or whether it will hold over next few years. Quote:

In particular, the Board reflected on the differences in the length and type of engagement with services, concluding that psychotherapy relationships with a service user tend to take place over a longer period of time than counselling engagements.

Additionally, and connected with the length of service user engagement, the Board also reflected on the differing types of presenting issues that counsellors and psychotherapists encounter, noting that psychotherapists can work with a wide range of complex presenting issues that vary in severity and present a wide range of diagnoses.

To whom it may concern:

I am hereby making a submission to CORU as part of the shareholder consultation process relating to draft documents for the education and training requirements for entry to registers for Counsellors and Psychotherapists, 28th November 2023.

I find it necessary to register my deep disappointment regarding the quality of the draft documents relating to the above registration requirements. As these draft documents stand the public will less be protected, guided, and informed going forward. If these proposals come into place the professions will become less safe for the public/clients. As the Draft documents read, they reflect a dilution of the standards presently in place in IACP as well as the equivalent Canadian and Australian accreditation associations. The standards aspired to by IACP have been far higher than those proposed by CORU. These draft documents represent a weak to dangerous baseline of the professional standards that I have come to expect in my profession.

Ref:

IACP Policies and Guidelines

Australian Counselling Association Policies and Guidelines.

Canadian Counselling and Psychotherapy Resources

In summary:

- Given the length of time these documents were being considered they reflect badly on the calibre of those who drafted them.
- The documents appear to be based on harsher, academically based models possibly suitable for other professional areas. Little regards for the experiential nature of the work.
- Minimal recognition as to the value of personal therapy during and post training.
- A worrying level of power is proposed for Educational and Training Programmes.
- Little or no evidence in the documents that consideration has been given to the exceptional nature of the work carried out by Counsellors and Psychotherapists.
- No definition of Supervision.
- No proposed regulation for Supervision.
- No evidence of an awareness of the role of Clinical Supervision in Training.
- Naïve and alarming propositions regarding the role of inhouse supervision in Training Programmes.
- There is very little evidence that consideration is given to the ongoing suitability of candidates entering /in training. No external oversight.
- No definition of CPD.
- CPD is mentioned in the context of 'training staff' only. Aspirational and without oversight.
- A strong element of a patronising agism in the Grandparenting section.
- Specific requirements must be in place regarding the qualifications, training and supervision of those therapists working with children and adolescents.
- Regulation is urgently required for Play Therapists.

- Regulation is urgently required for those working with adolescents.
- Recognition of Prior Learning should not be left to the sole discretion of the Training and educational programmes.
- Professional Proficiency needs to be further defined.
- Personal Therapy should be considered as a Pre-Training requirement.
- Level 8 minimum entry requirement is welcome.
- Renewal of Registration with CORU or Accrediting bodies as a career-long requirement should be considered as obligatory.
- Training Programme having sole control over the accrual of client hours will erode the wide range of experience presently available to trainees.
- Training programmes stand to gain financially if all training hours are carried out inhouse.
- Training programmes costs will rise with in house client- hours accrual, the trainees will carry the additional costs. Making access to training courses more exclusive.
- Most Training Programmes depend on income funds of the fees from privately paying trainees. No government funding is available to this sector unlike other third level training and educational systems.
- Training programmes are not the appropriate bodies to determine Fitness to Practice. No external oversight except for academic achievement.
- The Draft documents do not consider CPD with any gravitas. Presently aspirational with no indication regarding implementation or oversight.
- Draft doc on Standards and Prof for Psychotherapists; Point 32 should include the following 'prescriber or otherwise'.
- Draft doc on Standards and Prof. for Counsellors should include the following 'Be able to critically reflect on the conscious and unconscious dynamics of supervision and to be able to manage their personal involvement in and contribution to the process of Supervision.
- Regulation is needed for Supervision in Training
- Regulation is needed for Clinical Supervision.
- Statistics on the current trend of students graduating from educational and training programmes are showing a worrying increasing trend. The profession is becoming a 'base heavy' population (IACP Annual Report, 2023, pg 29). The swelling ranks of counsellors and psychotherapists are less experienced, less exposed to personal process, less aware of the client's needs yet fully qualified and registered for life in at least one of CORU's registers.

I respectfully request that serious review is given to the draft documents. Regulation of the professions is urgently required and welcome. The drafts which have been offered for consideration fall shocking short of what is needed to ensure that the public/client will be protected.

Yours sincerely,

[Redacted Signature]

[Redacted Name]

CORU.

Personal Experience:

I have been working in Counselling and Psychotherapy for over 14 years.

I am also a supervisor. My supervisees range from trainees to master-practitioners. A wide range of issues present in my practice. I remain very involved in my continuous professional and personal development.

Most of my professional learning has happened following my initial training. My initial training had a heavy experiential emphasis. This work was difficult and trying. At times the training place felt unsafe, with some trainers suffering burnout and unrecognised transference issues. At times this rendered the training space unsafe. During inhouse group supervision I found that there were client cases which I could not present to the group. I had to find external supervision to continue safely with some clients.

Little has changed. Today, one third of my practice is supervision. Repeatedly trainees report the training places as feeling unsafe. The same trainers lecture, correct assignments and often supervise the trainees. Supervision in training can feel like group therapy without any safe holding. There are unsafe boundaries in place.

The lack of safety has more recently been increased with the intake of trainees onto established training programmes via a 'bridging' system. Whereby the training places are facilitating entry to current courses based on a wide range of previous academic achievements and little to no regards for any emotional intelligence. Many trainees have no experience of personal therapy. A recent trainee complained that personal therapy was a tick-box process which he wanted to pay for rather than partake in. This is leading to very mixed capacity within classes. I am witnessing trainees who are very capable in putting together an assignment or essay and yet incapable of being empathically in a room with a client. The value of personal therapy in training can be assessed and reviewed as is evidenced over the years.

I was fortunate to be able to accrue my pre-accreditation hours with low cost counselling and psychotherapy centres. This offered me an opportunity to work with a wide range of issues and clients from a broad socio-economic base. This experience proved invaluable. Putting theory into practice and building clinical experience which stands to the strengths of my practice today.

During my initial and many subsequent trainings, I found my personal therapy to be valuable. Most especially when I undertook specialist training in children and grief. The self-reflective assignments also supported me during these trainings.

A training place is not by definition a safe place.

My practice has been massively supported by my clinical supervision experience. I have experienced it to be a safe place, with no conflict of interest. I would have felt isolated in my work, I would have missed blind-spots, compassion fatigue and burnout. My clinical supervision keeps my clients safer.

The second supporting pillar to my practice is my engagement in continuous professional development. The areas of my work relating to recent advances in neuroscience, pharmacology, memory formation and learning, trauma and adverse experiences are continuously changing and advancing. To keep abreast of these exciting learnings and to be in a position to improve the outcomes for clients and trainees I partake in a wide range of training and reading, much of which is discussed and planned in supervision.

CORU Supervision

Supervision is a distinct professional activity, a valued feature of the present accreditation requirements. It is not coaching or mentoring.

My experience of Supervision has been one of great value. Supervision has an important role in Counselling and Psychotherapy. Support, safe and free from any conflict of interest it offers the client an invisible safety. Supervision can be the guard against burn out, compassion fatigue and isolation within the work. A place to express the gravest concerns and doubts.

Supervision at its best can be educational and refreshing a space for collaborative interpersonal processes which can allow the supervisee to view the client through a slightly different lens. Viewed from a slightly different angle.

At its worst Supervision can be judgemental, damaging and a place to learn the art of hiding issues and difficult cases. This was my experience in training where the Supervisors had 'mixed' roles within the system, moving from teaching, assessing, and grading and always from a position of authority. To ask training places to Self-Supervise is unsound.

The suggestion that in training supervision would be directly or partially observed is naïve and impracticable. Training providers will not have access to provide such facilities. The added expenditure to provide such facilities would drive tuition fees higher. The benefits of such facilities are unproven.

- The Draft documents make little reference to supervision even though supervision is a key component in the standard of provision currently in place.
- CORU has no Draft Document of Supervision for Counselling and Psychotherapy.
- The Draft documents do not define the quality/qualifications of in training supervision.
- In training supervision can be punitive and corrective.
- Costs of in training supervision will drive the tuition fees to become even more exclusive as trainees will carry any additional costs.
- What are the standards, training and qualifications for in-training Supervisors?
- Supervision is not defined in the Glossary.

Ref;

Supervising the Counsellor, A Cyclical Model. Steve Page and Val Wosket.

Reporting in Counselling and Psychotherapy, Papadopoulos, Cross and Bor.

Supervision in the Helping Professions. Hawkins and Shoet.

CORU Consultation - Counsellors and Psychotherapists

To Whom It May Concern

I am submitting feedback on the following draft documents:

1. Criteria for Education and Training Programmes for Counsellors

Criterion 2 - Practice placements

2.2 The programme must ensure that each student completes 450 hours. A minimum of 300 of the 450 hours must be supervised service user contact experience, of which 75 hours is directly observed service user contact.

As a mature part-time student, I found it challenging doing my practice placement during my training in terms of cost and time. In the end, I had to go down to a 4.5-day week in order to do my hours as a volunteer within an agency that was a two-hour round trip from my home. This put pressure on me financially particularly with a young family. I did achieve it in the end but it took a few years.

Consideration should be given to the fact that the proposed hours for practice placement could be a barrier for someone who would be a great addition to this profession.

In order to make practice placements possible for someone like me i.e., a single Mum, already working full-time in a different profession, and studying part-time, having these hours reduced to half could help to make it possible to complete a programme that would meet the eligibility criteria to apply for entry to the profession's register.

If these hours could be reduced to 300-350 hours it might be more manageable. An alternative suggestion is that students (upon special request) could have a number of years once the academic part of the course is finished to complete these hours before graduating.

Counsellors being expected to do volunteer hours during practice placement is limiting. If it became mandatory for placement hours to be paid it would certainly help with being able to manage financially and would be good for morale. There could be a tiered approach e.g., during the first 100 hours a counselling student could be paid X amount and could see only mild presentations to help them build confidence in the basic skills. The next 100 hours they may be ready for moderate presentations and the amount paid could be increased and so on and so forth.

At the very least an agreement could be made between the programme provider and the practice placement that supervision be paid by the practice placement provider for the student.

I strongly agree with points 2.4 and 2.5.

Below are some additional questions:

As a professional therapist who has graduated from a Level 8 training programme, how will I know if that course has met the eligibility criteria to apply for entry to the profession's register?

Are there expectations for experienced therapists who have been in the field for several years?

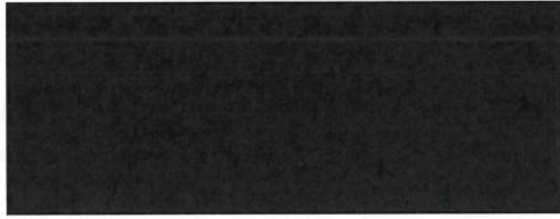
If there were gaps in my training programme would a top-up training be proposed to meet the criteria for registration?

2. Criteria for Education and Training Programmes for Psychotherapists

2.2 The programme must ensure that each student completes 500 hours. A minimum of 350 of the 500 hours must be supervised service user contact experience, of which 100 hours is directly observed service user contact.

As above I would see this as a very challenging requirement as a mature student who is working and has a young family. I appreciate that the experience gained from this number of practice hours would certainly contribute to safeguarding service users once a student graduates but to be able to do the hours within the period of the training programme may be a very big stretch for some students who have young families.

If these hours could be reduced to 350-400 hours it might be more manageable. An alternative suggestion is that students (upon special request) could have a number of years once the academic part of the course is finished to complete these hours before graduating.



Written Feedback Submission

on CORU's proposed

Standards of Proficiency and Criteria for Programmes of
Education and Training (Counsellors)

Standards of Proficiency and Criteria for Programmes of
Education and Training (Psychotherapists)

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Introduction

The College welcomes the opportunity to provide structured feedback on CORUs Standards of Proficiency and Criteria for Programmes of Education and Training for Counselling and Psychotherapy. Though the original intention was to submit a single response from the College President, it became apparent that there was considerable merit in expanding the opportunity to open an internal dialogue on the planned national registration process. It is noteworthy that though the primary intention may have been to organise feedback, it also served as a vital moment of dissemination prompting considered reflection on professional *zeitgeist*. Emerging from those engagements, it was agreed that a single submission that might capture channels of convergent and divergent opinion within the College community would be appropriate and so we opted for written feedback. Cognisant that unstructured written feedback would pose data analysis challenges for the end user, the online feedback consultation form was applied as a guide and the following collation reflects the structure of that approach. The submission is divided into two Chapters with proficiencies and criteria for counselling and psychotherapy presented as distinctive subsections within each Chapter.

Chapter 1 – Collated Feedback of Senior Academic Staff ICHAS

Standards of Proficiency and Criteria for Programmes of Education and Training (Counsellors)

Standards

There was general agreement that the proposed standards met threshold requirements with no omissions though some standards were identified as “partly threshold”.

In a lengthy commentary on standard 5.9 one respondent offered the following opinion:

“In my opinion Standard 5.9 is partly threshold. The ability for students to outline typical severe presentations is met within theoretical modules as is information on scope of practice and referral issues. However, students undertaking applied practice do not have access to clients experiencing Severe Mental Illness (SMI). This lack of exposure to clients experiencing SMI also excludes opportunities for students to apply psychological interventions for the treatment of this population. The current lack of openings for counselling students to gain proficiencies in working with this population may be associated with the paucity of appropriate resources. In relation to under provision of counselling services research has indicated that the endorsement of stigmatising attitudes is inversely related to resource allocation. Public and self-stigmas have also been associated with the underutilisation of individual and group counselling (Vogel et al, 2010).

Research has also indicated that in addition to the general population, mental health professionals may stigmatize those experiencing SMI, and these stances may obstruct the development of appropriate counselling services for them (Jouch, 2023). In a study that investigated health professionals' attitudes towards people experiencing SMI, Koutra et al (2020) recommended the exposure of mental health professionals to information on the impacts of stigma and the reduction of discriminatory tendencies.

“Specifically, in our sample, social workers and psychologists were found to hold the most favorable attitudes towards people with severe mental illness, while psychiatric nurses and other MHPs (i.e., occupational therapists, General Practitioners, counsellors, etc.) held the least favorable attitudes.”

Additionally, according to Knaack et al (2017) inadequate skills and training were associated with stigmatising attitudes by mental health practitioners (MHPs) towards people experiencing SMI. The authors found that a failure to address stigmatising attitudes, led to emotional anxiety or fear of people presenting with SMI concerns. These reactions towards clients by practitioners created avoidance and social/clinical distancing, impacting patient-provider interactions and quality of care resulting in poorer treatment outcomes.

Counselling students receive anti-stigma education but require exposure to people experiencing SMI. They are well placed to deliver psychotherapeutic interventions working within their scope of practice. Education on the theory and techniques associated with the development of the therapeutic alliance is intrinsic to counsellor education (Amos, 2023). In terms of the treatment of people experiencing SMI better therapeutic alliance has been associated with a reduction in symptoms, fewer hospitalizations, greater antipsychotic medication adherence, and improved client self-esteem (Rockville, 2020).

Research on increasing the Quality of Life (QOL) in people with SMI suggested that a decrease in mental distress was also required to improve personal recovery. Interventions to reduce distress such as the promotion of social networks, hope and regaining meaning was essential (Saavedra et al, 2022). The

authors proposed a model of care that emphasised psychosocial interventions in combination with pharmacological treatment aimed at increasing the QOL of people experiencing SMI. Arguably counsellors are well placed to deliver the types of interventions that lessen psychological distress (Rockville, 2020). However counselling students require placement experiences that provide access to clients experiencing SMI. Additionally, to address stigmatising attitudes towards people experiencing SMI counselling students need to engage in personal therapy (Bento and De Sousa (2022)).”

Commenting on Standards Standard 5.22, one Programme Director observed that the training and education of students “surrounding the applicability and practical elements, upheld through empirical evidence is a topic which needs further attention within an educational environment.”

Commenting on Standard 5.28, one respondent felt that “crisis intervention in its purest sense is a broad and immersive process” highlighting the need for students to be “introduced and educated in foundational and moderate crisis intervention strategies, theory and techniques”. The respondent elaborated on the need for placement provision to have “strong protocols surrounding assessment; student exposure to clients matching their level of training and updated policies on risk and safety processes”.

Differences of opinion were expressed on Standard 5.30. While one respondent felt that a “basic introduction to pharmacological processes is warranted”, the opinion was also expressed that a “comprehensive knowledge” of the effects of medications, prescribed or otherwise, relevant to service user was “not entirely necessary and certainly not necessary as part of a training program at counsellor level” and that this type of information would be more appropriately “garnered from online sources when necessary”.

Feedback on Domains

One respondent provided detailed feedback on Domain 5: Professional Knowledge and Skills. It was felt that it required “greater refinement” to account for the “numerous treatment modalities from Psychoanalytic Psychotherapy through to more contemporary approaches such as ECT and Solution Focused Brief Therapies and Trauma Informed interventions”. The respondent elaborated that “within and across the span of modalities it is not only important for education providers to offer a robust educational base on both traditional and contemporary therapeutic thinking and practice but to also establish a range of skills which may match or align with a specific modality. The skills and knowledge (not only about the theory but how and when to apply a technique/strategy to practice) are essential. A student may understand for example the fundamental underlying philosophical foundations of the Person-Centred approach but how do they demonstrate the skills or indeed how are these skills measured? Skills such as 'Use of open questioning; silence; summarizing; appropriate body language are all tangible and therefore measurable. Implicit skills such as Empathy; Genuineness; Presence and Congruence are difficult to measure because they are both subjective and idiosyncratic. This could be said for a broad range of theoretical concepts in that how can we measure multiple skills required for multiple theoretical frameworks? Part of my reasoning here is that educational providers need to embed students within core theoretical frameworks. Exposing students to single theory education and practice (skills assessments) are essential in the foundational years of their development. As with any new endeavour it takes time, patience, excellent mentors, practice and critical reflection to move through the following stages of learning and embeddedness.

- A. Unconscious Incompetence (We do not know or understand what we are not proficient in).
- B. Conscious Incompetence (Through learning and reflection, mentorship and education we become aware of areas in practice and knowledge that we are not particularly good at)

- C. Conscious Competence (The student is aware of their strengths, mastery)
- D. Unconscious Competence (After many years of practice, exposure to learning, skills development).

Therefore as Cooper et al (2017) suggest, assessment of therapist competence (skills and abilities) demands assessment of both knowledge and the competence to effectively and skillfully select use and evaluate therapeutic approaches in practice. Speaking towards an example of competency BACP (2020) suggest that one strand of competency is the Ability to:

- integrate counselling skills into a primary role
- remain focused on the purpose of the primary role
- use terminology specific to role and setting
- identify and manage any potential tensions when embedding counselling skills in a primary role

There are multiple facets towards competent skills development and practice, including, but not exclusive to risk evaluation, enhancement of therapy, working ethically and to your standard of training, skills and knowledge and advancing your skills , knowledge and competence through supportive structures such as external clinical supervision.

Placement Proposals

Differences of opinion were expressed on placement criteria. The practicality of Criterion 2.2 was questioned particularly for part-time students noting that setting the threshold too high might be “counterproductive to make it out of reach for potentially excellent candidates”. On the other hand another respondent believed the “practice placement hours to be completed within the lifetime of the related course [to be] valid and programmatically sound”. By way of elaboration, it was asserted that “completing the full requirement of 450 hours as proposed will, if planned for correctly and worked collaboratively between placement providers, educational providers, students and allied supportive structures could work effectively”. However, it was also felt that the proposals “represented a 'paradigm shift' in both understanding and application of the process”.

A second sub-component of Criterion 2.2. that 300 hours must be supervised service user contact experience, elicited varied opinion. It was noted that while it represented a fundamental shift in how training was currently structured and would test “practice placement availability”, the broadness and non-prescriptiveness of the criterion was welcome resulting in a “fair, balanced, educational and inclusive” approach. In outlining their “partly threshold” response respondents again questioned the practicality of the threshold especially for part-time students noting an attendant risk to potential talent attrition. Further reservations derived from how the proposals impacted current modes of novitiate accommodation from the perspective of placement providers. Feedback was as follows: “My concern arises within this recommendation in the availability of appropriate placement providers who may now see themselves engaging with a student over a much protracted and involved manner within practice placement than previously required to do. I am particularly concerned for small practice placements who may not have the personnel, time or resources to offer this investment in students. This may very much alter the 'Practice placement landscape' where more students are competing for fewer placement opportunities. Placement providers as a separate but integral entity within student education need adequate education, increased awareness and appropriate time and personnel to fulfil the above recommendation. Practice placement providers are stakeholders within and across student development, applied practice and exposure to valuable 'hands on' experience”.

Distinction was made between this criterion from the perspective of the education provider. “From an educator perspective I believe we can make the recommendation work, from the perspective of bringing

students into the 'Applied practice' arena at stage 2 of our programme as opposed to stage 3 (Level 7) as it currently stands."

It was also noted that changes to placement had a knock-on effect on models of personal development education. "From an educator perspective we may also be required to introduce 'personal therapy' in stage 1 of our programme to all student personal development, increased professional awareness and offer confidence to potential placement providers that personal therapy is taking place at an earlier stage which may enhance the opportunity for students looking for placement at stage 2 of the programme."

Commenting on the further sub-component of Criterion 2.2 that 75 hours must be directly observed service user contact, one respondent felt that "although excellent in its philosophy and conceptualization [it] may prove to be an onerous task for practice placement 'supervisors'/mentors' to perform". Again the extent of the departure from current norms was highlighted with reference to resourcing, role perception inter-stakeholder management and model of mentorship. "Although the vast majority of placement providers we currently work with provide access to an appropriate student liaison individual, I am still of the view that current engagement is completed in a time sensitive and un-structured manner. By unstructured I do not mean haphazard but 'an if and when approach' is currently working well. Again, I say this because students currently have a robust Triangulation process of monitoring, mentorship and clinical supervision (College; placement provider; Clinical supervisor) in place. For the placement provider to provide 75 hours of direct observation, whilst a very good concept, may prove too time consuming and there may be a lack of both knowledge/training of personnel to carry out assessment of proficiencies as required/proposed by CORU. I am not rejecting the idea but I am wary of its do-ability. From an educator perspective it may be that we will train certain individuals to carry out these assessment checks in alignment with CORU requirements, a form of mentorship if you will or indeed a further option may be to expand our current practice placement team and engage in a more frequent and widespread process on behalf of the college. Furthermore, I wonder about client consent towards 'direct observation' and how this may be managed and the willingness of placement staff to 'assess' students towards on-going practice. Appraisals of mid-way placement and at the end of placement are currently employed by the college."

Standards of Proficiency and Criteria for Programmes of Education and Training (Psychotherapist)

Standards

There was widespread agreement that the Standards for Psychotherapy met "threshold" requirements with no omissions identified.

Minimum qualification level for entry to the register

A majority of programme directors agreed that the minimum threshold for entry to the register was appropriate but one respondent indicating that any further expansion of "knowledge, skills and personal and professional development be progressed to Level 9" on the national framework of qualifications.

Placement Proposals

There was more varied opinion on the suggested number of placement hours. One respondent considered the threshold to be set too high and questioned the practicality of achieving those targets especially for part time students stating it "would be counterproductive to make it out of reach for potentially excellent candidates".

One respondent, who believed that a Level 9 qualification threshold was more appropriate to the title Psychotherapist felt that this should also be reflected in placement arrangements stating, “a candidate should acquire practice placement/clinical practice at 450 hours at undergraduate level and a further 200 hours of clinical practice under clinical supervision at level 9”.

There was no consensus around supervised service user contact experience with the range of potential feedback responses equally represented. That 100 hours must be directly observed service user contact was questioned by most respondents in terms of practicality, formatting and resourcing. No omissions from the profession-specific criteria were identified.

Additional Comments

One respondent “strongly” believed there should be a separation of minimum educational standards for the protected titles of 'Counsellor and that of Psychotherapist'. The rationale for this belief was outlined as follows, “the work of a psychotherapist is more specialist in nature, carries with it more professional and clinical experience, works within and across more complexity when compared to the profession of counselling and aligns itself more robustly towards Psychopathology and the medical/pharma model of treatment provision”.

Chapter 2 Feedback of the College President, [REDACTED]

Draft Feedback to CORU on Proposed Proficiencies for Threshold Practice in Counselling/Psychotherapy and Education Standards

Opening commentary

As an initial commentary, I wish to warmly welcome the publication of these Draft Standards of Proficiency as well as Standards for Educational Programmes.

I commend the Registration Board and the Executive of CORU for their very significant efforts in bringing the Regulatory process to this point and is seeking to support that process through the provision of structured feedback on both the Draft Proficiencies for Psychotherapy as well as Counselling and also the Draft Standards for Education Programmes. The following document will focus on the Draft Proficiencies, Draft Educational Standards and finally some feedback specifically on Personal Therapy and Clinical Supervision/ Clinical Education.

Feedback on the Draft Proficiencies for Psychotherapy

In its documentation outlining the Draft standards of proficiency for Psychotherapy (mirrored in the standards of proficiency for Counselling), CORU argues that:

*“The standards of proficiency detail the **skills and abilities** that individuals must possess in order to enter the register. They are the threshold standards deemed necessary by the registration board at the level of entry to practice. They are not standards for practice after entry to the register. Rather they offer a snapshot of the standards at entry to the register”.*

In that context CORU identify 5 Domains of Proficiencies, namely:

1. Professional Autonomy and Accountability
2. Communication, Collaborative Practice and Teamworking
3. Safety and Quality
4. Professional Development
5. Professional Knowledge and Skills

This is a common approach taken by CORU for all disciplines and is both welcome and helpful. It is very consistent with the core remit of CORU which, in essence is to ensure standards of practice in any discipline which it regulates are consistent with its mission to protect the public.

CORU has requested feedback in its consultation process on Domain 5 for both Counselling & Psychotherapy and in an effort to support the work of CORU in that regard, it might be helpful to start by questioning the consistency between defining a proficiency as being directly related to ‘skills and abilities’ while focussing on ‘knowledge’ as well as ‘skills’ in Domain 5. It might be more useful to consider Application of Knowledge of Skills/Competencies’ as a requisite Domain of Proficiency. This is not intended as a negative criticism, but more a constructive critique of how the proficiencies might be made more accessible to the reader of the documentation.

Part of the reason for saying that relates to the contention by Cooper et al (2017) that assessment of therapist competence (skills and abilities) demands assessment of both knowledge and the competence to effectively and skilfully select use and evaluate therapeutic approaches in practice. This seems a reasonable commentary and should transcend the assessment of those in training to reflect the necessary proficiencies for entry to an area of professional practice.

Another key reason for suggesting that the ability for applicants for registration to demonstrate proficiency in the application of knowledge and skills and inter alia become registrants in either Counselling or Psychotherapy relates to the requirement to be able to differentiate between adherence and competence. This is something which would (or should) be considered important for ‘threshold entry’ to any profession. Recently, Armusewicz, Steele, Steele and Murphy (2022) distinguished both concepts, noting that “Adherence demonstrates the clinician’s knowledge of how to apply treatment, while competence requires the knowledge of when and when not to apply specific interventions with distinct patient populations (Barber, Sharpless, Klostermann, & McCarthy, 2007)”. Accepting this argument implies that there also should be differentiated means of assessing and ensuring proficiency in any given Domain of Application of Knowledge and Skills in order to reflect measures of whether an applicant relies on appropriate knowledge to select appropriate intervention strategies, or ‘adheres’ to the application of appropriate intervention protocols; or indeed how competent they are in same. The same authors have argued convincingly that client/patient outcomes require a combination of both, citing a range of sources which indicate that while adherence is a prerequisite that competence predicts better outcomes than adherence alone (Barber, Crits-

Christoph, & Luborsky, 1996; Barber *et al.*, 2006; Boyer, MacKay, McLeod, & van der Oord, 2018; Ginsburg, Becker, Drazdowski, & Tein, 2012; Owen, & Hilsenroth, 2014; Wampold & Imel, 2015).

Being conscious that CORU has specifically suggested that the level of proficiency required for registration is at 'threshold' level, it is also important to note that there are a wide range of 'approaches' or modalities within both Counselling & Psychotherapy. The Proficiencies in relation to any of these modalities could well be proficiencies for Advanced Practice and arguably should also come within CORU's remit, in a similar way that Clinical Nurse/Midwife Specialist or Advanced Nurse/Midwife Practitioners are also under the remit of the Nursing and Midwifery Board (NMBI) – but they are not under CORU's remit at this time.

Within that context, significant work has been undertaken over the years on the constitution and measurement of competence within individual counselling and psychotherapy modalities – though because of ideological discourses relating to whether or not there are proficiency differences between both have often meant that the proficiencies are or have been conflated.

While they need to be considered within that context, some of the frameworks provide potential insights which might enhance the work completed to date by CORU and inform Domain 5 in particular in terms of both Counselling & Psychotherapy. For example, Roth and Pilling (2007) cite 5 key domains of core competence for CBT therapists. These are presented as over 50 individual competencies, but the model of the 5 Domains arguably holds some promise for broader application, in the context of threshold level entry to either Counselling or Psychotherapy. This would seem to provide a useful framework for articulating CBT domains of competence. They cite the following, which would seem (with modification) to be able to be applied more widely within either a Counselling or Psychotherapy context:

- Generic therapeutic competences (e.g., knowledge of mental health problems, ability to engage patient);
- Basic CBT competences (e.g., knowledge of CBT principles, ability to explain CBT rationale);
- Specific CBT techniques (e.g., guided discovery, use of thought records);
- Problem-specific competences (e.g., interventions outlined in disorder-specific treatment manuals);
- Metacompetences (e.g., capacity to select and apply most appropriate CBT method).

In the case of the Psychotherapy Proficiencies, that approach may be useful as a model to present the proficiencies proposed under the following types of categories or sub domains (or similar) of threshold level professional practice, so as to ensure that readers of the Standards can link them to specific Psychotherapy abilities and skills – underpinned by appropriate psychotherapy knowledge.

The following table presents some suggestions to try to focus the proposed Proficiencies on key categories of competence specific to Psychotherapy. Hopefully they will prove useful in the consultation process. However, it is also the case that Competence in areas such as cultural awareness and responsiveness or inclusive practice are not included. These generally would be assumed to be more appropriate to broader based competence or proficiencies.

CORU Draft Proficiencies for Psychotherapy	Knowledge Application in Psychotherapy Practice	Psychotherapy Assessment & Case Formulation competence	Psychotherapy Intervention Competencies (Application & Evaluation)	META COMPETENCIES	COMMENTS
Graduates will: 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.	Applicants for Registration will: Demonstrate adherence to and competence in the use of evidence-informed PSYCHOTHERAPY practice.	Applicants for Registration will:	Applicants for Registration will:	Applicants for Registration will:	While Applicants for Registration will be expected to be graduates, would it not be more appropriate to refer to them as Applicants in the context of an application to join a regulatory professional register?

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.	Apply knowledge from a range of biological, social and behavioural and other related sciences, together with knowledge of human development theories, health and wellbeing, disease, disorder and dysfunction relevant to Psychotherapy practice.				
Know and understand the principles and applications of scientific enquiry, including the evaluation of treatment/intervention efficacy, the research process and evidence-informed practice.					This seems a more generic Proficiency which would be more appropriate in Standards 1 - 4
Demonstrate skills in evidence-informed practice, including translation of theory, concepts and methods to clinical/professional practice.				Demonstrate skills in the application of evidence-informed practice, including translation of theory, concepts and methods to Psychotherapy practice.	

Be able to identify and understand the impact of organisational, community and societal structures, systems and culture on health and social care provision.						This seems a more generic Proficiency which would be more appropriate in Standards 1 - 4
Demonstrate safe and effective implementation of practical, technical and clinical skills.					Be able to work within a framework based upon scientifically established psychotherapeutic theory and practice.	
Demonstrate ability to participate in or lead clinical, academic or practice-based research.	Demonstrate ability to participate in practice-based research.					If the level of Education required remains at Level 8 then leading academic or practice based research would normally be beyond a level 8 competence.
Know the basic principles of effective teaching and learning, mentoring and supervision.	Demonstrate effective competence in practice based education, preceptorship, mentoring, coaching and practice education/supervision.					While the issue of professional learning is vital, if practitioners are, for example to engage in supporting student learning or engage in psychoeducational activities, the core proficiencies would seem to be more appropriate in terms of teaching, preceptorship, mentoring, coaching and practice education/supervision

Be able to appraise the benefits, limitations and contraindications of differing psychotherapeutic approaches.				Be able to appraise the benefits, limitations and contraindications of differing psychotherapeutic approaches.	
Be able to apply a chosen theoretical model to assess the service users' suitability for the type of therapy offered.		Be able to apply a chosen theoretical model to assess the service users' suitability for the type of psychotherapy offered			
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.			Be able to utilise a chosen psychotherapy model as appropriate for a wide range of presenting issues of varying degrees of complexity and severity, and across a wide range of diagnoses to support therapeutic change.		

Be able to critically appraise current policies applicable to the role of psychotherapy in the development and implementation of policy on health and social care on a national and international level.				Be able to critically appraise current policies applicable to the Psychotherapy in the development and implementation of policy on health and social care on a national and international level.	
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.				Be able to reflect on the impact of the service user's experience, feelings and emotions and communicate that understanding in a non-judgemental manner.	
Be able to review the therapeutic process and progress with the service user, and make adjustments in collaboration with the service user.				Be able to review & evaluate progress with the service user, and make appropriate adjustments informed by Service user experience.	

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.		Be able to identify and critically evaluate how psychosocial as well as wider ecological factors may effect both the service user and the therapeutic process	Be able to mitigate psychosocial as well as wider ecological factors which might have an extraneous influence on the progress of psychotherapy and the therapeutic relationship.		
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.				Be able to establish, build, maintain and conclude a long-term Psychotherapy relationship in a safe and ethical manner.	
Be able to use psychotherapeutic skills to build therapeutic relationships including the ability to demonstrate active listening skills.					This seems superfluous and arguably is not inherently different to the previous Proficiency

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.					Not clear how this essentially differs from the Proficiency that suggests "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" except for the specific issue of contracting and re-contracting – arguably they could be combined.
Be able to write concise, accurate and relevant reports which articulate and justify professional decisions made.					Be able to write accurate and relevant reports which articulate and justify professional decisions made.
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.					It is unclear why 'concise' is stipulated. Reports should be appropriate, irrespective of their length. They should also be GDPR and Data Protection compliant! Sometimes it may be extraneous factors that influence boundaries, so unclear how it might be wise to assume there is ever only one client – this would not be the case in Group work. So would suggest leaving this a little more open. Be able to reflect on and critically analyse the factors that influence therapeutic boundaries and the dynamics of the therapeutic relationship.

Be able to recognise personal emotional responses, vicarious trauma and the need to develop effective self-care strategies and burnout prevention.				Be able to recognise personal emotional responses, vicarious trauma and the need to develop effective self-care strategies to ensure optimal capacity to therapeutically engage with service users.	I'm not sure it is necessary to be explicit on burnout.
Be able to maintain professional and ethical boundaries with service users and be able to identify and manage any associated challenges.				Be able to maintain professional and ethical boundaries and be able to identify and manage any associated challenges.	Ethical Boundaries apply to other professionals, concerned persons as well as employers and others in addition to service users
Be able to practise therapy that is within psychotherapist's level of skill, knowledge and professional judgement.				Be able to practice therapy that is compatible with Threshold Standards of Proficiency.	There is an argument that this is the overall aim of the registrant's application and that this is superfluous. Perhaps if it needs to be included, it might be set at threshold level, which would seem to be consistent with what has been set out in relation to Threshold levels of practice.

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.			Be able to critically reflect on inter and intrapersonal dynamics in the therapeutic process and be able to manage their personal and professional involvement in, and contribution to, the process of psychotherapy.		While there is absolutely no inherent problem with reflecting on conscious or subconscious or unconscious dynamics, this seems a little limiting and arguably applicants for threshold level entry to Psychotherapy practice should be required to critically reflect on any and all dynamics
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.					While this seems reasonable at one level, given that it seems framed as a CLINICAL Supervision proficiency, there is an argument that it has no place in this list of proficiencies as the issue of Practice Based Teaching and Practice Supervision has already been addressed?
Be able to articulate the parameters and value of clinical supervision and demonstrate the ability to utilise supervision to assist in practice review and in areas for development.					While this seems reasonable at one level, given that it seems framed as a CLINICAL Supervision proficiency, there is an argument that it has no place in this list of proficiencies as the issue of Teaching and Practice Supervision has already been addressed?

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.		Be able to apply technologies and communication methods required for the delivery of therapy in a virtual setting therapeutically and safely while protecting privacy and confidentiality.			The privacy is for everyone concerned.
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.	Be able to identify, distinguish and critically evaluate the level and impact of trauma on psychological functioning			Be able to work within scientifically supported Psychotherapy approaches with service users who have experienced trauma.	I'd suggest dividing this into two proficiencies, one associated with Knowledge application and one associated with meta-competencies
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.		Be able to identify potential risk for harm (including suicide, self-harm or harm to others).	Be able to implement early Psychotherapeutic management strategies where appropriate.	Be able to support the immediate safety of the service user or others, and make referrals for additional treatment and/or agencies including statutory agencies with responsibility for safety and/or safeguarding where	I'd suggest that Psychotherapists need to be able to engage with Risk Management broadly (and that might be covered in Domain 3 or 4, but in cases of Harm, that is clearly stipulated as a Proficiency. I think it might be useful to divide it into Assessment Proficiencies as well as intervention ones related to Psychotherapy and a Meta competence associated with

					appropriate	Safety. In cases of potential harm to others, referrals to other sources may not be 'treatment' referrals
Be able to demonstrate knowledge of crisis intervention and prevention and be able to work with people in crisis for improved outcomes.	Apply knowledge of crisis intervention and prevention within Psychotherapy practice		Be able to engage in health/wellbeing promotion/prevention practices or support crisis intervention.			
Have a critical awareness of the need for organisation and resource management for practice.						It's not clear why this is a proficiency specific to Professional Knowledge and Skills related specifically to Psychotherapy. Would this not be more relevant within more core domains (Domains 1 – 4)
Be able to demonstrate an understanding of the impact of pharmacological use and history on psychological functioning and recognise potential implications for service users.	Be able to integrate an understanding of pharmacokinetics and pharmacodynamics within Psychotherapy practice	Be able to assess and plan interventions appropriately where there has been a history of substance use, misuse including prescribed medications and illicit substances	Be able to engage in Psychotherapy interventions appropriately where there has been a history of substance use or misuse including prescribed medications and illicit substances	Be able to recognise potential additional/alternative service needs and refer to other services/professionals when and if appropriate		

Feedback on the Draft Proficiencies for Counselling

CORU Draft Proficiencies for Counselling	Knowledge Application in Counselling Practice	Counselling Assessment & Case Formulation competence	Counselling Intervention Competencies (Application & Evaluation)	META COMPETENCIES	COMMENTS
Graduates will: Know, understand and apply the key concepts of the domains of knowledge which are relevant to the profession.	Applicants for Registration will: Demonstrate knowledge and understanding of the key concepts of the domains of knowledge which are relevant to the Counselling profession.	Applicants for Registration will:	Applicants for Registration will:	Applicants for Registration will:	While Applicants for Registration will be expected to be graduates, would it not be more appropriate to refer to them as Applicants in the context of an application to join a regulatory professional register?
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.	Demonstrate a critical understanding of relevant biological sciences, human development, social and behavioural sciences and other related sciences, together with a knowledge of health			Demonstrate adherence to and competence in the use of evidence-informed Counselling practice. Apply knowledge from a range of biological, social and behavioural and other related sciences, together with knowledge of human development theories, health and wellbeing, disease, disorder and	

	and wellbeing, disease, disorder and dysfunction.			dysfunction relevant to Counselling practice.	
Know and understand the principles and applications of scientific enquiry, including the evaluation of treatment/intervention efficacy, the research process and evidence-informed practice.	Demonstrate an understanding of the principles of scientific enquiry, including the evaluation of Counselling treatment/intervention efficacy, the research process and evidence-informed practice.			Apply the principles of scientific enquiry, including the evaluation of Counselling treatment/intervention efficacy, the research process and evidence-informed practice.	This seems a more generic Proficiency which would be more appropriate in Standards 1 – 4, but if it is appropriate to include it in Profession Specific Proficiencies, then the wording here may help?
Demonstrate skills in evidence-informed practice, including translation of theory, concepts and methods to clinical/professional practice.			Demonstrate skills in the application of evidence-informed practice, including translation of theory, concepts and methods to Counselling practice.		

Be able to identify and understand the impact of organisational, community and societal structures, systems and culture on health and social care provision.					This seems a more generic Proficiency which would be more appropriate in Standards 1 - 4
Demonstrate safe and effective implementation of practical, technical and clinical skills.				Be able to work within a framework based upon scientifically established Counselling theory and practice.	
Demonstrate ability to participate in or lead clinical, academic or practice-based research.				Demonstrate ability to participate in academic or practice-based research related to Counselling theory and/or Practice.	If the level of Education required remains at Level 8 then leading academic or practice based research would normally be beyond a level 8 competence.
Know the basic principles of effective teaching and learning, mentoring and supervision.				Demonstrate effective competence in practice based education, preceptorship, mentoring, coaching and practice based education/supervision.	While the issue of professional learning is vital, if practitioners are, for example to engage in supporting student learning or engage in psychoeducational activities, the core proficiencies would seem to be more appropriate in terms of teaching, preceptorship, mentoring, coaching and practice based education/supervision

Be able to outline typical presentations from mild to severe presenting concerns and be able to treat presenting concerns, within the limits of their knowledge skills and competence or refer to another professional.	Be able to outline typical presentations from mild to severe presenting concerns which are relevant to Interventions.	Be able to appraise the benefits, limitations and contraindications of differing Counselling approaches.	Be able to treat presenting concerns, within the limits of their knowledge skills and competence	Be able to refer to another professional where or if appropriate.	
Be able to practise counselling that is within counsellor's level of skill, knowledge and professional judgement.		Be able to apply a chosen theoretical model to assess the service users' suitability for the type of Counselling offered			
Be able to demonstrate the ability to use counselling skills to convey empathic understanding and to be informed by and connect compassionately to the perspective of the service user.			Be able to utilise a chosen Counselling model as appropriate for a wide range of presenting issues and demonstrate the ability to use core counselling skills in therapeutic engagement with service users.		

Be able to use counselling skills to build therapeutic relationships including the ability to demonstrate active listening skills.				Be able to use counselling skills to build therapeutic relationships including the ability to demonstrate active listening skills.	
Be able to analyse the theories of therapeutic relationship dynamics and be able to establish, build, maintain and conclude a therapeutic relationship with a service user.	Be able to analyse the theories of therapeutic relationship dynamics		Be able to establish, build, maintain and conclude a therapeutic relationship with a service user.		Very challenging to see why the second element of the proposed proficiency is essentially different from the previous one. The analysis of theories is essentially a knowledge competence.
Be able to collaborate with the service user to set specific goals for change; to re-contract goals and timeframes as necessary.		Be able to collaborate with the service user to set specific goals for change;		Be able to re-contract goals and timeframes as necessary.	
Be able to recognise and manage the dynamics of power and authority as experienced in the therapeutic relationship.			Be able to recognise and manage the dynamics of power and authority as experienced in the therapeutic relationship.		
Be able to orient service users to the counsellor approach and explain the responsibilities of the counsellor in a therapeutic relationship.				Be able to orient service users to the counsellor approach and explain the responsibilities of the counsellor in a	

					therapeutic relationship.	
Be able to initiate and manage engagement by developing rapport and trust.					Be able to initiate and manage engagement by developing rapport and trust.	
Be able to identify professional and ethical boundaries with service users and be able to identify and manage any associated challenges.					Be able to identify professional and ethical boundaries with service users and be able to identify and manage any associated challenges.	Not clear how this essentially differs from the Proficiency that suggests "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" except for the specific issue of contracting and re-contracting – arguably they could be combined.
Be able to critically reflect on the role of the counsellor in the therapeutic process and be able to manage personal involvement in, and contribution to, the process of counselling.				Be able to critically reflect on the role of the counsellor in the therapeutic process and be able to manage personal involvement in, and contribution to, the process of counselling.		It is unclear why 'concise' is stipulated. Reports should be appropriate, irrespective of their length. They should also be GDPR and Data Protection compliant!

Be able to articulate the necessity of engaging in clinical supervision to support, sustain and improve practice.				Be able to articulate the necessity of engaging in clinical supervision to support, sustain and improve practice.	Sometimes it may be extraneous factors that influence boundaries, so unclear how it might be wise to assume there is ever only one client – this would not be the case in Group work. So would suggest leaving this a little more open.
Be able to recognise personal emotional responses, vicarious trauma and the need to develop effective self-care strategies and burnout prevention.				Be able to recognise personal emotional responses, vicarious trauma and the need to develop effective self-care strategies and burnout prevention.	I'm not sure it is necessary to be explicit on burnout.
Be able to demonstrate skill in the technologies and communication methods required for the delivery of counselling in a virtual setting and be able to apply these therapeutically and safely while protecting user privacy and confidentiality.				Be able to demonstrate skill in the technologies and communication methods required for the delivery of counselling in a virtual setting and be able to apply these therapeutically and safely while protecting service user privacy and confidentiality.	Ethical Boundaries apply to other professionals, concerned persons as well as employers and others in addition to service users
Be able to appraise theories and research on mental health and obstacles to wellbeing and be able to use these to facilitate improved				Be able to appraise theories and research on mental health and obstacles to wellbeing and be able to use these to	There is an argument that this is the overall aim of the registrant's application and that this is superfluous. Perhaps if it needs to be included, it might be set at threshold level, which would

treatment outcomes.				facilitate improved treatment outcomes.	seem to be consistent with what has been set out in relation to Threshold levels of practice.
Be able to utilise a theoretical framework for practice with psychosocial factors and the impact on well-being.			Be able to utilise a theoretical framework for practice with psychosocial factors and the impact on well-being.		While there is absolutely no inherent problem with reflecting on conscious or subconscious or unconscious dynamics, this seems a little limiting and arguably applicants for threshold level entry to Psychotherapy practice should be required to critically reflect on any and all dynamics
Be able to analyse the impact of trauma on psychological functioning and be able to integrate this knowledge to inform practice.		Be able to analyse the impact of trauma on psychological functioning and be able to integrate this knowledge to inform practice.			While this seems reasonable at one level, given that it seems framed as a CLINICAL Supervision proficiency, there is an argument that it has no place in this list of proficiencies as the issue of Practice Based Teaching and Practice Supervision has already been addressed?
Be aware of the potential for harm to the service user in exploring trauma therapeutically, understand the need to refer on and be able to identify suitable referral pathways.	Be able to apply knowledge of factors associated with potential for harm to the service user in exploring trauma therapeutically			Be able to refer onwards to other professionals/services where appropriate and be able to engage with suitable referral pathways.	While this seems reasonable at one level, given that it seems framed as a CLINICAL Supervision proficiency, there is an argument that it has no place in this list of proficiencies as the issue of Teaching and Practice Supervision has already been addressed?

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.		Be able to identify potential risk for suicide, self-harm or harm to others.	Be able to implement early management, supporting the immediate safety of the service user, and make referrals for additional treatment where appropriate.	The privacy is for everyone concerned.	I'd suggest that Counsellors need to be able to engage with Risk Management broadly (and that might be covered in Domain 3 or 4, but in cases of Harm, that is clearly stipulated as a Proficiency. I think it might be useful to divide it into Assessment Proficiencies as well as intervention ones related to Counselling Assessment & Interventions proficiencies. In cases of potential harm to others, referrals to other sources may not be 'treatment' referrals
Be able to demonstrate knowledge of crisis intervention and prevention and be able to work with people in crisis for improved outcomes. Have a critical awareness of the need for organisation and resource management in various practice settings.	Be able to apply knowledge of crisis intervention and prevention.		Be able to work with people in crisis for optimal outcomes.		I'd suggest dividing this into two proficiencies, one associated with Knowledge application and one associated with meta-competencies
				Have a critical awareness of the need for organisation and resource management in various practice settings.	

Be able to demonstrate knowledge of the effects of medications, prescribed or otherwise, relevant to service user counselling work.	Be able to integrate an understanding of pharmacokinetics and pharmacodynamics within psychotherapy practice	Be able to assess and plan interventions appropriately where there has been a history of substance use, misuse including prescribed medications and illicit substances	Be able to engage in psychotherapy interventions appropriately where there has been a history of substance use or misuse including prescribed medications and illicit substances	Be able to recognise potential additional/alternative service needs for service users and refer to other services/professionals when and if appropriate	
					it's not clear why this is a proficiency specific to Professional Knowledge and Skills related specifically to Psychotherapy. Would this not be more relevant within more core domains (Domains 1 – 4)

Reflections on Personal Therapy

There is little doubt that the use of and experience of Personal therapy is valued within Counselling and Psychotherapy training. McMahon (2018) traces the value placed on personal therapy to the traditions and evocation of Freud's (1937/1964, p. 246) early edict on the matter (*"But where and how is the poor wretch [the trainee analyst] to acquire the ideal qualifications which he will need in his profession? The answer is in an analysis of himself"*). However, just as much as it is valued as a process, there are competing and polarised views on whether or not it is necessary within different psychological and psychotherapeutic traditions. Interestingly McMahon (2018) highlights some of these variations in traditions, noting that:

"Clinical psychology, social work, psychiatry, and cognitive-behavioural therapy (CBT) trainings have not traditionally mandated personal therapy, not considering it necessary for effective practice. In contrast, counselling psychology, psychodynamic, humanistic, and integrative psychotherapy trainings have normally mandated it, weighting it as an essential aspect of practitioner development"

Some evidence of the arguments presented by those who have a tradition of mandated personal therapy within their training is evident in a study by Grimmer and Tribe (2001) examining counselling psychologists' perceptions of the impact of mandatory personal therapy. That study reported their beliefs that:

"mandatory personal therapy can lead to perceived positive outcomes in terms of professional development including: a sense of the self as a professional through developing reflexivity as a result of being in the role of client; socialization into a professional role through validational and normative experiences such as the therapist modelling good and poor practice; support during times of personal difficulty; and, personal development that leads to a perceived improved ability for the participant to distinguish between personal issues and those of the client. An important effect for participants who did not have a previous substantial experience of personal therapy appeared to be the validation of therapy as an effective psychological intervention".

Those findings point, more broadly, to the value of opportunities to enhance Personal and Professional Development and certainly Personal and Professional Development (PPD) is generally considered as "a hallmark of counselling psychology" by the Psychological Society of Ireland (PSI, 2013, p. 13), building on earlier arguments that PPD is explicitly valued within clinical (as opposed to counselling) psychology as a criterion of competent, ethical practice (Hughes & Youngson, 2009).

PPD activities include those which support trainees or practitioners to develop a:

"capability to reflect critically and systematically on the work-self interface ... directed towards fostering personal awareness and resilience" (Gillmer & Marckus, 2003, p. 23).

Interestingly, engagement in PPD and development of self-awareness and self-care competence (PSI, 2009), or engagement in personal and professional development (PPD; British Psychological Society [BPS], 2016), are required during training for clinical psychology, with some instances where the inclusion of personal therapy may be mandated.

However, the key question, does not relate to the perceived benefits of engagement in personal therapy in terms of personal development, professional development and a depth level appreciation

of the experience of 'being a client', there is also some evidence based on qualitative research among those who have engaged in mandatory personal therapy that (in some instances) it increases levels of stress (Kumari, 2011).

Likewise in an Irish study among psychologists, differences emerged between Clinical and Counselling Psychologists (McMahon, 2018). This study reports divergent and indeed polarised views on the issue of mandated personal therapy, while not in any way questioning the value of the experience itself. McMahon (2018) reported that more counselling psychologists emphasised the "dangers and questionable efficacy of psychologists practising psychotherapy without personal therapy experience" while simultaneously, there was evidence of "more clinical psychologists questioning the efficacy and ethics of imposing a mandate on trainees". Interestingly, the study highlighted that there is strong professional endorsement for the perceived value of personal therapy in terms of clinical and professional development, there is little empirical evidence of the impact on the quality of therapeutic engagement or client outcomes or indeed that there may be similar impacts in the case of a range of other as PPD activities.

A key concern with most research undertaken on this topic relates to the type and focus of the research. While this does not purport to be a systematic review of existing research, there is little doubt that much of the research has focussed on the perceptions of the value of Personal Therapy among practitioners or trainees, who are nearly universally mandated to engage in personal therapy (perhaps with the interesting exception of McMahon's (2018) Irish study) – though that study did also focus on the subjective experience of professionals.

Chaturvedi (2013:455) makes the interesting point that

"while subjective methods are essential to answer questions about how therapists feel their personal therapy has impacted them, they do not offer answers to the second question. Even if therapists' opinions offer a favourable view of personal therapy, the fact that this has not translated into findings that show differences either in therapeutic outcomes for clients or in clients' perceptions of the therapy process indicates that the link between theory, research and practice is incomplete".

Another key concern relates to somewhat more fundamental concerns. The widespread support for mandatory engagement with Personal Therapy as the only means of enhancing 'self-knowledge' is strongly influenced by therapeutic ideologies and traditions. Orlinsky, Geller and Norcross (2005) note that analytic and humanistic modalities have traditionally perceived engagement in personal therapy as a means of personal growth, even in the absence of specific problems. Conversely, in broadly cognitive and behavioural traditions, therapy engagement should be undertaken where it is warranted by the presence of manifestations of symptoms. Within that tradition, it has generally been the practice that a universal requirement for all trainees is inconsistent with such an ideology. Indeed, Laireiter & Willutzki (2005) argue that there should be an unambiguous distinction between training and therapy undertaken to deal with personal problems by students in training.

In a review undertaken by Chaturvedi (2013) as well as the paper by McMahon (2018) it was noted that in the UK, the British Association for Counselling & Psychotherapy removed the mandatory requirement for engagement in Personal Therapy in 2006.

In a commentary on that development Murphy et al (2018) argued that:

"Atkinson (2006), however, has claimed that developing a high level of self-awareness during training does not require mandating personal psychotherapy. He argues other

methods not involving the same emotional and financial demands can be equally effective. Atkinson (2006) suggests that personal development groups are an alternative to the expensive and, time intensive, mandatory personal psychotherapy. Additionally, mandating personal psychotherapy might send a signal to trainees that this is all that is required to develop as a self-aware practitioner”.

Chaturvedi (2013:456) also noted the emphasis placed on personal ‘commitment’ to engage in therapy and highlighted that its framework takes an oppositional stance to violating any clients will, by imposing therapeutic engagement on them. The paper correctly questions how such a commitment to personal choice is inconsistent with mandated therapy for students, rather than on engagement on the basis of choice and informed decision making.

“The need for personal growth is a subjective one and is best assessed by clients. Consequently, the decision to enter therapy for personal growth should ideally be an autonomous one based on the clients’ sense of how they feel”.

There is arguably a certain elitism and exclusivity also associated with mandatory or prescribed engagement in Personal Therapy. This sense of elitism and exclusivity may be seen in the assertion of Geller et al. (2005, p. 3), that:

“Personal therapy or analysis is, in many respects, at the centre of the mental health universe. Our training, our identity, our health and our self-renewal revolve around the epicenter of personal therapy experience”.

Kumari (2011;212) , drawing on the work of McLeod (2003), presents some compelling arguments for what competencies are needed for the provision of therapy within different traditions, suggesting the following:

“A heightened awareness of the self is seen as a fundamental aspect of the majority of approaches to therapy, particularly those that aim to help clients change their behaviour or cognitive processes. For example, psychodynamic and psychoanalytically oriented training courses either require or strongly recommend that trainees enter personal therapy during their training. This is because they have to be able to distinguish between counter transference reactions that occur as a result of the client’s transference and reactions that are projections of their own unresolved issues. Adequate self-awareness is also essential to ensure that the therapist does not become completely overwhelmed by seeing clients who are often extremely distressed. It is argued that whilst the majority of people with whom clients may discuss their problems with, may not completely absorb the intensity of their emotional pain, therapists cannot use such defences and must develop ways of being with their clients during their despair, and personal therapy is seen as the ideal opportunity in which to develop such skills (McLeod, 2003)”.

The assumption that Personal Therapy is the exclusive means of attaining personal insight does not seem to be well founded or based on empirical evidence either and other disciplines involved in the ‘mental health universe’ do not necessarily share the same worldview. Likewise, even if it is ‘the ideal opportunity in which to develop such skills’, there are compelling arguments why it should be engaged with on an informed and voluntary basis rather than through compelling students to engage in such opportunities – normally with significant additional financial as well as potential emotional costs.

Ivey & Phillips (2016) noted that a series of previous studies highlighted some possible negative effects, noting:

"Of the reported negative effects, psychological distress arising from confronting one's own psychic 'woundedness' is the most common (Grimmer & Tribe, 2001; Macaskill & Macaskill, 1992; Macran, Stiles, & Smith, 1999; Malikioti-Loizos, 2013; Norcross & Connor, 2005). Importantly, some studies suggest that this personal distress may bleed into the therapist's own work, thereby making them less therapeutically effective (Clark, 1986)".

In one of the few systematic reviews undertaken, that of Murphy et al (2018), noted the contention evident in terms of a risk/benefit axis referred to above, as well as the dearth of quality studies in the field. The authors highlighted the arguments that proponents cite, mainly that mandatory personal therapy acts as an essential means of protecting the public, keeps clients safe and as a means of ensuring that psychotherapists develop high levels of self-awareness and gain knowledge of interpersonal dynamics; as well as enhancing therapist effectiveness. They also note that engagement in personal therapy is expensive, emotionally demanding and time-consuming.

In their systematic review, three positive and three negative themes emerged. The positive findings were identified as personal and professional development, experiential learning and therapeutic benefits. Negative findings related to ethical imperatives do no harm, justice and integrity.

In summary, there appears to be broad consensus that engagement in personal therapy has benefits for practitioners and is subjectively highly valued within the professional Counselling, Psychotherapy and Psychological community. The quality of the empirical evidence supporting the objective value in terms of therapeutic benefits for clients is equivocal at best and needs further study.

Ideologically, while practitioners in some traditions, especially humanistic, client centred and integrative approaches proclaim a strong value on the importance of voluntary engagement by clients, it seems inconsistent with that worldview to force personal therapy on students who may or may not have overt manifestations of mental health challenges. It also seems to place exclusive value on one modality of achieving personal insight as well as professional development, which may lead to missed opportunities to learn and grow and also it presents a danger that trainees may assume that personal therapy automatically makes them superior to those who may have achieved personal development and growth in alternative ways.

It may also be a somewhat 'lazy' approach on the part of Educators and Professional Accreditation or regulatory bodies to mandate a process of value. Educators and regulators should be able to articulate the evidence base and empirical support for the inclusion of any training requirement rather than simply force all participants to engage in the practice. Training Bodies, Regulators and others need to be conscious of the fairness of imposing additional costs on students, where or if there are alternative means of achieving the same training goals.

Imposing additional costs may negatively impact on the ability of those who come from socioeconomically deprived backgrounds and impede access to training. For these as well as other reasons, it should be recommended to CORU that engagement in Personal Therapy should be voluntary, rather than mandated.

It would be hoped that Programmes should and would continue to act as professional gatekeepers and consequentially evaluate evidence of preparedness to engage in professional practice, but they should equally seek to ensure that no practice mitigates against access to training because of

financial burden and perhaps more fundamentally allow students to make truly informed decisions to engage (or not) in Personal Therapy.

Clinical Supervision and Clinical Education for Student Counsellors & Psychotherapists

Clinical Supervision has multiple definitions and it is not the purpose of this element of my submission to dwell too long on definitional clarity. However, one of the more common understandings of Clinical Supervision is that it involves;

“the formal provision by senior/qualified health practitioners of an intensive relationship-based education and training that is case-focussed and which supports, directs and guides the work of colleagues” (Milne, 2007:437)

Clinical Supervision has a long standing and valued place in the practice of both counselling and psychotherapy as well as in educational approaches in these fields of practice. It is arguable that Clinical Supervision offered in conjunction with theoretical components as well delivered through lectures, seminars, course work and, not infrequently, personal therapy, as well as experiential practice based learning is a fundamental component of a student's overall learning journey and foundational in terms of skills acquisition, finding meaning in practice, enhancing ethical consciousness and contributing to professional development.

From a research perspective, there is a fairly consistent body of work to suggest that students or novice practitioners (in particular, though not exclusively) find clinical supervision helpful when restorative, formative and normative needs are met and where the supervisor was reliable as well as having opportunities for problem solving, reassurance and in the case of novice practitioners - direct guidance on clinical work (Hall, Kasujja and Oakes, 2015). Conversely, unreliability was not reported as helpful (Waldson & Byrne, 2014: East 2011)

It would appear, therefore that consistency, availability, professional knowledge, facilitation skills and having an educative ethos are key competencies associated with the promotion and maintenance of clinical competence. Clearly, the centrality of work based learning and clinical education is fundamental to student learning – in particular authentic learning in health related disciplines.

Work – based learning clearly affords opportunities to develop, refine, correct and enhance skills under expert supervision. While clinical education is frequently designed to develop and practice discipline specific skills, they also frequently afford the opportunity to vicariously learn through interdisciplinary engagement.

CORU's proposals in relation to work based learning are very welcome. They highlight and prioritise the development of authentic proficiencies in work based contexts and this emphasis is very welcome. The standards advocate (correctly) the centrality of oversight and practice based supervision and suggest the use of Clinical Educators. As a principal that makes sense. However, it should not be seen as a panacea for all shortcomings of Clinical Education. There is some evidence that in health care settings, opportunities to engage in meaningful and structured learning can be compromised when patient/client caseloads are high (O'Keefe, Wade, McAllister, Stupans, Miller, Burgess, LeCouteur, and Starr, 2014). Arguably this might partly help explain why the high reliance on external clinical supervision within Counselling and Psychotherapy as an almost exclusive means of supporting clinical education has emerged and has been sustained.

CORU's distinction between Clinical Supervision and Clinical Practice Supervision is therefore welcome but it will challenge extant professional training norms. That challenge should be met with enthusiasm and embraced. There are models of Clinical education in other disciplines, which can inform the evolution of Clinical Educators in these fields. Drawing on Physiotherapy practice, Gibson

et al, (2019) note that “a clinical educators’ typical responsibilities include facilitation of student learning, assessment of student performance, assisting underperforming students, and managing challenging situations” (Gibson, Porter, Anderson, Bryce, Dart, Kellow, Meiklejohn, Volders, Young, Palermo (2019).

In principal it would seem to be challenging to see logical arguments opposing the reliance on Clinical Educators, except their development has largely occurred in disciplines where there are more structured support and interdisciplinary work and within larger organisations. The current ecosystem of Counselling and Psychotherapy in Ireland is somewhat different. Many Counselling & Psychotherapy practices are small practices within the Voluntary and Community sector, so the ability to structure (for example) video recorded sessions or use two way mirror arrangements may not be immediately as feasible as they would in existing training hospitals (as an example). This is not to argue against them, but is suggesting that there may need to be an incremental approach necessary.

There is evidence that Clinical Educators are motivated to assume such roles on the basis of

“a sense of professional duty, perceptions regarding personal benefits, suitability of workplace, level of support, associated challenges, and readiness to assume the role”
(Newstead, Johnston, Wakely, and Nisbet, 2023:8).

Whilst it is wholly understandable from a management perspective to rely on Clinical Educators, most of whom undertake these roles on a voluntary basis, there is a danger that such an approach might be somewhat overly reductionist and may reduce opportunities for students in any discipline to miss opportunities for interdisciplinary influences and therefore needs some consideration.

Other models of Clinical Education involves facilitated learning by Clinical Educators from the College linked to Clinical Sites. Within these models, Clinical Education sessions might be structured on a regular basis and may include feedback from Service Users with whom the student is working as well as practitioners within the work placement.

Irrespective of the specific model, the distinction between Clinical Supervision and Supervision of Practice Education makes a significant contribution to professional discourse in these fields of practice and while there is certainly some overlap between the functions and attributes of Clinical Educators (e.g. provision of skilful feedback; teaching skills; fostering collaborative learning; understanding expectations; organisation and planning) and Clinical Supervisors, the promotion of this model of Clinical Educative roles is welcome. There is also little doubt that irrespective of the model used – there is a need for integration between academic and clinical educators, with a mutually supportive engagement between both necessary. While clinical educators, may need support from their academic educator colleagues to enable them to perform their clinical teaching and assessment duties in a means consistent with curricular demands, there is equally evidence that collaboration between academic and healthcare institutions is vital Duteau (2011).

Finally, while not directly related to the published draft standards for educational programmes, the issue of the transition from current programmes to programmes which will need to be modified to meet the eventual Standards needs to take due cognisance of those either on existing (legacy) programmes or those who have completed such programmes and who may have not been in pre-accreditation for a sufficient period of time to meet existing ‘grandparenting’ arrangements to facilitate entry to the Register. The college is of the firm view that appropriate arrangements need to be put in place to properly and fairly manage the interregnum period. While the focus of CORU

correctly needs to be on the protection of the public, no student on programmes or in the immediate aftermath should be disadvantaged. We do not see that as being in the public interest and we are confident that CORU will be mindful of their right to fair process.

In summary, Clinical Supervision has a well-established and valued place in the practice of both counselling and psychotherapy as well as in educational approaches in these fields of practice. There is a fairly consistent body of work to suggest that students or novice practitioners (in particular, though not exclusively) find clinical supervision helpful, but it arguably should not be the only or primary means of providing structures to support competence development and professional identity.

There is some evidence that immediacy as well as consistent availability of clinical education structures are important. CORU's distinction between Clinical Supervision and Clinical Practice Supervision is welcome but it will challenge extant professional training norms. That challenge should be met with enthusiasm and embraced, but it is not necessarily a panacea for all ills and needs to be monitored and be open to modification if the model needs change.

There is a need for integrative approach between academic and clinical educators, with a mutually supportive engagement between both necessary.

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A dhaoine uaisle,

The standardisation of requirements for counselling and psychotherapy in Ireland is very welcome. Increasing the standards also makes sense in my opinion, and indeed I think that higher standards than those proposed would be beneficial in areas like the module composition of courses. But, as a trainee psychotherapist and a disabled woman with a baby, I am conscious of the fact that the draft placement guidelines would likely exclude me from the field if I was starting my training under these requirements. And my experiences have indisputably been an asset to me as a therapist. I have major concerns about 1) **accessibility** and 2) **cost barriers**. (I refer mainly to the psychotherapy requirements in the following, but the same points are true for the counselling requirements also.)

- 1) The requirement for 500 hours physically on-site and no allowance for remote hours is particularly limiting. Requirement for solely or mostly on-site hours limits accessibility in the following ways:
 - For trainees with disabilities, finding an **accessible premises** and **suitable transport** can be extremely challenging.
 - For those with **fatiguing or painful** conditions, it is often much more difficult to work in an office than at home with their **own set-up and no commute**.
 - For **clients with physical disabilities or certain mental health issues** (e.g. agoraphobia), remote therapy may be the only realistic option. And given that disabled people often live in poverty due to the fact that the maximum disability payment amounts to less than €12,000 per year, they often need to avail of **low-cost therapy** such as that provided by trainees. Certain **services** (for example Turn2Me.ie, funded by the HSE) would have to drastically scale back or cease services if students **could no longer count online hours** towards qualification.

Given that the overwhelming weight of **evidence suggests remote therapy is equally effective to in-person therapy** (see for example the comprehensive APA-published meta-analysis by Lin et al (2021)), excluding remote hours from consideration without any exception for disability would amount to **unfair discrimination and a lack of reasonable accommodation**. It is also extremely important in fields such as psychotherapy that deal with many clients experiencing disability that disabled people are not unfairly excluded from training. Coru is a body given its remit by the State and it has a **moral and, quite possibly, legal obligation** to ensure reasonable accommodations for disability.

- 2) The second concern I have in relation to the new requirements would be around **cost and practicality** for even non-disabled trainees. Training to be a counsellor or psychotherapist in Ireland is **already prohibitively expensive for many**, between course fees, supervision fees and personal therapy fees. This means training is most open to people from more **privileged backgrounds** and limits **diversity** in a variety of ways, and these measures will make that even more true. Psychotherapists (and counsellors) have **clients from all kinds of backgrounds** and the profession should aim to be diverse also. My concerns would be:
 - Due to the **expenses and the unpaid nature of the work**, and a preference for trainees older than the usual college student age, counselling and psychotherapy training has traditionally been something people can do along with having another job. 500 hours of placement – particularly if it must all be in-person – will be **difficult for trainees to fit in around a paid job**.

- 100 hours of supervision at a standard rate (€60) will cost **€6000**. I see the value of direct observation (I assume this is meant to be by video, as having someone sit in on 100 hours would obviously be very hard to arrange) but perhaps something like 40 or 50 hours would be more reasonable. I also question where **traditional discussion-based supervision** (which is extremely important) would fit into the proposed hours.
- 500 hours unpaid work is the equivalent of **12.5 weeks full time**. Unless traineeships are going to change to being paid, this seems **exploitative**.
- For those with young children, 500 hours physically on-site is going to present significant **childcare** difficulties and costs, without any pay to cover it. The same is true for those with other **caring responsibilities**.

What would I propose?

To provide a basic level of accessibility for disabled people and not take training more out of reach of many financially:

- Given the clear evidence of the efficacy of remote therapy, **not to discriminate against remote hours, or at least to ensure exceptions are available for disability**.
- Provide more specific **module requirements** for courses to **increase academic standards** and uniformity.
- **For psychotherapy, 250 placement hours of direct client work with 30 being directly observed via video (with careful data protection in place) and 30 discussion hours**. I am unsure what to propose for counselling as the justification for the draft's lower hours requirements (but only slightly) is unclear.

Thank you for taking my submission and I hope you will take the needs and rights of disabled people, and the advantages of diversity within helping professions, into account.

Mise le meas,

Reference:

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Statutory
Regulation of
Counsellors and
Psychotherapists

CORU
Stakeholder
Consultation



December 2023



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Introduction

██████████ would like to acknowledge the hard work and diligence of the regulatory Board in producing the draft Standards of Proficiency and draft Criteria for Education and Training for Counsellors and Psychotherapists. The Board's commitment to ensuring high-quality practices and upholding professional standards is to be commended, and we believe it is essential to acknowledge the significance of your contributions.

██████████ welcomes statutory regulation of the professions, and whilst we agree that the Board's collaborative approach in producing said drafts has moved the professions into a realm that has not been tangible up to now, there are some areas within the draft criteria and proficiencies across both professions that we believe require reconsideration.

██████████, as a training institution delivering high-quality training and education in the field of counselling and psychotherapy for over 30 years, has never wavered from its mission "to make transformative contributions to individuals and society as the leading education establishment in the field of mental health and wellbeing, contributing significantly towards excellence in contemporary academic knowledge and ethical practice within the helping profession in Ireland".

Every programme-related decision is guided by a deep-rooted understanding of our ethical obligation to uphold the highest standards in producing competent and ethically sound mental health professionals. We are proud to be able to continue our founders' pioneering work by embracing the continued raising of academic standards in the context of proposed professional regulation while still making training as accessible as possible by continuing to set a high standard of personal development in training; raising awareness around the huge range of issues that people still struggle with in this country, and promoting an integrative approach within our field, and among our fellow professionals.

provides several programmes, University/QQI validation has a certain status due to the lecturing and programme design standard and is nationally and internationally recognised.

[REDACTED]

[REDACTED]

As one of the largest providers of third-level education in the field, whose programmes are designed by experienced academics and highly qualified counsellors and psychotherapists with many years of experience at the coal face of the profession, we believe that our insights serve as a valuable asset for informing the future of our profession. We hope that the CORU Board will be open to accepting that our feedback is rooted in a genuine commitment to protecting the public by promoting high standards of professional conduct, education, training, competence, and growing the professions. We trust that the Board will take our feedback seriously and recognise that our voice carries the wisdom of many years of collective practice experience and a deep understanding of what this profession needs to protect the public from risk and ensure those delivering our services are trained to the highest standards.

The Board states that the drafting of the standards was informed by an understanding of the contemporary practice of the profession in Ireland. However, we are seriously concerned about several elements of the proposed standards and would strongly encourage the Board to reconsider their position in relation to the following: the exclusion of personal therapy as a training requirement; the exclusion of clinical supervision; the structure of on-site supervision; the number of contact placement hours and the use of direct observation. In addition, we foresee issues with a number of the proficiencies across all of the domains, and we share our thoughts on this also.

The proposed draft standards and criteria risk permanently changing the identity of the professions at large. As a result, there will be many unintended consequences that will impact the future of counselling and psychotherapy and dilute the very mechanisms essential in protecting the public. We hope that the reasons we propose as to why the Board should reconsider their position on these criteria are acknowledged as coming from a place of familiarity and awareness of what is in the best interests of the public and a concern that if the draft standards are not reconsidered as we suggest, then not only will the public be at risk but so too would be practising therapists and the future of the profession.

[REDACTED]

We want to reassure the Board that our feedback is motivated by [REDACTED] commitment to upholding the core values of counselling and psychotherapy that are essential in guiding our responsibility to train competent practitioners within these professions. As an educational provider for over 30 years in this field, we are fully aligned with CORU's mission to protect the public by promoting high standards in professional conduct, education, training and competence; however, our responsibility to underscore the fundamental obligation of students to not just protect, but also to care for, their clients is evidenced in the following principles:

- Students' understanding that the well-being and welfare of the client must always be the primary concern. This includes physical, emotional, and psychological safety.
- Students' role in advocating for the rights of their clients, including their right to make autonomous decisions about their own life and fostering their empowerment in the therapeutic process. This involves acknowledging and respecting the client's values, preferences, and cultural background.
- Students' responsibility to establish and maintain clear professional boundaries to ensure a professional and ethical relationship with clients and their duty of care to avoid potential harm.
- Students' obligation to safeguard client confidentiality through measures that protect the privacy of client information and only share information with explicit consent or as legally required.
- Providing students with opportunities to explore their own beliefs, biases, and emotions in a supportive environment, promoting continuous self-reflection and improvement, valuing the supervisory relationship and the engagement in personal therapy.

We are open to working with you on this challenging task and want to thank you for the wisdom you have exercised in setting the academic level at level 8 for both professions, as this fully aligns with our position in relation to accessibility, progression and inclusivity.

SECTION 1: Entry Levels

Establishing a robust academic foundation for entry-level to the professions of counselling and psychotherapy is essential in ensuring those entering the professions are fully equipped with a deep understanding of psychological theories, research and evidence-based practice. Due to the complexity of the field, setting the academic threshold level of entry at level 8 for both counsellors and psychotherapists is crucial in providing a robust foundation for effective

practice and facilitating a more in-depth exploration of theories, interventions and treatment modalities.

The level indicators, as determined by the National Qualifications Authority of Ireland (NQAI) through the implementation of the NFQ for level 8, establish learning outcomes that:

relate to being at the forefront of a field of learning in terms of knowledge and understanding. The outcomes include an awareness of the boundaries of the learning in the field and the preparation required to push back those boundaries through further learning. The outcomes relate to adaptability, flexibility, ability to cope with change and ability to exercise initiative and solve problems within their field of study. In a number of applied fields the outcomes are those linked with the independent, knowledge-based professional. In other fields the outcomes are linked with those of a generalist and would normally be appropriate to management positions.

(QQI, 2003, p.21).

As indicated at level 8, the overall standard enhances public trust in the professions and allows for greater accountability by ensuring therapists meet specific educational requirements before practising. The criteria defined at level 8 on the NFQ establish benchmarks that meet the learning requirements regarding knowledge, skills and competence at a level that promotes quality and excellence in the study and practice of counselling and psychotherapy.

Within counselling and psychotherapy, the scope of practice often overlaps. While counselling may be determined to be more involved in specific life challenges and psychotherapy with a deeper exploration of psychological issues and mental health, setting the entry level for counselling below level 8 would not be sufficient in adequately preparing counsellors to work in this complex and challenging profession. Both counsellors and psychotherapists require in-depth knowledge and skills to address diverse challenges. Setting the academic standard at level 8 for both counselling and psychotherapy training as the minimum threshold for entry into each profession ensures a more robust foundation in theory, skills and competence to practice, thus enhancing graduates' ability to provide effective, ethical, and safe practice.

For entry to the counselling register, it is our position that level 7 would not be adequate in providing the learning opportunities to sufficiently prepare graduates to work with complex mental health issues or with the required knowledge and skills to address diverse challenges. Therefore, the minimum academic standard for counselling set at level 8 is at a sufficiently advanced level to enhance public trust in the profession and reassure clients in having confidence in the abilities of therapists who have undergone rigorous academic training.

Level 8 for entry to the psychotherapy register meets the requirements to ensure that practitioners in this field have demonstrated exceptional performance, strong critical thinking skills, a deeper understanding of the subject matter and the ability to conduct independent research. Level 8 also allows for a robust education in the essential training requirements necessary for effective psychotherapeutic practice from a broad base, including evidenced-based practice, ethics and the law, assessment and intervention.

We wish to address the contention put forward by some interested parties that the minimum level of entry to the psychotherapy profession should be set at level 9, in alignment with the European Association for Psychotherapy (EAP), often anecdotally referred to as the 'gold standard' for the profession. However, before doing so, it is important to acknowledge that areas of specialisation of practice within this profession require an advanced level of learning that may not be adequately met at level 8. In these highly specialised areas, for example, working with children and adolescents, working with addiction, and with families, a minimum level at level 9 would ensure greater competence, specialised knowledge, and expertise in a chosen field.

Many clients seeking psychotherapy have common mental health concerns, such as low mood and anxiety, which can be appropriately supported by therapists with level 8 training. Requiring level 9 training for psychotherapy would be excessive in such cases and could lead to overqualification within the field, which will not be cost-effective for working with less complex cases.

The EAP is an organisation with no statutory standing and, therefore, operates within a self-imposed framework which is based on the Strasbourg Declaration on Psychotherapy 1990. Overall, the Strasbourg Declaration on Psychotherapy serves as a guiding document that emphasises the importance of ethics, competence, human rights, and cultural sensitivity in the practice of psychotherapy while promoting its accessibility and collaboration within the broader mental health community. The EAP prides itself on following these five principles:

1. Psychotherapy is an independent scientific discipline, the practice of which represents an independent and free profession.
2. Training in psychotherapy takes place at an advanced, qualified and scientific level.
3. The multiplicity of psychotherapeutic methods is assured and guaranteed.
4. A full psychotherapeutic training covers theory, self-experience, and practice under supervision. Adequate knowledge of various psychotherapeutic processes is acquired.
5. Access to training is through various preliminary qualifications, in particular, human and social sciences.

(EAP, 2021).

There is no evidence to indicate that any of the above, including the guidelines within the Strasburg agreement, cannot be met effectively at level 8. It is stated in point 2 above that training in psychotherapy takes place at an advanced, qualified and scientific level. Consider the following level 8 NFQ indicators demonstrating just that:

- Demonstrate mastery of a complex and specialised area of skills and tools; use and modify advanced skills and tools to conduct closely guided research, professional or advanced technical activity.
- Use advanced skills to conduct research or advanced technical or professional activity, accepting accountability for all related decision-making; transfer and apply diagnostic and creative skills in a range of contexts.

QQI (2019).

Furthermore, on review of the training courses approved by the European Accredited Psychotherapy Training Institute (EAPTI) the vast majority are focused in the area of specialisms, such as Gestalt, Systemic, Child and Adolescent Psychotherapy, Somatic and Depth Orientated Psychotherapy, Transactional Analysis, Group Analysis, etc. There are 87 institutes listed on the EAP website as providing EAPTI-accredited programmes. Five of these had no website, one had no relevant course on offer, and we were unable to translate one. Out of the remaining 81 institutes, only 8 provide psychotherapy/integrative psychotherapy courses. The other 73 institutes listed provide training within psychotherapeutic specialisms. (EAP, 2023). Training at level 9 is best suited to specialisation and is not suitable as minimum entry to the profession. Setting the minimum entry level at 8 also leaves scope for courses in counselling and psychotherapy to exceed the minimum standard where this is deemed preferable.

Setting the minimum level of training above level 8 would make it more challenging for individuals from diverse backgrounds to enter the psychotherapy profession. This would impact the accessibility of training courses and limit the diversity of practitioners in the field. On the same theme of equality, diversity and inclusivity, this may discourage potential applicants from pursuing a career in psychotherapy due to the extended duration and costs associated with reaching level 9. A 2021 Irish study found that "financial cost is seen as being the single most significant barrier, with 48% of respondents stating that it was a major barrier" for mature adults accessing higher education (HEA, 2021, p. 27). While other barriers are cited in this study, such as family commitments, work commitments, etc., these are seen as easier to navigate through the type of course chosen, such as part-time over full-time, and/or the mode of study, for example, courses that include online teaching and learning methods, however, workaround solutions for financial support in accessing higher education courses were not as easy to come by. The findings were similar for minority populations, such as the Travelling Community, with two-thirds citing finances as a major barrier to accessing higher education. Similarly, for people with a disability, financial issues remain the highest barrier.

Finances were cited as the single highest barrier for lone parents and people from areas of economic and social disadvantage, too. (HEA, 2021). In addition to the issue of inclusivity, a smaller workforce, as a result of such barriers, could exacerbate a shortage of mental health professionals, making the psychotherapy profession elite and inaccessible.

Typically, in Ireland, those who choose to study in this area often pursue education later in life (often after age 25 or having spent some years in the workforce). Mature students bring a wealth of experience, unique perspectives and valuable qualities that better equip them to provide empathic, person-centred care that ultimately promotes positive and safe outcomes in therapy. It is not unusual for this cohort to not have completed a formal qualification prior to commencing their psychotherapy training programme. To exclude this cohort by setting the entry above an undergraduate level would have serious consequences for the provision of therapy in Ireland by limiting access to individuals interested in pursuing second-chance education.

Counselling and psychotherapy training programmes should endeavour to actively seek diversity among students by welcoming individuals from various backgrounds, cultures and life experiences. Ensuring fair and equitable access to a wide range of individuals would discourage elitism by favouring a select group based on academic success. Avoiding elitism in education is necessary to promote equality, social justice, and the wellbeing of individuals and society as a whole.

Striking a balance between ensuring high-quality care and maintaining accessibility, diversity, and practicality in counselling and psychotherapy is crucial to providing effective and efficient mental healthcare for all individuals. An inclusive and accessible education system ensures everyone has a fair chance to reach their full potential and contribute positively to their chosen profession. Level 8 training strikes a more reasonable balance in addressing these concerns.

For these reasons, [REDACTED] adds a strong statement of support in favour of the decision to set the threshold for entry onto the registers of both counselling and psychotherapy at level 8.

SECTION 2: Personal Therapy

When CORU was set up under the Health and Social Care Professional Act 2005 (as amended), its role was clear and unequivocal: to protect the public by promoting high standards of professional conduct, education, training and competence through statutory registration of health and social care professions. Part of the role of the individual boards tasked to set the standards for the diverse range of professions identified was to ensure that the relevant

educational bodies deliver qualifications that prepare professionals to provide safer and appropriate care.

While personal therapy as a course requirement for counselling and psychotherapy programmes is the established norm within counselling and psychotherapy programmes in Ireland, with the largest accrediting body, the IACP, requiring all accredited programmes to include a minimum of 50 hours of personal therapy during the training period, there is a very valid reason as to why this is the case. Its inclusion in training criteria is the single common feature uniting accrediting bodies and training institutes across Ireland.

The effectiveness of mental health professionals within this specialised field rests on their ability to form profound and meaningful connections with their clients, with the importance of relational depth resting in its capacity to catalyse transformative and healing experiences within the therapeutic relationship. The ability of any therapist to intentionally and ethically utilise their own personality, experience and presence as a therapeutic tool can only be effective if the therapist has engaged in the hard work of self-enquiry and understanding of their own values, biases, and personal challenges. Without this willingness to navigate their own emotions and reactions, their ability to foster empathy and connection with their client will be compromised.

Colleges and accrediting bodies have an ethical responsibility to ensure that students are psychologically robust enough to work with clients, and it has long been established that personal therapy in training provides an essential hammock of support to ensure adequate therapeutic processing and understanding of the client experience. Cologon et al. (2017) conducted research on the attachment style of counsellors/psychotherapists, isolating the variable of 'therapist reflective functioning' demonstrated that it was the capacity for reflection and processing of one's own life experience, including trauma, that allowed therapists to transform issues in their interpersonal relating stemming from insecure attachment into a positive asset in their client work.

Seminal research and therapeutic practice, stemming as far back as Freud, highlights the necessity of engaging in one's personal process in the becoming of a therapist/counsellor. This is recognised as essential learning in uncovering blind spots, forging meaningful therapeutic relationships and establishing a model for one's therapeutic approach and practice. Many studies have recognised personal therapy as an essential tool in developing the counsellor/therapist practitioner. (Rønnestad & Skovholt, 2003; Bike, Norcross & Schatz, 2009; Mackey & Mackey, 1994; Macran & Shapiro, 1998; Orlinsky, Schofield, Schroder, & Kazantzis, 2011; Sheikh, Milne, & MacGregor, 2007).

Geller et al., (2005), specifically emphasise the impact that personal therapy has in training through strengthening the integration of theory. Astrand & Sandell (2019) found that engagement in personal therapy resulted in personal and professional growth of the

emerging therapist by enhancing 'professional subjectivity'. Personal therapy led therapists to develop a professional attitude, subjective in nature, built from an integration of knowledge and theory from within a personal lens.

Those who enter this profession without having engaged in personal therapy as a mechanism to ensure their emotional readiness and awareness of their triggers and vulnerabilities are, in our opinion, a serious risk to the public, as a lack of awareness of our functioning and wellness can, according to Elman and Forrest (2007), leave therapists at risk of developing problems with our professional competence. One area of grave concern to us is that without the support received in personal therapy during training, future therapists will suffer from the distress of vicarious trauma, which, left unchecked over time, will lead to burnout, what Baker (2003) describes as "the terminal phase of therapist distress" (p. 21).

As those of us who work in the field are all too well aware, unlike any other healthcare profession, we are at risk of being traumatised by the emotionally charged nature of this kind of intervention. Many of the invasive and incapacitating symptoms that the client is seeking treatment for may consequently manifest in the counsellor/psychotherapist. To succeed in this unique caring profession, we must continually maintain our personal and professional vitality and avoid burnout. As stated by Skovholt, (1988,p.283),

"One of the most distinguished characteristics of our profession is our intense focusing on highly skilled perspective-taking: a combination of empathy, perceptual flexibility, tolerance for ambiguity and affective sensitivity. When successful, all of this translates into a profound ability to understand the world as other people understand it. This well-honed ability, one of our occupational strengths, is not possessed by many people in other occupations".

Therefore, we have a responsibility to protect our therapists from the risk of compassion fatigue, secondary trauma and burnout by ensuring they engage in a process of personal enquiry and self-analysis. The importance of self-development cannot be underestimated, as it is central to the development of a well-grounded counsellor/psychotherapist.

Research into the benefits of and necessity to include personal therapy in counsellor/therapist training is plentiful. For this reason, we request that the Board reconsider their decision not to include personal therapy as a mandatory requirement within counselling and psychotherapy training. It is important to note that recent research by Bento & Sousa (2022) found shortcomings in the methodologies of earlier studies that cast doubt on the effectiveness or desirability of personal therapy in training programmes. Moe & Thimm (2020) also demonstrated methodological weaknesses in previous studies that failed to show a positive correlation between personal therapy and client outcomes.

We are aware that courses have the autonomy to embed personal therapy within programmes without this needing to be dictated by the criteria and standards; however, the absence of personal therapy as a mandatory requirement dilutes the importance of this essential training element and opens the door to its exclusion in a general sense. It takes only one course to decide not to include personal therapy as a training component for others to follow suit. This would leave the profession at risk of eliminating personal therapy from developing a nascent counsellor/psychotherapist and, in turn, removing the evidence-based benefits outlined above from counselling and psychotherapy training. Counselling and psychotherapy training is unique in its experiential training model, an approach that must be respected and demanded by validating universities and QQI.

It is recognised that the Board may be in agreement regarding the value of personal therapy in counsellor/psychotherapy training, as it is noted in the FAQ section of the CORU Website that the rationale presented for its exclusion is tied to the Board's stance that personal therapy cannot be assessed against the standards of proficiency, which presents a separate argument. Respectfully, we would challenge that viewpoint.

There are several standards of proficiency across both professions that could be met through meaningful engagement in personal therapy. In order to protect the uniqueness of the therapeutic relationship, it is possible to assess these proficiencies via the practice education team in a number of ways, including a self-reflexive assessment process. This could include requiring learners to complete various reflexive assignments via a personal therapy workbook. The learning outcomes of such a tool would focus on the learner's ability to reflexively demonstrate their use of the therapeutic relationship to meet the standards of proficiency aligned to personal therapy. This could be accompanied by an attendance report submitted by the personal therapist verifying attendance/engagement in the sessions. The proposed assessment measures focus on the learner's ability to demonstrate awareness, reflexivity, and personal and professional growth.

Personal therapy is a reflexive process, and therapeutic outcomes are not typically measured by the counsellor/therapist's assessment of how well or not a service user is presenting. Personal therapy outcomes are typically self-assessed by the service user via CORE-OM or similar. Using a student-led (who in this case would also be a service user) self-reflexive assessment method, which the practice education team can assess, would mirror the real-life self-evaluation of subjective well-being that service users utilise in real-world settings. In addition, many of the proficiencies that would be attributed to personal therapy could be assessed via case studies, essays based on personal therapy insights, role-plays, etc.

Examples of how a self-reflexive method of assessment could be achieved for personal therapy are set out in the table below.

COUNSELLOR PROFICIENCIES	ASSESSMENT METHODS
Domain 1: Professional Autonomy & Accountability:	Self-Reflexive Therapeutic Workbook
<u>Proficiency 20:</u> Be aware of and be able to take responsibility for managing one's own health and well-being.	How have you worked in personal therapy sessions to increase your awareness of how you practice self-care? How would you rate your ability to be aware of and take responsibility for managing your own health and well-being? Please provide examples. Complete the Readiness for Therapy Questionnaire (RTQ) and critically reflect on your score with specific reference to your ability to take responsibility for managing your own health and well-being.
Domain 4: Professional Development:	
<u>Proficiency 4:</u> Understand and recognise the impact of personal values and life experience on professional practice and be able to manage this impact appropriately.	How have you worked to understand and recognise the impact of personal values and life experience on your personal and professional practice? Provide examples from your personal therapy engagement. From your learning through personal therapy, how would you rate your ability to understand and recognise the impact of personal values and life experience on professional practice and be able to manage this impact appropriately? Please provide examples.
Domain 5: Professional Knowledge & Skills:	

<u>Proficiency 16:</u> Be able to recognise and manage the dynamics of power and authority as experienced in the therapeutic relationship.	Demonstrate, using examples from your engagement with your personal therapist, your ability to recognise and manage the dynamics of power and authority as experienced in the therapeutic relationship. How would you rate your ability to recognise and manage the dynamics of power and authority as experienced in the therapeutic relationship? Provide examples from your personal therapy engagement.
<u>Proficiency 21:</u> Be able to recognise personal emotional responses, vicarious trauma, and the need to develop effective self-care strategies and burnout prevention.	Complete the Jo-Hari Window exercise and reflect on your developing awareness of your ability to recognise personal emotional responses, vicarious trauma and the need to develop effective self-care strategies and burnout prevention. Provide examples from your engagement in personal therapy that facilitated your awareness of these concepts. Create a self-care plan that effectively demonstrates your ability to develop effective self-care strategies and identify the challenges to this. How did you utilise your personal therapy sessions to inform this plan and navigate the challenges?
<u>Proficiency 19:</u> Be able to critically reflect on the role of the counsellor in the therapeutic process and be able to manage personal involvement in and contribution to the process of Counselling.	Critically reflect on the role of the counsellor in the therapeutic process. Provide examples from the client's perspective based on your engagement with personal therapy sessions. Rate your ability to critically reflect on the role of the counsellor in the therapeutic process and be able to manage personal involvement in and contribution to the process of Counselling.

	Use examples from your personal therapy sessions.
PSYCHOTHERAPISTS PROFICIENCIES	ASSESSMENT METHODS
Domain 5: Professional Knowledge & Skills:	Self-Reflexive Therapeutic Workbook
Proficiency 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.	Critically appraise the therapeutic relationship and your role in establishing, building, maintaining and concluding a long-term therapeutic relationship in a safe and ethical manner with your personal therapist. Please include examples of your engagement in this process.
Proficiency 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.	Provide two examples of how you demonstrated an awareness of conscious and unconscious dynamics in your therapeutic process. Outline, using examples from your therapeutic engagement, your personal involvement in, and contribution to, the process of psychotherapy.

With the protection of the public at the centre of CORU's mission, trainee counsellors and psychotherapists must be mandated to undergo their journey of personal process and discovery in the form of one-to-one personal therapy that mirrors what their clients will experience. The research above outlines that personal therapy encourages the development of reflexive functioning, which is paramount in a practitioner's ability to ethically apply therapeutic intervention with clients. Without this requirement, students may end up working therapeutically with a client, having never engaged in this process themselves. They may not have worked on themselves at the depth necessary to safely guide clients through this very same process, which creates an element of risk at worst and inefficient practice at best.

We request that the Board include personal therapy as a mandatory requirement within counselling and psychotherapy training.

SECTION 3: Model of Supervision

[REDACTED] has approximately 120 lecturers facilitating training across several training programmes specialising in various areas within the field of counselling and psychotherapy. Each of our lecturers is a practising therapist, many holding qualifications to doctorate level. When reviewing the draft standards, we collaborated with our lecturing team, our placement providers, our students, other course providers, and our accrediting body's members, all of whom were unanimous in their disbelief and shock that the Board had excluded the requirement for clinical supervision as part of the draft standards.

The exclusion of the need for students and practising counsellors/psychotherapists to engage in clinical supervision raises questions about whether the Board fully appreciates the professions it is proposing to regulate. That the regulatory body would exclude the requirement for clinical supervision within these particular professions raises many serious concerns about the future for us all, both currently qualified and those who will come after us, and more importantly, for the future safety of those seeking the help of clinically unsupervised practitioners.

Unlike other professions, CORU is tasked with regulating, whose members often work within a team environment which offers many benefits, including providing support, offering perspective, cultivating camaraderie and being solution-focused; counsellors and psychotherapists work alone, are isolated from their peers, and are bound to keep client disclosures confidential, so they cannot share or discuss their workload with others. As practising counsellors/psychotherapists, we cannot meet in the corridor with our peers or in the canteen to discuss our cases, ask for help or let off steam. Our relationship with our clinical supervisor acts as a crucible, which at its simplest is "a forum where supervisees review and reflect on their work in order to do it better" (Carroll, 2007. p.36).

There is a recurring theme in the academic literature linking the significance of clinical supervision to the prevention of burnout in counsellors/psychotherapists. Engagement in regular clinical supervision is cited as a protective factor for practitioners (Hou & Skovholt, 2019, Yang & Hayes, 2020). The role of supervision is specifically cited as a factor in preventing burnout amongst the student population (Thompson, Frick & Trice-Black, 2011). With the increased demand for services, the pervasive nature of trauma and the impact this has on counsellors/psychotherapists, and the many other conflicting roles that counsellors/psychotherapists have to deal with, including managing complex boundaries; responding to greater emotional pressures from clients; and meeting legal requirements and navigating ethical issues, the absence of a formal process or framework to manage this challenging and responsible role will harm practitioners and put their clients at increased risk.

The supervisory alliance enables the supervisee to gain ethical competence, confidence and professional growth, in the absence of which professional stagnation, limited skills development, ethical lapses and increased danger of stress and burnout are likely outcomes. The quality of client care will ultimately be compromised without the guidance and oversight that clinical supervision provides.

This form of supervision is a unique and defining feature of the professions, and it must be recognised that counsellors/psychotherapists in training (and once qualified) require clinical supervision due to the emotionally demanding and complex nature of the issues they encounter during sessions with clients, which present for professionals in this field very differently to how such issues present for other health and social care professionals. For example, a physiotherapist may encounter someone who is experiencing anxiety due to back pain and the effects this pain has on their lives, but they are not working directly with that anxiety or the psychological effects of the injury. Counsellors and psychotherapists are working at a very different level from those in other professions. Working predominantly with the psyche carries inherent dangers, as delving into the intricacies of the mind can unearth repressed trauma and emotional turmoil for clients. Inadequate understanding or unethical practices may exacerbate mental health issues, leading to distress or even psychological harm. Clinical reflexive supervision offered in a neutral space is crucial in this delicate field to protect clients from increased harm and the therapist from the risk of vicarious trauma and burnout.

It is recognised that the general model of supervision proposed within the draft standards is a somewhat standardised approach across all of the existing regulated health and social care professions. The Board should recognise that counselling and psychotherapy have many unique and defining features that set them apart from other regulated health and social care professions. Supervision within our professions extends way beyond assessing how a student demonstrates achievement of the standard of proficiencies. We do this all the time within the classroom, where peers act as service users for each other and where our highly qualified education team provide guidance, support, training, learning and development. Line management supervision, as indicated by the Board, falls way short of what a trainee therapist requires to protect the public. The nature of the work, the direct exposure to trauma over prolonged periods for counsellors/psychotherapists, requires a robust model of supervision that goes beyond engagement with an on-site placement supervisor. A model of supervision that enables a depth of personal and professional reflection and growth is an essential characteristic of the ethically developed practitioner, which in turn acts as a mechanism for protecting the public.

The British Association of Counsellors and Psychotherapists (BACP), which represents over 50,000 members of the counselling profession, states in their ethical framework (2018):

“Good supervision is much more than case management. It includes working in depth on the relationship between practitioner and client in order to work towards desired outcomes and positive effects. This requires adequate levels of privacy, safety and containment for the supervisee to undertake this work. Therefore, a substantial part or preferably all of supervision needs to be independent of line management” (p.22).

As a college with a large teaching team of qualified and practising therapists, we are in full agreement that the supervision model proposed within the draft criteria and standards is not fit for purpose within the counselling and psychotherapy professions. Further to the points outlined above, the role of the colleges in assessing, monitoring and governing clinical practice has been negated. There is no evidence to demonstrate that this existing governance, oversight and supervision model enacted by colleges is flawed or not fit for purpose. Colleges hold the same value as CORU of protecting the clients of their students, and this must not be overlooked or undermined. We should also not be ignored in the assessment and governance of clinical practice. We have a working model for college-based assessment of clinical skills that has long been endorsed by accrediting bodies, validating bodies and universities across Ireland and beyond.

We seriously question the rationale for overlooking the role of the colleges in overseeing this vital component of nascent counsellor/psychotherapist development. Colleges, [REDACTED], uphold counsellor/psychotherapist development at the very essence of what our courses set out to achieve. We are consistently informed, not merely by what is in the best interest of our students but by what is in the best interest of our students' clients. Our mission, vision and values in that regard are shared with the CORU Board. We ask that you defer to the experience of existing providers, such as ourselves [with 33 years' experience in counselling and psychotherapy training], in designing these essential training components.

Also, under this proposal, the role of the clinical supervisor in supporting, mentoring, and gatekeeping has been rendered null and void and should not be countenanced. There is a well-established practice for assessing students via the clinical supervisory relationship in one-to-one and group supervision settings.

On-site supervision may have many benefits that can complement the support that students receive, but clinical supervision provides a level of process, reflection and independent oversight that on-site placement supervision can never achieve for the professions of counselling and psychotherapy. Clinical supervision has long been one of the cornerstones, defining and protective features of the professions of counselling and psychotherapy, with its own distinct and defined set of standards. It is indispensable for fostering professional development, enhancing client outcomes, and maintaining ethical standards within the field. Currently, students must attend supervision at a ratio of one supervision hour to every five client hours, where the supervisor is given responsibility for the support, training, learning

and development of the student with the express purpose of supporting the student to progressively develop their proficiency. We wholeheartedly disagree with CORU's stance that this responsibility can only be undertaken by a professional situated on-site in a placement setting.

As per the current model of clinical supervision, which is widely accepted and endorsed by colleges, professionals and accrediting bodies in Ireland and internationally, taking supervision off-site has a distinct purpose in its own right. Engaging in clinical supervision away from the placement site enhances the ability to create a safe and confidential environment that promotes open discussion, personal growth, and professional development, which are essential components of counsellor/psychotherapist development and, in turn, strategies for protecting the public.

Some benefits of off-site clinical supervision can be argued as follows:

- **Confidentiality:** Holding supervision sessions off-site with a clinical supervisor ensures a higher level of confidentiality for both clients and therapists. This confidentiality fosters a sense of trust and security, allowing counsellors/psychotherapists to openly discuss sensitive cases and ethical dilemmas without concerns about breaching client confidentiality or compromising the privacy of the therapeutic setting.
- **Unbiased Feedback:** Conducting supervision away from the placement site helps to eliminate the influence of the immediate work environment, allowing supervisors to provide unbiased feedback and guidance. This separation enables supervisors to objectively assess the counsellor's/psychotherapist's performance and offer constructive criticism or guidance without being influenced by the dynamics or politics within the organisation or clinical setting.
- **Personal Development:** A neutral environment outside the placement site encourages counsellors/psychotherapists to reflect on their professional practice and personal development without the pressures of the placement environment. An off-site setting fosters introspection, self-awareness, and the exploration of personal biases and limitations, facilitating counsellors/psychotherapists' growth and enhancing their ability to engage in reflective practice effectively.
- **Enhanced Focus:** Conducting supervision sessions away from the placement site enables both supervisors and counsellors/psychotherapists to maintain a focused and dedicated space for discussing complex cases, ethical challenges, and professional development. This separation allows for an uninterrupted and concentrated discussion that promotes in-depth exploration of clinical issues, fostering a deeper understanding and facilitating more meaningful learning experiences for counsellors/psychotherapists.
- **Boundaries and Role Clarity:** Establishing a clear boundary between the supervision space and the clinical setting helps maintain professional boundaries and delineates the roles of supervisors and counsellors/psychotherapists. By conducting supervision sessions off-

site, supervisors can provide guidance, support and assessment in a manner that emphasises their role as mentors and educators rather than as direct managers, promoting a more balanced and conducive relationship between supervisors and counsellors/psychotherapists.

A sample of responses from a [REDACTED] survey of practitioner lecturers eligible to apply for one or both professional registers in response to the question "Do you have any concerns that there will be no requirement for clinical supervision?" include:

"It is crucial to have an external supervisor who can see things from a different perspective."

"Yes, very strong concerns. Clinical supervision is the cornerstone of the profession both for therapist development and self care, and protection of the public. To disregard this entirely feels unwise as it is removing a layer of protection and oversight."

"This [clinical supervision] is essential. The fact that it is being proposed is baffling. There is not one psychotherapist in the country who will agree with this. Supervision is a cornerstone of good practice and support and a lifeline for many during their working lives."

"I think this is very unsafe especially due to the nature of our work."

"I have grave concerns that there is a proposal that there will no longer be a requirement for clinical supervision as this puts the future of the profession of counselling and psychotherapy in grave peril.....Therefore clinical supervision needs to be a mandatory requirement for all counsellors and psychotherapists providing a service to the public in order ensure best ethical standards and practice."

In a further [REDACTED] survey of placement providers, 76% of respondents expressed doubts surrounding the proposed model of supervision, with 84% of placements expressing concerns regarding the absence of clinical supervision as a requirement. More than half of the placements surveyed reported that the proposed model of supervision would prevent them from taking on student placements in the future. This is highly problematic as it will drastically reduce affordable services available to the public.

A sample of responses from our placement providers include:

"This supervision model does not provide the same level of oversight as the current professional supervision model i.e., the supervisor is trained and accredited as a supervisor in the relevant profession. Furthermore, this model of supervision i.e. in-

house, does not afford the trainee the depth of oversight as the current model does. The current model of supervision requires that supervision takes place with a trained and accredited professional who is independent of the placement so that emerging issues relating not only to their clinical practice e.g. placement-related topics such as management issues, can be supervised in a nonbiased way. The proposed model of supervision causes us concerns regarding the quality of supervision based on the supervisor's qualifications, and issues regarding the requirements with regard to the potential blurring of boundaries i.e. an in-house supervisor would have obligations to their employer the placement' as well as to the college, the trainee and the client."

"I feel this model of supervision will be hard to implement in a not-for-profit community counselling services. the responsibilities listed of the on-site manager will take time. In our case with 10 to 12, trainees is at any time. This would be an additional role for the service who will fund this role as resources are scarce in community based counselling services."

"This model of supervision dramatically increases the demands of placement providers to deliver psychotherapy training and education."

"In my practice this would not be viable and would be a factor in removing student placement."

"Clinical supervision is an absolute must and should be included in the criteria. Most of the above is already implemented in my practice but i think I would have to reconsider the low cost programme if the students were not regularly receiving clinical supervision based on my experience, I think it would be reckless."

It has been brought to our attention that placement providers were not consulted in informing the draft criteria and standards, which impose significant responsibility within placement settings that are not regulated or funded, unlike other health and social care professions. A sample of responses from [REDACTED] placement providers when asked the question, 'Would you be confident that you are in a position to transition to this model?' is as follows:

"No. Would be unsure of competence of trainees without regular clinical supervision and I would not be able to offer that level of onsite supervision."

"Not at all."

"No. Would be unsure of competence of trainees without regular clinical supervision and I would not be able to offer that level of onsite supervision."

"The direct observation would not be achievable."

On the topic of observed practice, our current GDPR and Confidentiality policies and procedures do not extend to video recordings. Our service users are vulnerable adults, and our service is community-based. Most of our service users are from the local community, and as such, they are generally fearful that their identity or their presenting issues might be made known to the wider community. The introduction of observed practice would deter certain potential clients to whom anonymity is essential to their counselling journey.

The unintended consequences of the model of supervision proposed will restrict and reduce access to counselling and psychotherapy services for the public, particularly those unable to afford services at the full rate, in turn inadvertently making counselling and psychotherapy elitist and discriminating against the most vulnerable and disadvantaged sectors of Irish society. Placement provider concerns include:

"To implement such a model of supervision, we would need to revise our whole service and its policies and procedures. Given that clients are already sometimes reluctant to attend a trainee, the addition of session recordings would lead to a reduction in the number of clients willing to attend a trainee. Ultimately this means we would need to shift our model of service provision to employing qualified therapists and reducing the number of placements we offer - yes this would call for a revising of how we use our funding but based on our experience with service users, and our ethos of serving members of the local community, employing qualified therapists would be more conducive to our purpose than employing supervisors that would in turn lead to a reduced uptake of our service."

"We currently do not have the staff or resources to support 10 to 12, counsellors for up to 700 hours. This would mean we could not take any more trainees which would result in our service, maybe having to close. Our service is based in a disadvantaged area where finances can be a barrier to attending counselling, with no trainees, we cannot offer no cost, low-cost, counselling or psychotherapy."

"Most likely reducing or stopping completely the clinical placement programme."

"It would probably end the low cost / student model in the practice."

As long as the voluntary sector continues to take a leading role in the provision of counselling services, with much of the delivery of affordable counselling delivered by not-for-profit organisations, then the requirement for an on-site supervisor under the model proposed by CORU is not achievable. Placements do not have the existing infrastructure or financial

backing to support on-site supervision in the manner it is proposed. There is limited availability of suitable placement opportunities that can accommodate an on-site supervisor to complete the tasks identified by CORU.

Currently, within the profession, as mandated by the professional accrediting bodies, overseeing and assessing a student's development would never be left in the care of someone with no specific supervision qualification and who has not been a practising accredited therapist for less than five years. It is neither sufficient nor safe to mirror the model of supervision set out in other regulated health and social care professions. It simply is not applicable here due to the nature of the work carried out by counsellors and psychotherapists, which is not comparable to other professions in the health and social care domain.

Furthermore, the professional environment for students and qualified professionals does not provide access to a 'nine to five' or similar working structure instead, counselling/psychotherapy is availed of within a dedicated therapeutic hour (50-60 minutes in duration, with approx. 10-15 minutes to allow for note taking on-site). There is currently limited provision to enable students to avail of physical space within placement centres for anything beyond that, nor are there many opportunities to engage with other counsellors/psychotherapists on site due to those professionals also being employed to work directly with service users within the therapeutic hour model, in a private, one-to-one setting. The lack of standardisation/regulation across counselling and psychotherapy services means these resources/structures are unlikely to change.

As noted above, colleges have a long-upheld and widely accepted method for assessing clinical practice via clinical supervision. Some examples of how this could be achieved against the draft standards of proficiencies are outlined below. Please note that this is a sample of a small selection of the proposed proficiencies rather than a comprehensive mapping of all applicable instances where this could be achieved.

PROFICIENCIES	ASSESSMENT METHODS
Domain 1: Professional Autonomy & accountability:	
Proficiency 1: Be able to practise safely and effectively within the legal, ethical and practice boundaries of the profession	Students present case studies involving ethical dilemmas in clinical supervision, and the supervisor evaluates their ability to identify ethical issues, consider diverse perspectives, and make ethical decisions. An assessment report is submitted to the college by the supervisor. Students reflect on their process and engagement with clinical supervision within college-submitted case study assignments.
Proficiency 2: Be able to identify the limits of their practice and know when to seek advice and additional expertise or refer to another professional	Ongoing discussions between the clinical supervisor and trainee about the trainee's utilisation of supervision, exploring how the trainee applies feedback and integrates new insights into their practice. The supervisor submits a report to the college assessing the trainee's ability to meet the proficiency.
Domain 2: Communication, Collaborative Practice and Teamworking	
Proficiency 6: Be able to produce clear, concise, accurate and objective documentation.	Clinical supervisor provides feedback on trainee's note taking practices and assesses their ability via a supervisor's report submitted to the college.
Domain 3: Safety and Quality	

Proficiency 8: Be able to evaluate intervention plans using appropriate tools and recognised performance/outcome measures along with service user responses to the interventions. Revise the plans as necessary and where appropriate, in conjunction with the service user.	Review performance/outcome measures, service user responses and treatment planning approaches with your clinical supervisor. Clinical supervisor provides formative feedback for the trainee to integrate into practice and completes a performance review submitted to the college. Trainee includes their use of clinical supervision in their review of therapeutic approaches and outcomes within a course-submitted case study.
Domain 4: Professional Development	
Proficiency 5: Understand the importance of and be able to seek professional development, supervision, feedback and peer review opportunities in order to continuously improve practice	Clinical supervisor reviews written reflections submitted by the trainee after supervision sessions, assessing the depth of reflection, integration of feedback, and the trainee's commitment to continuous improvement.
Domain 5: Knowledge and Skills	
Proficiency 6: Demonstrate safe and effective implementation of practical, technical and clinical skills.	Clinical supervisor provides a comprehensive assessment of the trainee's overall performance in supervision, highlighting strengths, areas for improvement, and recommendations for future professional development in relation to their ability to safely and effectively implement skills in action.

Further to the above, it is worth noting that there are two proficiencies in Domain 5 that directly reference clinical supervision (proficiency 20 for counsellors and proficiency 26 for psychotherapists). Clearly, these could be assessed as per the variation of examples posed above. However, there is no requirement for clinical supervision in the draft Criteria for Education and Training. As such, it is vital to know how these can be met under the current criteria, which seem to be completely contradictory.

In summary, regarding the model of supervision, we respectfully request that the Board set aside the model of regulation as it currently exists and consider:

- the uniqueness of the professions of counselling and psychotherapy;
- the lack of vital infrastructure to support the model of supervision proposed
- the potential reduction of services to the public.
- the risk of burnout for students and the risk of harm to the public as a result
- the ethical cornerstone of reflexive practice, which is uniquely facilitated within the clinical supervisory relationship
- the role of the colleges and the clinical supervisor in assessing clinical practice

We request that the Board apply a more profession-centred model of supervision that upholds CORU's mission to protect the public and pays due regard to the best practice models of supervision, clinical practice and organisational structures already existing within counselling and psychotherapy.

SECTION 4: Service User Contact Hours

[REDACTED], as a long-established training provider tasked by its accrediting body to ensure every student has access to a practice placement in order to complete their clinical hours, is seriously concerned about the ability of all training colleges in Ireland to continue to provide this type of training if the Board's requirement for the number of placement hours is upheld.

The highly demanding requirement that 450 practice placement hours for counselling and 500 practice placement hours for psychotherapy, with 300/350 hours supervised service user contact and 75/100 hours directly observed by an on-site supervisor, takes no account of a number of highly significant variables.

Part-time training programmes have been historically offered in this type of training to ensure students can pursue their education without completely disrupting their current lifestyle. Many aspiring counsellors/psychotherapists already have existing commitments, with most in full-time employment upon enrolment. Also, in more recent years, many students have pursued this training to enhance the work they already do. This exorbitant increase from the current service user contact hours (approx. 200%) required on current training programmes will seriously jeopardise students enrolled on programmes that are expected to transition on to CORU regulated training programmes. The disparity between existing programme clinical requirements and those proposed by the Board is so vast that a transitional model for existing students is not possible, devolving students of their rights to achieve the qualification from the course that they enrolled on, whereby they entered into a contractual and legally binding training agreement with colleges that currently guarantees their qualification to practice.

The number of placement hours suggested by the Board raises concerns in respect of the understanding of the work that counsellors/psychotherapists do at an ethical level and the manner in which they achieve their clinical hours. In the first instance, in order for students on a part-time programme to achieve the client hours proposed, they would need to start client work in Year 1 of their programme. Counselling involves a set of complex interpersonal and therapeutic skills. Before students can effectively work with clients, they need time to develop and practice these skills in a controlled and supervised environment. Understanding and adhering to ethical guidelines is fundamental to the counselling profession. The first two years involve extensive training on skills development, personal and professional reflexivity, ethical considerations, professional boundaries and legal issues to ensure students are well-prepared to handle the complexities of client work. It would be inconceivable for any college to approve a student as ready to sit with clients before they have completed two years of the programme. To expect students to complete the required hours within the remaining two years, considering how counselling differs from other professional activities, is difficult to comprehend and not feasible.

The traditional part-time nature of many counselling and psychotherapy training programmes and the available time of students and, therefore, the capacity of both organisations and individuals to meet these requirements appears to have been completely ignored or discounted, risking deterring many suitable persons from applying for courses. This will inadvertently impact the number of qualified counsellors/psychotherapists produced in the professions, further limiting access to services for members of the public.

Counselling differs from other professional activities as a concentrated activity within a dedicated time-period (typically one hour), as opposed to a role enacted over a typical working day, such as nursing or social care, which typically consists of a range of discrete tasks. The unique nature of the work and its' tendency towards burnout dictates a standard maximum number of clients that should be worked with in a given day. Moving outside of this model is harmful to both the student and the member of the public working with a counsellor/psychotherapist due to this risk of burnout. The unique emotional demands of counselling and psychotherapy practice necessitate an ethical requirement to limit the number of direct service user contact hours undertaken on any given day. Counsellors and psychotherapists do not work in placements that offer extended duration of continuous, full-time immersion in a real-world setting. Currently, in [REDACTED], our students are only approved to do a maximum of five client hours a week. This is informed by the fact that taking on more than that would increase the risk of burnout for students. As most placements would have a limited number of clients seeking counselling with a student and can only offer sporadic hours due to infrastructure limitations, it is often the case that students have less than this maximum allowable number. When a client is assigned to a student, they only see this student once in that week, unlike in other professions, where the student may meet with the client a number of times throughout their week in placement.

In addition to these significant concerns, there is no rationale or clarity in the proposals for how additional work in preparation for direct service user contact completed by counsellors/psychotherapists may be counted towards on-site practice placement hours, rather it simply states that planning for sessions, completion of reports, completion of administrative duties in addition to directly engaging with service users can be counted as part of the 450/500 on-site required hours. The suggestion that such session planning and administrative duties could be facilitated on-site is not representative of typical placement settings across Ireland, where students (and indeed qualified professionals) work sessionally on an hourly basis with an individual client and then vacate the placement centre. There is no accessible national counselling service, facilities, supervisors or suitably qualified 'direct-observers' etc. to support these placement requirements. Issues with the infrastructure within the professions are outlined in Section 5: Direct Observation.

It is our expert opinion that the Board's requirement for 450/500 practice placement hours, of which 300 hours of direct service user contact is required for counsellors and 350 hours of direct service user contact is required for psychotherapists, is counterproductive, unrealistic and impractical for the following principal reasons:

- **Inadequate preparation and practice time for students as the increased direct service user contact numbers will require an earlier lead-in time to beginning clinical practice.**
- **Inadequate assessment time for colleges to determine students' suitability for clinical practice and support students with fitness-to-practice issues**
- **Increased demand on students leading to ethical concerns and a tendency towards burnout**
- **Inaccessibility of clients available via the current placement infrastructure**
- **Lack of infrastructure in placements to facilitate the completion of administrative duties and teamworking on-site**
- **The part-time nature of training courses in the professions**
- **The prohibitive implementation of a transitional model for existing students**

However, in order to uphold the values expressed by the Board through the increase in hours for students and maintain an ethical and safe approach to clinical practice in training, we would propose that 200 of the proposed 300 hours (counsellors) and 250 of the proposed 350 hours (psychotherapists) remain as direct service user contact hours. This would enable students to begin their clinical work in Year 3 of their programme and allow for approximately 100 hours of direct service user contact to take place per academic year (across Year 3 and 4).

SECTION 5: Direct Observation

While there is value in directly observing students in practice, a training intervention which is currently facilitated within the safety of the classroom environment with peers acting as clients, the risks are that this method of assessment posed by CORU far outweigh the benefits due to the uniqueness of the professions and the therapeutic relationship.

Directly observing client sessions raises several ethical and practical concerns, and it is, in our expert opinion, inappropriate and potentially harmful to therapy clients. In the first instance, the question of directly observing counselling sessions needs to consider the possible impact of such observation on clients. For the Board to include direct observation as a course requirement for our profession questions whether CORU is following its remit to protect the public from harm when this requirement directly puts the public at risk of further emotional distress, a sense of betrayal, or a fear of privacy invasion. Clients seek therapy in a vulnerable state, and the observation of their sessions can magnify this vulnerability. The effectiveness of the therapeutic process in the presence of an observer can significantly impact the therapeutic relationship, where clients can feel inhibited, self-conscious, or reluctant to share openly if they are aware they are being observed or recorded.

The correlation between vulnerability and the inclination to seek affordable counselling is a well-established phenomenon in Ireland. Socio-economic status can impact psychological wellness, with individuals with lower income levels often facing increased psychological vulnerability (Kelly & Doherty, 2013). Currently, there is an overreliance on student therapists to provide affordable/affordable counselling in our country. An under-resourced State counselling service relies on charities/not-for-profit organisations to fill the gap in the provision of counselling services. However, these charitable/not-for-profit organisations are underfunded by the State, so they rely on trainee therapists (who are generally not paid).

Vulnerable populations often face economic challenges, making traditional, higher-cost therapeutic services less accessible. Affordable counselling provides a more viable option for those with limited financial resources, with less financially affluent clients tending to access affordable counselling services (McLeod, 2003). Trainee therapists make up many therapists in these placement settings, working primarily with this vulnerable cohort and where CORU expects direct observation to occur. Along with the potential harm, this suggested course requirement would pose to a client's psychological wellness, would such a requirement prevent vulnerable clients from accessing therapy, and in particular, might these disadvantaged cohorts be disproportionately adversely affected? (Ballinger & Wright, 2003). More vulnerable clients can struggle to assert boundaries – this could include discomfort or refusal regarding observation of their sessions. As a training college working in this field for over 30 years, we must advocate for clients' best interests, including their right to privacy and comfort in the therapeutic process.

There are many concerns to be considered by the Board in relation to direct observation with the impact of the power dynamic in the therapy room worthy of critical attention. It is known that power differentials operate in the therapy room and that diverse groups may consequently be at a disadvantage concerning therapeutic outcomes due to stigma (Arthur & Collins, 2013; Guggenbuhl-Craig, 1971). It seems likely that higher functioning people would be more likely to accept (or tolerate) observation of their sessions than those who most need the confidentiality of the therapy room. Therefore, we would ask what meaningful purpose direct observation serves if the sample of clients is skewed in this way. What would this mean for the values of equality, diversity and inclusivity within counselling and psychotherapy training? Also, cultural factors may influence a client's willingness to be observed, with different cultures having various expectations regarding privacy and authority.

Another important consideration is how distrust of authority can impact the counselling process and the therapeutic relationship. There is great fear among those who distrust authority that something they say will be used against them, resulting in more problems. Fears amongst this client group include fear of consequences, the unknown, judgement, losing children and being institutionalised (Dew et al., 2007).

A growing body of research has argued that one overlooked or understated factor in the research to date is the fear of disclosure (Dew et al., 2007). Research shows that people who are disadvantaged in society have distrust for authority, represented by the State and the middle class. It is easily understood that clients coming from that perspective would be aghast at the idea of being recorded, in some way, by that same authority.

"There can be trust in the competence and worthy motivations of a general practitioner, but that the practitioner is also a gatekeeper to a wider system that cannot be trusted is the problem here. Individual trust is not enough to allow disclosure, but there needs to be systemic trust which for some is not present." (Dew et al., 2007).

Direct observation can also trigger shame and inadvertently lead to systematic selective exclusion of disadvantaged clients from some services. 'Loss of dignity and loss of power are crucial elements of humiliation.' (Miller, 1995: p. 44). Difficult as it is to disclose painful experiences in therapy, being watched doing so might be unbearable for some. 'People believe that they deserve their shame; they do not believe that they deserve their humiliation' (Klein, 1991: p.117).

A study conducted with Irish clients from disadvantaged backgrounds identified that this cohort was more likely to experience higher levels of shame and a sense of inadequacy (Ó Braonáin, 2013), leading to a rise in anxiety levels when engaging with counselling. In that

research, the majority of participants had an aversion to being videoed as part of the study. 'A common component of the shame experience is the desire to hide, to escape from further scrutiny and devaluation (Tangey & Dearing, 2002; p. 173).

A strong theme throughout O' Braonáin's (2013) research was the level of 'shame-proneness' identified within the client population. It was found that this shame-proneness, coupled with low self-esteem, resulted in a refusal to partake in the recorded sessions despite showing interest and engagement in non-recorded elements of the therapeutic interventions. So significant was this impact that one of the study's findings was that therapeutic interventions requiring recordings are not suitable for families from disadvantaged areas (O' Braonáin, 2013).

A 2020 St. Patrick's mental health survey showed that 63% of respondents believe that being treated for a mental health difficulty is still seen by Irish society as a sign of personal failure. How many of this population would be willing to have their perceived failures and level of stigma recorded? How is this training requirement in the best interest of protecting the public?

It is well documented in research that observer effects directly change the behaviour of those being observed. For students, this presents as an inclination towards following orders and a sense of vulnerability due to the nature of the therapeutic relationship. (Betcher & Zinberg, 1988). Due to the inexperience of students, such an exercise that aims to increase awareness and skill produces results that demonstrate poor performance compared to the same task being applied to qualified and more competent therapists (Innes & Young, 1975). Yager & Lee (2023) found that 'skewing' occurred in sessions with third-party observers. This refers to how counsellors/therapists alter their therapeutic style when they are being observed. This occurred irrelevant to the type of observer (i.e. a trainer or a supervisor) and the observation method.

Research into client effects of observation include:

- declining to engage in counselling (Van Atta, 1969)
- not disclosing issues such as sexual or physical abuse (Aveline, 1992)
- minimal inhibition coupled with a question as to whether the therapist would have been 'freer' had they not been under observation
- embarrassment
- delayed disclosures

(Goin et al, 1976).

It is, therefore, easy to see how direct observation is not in the best interests of the client.

There may be potential benefits of recording sessions for students, such as personal reflection and supervision purposes, but there are also risks and concerns related to privacy, confidentiality, informed consent, and the therapeutic relationship for the client:

1. **Privacy and Confidentiality:** Therapy sessions are typically considered confidential, and recording them raises privacy concerns. The recording may contain sensitive and personal information that needs to be safeguarded. If the recordings are not adequately protected, there is a risk of unauthorised access or accidental disclosure, potentially harming the client's privacy.
2. **Trust and Therapeutic Relationship:** Recording sessions may impact the trust and therapeutic relationship between the therapist and the client. Clients might feel self-conscious or inhibited if they know they are being recorded, potentially affecting the openness and authenticity of their communication. It is essential to consider how recording might influence the client's comfort and willingness to share sensitive information.
3. **Potential for Misuse:** Recorded therapy sessions could be misused if they fall into the wrong hands or are shared without consent. There is a risk of the recordings being used inappropriately or even maliciously. It is essential to ensure the security and proper handling of recorded material.

(Kogan, 2014).

There are multiple ethical concerns related to privacy, informed consent, and GDPR. Brown, Moller & Ramsey-Wade (2013) highlight some of the ethical concerns in their research, citing:

"the findings that clients might not understand exactly why they are being recorded and what the recordings are used for was troubling. Indeed, this finding suggests that some clients are agreeing to an intervention (audio recording) without an adequate understanding, enabling them to give informed consent. This is surely not ethical practice." (p. 260).

The concerns are further enhanced when it is considered that recorded sessions are beneficial for the therapist only, not the client. This gives rise to the risk of over-compliance and exploitation (Martin, 2019).

From a student's perspective, where they found direct observation to be a valuable experience, they report that being the observer, i.e. seeing a session in action, is crucially more valuable. This highly valuable and formative experience of seeing a session in action occurs within the classroom on a regular basis, with all lecturers also required to be accredited or, in the future, registered practitioners.

Negative themes emerging from the research on the student's experience of direct observation include: 'an anxious, inhibiting experience', 'distorts/misses reality', 'students' needs impinging on the therapeutic relationship', and a breach of confidentiality, indicating that Irish psychotherapists have strong yet mixed views about recording, reflecting the power of this practice and its ethical complexity. (McMahon & Ledden, 2019). The power differential and the potential to distort the therapeutic relationship can be summed up by Brown's (1990) metaphor:

"But whereas actors have a text to structure their interplay, the therapist and his patient do not. They are not even in the same 'play'. The patient brings his suffering, and he must speak not only about this suffering, but he must also speak from his suffering. The therapist must receive this personally, as addressed to him personally, but he does not respond in his own person [2], But if both people know' that they are addressing an unknown - or at any rate unseen - audience, then, it seems to me, they will probably create together that 'illusion of privacy' as actors do, but with the difference that the therapist is both one of the actors and the director. The TV camera is there to record his performance, to find out how he creates his effects. From this point of view, the patient is really only necessary for the therapist's demonstration, and for him surely the TV camera must function as a fantasy object. having the effect of isolating him. It seems to me that there is a danger that this whole process may so distort the nature of a psychotherapeutic session that the 'effective operations' extracted by subsequent examination of the film may be largely due to the effects of the unseen audience represented by the TV camera." (p. 140).

Ultimately, this practice is not in the public's best interest due to the exacerbation of shame, potential exploitation of vulnerable clients, exclusionary practice, potential for delayed and restricted disclosures and serious ethical concerns related to privacy, confidentiality and EU General Data Protection Regulation (GDPR). Coupled with the fact that the benefits of direct observation, which we recognise exist for students, can be achieved in ways that do not include putting the public at risk. For example, directly observed authentic peer client sessions as part of the training experience within the classroom rather than placement environment and opportunities to directly observe lecturer (practitioner) led client sessions with fellow students, which research shows is more beneficial than having their own work directly observed. In addition to this, there are a number of robust teaching and learning pedagogies that enable students to demonstrate their application of theory into practice, such as case studies, [reflecting recording formats](#), clinical supervision reports, outcome measures, etc.

As outlined above, the potentially harmful effects of direct observation for clients is the priority position for [REDACTED] in requesting the Board to reconsider this requirement. However, it is important to also highlight the infrastructural failings that would prevent this

method of assessment from taking place within the existing structures in the counselling and psychotherapy professions.

A large proportion of counselling/psychotherapy organisations in Ireland are not for profit and not in receipt of government funding. The larger organisations that are in receipt of government support, such as Pieta House or the National Counselling Service (NCS), do not typically take counselling/psychotherapy student placements; in fact, the NCS require a dual qualification for employees/contracted counsellor/therapists to work within that service so it is highly unlikely that they will open their doors further to students on counselling/psychotherapy training. The organisations that receive funding have publicly stated that this is significantly lower than what it currently costs to deliver the required services (Samaritans and Aware, as cited in Dwyer, 2023).

Dwyer (2023) highlights that the government primarily relies on charitable organisations to provide community mental health support in Ireland, which is underfunded. There has been little investment into the provision of counselling/psychotherapy in Ireland (only 5.1% of the 2022 budget was spent on mental health, according to Dwyer, 2023) and yet the requirements on behalf of the placement organisations within the draft criteria posed by the Board increase placement responsibilities rather than focusing on the existing structures within the profession, such as the responsibility of the college in governing the student's clinical work and that of the clinical supervisor, a model that has long been successful.

The requirement for direct observation to be carried out by an on-site placement supervisor is impractical and creates a very real barrier to students' access to placements and, in turn, to placement's ability to provide affordable services to the public. Underfunding in this area and the lack of standardisation/regulation of counselling and psychotherapy services prevents this criterion from being feasible.

At a recent meeting of the Oireachtas, the Chair of the Mental Health Commission, Dr John Hillery, reported that only 1% of mental health services in Ireland are regulated and that neither "the inspector [of mental health services] nor the commission has the powers to set standards and ensure services comply with these standards by way of monitoring and enforcement." (Cullen, 2023). These requirements are setting courses up for failure and equating counselling and psychotherapy courses with placement and employment models for health and social care professions that simply do not exist for counselling and psychotherapy.

It is also worth noting that not one of the other eight regulated health and social care professions includes the requirement for direct observation. All of these professions involve direct service user contact, and they have the advantage of operating within regulated employment structures that are well funded, such as hospital settings, multidisciplinary settings, government-funded agencies, etc, and are structured in the typical 9-5 (or similar)

employment settings. The professions of counselling and psychotherapy present as far more challenging, and there is no convincing argument/evidence that demonstrates why counsellors/psychotherapists should be assessed any differently (i.e. by the requirement of direct observation) in their levels of competence to work one-on-one with service users.

In a [REDACTED] survey of placement providers:

- 100% of placements disagreed with the inclusion of direct observation in the placement centre as a training requirement
- 76% stated that they did not feel direct observation by an on-site supervisor was an effective way to assess a student's learning or progress
- 100% stated that they would not be confident that clients of their service would consent to direct observation
- 69% stated they would no longer be able to facilitate student placements, which in turn would impact their ability to offer affordable provision to the public

When asked what support placements would require to introduce direct observation into their services, responses mostly consisted of significant financial support and/or for the college to take responsibility for the direct observation (i.e. provide staff to carry this out). A sample of answers can be seen below:

"Our view on this is that it is not beneficial to our service users. It is a training requirement and as such should remain the responsibility of the training provider. Our service's ethos is rooted in humanistic psychologies, and we believe that the establishment of a therapeutic relationship is dependent on the boundaries that are created within a safe and confidential space between a suitably skilled professional/trainee and the client. The proposal of observed practice poses direct challenges to our ethos and therefore would not be a viable option for us. "

"My perspective is shock! The essence of counselling is one of confidentiality, trust, intimacy, connection and to have a third party in the room is the opposite to what I believe one to one counselling is about . This is usually done in college with peers . Not with vulnerable clients who's life story and innermost secrets should be exposed and documented for educational purposes. I feel this is exploitation of people in our disadvantaged communities because this is where most of the trainees are placed . This would not be accepted in more affluent areas by private practice clients. This would leave no option for clients in disadvantaged areas if they wish to access low-cost no cost counselling."

"Not appropriate at all too invasive for our service users. one session for training and learning purposes is fine but 75 hours is totally inappropriate."

"I feel the trainee counsellor could possibly feel more uncomfortable, pressured, nervous and is more likely to make mistakes and less likely to be their authentic self. Are we forgetting the most important question here, how will the client feel !"

Of the placements that responded to the survey, 14% were government-funded, 43% were in the not-for-profit/charitable status sector, and 43% were in a private practice setting. This further highlights the over-reliance in the sector on services that receive little to no funding and rely on students to deliver affordable counselling/psychotherapy to the public. This raises a concern regarding not just the potential unintended consequence of limiting services to the public but also around accessibility for students to complete this work if placements that can accommodate such a requirement are in the vast minority.

In conclusion, in counselling/psychotherapy, direct observation, whilst used in some specialised contexts, such as family therapy, has not been used historically during training for one-to-one counselling as this would undermine the confidentiality expected by clients, compromise the therapeutic alliance and could potentially result in significant information not being shared by vulnerable people, such as the intention to take their own life by suicide or sexual abuse. It is disconcerting that this criterion has been included as it evidences a profound misunderstanding of how counselling/psychotherapy works and the importance of the trust between practitioner and client, in addition to the problematic infrastructure the professions currently work within.

The presence of direct observers would inevitably result in:

- a) Clients avoiding making significant, helpful personal disclosures.
- b) Clients declining to share their problems out of fear, embarrassment, criticism, censure or anxiety about judgemental attitudes of any kind due to the lack of proper confidentiality.
- c) A technique-oriented and surface-level form of therapy.
- d) Self-consciousness in counsellor and client as opposed to the self-awareness that can only emerge in a climate of safety.
- e) Therapy as performance.
- f) Psychological harm being caused to clients with a background involving sexual, emotional or physical abuse who may experience their boundaries being violated by this suggested procedure.
- g) Reduction in affordable counselling/psychotherapy services for the public in an already drastically underfunded industry.
- h) Significant GDPR risks.

It is invalid, therefore, to say that direct observation is a necessary criterion for counselling and psychotherapy training because it has been done before and, in some instances, produced positive outcomes; if it is done with more functional clients, it excludes vulnerable members of society and cannot be facilitated within the field. If students need clients who are willing to be observed, the profession is at risk of isolating students' clinical work to those from the more functional category of clients while at the same time denying access to the most vulnerable members of society who currently are most likely to access the services provided by students. In addition, affordable services are likely to significantly reduce nationwide with no government efforts to further invest in the organisations that could support such a placement structure. None of these outcomes are in the best interest of protecting the public, the opposite is predicted instead, a high risk of potential harm to the public.

██████████ strongly disagrees with the Board's decision to include direct observation as we deem it to be a serious ethical violation of a vulnerable population that can lead to profound and lasting effects on clients. ██████████ suggests that the Board take into account the function of clinical supervision as part of contemporary practice, in which counsellors are deemed able and bound by a Code of Ethics to self-select that material which merits professional scrutiny, including personally challenging aspects of process; legal and ethical compliance issues, transference and countertransference concerns, clinical interventions etc.

Section 6: Domains of Proficiencies

While it is essential to acknowledge the importance of regulatory frameworks in ensuring the safety and well-being of individuals receiving health and social care services, there are arguments to be made for exempting counselling and psychotherapy from specific proficiencies within the four domains of regulation universally applied to other professions in Ireland. It is crucial to consider the unique nature of counselling and psychotherapy and how overly restrictive regulations may hinder rather than enhance the effectiveness of these therapeutic practices.

Counselling and Psychotherapy, as mental health professions, primarily operate at an internal level, focusing on the psychological and emotional aspects of an individual's well-being. On the other hand, many other health and social care professions often work at an external level, addressing physical symptoms or observable behaviours and working in the external realm of multidisciplinary teams and systems. The therapeutic relationship is often client-centred, with the client actively participating in the process of self-discovery and healing. The therapist serves as a facilitator, guiding the client in exploring and resolving internal challenges. In many other regulated health and social care professions, the focus is often on the condition or symptoms, and the professional takes a more directive role in prescribing treatments or

interventions. The client's active involvement may be more limited, especially in cases where the condition is primarily physical. In the case of social care/social work, where there may also be an absence of physical issues, the interventions are systems-based, tangible, concrete and take place in a multidisciplinary context, again very different to the work of counsellors and psychotherapists.

The application of a uniform set of proficiencies across the first four domains does not take this into account, and in applying this mirror model of regulation, there are central tenants of counsellor and psychotherapist development that are omitted from the proficiencies, which dilutes the existing training standards and poses a major risk to those entering the profession and the public receiving services. These omissions centre around the themes of personal development, growth and personal process.

The therapeutic process involves understanding one's own thoughts and emotions, fostering self-awareness, and making internal changes to improve mental health and well-being. It is highly unethical for a counsellor/therapist to not have engaged in this process themselves before they work with clients to enable the same. Much of this argument has been addressed within Section 2: Personal Therapy. However, in addition to the importance of undergoing a personal one-to-one therapeutic journey, it is essential that students are facilitated in the classroom environment to experientially engage in a process of self-development. With the majority of the proficiencies focused on professional development, social policy, legislation and teamwork, courses will have to compromise essential personal process-related lesson planning to make room for less applicable and lower-priority proficiencies. This will significantly change the face of counselling and psychotherapy training and change the profile of the graduate, making them less equipped to sit alongside the personal transformative journey of their clients. This poses a major risk to the public.

Some essential proficiencies that are missing from the first four domains could include:

- The ability to attach meaning to experiences and to understand the meaning behind these experiences in order to facilitate service user insight and discovery.
- The ability to authentically engage with service users' search for purpose and understanding in the context of their unique life journey.
- The ability to emphasise the interconnected nature of human identity and the significance of relationships in shaping individual well-being.
- Be able to articulate a comprehensive understanding of the psychological, emotional and physiological dynamics of universal issues, such as grief and loss, sexuality, identity, spirituality and life transitions.
- Demonstrate a comprehensive understanding of the role of early life experiences in shaping one's current emotional, cognitive and relational well-being.

- Demonstrate the ability to engage in continuous self-reflection, employing the internal supervisor as a valuable tool for monitoring personal and professional growth, enhancing therapeutic effectiveness, and navigating ethical considerations within the counselling/psychotherapy context.
- Demonstrate an understanding of the stages of competence, particularly unconscious competence, and apply this awareness to enhancing counselling/psychotherapy practice.

Please see below examples of proficiencies posed by the Board that are not a priority for the counselling and psychotherapy professions:

DOMAINS AND PROFICIENCIES	ISSUES RELATED TO COUNSELLING AND PSYCHOTHERAPY
<i>Domain 2: Communication, Collaborative Practice and Teamwork</i>	
<u>Proficiency 5:</u> Be able to recognise when the services of a professional translator are required	This is not a priority proficiency for counselling and psychotherapy. Clients referred to students must undergo a referral assessment, which is carried out by a qualified professional to determine suitability in the first instance. Unless a service is equipped to provide the service with access to a translator, this referral would not be taken on, nor would such a case be referred to a student.
<u>Proficiency 8:</u> Be aware of and comply with local/national documentation standards, including, for example, terminology, signature requirements	This is not a priority proficiency for counselling and psychotherapy. Counsellors and psychotherapists are not required to interact extensively with complex documentation systems. In contrast, roles in multidisciplinary teams or institutional settings may involve more robust documentation requirements, making it more of a priority in those specific contexts, which are not generally available to the counselling and psychotherapy professions.

Proficiency 9: Be able to express professional, informed and considered opinions to service users, health professionals and others, e.g. carers, relatives in varied practice settings and contexts and within the boundaries of confidentiality	This is not a priority proficiency for counselling and psychotherapy. The primary focus of counselling and psychotherapy is on the well-being and needs of the client. While expressing professional opinions is important, the emphasis is typically on facilitating the client's self-exploration and decision-making rather than imposing the practitioner's opinions. Counsellors/psychotherapists often prioritise active listening, empathy, and understanding over expressing their own perspectives. Counsellors/psychotherapists work on a one-to-one basis with service users and do not engage with relatives and carers.
Proficiency 12: Understand the need to work in partnership with service users, their relatives/carers and other professionals, with service user consent, in planning and evaluating goals, treatments and interventions and be aware of the concepts of power and authority in relationships with service users	This is not a priority proficiency for counselling and psychotherapy. Counsellors/psychotherapists must work in partnership with their clients, in fact, the clients lead this work, but they will not, in the majority of cases, collaborate with families or other professionals. The nature of the one-to-one therapeutic relationship creates an insular dynamic that exists primarily between the counsellor/psychotherapist and the client.
Proficiency 13: Understand the need to build and sustain professional relationships as both an independent practitioner and collaboratively as a member of a team	This is not a priority proficiency for counselling and psychotherapy. As previously discussed, counsellors/psychotherapists do not work in team settings.

Proficiency 14: Understand the role and impact of effective interdisciplinary team working in meeting service user needs and be able to effectively contribute to decision-making within a team setting	As above.
Domain 3: Safety and Quality	
Proficiency 3: Be able to determine the appropriate tests/assessments required and undertake/arrange these tests	The language is not helpful as test and assessment typically refer to diagnostic processes, which is not the role of the counsellor/psychotherapist
Domain 5: Professional Knowledge and Skills	
Counsellor Proficiency 20: Be able to articulate the necessity of engaging in clinical supervision to support, sustain and improve practice.	How is it possible to meet this proficiency when clinical supervision is not a training requirement?
Psychotherapy Proficiency 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.	This is also applicable to the counsellor proficiencies and should not be omitted.
Psychotherapy Proficiency 26: Be able to articulate the parameters and value of clinical supervision and demonstrate the ability to utilise supervision to assist in practice review and in areas for development.	How is it possible to meet this proficiency when clinical supervision is not a training requirement?

We request that the Board review all domains of proficiency with the primary focus on the uniqueness and identity of the professions and detach from the goal of applying a uniform set of proficiencies, more suited to professions concerned with an external focus of practice, than that of the professions of counselling and psychotherapy.

Conclusion

██████ thanks the Board for their hard work in producing the draft standards and criteria for counsellors and psychotherapists and acknowledges the challenges that the Board faces in regulating the counselling and psychotherapy professions, where the essence of training is formed around the process of 'being' rather than 'doing'. If the Board does not reconsider their position and move from a mechanistic, generalised cross-profession approach to training, then our prediction is that the identity of the professions will be irreparably changed forever. If it is CORU's expectation that this is how colleges will train counsellors and psychotherapists in the future, this poses a significant risk to the public.

We hereby request:

1. The inclusion of personal therapy as a mandatory training requirement as an ethical duty of care to the students and the public.
2. A reduction of the total number of practice placement hours as an ethical duty of care to the student therapist and to better represent the infrastructure of counselling and psychotherapy services in Ireland.
3. The removal of the inclusion of direct observation as a training requirement as an ethical duty of care to the public.
4. A review of the model of supervision to better represent the uniqueness of the profession and the existing structures in place for gatekeeping, namely assessment through the colleges rather than on-site in placements and the inclusion of clinical supervision.
5. A review of the proficiencies within the first four domains to better align to the professions in order to protect the identities of counselling and psychotherapy.

We also add a strong statement of support for the minimum threshold for entry onto both registers.

Thank you for taking the time to consider our feedback on this important process.

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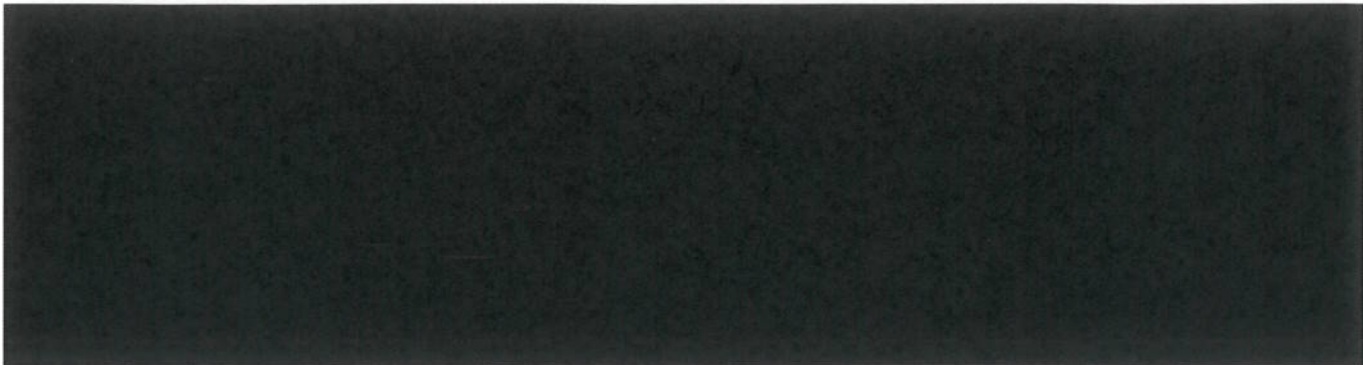
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CORU PUBLIC CONSULTATION

**STANDARDS OF PROFICIENCY AND
CRITERIA FOR EDUCATION AND TRAINING PROGRAMMES FOR
COUNSELLORS AND PSYCHOTHERAPISTS**

FEEDBACK FROM [REDACTED]

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Our submission is made in response to the Standards of Proficiency and the Criteria for Education and Training Programmes for both Counsellors and Psychotherapists.

We provide feedback on the following:

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Two Professions

We note and support your decision to differentiate between the professions of Counselling and Psychotherapy. You do not, however, provide any clarity about these differences. In fact, we note that you make **no** distinction between the professions of counselling and psychotherapy with regard to:

- the Criteria for Education and Training Programmes
- the Standards of Proficiency:
 - Professional Autonomy and Accountability
 - Communication, Collaborative Practice and Teamworking (barring one omitted phrase in item 12. For more detail please see feedback on Standards of Proficiency below.)
 - Safety and Quality (barring one omitted phrase in item 2. For more detail please see feedback on Standards of Proficiency below.)
 - Professional Development
 - 16 of the Professional Knowledge and Skills.

Please can you offer a clear working definition of each profession and the distinguishing factors of each?

Psychotherapy

Level of qualification

We disagree that the minimum level of qualification for both Counselling and Psychotherapy should be at Level 8 on the National Framework of Qualification (NFQ). We believe that Psychotherapy requires qualification at Level 9. We are not alone in our position. The minimum education and training requirements to become a psychotherapist in nine European countries are a three-year University Degree followed by a Masters level qualification. If we proceed with the CORU proposal as it stands, Ireland will be notably out of step with our European partners. The profession of psychotherapy in Ireland will be substantially diminished.

The NFQ Level 9 learning outcomes require evidence of an ability to “integrate knowledge, handle complexity and formulate judgements”, “select from complex and advanced skills” and “scrutinise and reflect on social norms and relationships and act to change them”. In line with these NFQ Level 9 descriptors, we see psychotherapy as a more in-depth and long-term process than counselling requiring advanced knowledge and skills in the field of mental health, with psychotherapy often concentrating on personality formation and development, working towards reconstruction and change. Similarly, the Professional Knowledge and Skill Standard of Proficiency no. 11 requires psychotherapists to work with... varying degrees of complexity... in order to facilitate long-term change. This would appear to be in line with the NFQ Level 9 standards.

Learning outcomes at Level 9 further require the learner to “act in a wide and often unpredictable variety of professional levels and ill-defined contexts”. Indeed, in addition to working in the community and private practice, psychotherapists are likely to work in hospitals, clinics and mental health settings, including with clients who have experienced profound deprivation, dysfunction and breaks from reality as we ordinarily understand it. Psychotherapists work in multi-disciplinary teams, alongside, and in collaboration with, psychiatrists, psychologists, psychiatric social workers and mental health nurses. Psychotherapy practice requires psychotherapists to maintain and tolerate several complex and apparently contradictory perspectives in an attempt to remain available and open to therapeutic possibilities.

The NFQ Level 9 requirement to “learn to self-evaluate and take responsibility for continuing academic/ professional development” is in line with the Professional Development Standards of Proficiencies for Psychotherapists.

We thus, believe, on the whole, that psychotherapy training more closely meets the standards for qualification at Level 9 than at Level 8 on the NFQ.

Mental Health Placement

In preparation for their work in mental health setting and in collaboration with allied professionals, we believe that psychotherapists in training should be required to undertake a mental health placement. We suggest this addition to the Criteria for Education and Training Programmes for Psychotherapists. In line with European norms, we suggest that this mental health placement would be 120 hours in duration.

Personal Counselling

Personal Counselling in the Criteria

We note that attendance at personal counselling is not included in either the Criteria nor the Standards for either profession. We read in the Introduction to the Criteria for Education and Training Programmes for both Counsellors and Psychotherapists that "The criteria specify the requirements for the design, organisation and management of a programme..." to ensure that it can consistently and effectively produce graduates who meet the standards of proficiency. We accept that *attendance* at personal counselling is not a proficiency per se and thus cannot be inserted into the standards of proficiency. However, given the above description of the criteria we hold that attendance at personal counselling can and should be included in the *design* of approved counselling programmes and so should be included in the Criteria for each profession.

Personal Counselling in the Proficiencies

Personal counselling linked to the achievement of proficiencies.

The rationale given by Catherine Byrne in response to a question about the omission of personal counselling posed at the 1 September 2023 CORU Briefing on the Regulation of Counsellors and Psychotherapists in Ireland was that personal counselling hours are not linked to the achievement of proficiencies. We, experienced practitioners and educators in the professions, strongly disagree with such a perspective. Indeed, consistently, over time, research has found that "it is the relationship heals" (Yalom, 2012, p.112; Cooper, 2008). "Psychotherapy works predominantly, not because of the unique contributions of any particular model of therapy or unique set of interventions (what we call the model-driven change paradigm), but rather because of a set of common factors or mechanisms of change that cuts across all effective therapies." (Sprenkle et al., 2009, p.2). The therapist's ability to be fully present (Johns, 2013), their knowledge and use of self is a significant factor in positive therapeutic outcomes (Aponte, 2021).

Research shows that it is through personal counselling that trainee counsellors and psychotherapists develop this requisite self-awareness and relational capacity (Macran, Stiles & Smith, 1999). It is here that they further their ability to be congruent, authentic, empathic, open to experience, and to stay in emotional contact with self and others (Bento and Sousa, 2022). They further enhance their ability to recognise, heal and repair ruptures, to deal with unprocessed feelings, emotional avoidance, hostility and overidentification. Personal counselling allows them to become clear on their own boundaries and those of the clients and

recognise their limitations (Lundgren, 2013). We hold that courses must be designed to include self-exploration thus allowing students the potential to relate to themselves and their clients in a necessary and sufficient manner so that they can meet the standards of proficiency for the professions. Courses which exclude personal counselling, prioritising the practising of microskills to the exclusion of self-awareness and relational capacity risk producing expert technicians who are unable to provide the very thing which makes counselling and psychotherapy effective.

Personal counselling is measurable.

We further submit that personal development is indeed measurable. We have a great many years of experience in setting out the personal and professional development evidence that is required of students and in designing experiential learning opportunities and assessment tasks to facilitate and assess achievement of these standards. To this end, in the Standards of Proficiency section below we set out some suggested measurable personal development proficiencies.

Achievement of these personal development standards can be evidenced live by students in their relationships with peers, trainers and supervisors (Pieterse et al., 2012). Students can undertake self-assessment, maintain reflective personal development journals and include evidence of their personal and professional development in assignments, case studies and recordings of practice sessions (Jorgensen et al., 2003). Peers can offer feedback on their experience of one another's relational capacity in the training group and in practice counselling sessions. Trainers and supervisors can further assess and comment on same in trainers' and supervisors' reports.

As further evidence of the centrality, aims (proficiencies), methods and assessment of personal development in counsellor and psychotherapist training we direct you in the first instance to Johns (2013). We refer you to the extensive and still growing body of literature on the use of self-development and self-awareness of the therapist as a distinctive part of the therapeutic process and psychotherapy training programmes (Kissel et al., 2018; Simon, 2006, 2012). We invite you to see Aponte (2022) for a description of another training programme, which systematically focuses on the person of the therapist and how to develop the trainees' knowledge and mastery of their personal development and appropriately apply and integrate it in their counselling practice. Finally, we refer you to the SCoPEd Framework (2022), a collaboration of the Professional Counselling and Psychotherapy Standards Authorities in the UK. This framework sets out the core competencies required for

safe and ethical practice for Counsellors and Psychotherapists in the UK and details several proficiencies relating to the use of personal development.

Training Institute Discretion in Relation to Personal Therapy

We acknowledge that individual courses and professional bodies may continue to include attendance at personal counselling in their requirements. Nonetheless, we are concerned that some will not do so. Such courses will remove the financial cost of personal counselling and will thus become more attractive to a potential student. Students graduating from such courses will still be entitled to join the Register, irrespective of the standards held by the professional bodies. This will create confusion for the public, not clarity.

Unsafe

Over time, the demand for more affordable courses will mean that training without the requirement of attendance at personal counselling will become the norm. The absence of personal counselling in training courses will undermine our standards of practice and diminish the quality of our awards. Increasingly over time, our profession will be populated by practitioners who have never attended counselling or psychotherapy, who have not attended to their own personal development needs, who cannot relate to the client's experience and who are unaware of the impact they are having on clients. At best they will be ineffective; at worst they will cause unknown harm. The much sought after protection for the public will be rubbished.

Beyond the relationship and impact on clients, personal counselling affords counsellors and psychotherapists the essential forum and scaffolding to support their personal and professional development. Counselling & psychotherapy, by their very nature, attract those who are empathic, helpful and also often wounded in their own lives (Lewis, 2004). Given the nature of helping, it understandably provides a great distraction from one's own wounds when one helps others. Without then, the support and protection of personal therapy, the trainee therapist's processing will be inhibited. The possibility of helping, in order to meet the therapist's needs, rather than the client's, is more likely.

Personal counselling, furthermore, offers a forum for counsellors and psychotherapists to unravel the complex interpersonal and co-created dynamics that emerge in the therapeutic relationship. Without a grounding in personal counselling, counsellors and psychotherapists will have limited awareness of their own contribution to the process, or of how 'unconscious' or 'out of awareness' processes

and reenactments, in both client and therapist, may shape perceptions and experiences and influence the therapeutic process (SCoPEd Framework, 2022). Personal therapy thus protects both therapist and client and clears the therapeutic space for relationship, therapeutic and supervision work to occur.

In addition, training institutes will fail in their ethical responsibility and duty of care to support and assess the psychological resilience, professional suitability and fitness to practise of students preparing for these professions. Levels of vicarious trauma, compassion fatigue and professional burnout amongst counsellors and psychotherapists will increase. We will create a worsening mental health crisis further undermining the protection sought and purported by CORU.

Supervised "Service User" Contact

We reject the term "Service User". Like MacLaughlin (2009) we feel it gives people a very narrow identity in terms of what services they use in their lives and it ignores many other aspects of the person's identity that are resourceful, creative and positively functional. In our professions the most commonly used term is "Client".

We appreciate CORU's recognition that students on placement are required to learn and practise a vast array of tasks and skills outside of direct client contact that are fundamental to the practising of the profession.

Having noted the above, however, we are concerned at the number of direct client contact hours that both counselling and psychotherapy students are required to undertake. There are a number of reasons for this concern:

1. Requiring each student to undertake 300 or 350 hours of direct client contact will put real and overwhelming pressure on the professions in terms of availability of suitable placements, clients, counselling rooms, in-placement supervisors/ mentors, and clinical supervisors. Demand will exceed capacity and the hours will prove impractical.
2. Unlike other medical and allied professions who undertake placement blocks thereby relatively quickly accumulating placement hours, counselling and psychotherapy require ongoing consistent availability for a therapeutic relationship across time, making for a slower, reflective progression through placement. The length and nature of each therapy session is quite different from that of a medical and/or nursing consultation. In counselling and psychotherapy the time with the client is, by design, slower and more considered. In some of the work we do with placement students, we deliberately encourage them to slow down and often stay with the emotional intensity. If our goal is knowledge retention, therapeutic process and reflection then a slow pace, over time is essential.
3. Because of the process outlined in no.2 above, there are professional and ethical considerations regarding the number of clients that students can safely and effectively hold at any one time, thereby limiting the rate at which students can accumulate placement hours. We are concerned that if students are under pressure to move through high numbers of client sessions, then there is introduced an unethical temptation to ignore clients' needs and students' capacity, relationship dynamics, well-being and effectiveness in favour of accumulating hours.

4. There will be insufficient time over the course of three to four years for students to properly undertake that number of placement hours in addition to attending to the other course requirements.
5. Additional allowances need to be made for cancellations and no shows at the novice practitioner level.

We further submit that awareness of the limitations of capacity are key. Students should not be allowed to begin any client contact until certain proficiencies have been obtained. Thereafter, the client contact tasks undertaken at each stage of training should be incremental and proportionate to the student's stage of learning. For example, students in the early stages of a training programme would not be sufficiently trained to offer counselling or psychotherapy to clients and should not do so.

Direct Observation of Client Sessions

We appreciate the need for some direct observation of student practice in order to assess proficiency. We are, however, highly concerned about the amount of direct observation that is proposed by CORU. The effect of such observation on the client and on the therapeutic relationship, is complex, rendering the stipulation unethical and dangerous for some clients.

Clients seeking counselling tend to have been hurt and disempowered in some way. Their trust has oftentimes been broken. Counselling and psychotherapy offer a protected, confidential space where the client can engage in a trusted relationship with a known professional. Counselling placements too, are often community-based, delivering services to marginalised groups. Such client groups are, by their very nature, sensitive to being objectified or overpowered in professional arenas. The introduction of direct observation undermines the very safety on offer, changes the contract and raises questions around coercive consent. The complexities include:

- why the client would consent to direct observation,
- whether or not clients have the capacity and autonomy to refuse consent,
- what will be the impact of refusing consent,
- what possible implicit processes pre-exist that cause clients to opt for therapy with students under direct observation and prevent them from attending a qualified practitioner without the stipulation of direct observation. Will these same processes affect the client's ability to consent/ refuse consent?

One might go so far as to suggest that the proposal, with the high number of direct observation hours, could unintentionally result in the exploitation and abuse of the most vulnerable clients. One might ask who is benefitting from this imposition.

Direct observation introduces complex dynamics that will affect the therapy. We doubt if students in training are sufficiently experienced to manage these dynamics such that the well-being and needs of the client are prioritised. One must then favour an alternative means of assessing for proficiency that significantly reduces the risk of harm to the client. We would like to submit such a proposal.

Direct observation of skills practice

The current mechanisms for ensuring proficiency in the professions require students to undertake directly observed formative and summative skills practice, firstly with peers in the role of client. Where peer-clients are instructed to bring real issues and where counsellors work with the same peer-client for a number of sessions the

reality of these practice sessions is maintained. These peers could come from a different training group/ year thereby minimising the possibility of a dual-relationship. As both parties are students in training, direct observation of these sessions creates fewer ethical concerns.

Catherine Byrne asserted that the development of counselling or psychotherapeutic practice is an incremental process and we agree that such direct observation might be usefully weighted more towards the earlier stages of practice. Some lesser amount of direct observation of client work in latter years is still possible, for example through sitting in on sessions with a qualified practitioner, submitting session notes and process notes, audio recording sessions and writing case studies. We might suggest that such direct observation of client contact work (not peer practice sessions) could amount to 25 hours. Placement tasks and professional relationships outside of the therapy room can also be directly observed.

Clinical supervision

Most importantly, the quality and effectiveness of *qualified* counsellors' and psychotherapists' work is maintained through engagement in clinical supervision. If we are preparing students and assessing their readiness to practice in these professions then we need to teach them to engage in reflexive practice, to appreciate the nature and purpose of supervision, and to practice exploring the effectiveness of their client work in supervision. It is here, in clinical supervision, that student's attainment of minimal levels of proficiency in providing therapy and reflecting on their work can be effectively taught and assessed.

Supervision

We note an alarming discrepancy between what CORU term supervision and what the professions of counselling and psychotherapy understand supervision to mean. Contrary to the monitoring and assessment detailed in the Criteria for Education and Training Programmes for both Counsellors and Psychotherapists, clinical supervision within the counselling and psychotherapy professions is "a forum where supervisees review and reflect on their work in order to do it better" (Carroll, 2007: 36). Hawkins and Shohet (2012) state that "supervision is a joint endeavour in which a practitioner with the help of a supervisor, attends to their clients, themselves as part of their client practitioner relationship, and the wider systematic context" (p.5). Though critical reflection, supervisees make sense; in making sense they understand, and in understanding they learn (Carroll, 2007).

It is this transformational learning, learning which extends beyond the transfer of ideas or knowledge to a change of mindset or behaviour, which results in more competent, creative practice into the future (Carroll, 2008). Clinical supervision thus "improves the quality of their work, transforms their client relationship, continuously develops themselves, their practice and the wider profession" (Hawkins & Shohet, 2012, p.5).

Supervisors, drawing on their experience and training, facilitate this reflective, transformational process. They further offer feedback, guidance and suggestions to enhance supervisees' skill development. Through exploration of challenges and ethical dilemmas trainees learn applied ethical decision-making processes ensuring safe, ethical and professional practice. Clinical supervision offers an appropriate, bounded space for therapist emotional processing and support. Awareness of dynamic processes, biases, and blindspots is facilitated. All of this serves to prevent therapist burnout and harm to clients. Therapeutic effectiveness is enhanced.

The professions are not negligent with regard to the need for monitoring and assessment of proficiency either. Supervisors oversee, monitor and assess the quality of each therapist's practice in line with specified standards of proficiency and ethics, thereby acting as gatekeepers to the profession. Areas for ongoing learning and continuing professional development can be identified and monitored.

In this sophisticated manner clinical supervision fulfils normative (monitoring), formative (learning and growth) and restorative (support) functions (Proctor, 1987). Therapists' standards of competence are monitored, maintained and developed and

the quality of the therapeutic service given by the therapist to the client are ensured and promoted.

Internationally, the professions of counselling and psychotherapy require their members to attend *this* reflective clinical supervision. Professional bodies state that it is unethical to practice without *this* supervision. We require this same standard of clinical supervision to be included in the Criteria for Education and Training Programmes for both Counsellors and Psychotherapists separate from and in addition to in-placement management.

Clinical Supervision in the Standards of Proficiency

We note that The Standards of Proficiency of Personal Development refer to the requirements to

3. Be able to evaluate and reflect critically on own professional practice to identify learning and development needs; be able to select appropriate learning activities to achieve professional development goals and be able to integrate new knowledge and skills into professional practice
4. Understand and recognise the impact of personal values and life experience on professional practice and be able to manage this impact appropriately
5. Understand the importance of and be able to seek professional development, supervision, feedback and peer review opportunities in order to continuously improve practice to be able to evaluate and reflect critically on one's own professional practice, to identify learning and development needs,

We believe that these, and other requirements, can be best met, developed and monitored in clinical supervision.

Supervision for Registered Members

We further require qualified counsellors and psychotherapists to continue to attend regular clinical supervision for the duration of their career.

"For those who still need convincing of its [Clinical supervision's] utility, it may be important to emphasize the advantages of this reflective practice and to stress the privilege of being part of a profession that emphasizes the importance of creating a professional watering hole. The access to clinical wisdom, the sense of professional identity which is created in the inter-subjective space between therapist and supervisor, the fact that the learning

is custom-made to the individual struggling with a problem, and the notion that supervision can be an antidote to burnout, staleness and grandiosity may be the more significant reasons to continue to encourage a culture of supervision".

(Grant & Schofield 2007, p.14)

Clinical supervision should be stipulated as a requirement for ongoing membership of a Registration Board.

Governance of Training Institutes

We are concerned about the governance of training institutes. Please can you direct us to your requirements on the financial, legal, governance, external regulation, and academic quality assurance structures and practices? You say that "The criteria specify the requirements for the design, organisation and management of a programme..." but we see little about the organisation and management requirements.

We are further concerned about what we perceive to be the low standards required of trainers and supervisors. We understand any individual involved in the teaching, supervising and/or assessing of students will be required to have the appropriate qualifications, expertise and knowledge to undertake the role and (in time) will be required to be members of the appropriate registration board. You do not appear to specify further about what these qualifications are, nor the amount of experience required. We hold that the training of counsellors and psychotherapists (who will ultimately practice with vulnerable clients), is an onerous responsibility, demanding at least the more senior members of each Training Team to be experienced beyond the level of basic qualification and registration with the professional board. The current requirement of the IACP for core trainers is that they would be five years accredited (that is seven years post-qualification) and have four years' experience as a trainer. We suggest this standard is at least maintained.

Whilst we agree that trainers and supervisors should come from within the professions we also believe that other professions have valuable contributions to make. What provision have you made for trainers from different/ non-registered professions? For example, we employ a research trainer who is not a counsellor nor a psychotherapist but from an allied social science.

Standards of Proficiency

We understand that CORU has drafted one set of standards, specific to each profession. We wish to state that the set of standards issued in relation to counsellors and those for psychotherapists contain language and set out proficiencies that are either completely unrelated to our professions and/or are in direct opposition to our values and practices. For example,

- As noted above, the term "Service User" is not used in our professions. Please use the term "Client" instead.
- You repeatedly refer to health and social care but fail to refer more specifically to counselling, psychotherapy, the therapeutic process, well-being, etc. We appreciate that the registration of Counsellors and Psychotherapists is being prepared under the Health and Social Care Professionals Act (2005) and we view our professions as being aligned with this, however we would like the language of our documents to more closely reflect our counselling and psychotherapy work. For example, in the Safety and Quality proficiency no.1, we believe that, in addition to gathering information relevant to the client's health and social care needs, counsellors and psychotherapists should also enquire about the client's therapeutic needs.
- Very many counsellors and psychotherapists do not diagnose unless otherwise specifically trained to do so. They do not "treat" clients, create "problem lists" or undertake tests.
- Whilst counsellors and psychotherapists might make interventions, these are reflective and dialogical in nature rather than prescriptive or medical.
- We are not involved in infection prevention or control.
- Counsellors and psychotherapists work collaboratively with clients to empower them and promote their own sense of autonomy, agency and well-being. Generally speaking, we do not communicate with carers, relatives or other health professionals unless safety concerns require us to do so. Oftentimes, we try to create a protected space for the client, boundaried and separate from others.

All of these proposed standards appear to originate in the medical professions and do not relate to our work.

Here below we respond to the specific Standards of Proficiency for each profession. The numbers relate to the item number in the draft Standards of Proficiency for both

professions. Where a comment relates to just one profession or the other this is clearly indicated.

Professional Autonomy and Accountability

- 5.** Many counsellors and psychotherapists do not have a role in diagnosing clients unless otherwise specifically trained to do so. This term should be removed.
- 9.** There are other stakeholders. Students and supervisors should be included.
- 11.** "the team setting" - what team setting? Do you mean in the context of *a* team setting or within a specific placement? Whilst trainees will undertake practice in a placement setting many counsellors and psychotherapists operate in private practice and not in a team.
- 12.** "the limits of the concept of confidentiality" - we suggest that you remove the phrase 'the concept of'. We do not believe that confidentiality is a concept and do not want students to conceive of it ethereally. It is a commitment.
- 15.** The language of assessment and treatment here is medical in origin and does not describe what we offer. In the Counselling and Psychotherapy professions "the term assessment is used to indicate the ability to evaluate suitability for therapy (consistent with one's therapeutic training) and develop a working-plan of therapeutic steps" (SCoPEd Framework, 2022).

Communication, Collaborative Practice and Teamworking

- 1.** We reject the terminology of assessment, diagnosis, treatment and management. This does not describe what we do or how we do it. Indeed, in many instances it is the direct antithesis of what we offer. This language demonstrates a lack of understanding of our professions.
- 2.** Also considering the nature of the experiences and emotions that the client is trying to convey.
- 2.** What do you mean by social care needs in this context?
- 3.** The inclusion of health and social care needs is correct however this is not the primary concern of counselling and psychotherapy. Why is there no reference to counselling/ psychotherapy, therapeutic process, wellbeing, etc.? We are counsellors and psychotherapists, not medical or social care professionals.
- 4.** Counsellors and psychotherapists rarely advise.
- 4.** What is meant by self-treatment in the context of counselling and psychotherapy? Again, this medical terminology is out of place in our profession.
- 9. and 12.** Whilst counsellors and psychotherapists might on occasion communicate with careers or relatives this practice is much less frequent than within the medical/ social care professions. Their inclusion is overemphasised here.

12. We note that counsellors are required to work “with service user consent” whereas this phrase is not included for psychotherapists. We assume that this is an oversight. If not, can you please explain the rationale for the discrepancy?

12. The focus of this proficiency is misplaced in the counselling and psychotherapeutic professions. The primary (and often only) active participant is the client themselves. Typically, the work is at the exclusion of other interested parties unless safety concerns require otherwise.

Safety and Quality

2. We note that psychotherapists' assessment “must be relevant to what is necessary for the safe practice of psychotherapy” whereas an equivalent phrase is not included for counsellors. We assume that this is an oversight. If not, can you please explain the rationale for the discrepancy?

3. Counsellor and psychotherapists do not determine, undertake or arrange tests. This is entirely out of place in our professions.

4. Counsellors and psychotherapists are not required to analyse client information. Instead, we seek to understand the client and their worldview, as they see it themselves.

5. Many counsellors and psychotherapists do not determine problem lists, action plans and goals. Instead, we seek to understand the client, their worldview and their presenting issues. We seek to empower the client to determine their own goals for counselling/ psychotherapy. We work together with the client, regularly empowering them to review their goals and to discover what helps and what hinders this process for each individual client. Research shows that “the quality of the client’s participation in psychotherapy is the most important determinant of outcome” (Orlinsky, Ronnestad & Willutski, 2004, p.307-389).

14. Counsellors and psychotherapists are not involved in infection prevention and control strategies. This does not belong as a standard of proficiency in our professions.

Professional Knowledge and Skills

Common to Both Sets of Standards

1. We note that psychotherapists are required to work within a framework based upon established psychotherapeutic theory and practice but counsellors do not have an equivalent requirement to work within a framework based upon established counselling theory and practice. Can you please explain the rationale for this discrepancy?

5. Students should also identify and understand the impact of these systems on individuals and the therapeutic process.

8. What is the rationale for counsellors and psychotherapists knowing effective teaching, learning, mentoring and supervision principles?

21. How would trainee counsellors and psychotherapists be able to recognise personal emotional responses, vicarious trauma and the need to develop effective self-care strategies and burnout prevention when they have never been required to attend personal counselling or clinical supervision. This further emphasises the importance of incorporating personal counselling and appropriate clinical supervision into the Criteria for Education and Training Programmes and the latter as an ongoing condition of membership of the Registration Board.

22 Counselling. and 27 Psychotherapy. We wholly disagree with the inclusion of this proficiency. Its inclusion is unethical. The provision of counselling and/ or psychotherapy through virtual methods is a distinct practice, with unique, and often complex dynamics including issues of identity and presence, fantasies and assumptions about the therapist and client and the lowering of inhibitions, which unless addressed pose inherent dangers. It requires specialised training. Whilst graduating counsellors and psychotherapists should be aware of the uses and dangers of practising virtually in no way will they be fully qualified in it unless their training is a specific cyber counselling programme. It is thus an inappropriate general proficiency for this profession at this level. Its inclusion is akin to requiring all counsellors and psychotherapists to offer play therapy where their training might not have been a specialised play therapy programme.

Counsellors Only

9. Counsellors do not treat presenting concerns. They provide counselling to clients.

14. We believe that the phrasing of the psychotherapy proficiency 18 should be included here to include "ensuring the therapeutic goals and each person's expectations and responsibilities are clear to all parties involved".

18. Counsellors should be able to identify *and maintain* professional and ethical boundaries.

20. How would a trainee counsellor be able to articulate the necessity of engaging in clinical supervision when they have never been required to engage in it? The learning will remain at an academic/ theoretical level. This requirement further emphasises the importance of incorporating appropriate clinical supervision into the Criteria for Education and Training Programmes and as an ongoing condition of membership of the Registration Board. We believe that graduating counsellors should not only appreciate the need for supervision; they should also demonstrate

knowledge of the aims, functions and processes of supervision, negotiate an effective supervision relationship and effectively *engage* in supervision.

24. It is unclear what is required here. The psychotherapists' standard is clearer and should be adopted: Be able to identify and critically evaluate how psychosocial factors may affect both the client and the therapeutic process, and manage these in the therapeutic relationship.

Suggested Additions – Counsellors Only

We believe that counsellors should be able to critically appraise current policies applicable to the work of their profession and the role of counselling in the development and implementation of policy on health and social care on a national and international level. This is required of psychotherapists and we believe equally that counsellors should represent themselves.

We believe that counsellors should be able to reflect on the impact of the client's experience, be able to demonstrate an understanding of their feelings and emotions and communicate that understanding in a non-judgemental manner. This standard is included for psychotherapists and equally applies to counsellors.

Psychotherapists Only

25. and 26. These standards of proficiency would necessitate for a psychotherapy trainee to actively engage in clinical supervision as part of their training. This requirement indicates that appropriate clinical supervision should be included in the Criteria for Education and Training Programmes and as an ongoing condition of membership of the Registration Board.

Suggested Additions – Psychotherapists Only

We believe that psychotherapists should be able to recognise and manage the dynamics of power and authority as experienced in the therapeutic relationship. We wonder why this standard is included for counsellors but excluded for psychotherapists.

Given their particular role in the field of mental health we believe that in addition to the proficiencies outlined in the draft documentation, psychotherapists should also be able to:

- "understand the language and discourses around diagnosis, psychopathology and mental disorders" (SCoPEd Framework, 2022) originating within nursing and medical models. In so doing, psychotherapists should be able to converse

across different frameworks and terminology, with a variety of professionals, as required,

- critique the diagnosis framework through their own psychotherapeutic lens, and know differences between their own model and that of other professionals,
- understanding the parameters of law as it relates to mental health and involuntary hospitalisation.

Suggested Additions – Both Professions

In line with the requested inclusion of personal counselling and clinical supervision we believe that both counsellors and psychotherapists should be able “to make use of personal development, self-awareness and supervision to reflect on, learn from and enhance therapeutic practice”. They should be able “to be emotionally prepared for intense and complex work, which requires sustained reflexivity” and should “evidence reflexivity, self-awareness and the active use of self to work at depth in the therapeutic relationship and throughout the therapeutic process” (SCoPEd Framework, 2022).

We believe that both counsellors and psychotherapists should understand abuse and abusive systems. They should be able to define, discuss and understand the misuse of power and abuse and how this manifests itself in individual behaviour and in its systemic influence on families, organisations, and groups, including ‘unconsciously’ or ‘out of awareness’. They should be able to name abuse directly and be aware of the implications for intervention. They should identify their own ongoing experiences with their personal power and tendencies of abusing, being abused, and enabling abuse and commit openly to non-abusive living.

In addition to working within their limits of knowledge and skills we believe that counsellors and psychotherapists should be able to tolerate and manage ambiguity, uncertainty, disapproval, ruptures and complaints. They should be able to challenge others in a respectful manner, clearly and directly articulate limits and boundaries, and deliver constructive positive and negative feedback, all whilst maintaining the relationship.

We believe that the standards of proficiency should explicitly require counsellors and psychotherapists to demonstrate an in-depth appreciation of the role of socio-cultural-political factors in human experience, display awareness of assumptions, biases and prejudices in self and others, and demonstrate an ability to work

empathically and relationally with difference. They should also be able to recognise and discuss “the harm caused by discriminatory practices and aim to reduce insensitivity to power differentials within therapeutic service provision, training and supervisory contexts”. (SCoPEd Framework, 2022)

Recognition of Degrees awarded by UK Validating Partners

In response to a question posed at the 1 September 2023 CORU Briefing on the Regulation of Counsellors and Psychotherapists in Ireland Margaret Hynds O'Flanagan stated that, "By law if a qualification is awarded outside the State it cannot be accredited by the State". Please can you direct us to the cited legislation?

From our reading of your proposed documentation, our [REDACTED]

[REDACTED] would not be eligible to apply for approved course status, despite being able to meet the criteria for education and training programmes for counsellors and psychotherapists, simply because it is academically validated by a UK University.

Further, the Criteria for Education and Training Programmes for both Counsellors and Psychotherapists: Introduction: Approval and Monitoring of Programmes state that "Students graduating from a non-approved programme are not eligible to apply for entry to the profession's register". As it stands then, we, as a training provider, are to be excluded from application for approved course status based on our UK academic validation, and in turn, our students would not be eligible to apply for entry to the profession's register.

We are extremely concerned at the culminative effect of these two statements. Such a position would render our course defunct thereby putting our training institute and counselling service out of business. We wish to lodge a formal challenge and submit the following for your consideration:

Lisbon Recognition Convention

The Lisbon Recognition Convention, officially the Convention on the Recognition of Qualifications concerning Higher Education in the European Region, provides legal agreement on credential evaluation. The Convention, which has been ratified by both Ireland and the UK, stipulates that degrees and periods of study must be recognised unless substantial differences can be proved by the institution that is charged with recognition.

Memorandum of Understanding between QAA and QQI

Substantial differences do not exist between a [REDACTED]

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From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Review
Date: Thursday 2 November 2023 18:42:33

Dear CORU Team,

My name is [REDACTED], I am a Psychotherapist and Counsellor with a [REDACTED] [REDACTED]. I live in and practice [REDACTED]. I am a member of [REDACTED]

I'm genuinely concerned for the future of mental health. For a long time the profession has been waiting for registration for psychotherapists and welcoming of the need to regulate psychotherapy. This is essential for setting the professional standard and ultimately to create safety for clients and professionals in this area.

The proposed draft criteria that CORU plan for the registration of psychotherapists and also for counsellors and their training in the near future is very concerning.

Across my 5 years of training to be qualified I have experience in group therapy, personal therapy and supervision of my work by an independent supervisor. All of these inputs and experiences were essential to my training and also to my growth and development as a practitioner. Certainly it also is recognised empirically that these elements of therapist training are essential to ensure practitioners deliver safe services for clients.

CORU are proposing to standardise entry to both registers at Level 8, will not be including any criteria on supervision within the training (only on placement) and are removing the inclusion of personal therapy for students in training.

You can understand my concerns regarding the lowering of standards and lowering of qualification for both registers in Ireland. With these proposals by CORU, I'm very concerned that registration of Psychotherapists will bring a reduced quality to the work and diminish the current quality provided by qualified and accredited therapists who have set the high standard we currently work under.

I believe a minimum Level 8 training should qualify a practitioner for the Counsellor registration and a minimum Level 9 training should be used for entry to the Psychotherapists registration. The work carried out at both levels varies greatly and registration should reflect this.

A medical model can not be applied to these professions as a standard template.

Currently there are questionable training providers who provide shorter trainings and trainings without those elements and this undoubtedly puts the public in danger. I have worked with clients who have experienced poorly trained practitioners that harmed their mental health as a result. External supervision and personal therapy should be requirements in the training standards without question.

I'm asking for my input to be considered for the training and registration drafts.

Lower quality of care for clients and genuine risk of danger if working with not appropriately trained and supervised practitioners will be the result of the current drafts. This is not acceptable.

Thank you for taking the time and attention. I await your response.

Warm regards,
[REDACTED]

Sent from my iPhone

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Feedback to CORU from Brian Kavanagh MSc Psychotherapy
Date: Friday 17 November 2023 20:51:46

Dear [REDACTED]

Many thanks for all the work you and your team have been doing with regard to the counselling and psychotherapy profession.

The education and training programmes where I have received my formation as a counsellor and psychotherapist have been excellent.

I completed my first year in [REDACTED]. The following two years I completed a Higher Diploma with [REDACTED] y. I then participated in a Level 8 course with [REDACTED]. I finally attended [REDACTED]

[REDACTED] I am presently studying for a Diploma in Supervision, presented by [REDACTED]

The need for quality, expert and verifiable training is vital in the field of Counselling and Psychotherapy in order that this field of expertise can be of service to the health and well-being of every citizen in Ireland. Psychiatry and Psychology are recognized and valued and I hope through CORU the counselling/psychotherapy profession will also be brought to the same level of recognition and value for the benefit of Irish people.

I am disappointed that [REDACTED], there seems to be unreasonable and biased preference given to counsellors and psychotherapists accredited with IACP. The HSE does not give equal opportunities to those accredited with [REDACTED].

I hope that through CORU that all counsellors and psychotherapists with equally high standard training and education will be equally valued and given the same opportunity to use their skills and profession for the benefit of those in need of help to respond to the challenges they are facing in their lives.

Many thanks,
[REDACTED]

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: recommendations for regulation of counsellors/psychotherapists
Date: Friday 27 October 2023 08:56:54

Hi

I am a counsellor/psychotherapist accredited with IACP. I would like to make the following points regarding regulation of the profession.

1. I can not stress the importance of personal therapy for trainees enough. It is a core part of the training. It is essential so that counsellors/psychotherapists are able to understand clients that they sit with and to have empathy for them. If a counsellor/psychotherapist hasn't experienced their own therapy, it is impossible for them to understand and support fully their clients.
2. The register for counsellors/psychotherapists should be the same. No counsellor or psychotherapist you speak to will say there is a difference. There is a cross over between the 2 all the time. Even though it is in an Act doesn't mean that the Act cant be changed to the correct position.

Kind regards

[REDACTED]

Sent from [Mail](#) for Windows

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Regulation of Counsellors and Psychotherapists
Date: Thursday 30 November 2023 00:38:23

To whom it may concern,

I am writing to express my concerns around some of the proposals for the regulation of Counsellors and Psychotherapists.

Overall within the documentation there seems to be a lack of understanding of the role and practice of Counsellors and Psychotherapists. It appears to be a copy and paste of another profession. To look at any of the 100s, or more likely 1000s of books used for reference and in the study of Counselling and Psychotherapy, the people that the Counsellor or Psychotherapist is working with is referred to as the client. They are not identified as service users, as they are in some of the social health professions. It is an inaccurate term to use for those attending Counselling or Psychotherapy. Could this please be rectified. There are mentions of assessment, diagnose, analyse - As Counsellors and Psychotherapists we do not carry out assessments, analysis, and we are not qualified to diagnose.

Regarding the training of Counsellors and Psychotherapists, I cannot see mention of attending personal therapy for the students. It is a vital part of training for students to engage in personal therapy. If someone is not willing to sit in the counselling space and work on themselves they really are not in a place to be able to sit with another and hold the space safely for them.

A very concerning suggestion within the documents is that of 'direct observation' of a Counsellor or Psychotherapist while they are with a client. This again suggests a lack of understanding of what Counselling and Psychotherapy is. A client should not be subjected to the presence of a third person. Coming to therapy is a big step to take and it takes courage for them to make the call and attend. The dynamics of two people in the space with the client would not be conducive to a safe environment. Over the years research repeatedly demonstrates that it is the relationship which contributes the most to successful therapy. To have someone else directly observe would not be conducive to a safe space and would negatively impact the possibility of a relationship developing.

The therapist / supervisor relationship is a valuable one and informs best practice. Within this relationship the clinical supervisor works with the Counsellor or with the Psychotherapist ensuring the safety of the client, that the best work possible is being carried out for the client. Also the clinical supervisor is working with the Counsellor or the Psychotherapist monitoring them, which helps prevent burnout through suggestion of engaging in personal therapy where necessary or guidance regarding appropriate professional development.

While I do identify clinical supervision as an invaluable part of any Counsellor or Psychotherapist's work, the high ratio of 300 of 450 Counselling hours being supervised and 350 of 500 of the Psychotherapy hours being supervised, is both excessive and prohibitive as it is not practical. It is unrealistic and unnecessary. There is evidence there from the years of Counselling and Psychotherapy that has been happening that the criteria already there has been working. Standards have been put in place by the accrediting bodies as a result of hard work on their part setting the criteria.

Kind regards,

[REDACTED]

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From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Submission to Consultation on the regulation of Counsellors and Psychotherapists
Date: Friday 24 November 2023 21:04:47

A chara,

Please find below my submission as part of the consultation on the draft documents concerning the statutory regulation of counsellors and psychotherapists.

I apologise in advance if what follows appears very direct, at times passionate. I am a counsellor and psychotherapist, not a politician, not an academic, not a diplomat, and I care deeply about the future of my profession. As you will know, emotions, often unwelcome in society, are welcomed and indeed central to the work of counsellors and psychotherapists, and often the key to healing, so it would be rather strange to excise them from the feedback. It is not my intention to offend any of the very fine individuals serving in various capacities and working towards the desirable goal of statutory regulation, nor indeed the institutions in which they serve.

I have spent several hours completing the online survey on the regulation of Counsellors. I am qualified in, and practice, both counselling and psychotherapy and the clinical supervision of both professions.

My first item of feedback is concerning the online survey which was very cumbersome and has been confusing and off-putting for many. It would be beneficial if it could be borne in mind that many practitioners practice both professions currently and disagree with the division into two professions, which is, in our opinion, lacking any evidential basis. While I appreciate that the division arose because our professions could not find agreement, those responsible would be well advised to understand that much of the feedback from both surveys represents the views of both counsellors and psychotherapists, as many will not be able to allocate the time to complete the process twice.

It is my opinion that the public consultation process is too short, and not very public, consisting of a matter of some weeks, after having waited some six years for the documents to be published. I am also meeting and speaking with many stakeholders, including colleagues, who are not aware of the consultation process. None of my clients nor any member of the public that I have spoken to appears to be aware of the public consultation process. I appreciate this is anecdotal evidence and I do not know if CORU will be gathering empirical evidence to establish the extent to which

both the professions and the public are aware of the consultation process, in order to afford it increased validity.

I would offer the following thoughts for your consideration:

1. CORU is proposing to make personal therapy/counselling hours in training optional, and a matter for training courses, not for CORU.

I most strongly object to this proposal. Whilst the long tradition and current best practice whereby trainee practitioners first undertake therapy or counselling themselves, which we call personal therapy, is in itself no guarantee of safe practice, nor is a level 8 degree, nor is a level 9 or 10 qualification. Indeed nothing is, in itself, a guarantee. This is why the regulatory framework includes fitness to practice processes for registered practitioners. Together with every colleague and member of the public to whom I have spoken about this, I am deeply shocked and concerned that a high level of personal development and self-awareness does not appear to be one of CORU's priorities in the draft standards and criteria. It is unfair (to students and training providers) and I would argue very unwise to remove this from the regulatory framework, although I do understand that it is difficult for those outside the profession to understand its importance. However, counsellors, psychotherapists and our clients understand very well its importance. This was a universally agreed principle of training until more recently when, to the best of my knowledge, largely led by at least one, possibly more training providers, attempts have been made to erode its importance, or remove the practice altogether. To those familiar with this recent development, it can only seem ironic that CORU's proposal is to leave this to the discretion of training providers. Surely CORU's role is to protect the public, not to appear to wash its hands of such a central and crucial aspect of counsellor and psychotherapist training. This is such a radical proposed change to current and longstanding practice, worldwide, that I would expect a very strong evidence base to be presented in order to support such a change. I am not aware that any such evidence base exists or has been put forward to support this proposal. In response to any argument that CORU cannot regulate personal therapy in training, this seems to me very simple. CORU can simply stipulate that this is the responsibility of training providers to ensure that it has been completed, as the vast majority of training providers do currently. If the argument is that some training providers do not currently require this, then the reply is that CORU is proposing many other radical changes to the majority of existing training courses, and it is not equitable to require some courses to change and others not to change. If CORU is mandated to protect the public, surely something which is very widely held to contribute to, indeed viewed by most as fundamental to safe practice, should be maintained and protected

within the regulatory framework.

2. CORU is proposing to make independent clinical supervision optional, even during training.

I most strongly object to this proposal. Again, no one element of current or historic practice is in itself a guarantee of safe practice. However, like the vast majority of current practitioners, I have experienced the huge role in which independent clinical supervision, uncontaminated by confusion with line management, plays in safe and competent practice. Training in counselling and psychotherapy is not a matter of counting hours. As client, counsellor/psychotherapist and now clinical supervisor, I would strongly argue that a safe and competent practitioner develops over many years of supervised practice, years beyond the initial period of study and training. It is a profession that has led the way in being intrinsically committed to lifelong learning long before this was introduced into other HSC professions. If harmonisation with other HSC professions is required, perhaps serious consideration should be given to requiring those professions to engage in lifelong clinical supervision. My experience of talking with many other HSC professionals, including those whom I have been privileged to support as their therapist, is that they view this aspect of our profession, as well as our commitment to self-awareness and insight gained in personal therapy, with admiration perhaps even with envy. Those I have met are only too aware of how unsupported and undermanaged they can find themselves to be in their demanding work life. At a time when we read and hear regularly of high rates of attrition and burnout in HSC and other frontline professions, it is staggering that CORU is approaching the regulation of counselling and psychotherapy by proposing to remove one of the central pillars of safe and ethical practice from our profession.

3. CORU is proposing to replace career-duration clinical supervision by more intensive "on site" (in house) Supervision provided by "placement centres" which do not currently exist in the form proposed. Placement hours during training are proposed as 450 hours for Counsellors and 500 hours for Psychotherapists, all during the (4?) training years. (No pre-accreditation equivalent). This would include up to 75 hours of "direct observation" of the student, a practice which I'm informed is not a requirement for other health and social care professions. Although verbatim reports are among the options for "direct observation", other options include having supervisor in the room during sessions, recordings, two way mirror etc.

Again, this is a radical proposed change which appears to be based on a model of different professions – psychology / psychiatry – these are distinct, valued

professions – but they are different professions. Why is a different profession being proposed as a model for our profession, when we already have well established methods of training. It raises serious ethical questions regarding client privacy and confidentiality and is not consistent with the vast majority of historic and current practice. Again what is the evidence base for such a radical change? I understand there is strong evidence that client and practitioner behaviour is significantly altered when being observed by a third party. What is therefore the evidence of any benefit or validity in the proposed new and radically different practice? Whilst an increase in the level and emphasis on supervised practice is to be welcomed, this huge increase in the clinical hours required would almost certainly result in training becoming full time and this would exclude many fine practitioners from the profession due to lack of financial means.

4. It is likely that 2, and 3 above will massively increase the cost of training, putting it further out of the reach of many, because the infrastructure does not exist and will be expensive to run. Placement centres will have to provide a supervisor on site while students are working there. The current practice of supervision will be threatened. I strongly object to these proposed changes which are not in proportion (EU directive) and in my opinion run directly contrary to the stated commitment to protect the public.

5. As a passionate advocate of equality and diversity, I feel the lack of any reference to neurodiversity in the draft standards and criteria is very concerning. I would argue strongly that specific reference should be made to neurodiversity, alongside the other aspects of diversity which are included – e.g. sexual, relationship, gender, ethnicity, race, and so on. Research suggests that minority groups are over-represented in the population of clients seeking counselling and psychotherapy. There is a growing body of opinion in counselling, psychotherapy, psychology and psychiatry, that many of the emotional and mental health difficulties which bring many clients to therapy or counselling are in fact symptoms arising from the struggle of being neurologically different, in a world of systems designed by and for a majority. As awareness increases, large numbers of individuals are discovering the strengths and challenges of their own neurology, and they are seeking not just diagnosis but therapy and counselling. Whilst this omission is understandable, given that research is leading to change and debate in this area, and that it reflects a lack of awareness in wider society regarding this significant issue, I would urge that consideration be given to the inclusion of awareness of, and training in working to support the specific needs of neurodivergent adults seeking counselling and therapy (e.g. those who identify or are formally diagnosed as autistic, ADHD, dyspraxic, etc) in the draft standards and criteria.

Summary:

I have always wholeheartedly supported the principle of statutory regulation, as both client and practitioner safety are of paramount importance to me, as they are for the majority of the thousands of accredited and ethical practitioners who currently constitute our profession. However, I now feel extremely disappointed, indeed it is not an exaggeration to say that I feel betrayed by what is currently proposed. I have engaged with many colleagues since the documents were published. Those I have spoken to expressed surprise to learn what is being proposed, as well as a similar level of concern. Whilst I have urged them to participate in the consultation process, I have noted that many are feeling intimidated by the process and do not feel confident about articulating their views. I have also encountered a degree of despondency in some colleagues, and for some of them it has sadly accelerated a decision to retire early from the work. This is anecdotal evidence, but I offer it here as part of my feedback, as I do not know of any process to gather empirical evidence on this phenomenon.

My support was for the establishment of a registration board to regulate the existing profession of counselling - to celebrate and enhance the excellent level of client safety provided by the vast majority of accredited practitioners, and to deal with rogue practitioners through enshrining current best practice in law, as well as offering recourse to fitness to practice processes for clients who have been harmed by rogue practitioners.

What is proposed in the documents is effectively to create two new professions which do not currently exist - with potentially arguably lower standards of personal and professional development – due to the omission of personal therapy and clinical supervision - and an unrecognisable system of training, based on a medicalised model whereby "service users" are subjected to "treatment", and is suggestive of an agenda to subordinate counsellors and psychotherapists to other separate and distinct professions such as psychiatry - which many see as itself being a profession in crisis, with no disrespect to the many excellent practitioners among our psychiatrists. This is not something that I would have supported and I feel let down. Perhaps I was naive but I feel that we were deceived in offering our support. I am now very worried about the future of our profession. I realise that these words are full of emotion, but for the information of those who are not aware, the emotions are at the core of counselling and psychotherapy, and our valuing of, and effort to understand and help people navigate their human emotions is one of our greatest and most distinctive strengths. It is notably and disturbingly absent from the draft documents.

[illegible]

(Received three letters in support of IACP submission)

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: IACP submission
Date: Monday 27 November 2023 22:12:26

I wish to lodge my support for the IACP submission to CORU regarding Counselling and Psychotherapy regulation.

Regards

[REDACTED]

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Regulation of Counsellors & Psychotherapists
Date: Friday 24 November 2023 10:48:00

Dear Sir/Madam,

I wish to make a formal submission in relation to the above.

I am a Psychotherapist, working in [REDACTED] for almost 20 years. In addition I run the counselling service for the members (and their families) of a national organisation (approx 6,000 members throughout Ireland).

[REDACTED]

[REDACTED]

I hold an undergraduate qualification in Counselling and Psychotherapy [REDACTED] [REDACTED] and a MSc (Hons) in Psychotherapy Studies from the [REDACTED] [REDACTED]. I have undertaken regular additional training over the past 20 years to broaden and deepen my knowledge to enhance my client and teaching work.

I have reviewed the Draft Standards of Proficiency and the Criteria for Education and Training for both Counsellors and Psychotherapists and I wish to propose some inclusions/amendments to these:

Counsellors v Psychotherapists

Differences are made between the role of Counsellors and Psychotherapists and, as outlined in the Standards of Proficiency for both, these distinctions lie in the depth of the work, with Psychotherapists working at greater depth, including understanding and managing the unconscious aspects of the therapeutic relationship.

I believe it would be ideal that Psychotherapists attain the level of knowledge and self awareness required to work with the complexity and at the depth needed for this work through attaining a Level 9 qualification.

I also believe, however, that it is more important that both Counsellors or Psychotherapists attain their qualification through relevant study over a period of no less than 4 academic years. Whether the qualification is Level 8 or Level 9 is of less importance in my view.

As well as attaining the standards of proficiency as outlined in your draft documents, a high degree of self awareness is required in order to develop the capacity to hold those clients in emotional distress and to avoid doing harm to those most vulnerable. I do not believe this can be cultivated over a timeframe of any less than 4 years of relevant study along with personal therapy, suitable clinical placement and a robust supervision process.

Personal Therapy as a Client

At present personal therapy is not included in the Draft documents as a requirement for either counsellors or psychotherapists. While as proposed, the education providers may provide this, there is no specific requirement or standard set out in the Draft criteria. This, I believe, needs to be addressed.

Personal therapy is a fundamental part of training as either a Counsellors or Psychotherapist

There are a number of aspects of the work that this supports and enhances: sensitivity towards clients/patients, capacity for empathy, presence, engagement at a more human/personal level, strengthening of self knowledge and thus ability to be authentic, build trust, stability, safety, ability to 'hold' another in deep emotional distress. All of this can not be achieved without engaging in a considerable amount of weekly 1:1 (face to face) personal therapy and with a suitably qualified (registered) therapist. I believe this should be no less than 120 hours of personal therapy, to be undertaken throughout a programme of minimum 4 years at Level 8 standard.

In addition, I believe there should be a further profession specific criteria for education and training programmes around minimum 60 hours of Group Therapy/Process Group to be undertaken during the minimum 4 year Level 8 programme. Group Therapy/Process invites the student to reflect on group behaviour and dynamics informed by their own experiences in teams, family and society generally and this further enhances self awareness and self understanding which ultimately benefits the client work.

Practice Placements

I support the practice placements as proposed however I recommend some further stipulations:

Practice placements should not begin before Year 3 of a 4 year Level 8 programme. In my own experience and also as a Lecturer/Trainer, I do not believe students are ready to begin client work prior to Year 3 of a 4 year programme. Thus both the wellbeing of the student and the care for the client is at issue here. We have a duty of care to both and we must ensure that we harm neither.

Supervision

At present the Draft Criteria for Counsellors and Psychotherapists does not stipulate any requirement around student engagement in Clinical Supervision.

In addition there are no guidelines/standards/requirements set out for ongoing supervision of client work, post registration.

Also, no standard has been set down for Supervisors.

All of this, I believe, needs to be addressed, and specific requirements set out.

Supervision is an essential component of therapist training and is a key support for therapists in training as well as a vital part of client care. Ongoing supervision helps to

maintain a high standard of clinical practice and care of both client and therapist.

I believe there should be no dilution of the existing standards of supervision during the training process. While this currently varies across the current profession bodies, in my view is:

- min 200 hours of face to face supervision during training.

- 50% of supervised practice should be by way of individual supervision - minimum monthly.

50% of supervised practice can be group supervision but subject to minimum standard of Ratio 1:5 (1 hour's supervision for every 5 hour's client work) and in a max supervision group of 4 students.

Supervision post Registration should be provided By a therapist who has attained a suitable supervision qualification.

Minimum monthly supervision - Ratio 1:50: ie Ratio of 1 hours supervision for every 50 hours of client work.

Overall, while there are many positive aspects to the Draft Standards of Proficiency and Education Criteria for Counsellors and Psychotherapists, as they have been presented they are not sufficient to meet the standard of care for clients and therapists that I as a practicing professional aspire to or would wish for my students entering the professions.

I am deeply concerned that the standards as currently presented would result in a dilution of standards rather than a raising of them. Client safety and care would be negatively impacted and this is not something I could support as a practitioner or a teacher in a profession I am proud of and care deeply about.

I would ask that you give all of the points I raise above careful consideration as you proceed towards regulation.

Many thanks,

[Redacted]

[Redacted]

[Redacted]

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Please take into consideration.
Date: Thursday 30 November 2023 09:37:56

Dear Sir/Madam,

I am saddened to be writing this letter in response to the draft of criteria that has been put forward for regulation of the counselling and psychotherapy sector in Ireland. I must admit to being shocked to see the level of understanding of what our profession means and how we are to train future counsellors and psychotherapists. I am accredited with the IAHIP and EAP and therefore my work as a psychotherapist has met the gold standard of requirements both professionally and personally. The CORU criteria put forward falls extremely short of these standards. This I know will damage the profession that is growing and presently needed and will affect the general public.

These are my issues with the drafts -

There is no recognition at all of the role of personal psychotherapy for trainees. This is at the fore of all requirements of being a psychotherapist. The ability to recognise ourselves, our history, our emotions, our attachment histories, our past traumas are at the core of being grounded to sitting and being present to our clients. This along with continuing to develop ourselves by therapeutically working on ourselves is what brings safety, presence and deep understanding to our client work and success.

The requirements to distinguish a counsellor and psychotherapist being 50 hours is unsatisfactory and reckless. The European requirement is 7 years or similar extra training that meets a standard of learning and experience. An extra 50 client hours diminishes the need to retrain, learn, develop as a psychotherapist which takes time and commitment and passion. This is what we have previously believed in so please do not change this and thus impact on our service users.

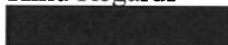
There is no requirement to use a fully qualified and trained supervisor during the training. Again this is preposterous as it has safeguarded the profession and the work and thus the client. The client is the foremost of our therapeutic work and supervision is another means to safeguard them. All supervisors have a minimum amount of years working and also completed a year long supervision course. The idea that the college along with the training centre provide this will not work. The centres that trainees receive their counselling favours from are all underfunded, stressed to capacity and cannot be made responsible for the trainees. This system will fail terribly - to the detriment of the trainees and thus clients.

There is no reference to the necessity that trainees see clients over a long term basis and not for six to eight sessions. This does not lead to learning of the psychotherapeutic process. Clients need to be able to hold clients for over 20 sessions to start to practice deeper therapeutic work. It does not state this requirement. A therapist that completes their hours working with short term clients is not practicing psychotherapy.

There is no mention either of an age restriction requirement to start a psychotherapy training course. There needs to be an age limit of 25 and over only.

Please consider my letter carefully and take into consideration what I and my fellow psychotherapists are saying here. The current criteria put forward will undermine public trust and safety and the profession itself. This is the only chance we get to get this right please don't undermine the tried and tested systems and knowledge that already exist.

Thanks
Kind Regards



Ms. Jennifer Griffin
Chairperson of the Counsellors and Psychotherapists Registration Board
CORU, Infinity Building,
George's Court, George's Lane,
Smithfield, Dublin 7,
D07 E98

30th November 2023

Via email to strategyandpolicy@coru.ie

Re: [REDACTED] Response to CORU Public Consultation: Standards of Proficiency and Criteria for Education and Training Programmes for Counsellors and Psychotherapists.

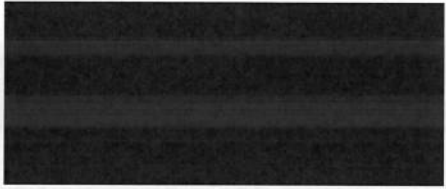
Dear Ms Griffin,

[REDACTED] is writing to you to submit feedback on the CORU Standards of Proficiency and Criteria for Education and Training Programmes and Standards of Proficiency and Criteria for Education and Training Programmes for Counsellors and CORU Standards of Proficiency and Criteria for Education and Training Programmes and Standards of Proficiency and Criteria for Education and Training Programmes for Psychotherapists.

The [REDACTED] welcomes the decision of the Minister for Health to regulate the professions of Psychotherapy and Counselling as it views this as essential in order to protect the general public and clients. In addition, the [REDACTED] views regulation as paramount to protecting the interests of our members as well as enhancing the reputation of and trust in the profession.

The [REDACTED] wishes to express appreciation for the dedicated efforts and diligence of the Registration Board in formulating the draft Standards of Proficiency and draft Criteria for Education and Training in the professions of counselling and psychotherapy. The Board's steadfast commitment to fostering high-quality practices and maintaining professional standards is duly recognised, and we acknowledge the importance of the work completed to date by the Registration Board.

The [REDACTED] is very pleased to see in the drafts that the entry level to both professions is proposed at Level 8 for both registers, which is in line with our professional standards and which the [REDACTED] has been advocating for many years. It is very important that entry to both registers be maintained at Level 8 and the [REDACTED] will be, as part of its submission, strongly supporting this proposal.



However, we also note specific concerns regarding proposed placement hours, the structure of placements, no specific mention of personal therapy, and a different understanding of supervision in training.

We have detailed these concerns and put forward proposals as to how they can be addressed in the accompanying documentation.

Should you require any further information, please do not hesitate to contact us via email at



Yours sincerely,

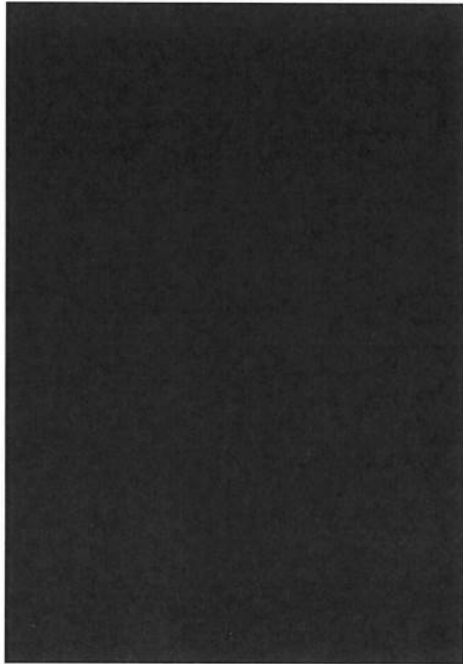
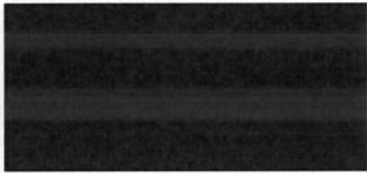


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Introduction

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

We represent the counselling and psychotherapy profession at both national and international level, and we partner with other national and international counselling and psychotherapy associations to advance the development of counselling and psychotherapy globally.



Methodology

This document is a result of an extensive feedback collection process and engagement with the [REDACTED] members and our Accredited Training Course Providers. We engaged our membership in a number of consultation processes which are outlined below:

1. The [REDACTED] set up an email address for members [REDACTED] and asked members to provide their written feedback by email. We have received many emails from members with their feedback and suggestions.
2. The [REDACTED] also sought feedback via a member survey asking direct questions in relation to both sets of CORU draft documents. We have received a significant response from members.
3. The [REDACTED] Regional Committees held four consultation sessions for members on Zoom to seek and gather feedback.
4. The [REDACTED] Head Office held a national consultation session on Zoom to seek and gather feedback.
5. The [REDACTED] held meetings with [REDACTED] Accredited Course Providers to discuss the draft documents.
6. The [REDACTED] also had significant engagement with its central committees who met and provided valuable inputs to the process.

All feedback was collated and reviewed by both the senior management team and the [REDACTED] Board of Directors to inform this final submission.

Feedback regarding CORU Draft Standards of Proficiency and Criteria for Education and Training Programmes for Counsellors and Psychotherapists

[REDACTED]

You will see from our submission that all the concerns raised, and suggestions put forward have been articulated in response to significant identified risks to the public.

These risks present in two ways, firstly the potential for actual harm to be caused during the therapeutic process, resulting from a lack of mandatory personal therapy in training, as well as the absence of a requirement for ongoing clinical supervision.

Secondly, there is the risk that due to the onerous requirements being applied to placements that an unintended consequence could be a reduction in the number of training placements available and indeed training providers. This would have a detrimental effect on future recruitment to the profession and a negative knock-on effect to mental health service provision. At a time when Government has committed to invest in mental health supports and, in the profession, it would undermine the significant progress that has been made and reduce accessibility for those in need of counselling and psychotherapy supports, directly conflicting with the "Vision for Change¹," a national policy aiming to enhance mental health care across Ireland.

There are many positive outcomes that the [REDACTED] and our members see in relation to statutory regulation of our sector. We know from our [REDACTED] Member Surveys over the years that our members welcome regulation, most are strongly in favour of it and think that it will be good for their profession. Feedback from our members indicates that they think the regulation of the counselling and psychotherapy professions plays a vital role in upholding professional integrity. Members also feel that through standardisation of training, it will establish consistency and reliability in the delivery of counselling and psychotherapy. The [REDACTED] recognises that statutory regulation, supported by legal requirements, fosters confidence among clients and protects the standards of ethical care, particularly for vulnerable individuals. The implementation of these standards will bring accountability, clarity and credibility to the profession, ultimately enhancing client safety and well-being, if identified risks to the public and to mental health sector are addressed.

¹ Source: <https://www.hse.ie/eng/services/publications/mentalhealth/mental-health—a-vision-for-change.pdf> downloaded on 20/11/2023



The IACP Supports Entry at Level 8 for both Counsellor and Psychotherapist Registers

As per the  Position Paper on Regulation of Counselling and Psychotherapy 2015, the  fully supports the proposal to establish the academic threshold for entry at NFQ Level 8 for both counsellors and psychotherapists. This proposal holds significance in laying a robust foundation for effective practice and fostering a more comprehensive exploration of theories, interventions, and treatment modalities.

Setting Level 8 as the entry standard for both counselling and psychotherapy registers aligns with the requirements to ensure that practitioners exhibit exceptional performance, robust critical thinking skills, a deeper understanding of the subject matter, and the capability to conduct independent research. Level 8 facilitates a comprehensive education in the fundamental training requirements essential for effective psychotherapeutic practice, encompassing evidence-based practice, ethics, the law, assessment, and intervention.

Quality and Qualifications Ireland (QQI) and the National Framework of Qualifications (NFQ) outline specific learning outcomes in relation to Level 8 qualification. These outcomes encompass an awareness of the field's boundaries and the preparation required to expand those boundaries through further learning. Adaptability, flexibility, the ability to cope with change, and the capacity to exercise initiative and solve problems within the field of study are integral components of the outcomes. In several applied fields, the outcomes are aligned with independent, knowledge-based professionalism, while in other fields, they correspond with those of a generalist and are typically suitable for management positions. (QQI, 2003)

At Level 8, the overall standard not only enhances public trust in the profession but also promotes greater accountability by ensuring that therapists meet specific educational requirements before commencing practice. The defined criteria at Level 8 on the NFQ establish benchmarks that fulfil learning requirements in terms of knowledge, skills, and competence, fostering quality and excellence in the study and practice of counselling and psychotherapy.

Establishing Level 8 as the minimum threshold for entry into both the counsellor and psychotherapy registers ensures a robust foundation in theory, skills, and competence for practice. This assures graduates' capability to deliver effective, ethical, and safe practice.

The  agrees also that establishing the minimum training level beyond Level 8 would pose greater challenges for individuals from various backgrounds to join the counselling and psychotherapy profession. This could affect the accessibility of training courses and restrict the diversity of professionals in the field. In line with the principles of equality, diversity, and inclusion, this could discourage potential applicants from embarking on a career in counselling and psychotherapy due to the prolonged duration and expenses linked to attaining postgraduate qualifications.

The [REDACTED] Equality Diversity and Inclusion Committee welcomes and fully supports the stated intent as set out by the above draft documents, to set future threshold qualification levels for counsellors and for psychotherapists on a par with each other, at Level 8. It is the opinion of the EDIC that this strategy provides a more practical and inclusive approach to both professions.

Counselling and psychotherapy training programmes should make an active effort to attract diversity among students by embracing individuals from different backgrounds, cultures, and life experiences. Guaranteeing fair and equitable access to a diverse range of individuals would deter elitism by not giving preference to a select group solely based on academic success.

Setting the minimum level for registration at Level 8 will also establish the level of qualifications for counsellors and psychotherapists on a par with other regulated healthcare professions. It will ensure a fair registration process, higher standards of practice, and ultimately, a safer environment for clients. This minimum standard will also provide a clearer platform upon which to enable the pursuit of further professional development.

As outlined above, the [REDACTED] supports the proposal to set the entry level for both registers at Level 8. As professional body, we promote the development of and excellence in the profession and accredit courses at both level 8 and level 9, as well as requiring compliance with on-going professional development in the form of quality CPD.

As outlined above, the [REDACTED] supports the proposal to set the entry level for both registers at Level 8. As professional body, we promote the development of and excellence in the profession and accredit courses at both Level 8 and Level 9, as well as requiring compliance with on-going professional development in the form of quality CPD.



Lack of a Specific Personal Therapy Requirement in Training

The [REDACTED] position is that personal therapy is a necessary element of counselling and psychotherapy training. The [REDACTED] has mandated personal therapy for over 30 years. It is required that all accredited programmes incorporate a minimum of 50 hours of personal therapy during the training period.

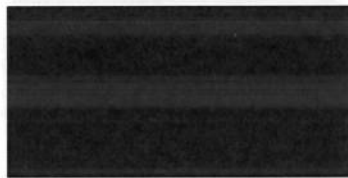
This requirement for personal therapy, together with clinical supervision, is a shared element unifying accrediting bodies and training institutes throughout Ireland and internationally. In addition, international counselling and psychotherapy associations, such as the European Association for Psychotherapy and the World Council for Psychotherapy, list personal therapy as a mandatory requirement. The Strasbourg Declaration on Psychotherapy (1990), a manifesto, signed on October 1990 by the representatives of 14 European professional bodies, and since, signed by 40 Psychotherapy Organisations throughout Europe, states "A full psychotherapeutic training covers theory, self-experience, and practice under supervision."

In Europe, a number of countries including Austria, Germany, the Netherlands and Sweden have regulatory authorities that have mandated hours of self-experience / personal therapy. The number of personal therapy hours range from 50 hours in the Netherlands to 250 hours in Austria (Regulation of the Professions of Psychotherapist, Clinical Psychologist, Health Psychologist in the Member States of the EEA and the Swiss Confederation, April 2004).

The [REDACTED] proposes that CORU link with its regulatory counterparts in these countries to ascertain how these regulated authorities assess personal therapy hours against the proficiencies. The [REDACTED] has also outlined below a number of assessment techniques that are currently being used in counselling and psychotherapy training.

Traditionally, and as a matter of course, personal therapy has been looked upon as an integral part of a psychotherapy candidate's training, besides theoretical seminars and clinical supervision. In the early years, psychotherapy was generally thought about as a kind of objective examination with the purpose to interpret and thus make conscious the patient's unconscious ideas and feelings. It soon became clear, however, that the therapist's own unconscious ideas and feelings were blind spots that would interfere with the therapeutic process. To reduce that hazard personal therapy was recommended by Freud (1953) as a sine qua non in psychoanalysts' training, a recommendation that was more or less automatically generalized to the training of psychotherapists.²

² Katarina Åstrand and Rolf Sandell, Psychoanalytic Psychotherapy, 2019 Vol. 33, No. 1, 34–48, <https://doi.org/10.1080/02668734.2019.1570546> © 2019 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group.



International Best Practice

Based on Table 2.8: Psychotherapy – minimum hours and subjects of practical training, Regulation of the Professions of Psychotherapist, Clinical Psychologist, Health Psychologist in the Member States of the EEA and the Swiss Confederation, these are requirements for personal therapy/ self-experience in training in EEA regulated countries.

EEA regulated country	Self-experience/ personal therapy – Psychotherapy training
Germany	120 hours of self-experience in the psychotherapy method chosen for intensified training
Finland Special training in PT	Personal therapy to an adequate degree
Advanced special training in PT	Personal therapy to an adequate degree
Netherlands	50 hours of training therapy

Austria	Total number of hours: 250
Preparatory instruction	50 hours of individual and group self-experience
Special instruction	200 hours of teaching therapy, teaching analysis, in- dividual or group self-experience
Sweden Basic training in psychotherapy	50 hours of individual therapy or 110 hours of group therapy
Post-graduate training in psychotherapy	- Prerequisites - 125 hours of individual therapy or 280 hours of group therapy in the PT method chosen (incl. therapy hours of basic training stage) - 50 hours of individual therapy and 30 hours of family reconstruction in the case of training in family therapy - During training: 75 hours of individual therapy





As highlighted in our introduction the [REDACTED] has significant concerns about the absence of mandated personal therapy hours in training and that this could lead to a considerable risk of harm to clients. Personal therapy plays a pivotal role in the training of counsellors and psychotherapists in order to deal with the potential for the presence of unresolved personal issues among trainees and develop their self-awareness in managing these issues safely when working with clients. As therapists work extensively with deep-seated emotions and traumas, trainees, who haven't adequately addressed their own unresolved issues, will unknowingly pose a risk to clients. This will result in instances where clients will be damaged and further traumatised by therapists who are unable to contain their own triggers, thereby undermining the effectiveness of therapy and resulting in harm to clients.

Another critical aspect is the phenomenon of transference and countertransference within therapeutic relationships. Without personal therapy, trainees might lack awareness of their own triggers, making it challenging to manage these dynamics. Clients projecting their feelings onto therapists (transference) and therapists responding with their own unresolved issues (countertransference) could interfere with the therapeutic process, impacting the quality of care.

Astrand & Sandell (2019) discovered that participation in personal therapy contributed to the personal and professional development of emerging therapists, fostering the enhancement of 'professional subjectivity.' Engaging in personal therapy guided therapists in cultivating a professional mindset, inherently subjective, constructed by integrating knowledge and theory viewed through a personal lens.

Geller et al. (2005) particularly highlight the role of personal therapy in training by emphasising its influence on reinforcing the integration of theory.

We acknowledge CORU's mention of personal therapy, stating that education providers, as part of their programme requirements, have the flexibility to specify whether a student on their programme needs to complete a set number of personal therapy hours.

However, while courses can still include a personal therapy requirement in their training, the absence of a mandatory requirement by the regulator provides an opportunity for some courses to potentially remove it to meet the demand for more affordable training. Additionally, over time, it may become an industry standard for courses to no longer mandate the completion of personal therapy hours.

Our rationale to mandate at least 50 hours of personal therapy, as per the [REDACTED] training standards includes:

- We see that the lack of stipulated requirement for personal therapy is a risk to the public. It undermines current best practices, as demonstrated in other European countries, putting the welfare of the client and general public at risk and lowering training standards.

- 
- Personal therapy is a fundamental best practice for students in training and has long been established as a foundation for best practice in counselling and psychotherapy.
 - Personal therapy provides a supportive scaffolding for personal and professional development of the therapist, specifically in relation to development of self-awareness of the therapist, ensuring adequate therapeutic processing and understanding of the client's experience as well as containing both client and therapist emotions safely in a therapeutic space.
 - Personal therapy in training is our ethical responsibility to assure that students are psychologically robust enough to work with clients.
 - Personal therapy differentiates the professions of counselling and psychotherapy from other health professions. Counselling and psychotherapy is unique in its experiential training model and personal therapy plays an integral role in it.

Please see below some examples of the feedback received from  members in relation to personal therapy:

"I find it extremely disturbing that personal therapy is not a requirement during training. In counselling and psychotherapy, we are concerned with the client's (service user's) process and way of being in the world. If a trainee is not doing/has not done their own work, how can they sit with a client (service user) as a facilitator of change."

"Personal therapy is vital in developing a trainee's self-awareness and ability to deal with and contain difficult triggers and emotions, whether their own or those of the client. If a trainee/therapist has not done their own work, they will be unable to hold the therapeutic space for their own and the client's safety – clients will be harmed, resulting in additional trauma, and lack of trust in therapy, meaning they will be worse off than when they started."

"It would be dangerous not to have the requirement of personal therapy as part of training and to have counsellors and psychotherapists working with clients without first working on their own issues."

"We recognise that personal therapy is a crucial part of any training. Without having engaged deeply with our own process through ongoing personal therapy, we cannot provide the necessary holding necessary to support our clients with their process work."

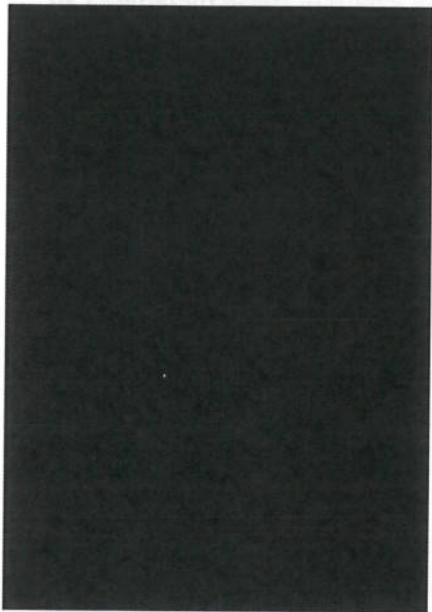
"Personal therapy is essential. One needs to experience being a client first to be able to sit in the other chair."

"I strongly disagree with CORU's position not to make a student therapists personal psychotherapy a mandatory component of their professional qualification. This is unethical and dangerous to their clients. Fitness to practice should be a rigorous and mandatory"



assessment process for a psychotherapy qualification. The person of the psychotherapist is the very tool or instrument of effective psychotherapy if the therapist has not under-gone deep personal psychotherapy, they do not have capacity to safely hold and to contain dysregulated clients. They will cause harm."

"Personal therapy is an absolute must and the expected hours of completed should be articulated. Leaving it open to the training college is a dangerous practice, as it suggests that unsuitable people may complete counselling/psychotherapy courses without an inner work. Personal therapy brings such richness and to the work of therapists, and I believe our profession would be bereft of quality in a number of years if this important aspect of training is not made mandatory."



In addition, nine out of 10  members (90%) consider it important that practitioners continue with personal therapy post-training/accreditation  (Member Survey 2018).

This shows a strong commitment of our members to self-care and personal therapy as an important part of their therapist identity.

Assessment of Personal Therapy in Training

We note CORU's position that personal therapy is not connected with the assessment of the student and does not contribute to an assessment of whether a student has achieved the standards of proficiency. The  wishes to challenge this statement and argue that personal therapy can be assessed against specific CORU proficiencies.

Assessing personal therapy against proficiencies in counselling and psychotherapy training involves evaluating the therapist's personal growth, self-awareness, and ability to apply therapeutic techniques.

It's important to note that assessing personal therapy against counselling and psychotherapy training proficiencies requires a comprehensive and holistic approach. It could utilise a combination of self-assessment, reflective practice, journaling, personal therapist's report, which would provide a well-rounded perspective on the student's abilities and any areas for improvement.



Self-Exploration and Self-Awareness: Personal therapy can provide trainees with an opportunity for self-exploration and self-awareness. Understanding one's own emotions, biases, and personal history can enhance empathy and help therapists relate better to their clients' experiences.

Personal Growth: Engaging in personal therapy can facilitate personal growth and emotional healing, which can be valuable for therapists as they work through their own issues. A therapist who has worked through their own challenges may be better equipped to help clients navigate similar issues.

Countertransference and Projection: Personal therapy can help therapists recognise and manage countertransference (therapist's emotional reactions to clients) and projection (attributing one's own feelings or traits onto clients). Being aware of these dynamics can prevent them from negatively impacting the therapeutic relationship.

Experiential Learning: Experiencing therapy allows trainees to understand the therapeutic process from the client's perspective. This experiential learning can enhance their theoretical knowledge and clinical skills.

Destigmatising Therapy: By participating in therapy, themselves, trainees can help reduce the stigma associated with seeking mental health support. It sets an example that therapy is a valuable and acceptable way to address personal challenges.

Personal therapy can be assessed against the specified proficiencies for both counsellors and psychotherapists as set out by CORU in number of ways, including:

Counsellor Proficiencies:

Autonomy & Accountability:

- **Assessment Criteria:** Evaluate the counsellor's ability to manage their own health and well-being through self-awareness, stress management, and coping strategies, demonstrated through personal therapy sessions.
- **Assessment Method:** Self-assessment questionnaires, feedback from personal therapy sessions.

Professional Development:

- **Assessment Criteria:** Assess the counsellor's ability to recognise and manage the impact of personal values and life experiences on their professional practice, as discussed and processed in personal therapy.
- **Assessment Method:** Reflective essays, case studies demonstrating self-awareness and personal impact management.

Knowledge & Skills:

- **Assessment Criteria:** Evaluate the counsellor's understanding and management of power dynamics, emotional responses, vicarious trauma, and self-care strategies, demonstrated through personal therapy discussions and interventions.

- 
- **Assessment Method:** Role-play scenarios addressing power dynamics, self-care plans developed based on personal therapy insights.

Psychotherapist Proficiencies:

Knowledge & Skills:

- **Assessment Criteria:** Assess the psychotherapist's ability to reflect on the service user's experience, demonstrate empathy, and manage their own emotions, as practiced and refined through personal therapy.
- **Assessment Method:** Role-play exercises simulating therapeutic interactions, peer feedback on the therapist's empathetic responses during personal therapy sessions.

Knowledge & Skills:

- **Assessment Criteria:** Evaluate the psychotherapist's understanding and application of therapeutic relationship theories, ability to establish and maintain long-term relationships, and manage personal involvement, discussed and analysed within personal therapy sessions.
- **Assessment Method:** Case studies analysing long-term therapeutic relationships, self-reflection exercises on managing personal involvement, feedback from personal therapist.

Assessing these proficiencies through personal therapy allows for a holistic evaluation of the counsellor's or psychotherapist's self-awareness, emotional intelligence, and professional growth, ensuring they meet the necessary standards for ethical, effective and safe practice.

The assessment of personal therapy is also evidenced by the other European regulatory bodies noted within the above Table 2.8 in Psychotherapy – minimum hours and subjects of practical training, Regulation of the Professions of Psychotherapist, Clinical Psychologist, Health Psychologist in the Member States of the EEA and the Swiss Confederation.

In summary, the  strongly advocates for the inclusion of personal therapy as an integral part of counselling and psychotherapy training, requiring a minimum of 50 hours during the training period. This requirement aligns with international standards upheld by various counselling and psychotherapy associations across Europe and globally. The absence of mandated personal therapy hours poses significant concerns for the  due to identified risks to clients. Unresolved personal issues among trainees could inadvertently harm clients, impacting the therapeutic process and the quality of care provided. Moreover, without personal therapy, trainees may struggle to manage dynamics like transference and countertransference within therapeutic relationships, potentially compromising the effectiveness of therapy.



The [REDACTED] firmly believes that personal therapy is essential for the ethical and professional development of therapists, fostering self-awareness and ensuring psychological resilience to effectively support clients.

The [REDACTED] firmly believes that personal therapy is essential for the ethical and professional development of therapists, fostering self-awareness and ensuring psychological resilience to effectively support clients. [REDACTED] members stress the necessity of personal therapy, highlighting its role in enabling therapists to navigate their own triggers and emotions while creating a safe therapeutic space for clients.

Despite CORU's position that personal therapy cannot be linked to student assessment, we, our members and accredited training providers argue that it can indeed be assessed against specific proficiencies. Evaluating personal therapy against counselling and psychotherapy proficiencies involves examining the therapist's personal growth, self-awareness, management of countertransference, experiential learning, and destigmatising therapy, contributing significantly to a therapist's competence and ethical practice. We cannot support a counselling and psychotherapy framework that does not stipulate personal therapy as a training requirement. Personal therapy requirement is necessary in order to train competent professionals and to protect the public.



Feedback Regarding Supervision in Training

“Supervision is a working alliance between two professionals where supervisees offer an account of their work, reflect on it and receive feedback... and guidance where appropriate” (Inskipp, F and Proctor, B, 1993).

The CORU draft standards propose a general model of supervision that aligns with the standardised approach in existing regulated health and social care professions. However, it is crucial for the Board to recognise the unique aspects of counselling and psychotherapy as a profession, setting it apart from others. Given the nature of the work, the intensity of the therapeutic process and high risk of burnout, a robust model of clinical supervision is necessary, extending beyond engagement with an on-site placement supervisor. The model of clinical supervision facilitates deep personal and professional reflection for ethically developed practitioners, serving as a mechanism to protect the public.

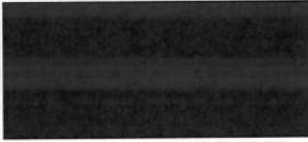
The proposed CORU model of on-site supervision within the draft criteria and standards is unsuitable for the counselling and psychotherapy professions for the reasons below:

1. The placement providers lack the infrastructure to support on-site supervision as proposed.
2. The 9-5 block placement structure, which seems to be proposed by CORU for placements and on-site supervision, will be difficult to implement for many counselling organisations. This proposed framework does not align with the current operational structures across the voluntary counselling sector, which are characterised by non-traditional sessional working hours and limited physical space in placement centres. To meet client needs many centres work outside of 9am – 5pm. A block 9am – 5pm imposed structure is likely to impact on physical space for placements and onsite supervision. The block placement approach is at odds with the unique nature of counselling and psychotherapy work. The potential for burnout, particularly with students, means that there must be limits applied to the number of clients seen.
3. The crucial gatekeeping role of the clinical supervisor in the current draft proposals, has been undermined, which poses significant risk to client and therapist safety.

In section 2.6 of the Vision for Change, which refers to Mental Health Professionals, it states:

Everybody who provides mental health services, especially those in the front line, needs to be made aware that their work is highly valued. Mental health staff are no different to service users and carers in that they share the same need to be respected, valued, listened to and involved. Their need for training and supervision must also be recognised and provided for.

Clinical supervision, an indispensable feature of counselling and psychotherapy training, cannot be replaced by on-site supervision. Clinical supervision, as endorsed by the  and other professional bodies, by  members and our Accredited Course Providers, plays a



vital role in fostering professional development, enhancing client outcomes, and maintaining ethical standards.

The emotionally demanding and complex nature of counselling and psychotherapy necessitates clinical supervision due to the distinct issues encountered during sessions. Like other health and social care professionals, counsellors and psychotherapists work with a wide range of issues presented, making them susceptible to burnout.

In our view, clinical supervision is crucial in counselling and psychotherapy training, mitigating serious risks to client care and trainee care for several reasons:

Professional Development

In the 's view, clinical supervision provides a structured and supportive environment where trainees can discuss their cases, share their experiences, and receive feedback from experienced supervisors. This process enhances their clinical skills, helping them develop into competent and confident therapists. This mitigates the risk of trainees, counsellors and psychotherapists dealing with cases beyond their experience where the potential for harm is greatest by providing a space for growth ensuring the client is professionally cared for, and the therapist is able to grow their practice experience in a manner that is safe for them and the client.

Skill Enhancement

As we know, supervision sessions allow trainees to receive guidance on specific therapeutic techniques, interventions, and approaches. Supervisors, drawing from their experience, can offer valuable insights and suggestions to enhance trainees' skills and effectiveness in working with clients. This addresses the risk where trainees have inadequate experience with certain therapeutic approaches where clients may be harmed by therapist lack of skills and experience.

Ethical Decision-Making

Supervisors help trainees navigate ethical dilemmas and challenges that may arise in their counselling practice. By discussing ethical considerations within the context of real cases, trainees learn how to make sound ethical decisions, ensuring the well-being and safety of their clients. There's a significant risk of harm when trainees are pushed beyond their experience limits. Without ample support from their supervisors, initial poor decisions might escalate into more significant issues. Notably, upon reviewing a number of complaints against counsellors and psychotherapists in the US and UK, most upheld complaints stem from a gradual decline wherein professionals make minor initial errors in judgement. These errors, when left unaddressed, escalate and lead to substantial harm to clients. Addressing and rectifying these initial misjudgements at an early stage in clinical supervision, could prevent harm to clients, preserve the therapeutic relationship, and avert any resultant harm.



Emotional Support

The nature of counselling and psychotherapy work can often be emotionally demanding. Supervision provides a safe space for trainees to process their own emotional reactions to client issues. Supervisors offer emotional support, feedback and guidance, helping trainees manage their feelings and prevent burnout. The risk here is to trainee burnout and to client's wellbeing, where the trainee is then unable to provide safe support.

Self-Reflection

Through supervision, counselling and psychotherapy trainees engage in reflective practice, exploring their thoughts, feelings, and reactions during client sessions. This self-reflection enhances self-awareness, allowing trainees to recognize their biases, assumptions, and countertransference issues, ultimately improving their therapeutic effectiveness and allowing for growth as a therapist. Without the safe supervisory space for reflection of clinical supervision, the risk of harm to clients escalates significantly as trainee's blind spots emerge that they otherwise address within the supervisory space.

Accountability

Supervision ensures that trainees are accountable for their actions and decisions in therapy. Supervisors monitor the quality of care provided, ensuring that trainees adhere to ethical standards and best practices. This accountability promotes responsible and professional conduct. In the absence of effective supervision, trainees can drop standards, exercise poor decision making, and ultimately not exhibit the highest standards of client care, resulting in, at best, poor therapy, and at worst, significant harm to clients.

Quality Assurance

Clinical supervision maintains the quality and integrity of counselling and psychotherapy services. By overseeing trainees' work, supervisors contribute to the overall quality assurance of mental health services, promoting safe and effective therapeutic practices, thereby mitigating the risk to the public.

Continuing Professional Development

Supervision is a continuous component of counsellors' and psychotherapists' professional life. It continues beyond the training phase and into professional practice of counsellors and psychotherapists. Even experienced therapists engage in supervision to enhance their skills, stay updated with new techniques, and receive feedback on challenging cases, fostering lifelong learning and professional growth. Harm occurs when trainees encounter new, challenging issues and fail to recognise where they need to focus their CPD, learning and growth activities, so that they do not fail or harm clients.

As per the Health & Care Professions Council in the UK: *Supervision can also be an effective way to address competence or conduct issues. Appropriate supervision can demonstrate insight into what has gone wrong, and that you have taken steps to avoid repeating the concerns in future. If a concern is raised with the HCPC about your fitness to practise,*

*effective supervision can be an important mitigating factor in deciding whether your fitness to practise is impaired, and what action, if any, might be needed.*³

Clinical supervision has been recognised as a distinct professional competency that requires specific training and competence apart from general clinical competencies (Falender & Shafranske, 2004; Fouad et al., 2009; Kaslow et al., 2004). There is state recognition and education and training developments in the international arena in relation to clinical supervision (e.g., British Psychological Society, 2003, 2006; New Zealand Psychologists Board, 2010; Psychology Board of Australia, 2013).

Clinical supervision lies at the heart of the National Health Service (NHS), providing an instrument for delivering clinical governance [Department of Health (DoH), 1999, fostering evidence-based practice (EBP; DoH, 2001a) and promoting continuing professional development (DoH, 2001b). (Falender 2014)].

The Laws of Malta (Chap. 538) regulate the practice of supervision in the counselling profession. Counselling training regulated in Malta, requires clinical supervision on their training courses: Student: for every ten (10) counselling hours they have to attend one (1) hour of supervision; (Guidelines for Counselling Supervisors - Chapter: About Supervision).

Clinical supervision is not only mandated in the counselling and psychotherapy professions, but is also a requirement across several other regulated health and social care professions. For example, clinical supervision is mandatory in the nursing profession which is regulated in Ireland.

As per the HSE's Clinical Supervision in Mental Health Nursing FAQs⁴, clinical supervision is seen as an essential requirement for the profession:

Who should receive clinical supervision? All nurses and midwives registered with the Nursing and Midwifery Board of Ireland (NMBI) are advised to engage in the process of clinical supervision in their career whether they remain in clinical practice or move into management, research, or education.

What are the benefits of clinical supervision? It supports nurses to develop their clinical skills and professional practice in response to service user needs; it values and enables the development of professional and practice knowledge to meet these demands; it provides relief from the emotional and personal stress involved in nursing; it encourages professional and personal growth; it is a component of clinical governance; it is an aid to improving standards and the quality of nursing care; and it is for nurses, about nurses and on the whole provided by nurses.

Clinical supervision in Health and Social Care Professions is seen as different and additional to case management. The case management approach can be likened to CORU's proposed onsite placement supervision.

³ <https://www.hcpc-uk.org/news-and-events/blog/2019/reflect-discuss-develop-the-value-of-supervision/>

⁴ <https://healthservice.hse.ie/filelibrary/onmsd/clinical-supervision-in-mental-health-nursing-frequently-asked-questions.pdf>

Clinical supervision is a confidential contractual arrangement and as stated in the HSE FAQs: "Where possible the supervisee should have a choice as to who they want to be supervised by. The supervisor and supervisee will collaboratively agree a contract during the contracting stage of clinical supervision to establish boundaries about how best they may work together." We cannot see how essential clinical supervision arrangements can be achieved or replaced by onsite placement supervision.

We cannot see how essential clinical supervision arrangements can be achieved or replaced by onsite placement supervision.

Looking again to other health and social care professions, the British Journal of Wellbeing Vol. 2, No. 6 Clinical Supervision - Separating clinical and line management supervision in occupational therapy⁵ shows differences (Table 1) between clinical supervision and line management supervision. In the occupational therapy profession comparisons can be drawn between line management supervision and onsite placement supervision and those proposed by CORU for counselling and psychotherapy. As both forms of supervision differ greatly it is our view that one cannot replace the other:

Table 1:

Clinical supervision	Line management supervision
● Case discussion ● Reflecting on practice ● Clinical reasoning ● Interventions ● Skills and knowledge ● Evidence based practice ● Successes ● Dealing with complex/emotional/stressful cases ● Live supervision ● Risk management ● Feedback on performance ● Assessment tools ● Models	● Caseload management ● Waiting lists/times ● Referrals/discharges ● Training needs/professional development plan/Knowledge and Skills Framework ● Service delivery ● Time management ● Annual leave/sick leave ● Attendance management ● Team dynamics ● Team developments ● Signposting staff to other services (e.g. staff support) ● Fieldwork education ● Supervision of junior staff ● Financial issues/resources ● Audit ● Performance management issues ● Documentation ● Professional/conduct issues ● Standards of practice ● Demands on service (local and national) ● Change management ● Complaints

⁵ Published Online:20 Feb 2014 <https://doi.org/10.12968/bjow.2011.2.6.18>

[REDACTED]

The [REDACTED] requires all our members, including students, to attend clinical supervision.

Clinical supervision is seen by the [REDACTED] as vital to the process of ongoing maintenance of counsellor and psychotherapist competency. Clinical supervision mitigates significant risk of harm to clients and therapists. All [REDACTED] members working as counsellors and psychotherapists are bound by the [REDACTED] Code of Ethics and Practice to monitor their work through regular supervision, to ensure that their standard of counselling and psychotherapy is competent and continues to develop. Different membership categories are subject to different supervision requirements.

As per the [REDACTED] Accreditation Policy:

Supervision of Students

Frequency: Regardless of the number of client contact hours the student must meet their supervisor at least one hour a month.

Ratio: The student is required to have a minimum of one hour of individual supervision for every five client contact hours.

The [REDACTED] advocates for clinical supervision to be included in the CORU's training standards and frameworks for both counsellors and psychotherapists.

[REDACTED] Members' Feedback in relation to Clinical Supervision:

"Supervision is so multidimensional - care of the client, care of the therapist, CPD, minimising burnout or risk escalation issues, ethical issues, feedback space, client challenges space. In most of the other healthcare professions, it's more about Supervising - case management or Supervising - organisational issues or protocols."

"Supervision should be an essential element to be considered as a standard of proficiency. For me it is an essential part of the counselling process, both as a safeguard for me as a practitioner, and for the clients."

"Supervision is the heart of your development and best practice. It must be a part of this set of standards to protect our clients and provide the most ethical standards of work."

"I could not find any references to supervision in this draft. Supervision is necessary for the safety of both counsellors and clients. Beyond safety, it is also essential for enhancing practice. None of us are perfect and we all experience blind spots. Due to the confidentiality required in this work, it is very helpful to have support from another, suitably qualified and experienced supervisor."

"With no criteria in place and recognition of Supervisors and Supervision as part of growth and development of a Counsellor my concern is that blind-spots; transference and counter-transferences, bad habits, judgements and bias may become embedded without the challenges and capacity for self-reflection, deeper learning and meaning-making that Supervision creates an opportunity to engage in. Where might the slippery slide into burnout be explored? CORU may end up being busy processing Fitness to Practice cases, particularly



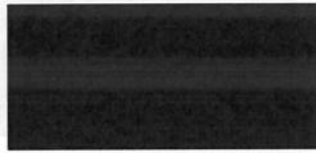
for Counsellors in Private Practice who may descend into burnout unimpeded if they lack professional support that regular supervision provides.”

We see the need to highlight the divergence between the CORU draft standards proposed general model of supervision and the distinct needs of counselling and psychotherapy as a profession.

In summary, we see the need to highlight the divergence between the CORU draft standards proposed general model of supervision and the distinct needs of counselling and psychotherapy as a profession. While CORU's framework aligns with established practices in regulated health and social care professions, it overlooks crucial nuances specific to our professions. The intensity of our therapeutic work and the risk of burnout demand a robust model of clinical supervision that goes beyond proposed on-site placement supervision. This supervision model isn't just about meeting regulatory standards, it is about fostering deep reflection, ensuring ethical practice, and safeguarding the public.

There are several reasons why the proposed on-site supervision model by CORU is unsuitable for our profession. Existing placement providers lack the infrastructure to support this form of supervision, and the block placement structure doesn't align with the non-traditional sessional working hours characteristic of our field.

Also, the proposed approach doesn't account for the unique nature of counselling and psychotherapy work, where therapists assess their own limits, which is crucial to prevent burnout and ensure client safety. The critical role of clinical supervisors is undermined in CORU's draft, posing risks to both client and therapist safety. We insist that clinical supervision, an indispensable aspect of our training, isn't interchangeable with on-site supervision.



Feedback regarding Clinical Placements

members and accredited course providers expressed concerns over the proposed number of placement hours for both registers as well as the proposed structuring of placements:

Main issues listed:

- Demand for 450-500 hours of clinical practice during the program, coupled with a high number of directly observed service user contact hours, poses infrastructural, ethical and public safety issues and financial burdens on education providers and students. Also, high volume of required placement hours could require students to engage in client work prematurely, which could pose a significant risk to the public.
- Course providers expressed a concern that there are currently no placements in Ireland that would be in a position to adhere to the placement conditions described by CORU.
- Financial burden might lead to increased course fees, limiting accessibility for students and reducing the number of qualified counsellors and psychotherapists. This in turn could have a negative impact on future recruitment, thereby limiting access for the public to essential therapeutic services.
- Excessive direct observation hours can be intrusive, impacting the client's confidentiality (GDPR), safety, and the overall quality of therapy.
- No other CORU profession has a requirement for directly observed placement hours.

Observed Hours

The inclusion of direct observation in the Criteria for Education and Training for Counselling and for Psychotherapy needs careful consideration due to its potential negative impact on clients.

The level of direct observation is seen as excessive and intrusive on vulnerable clients, primarily in low-cost counselling with few alternatives

The level of direct observation is seen as excessive and intrusive on vulnerable clients, primarily in low-cost counselling with few alternatives. It risks taking advantage of these vulnerable clients for the purposes of trainees, where a significant power imbalance is in place, and a client is likely to feel pressured to either accept the level of intrusion or leave





therapy where they have little to no alternative options for low-cost counselling without this intrusion on their privacy.

The requirement for observed hours goes against the Principle 1 of the  Code of Ethics and Practice:

“Respect for the rights and dignity of the client. Practitioners are required to treat their clients as persons of intrinsic worth with a right to determine their own priorities, to respect clients' dignity and to give due regard to their moral and cultural values. Practitioners take care not to intrude inappropriately on clients' privacy. They treat as confidential all information obtained in the course of their work. As far as possible, they ensure that clients understand and consent to whatever professional action they propose.”

The heightened vulnerability experienced by some potential clients, stemming from feelings of shame or inadequacy, may lead to reluctance to engage in therapy if subjected to observation or recording. This vulnerability, more prevalent in disadvantaged cohorts, could result in the exclusion of clients from more vulnerable sectors of society. Studies, such as those by Tangney and Dearing (2002) and Ó Braonáin (2013), suggest that shame and a sense of inadequacy are significant barriers to engagement in counselling, with many participants expressing aversion to being recorded.

Power differentials in the therapy room, coupled with potential stigma, may disadvantage diverse groups in therapeutic outcomes (Arthur & Collins, 2013; Guggenbuhl-Craig, 1971). The likelihood that higher-functioning individuals may be more accepting of observation raises questions about the meaningful purpose of direct observation, particularly if it results in a skewed sample of clients. This raises concerns about upholding values of equality, diversity, and inclusion within the counselling and psychotherapy professions.

In addition, there are also significant privacy, confidentiality, and ethical concerns. Issues related to informed consent, GDPR compliance, and the potential for misuse of recorded material pose risks to client well-being. Brown, Moller, and Ramsey-Wade (2013) emphasise the ethical challenges of clients not fully understanding the purpose of recordings, raising questions about informed consent.

Research on observer effects indicates changes in behaviour among those being observed, with potential negative consequences for clients, such as declining engagement and delayed disclosures. The potential for harm to clients, including exacerbation of shame and exploitation, raises ethical concerns about the requirement for direct observation. The Hawthorne effect is a psychological phenomenon where individuals modify their behaviour or performance in response to being observed or knowing that they are being studied. (Gale EAM. The Hawthorne studies—a fable for our times? Q J Med 2004; 97:439–449.)

Notably, clients with lower financial means often access low-cost counselling, where trainees frequently provide therapy and direct observation may occur. This setting could trigger shame, potentially leading to the selective exclusion of disadvantaged clients from services. The fear and distrust of authority among disadvantaged populations, as highlighted

[REDACTED]

by Dew et al. (2007), further underscore the potential negative impact of direct observation, potentially impeding disclosure and access to mental health support.

In terms of the cost of the observation hours, the assumption is that clients with lower financial means will be unable to bear this cost, nor should they be expected to. Therefore, without government/HSE funding, the burden of this cost will fall to students. A simple lower bound estimate of the cost of this would be as follows. The observer needs to be a qualified and registered counsellor or psychotherapist so the hourly rate will be one-to-one with observed hours, plus at least 25% additional hours for developmental feedback. This excludes any additional costs of observation process.

If we take a sample rate of €75 per hour, the additional training costs are:

- Estimated Counsellor Observation Cost: 75 hours of observation - €7,031;
- Estimated Psychotherapist Observation Cost: 100 hours of observation - €9,375.

From a practical standpoint, the infrastructure of counselling and psychotherapy placements in Ireland poses challenges to the implementation of direct observation, as described by CORU.

The organisations receiving funding have openly acknowledged that the allocated funds fall considerably short of the actual costs required to provide the essential services (Samaritans and Aware, as referenced in Dwyer, 2023).

Dwyer (2023) highlights the government's heavy reliance on charitable organisations to deliver community mental health support in Ireland, which suffers from inadequate funding. Notably, there has been minimal financial commitment towards offering counselling/psychotherapy in Ireland (as reported by Dwyer, 2023, only 5.1% of the 2022 budget was allocated to mental health).

The feedback from [REDACTED] accredited course providers is that it will lead to many placement centres closing, training courses not being able to secure student placement opportunities, with the effect of less and less students being admitted to counselling and psychotherapy training.

Many non-profit organisations, crucial for community mental health support, lack government funding and would not be able to provide placement structures as described in CORU draft documents. The requirement for on-site placement supervisors for direct observation is deemed impractical, creating barriers to student access to placements and hindering the provision of low-cost services to the public. The feedback from [REDACTED] accredited course providers is that it will lead to many placement centres closing, training courses not being able to secure student placement opportunities, with the effect of less and less students being admitted to counselling and psychotherapy training.



In the long-term, there is a risk that this will result in a deficit of counsellors and psychotherapists and create future recruitment issues in relation to counselling and psychotherapy roles, in the same way other health professions have been impacted. This is a risk to public safety and will lead to an increase in untreated mental health conditions and mental health related emergencies, overprescription, and increased overreliance on medication.

Also, imposing a high amount of placement hours in blocks rather than sessional, as these happen currently, might create a shift towards full-time programmes, which could markedly diminish the attraction and access for students with relevant prior professional or life experience, who require flexibility for a multitude of reasons, e.g. personal, health, caring or financial commitments.

As we know, mental health services in Ireland are underfunded, relying in part on voluntary sectors to supplement their delivery, including counselling services provided by students. Heightening financial burdens for training courses, placements and students could potentially reduce the number of students in training programmes. This in turn could create a barrier to access, for those from low-income backgrounds, impacting diversity and equality in the sector and impacting the inclusive nature and identity of the profession.

In addition, feedback from a number of placement providers raises concerns that as placement providers have limited interaction with students compared to college lecturers, it would be unrealistic to expect placement providers to validate specific competencies.

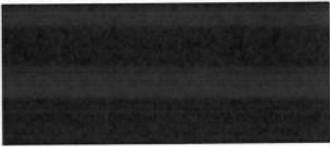
Please see below examples of feedback received from  members and course and placement providers in relation to CORU's proposed clinical placements and observed placement hours:

"I believe that this is not practical and achievable. The academic workload during the training, current placement hours are a struggle for students who are often in full time employment. Second, direct observation does not uphold the boundary of confidentiality and compromises the client's sense of safety. I believe it would prevent a client from being able to be vulnerable and held safely."

"I believe that some community projects will not be able to operate due to increased financial pressure placed on them to adhere to this regulation."

"How will a trainee manage to complete 300 hours in 2 years of clinical practice. The focus will shift from quality to quantity. 75 hours of directly observed client work- unless these hours are part of course simulated counselling sessions observed by a course tutor...there isn't a placement in Ireland equipped to provide this for trainees, and who will pay observer to observe...will they have to be accredited supervisors...and what about client's autonomy... It does not seem to be thought out for part time training courses and seems to be more in line with medical model."

"This is not realistic on the assumption that students do not start their placement until end of year 2/beginning year 3. In the context of placements, it will not be possible (or



appropriate for the client/service user) that 75 hours are directly observed. Counselling placements are quite different from other social care/medical environments and are not done 'in block'."

"The client's trust and feelings of safety within the therapeutic relationship with their therapist are developed over time. The inclusion of a third party either in person or by observation would at minimum, lead to a stilted, inauthentic interaction that may not accurately reflect the reality of a normal session. This is an unnecessarily intrusive practice which only serves the therapist's benefit, not the clients. Which is in direct conflict with the primary ethical consideration of always acting in the client's best interest. The imbalance of power is also a consideration. If the client agrees to the observation, it may be due to their fear of affecting the therapeutic relationship."

"I already undertake student placements at my practice. I coordinate placing low acuity clients with these student therapists. I am in the background should they need to consult on areas such as a risk or mandatory reporting. I liaise with the college as required. That being said, I personally would not have the time or resources available to become an 'on site supervisor' assessing students, signing them off. I would wager that most in my position would not. We would also be seeking to be remunerated if this had to be done. Who will fund this? CORU/Dept of Health? The college? Otherwise practices simply won't be prepared to take on students and there will be few options out there for those seeking placements. We are not in the room with these student therapists. We do not have the degree of contact that the college lecturers have with them. It does not make sense to ask us to sign off on competencies etc. In fact, it would be a totally inaccurate assessment and therefore represents another failing of the proposed regulations to protect the public. I urge you to strongly reconsider what has been set out and to place the responsibility with the college for this task."

"As a Placement manager I find the proposed CORU guidelines in relation to placements and assessments of students alarming. I am not sure how we would be able to continue providing a placement to students with the demand for in-house supervision and direct observation. While we are happy to provide non mandatory group supervision once a month as an addition to students' external clinical supervision, to be expected to take over both full supervision and assessment of students seem untenable. Assessment is in the hands of the training colleges and to expect us to do this seems to diminish rather than add to how students are assessed."

The ethics of direct observation are at odds with our code of ethics respecting the dignity of the client. Our focus is always on client safety and best practise and these suggestions by CORU seem to fly in the face of this.

I fear that many placements including our own will have to close their doors to students if CORU continues with its current set of proposals."

"The key pillar of the CORU proposals assumes the active collaboration and involvement of the placement organisations used and relied upon by colleges for student client practice."





Some of these organisations are community-based, others are operated, by necessity, on a more commercial basis and have various sources of funding, mostly via client fees. These organisations are not in any way under the control of or even formally affiliated to the training colleges. They are entirely independent service-providers and have no obligation to adapt in any way to the 'requirements' or standards of CORU.

There is no incentive for them to do so. There is no current provision for additional State funding in order to provide such incentives. The onerous responsibility of assessing students would be unprecedented for them and would carry little attraction. Student assessment is also a sensitive area in terms of potential litigation. They are not trainers or educators or assessors. They see other important roles for themselves as independent service-providers to the public.

Arguably they could be encouraged to 'hire-in' additional staff (presumably funded by colleges) who would be suitably qualified to carry out the assessment etc tasks envisaged, but there is no reason this unprecedented and extensive degree of co-operation by independent and variously constituted organisations could be relied upon as part of responsible future planning. "

In summary, our position informed by our members and our accredited course providers, is that the insistence on 450-500 clinical practice hours, alongside an excessive focus on directly observed service user contact hours, presents significant concerns in terms of infrastructure, ethics, public safety, and financial strain for education providers and students. The lack of placements in Ireland that align with CORU's stipulated conditions is a significant concern voiced by course providers, placement providers, and  members.

Financial burdens could escalate course fees, limiting access for students, and potentially reducing the number of qualified counsellors and psychotherapists, impacting future recruitment and public access to crucial therapeutic services. Another concern is that the sheer volume of required placement hours would require students to engage in client work at an early stage of their training, and this could pose a significant risk to the public.

The requirement for direct observation within counselling and psychotherapy training is a matter of deep concern for us at the  due to its potential repercussions on client well-being. Research shows that the level of direct observation, especially in low-cost counselling settings, may intrude upon the privacy and dignity of vulnerable clients, creating an uncomfortable power imbalance and leaving little choice for clients seeking affordable counselling options.

The impact of direct observation could be particularly detrimental to individuals from disadvantaged backgrounds, as studies have shown that shame and a sense of inadequacy are significant barriers to counselling engagement. This requirement risks excluding these vulnerable individuals from accessing much-needed mental health support, contradicting our commitment to equality and inclusion within the counselling and psychotherapy professions.



Furthermore, ethical concerns related to informed consent, confidentiality, and potential harm to clients' well-being due to changes in behaviour under observation deeply trouble us. The financial burden of meeting these observation requirements, especially for those accessing low-cost counselling, is concerning, as it would reduce access to services and hinder diversity in our profession.

Practically, implementing extensive direct observation hours within our current counselling and psychotherapy infrastructure poses significant challenges, impacting placement provision and limiting opportunities for future professionals. Feedback received from both course providers and placement providers indicates that a high proportion of placement providers will be unable to meet the requirements of CORU. Placements are integral to course provision and training cannot be completed in the absence of quality placement opportunities. The overly onerous requirements being imposed on placement providers, in the absence, we understand, of any consultation with said providers, are unrealistic and unimplementable. The knock-on-effects of this will be the inability of course providers to meet CORU requirements, thereby, leading to closure of colleges and in turn, significant reduction in qualified professionals.

In the long run, there's a potential for a shortage of counsellors and psychotherapists, which could generate future recruitment challenges similar to those experienced by other healthcare professions currently. This poses a risk to public safety, potentially leading to a rise in mental health conditions and related emergencies. Additionally, it may result in overprescription and increased dependency on medication to address mental health issues in the absence of access to therapeutic supports.

Overall, the proposed requirement for excessive placement hours coupled with the requirement for direct observation hours, raises ethical, practical, and financial dilemmas that would compromise our clients' safety, access to mental health services, and the inclusivity of our profession.

In light of our concerns highlighted above, the [REDACTED] is not in a position to support the requirements for observed hours as outlined in the draft proposals, and is therefore obliged to oppose them.



Conclusion

Regulation will introduce a statutory basis for mechanisms similar to those already in place within the [REDACTED], such as those related to accreditation and fitness to practice. Regulation aims to safeguard the public, especially those who are most vulnerable, by enforcing agreed standards of training and competency, as well as introducing a legal framework to ensure visibility and accountability. It should also lead to a better understanding and recognition of counselling and psychotherapy.

However, to ensure that the regulatory standards applied to both professions, are effective in protecting the public, it is the view of the [REDACTED] that the Registration Board must amend the proposed standards to address the significant and valid risks to the public and to the profession we have raised in this submission.

Firstly, we firmly advocate for the necessity of personal therapy in training programs. It serves as a cornerstone for ethical and professional growth, aiding therapists in managing their emotions and potential triggers during client work, ultimately safeguarding clients from harm.

Secondly, our perspective on clinical supervision underscores its indispensable nature, extending beyond regulatory compliance. The proposed on-site supervision model by CORU lacks alignment with our profession's unique needs for clinical supervision, posing risks to client and therapist safety, also due to infrastructure limitations and incompatibility with the non-traditional working hours.

Lastly, the issue of clinical placements and observed hours presents significant concerns. The demand for excessive observed hours creates infrastructural, ethical, and financial burdens, potentially leading to compromised client safety, diminished therapy quality, and heightened risk of burnout among therapists.

The [REDACTED] has been self-regulating the professions for more than 40 years and is the largest and longest established professional body for counselling and psychotherapy. We are extremely well positioned to say that standards proposed by CORU in the current form, pose a risk to both – therapist's and client's safety.

We cannot support the qualifications of practitioners, who do not complete mandatory hours of personal therapy and have no clinical supervision in training.

Also, clinical placement as proposed by CORU will have a detrimental impact on the future of the profession, leading to many placements' closures, which in turn will impact on the student numbers and future recruitment.

For these reasons, the [REDACTED] is not in a position to support these aspects of the Standards of Proficiency and Criteria for Education and Training Programmes for Counsellors and Psychotherapists in their current form and, as a result we are compelled to oppose them.

For these reasons, the [REDACTED] is not in a position to support these aspects of the Standards of Proficiency and Criteria for Education and Training Programmes for Counsellors and Psychotherapists in their current form and, as a result we are compelled to oppose them. However, the [REDACTED] fully supports the proposal to establish the academic threshold for entry at NFQ Level 8 for both counsellors and psychotherapists. Entry at Level 8 aligns with the requirements to ensure that practitioners exhibit exceptional performance, robust critical thinking skills, a deeper understanding of the subject matter, and the capability to conduct independent research.

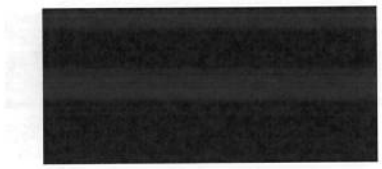
[REDACTED] members are highly experienced, qualified, and ethical professionals. The vast majority of the [REDACTED] membership is made up of fully accredited members or supervisors (72%) while student and pre-accredited members make up just over a quarter (26%). The organisation enjoys a loyal, long-standing, well established, and trusted membership. Almost a quarter have been members for between six to 10 years, more than a quarter have been members for between 11-20 years and almost a tenth have been members for more than 20 years ([REDACTED] Member Survey 2021). Our members together with our 22 accredited degree Level 8 and Level 9 course providers have given us invaluable feedback, insights and suggestions, which demonstrate the depth and breadth of professional expertise, skills, knowledge, and experience contained within our membership. The [REDACTED] trusts that the Registration Board will listen to the voices of our profession and address their well-founded and evidenced concerns.

The [REDACTED] is keen to support the Registration Board in any way that the board would find helpful and would be very happy to engage further in relation to any aspect of this submission.



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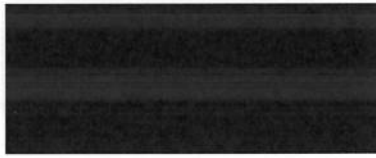
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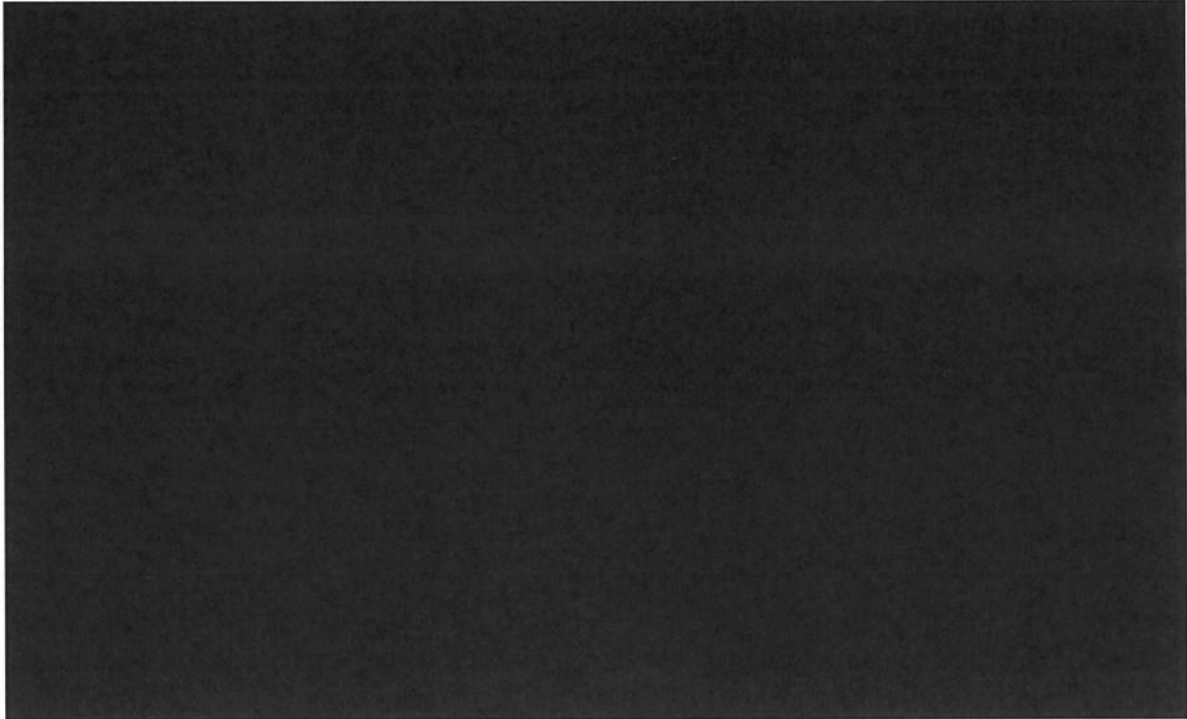
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Appendix 1

Membership Numbers

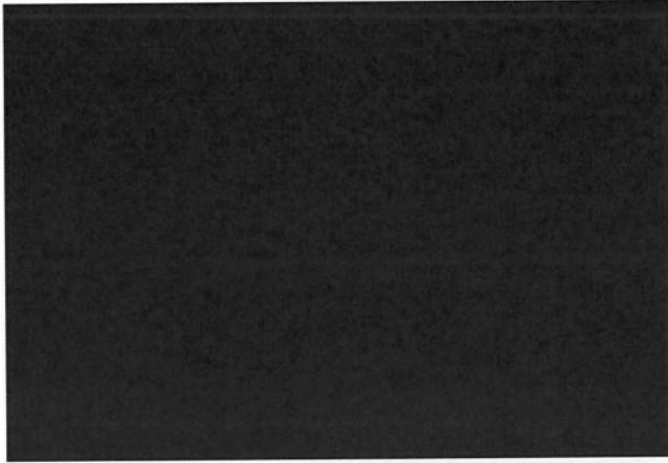




Appendix 2



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Counselling and Psychotherapy
CORU Response
1st December 2023

Release: Version <1.0>

Author:



Date Created: November 2023

1. Document

The document will be found within the Counselling & Psychotherapy – CORU folder on Google drive.

2. Revision History

Revision Date	Version	Primary Author(s)	Summary of changes
11/2023	1.0		1 st draft issued

3. Approvals

The following approve this Response Document and approve proposed actions based on the contents within.

Name	Title	Signature	Date of Issue	Version
	Academic Dean			
	Academic Director; Human & Social Sciences		11/2023	V1.0

4. Distribution

Name	Title	Purpose	Date of Issue	Version
	Registrar			

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Purpose of Response

In 2023, CORU proposed a Standards of Proficiency and Education Criteria for Counsellors and Psychotherapists ahead of the establishment of a professional registration process for the professions of Counsellor and Psychotherapist in Ireland. This response is [REDACTED]' review of the standards and criteria proposed by CORU and was undertaken at an organisational level.

The aim of this document is to provide feedback and a clear outline of any potential concerns with the proposed standards and criteria and how these may impact on the provision of training courses for Counselling and Psychotherapy going forward.

Executive Summary

[REDACTED] Department of Psychotherapy is in the main part in agreement with CORU's draft Standards of Proficiency; however commentary from responses received across the department are included under each heading, in particular where it is felt that there are wider considerations which may need to be reflected (notwithstanding that [REDACTED] recognises that the Standards of Proficiency set out the minimum threshold).

[REDACTED] disagrees with the section Education, 2 (2.2) regarding the requirements for 75 (Counsellors) and 100 (Psychotherapists) client contact hours to be directly observed.

This requirement places undue pressure on vulnerable clients, likely from poorer socio-economic backgrounds, attending low-cost or free services, to agree to having some of their personal therapy sessions audio recorded. This raises a serious ethical question about the validity of this requirement, one that could be addressed by way of robust clinical supervision, both individual supervision, and group supervision as part of the students training programme. This coupled with the clinical supervision and practice management provided as part of the students' placement in collaboration with the training programmes practice education team.

Specific commentary was also received on number of practice hours versus quality, the level of the programme, and requirements around Personal Therapy and other elements such as Process/Group Therapy, ratios and group size for Clinical/Placement Supervision, individual v Group Supervision, whether this needs to take place within college or placement environment, and supervisor qualifications/requirements, and requirements for ongoing supervision post qualification/registration.

Standards of Proficiency

1. Professional Autonomy and Accountability:

(1) Be able to practice safely and effectively within the legal, ethical and practice boundaries of the profession:

Response:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) The profession has consistently worked on legal, ethical and practice boundaries and has established codes of practice for clinicians to ensure safety for clients.

(2) Be able to identify the limits of their practice and know when to seek advice and additional expertise or refer to another professional:

Response:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is why the personal process for trainee therapists is so important. The ability of the observing ego to make a judgement call as to their boundaries of practice and holding. Without this awareness they can be still operating out of the ego where they are unaware of their capabilities to ensure and tolerate a client's pain.
- (iii) This area is essential for safe practice, again to protect both the client and the therapist. The current guidelines stipulated by the professional bodies ensure that internal processes that are out of the clinician's awareness are offered an opportunity for exploration. This is the task of supervision. This enables safe exploration by the client in the therapeutic space.
- (iv) This is of immense importance in the context of 'Do No Harm' to the client.

(3) Be able to act in the best interest of service users at all times with due regard to their will and preference:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) As previous comment, if they are unaware of the transference and countertransference.
- (iii) This has been covered above and is recognized as an ongoing process for all clinicians.
- (iv) However the use of standardised criteria across all health professions fails to recognize the different practice positions of the psychotherapist. They do not take into account that therapists are working with unconscious processes where clients are not necessarily aware of their preferences.

(4) Be aware of current guidelines and legislation relating to candour and disclosure:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential for all clinicians and is part of Continuous Professional Development guidelines stipulated by professional bodies.

(5) Respect and uphold the rights, dignity and autonomy of every service user including their role in the diagnostic, therapeutic and social care process:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) Psychotherapists and Counsellors have a particular role here with respect to the uniqueness of each individual they are in contact with as professionals.

- (6) **Be able to exercise a professional duty of care:**
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) Again, the level of unconscious awareness impacts on this.
 - (iii) Ongoing training and ongoing supervision are essential elements here and are addressed by current guidelines stipulated by the professional bodies.
- (7) **Understand what is required of them by the Registration Board and be familiar with the provisions of current Code of Professional Conduct and Ethics for the profession issued by the Registration Board:**
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and should be part of the training programme.
 - (iii) Impact of a standardised criteria in terms of differing practice approaches.
- (8) **Recognise the importance of practicing in a non-discriminatory, culturally sensitive way and acknowledge and respect the differences in beliefs and cultural practices of individuals or groups:**
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) Multicultural training should be included in the training and self-awareness through personal therapy will bring awareness to any bias and judgements.
 - (iii) Self-awareness and ongoing education are essential to ensure this.
 - (iv) Deeply engaging with your own personal process is essential to understanding and confronting any unconscious bias.
 - (v) Importance of continuous engagement with personal therapy.
- (9) **Understand the role of policies and systems to protect the health, safety, welfare, equality and dignity of service users, staff and volunteers:**
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and should be included in the training programme to ensure readiness to work and the standards of proficiency.
- (10) **Understand and respect the confidentiality of service users and use information only for the purpose for which it is given:**
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential.
- (11) **Understand confidentiality in the context of the team setting:**
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential.
- (12) **Understand and be able to apply the limits of the concept of confidentiality particularly in relation to child protection, vulnerable adults and elder abuse:**
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential.
- (13) **Be aware of current data protection, freedom of information and other legislation relevant to the profession and be able to access new and emerging legislation:**
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential.

(14) Be able to recognize and manage potential conflict that can arise between confidentiality and whistleblowing:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This should be covered in the training programme; however, concern is questioned here about the term 'whistleblowing' as there may be misunderstanding around what is consider 'Doing your job' and that of 'Whistleblowing.'

(15) Be able to gain informed consent to carry out assessments or provide treatment/interventions and document evidence that consent has been obtained:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential.

(16) Be aware of current legislation and guidelines related to informed consent for individuals with lack of capacity:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential.
- (iii) Also supported by engagement with personal therapy. The foundational role of experiencing personal therapy for training in counselling and psychotherapy needs to be acknowledged by including it in the requirements of any counselling and psychotherapy training course. However, if CORU seeks to protect the public, it cannot leave such a serious loophole which could lead to the accreditation of practitioners with no experience on which to base their practice. To omit it from the requirements could be very damaging for the profession of counselling and psychotherapy in the future and ultimately expose the public to danger.

(17) Recognise personal responsibility and professional accountability for one's actions and be able to justify professional decisions made:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) Again, the importance of understanding the unconscious judgements that can be present due to a lack of awareness in the personal process of the therapist.
- (iii) This is essential and again the role of supervision is vitally important here.
- (iv) Also supported by engagement with personal therapy. The foundational role of experiencing personal therapy for training in counselling and psychotherapy needs to be acknowledged by including it in the requirements of any counselling and psychotherapy training course. However, if CORU seeks to protect the public, it cannot leave such a serious loophole which could lead to the accreditation of practitioners with no experience on which to base their practice. To omit it from the requirements could be very damaging for the profession of counselling and psychotherapy in the future and ultimately expose the public to danger.

(18) Be able to take responsibility for managing one's own workload as appropriate:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) Should be part of the training of therapists and the importance of self-care.
- (iii) This is a necessary part of the work, is part of the training of psychotherapists and counsellors and is addressed by self-awareness and ongoing supervision and personal work.
- (iv) Also supported by engagement with personal therapy. The foundational role of experiencing personal therapy for training in counselling and psychotherapy needs to be acknowledged by including it in the requirements of any counselling and psychotherapy training course. If CORU seeks to protect the public, it cannot leave such a serious

loophole which could lead to the accreditation of practitioners with no experience on which to base their practice. To omit it from the requirements could be very damaging for the profession of counselling and psychotherapy in the future and ultimately expose the public to danger.

(19) Understand the principles of professional decision making and be able to make informed decisions within the context of competing demands including those relating to ethical conflicts and available resources:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) The importance of the underlying unconscious personal process which can impact on the therapeutic relationship and damage a client and the therapeutic relationship.
- (iii) This is of course essential in the work and is addressed currently by the guidelines set out by professional bodies for self-awareness through personal process and continued supervision of the work undertaken with clients.
- (iv) Also supported by engagement with personal therapy. The foundational role of experiencing personal therapy for training in counselling and psychotherapy needs to be acknowledged by including it in the requirements of any counselling and psychotherapy training course. If CORU seeks to protect the public, it cannot leave such a serious loophole which could lead to the accreditation of practitioners with no experience on which to base their practice. To omit it from the requirements could be very damaging for the profession of counselling and psychotherapy in the future and ultimately expose the public to danger.

(20) Be aware of and be able to take responsibility for managing one's own health and wellbeing:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This again is a matter of self-awareness through the insight developed through personal process.
- (iii) Also supported by engagement with personal therapy. The foundational role of experiencing personal therapy for training in counselling and psychotherapy needs to be acknowledged by including it in the requirements of any counselling and psychotherapy training course. If CORU seeks to protect the public, it cannot leave such a serious loophole which could lead to the accreditation of practitioners with no experience on which to base their practice. To omit it from the requirements could be very damaging for the profession of counselling and psychotherapy in the future and ultimately expose the public to danger.

2. Communication, Collaborative Practice and Teamworking:

(1) Be able to communicate diagnosis/assessment and/or treatment/management options in a way that can be understood by the service user:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This should be part of the training programme to achieve readiness to work and the standards of proficiency.

(2) Be able to modify and adapt communication methods and styles, including verbal and nonverbal methods to suit the individual service users considering issues of language, culture, beliefs and health and/or social care needs:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) Important to gain a deep understanding of the importance of the Therapeutic Framework and the Therapeutic Alliance to support and facilitate a collaborative journey with the client. Based on mutuality rather than Therapist as expert.

(3) Recognise service users as active participants in their health and social care and be able to support service users in communicating their health and/or social care needs, choices and concerns:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) Important to gain a deep understanding of the importance of the Therapeutic Framework and the Therapeutic Alliance to support and facilitate a collaborative journey with the client. Based on mutuality rather than Therapist as expert.

(4) Understand the need to empower service users to manage their wellbeing where possible and recognize the need to provide advice to the service user on self-treatment, where appropriate:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) Important to gain a deep understanding of the importance of the Therapeutic Framework and the Therapeutic Alliance to support and facilitate a collaborative journey with the client. Based on mutuality rather than Therapist as expert.

(5) Be able to recognize when the services of a professional translator are required:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This should be part of the training programme, with reference to equality, diversity, and inclusion.

(6) Be able to produce clear, concise, accurate and objective documentation:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This should be part of the training programme with an emphasis on working within a team, to achieve readiness to work and the standards of proficiency.
- (iii) The subjective nature of what is considered to be clear, concise, accurate and objective? The challenge of standardising reporting of unique clinic presentations.

(7) Be able to apply digital literacy skills and communication technologies appropriate to the profession:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This should be part of the training programme to ensure readiness to work and the standards of proficiency.

- (8) Be aware of and comply with local/national documentation standards including, for example, terminology, signature requirements:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This should be part of the training programme to ensure readiness to work and meeting the standards of proficiency.
- (9) Be able to express professional, informed and considered opinions to service users, health professionals and others e.g., carers, relatives in varied practice settings and contexts and within the boundaries of confidentiality:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This should be part of the training programme to ensure readiness to work and meeting the standards of proficiency.
- (10) Understand and be able to recognize the impact of effective leadership and management on practice:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This should be part of the training programme to ensure readiness to work and meeting the standards of proficiency.
- (11) Understand and be able to discuss the principles of effective conflict management:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This should be part of the training programme to ensure readiness to work and meeting the standards of proficiency.
- (12) Understand the need to work in partnership with service users, their relatives/carers and other professionals in planning and evaluating goals, treatments and interventions and be aware of the concepts of power and authority in relationships with service users:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This should be part of the training programme to ensure readiness to work and meeting the standards of proficiency.
- (13) Understand the need to build and sustain professional relationships as both an independent practitioner and collaboratively as a member of a team:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and should be part of the training programme, particularly important prior to students taking up clinical placements where they will be required to work in a team environment. It will also ensure that students achieve readiness to work and meet the standards of proficiency.
- (14) Understand the role and impact of effective interdisciplinary team working in meeting service user needs and be able to effectively contribute to decision making within a team setting:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential for readiness to work and should be part of the training programme.
- (15) Understand the role of relationships with professional colleagues and other workers in service delivery and the need to create professional relationships based on mutual respect and trust:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and should be embedded throughout the training programme to ensure that students achieve readiness to work and adopt the highest level of professionalism in all aspects of their work.

3a. Safety and Quality (Psychotherapists)

- (1) Be able to gather all appropriate background information relevant to the service user's health and social care needs:
 - (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and should be part of the training programme, particularly prior to students taking up clinical placements. It prepares students for readiness to work, both in private practice and as part of an organization setting.
- (2) Be able to justify the selection of and implement appropriate assessment techniques and be able to undertake and record a thorough, sensitive and detailed assessment relevant to what is necessary for the safe practice of psychotherapy:
 - (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) There can be too much emphasis on tests etc., there is an important connection at a relational depth rather than the head space of tests and judgement evaluations/diagnosis i.e., labelling.
 - (iii) Psychometric tests are a useful tool to help both practitioners and clients measure progress in therapy, therefore students must be able to use these in their private practice and in an organisational setting, this would ensure readiness to practice.
- (3) Be able to determine the appropriate tests/assessments required and undertake/arrange these tests:
 - (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential to ensure readiness to practice and should be part of the training programme.
 - (iii) How to determine a standardised approach to determine what is "appropriate" in the context of working with unique and unexpected presentations within the therapeutic encounter.
- (4) Be able to analyse and critically evaluate the information collected in the assessment process:
 - (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) The initial assessment is important in the context of 'Do No Harm' however as added information is revealed during the therapeutic process, assessment and evaluation is an ongoing process.
- (5) Be able to demonstrate sound logical reasoning and problem-solving skills to determine appropriate problem lists, action plans and goals:
 - (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and should be part of the training programme to ensure readiness to work.
- (6) Be able to demonstrate an evidence-informed approach to professional decision making, adapting practice to the needs of the service user and draw on appropriate knowledge and skills in order to make professional judgements:
 - (i) This is essential and should be part of the training programme to ensure readiness to work. It incorporates the process of putting theory into practice on an individual basis with clients.

- (7) Be able to prioritise and maintain the safety of both service users and those involved in their care:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) Both practitioner and client safety are paramount, this should be discussed as part of the training programme to ensure student readiness to work.
- (8) Be able to evaluate intervention plans using appropriate tools and recognized performance/outcome measures along with service user responses to the interventions. Revise the plans as necessary and where appropriate, in conjunction with the service user:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) As part of Proficiency need also to be able to hold in awareness the unconscious processes at play in the therapeutic relationship and to use the information available through this for the benefit of the client.
 - (iii) This is essential and should be part of the training programme to ensure student readiness to work. It will enable students to be confident in assessing client's needs, discussing appropriate interventions with clients, the use of psychometric tools, both in private practice and as part of an organization setting.
- (9) Understand the need to monitor, evaluate and/or audit the quality of practice and be able to critically evaluate one's own practice against evidence-based standards and implement improvements based on the findings of these audits and reviews:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) Self-awareness of the unconscious processes can build this awareness which is why the personal process is so valuable.
 - (iii) Ongoing clinical supervision is essential here.
- (10) Be able to recognize important risk factors and implement risk management strategies; be able to make reasoned decisions and/or provide guidance to others to initiate, continue, modify or cease interventions, techniques or courses of action and record decisions and concerns:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and is part of the training programme.
- (11) Understand the principles of quality assurance and quality improvement:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential for both private practice and as part of an organisation and should be part of the training programme.
- (12) Be able to carry out and document a risk analysis and implement effective risk management controls and strategies; be able to clearly communicate any identified risk, adverse events or near misses in line with current legislation/guidelines:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential for both private practice and as part of an organisation, it should be part of the training programme to ensure readiness to work.
- (13) Be able to comply with relevant and current health and safety legislation and guidelines:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and considered best practice – it should be part of the training programme to ensure readiness to work.

(14) Be able to establish safe environments for practice which minimizes risks to service users, those treating them and others, including the use of infection prevention and control strategies:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and should be covered in the training programme to ensure readiness to work and meet the standards of proficiency.

3b. Safety and Quality (Counsellors)

(1) Be able to gather all appropriate background information relevant to the service user's health and social care needs:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and should be part of the training programme, particularly prior to students taking up clinical placement. It ensures readiness to work and meets the standards of proficiency.

(2) Be able to justify selection of and implement appropriate assessment techniques and be able to undertake and record a thorough, sensitive and detailed assessment:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is part of the therapist working at a relational depth. A client walks through the door and there is already an assessment made as to what might assist the therapeutic relationship.
- (iii) Be able to consider the client and their presenting issues in the context of family, social and cultural etc. drawing on relevant modalities, approaches, techniques etc. and to use this information to inform treatment.

(3) Be able to determine the appropriate tests/assessments required and undertake/arrange these tests:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and should be a collaborative process between practitioner and client, this should be covered by the training programme to ensure readiness to work and prior to students taking up clinical placements.

(4) Be able to analyse and critically evaluate the information collected in the assessment process:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and should be covered in the training programme, prior to students taking up clinical placements as it ensures readiness to work.

(5) Be able to demonstrate sound logical reasoning and problem-solving skills to determine appropriate problem lists, action plans and goals:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is also impacted by the level of self-awareness in the personal process.

(6) Be able to demonstrate an evidence-informed approach to professional decision making, adapting practice to the needs of the service user and draw on appropriate knowledge and skills in order to make professional judgements:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This sounds like there is more importance on empirical evidence rather than the subjective relationship which is the utmost importance for healing.

- (7) Be able to prioritise and maintain the safety of both service users and those involved in their care:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and should be covered in the training programme as it is important to both working in private practice and as part of an organisation. It ensures readiness to work.
- (8) Be able to evaluate intervention plans using appropriate tools and recognized performance/outcome measures along with service user responses to the interventions. Revise the plans as necessary and where appropriate, in conjunction with the service user:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and should be covered in the training programme, prior to taking up clinical placements. It ensures readiness to work.
- (9) Understand the need to monitor, evaluate and/or audit the quality of practice and be able to critically evaluate one's own practice against evidence-based standards and implement improvements based on the findings of these audits and reviews:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and should be part of the training programme as it ensures readiness to work and collaborating ethically with clients. It includes health, safety, and risk management relevant to private practice and working as part of an organisation.
 - (iii) Ongoing clinical supervision is essential here also.
- (10) Be able to recognize important risk factors and implement risk management, initiate, continue, modify or cease interventions, techniques or courses of action and record decisions and concerns:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and should be part of the training programme as it is best practice for collaborating ethically with clients. This ensures readiness to work and meets the standards of proficiency.
- (11) Understand the principles of quality assurance and quality improvement:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED] agrees with this.
 - (ii) This is essential and should be covered in the training programme as it ensures readiness to work, particularly within organisational settings, but also relevant for private practice.
- (12) Be able to carry out and document a risk analysis and implement effective risk management controls and strategies; be able to clearly communicate any identified risk, adverse events or near misses in line with current legislation/guidelines:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and should be covered in the training programme, it ensures readiness to work, particularly in relation to organisational settings.
- (13) Be able to comply with relevant and current health and safety legislation and guidelines:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and should be part of the training programme, it ensures readiness to work and should be prior to students taking up clinical placements.

(14) Be able to establish safe environments for practice which minimizes risks to service users, those treating them and others, including the use of infection prevention and control strategies:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and should be part of the training programme, it ensures readiness to work and should be prior to students taking up clinical placements.

4. Professional Development

(1) Be able to engage in and take responsibility for professional development:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and should be embedded throughout the training programme, it ensures readiness to work, the emphasis is on working ethically and ensuring that practitioners regularly undertake relevant training that increases their skills and knowledge in line with professional standards and guidelines.

(2) Understand the need to demonstrate evidence of ongoing continuing professional development and education, be aware of professional regulation requirements and understand the benefits of continuing professional development to professional practice:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is where the quality of continuous professional development should be evaluated and certified. Too many CPD events are extremely poor and only tick a box for accreditation.

(3) Be able to evaluate and reflect critically on own professional practice to identify learning and development needs; be able to select appropriate learning activities to achieve professional development goals and be able to integrate new knowledge and skills into professional practice:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) Again, Personal Process at the self-relationship depth is so important in order to establish and integrate a strong and ethical Observing Ego.

(4) Understand and recognize the impact of personal values and life experiences on professional practice and be able to manage this impact appropriately:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) Personal Process and the unconscious only gained through good personal therapy.

(5) Understand the importance of and be able to seek professional development, supervision, feedback and peer review opportunities in order to continuously improve practice:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) Absolutely, again the usefulness of the Internal Observer to know what might be going on in the unconscious.

(6) Understand the importance of participation in performance management activities for effective service delivery:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and should be part of the training programme as many practitioners will likely work in organisations that funding restrictions result in limited number of sessions available to clients. Readiness to work requires training programmes to ensure that students are capable of working within such settings whilst adhering to standards of proficiency.

5a. Professional Knowledge and Skills (Psychotherapists)

- (1) Know, understand and apply 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:
 - (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (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:
 - (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and should be embedded in the training programme, it ensures that students are cognizant of the importance of continuing professional development in line with best practice, the standards of proficiency and ensures readiness to work.
- (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:
 - (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and should be part of the training programme, it encourages further learning through continuous professional development and ensures readiness to work.
- (4) Demonstrate skills in evidence-informed practice, including translation of theory, concepts and methods to clinical/professional practice:
 - (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and should be part of the training programme as it ensures readiness to work.
- (5) Be able to identify and understand the impact of organizational, community and societal structures, systems and culture on health and social care provision:
 - (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and should be part of the training programme as it ensures readiness to work.
- (6) Demonstrate safe and effective implementation of practical, technical and clinical skills:
 - (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and should be part of the training programme as it ensures readiness to work.
- (7) Demonstrate ability to participate in or lead clinical, academic or practice-based research:
 - (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This should be covered in the training programme, it emphasises clinical excellence and best practices aligned to the standards of proficiency and ensures readiness to work, particularly within organisational settings.
- (8) Know the basic principles of effective teaching and learning, mentoring and supervision:
 - (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This should be covered in the training programme; it provides students with the knowledge and skills for psychoeducation with their clients and ensures readiness to work.

(9) Be able to appraise the benefits, limitations and contraindications of differing psychotherapeutic approaches:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and should be part of the training programme, it enables students to confidently assess the appropriate psychotherapeutic approach for the work with their client(s) and meets the standards of proficiency and readiness to work.

(10) Be able to apply a chosen theoretical model to assess service users' suitability for the type of therapy offered:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and should be part of the training programme, it ensures that students are working ethically, are fully immersed in theory and practice and how this is used on a case-by-case basis with their clients. It ensures readiness to work and empowers students to know the limitations of the psychotherapeutic work they offer and when they may need to refer to an appropriate professional or service.

(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:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and should be part of the training programme and the clinical placement so that students can experience a wide range of presentations. It ensures readiness to work and meets the standards of proficiency.

(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:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is important and should be covered in the training programme as it encourages students to be aware of and engage with up-to-date policies and procedures and new developments within the profession.

(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-judgmental manner:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and is covered in the training programme, it emphasizes the importance of empathy and the core conditions.

(14) Be able to review the therapeutic process and progress with the service user, and make adjustments in collaboration with the service user:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and is covered in the training programme.

(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 process:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and is covered in the training programme.

- (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:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and is covered in the training programme.
- (17) Be able to use psychotherapeutic skills to build therapeutic relationships including the ability to demonstrate active listening skills:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and is covered in the training programme.
- (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:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and is covered in the training programme.
- (19) Be able to write concise, accurate and relevant reports which articulate and justify professional decisions made:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is important, particularly within organisational settings, it ensures readiness to work and should be covered within the training programme.
- (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:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and is covered in the training programme.
- (21) Be able to recognize personal emotional responses, vicarious trauma and the need to develop effective self-care strategies and burnout prevention:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) Proficiencies can only be achieved if a student is in personal therapy.
- (22) Be able to maintain professional and ethical boundaries with service users and be able to identify and manage any associated challenges:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) Proficiencies can only be achieved if a student is in personal therapy.
- (23) Be able to practice therapy that is within psychotherapist's level of skill, knowledge and professional judgment.
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) Proficiencies can only be achieved if a student is in personal therapy.
 - (iii) Supervision would be essential in achieving this.
- (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:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) Proficiencies can only be achieved if a student is in personal therapy.

- (iii) Many of these proficiencies can only be assessed through regular supervision, something which highlights the necessity for supervision to be an integral part of any training course.

(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:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) Proficiencies can only be achieved if a student is in personal therapy.
- (iii) This can only be assessed through regular supervision.

(26) Be able to articulate the parameters and value of clinical supervision and demonstrate the ability to utilize supervision to assist in practice review and in areas for development:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) Proficiencies can only be achieved if a student is in personal therapy.

(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:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) If appropriate to a particular practice.
- (iii) This is essential and should be part of the training programme as it ensures readiness to work and meets the standards of proficiency.

(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:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and is covered in the training programme.

(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:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) No difference in counselling as it is from the first contact where it needs to be taken account of.
- (iii) This is essential and should be covered in the training programme, it ensures readiness to work, gives students confidence in assessing potential risk, whether presented in the initial session or arises later in the therapeutic work with clients as often happens.

(30) Be able to demonstrate knowledge of crisis intervention and prevention and be able to work with people in crisis for improved outcomes:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and should be covered in the training programme, it is particularly relevant in relation to private practice but equally essential for working within an organisational setting. It ensures readiness to work and meets the standards of proficiency.

(31) Have a critical awareness of the need for organization and resource management for practice:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is important and should be covered in the training programme, it ensures readiness to work and brings awareness to the role of organisational structure and responsibilities.

(32) Be able to demonstrate and understanding of the impact of pharmacological use and history on psychological functioning and recognize potential implications for service users:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This should be part of any therapists training and no difference in Counselling and Psychotherapy. The awareness needs to be from the first session to inform the therapy.

5b. Professional Knowledge and Skills (Counsellors)

(1) Know, understand and apply the key concepts of the domains of knowledge which are relevant to the profession:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and should be covered in the training programme as it ensures readiness to work and meets the standards of proficiency.

(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:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential as it encourages further learning through continuous professional development and should be embedded throughout the training programme.

(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:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and should be embedded throughout the training programme.

(4) Demonstrate skills in evidence-informed practice, including translation of theory, concepts and methods to clinical/professional practice:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and is covered in the training programme.

(5) Be able to identify and understand the impact of organizational, community and societal structures, systems and culture on health and social care provision:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and should be covered in the training programme.

(6) Demonstrate safe and effective implementation of practical, technical and clinical skills:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and should be part of the training programme, it ensures readiness to work.

(7) Demonstrate ability to participate in or lead clinical, academic or practice-based research:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is important and should be covered in the training programme, it is particularly important within organisational settings and ensures readiness to work.

(8) Know the basic principles of effective teaching and learning, mentoring and supervision:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is important and should be covered in the training programme, it empowers students to use psychoeducation with clients, it ensures readiness to work.

(9) Be able to outline typical presentations from mild to severe presenting concerns and be able to treat presenting concerns, within the limits of their knowledge skills and competence or refer to another professional:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and should be part of the training programme, it ensures readiness to work and meets the standards of proficiency.

(10) Be able to practice counselling that is within the counsellor's level of skill, knowledge and professional judgment:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) No Difference to both classifications and will depend on personal awareness and self-knowledge.
- (iii) Ongoing clinical supervision is essential here.

(11) Be able to demonstrate the ability to use counselling skills to convey empathic understanding and to be informed by and connect compassionately to the perspective of the service user:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and is part of the training programme.

(12) Be able to use counselling skills to build therapeutic relationships including the ability to demonstrate active listening skills:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and is part of the training programme.

(13) Be able to analyse the theories of therapeutic relationship dynamics and be able to establish, build, maintain and conclude a therapeutic relationship with a service user:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and is part of the training programme.

(14) Be able to collaborate with the service user to set specific goals for change, to re-contract goals and timeframes as necessary:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and is part of the training programme.

(15) Be able to recognise and manage the dynamics of power and authority as experienced in the therapeutic relationship:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and is part of the training programme.

- (16) Be able to orient service users to the counsellor approach and explain the responsibilities of the counsellor in a therapeutic relationship:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and should be covered in the training programme.
- (17) Be able to initiate and manage engagement by developing rapport and trust:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and is part of the training programme.
- (18) Be able to identify professional and ethical boundaries with service users and be able to identify and manage any associated challenges:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) Supervision is the place for both classifications.
- (19) Be able to critically reflect on the role of the counsellor in the therapeutic process and be able to manage personal involvement in, and contribution to, the process of counselling:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) The process is the therapeutic relationship; there is no difference in the classifications.
 - (iii) Clinical supervision is essential here.
- (20) Be able to articulate the necessity of engaging in clinical supervision to support, sustain and improve practice:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) Same for both classifications, no difference and again the importance of therapists own personal process.
- (21) Be able to recognise personal emotional responses, vicarious trauma and the need to develop effective self-care strategies and burnout prevention:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) Personal Process and self-awareness of the unconscious.
 - (iii) Clinical supervision is essential here and if necessary, engagement with personal therapy also.
- (22) Be able to demonstrate skill in the technologies and communication methods required for the delivery of counselling in a virtual setting, and be able to apply these therapeutically and safely while protecting service user privacy and confidentiality:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and should be part of the training programme, it ensures readiness to work.
- (23) Be able to appraise theories and research on mental health and obstacles to well-being and be able to use these to facilitate improved treatment outcomes:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and should be embedded throughout the training programme as it encourages further learning, engagement with continuous professional development and how this can be effective in the therapeutic work with clients.
- (24) Be able to utilise a theoretical framework for practice with psychosocial factors and the impact on well-being:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.

- (ii) This is essential and is covered in the training programme.
- (25) Be able to analyse the impact of trauma on psychological functioning and be able to integrate this knowledge to inform practice:**
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and is covered in the training programme, it is important for students to understand the limitations and when to refer to appropriate services or other professionals.
- (26) Be aware of the potential harm to the service user in exploring trauma therapeutically, understand the need to refer on and be able to identify suitable referral pathways:**
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and is covered in the training programme, it aligns with readiness to work and the standards of proficiency.
- (27) 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:**
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and is covered in the training programme.
- (28) Be able to demonstrate knowledge of crisis intervention and prevention and be able to work with people in crisis for improved outcomes:**
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and is covered in the training programme.
- (29) Have a critical awareness for the need for organisation and resource management in various practice settings:**
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is important particularly in relation to organisational settings, it should be covered in the training programme as it aligns with readiness to work.
- (30) Be able to demonstrate knowledge of the effects of medications, prescribed or otherwise, relevant to service user counselling work.**
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
 - (ii) This is essential and is covered in the training programme.

Education

1. Level of qualifications for entry to the register

(1.1) The minimum level of qualification for entry to the register is Level 8 on the National Framework of Qualifications (NFQ):

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this as a minimum level.
- (ii) Further commentary received however questioned whether there will be any guidance on a minimum age requirement and if level 8 is sufficient for students to develop the required attributes. European standards generally require level 9, except level 8 courses of 5 years duration.
- (iii) Would further stipulate that this minimum level 8 qualification is obtained by a course of minimum of four academic years. This broad education, along with personal therapy and clinical placement best prepares the student for client practice.

2. Practice placements

(2.1) Practice placements must be integral to the programme:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) Engagement with personal therapy and supervision for the duration of the course needs to be an integral part of the course. Without the inclusion of a requirement for engagement with personal therapy CORU's stated aim of protecting the public cannot be achieved. Someone who has not undergone the therapeutic process is not in a position to facilitate others on a journey they have not taken themselves.
- (iii) Personal 1:1 therapy must also be an essential component. There should be no dilution of the current standards regarding this. Deep self-awareness of the Therapist is central to the care of the client – a therapist who has not engaged with their own process at sufficient depth will not be able to journey with or hold another (client) at any level deeper than that they have engaged with within themselves.

(2.2) COUNSELLORS: The programme must ensure that each student completes 450 hours. A minimum of 300 of the 450 hours must be supervised service user contact experience, of which 75 hours is directly observed service user contact:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED] does not agree with this.
- (ii) Further commentary received noted that this depends on the quality delivered. Hours do not mean anything if there is no quality of delivery. Purely a tick box exercise to bring in a difference. Training Supervisors should be of sufficient quality to mentor trainee therapists.
- (iii) The accumulation of hours is not a reliable indicator of fitness to practice. The key to determining fitness to practice is rigorous supervision.
- (iv) If relational depth/depth of the work is deemed the key differential between Counselling and Psychotherapy, then a minimum 4-year programme, combined with sufficient personal therapy, group/process work, rigorous clinical supervision (small supervision group numbers/high ratio client:SV hours) within the training setting (not afterwards) will best achieve this. Also, client work should not begin before year 3 in a 4-year programme.
- (v) The unethical aspect of "directly observed" work, and the impact on the therapeutic relationship. Impact on placement hours for trainees as clients might be dissuaded from beginning therapeutic work with a trainee if sessions are "directly observed".

(2.2) PSYCHOTHERAPISTS: The programme must ensure that each student completes 500 hours. A minimum of 350 of the 500 hours must be supervised service user contact experience, of which 100 hours is directly observed service user contact:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED] does not agree with this.
- (ii) As above, this depends on the quality delivered. Hours do not mean anything if there is no quality of delivery. Purely a tick box exercise to bring in a difference. Training Supervisors should be of sufficient quality to mentor trainee therapists.
- (iii) The notion of observed practice goes against the ethics of the therapeutic relationship. Having a third persona implicated in the relationship poses problems for the setting up of a transference and is not a standard practice in therapy training. Direct observation offers no further advantage over a good supervision. Introducing such a measure runs counter to CORU's aspiration to make these courses accessible to a wider cohort as it will only serve to increase costs for colleges and ultimately for the individual students.
- (iv) Draft CORU documents do not mention Personal Therapy, Process/Group Therapy. No specifics around Clinical/Placement Supervision as to ratio, group size, individual v Group Supervision, whether this will take place within college or placement environment, supervisor qualifications/requirements. Also, no mention of ongoing supervision post qualification/registration.
- (v) The unethical aspect of "directly observed" work, and the impact on the therapeutic relationship. Impact on placement hours for trainees as clients might be dissuaded from beginning therapeutic work with a trainee if sessions are "directly observed".

(2.3) The number, duration and range of practice placements, and their position within the programme must reflect the current practice and demands of the profession. They must be appropriate to facilitate translation of theory into practice and the achievement of the standards of proficiency:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) During placements, time limited client work (where a client's sessions are limited) are unsuitable for training purposes.
- (iii) This is essential, it aligns with readiness to work, it ensures that students gain valuable experience in providing short-term counselling sessions and longer-term psychotherapy sessions. As many practitioners will likely work for or within organisations that provide only short-term counselling due to funding restrictions, students need to gain knowledge and experience in this way of collaborating with clients.
- (iv) The impact on availability of placement/training hours due to the unethical aspect of "directly observed" work. Impact on placement hours for trainees as clients might be dissuaded from beginning therapeutic work with a trainee if sessions are "directly observed."

(2.4) The education provider will have a set of requirements for the selection of practice placements to ensure quality learning experiences for students that reflect the normal context and environment of practice. The education provider will work in partnership with the practice placement provider and have written agreements in place that clearly set out the responsibilities of all parties in ensuring that the placement supports the achievement of the standards of proficiency:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential.

(2.5) The education provider must maintain a thorough and effective system for approving and monitoring the quality of all practice placements. Students, the practice education team, placement providers and all relevant stakeholders – including service users where appropriate – must have a role in this review process including mechanisms for obtaining regular feedback:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and is current practice for the training provider.
- (iii) This is essential and is currently being implemented.

(2.6) Clear communication and governance structures should be in place to facilitate ongoing communication between the placement and education providers:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and is current practice for the training provider.
- (iii) This is essential and is currently being implemented.

(2.7) Student allocation to practice placements is based on the need to integrate theory and practice and to facilitate the student's progressive development of the standards of proficiency:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and is the current practice of the training provider.
- (iii) This is essential and is currently being implemented.

(2.8) Practice placement attendance requirements are explicit and detailed mechanisms and processes are in place to manage absence/non-attendance:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and should be co-created by the training provider and the placement provider.
- (iii) This is essential.

(2.9) Pre-placement requirements – including academic, legal, occupational health and other requirements, and procedures for non-compliance with these requirements are clear:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and should be in collaboration between the training provider and the placement provider.

(2.10) While on placement, appropriate support, guidance and supervision is maintained with the student by the placement education team:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential.
- (iii) This is essential and is currently being implemented.

(2.11) There must be a clear and explicit process in place for students to raise concerns in relation to their practice education and access to appropriate supports:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential.
- (iii) This is essential and is currently being implemented.

(2.12) The student code of conduct – and processes for dealing with breaches of that code whilst on placement is in place:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and should be co-created with the training provider and the placement provider.

(2.13) The profile and roles of the practice education team must be described. Practice educators must also be registered with the appropriate registration board:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential.

(2.14) Students, practice placement providers and practice education teams will be fully prepared and informed of the expectations of the practice placement, including the education/training provider's student fitness-to-practice requirements:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential.

(2.15) Supervision policies include guidelines on how students progressively achieve independence in practice:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential.

(2.16) Guidelines/procedures and supports are available for practice educators in managing students, including students who are in difficulty, throughout the placement:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential.

(2.17) The education provider will make regular support and training available to the practice education team to develop their practice education skills:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential.

(2.18) All stakeholders must be informed about practice education assessments, their link to the standards of proficiency and the marking criteria used. The practice education team must have access to assessment tools and be trained in completing these assessments and providing feedback during the placement:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential.

(2.19) Mechanisms for the return of placement assessments to the education provider must be in place:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and should be co-created with the training provider and the placement provider.

3. Programme Admission

(3.1) Clear and comprehensive information for prospective students about the programme and procedures for admission to the programme, including direct applications, must be available to ensure that prospective students can make an informed choice about taking up a place on the programme. Information provided should adhere to CORU's advertising guidelines regarding the approval status of qualifications and programmes:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) Substantial interviews should be used as a filter to safe potential issues that can cause hurt to the student trainee. No student should be able to obtain a place without this interview.
- (iii) The pre-intake assessment and interview process is important: Assessment for readiness and suitability to take on the programme, evaluate levels of self-awareness, capacity to engage in the personal process as well the standard of academic learning involved.

(3.2) The procedures for all student admissions to the programme must ensure that the stated criteria are met including any criteria relating to language proficiency, health requirements, criminal records and other appropriate academic and/or professional entry standards to ensure that students can participate in all elements of the programme:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential.

(3.3) The admissions procedures must detail procedures for the recognition of prior learning and other inclusion mechanisms at the individual and collective levels and document the evidence used to justify any programme exemptions in the context of their impact on achievement of the standards of proficiency:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential.

(3.4) The admissions procedures must ensure that the provider has suitable policies in relation to equal opportunities for applicants and students that meet the requirements of the most recent legislation together with an indication of how these are implemented and monitored:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential for equality, diversity, and inclusion.

4. Programme Management

(4.1) The programme must have a secure place in the education provider's plans to ensure that admitted cohorts of students will have the opportunity to complete the programme and be eligible to apply for registration:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.

(4.2) The named person with direct responsibility for the design and integration of the profession-specific components of the programme must have appropriate qualifications and experience. S/he must also be registered with the appropriate registration board unless other arrangements are agreed, for example, during the transitional period:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.

- (4.3) The programme must have regular monitoring and evaluation systems in place incorporating input from staff, students and all relevant stakeholders:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (4.4) All staff involved in the programme delivery and assessment of students must possess relevant qualifications, expertise and knowledge for the subject matter they teach:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (4.5) Those responsible for delivery and assessment of the core professional elements of the programme must be registered with the appropriate registration board:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (4.6) A programme for staff development must be in place to ensure continuing professional development relevant to their roles as educators of health and social care professionals:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (4.7) There is a mechanism in place to communicate and foster an understanding of the practice of the profession among non-professional staff involved in the delivery of the programme:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (4.8) There are resources to support student learning in all settings to achieve the standards of proficiency:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (4.9) There must be academic, health, wellbeing and welfare support mechanisms in place for students, designed with their needs in mind, and responsive to feedback from those who use them:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (4.10) The provider must identify any requirements for attendance, the procedure for monitoring attendance and the consequences of not meeting attendance requirements where relevant:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (4.11) Where students act as service users in practical and clinical teaching, relevant protocols must be used to obtain their consent:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (4.12) A profession-specific student code of conduct must be in place, including explicit information on processes and outcomes for dealing with concerns about students' profession-related conduct, and fitness to practice:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (4.13) There must be a quality assurance policy and system in place – which includes regular quality assurance audits, reviews and reports – that identifies quality issues and with clear accountability for addressing these issues:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (4.14) There must be formal processes in place for students to raise individual and collective concerns about the programme and to provide feedback on the content and quality of the programme:
- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.

(4.15) The programme provider must have secure mechanisms in place to manage and store student records/data and demonstrate compliance with data protection legislation:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.

(4.16) The programme provider must have detailed health and safety policies, procedures and implementation processes in place, including review of these policies and demonstrate evidence of appropriate insurance:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.

5. Curriculum

(5.1) The curriculum must ensure that those who successfully complete the programme meet the standards of proficiency:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.

(5.2) The curriculum must be guided by evidence-informed professional knowledge, relevant to current practice and the philosophy and core values associated with the profession with evidence of input from all relevant stakeholders including service users and employers:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
(ii) Does this take into account that differing forms of therapy have different core values? The profession is made up of many modalities not all operating from the same core values.
(iii) This is essential and reflects the core values that are present in all psychotherapeutic modalities that reflect the 'do no harm' ethos.

(5.3) The range of learning and teaching approaches used must be appropriate to the effective delivery of the curriculum and achievement of standards of proficiency:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
(ii) This is essential and is the current practice of the training provider, however further development of training in working therapeutically online is necessary to ensure readiness to work.

(5.4) Where the profession normally engages in interprofessional practice to achieve service-user outcomes, the curriculum must reflect evidence of relevant interprofessional education along with addressing the profession-specific skills and knowledge of each professional group:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.

(5.5) The curriculum should be designed to facilitate the timely integration of theory and practice with regular opportunities for feedback, reflection and consolidation:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.

(5.6) The curriculum must embed a culture of professionalism and make sure that students understand the implications of professional regulation including adherence to the relevant Registration Board's Code of Professional Conduct and Ethics:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.

6. Assessment strategy

(6.1) Assessments must ensure that the student who successfully completes the programme has met the standards of proficiency:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) Professional suitability interviews should be part of any training environment to assess and advise possible issues which if not resolved can impact on future therapeutic relationships.
- (iii) Twice yearly professional suitability interviews should continue to be incorporated throughout the training programme to monitor personal and professional development and learning and to identify and manage in early course any issues that arise during the programme.

(6.2) Assessments must be employed that assess learning outcomes (at module and programme levels) and appropriately and effectively facilitate progression decisions and the achievement of the standards of proficiency:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.

(6.3) There must be effective monitoring and evaluation mechanisms in place to ensure good practices are implemented in assessment including the use of formative and summative methods:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.

(6.4) Assessment regulations must clearly specify requirements for the appointment of at least one external examiner who must be appropriately experienced and qualified:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.

(6.5) Students must be informed about the assessments being used for their programme and be clear about requirements for progression and procedures for non-progression decisions:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) Yes, and currently being implemented.

(6.6) All staff involved in the assessment of students – formative or summative – must be informed about their link to the standards of proficiency and, where appropriate, trained to facilitate these assessments:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.

(6.7) All assessments must provide a rigorous and effective process by which compliance with external-reference frameworks can be measured:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.

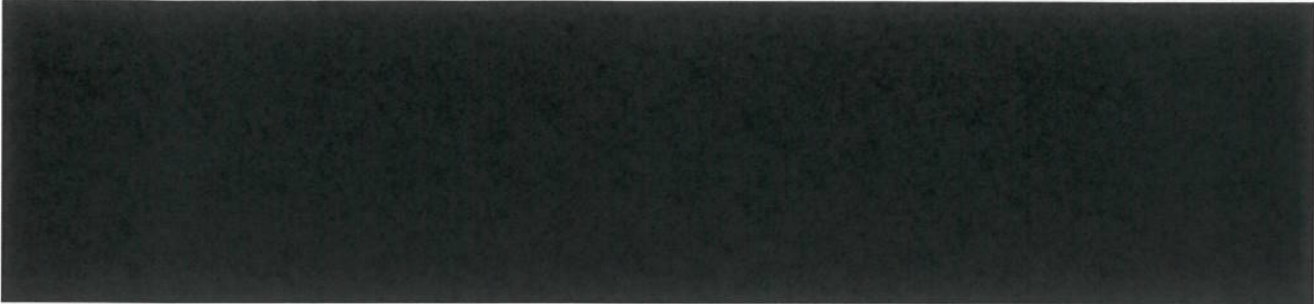
(6.8) The assessments in both the education setting and practice placement setting should be constructively aligned to achievement of the standards of proficiency:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.

(6.9) Procedures are in place for students to obtain results and feedback and to make an appeal of their results. Students and staff are informed of these procedures:

- (i) Discipline of Counselling and Psychotherapy, [REDACTED], agrees with this.
- (ii) This is essential and currently being implemented.

<End>



Submission to CORU

Proposals for Counselling and Psychotherapy Placement Practice

(Criteria for Education and Training Programmes)



Requirements for Psychotherapy Training Placements

Introduction:

This submission is made by [REDACTED] which has been providing placement practice to counselling and psychotherapy students [REDACTED]. In total, more than 200 students have completed their training placements in [REDACTED] during this period. Feedback from students, service users, clinical supervisors, training programme tutors and [REDACTED] staff has continuously informed the development of professional and ethical standards for the provision of a safe environment for service users and a valuable learning process for students as they navigate early practice experiences.

Client Safety:

The first priority in the management and delivery of the clinical services in a placement setting is the safety and wellbeing of clients who use the service. The duty of care to clients is paramount and informs all aspects of the provision of placement opportunities to student psychotherapists during their training.

To this end, the following should be evidenced by students before commencing a placement:

1. Assessment by the training institute regarding the student's fitness and readiness to begin placement practice.
2. Clear understanding on the part of the student of their ethical responsibilities to ensure client safety and privacy and an understanding of the legal and ethical parameters of client confidentiality.
3. Indemnity insurance policy appropriate to status as a student practitioner.
4. Appropriate arrangement for external clinical supervision with a suitably accredited supervisor.
5. Signed agreement between training institute and placement organisation regarding the parameters of student engagement in the practice learning setting.

Observation or Recording of Client Sessions:

There should be no direct observation or recording of the therapy sessions as this would significantly undermine the confidence and openness of the client. Being observed has the very likely effect of rendering the therapy space unsafe for the client and would likely result in a disingenuous level of engagement and a consequent undermining of the entire therapeutic purpose and endeavor. Furthermore, for these reasons, such sessions are of very little value in the learning process of the student.

It is also decidedly questionable as to whether appropriate consent can be obtained from a vulnerable client who is depending on the service provided and who might feel unable or be unwilling to decline their consent despite their wish to do so.

Roles and Responsibilities:

It is the sole responsibility of the training institute to provide the education and training to support the student in their practice learning. This cannot be the responsibility of the placement organisation in any respect as there is no training contract between the placement organisation and the student. To introduce such a contract would present the potential for conflict between the training institute and the placement organisation and would serve only to undermine the student. It is essential that a clear boundary delineates the responsibility for delivering training. The placement organisation's sole responsibility is to provide and manage the work environment.

Clinical Supervision:

All aspects of the clinical process are reviewed and supported in the external clinical supervision and it is expected that the supervisor will report on student progress directly to the training institute. It is essential that clinical supervision is arranged outside of the placement organisation to ensure the observation of ethical boundaries.

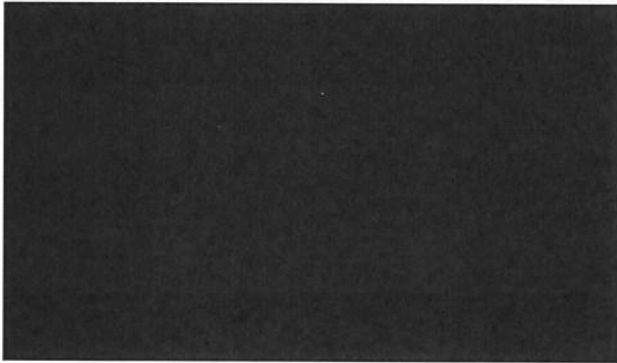
Assessment of Student Competence:

It is the responsibility of the training institute, in consultation with the appointed clinical supervisor, to assess the developing competence of the student as a clinical practitioner. This cannot be part of the remit of a placement supervisor as the process of clinical supervision is central to assessment and cannot be undertaken by a placement supervisor for ethical reasons (basic principles governing ethical boundaries and dual relationships).

As part of the agreement between the training institute and the placement organisation there is the requirement for contact and feedback insofar as the placement supervisor has cause for any concern about the student's engagement in placement practice, adherence to ethical guidelines or capacity to discharge responsibilities in the manner expected of a student on a professional training programme. Other than such concerns, it is inappropriate for the placement supervisor to participate in the assessment of the student's progress and development as a clinical practitioner. This is the responsibility of those who are qualified to make this assessment i.e. the training institute team and the appointed clinical supervisor.

The student will report to the placement supervisor regarding the practicalities of engaging with the placement organisation e.g. use of space/facilities, process of referrals and cancellations, client records system and other administrative matters, policies, protocols and general case management. These are the limits of support that should be offered by a placement supervisor to a student.

Signed:



Date: 27th November 2023

[REDACTED]

CORU - Regulating Health & Social Care Professionals
Infinity Building,
George's Court,
George's Lane,
Smithfield,
Dublin 7,
D07 E98Y

01st December 2023

Re: Coru Public Consultation - Standards of Proficiency and Criteria for Education and Training Programmes for Psychotherapists and Counsellors

To Whom it May Concern

Thank you for the opportunity to contribute our feedback to your most recent public consultation on the Standards of Proficiency and Criteria for Education and Training Programmes for Psychotherapists and Counsellors.

After careful consideration [REDACTED] is not in a position complete either of the surveys on the specifics of this consultation. However, we would like to note in the context of this consultation the importance of ensuring that psychotherapists and counsellors have sufficient, contemporary bereavement-related competence to meet the needs of their clients facing difficulties following a death. We wish to highlight this for two reasons:

- We are concerned that understanding and practice in bereavement and grief has developed considerably over the last few decades, yet there is a time lag in adoption to psychotherapy and counselling practice and there are serious implications to this.
- Currently there is a lack of bereavement and loss related learning outcomes in the QQI level 8 framework for counsellors and psychotherapists.

Context for our contribution

[REDACTED]

[REDACTED]

Our work [REDACTED] aims to underpin developments at each level of this framework and includes education, training, service and infrastructure developments. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

We use a public health model in our work advocating for a strategic and coordinated approach to bereavement care.³ A public health model recognises that all bereaved people have needs; for compassion, information, and the support of those around them. However, some factors can indicate a minority of bereaved people (approximately 10%) will require additional support. It is the needs of this cohort that we believe hold a direct relevance to the current consultation and development of standards and criteria for psychotherapists and counsellors.

Rationale for our contribution

Contemporary models of grief and bereavement reflect a diversity in peoples' grief responses and also give direction on coping and intervention strategies. Many of these, e.g. Dual Process Model of Coping, Continuing Bonds, Meaning Making, build on established theoretical foundations used in psychotherapy and counselling including attachment theory and social construction.

The roles of risk and protective factors for bereavement outcomes are now better understood – these can relate to personal factors including gender and attachment style, interpersonal factors such as the nature of a relationship, the availability of social support or situational factors such the type of death, or existence of concurrent stressors.

While facing loss and bereavement are natural life events, some individuals will encounter difficulties in their journey and the tools and approaches to working with these issues are best met with enhanced knowledge and skill, based on contemporary research and knowledge.

A smaller section still (around 10%) may require intense psychological intervention in the face of their more complex grief. Both the DSM and ICD-19 have identified the

³ Aoun SM, Keegan O, Roberts A, Breen LJ. The impact of bereavement support on wellbeing: a comparative study between Australia and Ireland. *Palliative Care and Social Practice*. 2020;14. doi:10.1177/263235242093513

[REDACTED]

characteristics of what is termed 'Prolonged Grief Disorder' which can be both identified and treated.⁴

There is now more evidence available on a range of ways of working with grief⁵ while recent research has shown access to formal training and CPD in bereavement can vary across the psycho-social professions.⁶

Research has shown that complicated grief/Prolonged Grief Disorder has the potential to adversely affect bereaved individuals, and in this context, understanding how mental health professionals specifically engage with it in practice is of relevance.⁷ An Irish study by Dodd et al (2022)⁸ sought to gain an understanding of professionals' knowledge, attitudes, skills and training in relation to complicated grief in order to provide insights to inform their training and professional development.

The study found that professionals (psychologists, psychiatrists and counsellors / psychotherapists) expressed high confidence in their competence to identify and treat complicated grief despite a less than full knowledge of the research evidence. There was "scant" evidence of grief-specific screening instruments in the identification of complicated grief and small rates of referral when client needs may be outside of a domain of competence.

Recommendations for training and addressing research-practice gaps were made based on findings and literature. These echo applied Irish research from as far back as 2008 and a Department of Health commissioned report which made recommendations for mental health providers' bereavement training to extend beyond 60 hours input⁹.

Points of note for Coru with regards to this consultation

Noting the context and the rationale for our contribution we would like to note the following points in terms of your current consultation:

- We appreciate that Coru does not have responsibility for curriculum development, however we would ask that you use your influence in the context of this consultation to highlight that there is a lack of bereavement related learning outcomes in the QQI level 8 framework for counsellors and psychotherapists and that the information which is being provided is out of date and discussing bereavement models which have moved on.

⁴ Lundorff M, Holmgren H, Zachariae R, Farver-Vestergaard I, O'Connor M (2017). Prevalence of prolonged grief disorder in adult bereavement: a systematic review and meta-analysis. *Journal of affective disorders*, 212. 138-149.

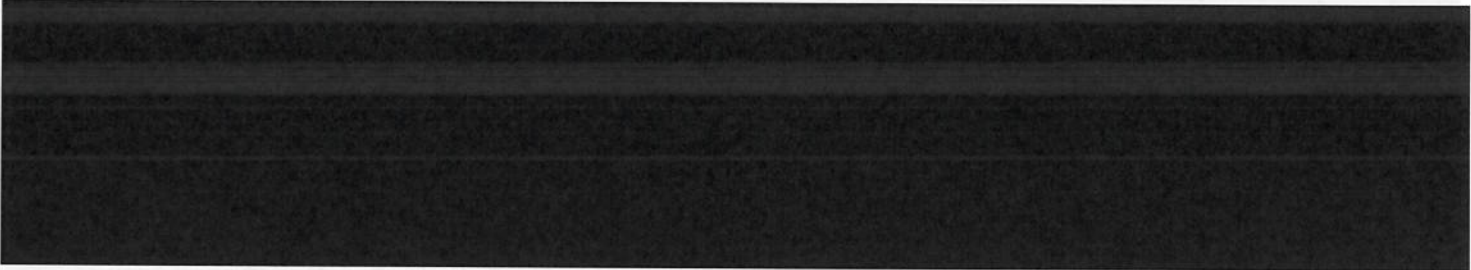
⁵ Johannsen, M., Damholdt, M. F., Zachariae, R., Lundorff, M., Farver-Vestergaard, I., & O'Connor, M. (2019). Psychological interventions for grief in adults: A systematic review and meta-analysis of randomized controlled trials. *Journal of affective disorders*, 253, 69–86. <https://doi.org/10.1016/j.jad.2019.04.065>

⁶ Dodd, A., Guerin, S., Delaney, S., & Dodd, P. (2017). Complicated grief: Knowledge, attitudes, skills and training of mental health professionals: A systematic review. *Patient Education and Counseling*, 100(8), 1447-1458.

⁷ [How can we know what we don't know? An exploration of professionals' engagement with complicated grief - ScienceDirect](#)

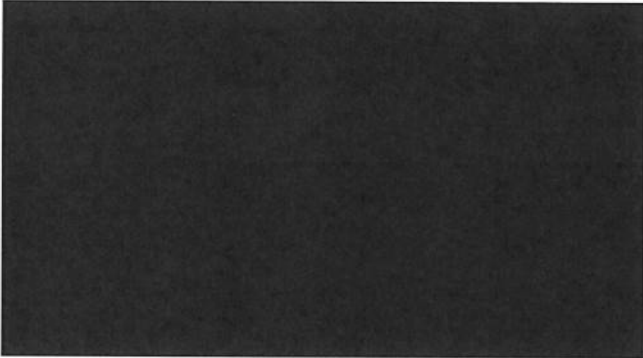
⁸ Ibid

⁹ <https://www.hse.ie/eng/services/list/4/mental-health-services/nosp/research/reviewbereavementsupport.pdf>

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- It is noted in the consultation that psychotherapists and counsellors must demonstrate a critical understanding of relevant biological sciences, human development, social and behavioural sciences and other related sciences. In our view it would be important to add that therapists demonstrate a critical understanding of the universal experience of death and loss encompassing bereavement knowledge and skill; ethical practice knowledge and skill; communication knowledge and skill; self-care and culture.
 - As noted in the consultation, it is vital that both professions are able to apply a chosen theoretical approach, however it is equally important that they apply a **contemporary model**, particularly in terms of grief and loss, to assess their service users' suitability for the type of therapy offered.
 - Both professions must be able to critically and theoretically reflect on their own frame of reference in terms of mortality and their experience of loss when client and psychotherapist / counsellor dynamics are required. Equally, our experience has shown that when a therapist's education of bereavement models has been superseded or is limited, then there is a risk that the psychoeducation given to their clients will also be limited and potentially misleading.

We would be happy to engage with you further on any of the topics or points raised in this letter and we hope that you will give them due consideration. We wish you the best with the consultation and the subsequent issuing of standards and criteria.

Yours sincerely,



CORU Counselling & Psychotherapy consultation
Items for feedback – Written Submission

Firstly, thanks to everyone involved in bringing us to this place. I appreciate the hard work and commitment involved, particularly in such a fragmented and complex field.

I have contributed to a number of feedback documents, online and written, in my various roles. Here, I am highlighting a number of areas I feel are key and more easily addressed than in the online forms.

I'm writing these from a number of perspectives:

- I am the manager of a counselling/psychotherapy service, and placement centre.
- I have written courses on counselling/psychotherapy to degree, masters and doctorate level, and have delivered training at each of these levels.
- I have been in practice for close to 30 years.
- I am a clinical supervisor for 20 years, and also a consultant supervisor.
- I have managed trauma centres internationally, and have sat on task forces for policy development in these areas.
- I am a counselling/psychotherapy researcher and have contributed in this research field in Ireland and internationally.

Bringing these together I want to submit the following thoughts for your consideration – I have kept them relatively brief with due consideration to the amount of material you will receive. Any of these areas can be expanded on.

Placement:

I agree that there needs to be a way of conducting direct observation, though to what level this needs to be detailed. A significant number of counsellors/ psychotherapists complete their placements in community and voluntary organisations. These organisations often, if not usually, have very limited resources. The criteria for placement centres have to be workable within that understanding. There can be issues of space or

technology, depending on what direct observation is going to mean. Likely this will also mean a significant burden of time and resources for these organisations. One such area is the issue of who supervises the work - this is not detailed, nor is the area of clinical supervision addressed. Supervisors will need to learn how to observe and grade accordingly to the standards and therapeutic modality. This can be a difficult shift for many of them. It also gives rise to the issue, for some approaches, of keeping clinical supervision and other types of supervision separate – though also important to acknowledge this is not a concern for some approaches.

Students on placements in these organisations are exposed to a wide range of presentations and contexts (and should be safely managed by the centre) – this is ideal for assisting them in their learning and development. Additionally, students help to deliver services – at a suitable level - to people and communities that otherwise would not be able to access support. If this area of the proposals is not comprehensively and appropriately designed there is the danger that such organisations will not be able to do placements, this will significantly limit the options that education providers have for placement and partnership for their students. Also, these placement centres offer a context that is welcoming and experienced in supporting people who have not had previous educational opportunities, but have rich life experience.

Counselling/Psychotherapy:

The proposal to keep both counselling and psychotherapy at the same level has likely detrimental consequences for the field – clients, training providers and placement centres. The proposed differences between the two levels is narrow. Yes, there are extra elements and thresholds, in the psychotherapy section but only a minimal amount of time to be exposed to and learn them.

Overall, looking at the proposed standards, thresholds etc, psychotherapy is considered to be more ‘senior’ (for want of a better expression)...so why would someone train in counselling, when doing a relatively few extra hours, will allow them to become a psychotherapist. Consequently, there is no reason for education providers to provide

counselling courses. This will undermine the title and approach of counselling in Ireland, and for counsellors when applying for grandparenting.

I appreciate a central task for CORU is to protect the public, I agree with this and welcome the changes for our profession. I would argue that keeping psychotherapy and counselling at the same level et al goes against this central tenet. Safety can't be at the minimal level considering the range of presentations. The public, as you know, includes clients with complex and major presentations - for instance, someone with anorexia, who self-injures, and has a complex trauma past. Such a client needs to attend a therapist who has studied and committed to their professional knowledge, skills and development in the field. I contend that the proposal to keep a minimal difference creates a situation where the incentive to continue to train or to commit to a higher level of training is removed. The next step is doctorate level, which will be outside many peoples' ambitions or resources, and becomes further removed without having a Masters. Psychotherapy, at a higher level allows, for therapists to be better prepared to be safe with clients who have more complex needs.

Counselling/Psychotherapy, as you know, does not exist in an isolated field. We interact with GP's, Psychiatrists, Clinical psychologists, HSE, Tusla, Social work teams - to name a few. Part of that interaction is to enable the safety of clients; I note that there are thresholds proposed that recognise this. Our profession has always struggled to be taken as seriously as other helping professions, with a lack of education being historically and sometimes currently stated and implied, as a reason for this. This proposal to remove masters' level training will not assist the field in the context of interaction with these other professions. It implies a lack of ambition in the realm of education and erects a potential barriers – which will have consequences for client safety. Furthermore it will diminish our interactions with European bodies, which will stifle learning, research, evidence informed practices, etc – all which will impact on client safety over time.

Many thanks for your time, and I hope these thoughts are of help in your considerations.

[Redacted Signature]

Practitioner feedback – Public Consultation 2023

Counsellors & Psychotherapists Registration Board

Documents Reviewed:	Standards of Proficiency for Psychotherapists Standards of Proficiency for Counsellors Criteria for Education and Training Programmes for Psychotherapists Criteria for Education and Training Programmes for Counsellors
Submission by:	[REDACTED]
Consultation Round:	Public Consultation 2023
Date:	26 th November 2023
To:	The Counsellors & Psychotherapists Registration Board
CC:	Board of Directors, Irish Association of Counselling & Psychotherapy

To Whom It May Concern:

I write in reply to your recent request for feedback on both the *Standards of Proficiency for Counsellors and Psychotherapists* and the associated *Criteria for Education and Training Programmes* for both professions.

To introduce myself, my name is [REDACTED] and I am a counsellor and psychotherapist working in private practice with over 19 years of experience. I have been a clinical supervisor of therapists since 2015, and have worked as an educator in the field for over 11 years. My submission to the Board is rooted in my original training and ongoing professional development as a humanistic-pluralist therapist, my professional standing as a long-time member of the IACP, my academic credentials, my lived experience as a client for many years and my professional experience having worked with hundreds of clients in nearly nine thousand hours of one-to-one counselling and psychotherapy since my first session in 2005.

Before setting out specific feedback, I would like to commend the Board in your efforts to address the task of regulating the professions which many elsewhere have previously failed to accomplish. The challenge is enormous, complex and fraught with political, social and philosophical implications. Due to this complexity I strongly urge the board to take the necessary time to carefully consider what is extant in the current professions before rushing to get the boards up and running. We have waited a long time for regulation so some additional months of consideration and careful deliberation appears not just wise but warranted.

I will, below, outline specific feedback on the standards and proficiencies outlined in the four documents reviewed, however, the primary issues can be summarised as; the vital need to place three cornerstones of counsellor/therapist training and practice at the centre of the standards and proficiencies; personal therapy, one-to-one clinical supervision (at a minimum in training) and ongoing clinical supervision as a cornerstone of professional practice.

[REDACTED]

[REDACTED]

Detailed Feedback

Note: in my comments below, I will use the word therapist and therapists to refer to counsellors and psychotherapists. Where I refer to a specific profession, I will refer to that title explicitly.

General Observations & Comments

The absence of a definition for either of the professions.

The decision to split the work of counselling and psychotherapy into two distinct registers has previously been made without sufficient transparency as to the defining characteristics of each profession such that two registers are warranted. The question then becomes - how can your work in defining standards and proficiencies progress without a baseline definition of each profession. Surely, the key aim of Statutory Regulation is to protect the public, but creating the registers in the absence of a definition of each profession does nothing to address the public's perception or understanding of what these endeavours actually are in order to decide which service to access.

When extended to professional practice, how can you ask professionals to work within the limits of competence set out by the standards and proficiencies if you don't define the scope of each profession's practice? Four of the five areas say little about what actually happens in counselling / psychotherapy, so how do you set boundary conditions in the absence of clear demarcation for practitioners?

Thinking ahead to the opening of the two registers - how can an applicant to the register know which register to join if they don't have a definition of what each register represents in order to adjudicate application to one or more registers?

With no requirement for clinical supervision post-registration, you have created a situation where therapists themselves have no external objective means of ensuring compliance with the scope of practice of each/both registers. This seems like a fatal flaw in the goal of protecting the public as it essentially erases longstanding core aspect of ongoing professional practice – a more experienced clinician overseeing (sometimes gatekeeping) the work of therapists so that clients have a second line of protection in the form of the supervisor.

Use of terminology – service user versus client

Our profession has had a longstanding tradition in custom and in practice of referring to those availing of therapy as *clients*. There are several reasons for this including early rejections of therapy as a purely medical treatment as it branched out from early mental-illness paradigms. Patients are sick, clients however are those availing of many varieties of supports to enhance their emotional wellbeing and quality of life, as well as addressing more serious mental health issues. The term service user however has often been rejected as de-personalising. Therapy is, after all, a relational endeavour, an *I-Thou* paradigm and not an *I-It* construct. Retaining use of the word client in deference to longstanding practice, emphasising the vital nature of relationship as central to the work of therapy requires careful consideration rather than the dogma of standardisation across the allied health professions through the imposition of linguistic orthodoxy.

Use of terminology – supervisor

Throughout the standards and proficiencies for training and in practice, use of the word supervisor during placement is misleading as it essentially re-defines the role of supervision. As read, the role of supervisor (placement supervisor) bears little resemblance to clinical supervision – the signature pedagogy of our profession. The Board appears to have clipped the wings of supervision to mere line management or trainee/administrative oversight of checklist competency/proficiencies with a brief

nod to availing of clinical supervision as necessary. This essentially eviscerates the heart of clinical supervision practice as an essential reflective space in which a therapist in training can be formed into an effective practitioner and an established practitioner can have their work actively supported in the form of ongoing support, education and management. I strongly caution the Board on its current framing of supervision as stated in the standards and proficiencies. In my view, this will have a significant detrimental impact on the safety of clients due to the fact that no matter how skilled or trained we are, we can't see our professional blind spots. We need to have a second pair of eyes, super-vision if you will, to effect compassionate, ethical care to clients and assist us in remaining within the guardrails of effective high-quality practice within the context of each register.

Specific Observations & Comments - Criteria for Education and Training Programmes **Counsellors & Psychotherapists**

My side-by-side analysis of the documents shows only 11 differences between the documents. Discounting typographical errors, and replacements of the word counselling for psychotherapy, there are only three differences between the training standards, all of which are to be found in Criterion 2 – Practice Placements subheading 2.2 which describes the number of practice placement hours and 'observed' elements required for each profession.

With only fifty hours difference between the two, it is difficult to see why anyone would undertake counselling training when they could be a psychotherapist for a mere additional 50 hours of client work. This obfuscates the distinction between the professions and places insufficient value on differential skills. With the current documents providing essentially the same educational criteria for two different professions with insufficient (minimal) differentiation centred on client experience hours, it would appear that both content and pedagogy are then left in the hands of training providers. Further, the standards are silent as to the duration of training. This may create the impression that it takes essentially the same amount of time to create a counsellor as it does a psychotherapist (bar fifty hours).

At present, training providers (accredited courses and those validated by awards bodies) must determine career progression pathways the qualifications they offer. This raises an issue for the Board in that in gatekeeping the standards for both registers, you are silent on how someone who is qualified as a counsellor can train as a psychotherapist should they wish to broaden or deepen their skills and proficiencies. Indeed, by the same logic, what are your training proficiency standards for someone to train as a counsellor who is currently a psychotherapist or are you inferring a hierarchy where psychotherapists are actually uber-counsellors? It would appear that the Board acknowledges that counselling and psychotherapy are in fact distinct professions but in actuality, they overlap significantly in terms of their common factors, protocols, interventions and approaches. This is not described anywhere in the training criteria for either profession. Indeed, from the client's point of view, it complicates an already fragmented mental health landscape. To which does a client attend? What can they get from one that they cannot get from another? Should the complexity of the client's issues emerge during counselling, does the counsellor stop and refer on? This is utterly impractical leading to significant discontinuity for the client who will be faced with the prospect of essentially starting all over again with someone new. Further, it is not at all uncommon for counselling skills to be part of psychotherapy, and, occasionally, Integrative counsellors often draw from aspects of psychotherapy during a course of treatment. This is exacerbated by the absence of robust definitions (discussed previously) thus maintaining ambiguous boundaries between the professions.

Specific observations & comments - Standards of Proficiencies for Counsellors & Psychotherapists

Section 1.

I note that there are zero differences between autonomy and accountability proficiencies between the two professions. This does not make sense especially if client case complexity is a noted difference in the scope of professional practice, more so, if working in a multi-disciplinary team versus a private practitioner. Surely autonomy and accountability are more related to working context, not whether you are a counsellor or a psychotherapist?

Section 2.

Item 12 is the only item differentiating the proficiencies for both professions. It would appear that the requirement for counsellors exceeds that of psychotherapists in that counsellors must seek user consent, this is absent from the psychotherapist standard. Therapists must routinely override client consent due to our mandatory reporting obligations under Children First. We are the only link in the support chain (client, therapist, TUSLA, Gardai, etc.) obligated to override consent in instances of retrospective abuse experienced during childhood. This is a universal feature of counselling/psychotherapy as our Mandated Person status is not tied to our designation, but our context.

Section 3.

Item 2 is the only item differentiating the proficiencies. In the psychotherapy document the addition of “relevant to what is necessary for the safe practice of psychotherapy” would appear to apply equally to the counselling standard but substituting psychotherapy for counselling which is omitted in the counselling document. The obvious question here is what constitutes ‘safe practice’? Clients routinely conflate being uncomfortable with being unsafe. Self-reflection and effective therapy are emotionally and psychologically challenging. If not managed sensitively and carefully, ruptures which occur in the therapy context have the potential to damage the relationship between therapist and client and lead to early termination of clients leaving them unsupported and potentially worse off than when they entered therapy. It would seem important therefore to describe ‘safety’ in terms of harm avoidance (risk factors) and working consistently within a robust ethical framework to mitigate against these factors.

However, item 3 contains an unexpected addition to the function of therapists; to “determine the appropriate tests/assessments required AND [emphasis added] undertake/arrange these tests”. Therapists are not and should not be diagnosticians. Knowledge about standard psychological testing, administering testing and diagnosis fall outside of the scope of therapeutic practice, unless therapeutic practice sits within an appropriate Psychological/Psychiatric context. To add this function to counselling/psychotherapy further blurs the boundaries between Counselling / Psychotherapy / Psychology and Psychiatry.

Section 4.

I note that there are zero differences between the professional development proficiencies between the two professions.

Strangely, item 4 requires that therapists “understand and recognise the impact of personal values and life experience” on both practice and process. How is this to be achieved without a formal mechanism based on best-practice for over one hundred years – the need for personal therapy? Further, by removing the requirement for clinical supervision in both training and post-qualification, how are blind-spots to be revealed without some support in the form of super-vision?

Section 5.

Item 1. There appears to be no material difference in the standard. Both will require working within the standards of each profession, but, again, without a definition of those professions and clear articulation of the boundaries for each, how are practitioners who join the register to be compliant? Without supervision, who safeguards this standard? The regulator? When? On receipt of a complaint from a client? That is too late. Effective supervision safeguards clients. In trying to protect clients by registering the professions but eviscerating the mandated primary method of self-governance is likely to do nothing but increase risk of harm to clients not out of malice or abuse on the part of a therapist, but because they cannot see what they cannot see.

Items 2 - 8 are exactly the same in both standards .

Items 9 – 32 have broad overlap in terms of skills, process factors, professional factors, personal factors and scope of practice. It is again very difficult to see where some of the requirements for psychotherapy as stated are rooted without appropriate reference to definitions of the professions.

For example, does the unconscious not appear in counselling? Or, are counsellors to remain mute or blind to the role of the unconscious? Are they to refer on when unconscious dynamics are exposed? Are client's dreams off-limits to counsellors? This makes the work of therapy far more difficult in a post regulation landscape for the thousands of practitioners like myself who are qualified and experienced Counsellors AND Psychotherapists.

Closing Comments

I strongly recommend that the Board carefully consider the explicit differences between professions. May I suggest the Board develop a side-by-side table comparing/contrasting the scope of practice of each profession rather than a list of somewhat generic, sometimes ambiguous, broadly overlapping features of Professional Knowledge and Skills. This would go a long way to assist with grandparenting later, provide much needed clarity and confidence to the professions and assist clients in the evaluation of their needs against what is on offer from each system.

Additionally, I advocate in the strongest possible terms that the Board re-evaluate its position on the role of clinical supervision as fundamental to the training and practice of therapists. I invite the Board to re-affirm clinical supervision as the signature pedagogy of counselling and psychotherapy and the enormous benefits and contributions to the goal of client protection.

I recognise that all of this will take time, and I again caution the Board against rushing this incredibly important step in the attempt to get it done.

The first draft and this public consultation is a good beginning and I again commend your work in this incredibly difficult task.

I hope that this feedback is useful to the Board and look forward to the next round of consultation following appropriate reflection and consideration of what I'm sure will be detailed and extensive feedback from other stakeholders in our profession.

For attention of the Counsellors and Psychotherapists Registration Board at CORU and other relevant strategy and policy makers related to CORU

I am writing as an experienced psychotherapist and counsellor.

These are my comments on the draft standards of proficiency for psychotherapists and counsellors and the draft criteria for education and training programmes for both professions. The comments apply to both the documents for psychotherapists and for counsellors. The term therapist is used to refer to psychotherapists and/or counsellors.

It is considered that significant changes are required to the documents to make them safe and fit for purpose.

1. It should be a requirement to engage in regular personal therapy during training. This is necessary to work effectively at the depth required for therapeutic engagement with clients. As the work necessarily involves the therapist facilitating the client in exploring their own life and process, it is important to have a good therapeutic relationship between therapist and client. If the therapist does not have the self insight and reflective capacities that can come from a significant body of personal therapy then they may be unable to reflect effectively on their contribution to what is occurring in the therapeutic relationship and to distinguish it from the client's contribution. There is the risk that their own issues will get in the way of supporting the client with what they are bringing for therapy. There is also a risk that the therapist won't be able to accompany the client to the depths of processing and connection to painful experience that is needed for the healing to occur, often below the level of symptoms. It is important that the client experience feeling met at these deep and vulnerable places for the work to be therapeutic. For the therapist to be able to meet the client in these places it is important for the therapist to be able to connect to these places in themselves and to be reasonably at ease with them. These are important reasons for the therapist to have had a significant course of therapy.

For similar reasons to those outlined above, in addition to personal therapy, group therapy / process work during training is important in enabling the training therapist to deepen their understanding of their own processes, how they relate to themselves and to others. The input of the group facilitator in addition to the peers in the group can be very helpful in supporting the training therapist's own reflection and in contributing to identifying blind spots and unhelpful patterns of behaviour and relating. Such insights gained from group process work and therapy can help the therapist spot when unhelpful patterns are occurring in their relationship with the client. With this awareness, the therapist can change tack and choose to move to a more facilitative approach.

2. It should be a requirement to attend regular clinical supervision during training. This is necessary to provide the space for reflection that is needed for the therapist in training to mature. A separate perspective from the therapist's own one is important. Clinical supervision is important to support the therapist in exploring what is needed to facilitate both the client and therapist to engage creatively with the stuck places that will inevitably occur.
3. The absence of the inclusion of personal therapy and clinical supervision as part of the training within the draft regulatory framework raises the question of how well the nature of counselling and psychotherapy are understood and accommodated within the full CORU policy making system. The documents for psychotherapists and counsellors imply the medical treatment model of fixing problems, rather than the collaborative relationship which

therapy is.

In therapy, healing takes place with the support of the therapeutic relationship, with the aim of the client gaining a deepening awareness and understanding of their life and how to approach it. Following on the acceptance and discovery in regard to their own process that can take place in the therapeutic relationship, the client can learn to relate to themselves in a healthier way and to engage with the world in a healthier way. Through being validated and affirmed at a very deep level in the therapeutic relationship, the client can learn to be compassionate and less critical with themselves. However, this may not be objectively measurable or subject to assessment in a way that is implied in the draft documents.

As someone who is an engineer, as well as a psychotherapist and counsellor, I understand just how vital objective measurement is, in the world of engineering, for example when an electronic product is being developed and manufactured. The internal subjective reality of a human being cannot be usefully measured in a similar objective way.

Facilitating deep movement in a person's process of internal relating and their process of engagement with the external world is likely to take a significant amount of time and involve engaging with defences that have been developed and remained in place over a significant period of time. The therapist needs to be familiar with the equivalent interior territory in themselves and have a very good knowledge of their own defences, to be able to facilitate the client working at such a vulnerable level. Throughout this deep work, where the therapist accompanies the client on a significant and challenging journey, it is important for the therapist to remain grounded and centred. As a result, a significant course of personal therapy for the therapist themselves is essential.

4. It is not clear why amounts as high as 500 hours of practice placement (psychotherapists) and 450 hours of practice placement (counsellors) are being required for each student and why these are considered to be necessary.
5. It is considered impractical and unnecessary to require 100 hours (psychotherapists) and 75 hours (counsellors) of "directly observed service user contact" during training. The imposition of this requirement is likely to create more problems than it solves, as a result of the deeply personal material that is brought to therapy, the nature of the therapeutic relationship (which would be impacted by the direct observation) and the large number of specified hours. It is also unclear, from the draft criteria, the level of processing and analysis that would be carried out on these significant amounts of observed work in terms of checking the quality of practice.

I acknowledge the complexity of the task that the team responsible for drafting and deciding the documents is taking on and wish you all well in this endeavour.

[REDACTED]

Submission from [REDACTED] to CORU December 1st, 2023

[REDACTED] wholeheartedly supports the regulation of the professions of counselling and psychotherapy in the interests of public safety. [REDACTED] as an organisation with over 60 years' experience providing inclusive Couples and Relationships training and a Couples and Relationships counselling service is very committed to and conscious of the vital importance of the safety of adults, parents, and children in the best interests of their welfare and quality of life.

[REDACTED] has the following serious concern and recommendations in relation to the draft criteria published by CORU for education and training programmes for counsellors and psychotherapists.

Area of Concern: Safety of members of the public seeking couples counselling

The Nature of Couples Counselling

Couples counselling – also known as couples therapy and sometimes referred to as relationship counselling – is a specialised service which requires very substantial theoretical knowledge, skills training, and self-awareness work in addition to that which is covered with those counselling/psychotherapy students who are being trained to counsel individuals.

Couples work: takes into account the systemic interactions between partners – appreciating the circular causality that has long been a feature of family therapy; supports the couple as they become aware of themselves as a sub-system within the wider family system; identifies the characteristics of their relationship boundary and handles the dysfunctional dynamics when the boundary is excessively diffuse or rigid. There will also be an awareness of the capacity of each partner to define themselves in the context of the relationship and to use that awareness to support development towards a more mature stance - thus strengthening and stabilising the couple relationship as it grows and matures. A number of couple counselling models place central importance on attachment; advances in the application of this theory and its associated clinical interventions in the context of adult love relationships has brought about significant change for some emotion-centred approaches. There are many couple therapy models, and they can be clustered into a number of approaches. Major texts such as *The Clinical Handbook of Couple Therapy* (5th ed.) use the headings behavioural, emotion-centred, psychodynamic/multigenerational, social constructionist and systemic (Gurman, Lebow & Snyder, 2015).

In addition to having a sound working knowledge of at least one model, and significant understanding of how to incorporate interventions from a number of others, the competent beginning couples counsellor must be prepared during their training programme to recognise and where appropriate, work with the particular needs and requirements of special populations, and to identify problems and issues that require specific knowledge and understanding if they are to be managed safely and ethically in the couple setting.

Public Safety and Couples and Relationships therapy

In order for the public seeking couples and relationships therapy to be safe, counsellors must of necessity have completed all aspects of the relevant training in the specialism of couples therapy.

Couples therapy differs hugely from individual counselling. Individual therapists will not have had the opportunity to experience in training the in-session challenges presented by a couple in distress. They will not have the skills needed to manage and contain what can become highly stressful, volatile, and potentially explosive behaviour. Neither will they have the theoretical understanding which supports the couples counsellor when there is a tendency to lapse into a 'who's to blame' approach.

A practitioner trained to work with an individual is not sufficiently trained, knowledgeable, skilled or self-aware to work with couples. They will lack the skills to facilitate two individuals in a session, the knowledge of the couple therapy literature and of couple dynamics and issues, in-depth self-awareness in relation to their own family and couple experience and their potential impact on their practice.

Those practising as *Counsellors* and *Psychotherapists* who have not completed a robust programme of training for work as a couple therapist lack knowledge in a wide range of key areas including the following: skills required to work

safely with two individuals in the room; knowledge of couple dynamics, the conscious and unconscious processes at work, understanding of the impact of neurobiological processes now central to this area of work; a sound working knowledge of a wide range of models of couples therapy; issues specific to couples work, including: domestic abuse across all its forms from coercive control to the wide range of presentations found within situational abuse, pose a very significant risk to the safety of the public who may mistakenly choose to work with them – not realising that they may have no, or very limited training in this specialism.

The Urgent Need for Easy Access to Trained and Highly Skilled Couples Counsellors in the interests of public safety:

It is vital that the general public, in order to make informed choices, is given regular opportunities to learn that counsellors who can work safely and ethically with couples must have followed a very substantial specialized training pathway. There is a growing urgency to provide ready access to highly competent, specialized couple counsellors. As a result of raised expectations that couples have of their relationship: ...the public health importance of the 'health' of marriage and other committed relationships has understandably increased... the breakdown of intimate relationships exacts enormous costs.

At the present time there are few training opportunities on the island of Ireland for those who are already practising as individual counsellors to experience the powerful and lasting transformation essential to equip them to become competent couples counsellors capable of facilitating a similar transformation in their relational therapy clients.

When it comes to beginning counsellors finding a training programme that will take them through the whole journey from first steps to competent couples counsellor the opportunities are fewer still. Given the low level of public awareness that couples work is considered, by many of the world's leading experts in the field, to be the hardest form of therapy, it is very likely that couples and individuals distressed by their relationship difficulties will not realise the importance of factoring in the counsellor's couple-specific training credentials when they choose which agency or private practitioner to approach for help.

Training in Couples and Relationships Counselling

Currently [REDACTED] offers qualified and experienced *Counsellors* and *Psychotherapists* a [REDACTED] training programme which includes 100 clinically supervised placement hours, in [REDACTED] in year two, to train them to work safely and ethically with couples. This training programme consists of 16 x 8-hour class-contact days plus two 8-hour consolidation days while they are on placement – in addition to substantial hours spent in self-directed study.

In [REDACTED] very strongly held view anyone offering couples therapy who has less than the level of training equivalent to [REDACTED] presents a very significant potential danger, not only to those members of the public accessing couples and relationships therapy but also to the safety and welfare of the children in their care.

Recommendation

[REDACTED] strongly recommends that CORU, in the interests of the safety of members of the public seeking couples therapy and the children in their care, considers one of the following options:

1. Create an additional protected title of *Couples and Relationships Therapist*
2. Introduce a strict requirement that *Counsellors* and *Psychotherapists* who wish to work as couples therapists complete a substantial CORU-approved course of training in the specialism of couples and relationships therapy.

From: [REDACTED]
To: [Strategy and Policy](#)
Date: Thursday 2 November 2023 17:10:23

Dear Friends,

I am very pleased that you will have overall regulation of counsellors and therapists. I am, however, concerned about the upgrade from diploma to degree for those of us who did not have the opportunity to upgrade when we were training. My diploma took four and a half years with the Cork Counselling Service, beginning in 2000. I undertook years of research to enhance my counselling skills and published books. [REDACTED]

I am also in my 79th year, and at my age, it would not be feasible to return to college. I would, however, like to continue to counsel people for as long as I can. I hope you can facilitate people like me who have a wealth of experience and have done a great deal of research. It would be a pity if we were forbidden to practise. I am winding down on my paid work now and from January will do voluntary work, which will benefit those who cannot afford counselling. I am also an experienced EMDR therapist and deal with trauma all the time.

Thank you and with many good wishes.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: CORU Feedback - Register for Counsellors/Psychotherapists
Date: Thursday 30 November 2023 17:01:03

Dear Sir/Madam,

I write regarding the consultation process which is currently taking place with respect to the registration of counsellors and psychotherapists.

Having read the consultation document I would like to raise some concerns and offer my feedback.

Supervision by line management

I understand it is being considered that supervision (for students) be carried out by a designated person within the counselling placement rather than a qualified supervisor.

In my experience of working within an organisational context and being line managed by individuals who do not directly understand and appreciate the role of a counsellor/psychotherapist the client is at risk of being overlooked and the needs of the organisation being treated with priority. For example, a therapist having back to back appointments with no time to write notes, or comfort breaks, dealing with any urgent client issues or being able to leave one client 'mentally' and moving onto the next. This in turn creates burnout and stress within a profession who is trying to mirror good patterns to their clients. My personal opinion is this practice would be of a detriment to the client as well as to the therapist.

Whereas a supervisor is working with the client in the forefront of their mind. Making sure the therapist is working ethically, within their area of competence and supporting the therapist with any issues they may feel uncomfortable and unsupported with in the workplace. Supervision works from a client perspective.

No personal therapy

It concerns me that there is no requirement for students to have any personal therapy before embarking on this career path. In my opinion this will be to the detriment of the client. Therapists need to understand 'their own stuff' and acknowledge any transference or countertransference and 'own' what belongs to them. In my opinion personal growth and introspection on behalf of the therapist makes for a better therapeutic experience along with better outcomes for the client. If there is no requirement therapists could equally become triggered by their client's transference and this could lead to the breakdown of the therapeutic relationship, and cause harm to the client.

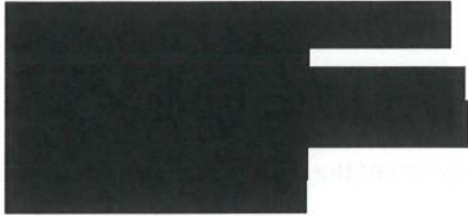
Assessments

In my opinion assessments start to take counselling and psychotherapy into a medical model and this work should always stand outside. As soon as measurements are put in place it takes the focus off talk therapy and it becomes a diagnostic tool. Therapists are not qualified to make a diagnosis even with the aid of an assessment. They should signpost to appropriate support and offer recommendations. Clients need to be treated holistically and not tied down to an assessment criteria which is structured to assess need. The complexity and uniqueness of every client should come first rather than try and fit an assessment

around an individual.

I would be grateful if my feedback **could** be considered as part of the consultation process.

Warmest wishes,
Kim



CORU. Grandparenting.

Comments on Draft document.

The transitional period of min 2 years period is welcome.

There is a distinct flavour of a patronising agism with this section of the Draft documents which I find to be hugely offensive.

When addressing the issues presenting with a population of counsellors and psychotherapists who have been in practice over many years, the Draft Document suggests that a 'Competency Test' (section 91) be a suitable tool to establish a fitness to practice.

Who or what agency would facilitate such a 'Test'?

I have failed to find any suggestion of a Competency Test for any ongoing evaluation of professional fitness in any part of the documents. CORU are clear from their very self-definition that their function is a registration process.

Might one consider evidence of the following as an alternative to the mentioned Competency Test:

- Ongoing Membership of an accrediting professional body.
- Evidence of ongoing and relevant continuous professional development.
- Evidence of client work.
- A personal and professional reflection paper.
- A Supervisor Report referencing Fitness to Practice.

Further, the draft suggests evidence in the form of a Tax record as a possible tool to for assessment to be deemed fit and proper. Might I suggest that there is no place in any of the current documents for consideration of any Inland Revenue documentation. This suggestion should be removed forthwith if the Draft is to be seriously considered an active working document which is supposed to include and involve all stakeholders.

Submission on the draft Standards of Proficiency and draft Criteria for Education and Training Programmes for Counsellors.

The members of [REDACTED] welcome the opportunity to comment on the proposed Standards of Proficiency and Criteria for Education and Training Programmes for Counsellors

We recognise the important role that CORU plays in protecting the public through regulating the health and social care profession listed in the Health and Social Care Professionals Act 2005.

We wish to direct our comments to the 75 hours of directly observed service user contact.

2.2 Practice Placements

The programme must ensure that each student completes 450 hours. A minimum of 300 of the 450 hours must be supervised service user contact experience, of which 75 hours is directly observed service user contact.

We understand and acknowledge that directly observed service user contact is necessary in assessing a student's achievement of the required standards of proficiency. However, we consider that 75 hours of directly observed service user contact will be very challenging for service users, students, supervisors, and practice placement organisations.

Reasons of concern

- Vulnerability of service users and Impact on counselling relationship
- No guarantee of the numbers of volunteer service user participants
- Cost of supervision of directly observed service user contact.

Vulnerability of service users and Impact on counselling relationship

The counselling relationship between the counsellor and client is different to the client relationships in the other CORU Health and Social Care registered professions.

When starting counselling, service users often feel nervous, anxious, fearful, and can be very vulnerable. Therapy is a process of uncovering deep emotions and sometimes confronting experiences in their lives that are painful and uncomfortable. It is the job of the counsellor to build and maintain rapport with the client. At any stage in the counselling relationship, asking the client to allow an observer to sit in, or observe through a two-way screen, be videoed, or be recorded can be very threatening to their very private conversation. In these observed situations, the client would more than likely withhold information and be reluctant to engage fully with the student counsellor.

Being observed in any of the above ways, creates an uncomfortable artificial scenario where both the student counsellor and the client find themselves putting on a 'performance' for the observer.

No guarantee of the numbers of volunteer service user participants

Deciding to go for counselling is a major decision for most service users, usually at a time of difficulty in their lives. They will have to agree to consent to engage with a counsellor who is being observed and many will be reluctant to agree for the above reasons, so the large number of volunteer service users needed to consent will not be guaranteed. Therefore, volunteer numbers will not be predictable and will be outside the control of the practice placement.

Ethically, when a service user comes for counselling, there can never be an expectation or demand or condition that they volunteer for participation in a directly observed counselling session.

High cost of supervision of directly observed service user contact.

The Board also recognised that the counselling and psychotherapy professions should reflect Irish society and the people they serve. Therefore, the Board factored into its decision that there should be an opportunity for all members in society to access higher education and enter these professions.

The cost of providing supervision for the 75 hours of directly observed service users contact will be very expensive and will drive up the cost of becoming a counsellor.

The supervisor, for each of the 75 hours for each student, will sit in and observe, or view a video, or read a formal written transcript. They will then spend more time writing a report on the session and then giving feedback to the student. Directly observed service user contact could be three to four times the cost of 'normal' supervision.

Student counsellors are usually older adults with life experience, many having made the decision to change career, often studying on a part-time basis. They pay for course fees, personal counselling, and many hours of supervision. The imposition of further high costs for 75 hours of directly observed service user contact could put the attainment of a counselling qualification outside the reach of many members of society.

We would like to strongly suggest that the assessment of a student's achievement of the standards of proficiency could be carried out successfully using a lower number of directly observed service user contact hours. This lower number would be, very importantly, less impactful on service users, more manageable for practice placement organisations and student counsellors, while successfully assessing the student's achievement of the standards of proficiency

[REDACTED]

Date: 30th November 2023

[REDACTED]

Response to CORU Public Consultation: Counsellors - Standards Of Proficiency And Criteria For Education And Training Programmes

Domains of Practice

- The four domains of proficient practice across both counselling and psychotherapy (common standards) are similar to other regulated professions. Therefore we believe that they can be achieved through education, training and clinical placements in a manner that is sufficient to protect the public.
- While the profession specific standards may adequately represent requirements of proficiency for entry into the registers, we suggest that there should be rigorous and specific standards for maintenance of ongoing competence
- The profession specific standards will potentially determine the scope of practice for addiction counsellors which we look favourably upon. Whereas psychotherapists will be expected to be proficient in practice across a wide range of diagnoses with varying degrees of complexity and severity. This may be somewhat more difficult to achieve.
- The overall standards of proficiency for counsellors and psychotherapists overlap, although they are articulated distinctly. We have some questions about the standards of professional knowledge and skills for psychotherapists. This level of professional competence represents a significant undertaking with a level 8 qualification.

Clinical Placement

- It can be difficult for trainees counsellors to access clinical hours. The importance of the number of hours is surpassed by the quality of the counsellor professional formation.
- It would be helpful to clarify whether the practice placement can be undertaken on both full time and part time basis.

Training Supervision

- Training supervision is vital in meaningfully scrutinising the trainees work. This may occur in both placement and the classroom environments. It is important for providers to be able to utilise both modalities.
- The difference between observed and supervised student \ service user contact during the practice placement requires further clarification

CPD & Post Qualification Supervision

- Supervision should be an ongoing facet of professional development following qualification.

- Criteria for what constitutes CPD requires further clarification.
- Ongoing CPD should incorporate a minimum of 30 hours annually, with a requirement for reflection on learning.

Personal Development in Training.

- [REDACTED] supports a requirement for personal development during training. In our view this may incorporate a combination of personal therapy, group process work and self-practise/self-reflection reflection activities.

[REDACTED] 23/10/23

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Safeguarding
Date: Wednesday 13 September 2023 17:26:31

To whom it may concern

I have read through the Coru guidelines and note that you do not recommend personal therapy or on-going supervision for the role of counselling or psychotherapy.

As an adolescent Gestalt psychotherapist I am regularly referred children who have gone through a failed CAHMS system. Often my young clients arrive with suicidal ideation. Interestingly some did not experience suicidal ideation before attending CAHMS. My concern has been that some of the counsellors in CAHMS are insufficiently trained. They have not engaged in personal therapy or do not attend regular supervision. This in my professional clinical opinion puts our young people at risk.

As a Gestalt psychotherapist who put in five years core training and now in seventh year with adolescent training included (plus weeks and hours of attending courses) I have been required to attend 35 hours of annual personal therapy for each year of training. I am expected to cover initially 1-4 hours of supervision whilst working with clients in training (500hrs) and to continue my profession clinical practice at 1-8 hours per client supervision. To put my professional commitment into a category that disregards this level of professionalism is concerning. We need to put people who are in a vulnerable mental health space into a safe guarded environment with people who have adhered to a high professional standard. Self care and personal therapy is the core basic principle of developing an awareness of transference and counter transference, without this basic principle we are putting peoples lives at risk.

Sincerely [REDACTED]

[REDACTED]

[REDACTED]

[Sent from Yahoo Mail for iPhone](#)

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Re Feedback for Psychotherapists
Date: Wednesday 13 September 2023 20:52:41

To whom it may concern,

I wish to strongly challenge what CORU have proposed got forward

1. No requirement for Personal Therapy
2. Minimal Clinical Supervision
3. Undermining our profession and setting lower standards than other European countries leaving the Public at risk.
4. Should be higher standards Level 9 to 9 recognise the value of our profession.

Regards,

[REDACTED]
Psychotherapist

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Psychotherapy
Date: Thursday 14 September 2023 09:50:04

Hi

I would like it to go on record that I'm deeply concerned that the current proposal for psychotherapy training requires no personal therapy.

This indicates a misunderstanding about the nature of psychotherapy. Many psychotherapists are humanistic integrative trained. This requires a level of attunement with the client that can only be met from a place of deep self-understanding so that therapists we can be aware of, and have processed, our own biases, needs, and experiences.

Psychotherapy is not a linear process and must be done from the clarity of self awareness. To misunderstand this is to misunderstand the very nature of psychotherapy.

Warm regards



 [Free webinars available](#)

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Feedback re-registration criteria for Psychotherapists
Date: Thursday 14 September 2023 12:18:05

Dear Committee,

I wish to comment on the proposed criteria for psychotherapist registration in the future with CORU

Thank you for all the work that has gone into the draft proposals.

I believe that in order to become a psychotherapist the level of education required should be a level 9 and not 8 as proposed. When I personally trained in psychotherapy it was a level 9 course.

The organisation offering the training was not affiliated with a University so we students graduated with a "Higher Diploma". Each trainee had already completed a level of education or training that was rigorously examined before we were accepted to the course. A personal interview was required to assess our suitability and maturity level. This training course has since been affiliated with a UK university and the qualification received now after 4 years of training is a masters level degree.

As regards the requirements to qualify I do not see anywhere in your proposal the requirement to attend personal therapy throughout a training. When I trained, it was compulsory to attend weekly personal therapy throughout the four years as well as fortnightly group therapy outside the academic training hours. How can a person offer therapy to a client if they themselves have never sat in the client's chair? It is imperative that trainee psychotherapists explore and examine themselves before they ever sit with a client.

I have had a young man attend therapy with me whilst completing a degree in psychotherapy. He told me that he could choose this option (to attend therapy) as a module rather than another academic exercise. I was shocked but delighted that he chose this option as he was aged 25 and had very little skill in how to develop a therapeutic relationship.

It is imperative that in your requirements to qualify, students must attend therapy and examine themselves thoroughly.

As regards Supervision during placement, you state;

"At each placement site, a student must be assigned a suitably qualified and experienced on-site supervisor who is available to the student throughout the course of the practice placement."

In this statement, you do not specify the ratio of supervision hours to client hours. It is vital that you clearly state that all the work must be supervised appropriately. Even after qualification and pre-registration, there is a criterion to be followed in regard to the ratio of client hours to supervision hours. Please examine this before you proceed.

One can never have enough supervision in this profession. We are constantly learning.

Thank you for the opportunity to give some feedback.

Kind Regards,

[REDACTED]

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Proficiency standards for Psychotherapists and criteria for training
Date: Monday 2 October 2023 13:05:20

To whom it concerns,

I am deeply concerned with regards to recent drafts put forward by CORU in relation to proficiency standards for psychotherapists and criteria for training.

Minimal supervision is very concerning. Also, no requirement for personal therapy is, in my professional opinion a seriously retrograde step for the profession, and I have no doubt as to the negative impact this will have on client safety. Traumatized therapists, who have not done the work on themselves are not well equipped to work with traumatized clients. The self-development of the therapist is integral to doing quality work. The integration of skills, personal development and theory is in my view the hallmark of good, ethical training.

It is my view that the standards set by the European Association of Psychotherapy (EAP) are the gold standard, and allow for ethical psychotherapy to be done in a way that maintains the integrity of the profession and thereby promotes good quality psychotherapy work which will be of benefit to the client.

Best regards,

[REDACTED]
[REDACTED]

From: [REDACTED]
To: [Strategy and Policy](#)
Date: Monday 9 October 2023 13:27:45

Dear Coru.

Please note a number of points below and which are being discussed by most Psychotherapists and professional bodies representing same across the country.

1. The difference in hours (50) in training as either counsellor and psychotherapist seem arbitrary.
Where are the courses for counsellors which meet this criteria? What happens to all the work carried out by counsellors.
2. Is there a definition of counsellors and psychotherapists. Does Coru know what the difference is and what areas of work covers either.
3. Not having SUPERVISION criteria is the death of psychotherapy. No trade, person operates once trained in the work without guidance and supervision. The deep work that of psychotherapy is one to one and the ONLY way this can be monitored, resourced, developed and keeping clients safe in the psychotherapy is with SUPERVISION. It shows a clear lack of knowledge of what psychotherapy is and places no value on its work. Psychologists are not trained psychotherapist unless they have a dual qualification and though the counselling that is carried out is positive and relevant to some clients, is completely different to psychotherapy.
4. No other service in the medical model working in teams as they do with the sharing of information about clients is able to provide the confidentiality of the deep trauma and psychotherapeutic work. And this further links to the need for supervision as above and the ;lack of real understanding of what it is.

At a time when medication and services in the state are seriously going in the wrong direction, CORU really cant afford to get this wrong. [REDACTED]

[REDACTED] Please consult better with the people and bodies who are doing this work.

[REDACTED]

Sent from [Mail](#) for Windows

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: standards of qualification for play therapists
Date: Monday 9 October 2023 19:15:33

I wish to make my concerns known about the suggested qualification criteria for play therapists to register with CORU.

My concern lies with whether you are likely to include the need for therapists to have attended their own personal therapy and also supervision of hours to ensure safe and professional practice.

Both of these elements are vital for a therapist to have embraced in order to ensure effective and appropriate therapy is offered to a client. I hold a masters [REDACTED] and in order to achieve this masters I did both personal therapy and required supervision. Both were enormous benefit to me.

I also hold a level 8 first class honours degree in [REDACTED]. A level 8 qualification is not enough in my experience as it does not focus and enable you to specialise in the way a masters degree curriculum forces you to do.

I urge you to set a suitably high standard of qualification requirement in order to ensure children in trauma receive the best therapy - the one they deserve!

with thanks,

[REDACTED]

Sent from my phone

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Concerns
Date: Monday 9 October 2023 12:56:53

To whom it may concern

As a psychotherapist and supervisor I'm massively concerned for the future of mental health. For a long time the profession has been waiting for registration for psychotherapists and welcoming of the need to regulate psychotherapy. This is essential for setting the professional standard and ultimately to create safety for clients and professionals in this area. The proposed draft criteria that Coru plan for the registration of psychotherapists in the near future is very concerning.

Current criteria under my own accrediting body, IAHIP, for a psychotherapist to train is at level 9 on a 4 year degree course, with a 3 year undergraduate degree. Training is set at this criteria presently including an inclusion of clinical placement hours, currently set at 200 hours with 60 hours of group supervision of this work while training, working out at for every 4 hours of clientwork, a student then attends a supervisor for 1 hour who oversees their work. Psychotherapy training also includes a personal therapy element where all students attend their own therapy for 120 one to one sessions and 60 hours with a group therapist. It is essential this happens as the student must be able to process their own thoughts, emotions and feelings and to fully understand the process.

Coru are proposing to lower the level 9 to level 8, will not be including any criteria on supervision within the training (only on placement), and are removing the inclusion of personal therapy for students in training.

With these proposals by Coru, I'm very concerned that registration of psychotherapists will bring a reduced quality and lowering of standards to the work and diminish, the current quality provided by qualified and accredited therapists who have set the high standard we currently work under.

My experience of working within mental health since 1997 and sitting with clients who have suffered and are traumatised having worked with under skilled and unprofessional therapists proves I know there is now a real danger for those who attend for support with new therapists who don't meet current standards.

I have worked for years with The Irish Association of Humanistic and Integrative Psychotherapy (IAHIP) supporting and also helping create criteria for therapy and training since I became an accredited member in 2005. These proposals diminish all the work I and many psychotherapists, supervisors and trainers volunteered into creating the standard for psychotherapy and the work my centre provides to the community in Clondalkin and beyond. As a registered member of the Irish Council for Psychotherapy and member of the European Association for Psychotherapy I can also extend my work to clients in Europe, many Irish who are living away from home. With this lowering standard proposed by Coru I will no longer be able to offer a low cost service for therapy to the community as I cannot support this standard for students in training (I currently work with training colleges for placement hours).

While myself and my current team will be grandparented first by Coru and I can be confident in their training, I will not take on future students in their placements or newly registered psychotherapists under this standard proposed as the quality of work will be compromised and real danger could come to clients. I hold a duty of care to all who access

my service which under these proposals, means I can no longer secure client safety therefore my service may not survive after registration according to the current Coru draft.

I'm asking now for your support for all psychotherapists in Ireland who do not support Coru's current draft registration standard for psychotherapy training. It will lower quality of care for clients and some will be at real risk and danger if working with registered psychotherapists who are not appropriately trained and supervised.

Thank you for taking the time to read this. I await your response.

Kind regards

[Redacted signature]

[Redacted contact information]

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Standards and criteria for psychotherapists
Date: Wednesday 11 October 2023 20:50:13

Good evening,

My name is [REDACTED], I am currently in my third year of a four year masters [REDACTED]. I have just attended an accreditation meeting with IAHIP and was incredibly concerned and alarmed by the proposal of allowing therapists with no personal therapy experience to practice under your regulation.

The idea of letting adults into a room with a traumatised child when they have not dealt with their own personal struggles (we all have something) or without a better understanding of themselves through personal therapy is negligent and dangerous. Unqualified therapists may be triggered by a vulnerable child leading to unknown chaos in the room.

Please consider this when making your decision. There is a very valid reason for all of our hours in personal therapy as trainee therapists. We are closely monitored through supervision and in our personal therapy so as to keep ourselves and the client safe. It is critical in the work we do.

Please do not make the mistake of leaving our most vulnerable children in a potentially more traumatising position.

Is mise le meas,

[REDACTED]

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Coru prospective standards for training
Date: Thursday 12 October 2023 17:39:04

To Whom It May Concern,

I'm writing to express my shock and concern at the extremely low standards put forward in your draft training detail for registration of psychotherapy.

As an accredited member of both IAHIP and ICP for a number of years I have serious concern about your proposed dilution of the standards of psychotherapy. It is my understanding that your proposal is only concerned with the academic side and there is no criteria laid down for either personal therapy or supervision. Can you please confirm this? If this is the case then I am utterly shocked and appalled!

It has come to my understanding that Coru also wished to further reduce the standards from level 9 training to level 8? Can you please supply a rational for these decisions?

May years ago when I voted to join CORU it was because at the time the field of psychotherapy was unregulated, the title was unprotected and anybody could just start practicing as a counsellor or psychotherapist.

IAHIP has excellent standards, higher in fact than EAP. This is something I believe to be proud of and strive towards. Perhaps your committee could peruse our byelaws - on IAHIP.org , paying particular attention to byelaw 11 to gain an understanding of what MINIMUM standards currently are for applicants who wish to become accredited with IAHIP.

I am sure, should any of the committee members, or their families ever need a therapist, (and actually understood the rational for therapists to have a minimum of 2 year personal therapy before ever meeting a client, along with the importance of quality supervision) they certainly would not want to meet with a therapist who had not received sufficient personal therapy or who was not in ongoing supervision.

I trust you will consider the importance of my e-mail.

Kind regards,
[REDACTED]

Sent with [Proton Mail](#) secure email.

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Submission to the PCRB consultation Process
Date: Friday 13 October 2023 16:16:25
Attachments: [image001.png](#)
[image002.png](#)
[image004.png](#)
Importance: High

To whom it concerns

I am writing in relation to the recent process initiated by CORU to engage public consultation on the *Standards of Proficiency for Psychotherapists and its Criteria for Education and Training Programmes*. I have decided to send my submission in this format rather than completing the online form and request that it be included in your report as it is still submitted in a format outlines as appropriate by your body.

I must be clear that I send this submission on my own behalf.

I am a practicing child and adolescent psychotherapist specialising in [REDACTED], and have been working in this capacity for 15 years. I work with a high level of complexity in my case work and the skill level required for this is very high [REDACTED].

Firstly, I am deeply concerned at the threshold level of proficiency CORU are setting out for psychotherapists. I watched the webinar you shared on your website and noted your reason cited for this decision is that the role of psychotherapist is not considered to be a specialised one. As a practicing child and adolescent psychotherapist working with extremely complex cases, I feel it is crucial I offer a clear insight into the very specialised role of a psychotherapist. This work is highly specialised and requires considerable expertise. I completed an undergraduate level 8 degree in psychology which was broad and not specialised. This **would not** have equipped me to work at this level with highly vulnerable children and adults. The level 8 degree I obtained did however prepare me, in part, for further training/education at level 9 to become an accredited child and adolescent psychotherapist. I say "in part" because prior to the level 9 MA, I also engaged in several years of relevant work experience, grounding me in the areas needed before I continued with more specialised training.

I do not agree that a level 8 threshold will be sufficient and have very serious concerns around how any practitioner, trained to this level only, could be expected to practice skills equivalent to those required of a mental health professional working with very vulnerable children and families. I have no doubt that such an eventuality would potentially lead to very harmful and dangerous outcomes both for the therapist and the clients. The condition of mental health services and access to them in Ireland is already under intense scrutiny and cause for concern. There is an opportunity, now, to protect correctly, the fundamental role psychotherapists and child and adolescent psychotherapists have with regards to providing, quality, safe and effective treatments to highly vulnerable clients.

Globally, a level 8 threshold would not be recognised as an appropriate level of proficiency for a psychotherapist. Ireland and Europe's leading accrediting bodies have set standards that recognise the need for a minimum of 4 years postgraduate study to achieve a suitable level of competency. The proficiencies you have presented in your document are indeed set at level 8 standards and thus do not encompass the specialised knowledge, skills and competency required

for safe practice.

A primary and fundamental goal of any mental health practitioner is, "do no harm". I fear that much harm, albeit inadvertent perhaps, would be generated if this particular area of the CORU standards are not readdressed. I urge this to be reconsidered in the consultation process.

Secondly, I have very serious concerns about the proposed stipulation for 100 directly observed client contact hours. This is a major concern in terms of protecting vulnerable clients confidentiality and their dignity. Ethically, as a mental health professional, this gives me serious cause for concern. How does this protect or safeguard clients?

Thirdly, I am also concerned that there is no stipulation for personal therapy in training. This is a fundamental part of any reputable psychotherapeutic training. It supports development of reflective processes, use of self (integral in this field and not something that can be taught in a purely academic manner) and is also a highly necessary component for the trainee therapist to become accustomed to, in order to safeguard their own mental health and self-care and, in so doing, protect the interests of their clients by ensuring safe practice with a self-aware practitioner. As mentioned, the complexity of this work is extreme and as such warrants due care and process.

Fourthly, I am gravely concerned that there does not seem to be a clear stipulation given with regards to *clinical* supervision during training. This is an integral element of training, whereby the burgeoning therapist integrates, safely, knowledge into practice. The ratios currently required in Ireland are very high and for good reason - to protect the safety and rights of vulnerable clients. This equally protects the trainee therapist and supports the education and development of such trainees to a standard of proficiency that is befitting a mental health professional who is trained and able to work with vulnerable clients with complex needs.

Although set by self-regulating professional bodies rather than by law in many countries, this is an international standard and it would be extremely unfortunate for Ireland if this standard of proficiency is not upheld accordingly.

I am aware of many colleagues and indeed training and accrediting bodies who echo the same concerns I have. I urge you to reconsider the proposed standards of proficiency and criteria for education and training and ensure that they are sufficient to match the level of skill required for this highly specialised occupation, not just for the sake of the many psychotherapists who are trying to protect our profession, but for the many vulnerable adults and children who will require contact with a psychotherapist and who have the right the quality, safe and effective practice and service provision.

Warm regards,

[Redacted signature block]

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Concerns regarding Coru Draft Detail Registration of Psychotherapy
Date: Friday 13 October 2023 10:15:34

To whom it may concern

I am a Psychotherapist & have concerns regarding Coru Draft Detail Registration of Psychotherapy.

1. The policy seems only concerned with academic requirements and the lowering from level 9 to 8 - what is the rationale behind this? Would we lower the qualification for a Psychiatrist or Doctor? This will impact the quality of therapy.
2. There is no reference to Personal Therapy or Supervision requirements which are a key & integral part while training as a psychotherapist & once qualified.
3. I firmly believe we have a serious health crisis in Ireland - our health service is on its knees, Mental health funding is at an appallingly low rate. Which can give an impression it is not important! Watering down standards & entry to a profession is not the answer, it will result in poor quality of therapy provided for some of the most vulnerable clients that come through the therapy door.

My understanding was that Coru will provide regulation & ensure a high quality & standard among Psychotherapists. It is my opinion that the draft documentation does not provide evidence of this.

Your sincerely

[REDACTED]

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Concerns Regarding Draft Regulation of Counselling & Psychotherapy
Date: Saturday 14 October 2023 15:57:06

Dear Sir or Madam,

I write to you as a senior psychotherapist and clinical lead in a large multidisciplinary practice in [REDACTED]. We are seeing in the region of 260 clients a week and the team is comprised of 20 therapists.

Having read the draft regulations for counselling and psychotherapy and also attending the consultative forum back in September, I have some serious concerns that I need to voice:

1. Clinical Supervision

It was very surprising to hear that CORU will not be issuing directives, or including in the regulations, guidelines on clinical supervision or the ratios required for students vs fully qualified therapists. Clinical Supervision is a central component of how we work as therapists. Ethical oversight, clinical guidance, attention to fitness and probity of the therapist are all undertakings of this important role. They are essential to the provision of professional therapy, ethical practice and ultimately the protection of both the client and the therapist. Whilst I understand that there are not other roles that CORU regulate which can be easily mapped across in terms of clinical supervision, I would ask you to strongly consider the implications of not overseeing that practice is supervised going forward. This in my view, does not achieve the goal of CORU to protect the public. It may in fact lead to quite the opposite occurring. We are working directly with vulnerable clients and often severe psychological symptoms. We do not function in any similarly to social workers. This needs to be understood by CORU and I am surprised that the registration board have not addressed it with CORU.

2. Personal Therapy

Similar to my above concern, the lack of directive in relation to personal therapy is alarming. In basic terms, someone CANNOT practice effectively as a counsellor or psychotherapist without first having done their own work. To me, this should be coming under your outline of what is involved in the assessment of Fitness and Probity for psychotherapists. That there be a requirement prescribed by CORU for minimum levels of therapy attendance during training and also beyond the training phase as required. Ironically, it would be the role of a clinical supervisor to help to identify this need. But as supervision appears to be becoming an optional support going forward, it is likely that therapists will in cases miss the cues and continue to practice when their own mental health is not stable enough to support them in the work.

3. Placement Supervisors

I already undertake student placements at my practice. I coordinate placing low acuity clients with these student therapists. I am in the background should they need to consult on areas such as a risk or mandatory reporting. I liaise with the college as required. That being said, I personally would not have the time or resources available to become an 'on site supervisor' assessing students, signing them off. I would wager that most in my position would not. We would also be seeking to be remunerated if this had to be done. Who will fund this? CORU/Dept

of Health? The college? Otherwise practices simply wont be prepared to take on students and there will be few options out there for those seeking placements. We are not in the room with these student therapists. We do not have the degree of contact that the college lecturers have with them. It does not make sense to ask us to sign off on competencies etc. In fact it would be a totally inaccurate assessment and therefore represents another failing of the proposed regulations to protect the public. I urge you to strongly reconsider what has been set out and to place the responsibility with the college for this task.

Yours sincerely,

[Redacted signature block]

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Standards of Proficiency for Psychotherapists and its Criteria for Education and Training Programmes
Date: Wednesday 18 October 2023 12:00:55

Good morning,

I would like to give some feedback re: above

Re: Proficiency:

I feel that the level of proficiency should be set at level 9. Ideally, a person should have a primary degree at honours level in a discipline related to psychotherapy, such as Psychology and then train at Masters level. Otherwise I fear that our profession runs the risk of being 'dumbed-down'

Direct observation of trainee in a service:

The part suggesting that students be 'directly observed' for 100 hours in a placement while training goes against client confidentiality. From my experience, most training includes practice with peers that is observed by supervisors and includes feedback from peers. Also, the trainee/Supervisor relationship has the capacity to hold the trainee, direct and develop their competence and deliver constructive feedback. This process can also support trainees who may not be ready to qualify just yet.

Personal therapy hours:

I believe strongly that one of the pillars of psychotherapy training is doing personal therapy. The number of hours required needs to be stipulated and should be at least equal to what is required by most associations currently (before a therapist can be accredited). A person may be a wonderful academic, know all the theories, but if they have not done their own inner-work they will not be able to meet the client where they are.

Best wishes with the work at hand,

[REDACTED]

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Feedback regarding new regulations for Psychotherapists.
Date: Wednesday 18 October 2023 10:12:24

Hello,

My name is [REDACTED]. I am a Child and Adolescent Psychotherapist. I am writing to you to express my concern with the draft criteria for future regulation of newly qualified psychotherapists in Ireland.

1. The problem lies in setting the qualification threshold at level 8 (equivalent to a primary degree) instead of level 9. This results in lower proficiency standards, potentially allowing students to enter directly after their Leaving Certificate. Graduates from such programs may not meet European registration requirements and international practice standards.
2. Mandating that all students complete placements supervised by on-site psychotherapists (registered with CORU) for 350 hours of 'service user contact' significantly limits the number of suitable placement sites available.
3. Requiring students to be 'directly observed' during 100 hours of 'service user contact' within the placement site poses challenges for clients, placement sites, and students.
4. Failing to specify requirements for personal therapy or clinical supervision during training could lead to some programs reducing or removing this crucial element. This may result in inadequately trained psychotherapists lacking the personal development associated with the field, and insufficient competence for safe practice.

I would strongly urge you to reconsider and possibly communicate with [REDACTED] to open communication and feedback in this area.

Kind regards,

[REDACTED]

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Re: Public Consultation: Psychotherapists - Standards Of Proficiency And Criteria For Education And Training Programmes For Psychotherapists
Date: Friday 27 October 2023 12:39:40

Re: Public Consultation: Psychotherapists - Standards Of Proficiency And Criteria For Education And Training Programmes For Psychotherapists

Prior to CORU's publication of the Standards of Proficiency & the Criteria for Education and Training Programmes for counselling & psychotherapy, there was concern among psychotherapist friends and colleagues that the standards and criteria would be of an inordinately high level that few of us in the profession would be eligible to register. On reading the standards and criteria I was frankly shocked by what I consider as setting a low standard. Of real and deep concern to me as a psychotherapist is that when the register is open a recent graduate can apply to register as a psychotherapist. During their Level 8 degree course there is no requirement for personal therapy. I wonder how a graduate who has not had undertaken psychotherapy as an undergraduate, can accompany clients to the depths that they rightly expect of their psychotherapist. Supervision needs to go beyond the graduate's degree programme. Regular supervision for all registered psychotherapists needs to be a requirement for the well being of psychotherapists and to protect the public.

The role of CORU is to protect the public. However, by implementing the standards and criteria as currently outlined in the public consultation document, could potential endanger the public. The standards and criteria will instead of providing the public with reassurance regarding the profession of psychotherapist, will in fact be putting the public at risk. I wonder if the Board Members would attend psychotherapy sessions with a recent graduate if they were struggling with severe mental health issues or complex mental health disorders? The proposed standards and criteria will undermine public confidence in the profession of psychotherapy, putting the public at grave risk and also putting the recent graduate at risk of burnout because of the complex nature of issues that clients present to us as psychotherapists.

Even though "the role of CORU is to protect the public by promoting high standards of professional conduct, education, training and competence", the standards and criteria will set lower standards that most European countries. I write this as a holder of The European Certificate of Psychotherapy (ECP). To hold The European Certificate of Psychotherapy it must be demonstrated the psychotherapist has undertaken at least 3200 hours of psychotherapy education and training. Included in the 3200 hours is at least 250 hours of personal therapy or equivalent. To quote from The European Association of Psychotherapy (EAP) website: "Psychotherapists are required to engage in extensive personal psychotherapy during their training which is up to seven years duration." If the standards and criteria presented in the public consultation document are implemented, Ireland will set one of the lowest standards to practice as a psychotherapist in Europe and the UK.

Therefore I request that The Board Members give serious consideration to the following proposals:

- <!--[if !supportLists]-->1. <!--[endif]-->That to register as a psychotherapist the applicant will have completed a Post Graduate Level 9 qualification
- <!--[if !supportLists]-->2. <!--[endif]-->That the applicant will have completed at least 250 hours of personal psychotherapy during their undergraduate and post graduate studies and training
- <!--[if !supportLists]-->3. <!--[endif]-->That regular supervision be a requirement for all registered psychotherapists

Kind regards,

[Redacted]

[Redacted]

[Redacted]

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Standards of Proficiency and draft Criteria for Education and Training Programmes
Date: Tuesday 31 October 2023 10:01:20

To whom it may concern,

As a [REDACTED] student of an MA [REDACTED], I would like to express some areas of the standards of proficiency which I see as problematic.

1. Having a level 8 degree as a threshold would mean that young people coming out of school would be training as mental health professionals... Given the need for high levels of maturity, personal development, and life experience in psychotherapy work and given the fact that the prefrontal cortex doesn't finish developing until the age of 25. It seems very amiss that we would have qualified psychotherapists who have not yet finished physiological brain development. Notwithstanding the points relating to life experience and overall maturity.

2. The proposed requirement that all placements be held at sites where there is an on-site psychotherapist to supervise their work.

- this sounds great, but I don't believe that it is feasible - certainly in the field of creative child and adolescent psychotherapy within which I work. Within my speciality there is a dearth of supervisors overall. Even finding an external supervisor to attend separate to the clinical placement takes time and often requires hours of travel to commute to the supervisor. It's not realistic for creative psychotherapists working with young people to find placements with on site creative psychotherapists. What's more, putting such a stipulation in place is a barrier to placement sites accepting students.

3. Given the therapeutic pillar of client confidentiality, it's not realistic to suggest that 100 hours of placement practice be directly observed. As part of my Masters Course, we have a requirement for sessions to be recorded and clips used in supervision and assessments. Even managing to find a placement whose policy allowed for this proved very challenging for me as many counselling centres simply wouldn't dream of sessions being recorded. Direct supervision would be a similar issue. Not only does it interfere with the trust established between the therapist and client, it interferes with the dynamic in the room and the work being done. It would be a barrier for centres to engage with students and offer placements and begs the question, who would supervise and what is a cost for this 100 hours of direct observation. This doesn't in any way seem ethical or feasible.

4. Finally, the need for personal therapy and clinical supervision within the training period seems amiss from the proposal.

- My course requires 120 hours of personal therapy in line with IAHIP requirements for accreditation and such a place for personal development is a crucial element of the developing therapist. For vast and complex reasons, it is simply not safe or ethical for a psychotherapist to enter practice without having done their own psychotherapeutic work over some years.

- Supervision requirements would typically be 1 hour of supervision to 4 hours of practice for the trainee psychotherapist and this is a crucial element of the training process where clients are protected and the trainee psychotherapist is guided in their own professional development. This crucial area seems to be missing from the draft criteria.

Many thanks,



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From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Consultation Feedback re Psychotherapy and Counselling Drafts
Date: Thursday 2 November 2023 15:31:41

Dear CORU Team,

My name is [REDACTED], I am a [Psychotherapist and Counsellor with a Level 9 Master \(MSc\)](#) [REDACTED]. I live in [REDACTED] and practice in [REDACTED]. I am a member of IACP (Irish Association for Counselling and Psychotherapy).

I'm genuinely concerned for the future of mental health. For a long time the profession has been [waiting](#) for registration for psychotherapists and [welcoming](#) of the need to regulate [psychotherapy](#). This is [essential](#) for setting the professional standard and ultimately to create safety for clients and professionals in this area.

The proposed draft criteria that CORU plan for the registration of psychotherapists and also [for](#) counsellors and their training in the near future is [very](#) concerning.

Across my 5 years [of](#) training to be [qualified](#) I have experience group therapy, personal therapy and supervision of my work by an [independent](#) supervisor. All of these [inputs](#) and experiences were essential to my training and also to my growth and development as a practitioner. Certainly it also is [recognised empirically](#) that [these elements of therapist training](#) are essential to ensure practitioners deliver safe services [for](#) clients.

CORU are proposing to [standardise](#) entry to both registers [at Level 8](#), will not be including any [criteria](#) on [supervision](#) within the training (only on placement) and are removing the inclusion of personal [therapy](#) for students in training.

You can understand my concerns [regarding](#) the lowering of standards and lowering of qualification for [both](#) registers in Ireland. With these proposals by CORU, I'm very concerned that registration of [Psychotherapists](#) will bring a [reduced](#) quality to the work and diminish the current quality provided by qualified and accredited therapists who have set the high standard we [currently](#) work under.

I believe a [minimum](#) Level 8 training [should](#) qualify a practitioner for the Counsellor registration and a [minimum](#) Level 9 training should be used for entry to the Psychotherapists registration. [The](#) work carried out at both levels [varies](#) greatly and registration should reflect this.

A medical model can not be applied to these professions as a standard template.

[Currently](#) there are questionable training providers who provide shorter trainings and trainings without those elements and this undoubtedly puts the public in danger. I have worked with clients who have [experienced](#) poorly trained practitioners that harmed their mental health as a result. External supervision and personal therapy should be requirements in the training standards without question.

I'm asking for my input to be considered for the training and registration drafts.

Lower quality of care for clients and genuine risk of danger if working with not appropriately trained and supervised practitioners will be the result of the current drafts.

This is not acceptable.

Thank you for taking the time and attention. I await your response.

Warm regards,

[REDACTED]

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: [Feedback](#)
Date: Wednesday 8 November 2023 12:50:13

To whom it may concern

I have been an advocate of a more legitimate process of protected title regarding the profession of counseling. I am qualified in Addiction, as well as psychotherapy and in clinical supervision. Each of these specialties came with robust criteria for accreditation. I have QQI degrees up to the master's level. I have like many others been treated shockingly by other accreditation bodies who are protecting pockets. In my view, CORU should now be the standard. Once a Supervisor is registered or a therapist that should be the entry level. The need to be accredited outside of this should be terminated. The profession should carry a three-year license. One must submit CPD as well as supervision hours to CORU. The qualification should be Level 8 at entry followed by Masters and respect the grandfather rule.

Kind Regards,

[REDACTED]

From: [REDACTED]
To: [Strategy and Policy](#)
Cc: [iacp](#)
Subject: Feedback on CORU's Document
Date: Saturday 11 November 2023 12:06:39

This feedback is following a group discussion by 4 psychotherapists and supervisors held on the 11 th November 2023

Between the group we have 92 years of practice experience in this work

Following group discussion this is my submission

Our two areas of concern are

- (1) That students have ongoing personal therapy for the entire duration of their training
- (2) That Supervision is essential during the training process and subsequently ongoing and regular monthly throughout the entire career of the therapist

This is to safeguard the client welfare and the competence and support of the therapist

Yours Sincerely

[REDACTED]

Sent from my iPad

From: [REDACTED]
To: [Strategy and Policy](#)
Cc: [IACP](#)
Subject: Feedback for CORU Draft Document for Psychotherapy and Counselling
Date: Saturday 11 November 2023 12:07:18
Attachments: [image001.png](#)

Dear CORU

This feedback is following a group discussion by Four Psychotherapists and Supervisors held on 11th November 2023.

Collectively we have 92 years of practice and experience in this work.

Our two key areas of concern are,

1. That trainee therapists have ongoing personal therapy throughout their training.
2. That Supervision is essential during the training process and subsequently throughout the career of the therapist. This supervision needs to be at least monthly to safeguard client welfare and to ensure professional support for Psychotherapists.

Yours sincerely

[REDACTED]



From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Feedback
Date: Friday 17 November 2023 07:02:35

Hi Team ,

I'm an accredited psychotherapist with NAPCP and I'm happy to see that there is movement with registration process.

I appreciate it is a challenging endeavour for everyone involved. I'll provide some feedback based on recommendations.

1. I agree that the level 8 Hons Degree is the right level of education required and your rationale behind this is valid.
2. I do think 50 hours personal therapy is beneficial for the psychotherapist while in training so I do think this should be a requirement.
3. I feel the fly on the wall approach to supervision may interrupt the therapeutic relationship between client/ therapist and could impact the trainee therapist's performance. I'm not in favour of this observational approach to supervision.

Best of luck going forward.

Regards

[REDACTED]

Sent from [Outlook for iOS](#)

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Criteria for Psychotherapy and Counselling
Date: Friday 17 November 2023 11:18:19

My name is [REDACTED] and I am a fully accredited psychotherapist and Supervisor with IAHIP.

I was accredited as a therapist in 1994 and as a supervisor in 2006.

I am deeply concerned about some of the suggestions being proposed as criteria for both the training and ongoing monitoring of psychotherapists.

As you comment in your rationales, psychotherapy can be long term and require very deep interpsychic work and for the safety of both the client and the therapist I think it is crucial that supervision continues to be a requirement for accreditation and reaccréditation.

My experience has been that in supervision I can explore without fear, my mistakes, concerns and frustrations regarding a client and their process. I have been held by my supervisors and in turn have been able to hold clients as they go through some very difficult and, at times, dark material. I have been able to tease out where I am missing the client and whether it is my stuff getting in the way or the client's. Failure to insist on supervision being a core requirement will, unfortunately, allow both the naive and overconfident as well as the unscrupulous, less ethically minded people to continue to practice.

Especially if the requirement for personal therapy is also not seen as essential. Personal therapy is very important in terms of helping an individual understand their own motivation for doing the work. This is essential to weed out do-gooders and other judgemental types thinking they know what is best for a client. Discovering our blindspots helps us to know when we are likely to be missing our clients and so failing to explore issues that are important to them because they are difficult for us to deal with.

The failure to require a level of maturity before being allowed to train as a therapist will, in my opinion, in concert with the above omissions, contribute to some very dangerous situations both for clients and therapist to develop.

Life experience and understanding is a very important ingredient in grounding a trainee and subsequent practitioner. Some way must be found to insist on a level of maturity being required before training and allowing 18 year olds to train will be highly unethical.

Wishing you well in what is a very complex situation. Psychotherapy is a very powerful resource for healing but needs to be managed from very high standards and a deep understanding of its uniqueness in the mental health field.

Yours sincerely

[REDACTED]

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Submission to Counsellors and Psychotherapists Registration Board Stakeholder Consultation
Date: Tuesday 28 November 2023 17:21:18

Dear Sir/Madam,

I wish to make the following submission in relation to Corú's proposals for the Counsellors and Psychotherapists Registration Board proposals.

1. I believe that the distinction between Counselling and Psychotherapy is a crucial one. It must be maintained, and must be reflected in the standards of training and qualification required.

2. As a psychotherapist and accredited member and supervisor in the Irish Association of Humanistic and Integrative Psychotherapy (IAHIP), I believe that the standards and criteria currently being proposed by Corú pose a risk to public safety and undermine the profession. They are diluting the gold standard approved by the European Association of Psychotherapy (EAP) with which IAHIP is aligned.

3. I have serious concerns that the current Level 9 postgraduate qualification, achieved after seven years of training, are proposed to be reduced to Level 8. The profession of psychotherapy requires a level of academic and process-based study and development which only Level 9 can achieve, if psychotherapists are to be able to work effectively with their clients.

4. From my own experience and understanding - both of the work itself and in relation to life experience - it is essential that the training requires a substantial level of personal psychotherapy. This is currently set at a minimum of 250 hours of individual and 60 hours of group psychotherapy.

It is my view, and my own personal experience, that undergoing one's own personal therapy is what really grounds one in the work - work that is often difficult and potentially triggering, if one is not able (through therapy) to know what is 'my stuff' and what is 'the client's stuff'. How can we ask, or safely guide, a client on a journey that we have not gone on ourselves?

To remove the requirement for any personal therapy as part of training is completely irresponsible, in relation to public safety as well as the safety of the therapist.

5. Supervision is, in my own experience both as a psychotherapist and a supervisor, essential to the work of psychotherapy. Supervision is the process whereby one continually deepens one's work through case discussions with another (usually more experienced) therapist. It also ensures the safety of the client, by having another 'eye' on the work with the client.

The current requirement of a pro-rata number of hours of supervision to client work must be maintained. During training, supervision of placements by suitably trained clinical supervisors can take place in a variety of settings. These are more appropriate than on-site or directly observed supervisions, given the complexity and confidentiality of the issues that can arise with clients.

6. The overall downgrading of training and accreditation standards currently being suggested for psychotherapy is greatly concerning. The current standards have been arrived at as a result of cumulative learning and experience. At a time when more and more people in our society are understanding and valuing the process of psychotherapy, why would we dilute the tried and tested national and international standards?

There is already a considerable risk to the public from poorly trained individuals entering into this important field. We need to recognise the value to society of having well-qualified professionals working in the field of psychotherapy.

I feel that the current proposals show a fundamental misunderstanding of the process of psychotherapy and the type of training and support it requires. I urge Corú to listen to the voices being raised from experienced professionals in the field and to revise these requirements accordingly.

Yours sincerely,

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Consultation on Psychotherapy standards contribution
Date: Wednesday 22 November 2023 13:04:27



Public Consultation,
CORU,
Infinity Building,
George's Court,
George's Lane,
Smithfield, Dublin 7,
D07 E98Y

22nd November 2023

Dear CORU

As an experienced psychotherapist, [REDACTED], I have critical concerns about the standards and criteria proposed by CORU for Psychotherapists because I believe they pose a risk to public safety and undermine the profession of psychotherapy.

The Irish Association of Humanistic and Integrative Psychotherapy (IAHIP), of which I am a member, is the largest Member Organisation of the Irish Council for Psychotherapy (ICP), and the largest accrediting body of psychotherapists in Ireland. We are accredited to the European gold standard approved by the European Association of Psychotherapy (EAP). This is the most exacting standard in Europe, and guarantees the integrity of our profession in Ireland. The EAP standard requires that Psychotherapists must meet the following criteria:

- Seven years of training, ending in a postgraduate qualification (level 9 in Ireland).
- Have personally undergone a minimum of 250 hours of Psychotherapy.
- An appropriately trained and qualified supervisor must have supervised their training.

In contrast, under the new CORU proposals, Psychotherapists would be required to only have a three- or four-year primary degree. Personal participation in therapy would not be a required part of their training, nor would their training need to be supervised by a supervisor who is appropriately trained and qualified.

I believe strongly that CORU's/these proposed standards will undoubtedly weaken the efficacy of psychotherapy as a practice; diminish and negatively impact the rigour of training; while ultimately undermining public trust and safety in psychotherapy and psychotherapists as professionals, all of which go against the purpose of statutory regulation.

Kind regards,

Yours sincerely,

[REDACTED]

[REDACTED]

[REDACTED]

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Submission for consideration
Date: Tuesday 28 November 2023 10:46:12

As a recently accredited psychotherapist I am aware of the financial commitment necessary to enter this profession. In order to ensure that the profession is not restricted to certain people, I think it might be worth considering offering bursaries or reduced fees to those on lower incomes. I have worked in low-cost counselling settings and have encountered many people who have experience and life skills to become excellent counsellors, but would find it impossible financially. Unpaid placement can also be very difficult and a token payment or at the least provision of supervision would be very helpful.

[REDACTED]

28 November, 2023

[REDACTED]

Dear CORU,

As an experienced psychotherapist, I have critical concerns about the standards and criteria proposed by CORU for Psychotherapists because I believe they pose a risk to public safety and undermine the profession of psychotherapy.

The Irish Association of Humanistic and Integrative Psychotherapy (IAHIP), of which I am a member, is the largest Member Organisation of the Irish Council for Psychotherapy (ICP), and the largest accrediting body of psychotherapists in Ireland. We are accredited to the European gold standard approved by the European Association of Psychotherapy (EAP). This is the most exacting standard in Europe, and guarantees the integrity of our profession in Ireland. The EAP standard requires that Psychotherapists must meet the following criteria:

- Seven years of training, ending in a postgraduate qualification (level 9 in Ireland).
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In contrast, under the new CORU proposals, Psychotherapists would be required to only have a three- or four-year primary degree. Personal participation in therapy would not be a required part of their training, nor would their training need to be supervised by a supervisor who is appropriately trained and qualified.

I believe strongly that CORU's/these proposed standards will undoubtedly weaken the efficacy of psychotherapy as a practice; diminish and negatively impact the rigour of training; while ultimately undermining public trust and safety in psychotherapy and psychotherapists as professionals, all of which go against the purpose of statutory regulation.

Kind regards,

[REDACTED]
[REDACTED]

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Re: Submission of feedback to CORU approaches
Date: Wednesday 29 November 2023 09:44:44

[REDACTED]

I've been through nearly 11 years of personal therapy plus a rigorous 4 years postgraduate training in psychotherapy and two years research masters with the Gestalt Institute of Ireland. This rigour and self awareness grounds me ethically and practically with clients. ..I feel such rigorous professional standards are required from CORUs Psychotherapists and Counsellors, and indeed anyone working in the field of mental health.

[REDACTED]

[REDACTED]

[REDACTED]

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Response to public consultation
Date: Thursday 30 November 2023 17:53:51

Dear Sir/Madam

I wish to convey my feedback on the draft proposals for proficiencies, training and education as a psychotherapist in Ireland.

1. Personal therapy should be an essential requirement of training. Understanding one's emotional blind spots, unresolved conflicts and awareness of one's own unconscious are crucial for our work as psychotherapists. It helps us to practice more safely, to recognise enactments and respect therapeutic boundaries. Personal therapy has always been an essential component of psychotherapy trainings internationally and should be maintained.
2. Psychotherapy supervision in training is essential. However, in-person observations by a trainer of the therapeutic work could be highly disruptive to the transference countertransference relationship. Video recordings of sessions could be an alternative.

Yours Sincerely

[REDACTED]

Sent from my iPhone

From: [REDACTED]
To: [Strategy and Policy](#); [Strategy and Policy](#)
Subject: Standards for Psychotherapy
Date: Thursday 30 November 2023 14:19:17

Hello,

I have just completed your public survey of CORU standards of proficiency and education for psychotherapists.

The layout of this survey made filling in the rationale along one line of text quite difficult.

I wish to make the comment which was impossible to do adequately on the survey form.

As your Standards of Proficiency for Psychotherapists state :

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.

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.

These clearly indicate the need for a psychotherapist to be aware of the unconscious processes on which they are supposed to reflect!! Education is not only of the academic variety, the more subtly nuanced personal aspects which are required for the practice of psychotherapy require both maturity and capacity for reflection, which is being undermined in our current time-poor quick-fix social media culture.

The biggest omission in your criteria is the requirement for trainees to undergo personal psychotherapy, and is the clearest distinction between psychotherapy and counselling; along with higher levels of academic study in the particular modality of training for psychotheapists.

Not only should this omission be rectified, it should be made public, for the information of potential clients—and their families or friends—who are entitled to this information. Just because persons suffer mental/emotional distress does not make them unintelligent! Though it is true that in the extremes of distress they may need adequate time in a supportive unbiased relationship, to be able to calmly take in the necessary information to help them reach a decision.

In England where I trained and practised for 7 years, it was common for professionals to state such descriptive [not evaluative], aspects of their training and supervision. Often on returning to Ireland, I had to spend some time with clients initially to answer their

questions on the difference between psychiatrists, psychologists, counsellors and psychotherapists.

Why should our population not be clearly informed and therefore more able to make judgements on their treatment?

Sincere Regards,

A thick black horizontal bar used to redact the signature.A thick black horizontal bar used to redact the signature.

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Psychotherapy
Date: Friday 1 December 2023 12:29:59

To whom it may concern,

I am working as a Clinical Psychotherapist, having completed a Masters Program and am accredited with IACP. I am very concerned about the new proposals recommended by Coru with regard to changing the need for Personal Therapy and Supervision while training. I feel both of these practices are crucial in the work while training to become a therapist.

I sincerely hope these proposals will not be sanctioned, for both the therapists sKe and more importantly for the potential clients.

Yours sincerely,

[REDACTED]

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: submission for public consultation on education and training for psychotherapists and counsellors.
Date: Friday 1 December 2023 13:41:25
Attachments: [image001.png](#)
[image002.png](#)

To whom it concerns,

Please see below a letter I am sending you in response to the public consultation call on the standards for education and training for counsellors and psychotherapists.

Yours truly,

[illegible]

[REDACTED]

[REDACTED]

CORU
George's Court,
Infinity Building,
George's Ln,
Smithfield,
Dublin, D07 E98Y

01-12-2023

RE: Submission on the Regulation of Counsellors and Psychotherapists in Ireland

To whom it concerns

I am writing to you as a member of the public who is also a Family/Systemic Psychotherapist and registered with Family Therapy Association of Ireland (FTAI), Irish Council for Psychotherapy (ICP) and European Association of Psychotherapy (EAP). I am also employed [REDACTED] and I am familiar with the requirements of standards of proficiency for the profession and for the need to protect the public by providing training that ensure high quality services that meets the needs of service users and of the profession,

As I am sure you are aware, the current standards for education and CPD for psychotherapists have been set by FTAI and ICP since 1993 when training standards in Ireland aligned with European standards set by European Association of Psychotherapy. Significantly, these standards have been ratified by four countries within Europe, including, Germany, Austria, Croatia and Malta. The FTAI has also signed a Memorandum of Understanding with the Association for Family Therapy (AFT) in United Kingdom in 2022 to allow for streamlining of dual registration in both jurisdictions following Brexit.

It is also important to bear in mind the submission to the Department of Health & Children by the Associations representing Counsellors and Psychotherapists in Ireland on The Statutory Registration of Counsellors and Psychotherapists in April 2008. This submission gives the views of the majority of Counsellors and Psychotherapists through the associations that represent or regulate them. A combined membership of over 5000 professionals participated and thus the recommendations from the group carry an authority on behalf of the vast majority of Counsellors and Psychotherapists in Ireland. This lends support to my view that entry into Psychotherapy training in Ireland remains aligned to the standards at post-graduate NFQ Level 9 (Masters) and not Level 8 as proposed by CORU. As you probably aware, this remains the view of the FTAI.

It is important that Family/Systemic Psychotherapy and Psychotherapy in general be recognised as specialisms due to complexity of the work and the potential for risks of harm to the members of the public should the standards for admission to psychotherapy training be lowered. Additionally, in order to safeguard the public, the requirement for personal therapy and live supervision must continue to be central components of training programmes to support practitioner development and safeguarding the public.

In brief,

1. It is important that standard of training for Family/Systemic Psychotherapists and Psychotherapists in general be at NFQ Level 9 (Masters) and in keeping with European standards.
2. The requirement for personal therapeutic experience is an essential part of Family Therapy Training Programmes and must be maintained as a core part of a clinician's personal/clinical development and as an approach to safeguarding.
3. Live supervision is a central part of family therapy training with a minimum of 30 hours as lead practitioner and overall 250 hours as reflective team member overseen by a registered supervisor within the discipline.

I look forward to the revised criteria for admission to psychotherapy training in Ireland and hope that my concerns as outlined above are reflected in these.

Yours sincerely

[Redacted signature block]

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Psychotherapy Training Reforms
Date: Friday 1 December 2023 10:21:57

Hi Team

I hope this email finds you well.

I am writing to you regarding the proposed reforms in Psychotherapy training currently being discussed.

As someone who has received therapy and has friends who have done so - I do not think it's apt to potentially open the door to young - under qualified therapists. I can see the logic to allowing a student with Level 8 experience to give therapy sessions - but usually these individuals will be relatively young and inexperienced. It is a dangerous situation for someone so young to be talking through people going through difficult experience with little to no experience.

I urge you to reconsider this proposal and ensure all qualified therapists are of grade Level 9 to ensure the correct level of experience.

In my own opinion I believe all therapists should themselves go to therapy as part of their training - I do not believe this is currently mandatory.

I also noted that therapist sessions will potentially have to be "supervised" as part of training. If this is for all therapists it will cause huge logistical issues for all parties - the therapist, patients, therapy locations and even the governing bodies. I would strongly oppose this suggestion.

I hope my thoughts are taken on board.

Kind Regards

[REDACTED]

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Psychotherapist Consultation
Date: Friday 1 December 2023 11:05:09

CORU Public Consultation Feedback:

My concerns are:

- - o Setting level 8 (primary degree) instead of 9 as the threshold level of qualification required which also leads to low standards of proficiency (see Domain 5 below) requirements.
 - o This would greatly diminish entry requirements for prospective students and could mean that students might enter directly following their Leaving Certificate;
 - o This also means that graduates of such programmes would not be eligible for registration with EAP in Europe and would not meet international criteria for practice.
- - o Requiring all students to complete placements where there is an on-site psychotherapist (registered with CORU) to supervise them for 350 hours of 'service user contact'.
 - o This will vastly reduce the number of suitable placement sites available.
- - o Requiring students to be 'directly observed' in 100 hours of 'service user contact' within the placement site while training.
 - o This poses significant difficulties for clients, placement sites, and students.
- - o Not stipulating any requirements for personal therapy or clinical supervision during training.
 - o This will result in some training programmes removing or reducing this requirement and lead to very poorly trained psychotherapists who will lack the personal development traditionally associated with the field, and will not have sufficient competence for safe practice.

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: CORU Consultation Psychotherapists
Date: Friday 1 December 2023 09:09:43

To Whom It May Concern,

I am a [REDACTED]. I have concerns about the Standards of Proficiency for Psychotherapy training and feel that the standards proposed are inadequate. These are my concerns:

- I think that level 8 rather than level 9 as the threshold level of qualification is too low.
- I think that the practicalities of having a fully qualified psychotherapist on site for the placement would be highly challenging.
- Being observed in 100 hours of service user contact in the room would be difficult because the therapeutic relationship is so significant in the therapy process and having another person in the space this would hinder this. It is a lovely idea to have two way screens but the practicalities of these seem really challenging for many sites.
- My greatest concern in the proposal is the idea that Psychotherapists would not need to have their own psychotherapy during training. We are required to have psychotherapy throughout the 4 years of our training and without this I believe I would not be able to practice with the professionalism in which I have been trained.
-

Thank you for your hard work in bringing into place regulations for the practice of the psychotherapy profession. I welcome this and greatly look forward to being part of a profession with high standards.

Warm regards,

[REDACTED]

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Criteria for Education and Training for Psychotherapists
Date: Friday 1 December 2023 16:52:49

To whom it may concern,

I am deeply concerned at some criteria that CORU is proposing!

I am a qualified and Accredited Psychotherapist for over 23 years. I also hold the European Certificate in Psychotherapy and prior to this I held the N.Q.S.W. My work as a psychotherapist is with people who have experienced enormous Trauma in their lives which requires particular training and expertise. Also requires self awareness at a very deep level

From what I have seen, The Criteria laid down by CORU do not meet the European Association for Psychotherapy (EAP) standards. Ireland will have lower standards of entry for psychotherapists and public safety than other European countries and those trained here may encounter difficulties working in other European countries. Why would we allow the standards for psychotherapy in Ireland to be weakened, made lower than the European standard, and thereby risk the safety of vulnerable members of the public? Training bodies in Ireland have spent years drawing up effective Standards in Training. Personal therapy has always been seen as critical, throughout the world. As an example. were a psychotherapist to work with some of the hostages released by Hamas, and with families who survived and witnessed the massacres, that therapist would need the highest possible standard of training. To change the current Supervision arrangements. to reduce the years of training and to no longer require personal therapy would certainly not lead to suitable candidates to carry out this work.

Yours faithfully , [REDACTED]

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Response to CORU Consultation re Psychotherapy
Date: Friday 1 December 2023 16:08:39

Dear CORU Strategy and Policy,

I have already submitted my response via the questions on the Survey, however omitted to include the following:

1) Before any Standards can be finalised and also Standards for Training, a Code of Ethics for Psychotherapist and a Code of Ethics for Counsellors needs to be developed. All practice and education needs a clear Code of Ethics.

2) It would be very helpful to have agreed clarity as to what Psychotherapy is and what Counselling is. I don't find it helpful that in some of the documents = there is little/no mention of psychotherapy.

Many thanks,

Yours Sincerely,

[REDACTED]

From: [REDACTED]
To: [Strategy and Policy](#)
Cc: [ICP Admin](#)
Subject: Psychotherapy consultation
Date: Friday 1 December 2023 15:27:51

Dear CORU,

We are writing in response to CORU's public consultation on Standards of Proficiency and Criteria for Education and Training Programmes for Psychotherapists.

The [REDACTED] is the leading organisation for psychotherapists and psychotherapeutic counsellors in the [REDACTED]. Alongside offering professional support for our members, we regulate the profession and promote access to psychotherapy for all. We hold a register of psychotherapists and psychotherapeutic counsellors in the [REDACTED], which is accredited by the Professional Standards Authority (PSA), who oversee our work in regulating the psychotherapy profession. Along with the Irish Council for Psychotherapy (ICP), [REDACTED] are members of the European Association of Psychotherapy (EAP).

[REDACTED] has shared with [REDACTED] its response to your consultation, which we wholeheartedly support.

In particular, we would highlight the following concerns [REDACTED] has raised:

- The need for entry onto the psychotherapy register to be the successful completion of a training at level 9 (not 8) of the NFQ for Ireland, equivalent to level 7 (masters level) in the UK.
- The need for the standards to reflect the complexities of the work of a psychotherapist as compared with a counsellor
- The importance of trainees learning from their own personal therapy, and the need for this to be a requirement in a recognised training programme
- The minimum length of training to be four years, in accordance with EAP standards
- The importance of clinical supervision
- Concern that direct observation of client/therapist interaction would go against the philosophy and practice of psychotherapy.

To assist CORU, you find the Standards of Education and Training that [REDACTED] has set for psychotherapy in the UK at the following link:

[REDACTED]

We have also undertaken extensive work with our colleagues in counselling and psychoanalytic bodies to ensure the differences in the levels of training and competencies are transparently understood in a commonly agreed framework. The framework can be found at the following link:

[REDACTED]

Please do not hesitate to contact us further should you require any assistance in taking forward the next stage of your work.

Regards,

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Re: CORU Feedback- my submission for the public consultation
Date: Friday 1 December 2023 14:25:28

To Whom It May Concern:

I would like to add my contributions to the CORU Consultation for the Psychotherapists - Standards Of Proficiency And Criteria For Education And Training Programmes For Psychotherapists.

I believe It would be preposterous to consider a Level 8 qualification instead of Level 9. Leaving Certificate students could then be considered for what I consider a vocation. Having an undergraduate qualification before joining psychotherapy training has many benefits.

This also means that graduates of such programmes would not be eligible for registration with EAP in Europe and would not meet international criteria for practice. Not requiring any requirements for personal therapy or clinical supervision during training is unsafe and unethical and would not provide appropriate care for young people receiving therapy. In the current climate where trauma is at the forefront of day-to-day living, we should be providing the very best and fully trained psychotherapists.

By reducing training programme requirements will result in inadequately trained psychotherapists lacking the personal development now associated with this profession. This will also lead to therapists not being competent for a safe practice.

I plead with CORU to reconsider and keep the welfare of our young and vulnerable as top priority. Provision of consultations with a proficient Psychotherapist will shape and form their lives going forward.

Yours sincerely.

[REDACTED]

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Feedback for CORU draft standards for psychotherapy
Date: Thursday 30 November 2023 20:32:57

Dear Sir or Madam,

I am an experienced, accredited psychotherapist, accredited clinical supervisor, and trainer of psychotherapists, and I have been working since 1986. I am accredited to or registered in the following professional bodies as a psychotherapist:

The Irish Council for Psychotherapy (ICP).
The Irish Association for Body Psychotherapy (IABP).
The Irish Association for Counselling and Psychotherapy (IACP).
The Irish Association for Humanistic and Integrative Psychotherapy (IAHIP).
The European Association for Body Psychotherapy (EABP).
The European Association for Psychotherapy (EAP).

I am deeply concerned about the draft standards and criteria for Psychotherapists proposed by CORU, which I believe undermine both public safety and the profession of psychotherapy.

All of the above associations (and all those in the Western world) support the inclusion of requirements for personal psychotherapy and clinical psychotherapeutic supervision for trainee psychotherapists. Ireland would be the only country in the world to forego these requirements for trainees.

These requirements are approved by the European Association of Psychotherapy's (EAP) Europe-wide standards, which guarantee the integrity of the psychotherapy profession in Ireland. The EAP standards are supported by:

<!--[if !supportLists]--> <!--[endif]-->the Irish Council for Psychotherapy (ICP)
<!--[if !supportLists]--> <!--[endif]-->the Irish Association for Humanistic and Integrative
Psychotherapy (IAHIP)
<!--[if !supportLists]--> <!--[endif]-->the Irish Association for Body Psychotherapy (IABP)

Similar standards are upheld by the Irish Association of Counselling and Psychotherapy (IACP).

The EAP standard requires that Psychotherapists must meet the following criteria:

- They must have undergone a minimum of 250 hours of personal psychotherapy.
- They must have been supervised for a minimum of 150 hours by qualified psychotherapy supervisors during their training.
- They must have undergone seven years of training, ending in a postgraduate qualification (level 9 in Ireland).

However, under the current CORU proposals, Psychotherapists:

<!--[if !supportLists]--> <!--[endif]-->Would not be required to participate in personal therapy as part of training.
<!--[if !supportLists]--> <!--[endif]-->Their work with clients during training would not need to be supervised by an appropriately trained and qualified supervisor.

<!--[if !supportLists]--> <!--[endif]-->They would only be required to only have a three- or four-year primary degree. Personal participation in therapy would not be a required part of their training, nor would their training need to be supervised by a supervisor who is appropriately trained and qualified.

I believe that CORU's proposed standards will:

<!--[if !supportLists]--> <!--[endif]-->significantly diminish the value of psychotherapy training,

<!--[if !supportLists]--> <!--[endif]-->distort and undermine the practice of psychotherapy,

<!--[if !supportLists]--> <!--[endif]-->undermine the safety of the public,

<!--[if !supportLists]--> <!--[endif]-->undermine public trust in psychotherapy and psychotherapists as professionals,

all of which go against the purpose of statutory regulation.

Yours faithfully,

[Redacted signature]

[Redacted signature block]

Dear CORU,

Re: Public Consultation on Education and Training Standards for Psychotherapists

We strongly welcome CORU's publication of draft standards of proficiency and educational and training standards. We applaud the requirement for direct observation of the practice of psychotherapy in training which is a key part of the culture & supervision standards in CBT.

We however believe that the level of qualification set as the threshold standard is not sufficient. Outcomes in trials of CBT have been based on an enduring tradition of post-graduate education in CBT, usually as an add-on to core professional training in mental healthcare. Even the low-intensity CBT provisions in the large UK IAPT studies are founded on providing additional training to existing graduates rather than training any individuals without pre-existing level 7 or level 8 qualifications. While it is commendable to consider accessibility issues which would promote diversity and inclusion in the entry to psychotherapy profession, it would be unwise to ignore both the grounding of scientific evidence and established custom and practice throughout Europe, that the provision of psychotherapy to date is only delivered by those with postgraduate training.

In Ireland there is very limited structured career pathways for psychotherapists and unlike most other health professions there are not clearly recognised grades within the HSE or independent hospitals. The typical pathway for social workers, OT's, physiotherapists etc is for there to be basic grade posts for new graduates and then progression to more senior grades with higher levels of responsibility. This all occurs within clear supervision, oversight and governance structures. These allow for a threshold standard of training that accepts graduates still have a lot of further learning to achieve within posts. Systems are organised so that new graduates are not required to work with the more complex cases.

Many psychotherapists now work and in the future will continue to work independently in the private sector. Psychotherapists will typically work with individuals who are psychologically and emotionally distressed. They must have sufficient skills, training and maturity to provide adequate interventions to those very vulnerable individuals who attend them at the point that they enter the Register of Psychotherapists and need to fully understand at that point how to keep within a safe range and scope of practice.

In terms of maintaining public safety and setting appropriate educational standards **we would strongly advocate for a minimum of a level 9 qualification for entry on the Register for Psychotherapists.**

We believe that the hours of practice requirement of 500 hours set in placements should explicitly articulate a minimum provision of 200 hours of an individual one to one psychotherapy. **Practice placement hours in psychotherapy are only meaningful when there is a stipulation about the minimum hours of experience that are required to be engaged in the delivery of the supervised psychotherapy.**

Assessments for therapy, preparation for therapy sessions, delivery of groups, administration, team discussions and review of patients may make up the other hours in practice placements to enhance professional training but the core training to provide psychotherapy necessitates a minimum hours of provision of one to one psychotherapy. Ideally there should be a further stipulation that within these hours should include treatment of a range of disorders/problems/with a minimum of 8 cases treated in the completion of the 500 practice placement hours. This would help ensure that there is a sufficient range of skills to be able to practice in competent and flexible manner.

When providing feedback to CORU we are making reference to the well-established minimum training standards for CBT psychotherapists within Europe - <https://eabct.eu/wp-content/uploads/2019/01/Thomas-Kalpakoglou-Training-and-Accreditation-2002-2013.pdf> These standards also align with BABCP minimum training standards which are used by IABCP to accredit its members who reach and maintain those standards - <https://babcp.com/Portals/0/Files/About/BABCP%20Minimum%20Training%20Standards%200823.pdf?ver=2023-08-01-143802-047> .

These standards are also the anchor for the core curriculum of the IABCP/BABCP along with the Roth and Pilling (2007) standards for competence which provide in the best possible evidence for CBT training-
<https://babcp.com/Core-Curriculum>
<https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/competence-frameworks-0>

Yours Sincerely,

[Redacted signature block]

Nov. 30, 2023

PRIVATE & CONFIDENTIAL:

To:

Ms. Catherine Byrne
Head of the Strategy and Policy Unit
CORU
Infinity Building
George's Court, George's Lane
Smithfield
Dublin 7, D07 E98Y

Dear Ms. Byrne,

The Irish Council for Psychotherapy submitted concerns on behalf of its registrants to CORU proposals for regulating the psychotherapy profession.

CORU might find it beneficial verifying the veracity of

- 1) accuracy of the ICP register
- 2) level of engagement in the consultation survey purported

CORU draft proposals for Counsellors and Psychotherapists are appropriate and justified on grounds of public interest objectives.

Yours faithfully,



Registrant of ICP

CORU Public Consultation
Infinity Building, George's Court, George's Lane
Smithfield,
Dublin 7
D07 E98Y

15 November 2023

Dear Sir/Madam,

Psychotherapy can cause harm if not conducted by properly trained Psychotherapists, who follow strict codes of professional conduct, ethics and continual professional development. In response to your queries regarding the CORU consultation "*Standards of Proficiency for Psychotherapists and its Criteria for Education and Training Programmes (Psychotherapists)*", [REDACTED] would like to raise the following concerns:

- The CORU proposed threshold level for entry into the Register is set at NQF8 (EQF6).
- The CORU proposal has no requirement of personal therapy. Personal therapy is the cornerstone of the therapist's training, health, self-renewal and identity, and there are consistent indicators that personal therapy influence both therapist's learning as well as treatment outcomes
- The proposal does not require clinical supervision with a qualified supervisor (e.g. a psychotherapy supervision diploma). Instead, there is a 'On-site placement supervision' requirement.
- At an 'On-site placement' the student would only have limited supervision access for that placement. Furthermore, meetings, completion of administrative duties, research, reading time, supervision, writing placement portfolio would all be counted towards clinical activity requirements within this 'placement'.
- The CORU proposal stipulates that students should complete 500 hours (450 for counsellors) and of this, only 350 hours should be 'on-site' (engaging with service users, completing reports, meetings, etc) whereas 'the other 150 hours maybe related to student time engaged in the academic elements of practice education'.

- In the CORU proposal, 'direct observation' refers to 'placement supervisor' observes the student via observation (supervisor sitting in a therapy session), co-therapy, two-way mirrors, transcription, video/audio recording.

The CORU proposals contrast with internationally established psychotherapy standards of education and training. Within the international and European community, the International Standardised Classification of Occupations (ISCO) has set the following classification for the profession of Psychotherapist:

Psychotherapist (ISCO Classification): which is: 2634.2.4

ec.europa.eu

ec.europa.eu

<https://esco.ec.europa.eu/en/classification/occupation?uri=http://data.europa.eu/esco/occupation/af69484e-b43f-4685-b22d-f3418df45c4d>

Psychotherapists are not required to have academic degrees in psychology or a medical qualification in psychiatry. It is an independent occupation from psychology, psychiatry, and counselling.

- THE TRAINING STANDARDS OF [REDACTED] ARE THAT THE TOTAL DURATION OF THE EDUCATION AND TRAINING IS AT MASTERS LEVEL OR EQUIVALENT, AND THAT IT FULFILLS EQF LEVEL 7. THE TOTAL LENGTH OF TRAINING MUST NOT BE LESS THAN 3200 HOURS. THE [REDACTED] IS AWARDED UPON SUCCESSFUL COMPLETION OF TRAINING.
- THE TRAINING IS CONDUCTED EITHER: Spread over a minimum of seven years with the first three years being a relevant University degree or equivalent. The later four years must be in a training specific to Psychotherapy, and must contain all the essential academic, research and practical elements required to become a Psychotherapist.

OR: Conducted as a five year full time academic education and training in Psychotherapy organized by a University. This must include both general training and training specific to Psychotherapy, and must include all the essential academic, research and practical elements required to become a Psychotherapist.

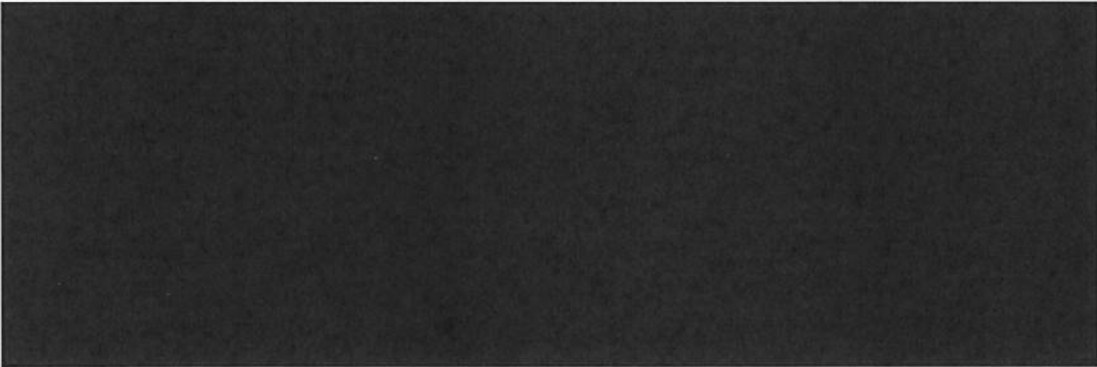
Within the last 10 – 20 years the work of Psychotherapists has changed significantly. The stigma surrounding Psychotherapy has reduced, and people don't think it is a negative thing to receive Psychotherapy. This is particularly true for the younger generation, and a Psychotherapy Law in your country will ensure that there are only fully trained and accredited Psychotherapists working to offer safe and effective Psychotherapy.

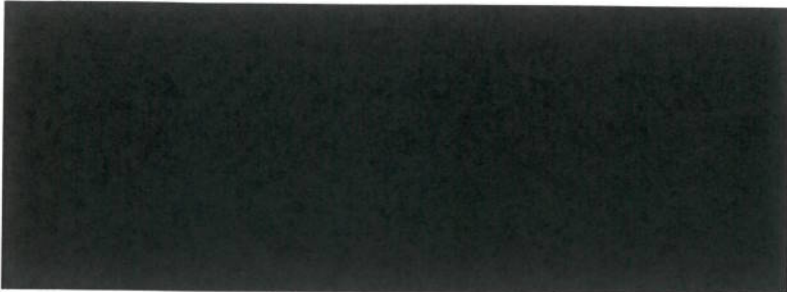


The countries that have already have a Psychotherapy Law, namely Austria, Germany, Malta, Croatia, Finland, Italy, Luxembourg, Netherlands, Poland and Sweden, report benefits from their national legal regulations, and report good results which are reflected through the increase in the quality of Psychotherapy Services provided and the reduction of waiting times for people in urgent need of Psychotherapy treatments. Psychotherapy research has demonstrated the beneficial financial effects of Psychotherapy to Governments, including reduced numbers of days of work lost due to mental health problems, and reduced need for hospitalisation.

www.europsyche.org/app/uploads/2021/03/eapbooklet_a4_210326_web.pdf

The vision of the  is of Europe being a places where emotion and mental well-being are a human right. A component part of fulfilling this vision is that Europe's citizens need access to high quality psychotherapy. In , we have the expertise, experience and knowledge to help you develop an effective Psychotherapy Law in Ireland which will help this vision become a reality. Please do not hesitate to contact us with any queries you may have.

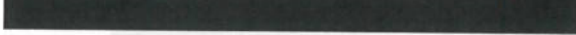




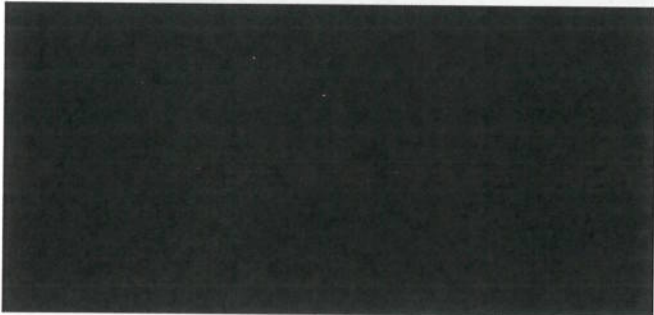
27 November 2023

For the attention of:
CORU - Counsellors and Psychotherapists Registration Board

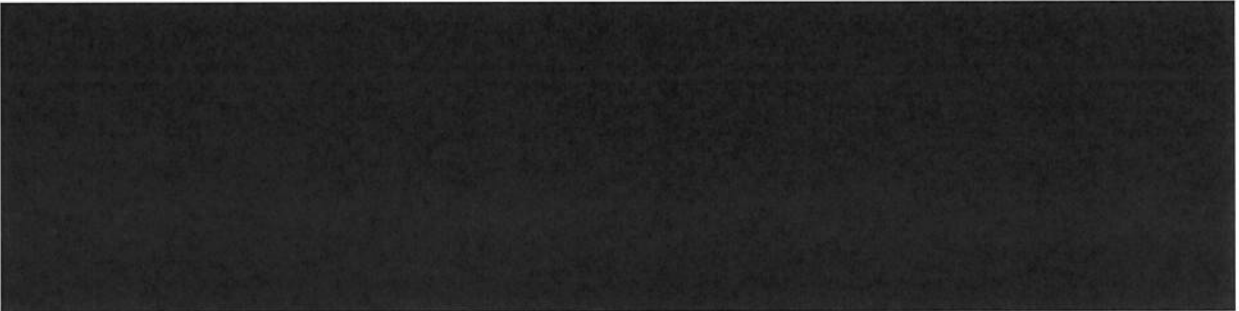
Regarding:
Public Consultation: Psychotherapists - Standards Of Proficiency And Criteria For
Education And Training Programmes For Psychotherapists

Please find the attached submission from the 


Yours sincerely,



15/11/2023 10:19



Submission to CORU

In response to:
Draft Criteria for Education and Training
Programmes for Psychotherapists



Summary of Concerns and Related Proposals

1. Multiplicity of Modalities

Issue: The title 'psychotherapist' is currently used by a diverse population of practitioners and differences in methods of practice and related training requirements cannot be appropriately reconciled through a 'common' set of proficiencies.

Proposal: To create one register for psychotherapy which contains three distinct categories of professional practice.

2. Academic Level and Entry Requirements

Issue: Current proposal for approved programmes to be provided at a minimum of NFQ Level 8 is below the threshold that professional training requires and the absence of specified minimum entry requirements creates the potential for inappropriate and unsafe admissions to approved programmes.

Proposal: To set the minimum threshold for approved qualifications at NFQ Level 9 and to specify minimum criteria, both personal and academic, for entry to approved programmes.

3. Pre-clinical Training

Issue: Absence of the requirement for a specified period of pre-clinical training as essential part of an approved programme creates risk for service users and students.

Proposal: To set a minimum period and minimum requirements for the pre-clinical phase of approved programmes.

4. Personal Development in Training

Issue: Absence of mandatory personal process work as part of approved programmes creates exceptionally high risk to the welfare of students and attendant risks to the safety of service users in placement organisations.

Proposal: To set minimum threshold for mandatory regular personal development work for the full duration of approved programmes.

5. Placement Practice Context

Issue: There are specific aspects to the psychotherapy placement context that are not comparable to any other health or social care profession.

Proposal: To adopt a psychotherapy-specific approach to placement practice regulation.

6. Clinical Supervision in Training

Issue: Clinical supervision in psychotherapy training and practice is not comparable to supervisory activities in any other health or social care profession.

Proposal: To regulate for the provision of clinical supervision external to placement organisations and to set minimum ratio of supervision to psychotherapy practice.

Criteria for Education and Training Programmes in Psychotherapy

Introduction:

We welcome efforts to provide a regulatory framework for professional psychotherapy practice which has a legal basis. It is imperative that this new framework reflects established professional standards and upholds the rigorous training standards which are already in place in many of the training institutes and which are aligned with standards for best practice both nationally and internationally.

It is equally imperative that the process of regulation recognises that the term 'psychotherapy' is used to describe a multiplicity of practices. Diversity is held as a strength of the profession, providing for a spectrum of approaches which is demanded by the complexity and diversity of service user needs. Holding a comprehensive understanding of psychotherapy is to recognise that different modalities of practice have common elements as well as critical differences. Training programmes have evolved to reflect this reality and therefore differ significantly in their duration, their processes and their learning outcomes.

To provide a robust and comprehensive process of regulation for the profession, it is clear that there must be an underpinning process of regulation applying to professional training programmes. Appropriate training regulation is essential and must reflect diversity so as to avoid the lowering of standards that regulation by uniformity would bring about.

Typology:

There are three distinct types of therapeutic practice which carry the descriptive title 'psychotherapy'. Each of these traditions within the broader profession of psychotherapy reflect different philosophical starting points, different practice methodologies, different practice proficiencies and different training processes and requirements.

These types can be described as follows:

1. **Strategic, solution-focused therapies** – individual therapy, often short-term using cognitive and behavioural strategies with a focus on symptom-reduction and problem-solving
2. **Systemic therapies** – therapeutic approach in which the service user is a ‘group’ of people as opposed to any one individual e.g. family group, group of work colleagues, a team etc., with the focus on interactions and relationships between group members and overall group functioning
3. **Psychodynamic and Relational therapies** – individual therapy (can include group work), often medium to long-term, where the relational dynamic between therapist and client is central to the process and where the unconscious process is engaged in an intentional way

Proposal for Inclusive and Comprehensive Registration Framework:

Registration primarily on the basis of proficiencies requires that all agreed proficiencies must apply to all practices of psychotherapy meaning that the framework can include only the common proficiencies. Any proficiencies that are modality-specific (i.e. not applying to all psychotherapists) must be **excluded**. This can only result in a flawed and inadequate regulatory framework which would lead to a lowering of standards for training in certain instances and would compromise the safety of practitioners and service users alike in respect of certain psychotherapy practices and processes.

It is proposed that CORU seeks to create a more **inclusive and comprehensive framework** for registration by establishing three sections within the register for psychotherapy. These sections would be created to reflect the typology outlined above. Common proficiencies would apply in all three sections and further proficiencies would apply in each specific section. Criteria for education and training would follow this framework ensuring that the robust structures and rigorous training standards already in place for each of the modalities are not undermined.

The following recommendations relate to ‘Type 3’ above as this is the realm of training and practice for humanistic and integrative psychotherapy which is represented by [REDACTED].

Existing Training Regulation:

Over recent decades the profession has developed internal regulatory frameworks through setting standards for training and accreditation. This process has been undertaken by numerous professional associations across all modalities. The large majority of training institutes have established academic validation for programmes and professional elements

are regulated according to modality-specific requirements. [REDACTED] has developed training standards that are aligned with the standards published by the European Association for Psychotherapy (EAP) and which are designed to ensure the safety of students as they engage in practice learning within the humanistic and integrative modality and the safety of service users within the placement organisations in which they work.

The following elements require specified threshold regulation in training for psychodynamic and relational psychotherapy practice ('Type 3'):

1. Academic Level 9 and related entry requirements (undergraduate degree or equivalent) for professional training
2. Minimum period of pre-clinical training i.e. preparation for placement practice
3. Mandatory personal process work with minimum threshold
4. Placement practice hours (clinical practice) with minimum threshold
5. Clinical Supervision with minimum ratio to clinical practice hours

Academic Level for Professional Training:

Qualified Psychotherapists should have achieved and demonstrated the following **academic standards** during their professional training which are commensurate with **Level 9** programmes of study:

1. Development of an authoritative, comprehensive, detailed and systematic knowledge base and understanding in specialised areas, informed by critical awareness of current issues, research based/theoretical insights at the forefront of the study of psychotherapy practice. This should reflect a narrow (specialised) and deep learning experience as opposed to the broader/shallower learning which characterises Level 8 study.
2. Ability to work with creativity and originality using knowledge and insights at the forefront of the areas of study.
3. Understanding of methodologies for psychotherapy practice which will be consistently reflected in both own research and advanced scholarship, effectively integrating advanced skills of analysis, synthesis, evaluation and application on a firm foundation of critical facility.
4. Capacity for self-direction, creativity and practical understanding, combined to demonstrate the qualities expected of an effective self-critical independent learner exercising measured judgement. This would require to be demonstrated through either a primary or secondary research dissertation at postgraduate level.

These academic standards cannot be adequately met in a Level 8 (or lower level) programme.

Related Entry Requirements:

Entrants to professional psychotherapy training should be able to demonstrate appropriate levels of personal maturity and a well-rounded understanding of the principles and requirements for expertise in the broader subject area (i.e. level 8 degree in psychology, social science, counselling, or equivalent training, work/life experience etc.). This should be the minimum level attained prior to beginning professional training.

The programme of professional training should be set to a level that builds advanced knowledge (not primary knowledge) in the subject and develops the student's research skills. The trainee is expected to be able to engage in the subject area meaningfully (critically) and be able to substantiate their ideas and arguments. In addition, psychotherapy students are expected to be far more self-directed and independent, go much deeper into the subject area and produce a more extensive dissertation or research project than at undergraduate level.

Pre-clinical Training Requirements and Duration:

Placement practice is a key process in professional training and the safety of both practitioner and client are regarded as paramount in the framing of ethical standards for this work. Preparation to begin placement practice ('pre-clinical training') is crucial to ensure safety and it is held that students should complete a three-fold training preparation over a minimum period of two years. The three elements which form an integrated process of preparation for practice are (a) theoretical learning, (b) skills development and (c) personal development. Assessment of fitness to commence practice (qualitative assessment) is the responsibility of principal members of the training team.

Centrality of Personal Process within the Training Process:

All psychotherapy practice is offered in the context of a professional relationship, irrespective of modality and whether short-term or long-term. That said, the psychodynamic and humanistic modalities of practice use the therapeutic relationship in a very different way to other practice methods. The efficacy of these practices relies essentially on the relational dynamic between therapist and client, both in the conscious engagement between the persons involved (which can be articulated) and in the unconscious elements of the relationship (more difficult to articulate). The unconscious elements (called 'transference' and 'counter-transference') are core aspects of the therapeutic endeavour and can only be safely used by a therapist who has appropriate experiential engagement with their own unconscious life in the context of a therapeutic relationship over time. To this end, the engagement in personal therapy by the student is an essential part of the entire training process and must not be construed as discretionary in the setting of training standards. The assessment of this element of the student's training (qualitative assessment) is the responsibility of principal trainers and suitably trained clinical supervisors.

Placement Practice Context and Requirements

The placement practice context for psychotherapy training is the therapeutic relationship itself. It is expected that students will work in an existing service which provides a supportive environment for this practice. It is also expected that students will report to a placement manager who carries responsibility for oversight of certain aspects of the work. This person also carries responsibility for direct contact between the programme team and the placement organisation. An appropriate contract in relation to placement provision should be agreed and signed by the programme leader, the student and the placement representative at the outset.

The monitoring of practice takes place via case management meetings within the placement. This is the responsibility of the placement manager but should not include any element of clinical supervision. Clinical supervision for psychotherapy work is a specialised practice which differs significantly from supervisory practices in other Health and Social Care Professions and is essential to the safety of practitioner and client alike. Psychotherapy supervision includes elements of educative and quality assurance support and, most importantly, it provides for a collaborative and reflective process which supports the practitioner in exploring the unconscious dynamics of the therapeutic work. This reflective process extends to the supervisory relationship also, making for a process that is utterly different to supervision in other professions.

Clinical supervision is the responsibility of a qualified clinical supervisor and is provided in an arrangement that is external to the placement organisation. External supervision (i.e. not within the placement) ensures that appropriate professional and ethical boundaries are observed.

There should be no direct observation of therapist-client engagement as this would compromise the safety of the therapeutic context for the client. Additionally, the observation or recording of therapy sessions would require the consent of a vulnerable person who is likely to offer consent that is contrary to their better judgement.

Role and Threshold Requirements for Clinical Supervision

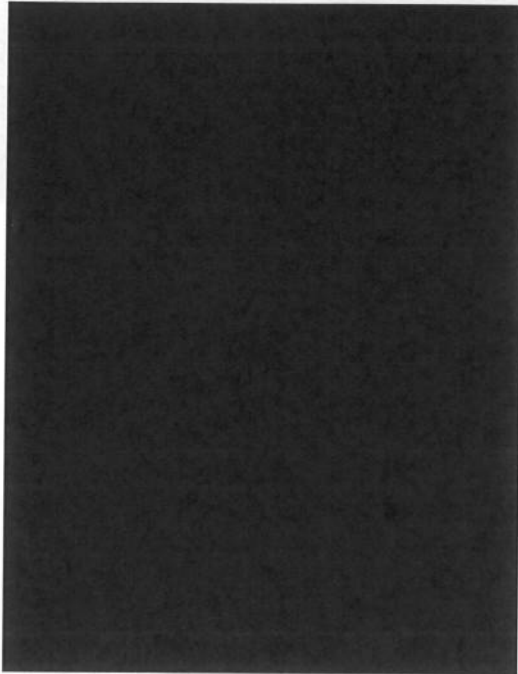
Clinical supervision is a specialised practice which requires extensive specialised training. Standards for supervision training programmes have been developed within the existing profession in Ireland over decades. Providing appropriate and adequate clinical supervision is a central pillar of the profession of psychotherapy, both during training and in post-training professional practice.

Qualified supervisors are the only people who carry the fitness to monitor and support the clinical development of the student and to provide reliable assessment of the student's fitness to practice.

Clinical supervision is critical to the learning process and to the continuing provision of a safe space for service users. Best practice requires that students in training attend a

minimum of one hour of clinical supervision for every four hours of clinical practice. This element of professional training must be included in the regulatory process as mandatory.

Submitted on behalf of





30/11/2023

To Whom it May Concern,

We are writing to you today in response to the proposed drafting of professional standards for proficiency for Child & Adolescent Psychotherapists in Ireland. Whilst [REDACTED] wholeheartedly welcomes the drafting of the professional standards, we feel strongly that the standards proposed are inadequate. We are concerned they will not protect potential clients and will lead to significant issues for and within the profession in the future.

[REDACTED] maintain a register of [REDACTED] who are qualified to EAP standards, and practice developmentally appropriate psychotherapy with children, adolescents, and significant adults in their lives. We promote the highest standards of training, ethical, and clinical practice.

[REDACTED] embraces that the CORU registration system will lead to the delivery of quality and accountability in the provision of Child Psychotherapy in Ireland.

The KEY issues we find problematic are as follows;

- Setting Level 8 (primary degree) instead of Level 9 as the base level of qualification required, may lead to low standards of proficiency as;
 - graduates of such programmes would not be eligible for registration with EAP in Europe and would not meet international criteria for practice.
 - this will greatly diminish entry requirements for prospective students and could mean that students may enter directly following their Leaving Certificate.
- No personal therapy requirement or clinical supervision being stipulated while undergoing training causes us grave concern.
 - This may result in some training programmes removing or reducing this requirement leading to poorly trained psychotherapists, who will lack the personal development training needed for competency and safe practice in the field.
 - It also means graduates will not meet the European standards and be eligible for EAP registration.



- Requiring all students to complete placements where there is an on-site psychotherapist (registered with CORU) to supervise them for 350 hours of 'service user contact'.
 - This will vastly reduce the number of suitable placement sites available.
- Requiring students to be 'directly observed' in 100 hours of 'service user contact' within the placement site while training poses significant difficulties for clients, placement sites, and students.

We truly hope you consider our concerns regarding the education and training of future psychotherapists. [REDACTED] would be happy to consult further with CORU on the concerns we have regarding the standards of proficiency as laid out in the draft proposal. [REDACTED] wish to ensure we are available to work towards maintaining the highest level of training and professional standards to all our members and the families we serve. We would be available for further consultation on these matters.

Yours Sincerely,

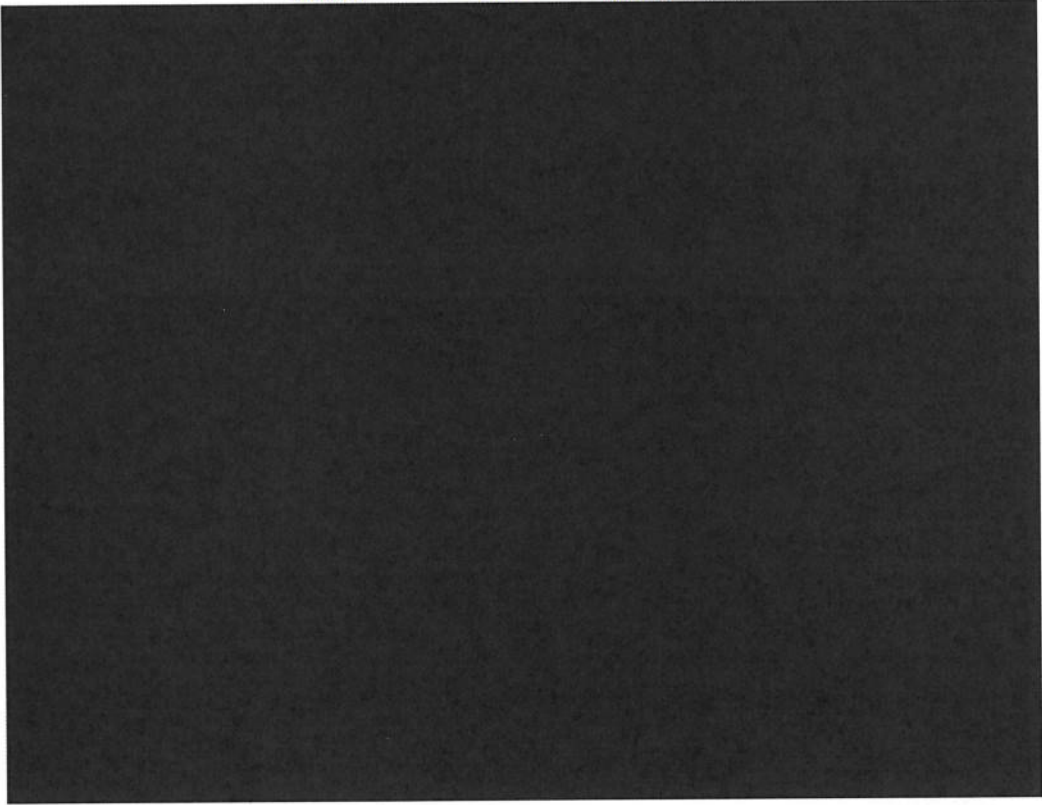
[REDACTED]

[REDACTED]

**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

Submitted on: 30th November 2023



Summary

In this submission, we lay out the key concerns of [REDACTED] 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.

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4. Conclusion

Appendix A: Comments and [REDACTED] Potential Revision to CORU Draft Proficiencies — Professional Knowledge and Skills

Appendix B: Identified Omissions and Proposed New Proficiencies

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

Appendix D: NFQ ‘Level 9 Indicators’ and the relevance of this to psychotherapy training as it is currently conducted on programmes recognised by [REDACTED]

1. Introduction

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

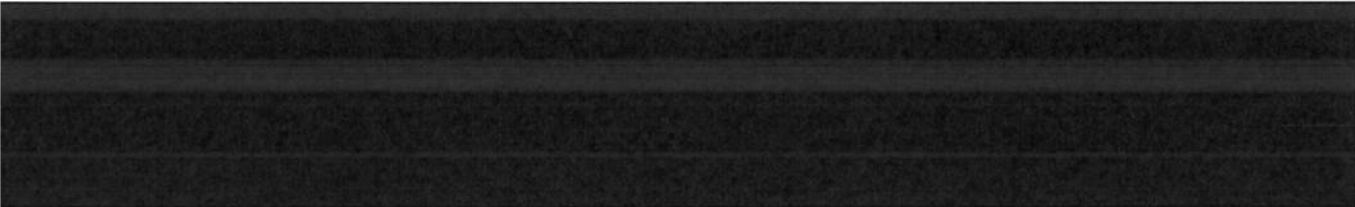
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[REDACTED]

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 [REDACTED] 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.

■ 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, ■ 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 ■

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

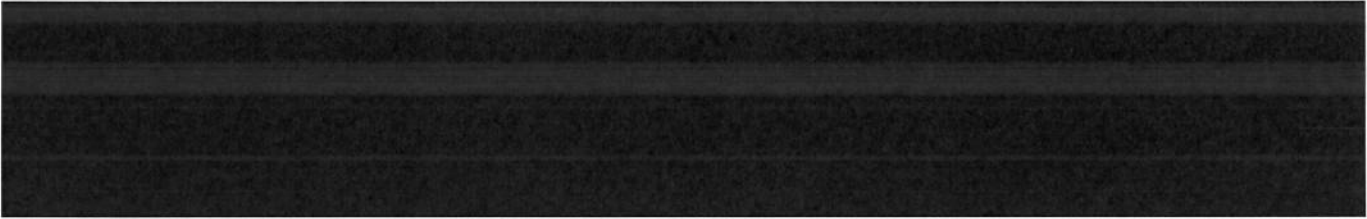
As for CORU, our most important concern in responding to these proposals for the regulation of psychotherapy as a profession relates to the safety of the public. We do not believe that the level and nature of training envisaged here would provide the kind of psychotherapy practice that we recognise as 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 [REDACTED] and [REDACTED] 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. [REDACTED] 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



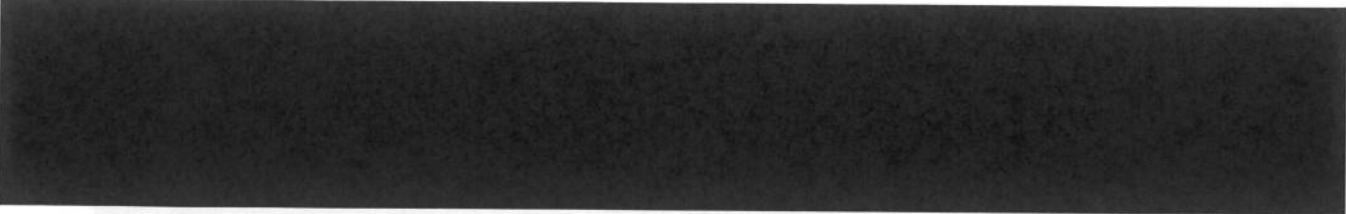
to psychotherapy – e.g., psychology, social studies, education – so that they have foundations in place for the advanced knowledge, skills and competence that are intrinsic to the practice of psychotherapy.

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



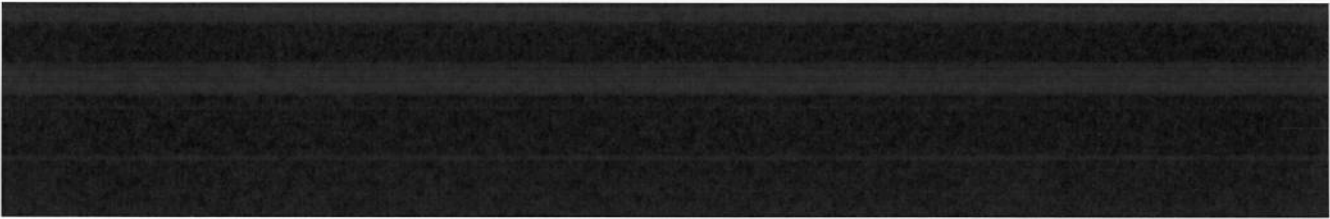
experience ensures that the trainee psychotherapist is alert to aspects of themselves, for example blind spots, defence mechanisms and attachment styles, when they are working with a client, in order for them to know how to provide a safe, professional, effective way of working with a client. It is this 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 ■■■ 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. ■■■ 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 ■■■ therefore proposes that the threshold level for entry to the register be set at level 9. See Appendix D.



2.8 Duration of Training

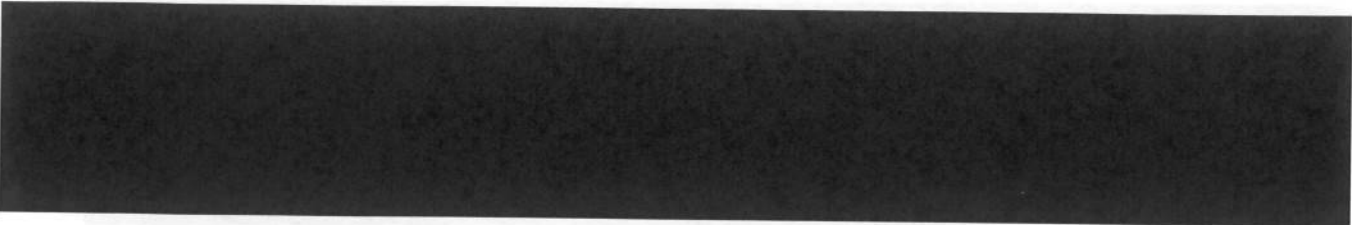
We are concerned that criteria in relation to the duration of training are omitted from the CORU drafts. We propose this might be addressed by a stipulation in regard to the duration of training as allowed for within Clause 25 of the Directive of the European Parliament and of the Council of 28th June 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,

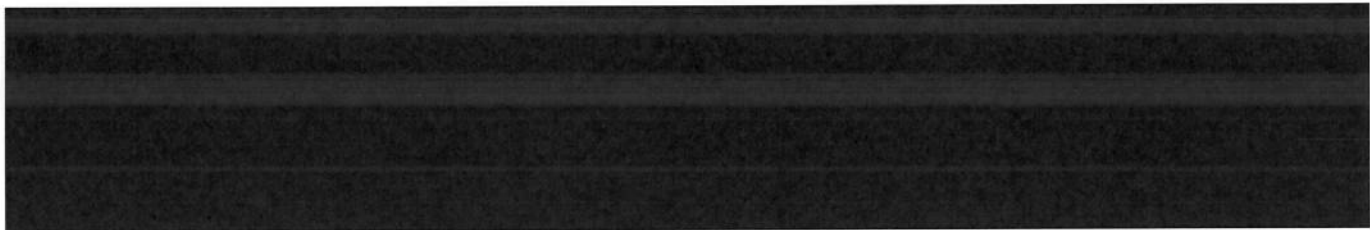


counsellors, psychiatrists, etc., and are self-employed. We believe that they should be able to complete clinical practice, under the eye of the practice education team – including the external clinical supervisor, within this setting.

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 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 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 [REDACTED] concerns in regard to duration of training, clinical supervision, level of qualification, and personal psychotherapeutic experience.

Currently, European requirements, which [REDACTED] 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 [REDACTED]-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

[REDACTED] 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.

[REDACTED]

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 [REDACTED] 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.

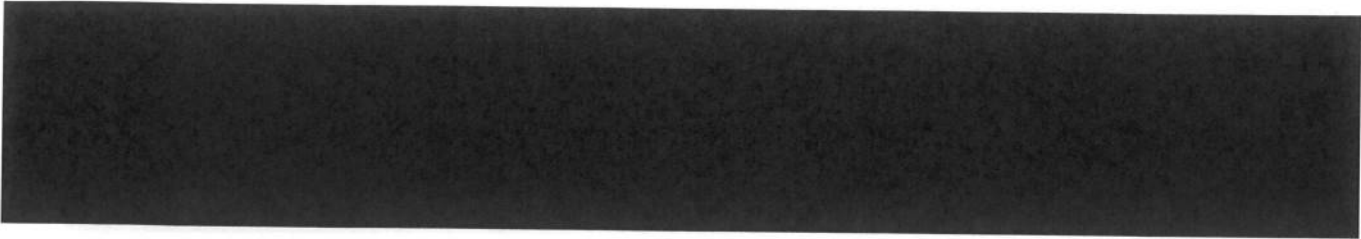
3.3 Recommendation 3: Criterion 2 — Practice Placements

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 [REDACTED] 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 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. 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	Comment
1.1 Q.56 - 57	The minimum level of qualification for entry to the register is Level 8 on the National	The ■ 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.
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(b) Criterion 2: Practice Placements

No	Current Proposed Wording	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.

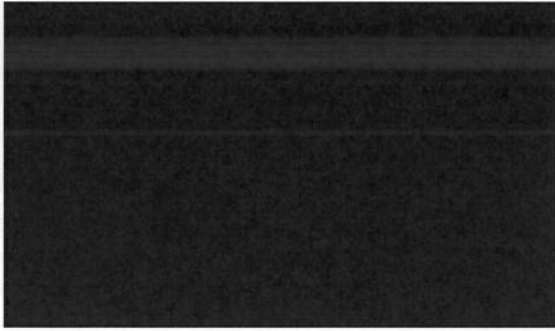
		4. Many placement sites are staffed by volunteers, and by staff who would not be able or willing to provide the intensive on-site 'supervision' that is envisaged. 5. The current proposals do not seem to recognise, or else totally disregard, the high quality of level 9 psychotherapy training that currently 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 assessment to 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 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 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.
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Appendix D: NFQ 'Level 9 Indicators' and the relevance of this to psychotherapy training as it currently conducted on programmes recognised by

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.

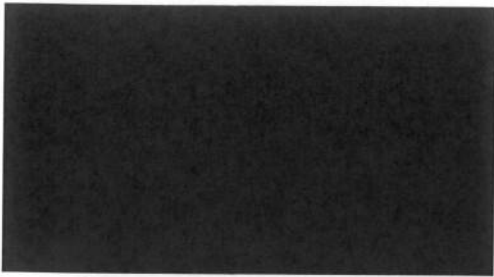


**Submission to CORU in response to the Public
Consultation on Standards of Proficiency and Criteria for
Education & Training Programmes for Psychotherapists**

Submitted via email to: strategyandpolicy@coru.ie

Submitted on: 1st December 2023





**response to the CORU
proposed Standards of Proficiency and Criteria for Education and
Training Programmes for Psychotherapists**

Introduction

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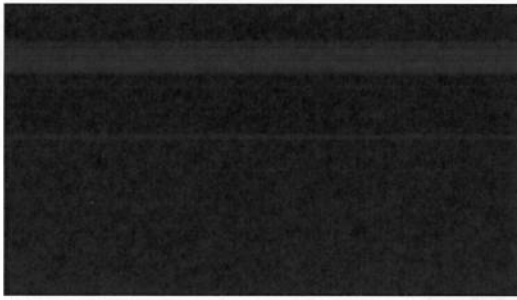
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Summary

Having given careful consideration to the proposed CORU standards, [REDACTED] recommends the following:

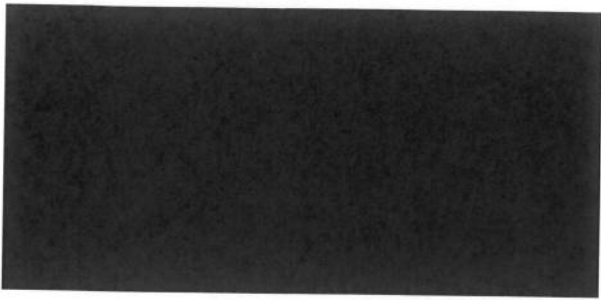
- 1) Key recommendation: Entry level into the profession should be maintained at Level 9 and not reduced to a Level 8.
- 2) The standards relating to observation in practice should be included as per the CORU proposal.
- 3) Supervisors must have modality-specific clinical supervision and training in order to adequately supervise trainees. They must be registered as a Supervisor with the accrediting body.
- 4) The requirement for personal therapy (Personal Psychotherapeutic Experience, also referred to as Personal Professional Development in the case of Systemic Psychotherapists) must be maintained as a core aspect of psychotherapy training.

Recommendations and Rationale

1) Entry level into the profession

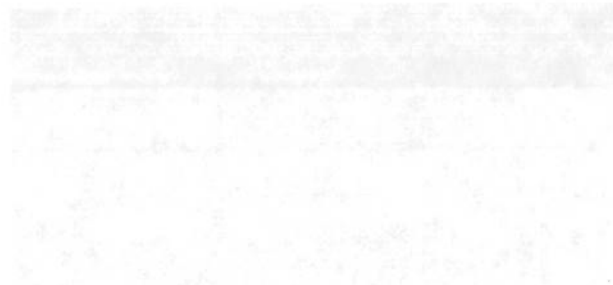
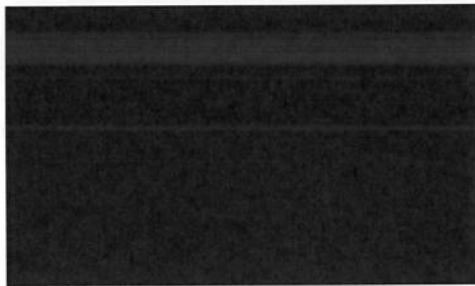
CORU have suggested that a Level 8 entry is sufficient. [REDACTED] is thoroughly opposed to this for the following reasons:

- In order to register as a psychotherapist a Level 9 qualification is a current requirement and it is essential that this remain in place.
- The European Association for Psychotherapy (EAP) definition of psychotherapy states that:
 - “The practice of psychotherapy is the comprehensive, conscious and planned treatment of psychosocial, psychosomatic and behavioural disturbances or states of suffering with scientific psychotherapeutic methods, through an interaction between one or more persons being treated, and one or more psychotherapists, with the aim of relieving

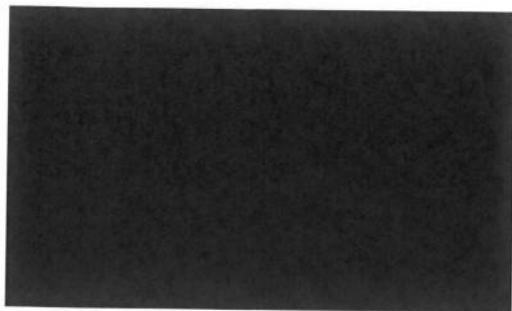


disturbing attitudes to change, and to promote the maturation, development and health of the treated person. It requires both a general and a specific training/education.

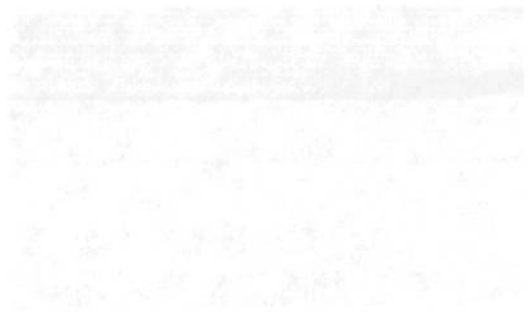
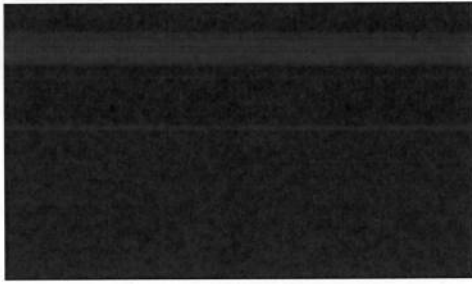
- The independent practice of psychotherapy consists of autonomous, responsible enactment of the capacities described in paragraph 1; independent of whether the activity is in free practice or institutional work: (see 1)” (2003, Appendix 1 to the Board Minutes).
- It is important that CORU understands and accepts that there is a distinct difference between the professions of Counsellor and Psychotherapist on this basis, and the entry level of qualification needs to reflect this by maintaining a Level 9 standard.
- Psychotherapy is a specialist discipline that involves extensive use of self in the therapeutic relationship and in active intervention with people in complex life situations, including chronic and severe mental health difficulties and significant trauma. We consider that, in order to afford those vulnerable adults, young people, children and families who engage in Psychotherapy the service they need, it is essential that their therapist has at least a Level 8 Human Sciences qualification (this is a broad field of training to encourage diverse entry) followed by advanced training at a Level 9 standard.
- The standard for psychotherapy qualification across the European Union is Level 9 for the above reason. It is important that Irish residents have the same level of protection and professional expertise as our European counterparts.



- It is also important that psychotherapists trained in Ireland have the freedom to travel and gain employment, afforded to all European citizens, by having their qualification recognised within the European Union.
- Of note, Social Workers, Occupational Therapists and other disciplines already registered with CORU have standards of proficiency and criteria for education that fall in line with European standards.
- Furthermore, [REDACTED]
[REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED]
[REDACTED] have a Memorandum of Understanding in place. This understanding recognises equivalency in the standard of training and requirements for initial and continued registration applied to the profession in each jurisdiction. This Memorandum of Understanding and agreed equivalency enables both organisations to hold a simplified, mutually agreed process by which members can hold dual registration. This dual registration process assists [REDACTED] [REDACTED] [REDACTED] Therapists to work cross border within Northern Ireland and the Republic of Ireland, as well as Great Britain. [REDACTED] standards are also in line with EAP standards. To jeopardise these standards, by failing to maintain a Level 9 entry requirement, would invalidate this Memorandum of Understanding and have a significant impact, in particular, on the livelihood of [REDACTED]
[REDACTED] Therapists working cross border.
- Ensuring that a Level 9 entry level remains in place is also imperative in maintaining the credibility and accountability of the profession, both at home and abroad, within the psychotherapy field and within other disciplines and multidisciplinary teams.



- Psychotherapy is a recognised profession with the depth of training at a Level 9 standard that provides the clinical capacity to treat and manage mental health and mental wellbeing. It is essential for public safety and accountability that the standard of training is maintained to ensure continued safe practice into the future.
- As previously mentioned, it is crucial for public safety that there is an understanding of the differences between the professions of Counsellor and Psychotherapist so that appropriate clinical support is accessed. This would be in line with the Slainte care right time right person etc. Maintaining a Level 9 qualification enables the public to understand the degree of professional training that is required in order to provide a quality and safe service to them.
- The public are aware of the importance of engaging with highly qualified professionals. Recent public reports and subsequent media coverage have alerted the public to the importance of such standards. [REDACTED] strongly supports public education in this regard as this ties in with public safety and service user involvement in decision making, and ensures that people are fully informed about the options for their own care. As a result, our members have experienced growing scrutiny of the level of their qualifications and comparison with that of other disciplines and professionals. Our Code of Ethics and Code of Professional Conduct and Practice are reviewed regularly to ensure best practice is maintained.
- CORU have set out fitness to practice processes for all registered professionals. Given the complexities of providing psychotherapy to vulnerable persons, it is imperative that graduates are prepared to meet the

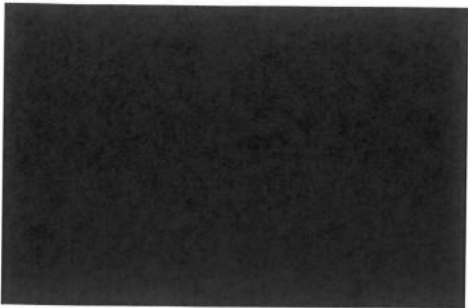


fitness to practice requirements by being trained to a very high standard. This can only be achieved if a Level 9 entry requirement is upheld.

- It should be noted that the pay scales for the grade of Family Therapist (3959) and Psychotherapist NCS (3028) both reflect Level 9 NFQ.
- CORU have advised that promoting diversity is the main reason behind the decision to reduce the standard of training to Level 8. While FTAI recognises and supports the need for diversity, we are adamant that this must be achieved through means that do not compromise the standard of training and increased risk to public safety. Of note, diversity among the student body is reflected within the training institutes through promotion of access programmes and diversifying pathways for progression. This adapted approach to education and training is already in place through recognition of prior learning processes within higher education institutes. This is currently being further adapted by the Irish Government by measures such as SUSI fee contributions and maintenance grants that are now available for postgraduate studies. [REDACTED] fully supports Government developments and initiatives to achieve policy objectives and welcomes higher education institutes now having a responsibility to compliment the initiatives of the Irish Government. This latter shows how diversity is increased among the profession without compromising standards.

2) Length of Training

- [REDACTED] is concerned that criteria in relation to the length of training are omitted from the CORU proposal. Currently, the length of training to achieve the award of [REDACTED] Psychotherapist is four years at postgraduate level. This span of time is necessary to allow for personal development, clinical



skills training and direct clinical work under observation by a clinical Supervisor.

3) Observation in Training:

- Direct observation is a longstanding aspect of [REDACTED] [REDACTED] [REDACTED] training. [REDACTED] welcomes this as an important learning outcome and accepts that observation of clinicians in training can take many forms.

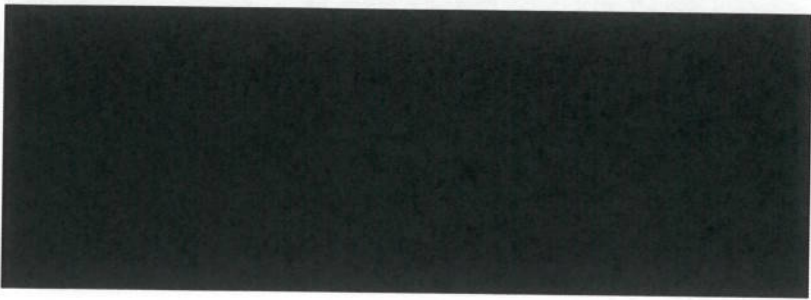
4) Supervision in Training:

- [REDACTED] holds firm to the opinion that Supervisors must have modality-specific clinical supervision training in order to adequately supervise trainees in assisting them to meet the professional and ethical standards of the profession. It is a requirement of [REDACTED] that Supervisors are registered with the accrediting body.
- [REDACTED] accepts that clinical governance is essential for trainees within the placement setting and agrees that having an on-site Supervisor/Manager is important in this regard. However, we consider that clinical governance/supervision and reflective supervision to be different, yet complementary, activities. We believe that it is possible to receive quality clinical supervision from a different discipline on placement, while accessing reflective modality-specific supervision from the training programme, without compromising clinical decision-making, student learning, and client safety. This is a model that is already in place for [REDACTED] [REDACTED] Therapists in training and has been very successful to date. This model has been implemented as structures are not currently in place in most institutions to allow for modality specific supervision to take place on-site.

5) Requirement for Personal Psychotherapeutic Experience (PPE), also referred to as Personal Professional Development (PPD):

- [REDACTED] Therapists in training are required to engage in PPE/PPD. PPE/PPD is a core pillar of [REDACTED] [REDACTED] Therapy and embedded in systemic psychotherapy training, both in Ireland and across Europe. The importance of self-awareness as a key aspect of psychotherapy practice cannot be stressed enough. PPE/PPD is undertaken within a group setting, as a Systemic approach to psychotherapy training, within each year of the four-year training. This pillar of training facilitates a deep engagement with the self of the therapist and the self in context throughout training. It is undertaken in order to enhance the maturity of self, reflective practice and self-awareness as a means of safeguarding ethical practice and protecting the therapeutic process. This essential element of systemic psychotherapy training, along with the other pillars of training leads to competent skilled professionals upon qualification.

Date:



1st December 2023

Dear Sir or Madam,

I am submitting this on behalf of the [redacted] who represent [redacted] nationally and are the national association for the European Association for [redacted] in Ireland.

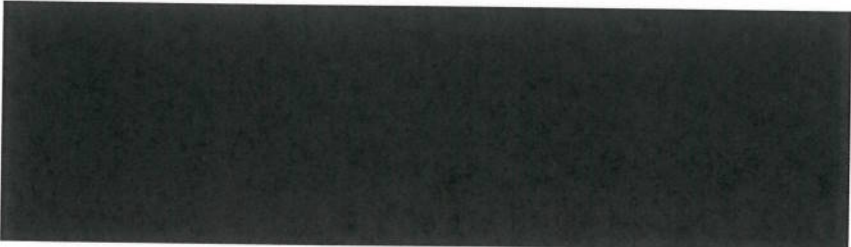
[redacted] Members are accredited to or registered in the following professional bodies as a psychotherapists:

The Irish Council for Psychotherapy (ICP).
The Irish Association for Body Psychotherapy (IABP).
The Irish Association for Counselling and Psychotherapy (IACP).
The Irish Association for Humanistic and Integrative Psychotherapy (IAHIP).
The European Association for Body Psychotherapy (EABP).
The European Association for Psychotherapy (EAP).

We are deeply concerned about the draft standards and criteria for Psychotherapists proposed by CORU, which we believe undermine both public safety and the profession of psychotherapy.

All of the above associations support the inclusion of requirements for personal psychotherapy and clinical psychotherapeutic supervision for trainee psychotherapists. Ireland would be the only country in the world to forego these requirements for trainees.

These requirements are approved by the European Association of Psychotherapy's (EAP) Europe-wide standards, which guarantee the integrity of the psychotherapy profession in Ireland. The EAP standards are supported by:

- the Irish Council for Psychotherapy (ICP)
 - the Irish Association for Humanistic and Integrative Psychotherapy (IAHIP)
 - the Irish Association for Body Psychotherapy (IABP)
- 



Similar standards are upheld by the Irish Association of Counselling and Psychotherapy (IACP).

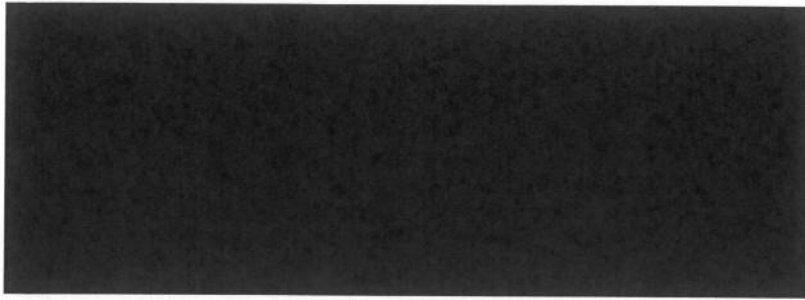
The EAP standard requires that Psychotherapists must meet the following criteria:

- They must have undergone a minimum of 250 hours of personal psychotherapy.
- They must have been supervised for a minimum of 150 hours by qualified psychotherapy supervisors during their training.
- They must have undergone seven years of training, ending in a postgraduate qualification (level 9 in Ireland).

However, under the current CORU proposals, Psychotherapists:

- Would not be required to participate in personal therapy as part of training.
- Their work with clients during training would not need to be supervised by an appropriately trained and qualified supervisor.
- They would only be required to only have a three or four-year primary degree. Personal participation in therapy would not be a required part of their training, nor would their training need to be supervised by a supervisor who is appropriately trained and qualified.

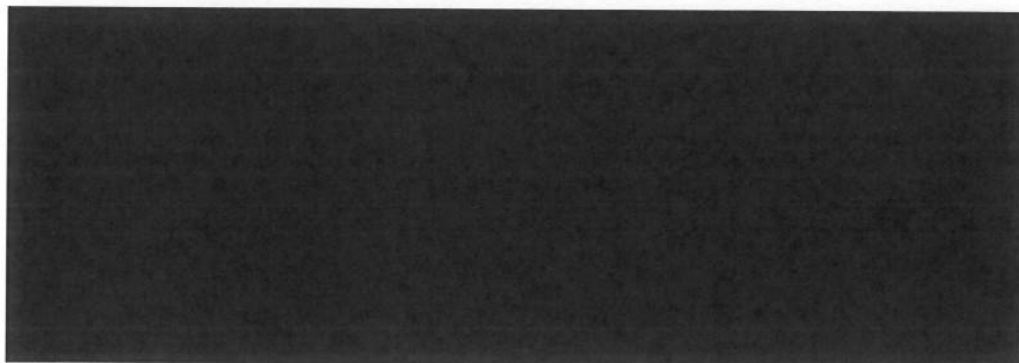




We believe that CORU's proposed standards go against the purpose of statutory regulation, and will:

- significantly diminish the value of psychotherapy training
- distort and undermine the practice of psychotherapy
- undermine the safety of the public
- undermine public trust in psychotherapy and psychotherapists as professionals,

Yours sincerely,

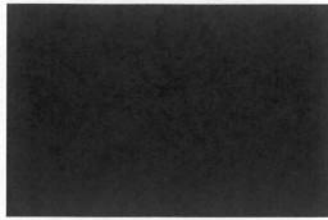


**Submission to the CORU Public
Consultation: Psychotherapists –**

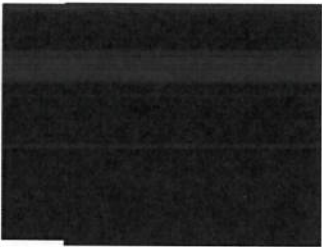
**Standards Of Proficiency And Criteria For
Education And Training Programmes For
Psychotherapists.**

From:

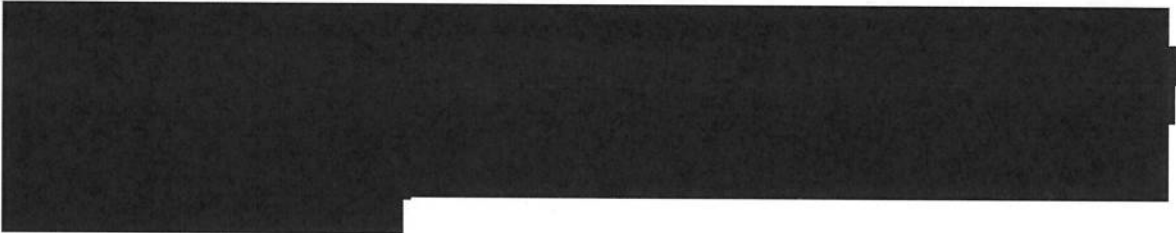
December 2023.



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Executive Summary	5
Explanation	6
Comments on Specific Points in the CPRB Draft Standards of Proficiency for psychotherapists	10
Comments on the Criteria for Education and Training Programmes for Psychotherapists	13
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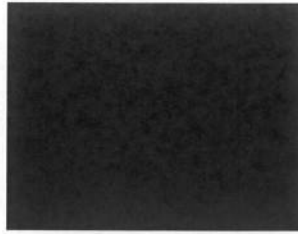
Introduction



 understand that the rationale for there being a specific State Register for a specific health and social care profession is that that specific profession, or form of professional practice is distinct and is not to be confused with other professional practices. There is a concern that the Standards of Proficiency include a number of points which expect the psychotherapist to practice forms of work that do not fall under the understanding of what psychotherapy is. It is a concern that practices of assessment, testing, gathering information and writing reports are being expected of a psychotherapist when these are the practices of a psychologist. There is a concern that the proposed Standards of Proficiency will lead to a State Register of practitioners with the title psychotherapist but who are practicing psychology. This will cause confusion and not be in the interests of the protecting the public. It is essential that the State Board for the Registration of the title Psychotherapist review the Standards of proficiency and redraft it in accordance with the principles and objectives of practices of psychotherapy. In general terms it is widely agreed that psychotherapy is process orientated rather than outcome-focussed. It invites those who enter the psychotherapy to engage in their own psychotherapeutic work and articulate in that work a sense of their lives that is more bearable and more conducive to living with their others. Psychotherapy does not set outcomes or judge outcomes apart from those who have engaged in their psychotherapy themselves *assessing* improvement. Psychotherapy occurs at a subjective level. This is its value.

 fully subscribe to CORU's purpose, namely the protection of the public. Not in any way incompatible with this purpose but alongside and supporting it is  purpose to deliver its clinical training in long-established modalities of psychotherapy in accordance with the rigorous principles of each modality.  is committed to protecting the specific modalities in psychotherapy in which it delivers training. This is an ethical position.

 believes that it is crucial to allow what is distinct and specific to the field of psychotherapy to be central to training so that psychotherapy can make its distinct, invaluable contribution to Irish society and culture. If what have been the core elements of psychotherapy training since the inception of these forms of work are not included clearly and emphatically in the CPRB Criteria for Education and Training Programmes in Psychotherapy documentation, there would be a CORU Register of Psychotherapists whose practice would not be recognised by the psychotherapy profession as psychotherapy.



It is crucial that the process of setting up and maintaining a State Register for the title psychotherapist communicates to the best of its ability the specific contribution psychotherapy can make to people's lives and Irish society and culture. Psychotherapy offers a different way into mental life and its disorders than that provided by the medical model - but one that can work alongside the medical. There is a challenge to have this *different* contribution recognised by some who work exclusively within the medical model and the clinical services model [where the dominant paradigms evaluate in terms of diagnoses and predictable outcomes]. This is a valid model but not the only one. Mental life is, arguably, more elusive and unpredictable than processes in the physical domain. Mental life needs to be approached in different ways. Psychotherapy as a field has established forms of practice to allow access to mental phenomena - both normal and pathological. Psychotherapy as a field provides practice positions which invite work on mental phenomena by the person availing of the service.

In the interest of protecting the public through clarity regarding different practice positions of professions whose titles are prefixed with psych- and in the interest of inclusivity and tolerance of long established forms of psychotherapy practice whose value is in their different practice position to other 'psych'-practice positions and objectives, we request you consider our points and observations below. Our real concern is that some current content in the draft documents for Standards of Proficiency and Criteria for Education and Training Programmes could be interpreted in such a way as to require Psychotherapy Education and Training programmes to educate and train their students as psychologists and not as psychotherapists leading to there being a State register of psychotherapists who are practising psychology and not practising psychotherapy.

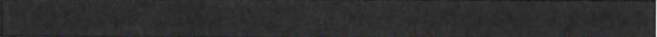
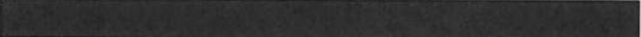
[REDACTED] request an inclusive approach to standards and criteria and not a set that excludes established modalities of psychotherapy.

In what follows the key points that we believe require urgent attention are set out but first we offer an Executive Summary of points we believe essential for CORU to review and revise in consultation with Psychotherapy Professional Bodies and with Psychotherapy Training Institutes.

This submission by the [REDACTED] has been supported by a number of consultant psychiatrists and general practitioners including, [REDACTED]

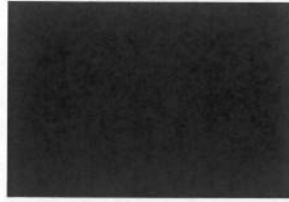


Executive Summary

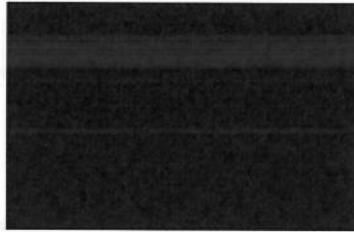
1. It is essential to include as the *sine qua non* of psychotherapy training and practice the requirement that trainees engage in their own psychotherapy, psychoanalysis or psychotherapy processes.
2. In-room supervisory observation / psychotherapy session recording would have a very detrimental impact on the transference and its handling for a significant sector of psychotherapy training, particularly those developed within the widely followed psychoanalytic and the humanistic-integrative traditions. It is essential to review and ~~the~~ the proposal for in-room supervisory observation / psychotherapy session recording [CPRB Criteria for Education and Training Programmes in Psychotherapy Draft Document, Criterion 2.2.
3. Review and revise proposal for psychotherapy training to be delivered as a level 8 qualification [CPRB Criteria for Education and Training Programmes in Psychotherapy Draft Document, Criterion 1.1]. For reasons indicated below, training qualifications culminating in State recognition under the title psychotherapist needs to be awarded at a minimum of level 9 for it to align with other jurisdictions in Europe and with our own QQI Awards Standards. If there currently are programmes delivered at Level 8, they should be given a timeframe to bring the programme up to Level 9 rather than have Level 9 programmes lowered to Level 8. This is in the interest of the profession so that it can make an effective and valuable contribution to Irish society and culture in relation to mental distress and difficulty. It is also crucially in the interests of the protection of the public – both those attending psychotherapy and the practitioners themselves.
4.  propose a distinction between a Placement Manager and Modality Specific Clinical Supervision of Practice. It may be possible for both to be held by the one person, but the majority of placements are not set up for this. Therefore, there needs to be an expectation that for the foreseeable future the roles of Placement Manager and Modality Specific Clinical Supervisor of Practice would be held by distinct professionals and the clinical supervision may not take place on the clinical site. We recommend that a period of time be designated to allow the relationship between the placement manager and the modality specific clinical supervisor to develop.
5. The CPRB Standards of Proficiencies document should also include as essential the ability on the part of the psychotherapist to articulate the principles of their practice based on texts that ground and found the modality – for example, a psychotherapist should have shown the ability to articulate in writing the concept of the unconscious, or of the person, or of the group, or of the family system.
6.  request that CORU, as a matter of necessity and urgency set up formal lines of contact with the principal stakeholders in the training of psychotherapists, namely the training institutes, alongside the input from the professional bodies.

Explanation:

1. It is essential to include as the *sine qua non* of psychotherapy training and practice the



requirement that trainees engage in their own psychotherapy, psychoanalysis or psychotherapy processes. This should be expected to be extensive over years. This must be

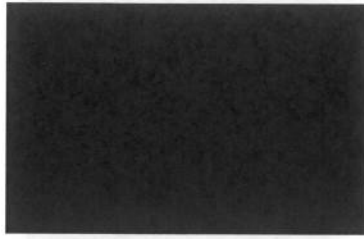


clearly represented as one of the essential cornerstones of psychotherapy training. One's own psychotherapy, psychoanalysis or psychotherapy process is what forms the practitioner. Without it a practitioner cannot access the practice position of a psychotherapist – even if that title is appropriated to describe what is not psychotherapy. Criteria for Education and Training which exclude explicit and emphatic mention of the requirement that trainees engage in their own psychotherapy, psychoanalysis or psychotherapy processes would result in the public not being fully protected and the field of psychotherapy being fundamentally misrepresented. It should be expected that a practitioner continues in their own psychotherapy, psychoanalysis or psychotherapy processes indefinitely through the lifespan of their practice. This fundamental requirement arises from the fact that the work of psychotherapy involves the person (or, subjectivity) of the practitioner in ways that are not immediately present to the practitioner's conscious reflection. Without one's own psychotherapy, psychoanalysis or psychotherapy processes, the practice position required for psychotherapy practice cannot be reached or maintained. Without one's own psychotherapy, psychoanalysis or psychotherapy processes named explicitly as a standard and as a criterion – the fundamental criterion – the practice being regulated will not be the practice of psychotherapy. This is not in the interests of protecting the public and it would terminate major forms of work that have for many decades been described under the term psychotherapy. Without this requirement, there would be a CORU Register of Psychotherapists whose practice would not be recognised by the profession as psychotherapy.

2. **It is essential to review and revise proposal for in-room supervisory observation / psychotherapy session recording [CPRB Criteria for Education and Training Programmes in Psychotherapy Draft Document, Criterion 2.2.]** This proposal is fundamentally at odds with the principles and ethics of practice in the major modalities of psychotherapy which have developed under the descriptors psychoanalytic, psychodynamic, humanistic-integrative. We request recognition of modality specific methods of supervision – methods that are themselves extensive and comprehensive. These long-standing methods have provided over many decades, robust assurance of a trainee's fitness to practice and protection of the public while at the same time following the ethics and principles of the specific modality of psychotherapy.

In-room supervisory observation / psychotherapy session recording would have a very detrimental impact on the transference and its handling for a significant sector of psychotherapy training, particularly those developed within the widely followed psychoanalytic and the humanistic-integrative traditions. The handling of the transference is fundamental for these major modalities of psychotherapeutic work. In-room supervisory observation / psychotherapy session recording is, therefore, not possible for these trainings in one-to-one psychoanalytic and humanistic-integrative psychotherapy. Central to training in these major modalities are the following components:

- Regular (often weekly or at least fortnightly) one-to-one clinical supervision with an experienced practitioner who is a recognised supervisor of practice.
- Regular (often weekly or at most fortnightly) small-group clinical supervision with an experienced practitioner who is a recognised supervisor of practice.

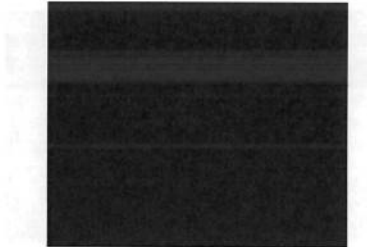


- Engagement by the trainees in their own psychotherapy / psychoanalysis. In these modalities engagement in one's own psychotherapy / psychoanalysis involves attending at least once a week and more than once a week for psychoanalysis. We will return to this fundamental component of training in point 2 below.

Our [redacted] include a [redacted] [redacted]. This modality of work has developed over decades a robust, effective method of Live Supervision. This is the practice of supervision live during the systemic psychotherapy sessions. There is also a method of retrospective supervision for the final two years of training. This can involve recording of sessions which are then brought to discussion in retrospective supervision. It is crucial to point out that this systemic approach to supervision is congruent with the principles of systemic practice. The Systemic approach to supervision is different from the proposed supervision observation but is important to note as it shows that across our programmes we have different methods of supervision in accordance with the different principles of the specific modality psychotherapy in which a training is being delivered.

Our [redacted] include a training in Group Analytic Psychotherapy. This training is block-delivered over nine weekends a year and takes seven years to complete. In accordance with the principles of Group Analysis, the clinical supervision for this training is delivered in small group format. When a trainee has set up and is running their own group each trainee attends 27 small group supervision sessions per year. It is crucial to point out that this group analytic approach to supervision is congruent with the principles of Group Analysis. The Group Analytic approach to supervision is different from the proposed supervision observation. It would undermine the approach to supervision and the understanding of the group dynamics at work to introduce an observer into this work. Again, it is important to note that across our programmes, we have different methods of supervision in accordance with the different principles of the specific modality psychotherapy in which a training is being delivered.

Decades of experience in using these modes of supervision specific to the principles of the modality of psychotherapy shows very robust and appropriate mechanisms for supervision. A trainee attends for supervision at a scheduled time and speaks back over a session. There is research evidence available by request to support these claims. The supervisor can question the source and the motivation of the trainee's interventions. Should a problem arise for the supervisee it is possible to contact the individual supervisor for direction. The individual supervisor is employed by the training programme and submits a report on the trainee in supervision. The small-group supervisor is on faculty in the training programme. She / he also submits a report on the trainees' practice and engagement in supervision. The small-group supervisors meet regularly to discuss any issues arising for the supervisees. Our programmes have mechanisms to require a trainee supervisee to withdraw permanently or step-off a programme for a period of time to address personal and professional issues, if there work in their training becomes inappropriate if their work becomes inappropriate. Therefore, we argue very strongly that there are in place, and have been for decades, methods for the conduct of supervision that follow from the principles of the specific modality of psychotherapy. In-room supervisory observation / psychotherapy session recording is fundamentally at odds with these principles and would terminate the delivery of training in



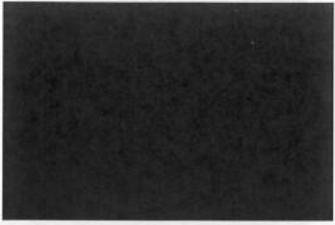
these modalities of psychotherapy. This would result in the psychotherapy profession in Ireland excluding major forms of psychotherapy.

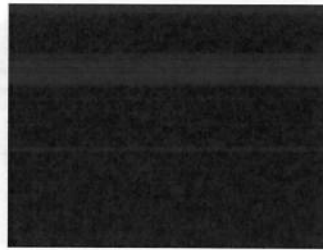
We request recognition of modality specific methods of supervision, which are themselves extensive and comprehensive. These long-standing methods have provided over many decades, robust assurance of a trainee's fitness to practice and suitability for qualification awarded by the training institute. **It is essential to review and revise proposal for psychotherapy training to be delivered as a level 8 qualification CPRB Criteria for Education and Training Programmes in Psychotherapy Draft Document, Criterion 1.1:** As communicated above in Point 1, psychotherapy training must require that trainees engage in their own psychotherapy, psychoanalysis or psychotherapy processes. It is the cornerstone of training and formation as a psychotherapist. This is because the 'person', or subjectivity, of the practitioner is a fundamental element in the work of psychotherapy. A practitioner must also be competent in managing their part in the work. This requires time and the maturity and confidence to hold a position. *QQI Awards Standards – Counselling and Psychotherapy 2014* recognised this *to some extent* but failed to give it the prominence and clarity it requires. That document wrote of 'self' and 'self-knowledge' without clearly acknowledging that the reason there are practices of psychotherapy is because self-knowledge is not easily reached and is, arguably, never reliable. In other words, the document failed to address the complexity and fragility of a concept such as 'self'. Nonetheless, notwithstanding this criticism, that document recognises that *"Counselling and psychotherapy practice require the development and demonstration of a suitable level of self-knowledge. This may be achieved through personal psychotherapeutic experience (or equivalent learning). The QQI Awards Standards do not prescribe the volume or kind of learning opportunities. Professional bodies can be expected to be more prescriptive."* [QQI Awards Standards – Counselling and Psychotherapy 2014] <https://www.qqi.ie/sites/default/files/2021-12/counselling-and-psychotherapy-qqi-award-standards-2014.pdf>

The documents produced by State Agencies such as QQI and CORU, tasked with the regulation of the field, particularly in its education and training practices need to engage with the language, principles and concepts of the major modalities of psychotherapy in order to effectively represent and regulate them so that they can make their own specific, invaluable contribution to Irish society and culture in a way that is, in its turn, effective and safe. By so doing it will be very evident that the field requires training at a minimum of level 9 to meet any kind of State recognition.

The same QQI document, following the established terminology that distinguishes Level 8 and Level 9 qualifications in terms of expected levels of Knowledge, Skill and Competence, uses the following words for Level 8: awareness, knowledge, understanding. These contrast with the terms used for Level 9: systemic understanding, critical awareness, critical understanding. Given the representation of what is required in a practitioner of psychotherapy here and in submissions from the Irish Council for Psychotherapy (ICP), we believe the learning outcomes must be described in the later terms, that is, the terms that describe level 9 professional qualifications. We also endorse the ICP point that setting the qualification at Level 8 would put us out of kilter with the regulation of psychotherapy across Europe where it is a Level 9 qualification.¹

¹ Austria may be an exception here where the Level 8 is a five-year qualification.

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3. **Placement settings.** [REDACTED] is committed to the vision of there being access to psychotherapy delivered by qualified psychotherapists in the Public Mental Health and Primary Care services. We also expect and encourage the on-going growth of psychotherapy uptake with practitioners in private practice. It is to be expected that psychotherapy training programmes will develop their arrangements for trainee placement with appropriate sites in both the public and private contexts. We propose a distinction between a Placement Supervision and Modality Specific Clinical Supervision of Practice. This distinction is already long in place across our training programmes. The Placement Supervisor is an employee / manager in a service. They are not necessarily trained themselves in psychotherapy but are expected to have some appreciation of it. They oversee the trainee in terms of the trainee working within the protocols of the placement setting as well as supporting the trainee in their day-to-day engagement with the clinical site. They do not provide clinical supervision. This is provided by an experienced practitioner recognised as a supervisor of clinical practice. This modality specific supervision works with the actual content and the direction of the practice of the trainee. The modality specific clinical supervision takes place in the office of the supervisor, to which the trainee travels; or, in the mode of small-group, in the training institute. Neither need take place in the clinical site. The Training Institute maintain contact with the Placement Supervisor and the Clinical Supervisors. There are mechanisms in place to allow communication between these different roles, should a situation arise that requires such. We believe that this form of arrangement and these precisely defined roles should be the model for supervision arrangements set out in the CPRB Criteria for Education and Training Document. There is not yet a system of practice tutors in place for psychotherapy. This would be a very welcome development and enhance the role of the Placement Supervisor where that person has their own training in psychotherapy. It does not remove the requirement for there to be specific modality clinical supervision provided by a recognised clinical supervisor involved in this core component of training.
4. The CPRB Standards of Proficiencies document should also include as essential the ability on the part of the psychotherapist to articulate the principles of their practice based on the texts that ground and found the modality – for example, a psychotherapist should have shown the ability to articulate in writing the concept of the unconscious, or of the person, or of the group, or of the family system, etc.. Articulation of one's practice and one's relation to one's practice should not have recourse to generalisations such as 'experience', 'feeling' or 'intuition'. The field needs more rigour than these words provide. This point is in line with the ICP request that the CPRB Standards of Proficiency and the CPRB Criteria for Education and Training contain the language, principles and concepts of the modalities of psychotherapy to properly represent them and ensure safe practice.
5. [REDACTED] request that CORU, as a matter of necessity and urgency set up formal lines of contact with principal stakeholders in the training of psychotherapists, namely the training institutes. This input would then be provided alongside the input from the professional bodies. There should be specific lines of communication between CORU and the entities it will be visiting to accredit training programmes. Such contact would provide CORU with access to the structures and content of current programmes. It would thereby contribute to providing field-specific vocabulary to the process from where it already exists in the representation of modalities of psychotherapy within



higher education structures and governance. This already existing regulatory framework for education and training in psychotherapy is the most appropriate source of guidance for setting up the health and social care regulatory structure and content.

Comments on Specific Points in the CPRB Draft Standards of Proficiency for psychotherapists

Page 11: Safety and Quality: points 1 – 6: these practices are not those of a psychotherapist. The value of psychotherapy is that it does not assess, test, gather information. These tasks are already carried out by other professions such as psychology, psychiatry and social work. **Point 7:** Psychotherapy practice can prioritise safety of service users and those involved in their care through supervision of practice.

Point 8: Psychotherapy is not a practice based on recognized performance/outcome measures. Again these are terms appropriate to other practices positions and would interfere with the psychotherapy work which brings the person/ people in psychotherapy to greater articulation of their lives in speech.

Page 13: Professional Development:

We support Points 1 – 5 as essential. As argued above it is a fundamental requirement that a psychotherapist be expected to articulate in speech and writing their practice. Point 6 would apply to employment contexts but not to private / sole-trader practice where much psychotherapy takes place.

We argue that the requirement for a Psychotherapist to engage in their own extensive psychotherapy should be included in this list of points under professional Development.

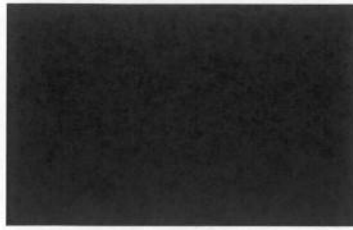
Page 14: Professional Knowledge and Skills

Point 2 runs the risk of being interpreted as a curriculum list. There is no requirement for a psychotherapist to have a critical understanding of relevant biological sciences. Human development is a theoretical construct in psychology and psychotherapy and not a universal basis of psychotherapeutic practice. We do argue that psychotherapists should have an awareness of the paradigms currently dominating responses to mental disorder such as the practice of psychiatry.

Point 19: report writing runs contrary to the ethics of major modalities of psychotherapy. Psychological report writing is a skill in the practice of psychology.

Point 24: here the document articulates a skill very specific to psychotherapy. It needs to be added to this list of points that reflect on unconscious dynamics requires the practitioner to be experiencing an extensive engagement in their own psychotherapy.

Point 27: It should be left to a practitioner to decide if the work can be carried out virtually using technology. This cannot be set down prescriptively. It will depend on the practitioner's relation to their practice and on the appropriateness of using phone or online arrangement with a specific service user. **We argue that the requirement for a Psychotherapist to engage in their own extensive psychotherapy should be included in this list of points under professional Development.**



Comments

Page 8: Professional Autonomy and Accountability.

Point 17: Here is an opportunity to add the requirement that a graduate “recognise personal responsibility and professional accountability for one’s actions and be able to justify professional decisions made *drawing on their own extensive experience of their own psychotherapy, psychoanalysis or psychotherapy processes* (italics added). This point could also be added to point 20: *Using their own extensive experience of their own psychotherapy, psychoanalysis or psychotherapy processes* to be aware of and take responsibility for managing their own mental health and wellbeing.

Page 9. Communication, collaborative practice and teamworking.

Point 1: Many of the major forms of psychotherapy do not diagnose and do not assess in terms of the diagnostic formulations of mental health and psychiatric practice. This is what makes psychotherapy distinct and valuable. It offers another way of working with difficult mental phenomena. We can understand assessment in terms of psychotherapy by clarifying that the assessment is of suitability for psychotherapy or assessment of indications of potential to engage in the work of psychotherapy.

Point 3: This is an important point reflecting the way in which psychotherapy is an invitation to a person or people to enter into the work of psychotherapy.

Page 11: Safety and Quality

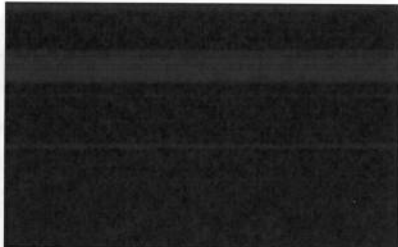
Point 2: Assessment needs to be understood as represented above: we can understand assessment in terms of psychotherapy by clarifying that the assessment is of suitability for psychotherapy or assessment of indications of potential to engage in the work of psychotherapy.

Point 4: psychotherapists do not evaluate information collected in the assessment process unless this is a reference to clinical supervision albeit couched in language alien to psychotherapy processes and therefore open to misunderstanding as a practice of psychology.

Point 5: Some forms of psychotherapy proceed in terms of determining problem lists, action plans and goals but many of the major forms of work described as psychotherapy do not. It is important that this Standards of Proficiency document tolerates these major forms of psychotherapy that are very distinct from psychology practices. [REDACTED]

[REDACTED] respects the practice of psychology but again underlines its understanding that the State Register under discussion here is for the title psychotherapist and an important function of having psychotherapist as distinct title is to assist the public in discerning the difference between the practice of the psychotherapist and the practice of the psychologist. What is to be highlighted and welcomed in this point is the expectation that graduates “demonstrate sound logical reasoning”.

Point 6: The language is not from the psychotherapy field but can be interpreted as follows: “Be able to articulate the basis of their interventions, engage the service-user in the work and draw on knowledge, skills and the principles of the modality of psychotherapy being practised in order to make professional interventions.



Point 9: [REDACTED] support the application of empirical evidence-seeking methodology to the study of psychotherapy practices but also recognises the limitations of that methodology in practises where the ‘evidence’ the material of the work is non-replicable or measurable. Its value is in its elusive status. The testing of it is through a practitioner’s interrogation of their understanding and interventions using supervision arrangements and their own extensive psychotherapy or psychoanalysis or psychotherapy processes. This latter essential component of training and practice provides a forum for the rigorous interrogation of the practitioners’ own relation to their practice and what they wish to get out of it.

Point 11: A psychotherapist needs to understand the principles of quality assurance and quality improvement in terms of the practice and principles of psychotherapy and using the mechanisms of psychotherapy – personal psychotherapy, psychoanalysis or psychotherapy processes primarily, along with supervision to maintain the standards expected by the specific modality of psychotherapy.

Page 14: Professional knowledge and skills

Point 13: Some forms of psychotherapy expect the psychotherapist to “to demonstrate an understanding of their feelings and emotions and communicate that understanding in a non-judgemental manner.” Other major forms of psychotherapy work to not do this and allow the person engaged in the work of psychotherapy to articulate in their own terms their singular sense of their lives. Communicating understanding of feelings can undermine a therapeutic relation.

Point 21: some forms of psychotherapy involve recognition of “personal emotional responses, vicarious trauma and the need to develop effective self-care strategies and burnout prevention.” Major forms of psychotherapy do not intervene in this directive way, and that is their value and the basis of a person engaging in the work.

Comments on the Criteria for Education and Training Programmes for Psychotherapists

Criterion 1: Level of qualifications for entry to the register

As above we object to Level 8 as minimum level of qualification for entry to the register.

Criterion 2: Practice Placements

As above we reject the criteria of 100 hours of directly observed user contact.

Criterion 5

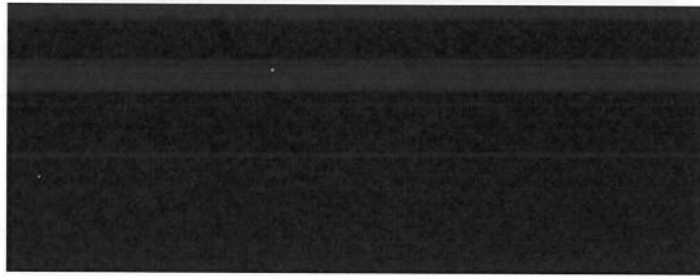
5.2: The curriculum must be guided by evidence-informed professional knowledge, relevant to current practice and the philosophy and core values associated with the profession with evidence of input from all relevant stakeholders including service users and employers.

**Submission to the CORU Public
Consultation: Psychotherapists –**

**Standards Of Proficiency And Criteria For
Education And Training Programmes For
Psychotherapists.**

From:

December 2023.



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[REDACTED]

[REDACTED]

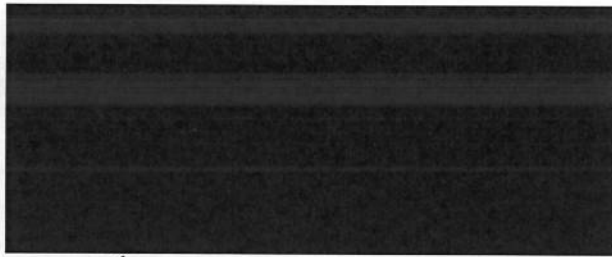
[REDACTED]

Not in any way incompatible with this purpose but alongside and supporting it is [REDACTED] purpose to deliver its clinical training in long-established modalities of psychotherapy in accordance with the rigorous principles of each modality. [REDACTED] is committed to protecting the specific modalities in psychotherapy in which it delivers training. This is an ethical position.

We believe it is essential that a State Board regulating a specific profession makes sure that its Standards of Proficiency and Criteria for Education and Training programmes relate very specifically to the specific profession and not to another one.

[REDACTED] understand that the rationale for there being a specific State Register for a specific health and social care profession is that that specific profession, or form of professional practice is distinct and is not to be confused with other professional practices. There is a concern that the Standards of Proficiency include a number of points which expect the psychotherapist to practice forms of work that do not fall under the understanding of what psychotherapy is. It is a concern that practices of assessment, testing, gathering information and writing reports are being expected of a psychotherapist when these are the practices of a psychologist. There is a concern that the proposed Standards of Proficiency will lead to a State Register of practitioners with the title psychotherapist but who are practicing psychology. This will cause confusion and not be in the interests of the protecting the public. It is essential that the State Board for the Registration of the title Psychotherapist review the Standards of proficiency and redraft it in accordance with the principles and objectives of practices of psychotherapy. In general terms it is widely agreed that psychotherapy is process orientated rather than outcome-focussed. It invites those who enter the psychotherapy to engage in their own psychotherapeutic work and articulate in that work a sense of their lives that is more bearable and more conducive to living with their others. Psychotherapy does not set outcomes or judge outcomes apart from those who have engaged in their psychotherapy themselves assessing improvement. Psychotherapy occurs at a subjective level. This is its value.

[REDACTED] believes that it is crucial to allow what is distinct and specific to the field of psychotherapy to be central to training so that psychotherapy can make its distinct, invaluable contribution to Irish society and culture. If what have been the core elements of psychotherapy training since the inception of these forms of work are not included clearly and emphatically in the CPRB Criteria for Education and Training Programmes in Psychotherapy documentation, there would be a CORU Register of



Psychotherapists whose practice would not be recognised by the psychotherapy profession as psychotherapy.

It is crucial that the process of setting up and maintaining a State Register for the title psychotherapist communicates to the best of its ability the specific contribution psychotherapy can make to people's lives and Irish society and culture. Psychotherapy offers a different way into mental life and its disorders than that provided by the medical model - but one that can work alongside the medical. There is a challenge to have this *different* contribution recognised by some who work exclusively within the medical model and the clinical services model [where the dominant paradigms evaluate in terms of diagnoses and predictable outcomes]. This is a valid model but not the only one. Mental life is, arguably, more elusive and unpredictable than processes in the physical domain. Mental life needs to be approached in different ways. Psychotherapy as a field has established forms of practice to allow access to mental phenomena - both normal and pathological. Psychotherapy as a field provides practice positions which invite work on mental phenomena by the person availing of the service.

In the interest of protecting the public through clarity regarding different practice positions of professions whose titles are prefixed with psych- and in the interest of inclusivity and tolerance of long established forms of psychotherapy practice whose value is in their different practice position to other 'psych-' practice positions and objectives, we request you consider our points and observations below. Our real concern is that some current content in the draft documents for Standards of Proficiency and Criteria for Education and Training Programmes could be interpreted in such a way as to require Psychotherapy Education and Training programmes to educate and train their students as psychologists and not as psychotherapists leading to there being a State register of psychotherapists who are practising psychology and not practising psychotherapy.

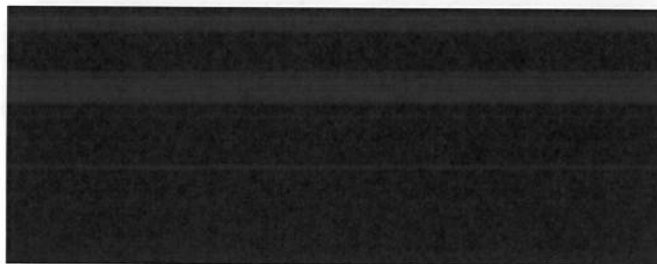
■ request an inclusive approach to Standards and Criteria and not a set that excludes established modalities of psychotherapy.

In what follows the key points that we believe require urgent attention are set out but first we offer an Executive Summary of points we believe essential for CORU to review and revise in consultation with Psychotherapy Professional Bodies and with Psychotherapy Training Institutes.



Executive Summary

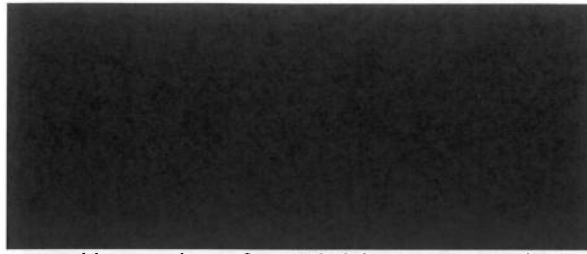
1. It is essential to include as the *sine qua non* of psychotherapy training and practice the requirement that trainees engage in their own psychotherapy, psychoanalysis or psychotherapy processes.
2. In-room supervisory observation / psychotherapy session recording would have a very detrimental impact on the transference and its handling for a significant sector of psychotherapy training, particularly those developed within the widely followed psychoanalytic and the humanistic-integrative traditions. It is essential to review and reject the proposal for in-room supervisory observation / psychotherapy session recording [CPRB Criteria for Education and Training Programmes in Psychotherapy Draft Document, Criterion 2.2].
3. Review and revise proposal for psychotherapy training to be delivered as a level 8 qualification [CPRB Criteria for Education and Training Programmes in Psychotherapy Draft Document, Criterion 1.1]. For reasons indicated below, training qualifications culminating in State recognition under the title psychotherapist needs to be awarded at a minimum of level 9 for it to align with other jurisdictions in Europe and with our own NFQ / QQI Awards Standards. If there currently are programmes delivered at Level 8, they should be given a timeframe to bring the programme up to Level 9 rather than have Level 9 programmes lowered to Level 8. This is in the interest of the profession so that it can make an effective and valuable contribution to Irish society and culture in relation to mental distress and difficulty. It is also crucially in the interests of the protection of the public – both those attending psychotherapy and the practitioners themselves.
4. [Redacted] propose a distinction between a Placement Manager (who supervises a trainee's professional conduct) and Modality Specific Clinical Supervision of Practice. It may be possible for both roles to be held by the one person, but the majority of placements are not set up for this. Therefore, there needs to be an expectation that for the foreseeable future the roles of Placement Supervisor and Modality Specific Clinical Supervisor of Practice would be held by distinct professionals and the clinical supervision may not take place on the clinical site.
5. The CPRB Standards of Proficiencies document should also include as essential the ability on the part of the psychotherapist to articulate the principles of their practice based on the texts that ground and found the modality – for example, a psychotherapist should have shown the ability to articulate in writing the concept of the unconscious, or of the person, or of the group, or of the family system.
6. [Redacted] request that CORU, as a matter of necessity and urgency set up formal lines of contact with the principal stakeholders in the training of psychotherapists, namely the training institutes, alongside the input from the professional bodies.



Explanation:

1. It is essential to include as the *sine qua non* of psychotherapy training and practice the requirement that trainees engage in their own psychotherapy, psychoanalysis or psychotherapy processes. This should be expected to be extensive over years. This must be clearly represented as the cornerstone of psychotherapy training. One's own psychotherapy, psychoanalysis or psychotherapy processes is what forms the practitioner. Without it a practitioner cannot access the practice position of a psychotherapist – and that title is appropriated to describe what is not psychotherapy. Criteria for Education and Training which exclude explicit and emphatic mention of the requirement that trainees engage in their own psychotherapy, psychoanalysis or psychotherapy processes would result in the public not being protected and the field of psychotherapy being fundamentally misrepresented. It should be expected that a practitioner continues in their own psychotherapy, psychoanalysis or psychotherapy processes indefinitely through the lifespan of their practice. This fundamental requirement arises from the fact that the work of psychotherapy involves the person (or, subjectivity) of the practitioner in ways that are not immediately present to the practitioner's conscious reflection. Without one's own psychotherapy, psychoanalysis or psychotherapy processes, the practice position required for psychotherapy practice cannot be reached or maintained. Without one's own psychotherapy, psychoanalysis or psychotherapy processes named explicitly as a standard and as a criterion – the fundamental criterion – the practice being regulated will not be the practice of psychotherapy. This is not in the interests of protecting the public and it would terminate major forms of work that have for many decades been described under the term psychotherapy. Without this requirement, there would be a CORU Register of Psychotherapists whose practice would not be recognised by the profession as psychotherapy.
2. It is essential to review and revise proposal for in-room supervisory observation / psychotherapy session recording [CPRB Criteria for Education and Training Programmes in Psychotherapy Draft Document, Criterion 2.2.] This proposal is fundamentally at odds with the principles and ethics of practice in the major modalities of psychotherapy which have developed under the descriptors psychoanalytic, psychodynamic, humanistic-integrative. We request recognition of modality specific methods of supervision – methods that are themselves extensive and comprehensive. These long-standing methods have provided over many decades, robust assurance of a trainee's fitness to practice and protection of the public while at the same time following the ethics and principles of the specific modality of psychotherapy.

In-room supervisory observation / psychotherapy session recording would have a very detrimental impact on the transference and its handling for a significant sector of psychotherapy training, particularly those developed within the widely followed psychoanalytic and the humanistic-integrative traditions. The handling of the transference is fundamental for these major modalities of psychotherapeutic work. In-room supervisory observation / psychotherapy session recording is, therefore, not possible for these trainings in one-to-one psychoanalytic and humanistic-integrative psychotherapy. Central to training in these major modalities are the following components:



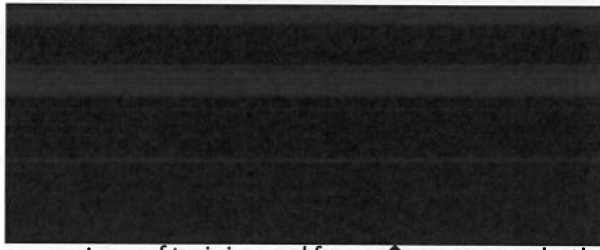
- Regular (often weekly or at least fortnightly) one-to-one clinical supervision with an experienced practitioner who is a recognised supervisor of practice.
- Regular (often weekly or at most fortnightly) small-group clinical supervision with an experienced practitioner who is a recognised supervisor of practice.
- Engagement by the trainees in their own psychotherapy / psychoanalysis. In these modalities engagement in one's own psychotherapy / psychoanalysis involves attending at least once a week and more than once a week for psychoanalysis. We will return to this fundamental component of training in point 2 below.

Our [redacted] include a training in Group Analytic Psychotherapy. This training is block-delivered over nine weekends a year and takes 7.5 years to complete. In accordance with the principles of Group Analysis, the clinical supervision for this training is delivered in small group format. When a trainee has set up and is running their own group each trainee attends 38 small group supervision sessions per year in total. It is crucial to point out that this group analytic approach to supervision is congruent with the principles of Group Analysis. The Group Analytic approach to supervision is different from the proposed observation of supervision. It would undermine the approach to supervision and the understanding of the conscious and unconscious group dynamics at work to introduce an observer into this work. Again, it is important to note that across our programmes, we have different methods of supervision in accordance with the different principles of the specific modality psychotherapy in which a training is being delivered.

Decades of experience in using these modes of supervision specific to the principles of the modality of psychotherapy shows very robust and appropriate mechanisms for supervision. A trainee attends for supervision at a scheduled time and speaks back over a session. The supervisor can question the source and motivation of the trainee's interventions. Should a problematic situation arise for the supervisee it is possible to contact the individual supervisor for direction. The individual supervisor is employed by the training programme and submits a report on the trainee in supervision. The small-group supervisor is on faculty in the training programme. She / he also submits a report on the trainees' practice and engagement in supervision. The small-group supervisors meet regularly to discuss any issues arising for the supervisees. Our programmes have mechanisms to require a trainee supervisee to step off a programme if their work becomes inappropriate. Therefore, we argue very strongly that there are in place, and have been for decades, methods for the conduct of supervision that follow from the principles of the specific modality of psychotherapy. In-room supervisory observation / psychotherapy session recording is fundamentally at odds with these principles and would terminate the delivery of training in these modalities of psychotherapy. This would result in the psychotherapy profession in Ireland excluding major forms of psychotherapy.

We request recognition of modality specific methods of supervision, which are themselves extensive and comprehensive. These long-standing methods have provided over many decades, robust assurance of a trainee's fitness to practice.

3. It is essential to review and revise proposal for psychotherapy training to be delivered as a level 8 qualification CPRB Criteria for Education and Training Programmes in Psychotherapy Draft Document, Criterion 1.1: As communicated above in Point 1, psychotherapy training must require that trainees engage in their own psychotherapy, psychoanalysis or psychotherapy



processes. It is the cornerstone of training and formation as a psychotherapist. This is because

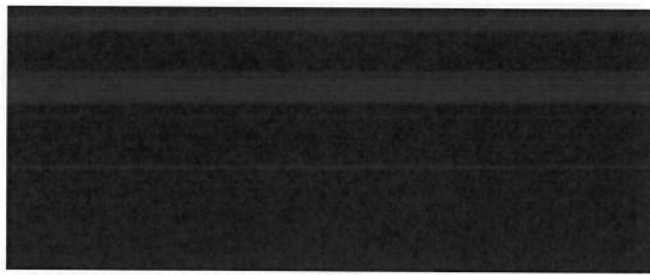


the 'person', or subjectivity, of the practitioner is a fundamental element in the work of psychotherapy. A practitioner must come to be competent in managing their part in the work. This requires time and the maturity and confidence to hold a position. *QQI Awards Standards – Counselling and Psychotherapy 2014* recognised this to some extent but failed to give it the prominence and clarity it requires. That document wrote of 'self' and 'self-knowledge' without clearly acknowledging that the reason there are practices of psychotherapy is because self-knowledge is not easily reached and is, arguably, never reliable. In other words, the document failed to address the complexity and fragility of a concept such as 'self'. Nonetheless, notwithstanding this criticism, that document recognises that *"Counselling and psychotherapy practice require the development and demonstration of a suitable level of self-knowledge. This may be achieved through personal psychotherapeutic experience (or equivalent learning). The QQI Awards Standards do not prescribe the volume or kind of learning opportunities. Professional bodies can be expected to be more prescriptive."* [QQI Awards Standards – Counselling and Psychotherapy 2014] <https://www.qqi.ie/sites/default/files/2021-12/counselling-and-psychotherapy-qqi-award-standards-2014.pdf>

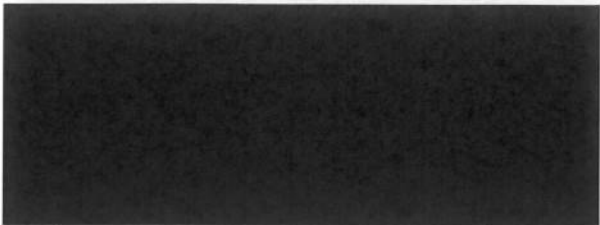
The documents produced by State Agencies such as QQI and CORU, tasked with the regulation of the field, particularly in its education and training practices need to engage with the language, principles and concepts of the major modalities of psychotherapy in order to effectively represent and regulate them so that they can make their own specific, invaluable contribution to Irish society and culture in a way that is, in its turn, effective and safe. By so doing it will be very evident that the field requires training at a minimum of level 9 to meet any kind of State recognition.

The same QQI document, following the established terminology that distinguishes Level 8 and Level 9 qualifications in terms of expected levels of Knowledge, Skill and Competence, uses the following words for Level 8: awareness, knowledge, understanding. These contrast with the terms used for Level 9: systemic understanding, critical awareness, critical understanding. Given the representation of what is required in a practitioner of psychotherapy here and in submissions from the Irish Council for Psychotherapy (ICP), we believe the learning outcomes must be described in the later terms, that is, the terms that describe level 9 professional qualifications. We also endorse the ICP point that setting the qualification at Level 8 would put us out of kilter with the regulation of psychotherapy across Europe where it is a Level 9 qualification.¹

4. **Placement settings.** [REDACTED] is committed to the vision of there being access to psychotherapy delivered by qualified psychotherapists in the Public Mental Health and Primary Care services. We also expect and encourage the on-going growth of psychotherapy uptake with practitioners in private practice. It is to be expected that psychotherapy training programmes will develop their arrangements for trainee placement with appropriate sites in both the public and private contexts. We propose a distinction between a Placement Supervision and Modality Specific Clinical Supervision of Practice. This distinction is already long in place across our training programmes. The Placement Supervisor is an employee / manager in a service. They are not necessarily trained themselves in psychotherapy but are expected to have some appreciation of it. They oversee the trainee in terms of the trainee working within the protocols of the placement setting as well as supporting the trainee in their day-to-day engagement with the clinical site. They do not provide clinical supervision. This is provided by an experienced practitioner recognised as a supervisor of



¹ Austria may be an exception here where the Level 8 is a five-year qualification.



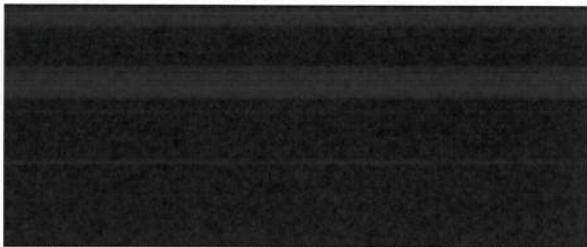
clinical practice. This modality specific supervision works with the actual content and the direction of the practice of the trainee. The modality specific clinical supervision takes place in the office of the supervisor, to which the trainee travels; or, in the mode of small-group, in the training institute. Neither need take place in the clinical site. The Training Institute maintain contact with the Placement Supervisor and the Clinical Supervisors. There are mechanisms in place to allow communication between these different roles, should a situation arise that requires such. We believe that this form of arrangement and these precisely defined roles should be the model for supervision arrangements set out in the CPRB Criteria for Education and Training Document. There is not yet a system of practice tutors in place for psychotherapy. This would be a very welcome development and enhance the role of the Placement Supervisor where that person has their own training in psychotherapy. It does not remove the requirement for there to be specific modality clinical supervision provided by a recognised clinical supervisor involved in this core component of training.

5. The CPRB Standards of Proficiencies document should also include as essential the ability on the part of the psychotherapist to articulate the principles of their practice based on the texts that ground and found the modality – for example, a psychotherapist should have shown the ability to articulate in writing the concept of the unconscious, or of the person, or of the group, or of the family system, etc.. Articulation of one's practice and one's relation to one's practice should not have recourse to generalisations such as 'experience', 'feeling' or 'intuition'. The field needs more rigour than these words provide. This point is in line with the ICP request that the CPRB Standards of Proficiency and the CPRB Criteria for Education and Training contain the language, principles and concepts of the modalities of psychotherapy to properly represent them and ensure safe practice.
6.  request that CORU, as a matter of necessity and urgency set up formal lines of contact with principal stakeholders in the training of psychotherapists, namely the training institutes. This input would then be provided alongside the input from the professional bodies. There should be specific lines of communication between CORU and the entities it will be visiting to accredit training programmes. Such contact would provide CORU with access to the structures and content of current programmes. It would thereby contribute to providing field-specific vocabulary to the process from where it already exists in the representation of modalities of psychotherapy within higher education structures and governance. This already existing regulatory framework for education and training in psychotherapy is the most appropriate source of guidance for setting up the health and social care regulatory structure and content.

Comments on Specific Points in the CPRB Draft Standards of Proficiency for psychotherapists

Page 8: Professional Autonomy and Accountability,

Point 17: Here is an opportunity to add the requirement that a graduate "recognise personal responsibility and professional accountability for one's actions and be able to justify professional decisions made *drawing on their own extensive experience of their own psychotherapy, psychoanalysis or psychotherapy processes* (italics added). This point could also be added to point 20: *Using their own extensive experience of their own psychotherapy,*



psychoanalysis or psychotherapy processes to be aware of and take responsibility for managing their own mental health and wellbeing.

Page 9. Communication, collaborative practice and teamworking.

Point 1: Many of the major forms of psychotherapy do not diagnose and do not assess in terms of the diagnostic formulations of mental health and psychiatric practice. This is what makes psychotherapy distinct and valuable. It offers another way of working with difficult mental phenomena. We can understand assessment in terms of psychotherapy by clarifying that the assessment is of suitability for psychotherapy or assessment of indications of potential to engage in the work of psychotherapy.

Point 3: This is an important point reflecting the way in which psychotherapy is an invitation to a person or people to enter into the work of psychotherapy.

Page 11: Safety and Quality

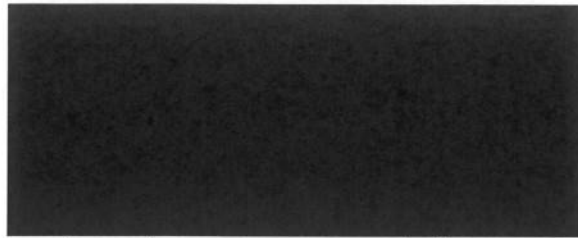
Point 2: Assessment needs to be understood as represented above: we can understand assessment in terms of psychotherapy by clarifying that the assessment is of suitability for psychotherapy or assessment of indications of potential to engage in the work of psychotherapy.

Point 4: psychotherapists do not evaluate information collected in the assessment process unless this is a reference to clinical supervision albeit couched in language alien to psychotherapy processes and therefore open to misunderstanding as a practice of psychology.

Point 5: Some forms of psychotherapy proceed in terms of determining problem lists, action plans and goals but many of the major forms of work described as psychotherapy do not. It is important that this Standards of Proficiency document tolerates these major forms of psychotherapy that are very distinct from psychology practices. The [REDACTED] respects the practice of psychology but again underlines its understanding that the State Register under discussion here is for the title psychotherapist and an important function of having psychotherapist as distinct title is to assist the public in discerning the difference between the practice of the psychotherapist and the practice of the psychologist. What is to be highlighted and welcomed in this point is the expectation that graduates “demonstrate sound logical reasoning”.

Point 6: The language is not from the psychotherapy field but can be interpreted as follows: “Be able to articulate the basis of their interventions, engage the service-user in the work and draw on knowledge, skills and the principles of the modality of psychotherapy being practised in order to make professional interventions.

Point 9: [REDACTED] support the application of empirical evidence-seeking methodology to the study of psychotherapy practices but also recognises the limitations of that methodology in practises where the ‘evidence’ the material of the work is non-replicable or measurable. Its value is in its elusive status. The testing of it is through a practitioner’s interrogation of their understanding and interventions using supervision arrangements and their own extensive psychotherapy or psychoanalysis or psychotherapy processes. This latter essential component of training and practice provides a forum for the rigorous interrogation of the practitioners’ own relation to their practice and what they wish to get out of it.



Point 11: A psychotherapist needs to understand the principles of quality assurance and quality improvement in terms of the practice and principles of psychotherapy and using the mechanisms of psychotherapy – personal psychotherapy, psychoanalysis or psychotherapy processes primarily, along with supervision to maintain the standards expected by the specific modality of psychotherapy.

Page 14: Professional knowledge and skills

Point 13: Some forms of psychotherapy expect the psychotherapist to “to demonstrate an understanding of their feelings and emotions and communicate that understanding in a non-judgemental manner.” Other major forms of psychotherapy work to not do this and allow the person engaged in the work of psychotherapy to articulate in their own terms their singular sense of their lives. Communicating understanding of feelings can undermine a therapeutic relation.

Point 21: some forms of psychotherapy involve recognition of “personal emotional responses, vicarious trauma and the need to develop effective self-care strategies and burnout prevention.” Major forms of psychotherapy do not intervene in this directive way, and that is their value and the basis of a person engaging in the work.

Page 11: Safety and Quality:

Points 1 – 6: these practices are not those of a psychotherapist. The value of psychotherapy is that it does not assess, test, gather information. These tasks are already carried out by other professions such as psychology, psychiatry and social work. **Point 7:** Psychotherapy practice can prioritise safety of service users and those involved in their care through supervision of practice.

Point 8: Psychotherapy is not a practice based on recognized performance/outcome measures. Again these are terms appropriate to other practices positions and would interfere with the psychotherapy work which brings the person/ people in psychotherapy to greater articulation of their lives in speech.

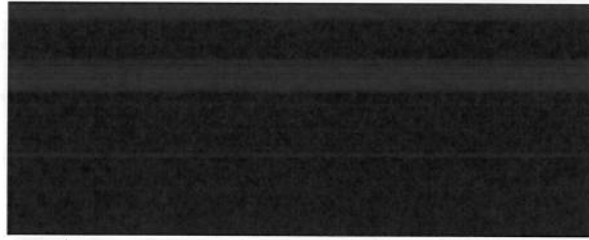
Page 13: Professional Development:

We support Points 1 – 5 as essential. As argued above it is a fundamental requirement that a psychotherapist be expected to articulate in speech and writing their practice. Point 6 would apply to employment contexts but not to private / sole-trader practice where much psychotherapy takes place.

We argue that the requirement for a Psychotherapist to engage in their own extensive psychotherapy should be included in this list of points under professional Development.

Page 14: Professional Knowledge and Skills

Point 2 runs the risk of being interpreted as a curriculum list. There is no requirement for a psychotherapist to have a critical understanding of relevant biological sciences. Human development is a theoretical construct in psychology and psychotherapy and not a universal basis of psychotherapeutic practice. We do argue that psychotherapists should have an



awareness of the paradigms currently dominating responses to mental disorder such as the practice of psychiatry.

Point 19: report writing runs contrary to the ethics of major modalities of psychotherapy. Psychological report writing is a skill in the practice of psychology.

Point 24: here the document articulates a skill very specific to psychotherapy. It needs to be added to this list of points that reflect on unconscious dynamics requires the practitioner to be experiencing an extensive engagement in their own psychotherapy.

Point 27: It should be left to a practitioner to decide if the work can be carried out virtually using technology. This cannot be set down prescriptively. It will depend on the practitioner's relation to their practice and on the appropriateness of using phone or online arrangement with a specific service user. **We argue that the requirement for a Psychotherapist to engage in their own extensive psychotherapy should be included in this list of points under professional Development.**

Comments on the Criteria for Education and Training Programmes for Psychotherapists

Criterion 1: Level of qualifications for entry to the register

As above we reject the qualification for psychotherapist being set at Level 8 as minimum level of qualification for entry to the register. We argue for it to be set at Level 9.

Criterion 2: Practice Placements

As above we reject the proposal of 100 hours of directly observed user contact as a required mode of supervision.

[REDACTED]

Response to CORU Consultation Documents

[REDACTED]

Introduction

The Psychotherapy team at [REDACTED] welcome the opportunity to comment on the CORU consultation documents for counselling and psychotherapy proficiency, education, and training. The psychotherapy team at [REDACTED] have been engaged in the delivery of three programmes of education and training for psychotherapists since 2006;

• [REDACTED]

Additionally the team have supervised numerous PhD candidates in the areas of Psychotherapy and its related fields and have a track record of conducting funded national and international research projects, contributing to national and international conferences and publishing extensively in research journals and educational textbooks. This experience, we

[REDACTED]

believe, makes us well placed to comment on the CORU consultation documents. We have outlined below specific comments which we believe warrant either reconsideration or further illumination.

From the outset it would be important, given the task placed on CORU, to distinguish the unique clinical work and practices that both counselling and psychotherapy bring to Mental health work and discourse in Ireland. With CORU establishing a registration process for Counsellors and Psychotherapists in Ireland, it would be critical for CORU to name and demarcate what both of these professions are, and how they are distinguished from each other. Despite the reluctance, possibly based on the reality of a shared customer base of people experiencing psychological distress and some shared techniques and skills, many practitioners in both professions shy away from drawing a distinction between the two, yet there are a number of points where they diverge. A point on which it is possible to distinguish counselling from psychotherapy refers to the degree of 'pathology' in clients. Counselling approaches are suited to 'adjustment reactions', that is, to normal people under stress; in cases of more far-reaching psychic damage, what is needed is psychotherapy, which aims towards restructuring of the personality. Another point for a counselling/psychotherapy distinction lies in whether or not the unconscious is addressed. Counselling approaches, as commonly taught and practised, tend most often to engage clients at a conscious level. 'While 'active listening' and empathic paraphrasing encourage clients to explore their inner worlds, and while this often leads to the articulating of material that an analyst might wish to interpret in terms of unconscious dynamics, in fact such interpretation does not occur within the classic counselling approach. Rogers avoided it, as part of his general avoidance of the 'expert' role, with its accompanying power differential.'⁴ Additional it should be possible to consider the The Strasbourg Declaration in creating a definition of psychotherapy:

'The basic position of the European Association for Psychotherapy (EAP) is enshrined in the 1990 Strasbourg Declaration on Psychotherapy, which states:

In accordance with the aims of the World Health Organisation (WHO), the non-discrimination accord valid within the framework of the European Union (EU) and intended for the European Economic Area (EEA), and the principle of freedom of movement of persons and services, the undersigned agree on the following points:

1. Psychotherapy is an independent scientific discipline, the practice of which represents an independent and free profession.
2. Training in psychotherapy takes place at an advanced, qualified and scientific level.
3. The multiplicity of psychotherapeutic methods is assured and guaranteed.
4. A full psychotherapeutic training covers theory, self-experience, and practice under supervision. Adequate knowledge of various psychotherapeutic processes is acquired.

⁴ Crago, H. (2000), Counselling and Psychotherapy: Is There a Difference? Does It Matter?. Australian and New Zealand Journal of Family Therapy, 21: 73-80.
<https://doi.org/10.1002/j.1467-8438.2000.tb00418.x>

5. Access to training is through various preliminary qualifications, in particular human and social sciences.’⁵

The EAP draw clear distinctions between European Psychotherapy and European Counselling:

‘Whilst there are some obvious similarities between these two professional activities, there are also considerable differences. Firstly, counselling is often not present as a significant professional activity in a number of European countries. There is a European Association for Counselling (www.eac.eu.com) and there are a number of articles available that differentiate between the two professions.

In academic terms, a counselling training is often set at a Certificate (1-year: EQF-4) or a Diploma level (2-years of tertiary education: EQF-5), though there are also some professional 3-year and 4-year trainings, as well as degree-level trainings (EQF-6). Entry into a full professional counselling training is usually not set at a post-graduate level.

While there are various different forms (methods) of counselling, it seems to be somewhat more multi-disciplinary than psychotherapy, where there are many very clearly defined different modalities. The professional core competencies of a European Counsellor are significantly different from the professional Core Competencies of a European Psychotherapist.’⁶

‘Unlike other psych disciplines, both Counselling and Psychotherapeutic work are embedded in not only clinical knowledge but in clinical practices informed through experiential insight. A counsellor or psychotherapist has to have undergone counselling/psychotherapy themselves in order to gain both intellectual and experiential knowledge to practise rigorously within this work. This requisite for experiential learning and insight is both critical and invaluable for the insurance of professionalism and the safeguarding of service users of psychotherapeutic and counselling work. Personal awareness and development work embodied in trainees’ own therapeutic encounters and experiences are integral to both our training and practices, and ensure the best standards and assurances of safety for clients. We note that no requirement for this essential attendance at counselling and/or psychotherapy is stipulated as part of the formation of the therapist and hold that it should be included at a minimum of 20 sessions per year throughout the duration of an education and training programme which we hold should be of 4 years duration.

Specifically in regard to the criteria for education and training programmes for counsellors and psychotherapists it is not clear whether the proposed CORU criteria had been matched against the QQI standards which are currently in place⁷ and which are in line with the National

⁵ chrome-extension://efaidnbmnnnibpcajpcgclefindmkaj/<https://www.europsyche.org/app/uploads/2021/05/Legal-Position-of-Psychotherapy-in-Europe-2021-Final.pdf>

⁶ chrome-extension://efaidnbmnnnibpcajpcgclefindmkaj/<https://www.europsyche.org/app/uploads/2021/05/Legal-Position-of-Psychotherapy-in-Europe-2021-Final.pdf>

⁷ <https://www.qqi.ie/sites/default/files/2021-12/counselling-and-psychotherapy-qqi-award-standards-2014.pdf>

Framework of Qualifications.⁸ In relation to QQI, we believe alignment with their standards would be important for colleges and training institutes who are not accredited by the Irish University system to ensure that graduates from these programmes have attained a clearly outlined and defined measurable standard of education in line with the current national standards which are aligned with the European Qualification Framework and the Qualifications Framework of the European Higher Education Area. Alignment with these two frameworks makes it easier to compare qualifications across Europe and enables mobility for graduates across the EU.

In addition, Irish Universities subscribe to the Bologna Process,⁹ which seeks to bring more coherence to higher education systems across Europe and to facilitate student and staff mobility. This also aims to make higher education more inclusive and accessible, alongside ensuring that it is attractive and competitive worldwide. As such, it would be important to ensure that the Irish criteria for education and training of counsellors and psychotherapists are matched to comparable qualifications across the EU. When considering this, it seems reasonable to consider the three-cycle higher education system consisting of bachelor's, master's and doctoral studies. We have noted in the consultation documents that Level 8 (NFQ) is the minimum standard for entry into the register for both counselling and psychotherapy. This raises a concern that applicants to the register may limit their educational attainment to Level 8 and not be exposed to the breadth and depth of learning that is achieved at Level 9 and 10. Level 9 and 10 programmes are more likely to prepare graduates for the often-complex work of psychotherapy and the essential work of research and development of the profession. The work of counselling and psychotherapy should never be undertaken lightly. We are strongly of the opinion that the depth and breadth of education required to prepare people to work as psychotherapists requires a programme delivered at Level 9. Also of note is that a Level 8 programme would most likely be open to applicants via the CAO process following completion of second level school. This would open programmes to young adults who may not have sufficient life or work experience to engage as a therapist in a counselling or psychotherapy setting. We believe that this could be problematic or even damaging for the mental health of both trainees and clients.

There is within the current level 9 training a recognition of potential students' significant prior experience or an already attained undergraduate degree for entry to psychotherapy education and training. Standard university entry systems facilitate RPL (Recognition of Prior Learning) which allows enhanced accessibility and equality progression. Students entering Psychotherapy/Counselling training as a level 9 programme allows for a variety of undergraduate and life experience, which can only enrich learning and trainee development, and is important in working with a wide range and diversity of service users. Also entry at level 9 allows for applicants to have had time and opportunity to engage in relevant work experience as a helping professional, a current key requisite that we adhere to in [REDACTED] for all potentially eligible psychotherapy students for evaluating both their preparedness and suitability for psychotherapy training.

⁸ <https://www.qqi.ie/what-we-do/the-qualifications-system/national-framework-of-qualifications>.

⁹ <https://education.ec.europa.eu/education-levels/higher-education/inclusive-and-connected-higher-education/bologna-process>

Additionally, many of the level 8 and level 9 programmes currently on offer in Ireland are closely aligned to the European Association of Psychotherapy (EAP)¹⁰ which creates mobility for those seeking psychotherapy education and training and accreditation within the EU. It is essential that the introduction of a national register for psychotherapy enables and enhances this mobility.

¹⁰ <https://www.europsyche.org/>

Document 1 Criteria for Education and Training Programmes for Counsellors

Criterion 1 Level of qualifications for entry to the register

1.1 The minimum level of qualification for entry to the register is Level 8 on the National Framework of Qualifications (NFQ). Level of qualifications for entry to the register

The same level of qualification is set out in the education and training programmes for both counsellors and psychotherapists. This will fail to draw an educational achievement distinction between both registers and enable education providers to offer Level 8 programmes with the dual title of counselling and psychotherapy, which will do nothing to distinguish and demarcate the two fields of practice. It will perpetuate the lack of clarity and distinction for the public when seeking help as to what might be different in the approach of a counsellor or psychotherapist.

Criterion 2 Practice placements

2.2 The programme must ensure that each student (counsellor) completes 450 hours.

A minimum of 300 of the 450 hours must be supervised service user contact experience, of which 75 hours is directly observed service user contact.

Completing 450 hours of clinical practice is a significant demand to place on students and practice placements, and mitigates against the delivery of such training in their currently student accessible format as part-time programmes. The model suggested by CORU would most likely only be operational for full-time students. There are alternative models that could be considered as templates for achieving the required number of practice hours and it should be feasible to have more than one model of delivery as an option to facilitate the range of people seeking to access training;

1. A suggestion would be to continue using the model of a lower number of hours of clinical practice to be garnered during students' training and subsequently, any additional hours required for accreditation to be achieved at the post training pre-accreditation stage, as has been the practice for many years with various registering groups. Given that counselling students currently cannot receive payment for their student training clinical hours, but can receive payment for pre-accredited, post-training hours, this demarcation would not only undermine the value of students' invisible labour within mental health in Ireland, but would again make counselling training more attractive and affordable for a wider range of students.
2. An alternative to consider would be the addition of an internship final year such as currently offered on Nursing programmes where students are paid employees of the Health Service while still registered as students of the University. This approach might allow education providers to frontload programmes with academic content and skills training prior to students commencing client work.
3. Alternatively the model used in clinical psychology, where there is a requirement for a higher level of supervision in the first two years post -training also appears to be feasible for counselling and psychotherapy graduates.

The education and training of counsellors normally attracts mature students who often have a professional qualification and/or a level of maturity and accumulated life experience alongside significant family and life commitments, making part time programmes attractive. Forcing the market into the delivery of full-time programmes will significantly reduce attracting students with previous professional or life experience that is valuable for the profession of counselling.

The demand for 75 hours of directly observed service user contact needs to be described more fully. As it is written, in a class of 20 students, this would require 1,500 hours of direct observation by appropriately qualified lecturer/practitioners. This will place a significant financial burden on education providers and practice placements. Inevitably this cost will be passed onto students and thus ultimately pushing up the course fees and/or in time the cost of the counselling services for clients. Currently many students benefit from placements in low and/or no cost services which contributes significantly to the health of the nation. Mental Health services in Ireland are underfunded and dependent in part on the voluntary sector to augment their delivery, this is achieved in numerous ways including the delivery of counselling by students. Increasing the burden of cost for students will most likely reduce the number of students on training programmes and/or prevent students from low-income backgrounds accessing psychotherapy education which will have an impact on diversity and equality in the sector, and thus an effect on the provision of services by voluntary organisations.

Overall, the demand of around 450 hours of practice for completion during the programme of study, coupled with 75 hours of direct observation is likely to reduce the number of people in a position to engage in counselling education and training, significantly increase programme fees, reduce the number of course providers and placement providers, and remove a percentage of therapy provision to those in most need from the market. It would be important to bear in mind that some placement providers might discontinue offering placements if such demands were made regarding observation and recording of client work, on their already over-stretched finances and workloads.

2.17 The education provider will make regular support and training available to the practice education team to develop their practice education skills.

It would be important to hold in mind the additional labour and cost factors involved in both the provision of, and sourcing of educational and practice cost factors in the provision of support and training for both education providers and practice education staff. In placing such demands on both education providers and practice education staff, compulsory education and training has the potential to remove some practice placement providers and and practice educators from the market.

Criterion 3

3.2 The procedures for all student admissions to the programme must ensure that the stated entry criteria are met including any criteria relating to language proficiency, health requirements, criminal records and other appropriate academic and/or professional entry standards to ensure that students can participate in all elements of the programme.

The turning of counselling education providers into monitoring bodies that are compliant with regulators of the state is questionable as this indicates that the education provider will be

required to verify data in relation to individuals' health, criminal record, immigration status and language ability when there are already a range of state agencies tasked with this work. While the third level sector already engages in some of this work for equivalent professional clinical educational programmes, it is essential that this work is covered at the administration level of the educational provider and not placed as additional time consuming labour for educators. This will clearly create problems for both staff and students in relation to dual roles for colleges who only offer counselling programmes and may lack an extensive administration system. We are in a privileged position in ■■■ in that the University has an administration section that does significant parts of this work. In many of the small private education providers this luxury may not exist. The concern here is that smaller organisations may not have the capacity 'to operate as agents of the state' (Parker, I. 2014)¹¹ who control who gets to live and study in a country.

Criterion 5 Curriculum

5.3 The range of learning and teaching approaches used must be appropriate to the effective delivery of the curriculum and achievement of standards of proficiency.

While we fully support this criterion clarification is required on how this will be monitored and measured.

¹¹ <https://doi.org/10.1002/ppi.1333>

Document 2 Standards of Proficiency for Counsellors

Professional Autonomy and Accountability

We welcome the 20 standards of professional autonomy and accountability that are outlined; however we are concerned that the critical importance and necessary value of ongoing clinical supervision which plays a significant role in the application of theory to practise and the monitoring of practice are only identified in two of the standards under the heading Professional Knowledge and Skills. We believe that clinical supervision is a central element in the formation of a counsellor. Currently most counselling education and training programmes operate from a tripartite approach which includes, but is not limited to personal therapy, clinical supervision and knowledge acquisition as the foundations for developing a counsellor.

Communication, Collaborative Practice and Team-working

We welcome the 15 standards for communication, collaborative practice and teamwork however again we want to emphasise that such standards are also transmitted, enhanced and developed via the practice of clinical supervision.

Safety and Quality

The 14 standards for safety and quality are the minimum level of attainment that would be expected from a counsellor.

Professional Development

The six standards for professional development are significant for all emerging counsellors and those currently working in the field. We believe it would be essential that the board outline how they intend to approve and monitor continuous professional development.

Professional Knowledge and Skills

The 30 standards under profession knowledge and skills are mainly appropriate for a Level 8 graduate. However standard 7 which includes the ability to lead clinical academic or practice based research would be extremely challenging for a graduate of a Level 8 programme. A research training to bring a graduate to the point of leading clinical relevant practice based research of significance to the profession at large is unlikely to be delivered unless they have studied at level 9 or 10. We suggest that this standard is modified so that it relates to participation in small scale studies related to specific local practice delivery issues.

Document 3 Criteria for Education and Training Programmes for Psychotherapists

Criterion 1 Level of qualifications for entry to the register

1.1 The minimum level of qualification for entry to the register is Level 8 on the National Framework of Qualifications (NFQ).

The same level of qualification is set out in the education and training programmes for both counsellors and psychotherapists. This will fail to draw an educational achievement distinction between both registers and enable education providers to offer Level 8 programmes with the dual title of counselling and psychotherapy which will do nothing to distinguish the two fields of practice. It will perpetuate the lack of clarity and distinction for the public when seeking help as to what might be different in the approach of a counsellor or psychotherapist. Clearly when CORU were tasked with setting up two separate registers for counselling and psychotherapy the intention was to bring some recognition to the distinction between both professions. By setting the same Level of educational attainment for both professions the boundaries remain blurred. It is evident that CORU have noted a distinction by suggesting more extensive clinical practice hours are required for potential psychotherapy registrants however the failure to also require this group to engage in a more in-depth study of the human condition is a retrograde step. While we acknowledge that a Level 9 programme of education requires more intensive study and research we would consider it the minimum level of attainment necessary to deliver psychotherapy effectively. The concern here is to adequately prepare psychotherapists to engage in successful treatment with complex human experiences and conditions. Additionally for any professional to grow, develop and operate as either a sole practitioner or part of a multidisciplinary team it is necessary to provide practitioners and educators of the future with a solid foundation in reading, understanding, applying and conducting research that is aimed at the development of a scientist/practitioner model. For this to be achieved the minimum educational requirement should be a Level 9 programme for psychotherapy that includes a foundation in conducting clinically relevant research. The practice of psychotherapy is markedly distinct from counselling and being more specialised requires both a breadth and level of knowledge and a rigour of experiential learning that is more likely to be achieved at Level 9 than at level 8.

Criterion 2

Practice placements

2.2 The programme must ensure that each student completes 500 hours. A minimum of 350 of the 500 hours must be supervised service user contact experience, of which 100 hours is directly observed service user contact.

Completing 500 hours of clinical practice during the duration of a 4-year programme equates to 125 per year. Assuming that students would not be sufficiently prepared or practised to commence clinical practice during year 1, there will be a burden of 166 hours to be completed in years 2, 3 and 4 of the programme of study. This is a significant demand to place on students and practice placements and mitigates against the delivery of part time programmes. The model suggested by CORU would most likely only be operational for full-time students. There are alternative models that could be considered as templates for achieving the required

number of practice hours and it should be feasible to have more than one model of delivery as an option to facilitate the range of people seeking to access training;

4. A suggestion would be to continue using the model of a lower number of hours of clinical practice to be garnered during students' training and subsequently, any additional hours required for accreditation to be achieved at the post training pre-accreditation stage, as has been the practice for many years with various registering groups. Given that counselling students currently cannot receive payment for their student training clinical hours, but can receive payment for pre-accredited, post-training hours, this demarcation would not only undermine the value of students' invisible labour within mental health in Ireland, but would again make counselling training more attractive and affordable for a wider range of students.
5. An alternative to consider would be the addition of an internship final year such as currently offered on Nursing programmes where students are paid employees of the Health Service while still registered as students of the University. This approach might allow education providers to frontload programmes with academic content and skills training prior to students commencing client work.
6. Alternatively the model used in clinical psychology, where there is a requirement for a higher level of supervision in the first two years post -training also appears to be feasible for counselling and psychotherapy graduates.

Completing 500 hours of clinical practice is a significant demand to place on students and practice placements, and mitigates against the delivery of such training in their currently more accessible format as part-time programmes. The education and training of psychotherapists normally attracts mature students who often have a professional qualification and/or a level of maturity and accumulated life experience alongside significant family and life commitments making part time programmes attractive. Forcing the market into the delivery of full-time programmes will significantly reduce attracting students, who need to remain in employment to finance their studies. Additionally it would require psychotherapy students who are currently working in other helping professional roles (which is typically the case) to abandon their careers and therefore would add to the depletion of healthcare professionals, which is a significant ongoing manpower issue in the Irish Health Services. It also mitigates against attracting students with life experience that is valuable for the profession of psychotherapy.

The demand for 100 hours of directly observed service user contact needs to be described more fully. As it is written, in a class of 20 students, this would require 2000 hours of direct observation by appropriately qualified lecturer/practitioners. This will place a significant financial burden on education providers and practice placements. Inevitably this cost will be passed onto students and thus ultimately pushing up the course fees and/or in time the cost of the psychotherapy services for clients.

Directly observed practice may be helpful for student development. However, 100 hours could be considered excessive for reasons of logistics, service user confidentiality and staffing management, not least of all because of the potential intrusive nature of observation on the psychotherapeutic practice which can significantly impact on service users safety and confidentiality concerns. Psychotherapy has always been considered as operating in a private

confidential space occupied by the therapist and the client(s). The introduction of a third party as an observer interrupts that privacy and may inhibit the work. We anticipate that many clients would not be open to this process. This is an additional erosion of the contract between therapist and client. In addition there are significant data protection issues that seem in conflict with current GDPR rights. Data protection is a fundamental right set out in Article 8 of the EU Charter of Fundamental Rights, which states¹²;

1. Everyone has the right to the protection of personal data concerning him or her.
2. Such data must be processed fairly for specified purposes and on the basis of the consent of the person concerned, or some other legitimate basis laid down by law. Everyone has the right of access to data which has been collected concerning him or her, and the right to have it rectified.
3. Compliance with these rules shall be subject to control by an independent authority.

This means that every individual is entitled to have their personal information protected, used in a fair and legal way, and made available to them when they ask for a copy. In order to process personal data, organisations must have a lawful reason. The lawful reasons for processing personal data are set out in Article 6 of the data protection regulations. The six lawful reasons for processing personal data are outlined below. Of note number six has the potential for a legal challenge as direct observation may contradict or harm the interests of the client.

1. Consent.
2. To carry out a contract.
3. In order for an organisation to meet a legal obligation.
4. Where processing the personal data is necessary to protect the vital interests of a person.
5. Where processing the personal data is necessary for the performance of a task carried out in the public interest.
6. In the legitimate interests of a company/organisation (except where those interests contradict or harm the interests or rights and freedoms of the individual).¹³

Currently many students benefit from placements in low and/or no cost services which contributes significantly to the health of the nation. Mental Health services in Ireland are underfunded and dependant in part on the voluntary sector to augment their delivery, this is achieved in numerous ways including the delivery of psychotherapy by psychotherapy students; 'The College of Psychiatrists pre 2021 budget submission points out that for more than ten consecutive years the percentage of the Health Budget for Mental Health and delivering on national policy has been scandalously low at 5 to 6 percent. As per numerous official documentation and investment in similar jurisdictions it needs to move to 12 percent of the budget which amounts to the current one billion euro mental health budget being doubled

¹² <https://www.dataprotection.ie/en/individuals/rights-individuals-under-general-data-protection-regulation>

¹³ <https://www.dataprotection.ie/en/individuals/rights-individuals-under-general-data-protection-regulation>

to two billion euro.¹⁴ Increasing the burden of cost for students will most likely reduce the number of students on training programmes and/or prevent students from low income and socially diverse backgrounds accessing psychotherapy education which will have an impact on diversity and equality in the sector and an effect on the provision of services by voluntary organisations which further erodes a beleaguered mental health service.

Overall, the demand around 500 hours of practice for completion during the programme of study, coupled with 100 hours of direct observation is likely to reduce the number of people in a position to engage in psychotherapy education and training, significantly increase programme fees, reduce the number of course and placement providers and remove a percentage of psychotherapy provision to those in most need from the market. It would be important to bear in mind that some placement providers might discontinue offering placements if such demands were made regarding observation and recording of client work, on their already over-stretched finances and workloads.

A standard that we currently follow in [REDACTED], and one which we would recommend as a standard going forward for psychotherapy training, is the incorporation of intensive observed skills practise with focused feedback which is then reflected upon by the students. Observed skills practice is a critically embedded part of a psychotherapy student's first year of training within practice and theory modules, as well as being inherent to practice and theory modules across the four years of the MSc programme. While this would amount to 100 hours of direct observation of skills and techniques on which students receive feedback it does not meet the suggested requirement of 100 hours directly observed service user contact. We would urge the board to take into account the myriad ways in which skills are developed, reflected on and assessed prior to, and in addition to, students applying these in practice with service users.

In [REDACTED], before any student can progress to psychotherapeutic clinical work with service users, recorded readiness to practice assessments are carried out by staff teams. This readiness to practice is considered a cornerstone within the programme as ultimately it serves both to form and inform continuing education as a trainee psychotherapist and thus underlines an enhanced safeguarding and professionalism for service users.

An additional alternative to direct observation that we employ is consented audio recording and transcription of client work, which is then anonymised and reflected on by the student prior to submission for review and examination by the teaching and training staff. Each year, students engage in an in-depth critical analysis and reflection on their own client work, and they receive detailed feedback and specific recommendations for improving and developing their practice. Students and staff have found this a valuable aspect of clinical training, and as a result we would support requiring some observation of recorded client work. However, we suggest that one hour per year of recorded client work alongside ongoing clinical supervision at a ratio of 4:1 provides sufficient material for this purpose, and that there is no benefit (and many costs, as outlined above) in requiring more than this.

2.17 The education provider will make regular support and training available to the practice education team to develop their practice education skills.

¹⁴ <https://irishpsychiatry.ie/wp-content/uploads/2020/10/CPsych-Press-statement-re-Pre-2021-Budget-and-WMHD1010120.pdf>.

While we fully support the principles of continuous professional development, it is important to hold in mind the additional labour and cost factors involved in the provision of support and training, on both education providers and practice education staff. We are supportive of developing and enhancing links between the educational and practice areas to ensure the best possible student learning experience. However, in placing this demand on both education providers and practice education staff, compulsory education and training has the potential to remove some practice placement providers and practice educators from the market, simply because many service providers operate in tight financial margins where it would not be possible to enable staff to attend training during contracted hours. Placing the burden for this cost solely on the education provider does not take into account how many service providers avail of the free labour of students who are not remunerated for the work they do with clients. Clarity is required on whether this support and training would be considered as meeting CPD requirements for registered psychotherapists, which of course would add to its attractiveness as an option to engage with but at the same time might discourage therapists from developing skill and knowledge in other areas. Compulsory education and training is usually undervalued by recipients as evidenced by Smith (2011)¹⁵; 'Mental health professionals in the United States invest huge amounts of time, energy, and money in obtaining and maintaining their professional licences. Many will not attend events if continuing education credits are not offered. Increasingly, continuing education is something done just to meet licensing requirements rather than as a personal learning experience.' We believe that there are innovative ways to meet this requirement that warrant consideration. In [REDACTED] we currently offers additional, specialised training and conferences and workshops to our affiliated clinical placements at a reduced, or no cost to demonstrate our appreciation for their contribution to the development of students and to enhance our working relationships.¹⁶

Document 4 Standards of Proficiency for Psychotherapists

Professional Autonomy and Accountability

We welcome the 20 standards of professional autonomy and accountability that are outlined; however we are concerned that the critical importance and necessary value of ongoing clinical supervision which plays a significant role in the application of theory to practise and the

¹⁵ James B. Smith (2011) Licensing of Psychotherapists in the United States: Evidence of Societal Regression?, Transactional Analysis Journal, 41:2, 139-146, DOI: 10.1177/036215371104100209

[REDACTED]

[REDACTED]

monitoring of practice are only identified in two of the standards under the heading Professional Knowledge and Skills. We believe that clinical supervision is a central element in the formation of a psychotherapist. Currently most Psychotherapy education and training programmes operate from a tripartite approach which includes, but is not limited to personal therapy, clinical supervision and knowledge acquisition as the foundations for developing a psychotherapist. We note that no reference to clinical supervision has been made in the standards documents. We are assuming that the 100 hours of directly observed practice suggested is to provide clinical supervision to students but believe that supervision should be spread across all of the required hours of clinical practice and delivered in its more traditional format of a student meeting with their clinical supervisor to discuss their practice outside of the clinical encounter. Additionally we hold that this should be conducted at a ratio of 1 supervision session for every 4 sessions of psychotherapy delivered.

Communication, Collaborative Practice and Team-working

We welcome the 15 standards for communication, collaborative practice and teamwork and believe that they are currently embedded in [REDACTED] however again we want to emphasise that such standards are also transmitted, enhanced and developed via the practice of clinical supervision.

Safety and Quality

The 14 standards for safety and quality are currently embedded in [REDACTED] and are the minimum level of attainment that would be expected from a psychotherapist. These standards are transmitted via the tripartite approach which includes, but is not limited to personal therapy, clinical supervision and knowledge acquisition as the foundations for developing a psychotherapist.

Professional Development

The six standards for professional development are significant for all emerging psychotherapists and therapists currently working in the field. We believe it would be essential that the board outline how they intend to approve and monitor continuous professional development.

Professional Knowledge and Skills

The 32 standards under profession knowledge and skills are appropriate for a Level 9 graduate but it is unlikely that all of these standards could be delivered at the required level and/or be achievable within the confines of a Level 8 programme.

The specifically standards that we believe require a Level 9 programme are listed below;

7. Demonstrate ability to participate in or lead clinical, academic or practice-based research.

8. Know the basic principles of effective teaching and learning, mentoring and supervision.

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.

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.

31. Have a critical awareness of the need for organisation and resource management for practice.

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.

We note that clinical supervision is named in the following standards and welcome that it is given some consideration. However as stated earlier we wish to emphasise that clinical supervision is an essential element in the education, training and ongoing development of a psychotherapist and this needs to be embedded in both the standards and Criteria for Education and Training Programmes for Psychotherapists.

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.

26. Be able to articulate the parameters and value of clinical supervision and demonstrate the ability to utilise supervision to assist in practice review and in areas for development.



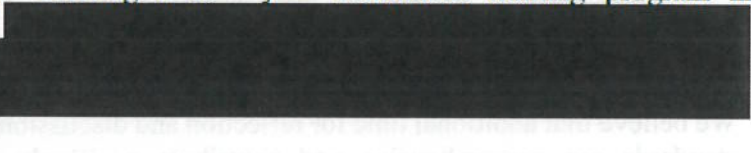
CORU SUBMISSION

Date: 30/11/2023

CORU - Health and Social Care Professionals Council
Infinity Building, George's Court, George's Lane
Smithfield, Dublin D07 E98Y
Ireland

Subject: Request for Extension of Submission Deadline and Consideration of Amendments to Proposed Standards of Proficiency for Psychotherapists and Criteria for Education and Training Programmes

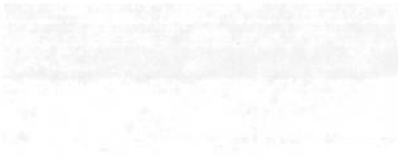
Dear CORU Health and Social Care Professionals Council,

The  is a training institute offering a four year continuous training program in Psychoanalytic Psychotherapy. 

The  would like to thank CORU for the Draft Standards of Proficiency for Psychotherapists. As a training institute, we are broadly in agreement with the Professional Knowledge and Skills 1 -32 listed in the document.

In our view, the development of these skills requires the following changes:

1. We understand CORU's concern in relation to the accessibility of psychotherapy as a profession. However, skills 3, 7, 9 and 16, in particular, are reflective of Level 9 training requiring critical judgement and appraisal of complex clinical quantitative and qualitative research.
2. Skills 11, 16, 20, 21, 24, 25, 28, and 29 reflect capacities developed and honed through personal therapy. We understand CORU has omitted personal therapy because it cannot be evaluated. However, we propose that attendance at a specified minimum number of hours of therapy is necessary to protect both therapists and clients from harm. Personal therapy fosters self-awareness and empathy, which are crucial components of effective therapeutic relationships. Ensuring that therapists have engaged in personal therapy contributes to the enhancement of client safety by promoting a deeper understanding of the therapeutic process and facilitating the therapist's ability to navigate their own emotional responses.

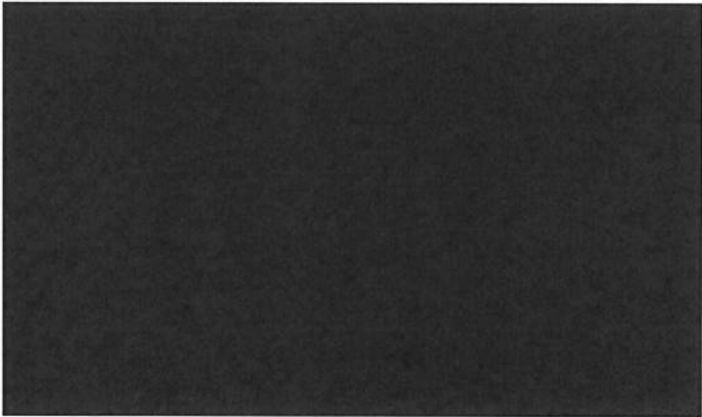
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3. The rigour of clinical supervision maintains client safety and fosters therapist self-reflection and critical judgement. The demands and depth of clinical supervision far exceed the line management relationship of the onsite supervisor. We would propose that the relative emphasis on these structures reflect this.
 4. Confidentiality is an ethical imperative and core to building safety for clients and a requirement for observed practice impinges on client confidentiality. Clients behave differently when they are aware that they are being recorded and observation fundamentally changes the boundaries and structure of a one-to-one therapeutic alliance. The introduction of a “third” in the therapeutic space would greatly impact the core safety and trust in the confidentiality of the space.
 5. Currently, the training and proficiencies of Irish psychotherapists align with those of psychotherapists across Europe as defined by the European Council for Psychotherapy. These proficiencies were drafted with the agreement of experts from many different countries. We are concerned that the CORU Standards would deviate from these, impacting the quality of therapeutic provision and safety for clients and therapists in the future. A level 9 masters provides a more comprehensive and specialized education, ensuring that psychotherapists are equipped with the advanced knowledge and skills necessary to address the diverse and complex needs of their clients. This elevated standard is essential for maintaining high-quality psychotherapy services and upholding the welfare of clients.

We believe that additional time for reflection and discussion is essential to ensure that the final standards are comprehensive and contribute positively to client safety and the overall effectiveness of psychotherapy services.

Therefore, the  respectfully request an extension to the consultation process in order to allow for further reflection and discussion on these critical issues. Additionally, I urge the council to reconsider the matters listed above in order to ensure both the educational and ethical integrity of psychotherapy training programs.

Thank you for your attention to these matters. The  look forward to contributing to the development of robust standards that prioritize client safety and the overall advancement of psychotherapy services.

Kind regards,



**Response to CORU Public Consultation on the Draft Criteria for Education and Training Programmes for Psychotherapists and Standards of Proficiency for Psychotherapists
December 1st 2023**

The following submission identifies areas of concern that [REDACTED] has regarding the CORU draft documents titled: *Criteria for Education and Training Programmes for Psychotherapists* and *Standards of Proficiency for Psychotherapists*. It is submitted in response to a call for responses to these named documents.

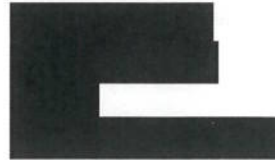
Specifically:

1. While we appreciate the consideration that CORU have given to determining an appropriate entry level for counselling and psychotherapy, a level 8 qualification for entry to the register appears low and out of kilter with the European Association of Psychotherapy with which many trainings in Ireland are aligned. Implementing a lower standard of acceptable training in Ireland in comparison with our European neighbours has many implications including a negative impact on our ability to attract international students who wish to complete their training in Ireland and to subsequently return home to practise. Lower qualification standards could also have the impact of damaging of Irish competitiveness in relation to potential research collaborations in this field.
2. The draft documents do not seem to have included a minimum threshold for the duration of training. Given the work that Higher Education Institutions have invested over the years in revising curricula to ensure adherence to the Bologna process, if this oversight remains, it positions Ireland's training and standards in this specialism outside of European standards.
3. The lack of a requirement for personal therapy in the draft documents raises serious concerns in terms of the student's own readiness for practice as well as gatekeeping issues for potential clients. It is noted that the Board acknowledges that education providers can stipulate that student engagement with a set number of personal therapy hours is a requirement but the omission of this key component of training from the criteria is concerning and may undermine the importance of the role of personal development in training and practice. While it is recognised that this requirement is an often-debated issue, "in most European countries a certain number of hours of personal therapy are mandatory to qualify for admission to the profession" (Malikiosi-Loizos, 2013). It is a retrograde move to position Ireland's standards outside those practiced by the majority in mainland Europe.
4. We note that a distinction is drawn between clinical supervision and on-site placement supervision in the draft standards for education and training programmes, with requirements outlined for the latter. The draft standards do not outline any

requirements for student engagement in clinical supervision. The lack of an explicit ratio for service user contact hours and clinical supervision in the draft documents is of concern and raises ethical questions regarding practice and gatekeeping issues. Furthermore, this omission is in direct conflict with guidance from the Psychological Society of Ireland (PSI), the professional body which accredits both undergraduate and postgraduate psychology programmes in the the [REDACTED]

This opportunity to raise issues warranting review in the draft documents is welcomed and we trust the points noted above will inform further discussion regarding education, training, and standards of proficiency for psychotherapists in Ireland.

13th November 2023



CORU
George's Court,
Infinity Building,
George's Ln,
Smithfield,
Dublin, D07 E98Y

RE: Briefing on the Regulation of Counsellors and Psychotherapists in Ireland

To whom it concerns

I am writing to you as a member of the public who also happens to be a Family/Systemic Psychotherapist employed within [REDACTED] and registered with Family Therapy Association of Ireland (FTAI), Irish Council for Psychotherapy (ICP) and European Association of Psychotherapy (EAP).



The standard of training and qualification required by HSE are consistent with standards set by FTAI and ICP since 1993 when training standards in Ireland aligned with European standards set by EAP. Significantly, these standards have been ratified by four countries within Europe, including, Germany, Austria, Croatia and Malta. Moreover, FTAI signed a Memorandum of Understanding with Association for Family Therapy (AFT) in United Kingdom in 2022 to allow for streamlining of dual registration in both jurisdictions following BREXIT. Furthermore, consideration must be given to submission made to Department of Health & Children by the Associations representing Counsellors & Psychotherapists in Ireland on The Statutory Registration of Counsellors & Psychotherapists in April 2008 (Appendix, 2) This submission gives the views of the majority of Counsellors & Psychotherapists through the associations that represent or regulate them. A combined membership of over 5000 professionals participated and thus the recommendations from the

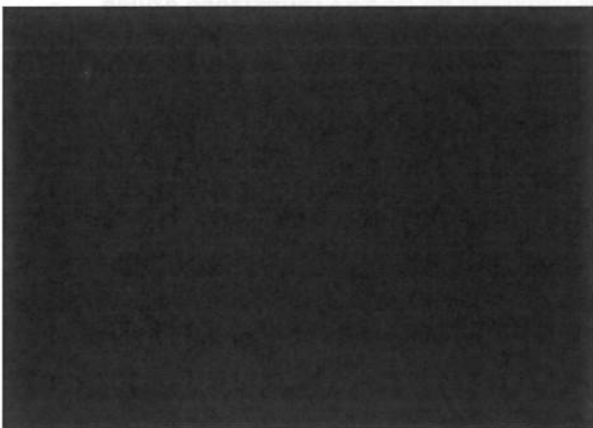
group carry an authority on behalf of the vast majority of Counsellors and Psychotherapists in Ireland. The Plenary Group met on fifteen occasions between November 2005 and April 2008.

The process of compiling the submission was informed by the work of numerous working groups. The commitment and dedication of the participating organisations to this process is evidenced by the fact that over €150,000 in professional and service fees was invested by the various groups in creating this submission. The initial meeting was addressed by Mr Tim O'Malley, Minister of State, at the Department of Health & Children who encouraged the group to formulate a submission in order to expedite and facilitate the professions to come under the auspices of the Health and Social Care Professionals Act 2005. As such, it is essential that the Psychotherapy in Ireland remains aligned to the standards at post-graduate NFQ Level 9 (Masters) rather than Level 8 as proposed by CORU.

It is important that Family/Systemic Psychotherapy and Psychotherapy in general be recognised as specialisms due to complexity of the work. As such, the requirement for personal therapy and live supervision must continue to be central components of training programmes to support practitioner development and safeguarding the public.

In summary

1. It is important that standard of training for Family/Systemic Psychotherapists and Psychotherapists in general be at NFQ Level 9 (Masters) and in keeping with European standards.
2. The requirement for personal therapeutic experience is an essential part of Family Therapy Training Programmes and must be maintained as a core part of a clinician's personal/clinical development and as an approach to safeguarding.
3. Live supervision is a central part of family therapy training with a minimum of 30 hours as lead practitioner and overall 250 hours as reflective team member overseen by a registered supervisor within the discipline.



Attachment:

- Appendix 1. Family Therapist, Job Description, HSE
- Appendix 2. Submission on the Statutory Registration of Counsellors & Psychotherapists in Ireland, by the various Associations representing membership

Appendix 1.



Family Therapist
SASSY (Substance Abuse Service Specific to Youth)
HSE Social Inclusion, Addiction Services
Dublin North City and County Community Healthcare
Job Specification & Terms and Conditions

Job Title, Grade Code	Family Therapist (Grade Code: 3959)
Campaign Reference	NRS14116
Closing Date	22 nd November 2023 at 12.00 Noon.
Proposed Interview Date (s)	Candidates will normally be given at least two weeks' notice of interview. The timescale may be reduced in exceptional circumstances.
Taking up Appointment	A start date will be indicated at job offer stage.
Location of Post	SASSY (Substance Abuse Service Specific to Youth), HSE Social Inclusion/Addiction Services, Dublin North City & County Community Healthcare. There is currently one permanent vacancy available in SASSY (Substance Abuse Service Specific to Youth) Lisburn Street, Dublin 7. <i>(The post holder will be required to attend SASSY clinics throughout CHO DNCC)</i> A panel may be formed as a result of this campaign for SASSY (Substance Abuse Service Specific to Youth) HSE Social Inclusion, Addiction Services, Dublin North City & County Community Healthcare from which current and future, permanent and specified purpose vacancies of full or part-time duration may be filled.
Informal Enquiries	Stefano Donati, Senior Counsellor, SASSY HSE Addiction Services Tel: 087/637 45 22 Email: stefano.donati@hse.ie
Details of Service	HSE Social Inclusion Addiction Service, CHO Dublin North City and County provide confidential professional, support and counselling to persons living in the North Dublin city and county area for whom drug, alcohol, gambling and gaming is having a significant negative impact on their daily lives. SASSY is a multi-disciplinary team working with young people under the age of 18 for whom drug or alcohol use or behaviour/process addictions are having a significant negative impact on their daily lives. SASSY is a dynamic and evolving service that covers Dublin North City and County, providing assessment, risk reduction intervention and treatment of addictive behaviors, including substance of abuse, gaming, gambling and PUI (problematic use of internet) for young people. There is no restriction on the number of sessions available to young people and clinicians have the autonomy to work creatively, using a number of therapeutic modalities to match the need of the young person referred.

	Referrals can include high-risk and complex cases in relation to substance misuse, behaviour/process addiction, dual diagnosis (e.g., addiction alongside ASD, ADHD, self-harm, suicide ideation, PTSD and complex trauma), problematic behaviours/symptoms and young people in care. We frequently collaborate with the judicial service and CAMHS. SASSY services are readily available to young people and their families where they live. We operate clinics throughout Dublin North City and County. SASSY is currently the pilot site for the Dual Diagnosis National Clinical Programme for under 18s. Dual Diagnosis programme is an initiative to address mental health and addiction presentations within one service. The SASSY team is recruiting new clinical disciplines to offer a more comprehensive management of these complex cases. SASSY is also a pilot treatment programme for under 18s experiencing difficulties with gaming and gambling.
Reporting Relationship	The reporting relationship for the Family Therapist will report as follows: - Operationally to the Area Operations Manager, HSE Addiction Services. - Clinically to the Consultant Child & Adolescent Psychiatrist.
Key Working Relationships	Family Therapists will work with members of the adolescent Addiction Service Multi-disciplinary team (MDT) <i>Members of the team:</i> Members of the team may come from a wide range of backgrounds including, nursing, psychiatrists, counsellors, etc. As there may be input from two or three team members into an individual client's treatment plan, there is a need for good communication and collaboration among all team members. This is facilitated by regular team meetings. Depending on the need of the catchment area, the Family Therapist may also work alongside staff working in Tier 2 adolescent addiction services in the community.
Purpose of the Post	The Family Therapist will work closely with the other members of the SASSY MDT team to ensure that they are cognisant of other services which the client / family may be receiving and to ensure an integrated approach to care.
Principal Duties and Responsibilities	Principal Duties & Responsibilities <u>Professional / Clinical</u> • To work as part of multidisciplinary team to provide family/systemic therapy for adolescents experiencing substance use disorders. • Foster an understanding of the role and contribution of family therapy by providing professional consultation, education, guidance and support to others as appropriate. • Be responsible for the delivery of Family Therapy services appropriate to the post in line with HSE best practice. • Provide a Family Therapy service across the geographical work area as required. • To provide systemic psychotherapy as a professional employing methods based upon evidence. • Ensure the principles of clinical governance are incorporated in service delivery by maintaining a high quality service based on agreed clinical standards

- At all times work in ways which are sensitive to and appropriate for the needs of families from a wide range backgrounds, including families from diverse backgrounds and minority groups.
- To be responsible for implementing a range of systemic interventions for individuals and their families, including meetings with parents and groups.
- To prioritise his/her workload in agreement with the team and the responsible Consultant Psychiatrist to address the more severe and acute presentations.
- Be professional and take responsibility for the assessment, treatment and discharge of clients whose problems are managed by family/systemic therapy based intervention.
- To supply services within the context of existing multi professional teamwork and to negotiate appropriate professional relationships with both statutory and voluntary agencies to ensure the referral of appropriate casework and communicate highly complex clinical information in a manner that is relevant and appropriate to the child and family's needs.
- Detailed Case Notes to be kept securely in line with HSE policy and contribute to client shared notes in line with HSE Policies.
- Observe professional ethical standards and behaviours as required by HSE policies and Guidelines, Freedom of Information Act, Data Protection Act and requirements of relevant Professional Accrediting Bodies, ensuring confidentiality of records and security of same.
- To liaise with other health, social care and community-based services to advocate for the wider needs of adolescents and their families to be met within their care plan.
- Maintain compliance with statutory registration requirements and/or ongoing accreditation requirements of professional bodies recognised by the HSE.

Management and Leadership

- To participate in the formulation and implementation of clinical and operational practices and procedures as appropriate.
- Participating in multidisciplinary meetings, child protection case conferences and reviews, etc. providing professional advice on individual care programme planning and other clinical matters as necessary.
- To work as part of Multidisciplinary Team and have input into the development and organisation of the service through relevant management.
- To participate, when appropriate, in an area of a special clinical interest, clinical group or clinical problem of relevance to the service.
- Initiate and participate in evaluating systemic approaches within particular areas of the service, so that the effects go beyond individual cases and improve the effective running of the service for the individuals, children, young people and/or their families.
- To participate in the implementation, monitoring and updating of an operational policy and philosophy for the clinical area.
- Contribute towards the provision of advice and consultancy to local teams / services for members to incorporate informed systemic practice within their day-to-day work with clients. In this respect, to advise on the development and integration within the team of systemically based assessment and intervention techniques that might at a

systems level be incorporated within the team's operational policy, and be applied on a routine basis by other team members.

- To participate in supervision of newly qualified systemic psychotherapists and trainees.
- To facilitate the training of Trainee Systemic Psychotherapy students and trainees from other disciplines.
- To manage, participate and play a role in the practice education of student therapists'
- To participate in work and establish own priorities for non-clinical activities such as projects, audits and research.

Professional Development and Education

- Contribute to the requirements of CPD provision and support the learning of multi-disciplinary staff team at all levels of expertise
- To participate in developing in-house professional development meetings including discussion regarding policies and service development.
- To receive regular clinical supervision from an appropriately qualified systemic clinical supervisor to ensure quality of professional practice.
- Participate actively in regular case management and managerial supervision with designed Clinical Supervisor.
- Actively participate in peer supervision with Family Therapy Colleagues as appropriate.
- To engage in professional reflective processes to ensure that Continuing Professional Development (CPD) requirements are met in order to maintain registration requirements.
- To participate in annual personal development/appraisal reviews with relevant professional line manager.
- Engage in the HSE performance achievement process in conjunction with your Line Manager and staff as appropriate.
- To ensure a quality assurance performance standard within family therapy service.
- Take responsibility for being informed of advances in professional knowledge practice
- Comply with Health and Safety regulations and review procedures.
- Be aware of the principles of risk management.
- Identify risk situations and take appropriate action.
- As a mandated person under the Children First Act 2015 you will have a legal obligation to report child protection concerns at or above a defined threshold to TUSLA & to assist Tusla, if requested, in assessing a concern which has been the subject of a mandated report.
- Promptly bring clinical governance issues such as risk, child protection etc to the attention of the Senior Counsellor or designate as appropriate.
- Adequately identifies, assesses, manages and monitors risk within their area of responsibility.

	• Have a working knowledge of the Health Information and Quality Authority (HIQA) Standards as they apply to the role for example, Standards for Healthcare, National Standards for the Prevention and Control of Healthcare Associated Infections, Hygiene Standards etc. and comply with associated HSE protocols for implementing and maintaining these standards as appropriate to the role. • To support, promote and actively participate in sustainable energy, water and waste initiatives to create a more sustainable, low carbon and efficient health service. The above Job Specification is not intended to be a comprehensive list of all duties involved and consequently, the post holder may be required to perform other duties as appropriate to the post which may be assigned to them from time to time and to contribute to the development of the post while in office.
Eligibility Criteria Qualifications and/ or experience	Candidates must have at the latest date of application: - (a) Candidates must, (i) Possess a post graduate qualification at NFQ Level 9 or higher from a 4 year professional training course in systemic family therapy designed to meet the standards of education and training detailed by the Family Therapy Association of Ireland and the European Association for Psychotherapy And (ii) Be currently registered as a Family therapist with FTAI, if applying from another jurisdiction will meet the criteria for registration with FTAI. And (a) Candidates must have 1-year post qualification experience of working in a relevant setting with children and young people Or (b) Be currently working for minimum of 1 year in a Mental Health service or similar for young people and children. Or (c) Be currently employed as a Family Therapist in the Irish Public Health Sector. Health A candidate for and any person holding the office must be fully competent and capable of undertaking the duties attached to the office and be in a state of health such as would indicate a reasonable prospect of ability to render regular and efficient service. Character Each candidate for and any person holding the office must be of good character. <i>Please note that appointment to and continuation in posts that require statutory registration is dependent upon the post holder maintaining annual registration in the relevant division of the register maintained by the Family Therapy Association (FTAI) and the European Association of Psychotherapy.</i>
Post Specific Requirements	Demonstrate depth and breadth of experience in providing Family Therapy Services as relevant to this role.
Other requirements specific to the post	• Due to the nature of the post the candidate may be required to work unsocial hours. • Access to appropriate transport to fulfil the requirements of the role.

Skills, competencies and/or knowledge	Professional Knowledge & Experience • Demonstrates a high level of professional knowledge to carry out the duties and responsibilities of the role safely and effectively within the legal, ethical and practice boundaries of the profession. • Demonstrates knowledge of the various theoretical models, approaches and interventions that apply in current practice. • Demonstrates a commitment to promoting and applying evidence based practice and research. • Demonstrate a clear understanding of risk assessment and management. • Demonstrate a willingness to engage with ICT and develop ICT skills relevant to the role. • Demonstrates a strong interest in ongoing learning and a commitment to continuing professional development. Demonstrates the ability to utilise supervision effectively. Planning and Managing Resources • Demonstrates the ability to effectively plan and manage activities and resources to ensure value for money and maximum benefit for the organisation, within a model of person-centred care. • Has a thorough understanding of the practicalities of service planning, budgetary management, value for money and cost-benefit analysis. • Aligns the profession with the strategy of the organisation. • Develops service plans that aim to anticipate the changing needs of service users and harness developing professional practice. • Takes responsibility for the achievement of delivery targets by regularly quantifying and evaluating activities against service plans (including value-for-money audit) and takes timely action to correct potential difficulties. Managing & Developing (Self & Others) • Demonstrates the ability to manage and develop self and others in a busy working environment including the ability to prioritise caseloads for self and others. • Demonstrates effective leadership and team management skills. Provides clear direction for staff in relation to the goals of their function and how they fit in with the broader organisational strategy. • Leads by example. Displays motivation, is flexible during challenging times and perseveres despite setbacks to ensure that goals are achieved. • Motivates and empowers staff by appropriately delegating responsibility and authority. Commitment to providing a Quality Service • Demonstrate a commitment to the delivery of a high quality, person centred service. • Clearly accepts accountability for standards of performance in area of responsibility. • Ensures that the full potential of their profession is fully considered in the development of strategic plans for their area of the organisation. • Strives to keep staff directed towards the longer-term change agenda, while maintaining efficiency of day-to-day service. Evaluating Information and Judging Situations • Recognises the implications and consequences of decisions in political and strategic terms for the organisation as a whole; considers precedence to ensure consistency. • Demonstrates the ability to critically analyse, evaluate information, and make effective decisions with regard to service user care. • Establishes integrity by ensuring that the professional, ethical and safety factors are fully considered in decisions into which they have input. • Makes decisions in a transparent manner by involving and empowering others where appropriate. Communications and Interpersonal Skills
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	• Display effective communication (verbal & written) and interpersonal skills. • Demonstrates sensitivity, diplomacy and tact when dealing with others. • Works collaboratively with multiple stakeholders in understanding and establishing expectations and desired outcomes. • Demonstrates strong negotiation skills, remains firm but flexible when putting forward a point of view.
Campaign Specific Selection Process Ranking/Shortlisting / Interview	A ranking and or shortlisting exercise may be carried out on the basis of information supplied in your application form. The criteria for ranking and or shortlisting are based on the requirements of the post as outlined in the eligibility criteria and skills, competencies and/or knowledge section of this job specification. Therefore it is very important that you think about your experience in light of those requirements. <u>Failure to include information regarding these requirements may result in you not being called forward to the next stage of the selection process.</u> Those successful at the ranking stage of this process (where applied) will be placed on an order of merit and will be called to interview in 'bands' depending on the service needs of the organisation.
Diversity, Equality and Inclusion	The HSE is an equal opportunities employer. Employees of the HSE bring a range of skills, talents, diverse thinking and experience to the organisation. The HSE believes passionately that employing a diverse workforce is central to its success – we aim to develop the workforce of the HSE so that it reflects the diversity of HSE service users and to strengthen it through accommodating and valuing different perspectives. Ultimately this will result in improved service user and employee experience. The HSE is committed to creating a positive working environment whereby all employees inclusive of age, civil status, disability, ethnicity and race, family status, gender, membership of the Traveller community, religion and sexual orientation are respected, valued and can reach their full potential. The HSE aims to achieve this through development of an organisational culture where injustice, bias and discrimination are not tolerated. The HSE welcomes people with diverse backgrounds and offers a range of supports and resources to staff, such as those who require a reasonable accommodation at work because of a disability or long term health condition. For further information on the HSE commitment to Diversity, Equality and Inclusion, please visit the Diversity, Equality and Inclusion web page at https://www.hse.ie/eng/staff/resources/diversity/
Code of Practice	The Health Service Executive will run this campaign in compliance with the Code of Practice prepared by the Commission for Public Service Appointments (CPSA). The CPSA is responsible for establishing the principles that should be followed when making an appointment. These are set out in the CPSA Code of Practice. The Code outlines the standards that should be adhered to at each stage of the selection process and sets out the review and appeal mechanisms open to candidates should they be unhappy with a selection process. The CPSA Code of Practice can be accessed via https://www.cpsa.ie/.
The reform programme outlined for the Health Services may impact on this role and as structures change the Job Specification may be reviewed. This Job Specification is a guide to the general range of duties assigned to the post holder. It is intended to be neither definitive nor restrictive and is subject to periodic review with the employee concerned.	

**Family Therapist
SASSY (Substance Abuse Service Specific to Youth)
HSE Social Inclusion, Addiction Services
Dublin North City & County Community Healthcare
Terms and Conditions of Employment**

Tenure	The current vacancy available is permanent and whole time. The post is pensionable. A panel may be created from which permanent and specified purpose vacancies of full or part time duration may be filled. The tenure of these posts will be indicated at "expression of interest" stage. Appointment as an employee of the Health Service Executive is governed by the Health Act 2004 and the Public Service Management (Recruitment and Appointments) Act 2004 and Public Service Management (Recruitment and Appointments) Amendment Act 2013.
Remuneration	The Salary scale for the post (as at 01.10.2023) is: €75,473 - €77,661 - €81,072 - €84,484 - €87,895 €91,310 New appointees to any grade start at the minimum point of the scale. Incremental credit will be applied for recognised relevant service in Ireland and abroad (Department of Health Circular 2/2011). Incremental credit is normally granted on appointment, in respect of previous experience in the Civil Service, Local Authorities, Health Service and other Public Service Bodies and Statutory Agencies.
Working Week	The standard working week applying to the post is to be confirmed at Job Offer stage.
Annual Leave	The annual leave associated with the post will be confirmed at Contracting stage.
Superannuation	This is a pensionable position with the HSE. The successful candidate will upon appointment become a member of the appropriate pension scheme. Pension scheme membership will be notified within the contract of employment. Members of pre-existing pension schemes who transferred to the HSE on the 01st January 2005 pursuant to Section 60 of the Health Act 2004 are entitled to superannuation benefit terms under the HSE Scheme which are no less favourable to those which they were entitled to at 31st December 2004
Age	The Public Service Superannuation (Age of Retirement) Act, 2018* set 70 years as the compulsory retirement age for public servants. <u>* Public Servants not affected by this legislation:</u> Public servants joining the public service or re-joining the public service with a 26 week break in service, between 1 April 2004 and 31 December 2012 (new entrants) have no compulsory retirement age. Public servants, joining the public service or re-joining the public service after a 26 week break, after 1 January 2013 are members of the Single Pension Scheme and have a compulsory retirement age of 70.
Probation	Every appointment of a person who is not already a permanent officer of the Health Service Executive or of a Local Authority shall be subject to a probationary period of 12 months as stipulated in the Department of Health Circular No.10/71.

Protection of Children Guidance and Legislation	The welfare and protection of children is the responsibility of all HSE staff. You must be aware of and understand your specific responsibilities under the Children First Act 2015, the Protections for Persons Reporting Child Abuse Act 1998 in accordance with Section 2, Children First National Guidance and other relevant child safeguarding legislation and policies. Some staff have additional responsibilities such as Line Managers, Designated Officers and Mandated Persons. You should check if you are a Designated Officer and / or a Mandated Person and be familiar with the related roles and legal responsibilities. For further information, guidance and resources please visit: HSE Children First webpage.
Infection Control	Have a working knowledge of Health Information and Quality Authority (HIQA) Standards as they apply to the role for example, Standards for Healthcare, National Standards for the Prevention and Control of Healthcare Associated Infections, Hygiene Standards etc. and comply with associated HSE protocols for implementing and maintaining these standards as appropriate to the role.
Health & Safety	It is the responsibility of line managers to ensure that the management of safety, health and welfare is successfully integrated into all activities undertaken within their area of responsibility, so far as is reasonably practicable. Line managers are named and roles and responsibilities detailed in the relevant Site Specific Safety Statement (SSSS). Key responsibilities include: • Developing a SSSS for the department/service¹, as applicable, based on the identification of hazards and the assessment of risks, and reviewing/updating same on a regular basis (at least annually) and in the event of any significant change in the work activity or place of work. • Ensuring that Occupational Safety and Health (OSH) is integrated into day-to-day business, providing Systems Of Work (SOW) that are planned, organised, performed, maintained, and revised as appropriate, and ensuring that all safety related records are maintained and available for inspection. • Consulting and communicating with staff and safety representatives on OSH matters. • Ensuring a training needs assessment (TNA) is undertaken for employees, facilitating their attendance at statutory OSH training, and ensuring records are maintained for each employee. • Ensuring that all incidents occurring within the relevant department/service are appropriately managed and investigated in accordance with HSE procedures². • Seeking advice from health and safety professionals through the National Health and Safety Function Helpdesk as appropriate. • Reviewing the health and safety performance of the ward/department/service and staff through, respectively, local audit and performance achievement meetings for example. Note: Detailed roles and responsibilities of Line Managers are outlined in local SSSS.
Ethics in Public Office 1995 and 2001	Positions remunerated at or above the minimum point of the Grade VIII salary scale are designated positions under Section 18 of the Ethics in Public Office Act 1995. Any person appointed to a designated position must comply with the requirements of the Ethics in Public Office Acts 1995 and 2001 as outlined below: A) In accordance with Section 18 of the Ethics in Public Office Act 1995, a person holding such a post is required to prepare and furnish an annual statement of any interests which could materially influence the performance of the official functions of the post. This annual statement of interest should be submitted to the Chief Executive Officer not later than 31st January in the following year.

¹ A template SSSS and guidelines are available on the National Health and Safety Function, here: <https://healthservice.hse.ie/staff/health-and-safety/safety-statement/>

² See link on health and safety web-pages to latest Incident Management Policy

	B) In addition to the annual statement, a person holding such a post is required, whenever they are performing a function as an employee of the HSE and have actual knowledge, or a connected person, has a material interest in a matter to which the function relates, provide at the time a statement of the facts of that interest. A person holding such a post should provide such statement to the Chief Executive Officer. The function in question cannot be performed unless there are compelling reasons to do so and, if this is the case, those compelling reasons must be stated in writing and must be provided to the Chief Executive Officer. C) A person holding such a post is required under the Ethics in Public Office Acts 1995 and 2001 to act in accordance with any guidelines or advice published or given by the Standards in Public Office Commission. Guidelines for public servants on compliance with the provisions of the Ethics in Public Office Acts 1995 and 2001 are available on the Standards Commission's website https://www.sipo.ie/.
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Appendix 2.

Submission on The Statutory Registration of Counsellors & Psychotherapists in Ireland

(Final Document April 2008)

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INTRODUCTION

This is a period of growing interest in issues related to Counselling & Psychotherapy and its regulation in Ireland. The roles of Counsellor and Psychotherapist are now recognised as being part of any best practice holistic response to the health and social care needs of our population.

It is imperative that the public shall be protected by promoting high standards of conduct, education, training and competence among the professions of Counselling and Psychotherapy. This protection is currently offered through a process of self regulation. All of the bodies outlined in Appendix 1 provide codes of ethics and practice which their members must abide by. Each organisation also provides standards which a person must achieve before they are accredited as a Counsellor or Psychotherapist. Whilst this form of self regulation indeed provides protection to clients of those organizations, it falls short of optimal protection as under our common law system it is possible for any person to take the title Counsellor or Psychotherapist and practice accordingly without the required training and competence.

This current anomaly does not lend itself to good clinical governance and the maintenance and improvement of high standards of patient/client care. The Health and Social Care Professionals Act 2005 creates a mechanism to drive forward the clinical governance agenda. It creates a framework through which practitioners are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence will flourish and optimal protection is offered to the public.

The Health and Social Care Professionals Act 2005 facilitates the State in providing optimal protection to clients who wish to avail of Counselling & Psychotherapy. Section 4 (3) (d) of the Health and Social Care Professional Act defines (for the purposes of the Act) a health or social care profession as: ***“any profession in which a person exercises skill or judgment relating to the care of those in need of protection, guidance or support.”***

This definition quite clearly allows for the professions of Counsellor and Psychotherapist to fit within the spectrum and compass of the act. The agreement of all the participating groups in this process to opt for a registration board for Counsellors & Psychotherapists is a critical milestone in achieving this objective, as is the decision of all groups to adopt the name of ***“Psychological Therapist”*** to cover both professions.

The establishment of a State registration process for *“Psychological Therapists”* would close the common law loophole and consequently ensure higher levels of protection for the public. Section 27 of the Act states: *“The object of the registration board of a designated profession is to protect the public by fostering high standards of professional conduct and professional education, training and competence among registrants of that profession.”*

This submission has been written in the context of this interest and in response to a request from the Department of Health and Children. It follows an initial Forum on regulatory issues held at the Camden Court Hotel on November 10th 2005.

No national statistics exist on the numbers of Counsellors & Psychotherapists in Ireland or on the associations that represent them. This submission gives the views of the majority of Counsellors & Psychotherapists through the associations that represent or regulate them. The Counselling and Psychotherapy organisations behind this submission (Appendix 1) have a combined membership of over 5000 professionals and thus the recommendations from the group carry an authority on behalf of the vast majority of Counsellors and Psychotherapists in Ireland and facilitates the Department of Health & Children in expediting the process of State registration.

The Plenary Group met on fifteen occasions between November 2005 and April 2008. This plenary group was assisted and informed through the work of numerous working groups throughout this period. The commitment and dedication of the participating organisations to this process is evidenced by the fact that over 150,000 EURO in professional and service fees was invested by the various groups in creating this submission.

The initial meeting was addressed by Mr Tim O'Malley, Minister of State at the Department of Health & Children. The Minister expressed an enthusiasm for the professions of Counselling & Psychotherapy to structure themselves in a format which would facilitate statutory recognition of both professions. He encouraged the group to formulate a submission to expedite and facilitate the professions to come under the auspices of the Health and Social Care Professionals Act 2005.

STEPWISE SYNOPSIS OF THE PROCESS:

Date	Action
November 2005	All groups agreed to submit a position paper outlining details of their organisation, including: • Scope of practice and membership numbers • Basic Training requirements • Range of competencies • Professional Development • Post-training experience • Supervision • Personal therapy requirements • Ethics & Practice • Regulation of Members, including issues around professional misconduct • Indemnity insurance requirements
Nov 2005	Two separate working groups were established to examine in detail the theory and practice underpinning the professions of Counselling & Psychotherapy.
November 2005 – April 2006	Detailed analysis of Health and Social Care Professionals Act 2005.
April - September 2006	Communications with Department of Health & Children. Discussion and consensus that the two professions had enough similarities to come under one registration board titled <i>“Psychological Therapist”</i>. This title was brought back to the executive of each organisation and received unanimous backing. The Act permits a Board to establish categories which in this case would protect the professional titles of Counsellor and Psychotherapist.
September 2006 – March 2007	The legislation requires clear criteria around the minimum baseline qualifications that individuals must have in order to be registered. The two groups set about articulating criteria

	for each category (Counsellor and Psychotherapist) to include: • Baseline academic qualification for entry and exit from training. • Baseline experiential requirements – Clinical hours, Personal therapy and Supervision. • Baseline Grandparenting arrangements for access to registration within the two year window as set out in the Act.
April - June 2007	Draft Recommendations & final submission
June 2007 – April 2008	Consultation Process with all the organisations

CONCLUSIONS & RECOMMENDATIONS

Sincere thanks are due to the many national organisations for Counselling & Psychotherapy in Ireland (Appendix 1) who participated actively in this process and shared of their clinical knowledge, organisational time and resources. Our thanks are due to Minister Tim O’ Malley who prompted, informed and welcomed this submission. The group would also like to acknowledge the support and expertise received from Simonetta Ryan, Maeve O’Brien and Caroline Kelly of the Department of Health & Children. Special thanks to Mr Frank Scott Lennon who facilitated the submission process.

Throughout the fifteen meetings over the two and a half year period much debate and discussion took place. It has also established a clear consensus and pathway to the establishment of a state registration board for *“Psychological Therapists”*.

The Health and Social Care Professionals Act 2005 facilitates the State to initiate a registration process, Section 27 of the Act states: *“The object of the registration board of a designated profession is to protect the public by fostering high standards of professional conduct and professional education, training and competence among registrants of that profession.”* It is also quite clear that the role of *“Psychological Therapist”* falls within the scope of the Act as section 4 (3) (d) defines (for the purposes of the Act) a health or social care profession as: *“any profession in which a person exercises skill or judgment relating to the care of those in need of protection, guidance or support.”*

The work of this group indicates a consensus among the 5000 Counsellors & Psychotherapists in Ireland to come under the remit of the Health and Social Care Professionals Act 2005. The group has formulated three specific recommendations which create a consensual and smooth pathway into the future, ensuring Ireland is at the cutting edge of *“Psychological Therapy”* whilst offering the optimal public protection.

Recommendation One

That the name of the proposed registration Board be: “PSYCHOLOGICAL THERAPISTS”.

Recommendation Two

That the titles “Counsellor” and “Psychotherapist” be protected within the registration board.

Recommendation Three

That the following criteria are adopted for recognition and registration as Psychological Therapist.

PSYCHOTHERAPIST (PSYCHOLOGICAL THERAPIST)

Baseline academic qualification for entry to training is:

1. Degree or equivalent in human sciences (medical, psychological, social, educational etc).
2. Interview

Baseline qualification and experience for registration as psychotherapist:

Minimum four years of training in specific psychotherapy modality at master’s level (1,400 hours) to include, for example:

1. 250 hours/sessions personal psychotherapeutic experience
2. 500 – 800 hours theory or methodology
3. 300 – 600 hours/sessions supervised clinical practice with clients/patients
4. 150 hours/sessions supervision
5. Clinical placement in a mental health or psycho-social setting.

Criteria for grandparenting practicing psychotherapists

Academic:

M.A./ post Graduate or equivalent psychotherapy training

Experiential:

1. 250 hours/sessions of personal psychotherapeutic experience and/or other modality-appropriate reflective process
2. 500 hours/sessions (minimum) of supervised client work in professional practice for not less than five years.
3. 150 hours/sessions of supervision – ratio 1:10
4. Membership of a recognised professional psychotherapy body* and subscribe to their code of ethics and practice.

* such bodies must be existence for a minimum of four years

COUNSELLOR (PSYCHOLOGICAL THERAPIST)

Baseline academic qualification for Entry to training is:

- 1 a- Entry level 1 –Leaving certificate or equivalent
b- Entry Level 2 – relevant Degree or equivalent accredited prior learning considered.
- 2 Interview

Baseline qualification and experience for registration as Counsellor:

Minimum 4 years training in specific counselling and psychotherapy modality Minimum 1250 hours to include

- 1 600 hours of academic training including theory over minimum of 4 years
- 2 400 hours of supervised clinical practice with clients/patients during training
- 3 100 hours supervision (Supervision ratio 1:4)
- 4 150 hours Personal development experience to include minimum of 100 hours of personal psychological therapy
Leading to a degree or recognised accredited equivalent in Counselling
(Training body responsible for undergraduate)

Criteria for grandparenting practicing Counsellors:

1. Membership of a recognised professional counselling body* and subscribe to their code of ethics and practice.

2. 500 hours (minimum) of supervised client work in professional practice for not less than five years.
3. 50 hours of supervision – ratio 1:10
4. Evidence of Continuing Professional development

* such bodies must be existence for a minimum of four years

APPENDIX 1

ACCORD Marriage & Relationship Counselling Service

The Association for Psychoanalysis and Psychotherapy in Ireland (APPI)

The Irish Association for Cognitive Analytical Therapy (ICAT)

The Irish Association of Alcohol and Addiction Counsellors (IAAAC)

The Irish Association of Christian Counsellors (IACC)

The Irish Association for Counselling & Psychotherapy (IACP)

The Irish College of Psychiatrists (as of Jan 01, The College of Irish Psychiatrists)

The Irish Council for Psychotherapy (ICP) incorporating

1. Cognitive Behavioural Therapy (CBT)
2. The Family Therapy Association of Ireland (FTAI)
3. The Irish Analytical Psychology Association (IAPA)
4. The Irish Association of Humanistic & Integrative Psychotherapy. (IAHIP)
5. The Irish Constructivists Psychotherapy Association (ICPA)
6. The Irish Forum for Psychoanalytic Psychotherapists (IFPP)
7. The Irish Forum for Child & Adolescent Psychotherapy (IFCAPP)
8. The Irish Group Analytic Society (IGAS)
9. The Irish Psychoanalytic Association (IPAA)

The Northern Ireland Institute Of Human Relations (NIIHR)

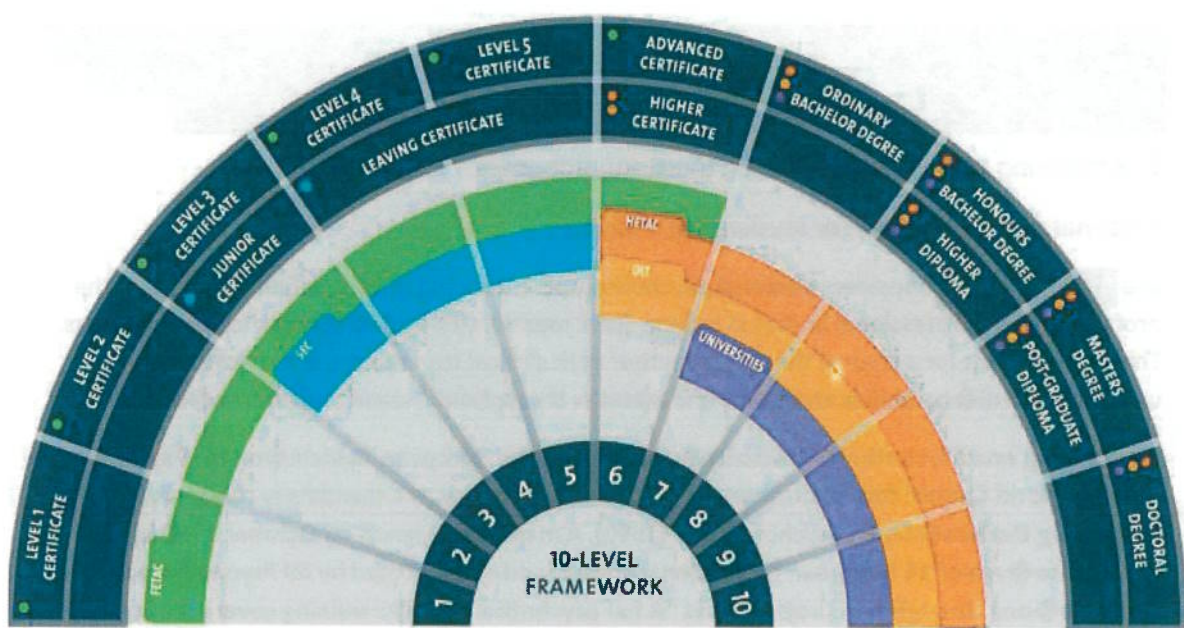
The Irish Institute of Counselling & Hypnotherapy

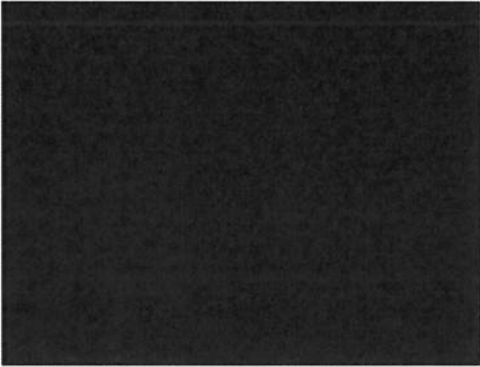
The Irish Gestalt Society (IGS)

Marriage and Relationship Counselling Service (MRCS)

The National Association for Pastoral Counsellors and Psychotherapists (NAPCP)

APPENDIX 2 – HETAC FAN





Submission to Coru in relation to Counselling and Psychotherapy standards.



The following are our comments on the Coru proposals:

Personal psychotherapy for students in training

The  considers personal psychotherapy in training to be a defining feature of the profession. The professional bodies in Ireland have mandated personal therapy for over 30 years. This requirement for personal therapy, together with clinical supervision, is a shared element unifying accrediting bodies and training institutes throughout Ireland and internationally.

Counselling and Psychotherapy Associations, such as the European Association for Psychotherapy and the World Council for Psychotherapy, list personal therapy as a mandatory requirement. The Strasbourg Declaration on Psychotherapy (1990), a manifesto, signed on October 1990 by the representatives of 14 European professional bodies, and since, signed by 40 Psychotherapy Organisations throughout Europe, states "A full psychotherapeutic training covers theory, self-experience, and practice under supervision." In Europe, a number of countries including Austria, Germany, the Netherlands and Sweden have regulatory authorities that have mandated hours of self-experience / personal therapy. The number of personal therapy hours range from 50 hours in the Netherlands to 250 hours in Austria. .

Recording of interview with the General Secretary of the European Association for Psychotherapy

In this interview of Nov 2023, Edward Boyne,  talks to Tom Warnecke about the Coru proposals and essential role of personal psychotherapy for students in training. The interview can be viewed here:

[Edward Boyne interviews Tom Warnecke EAP Gen Sec - YouTube](#)

Supervision and clinical placement

The proposed CORU model of on-site supervision within the draft criteria and standards is entirely unsuitable for the counselling and psychotherapy professions for several reasons:

1 The placement providers are usually independent service provider organisations which do not rely on students and are not formally affiliated with training colleges. They have no provision for or tradition of assessment of students. They are not educators. That is not their role as typically defined by their constitutions or memoranda of association etc. They generally would not be prepared to take on the possible legal exposure arising from the assessment of students where eg a student fails the clinical work module. We have been so informed by placement providers in quite clear terms on several occasions recently.

They cannot be compelled in any way to agree to or implement the Coru placement model. They have not been adequately consulted and many of our placement organisations have indicated to us that they would not in any circumstances collaborate with this model as proposed. If we in the [redacted] are left without sufficient placement opportunities for students we will have no alternative but to close down the courses. This is an alarming but very real prospect arising from the Coru proposals.

For Coru to propose a new policy/structure for placements and placement supervision without adequate consultation with the placement and service providers involved is most unusual and quite inexplicable.

2. The professional environment, characterised by non-traditional sessional working hours and limited physical space in placement centres, does not align with a typical 9-5 block placement structure, which seems to be proposed by CORU for placements and on-site supervision.

3. The crucial role of the clinical supervisor in the current draft proposals, has been undermined, which poses significant risk to client and therapist safety. Clinical supervision, an indispensable feature of counselling and psychotherapy training, cannot be replaced by on-site supervision. Clinical supervision is endorsed by the IACP and other professional bodies nationally and internationally. It is not an optional extra and is an essential part of training..

Assessment via direct observation

• Excessive direct observation hours can be intrusive, impacting the client's confidentiality (GDPR), safety, and the overall quality of therapy.

• No other CORU profession has a requirement for directly observed placement hours. The inclusion of direct observation in the Criteria for Education and Training for Counselling and for Psychotherapy needs careful consideration due to its potential negative impact on clients. Fairness and equity must apply to the issue.

The very high level of direct observation proposed by Coru is seen as greatly excessive and intrusive on potentially vulnerable clients, primarily in low-cost counselling with few alternatives. On ethical grounds we would not be in a position to agree to this level of observation..

[redacted]

[redacted]

To whom it may concern,

I would like to add my contributions to the CORU Consultation for the **Psychotherapists - Standards Of Proficiency And Criteria For Education And Training Programmes For Psychotherapists**.

As a trainee child and adolescent psychotherapist currently in my [REDACTED] year of training there are many areas that I find quite concerning and I hope that due consideration is given to these concerns. My opinions listed below are based on my experience to date as a trainee psychotherapist for young people. I have many concerns that endanger the public safety of vulnerable people.

I believe that setting a Level 8 qualification instead of Level 9 is problematic. Students could come directly from Leaving Certificate level into this complex profession. From a neuroscience point of view, as a brain isn't fully developed until age 25, it is bewildering to think that a student could be a practicing psychotherapist before this stage! Having life experience, further education experience and experience in a workplace collaborating and dealing with people, particularly young people, has been a valuable asset in my training and understanding of psychotherapy to date. This change could also jeopardise eligibility with EAP in Europe. Being a psychotherapist is a complex job and the complexity of training should reflect that. Providing psychotherapy courses below a Level 9 would put Irish psychotherapists below the accepted standard in Europe, USA and Canada which would lead to an unsafe environment for both clients and practitioners. I believe that this should be addressed.

Changing the placement with a requirement to have an on-site CORU registered psychotherapist would be a very challenging experience for trainees. Accessing suitable placements sites will be next to impossible in many areas, reducing the accessibility for students of psychotherapy training courses.

Having a stipulation of 'directly observed' placement hours is not achievable or appropriate. It would be difficult to find a placement that could offer this not to mention how unethical and unnerving it would be for young clients to have their therapy sessions observed by a stranger.

The absence of mandatory personal therapy or clinical supervision during training is the most alarming element for me and fills me with panic for our vulnerable young people that may potentially be receiving care, developing a therapeutic relationship with a psychotherapist that is not adequately trained and has not done their own psychotherapeutic work on themselves. Not being aware of their own triggers, unhealed trauma and blind spots to name but a few would be dangerous when developing the client relationship. It is not possible to help anyone heal further than the stage of your own healing. Having completed four years of personal psychotherapy to date, this has been an invaluable asset to my therapeutic work. Having a level of emotional functionality and self-awareness gained through personal therapy guides me with my clients. Clinical supervision embedded in my training course has been priceless and instrumental in my learning journey and given me the space to explore my case conceptualisation and develop my internal supervisor.

It is dangerous and unethical to not have a mandatory requirement of personal psychotherapy and clinical supervision before beginning to help clients on their healing journey. From speaking with colleagues in other areas, they are full of admiration for the level of diligence we have when it comes to personal therapy and clinical supervision. Having both as part of the psychotherapy training ensures safe practice for both psychotherapist and client. The current proposals do not seem to recognise 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.

The standards of proficiency laid out, I believe, will lead to poorly trained psychotherapists and will undermine this very important profession in our country. Now more than ever, we should be doing

everything in our power to protect vulnerable young people and ensure that robust, appropriate training is a requirement when working in this field.

I implore CORU to give these concerns adequate discussion among the review panel and that the welfare and protection of vulnerable young people is kept to the forefront of your minds throughout.

Many thanks,

A solid black rectangular box used to redact the signature of the sender.

CORU Public Consultation 2023

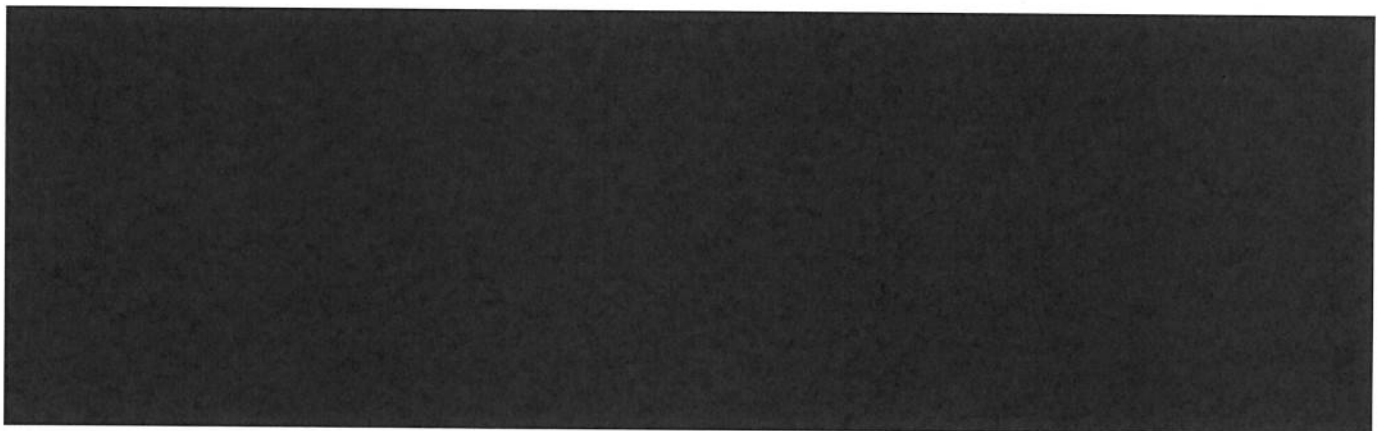
Counsellors and Psychotherapists Registration Board

-Criteria for Education and Training Programmes

-Draft Standards of Proficiency for Psychotherapists

Feedback and comments on the CORU proposals for registration of Psychotherapists :

Please see feedback and comments on the CORU proposals for the regulation of Psychotherapy. I am an accredited member of IAHIP and a Registered Psychotherapist with the Irish Council for Psychotherapy (ICP).



Feedback and comments on CORU proposals for the regulation of Psychotherapy .

Feedback on Entry requirements to training as a psychotherapist :

On page 3 of the QQI Award Standards for Counselling and Psychotherapy (May 2014/HS2), the following sentence gives recognition to the entrance requirement to psychotherapy training courses

"It is also recognised that entry to some professionally oriented education and training programmes in counselling and psychotherapy , some of up to four year's duration , will require an honour's bachelor degree in the human sciences or equivalent" .

In my opinion the entry standard for training as a psychotherapist should continue to be an honours bachelor's degree in human sciences or equivalent ; supporting such an entry standard would continue to guarantee the very high standard of training and education which already exists in the Irish context. This would then lead to a threshold of Level 9 as a minimum for entry to a register for psychotherapists. As most psychotherapy training programmes currently produce graduates at level 9, following 4 years of training in a particular modality, this would guarantee the maintenance of the high standard which currently exists .

It is disappointing to read how the current CORU proposals fall very short of this accepted European (EAP) and Irish (ICP) entry standard and how, if accepted, these current draft proposals, will lessen and devalue the current high standard which has been set by the Professional Bodies representing psychotherapy in Ireland . I would advocate for a return to this entry to training standard and argue that it does not exclude anyone from entry to the profession of psychotherapy ; anyone interested in third level education can by a variety of pathways, make a commitment to becoming a psychotherapist . For example, following a primary degree in counselling or human sciences and achievement of a level 8 honours degree, students could then embark on professional training as psychotherapists, graduating at level 9 and being eligible to enter the psychotherapy register.

In the CORU draft documents there are two essential aspects of training to become a psychotherapist which appear to be missing from the draft proposals and again I would advocate that these need to be included as crucial and mandatory criteria for training as a psychotherapist .

1) Personal Psychotherapeutic Experience , or equivalent : (not less than 250 hours : EAP Standards for training)

It is required that learners are in their own personal psychotherapy contemporaneously while undertaking a training programme in Psychotherapy. Personal psychotherapy will need to be humanistic / integrative / psychodynamic and therefore comprises of weekly sessions. In some modalities more weekly sessions may be required .

This *Personal Psychotherapeutic Experience, or equivalent*, has been proven as one of the most valuable aspects of one's foundation as a therapist and is clearly delineated in the EAP standards for training as a psychotherapist : (see section 4.2.1 of the EAP The European Certificate of Psychotherapy document).

2) Process Group/Group experiential Learning :

Group experiential learning is a fundamental part of training in humanistic / integrative / psychodynamic psychotherapy. It has a crucial function in providing learners with the challenge to articulate in a group context the issues that arise over the duration of the training programme. Formats such as weekly Process groups constitute an indispensable component for personal development. It is essential during training to engage in a group process to provide learners/trainees with appropriate facilities in which to deepen their understanding of themselves, their relationships and of others, and to encourage self-reflection. Through continuing their engagement and commitment to a Process group, learners are facilitated in becoming more aware of the way in which their own personal convictions or prejudices can impact on interpersonal processes in psychotherapeutic work.

Thus the two elements of a) personal psychotherapy and b) process/group experiential work, must form part of one's foundational experience in order to reach the depth of self knowledge, self experience, understanding of other, and ensure that trainees have a critical analytic knowledge of the therapeutic relationship which is the cornerstone of the therapy process.

These aspects of a training programme are fundamentally different to theoretical learning, lectures, or other forums for engaging with learning and are an exceptional feature of training as a psychotherapist. It is essential that they are articulated in any draft criteria for education and training programmes for psychotherapy.

Supervision:

The requirements for supervision outlined in the draft criteria seem to fall short of the intensive training supervision element that is currently a feature of most post graduate training programmes. This element of training cannot be measured in hours alone and simply increasing the number of hours does not in any way demonstrate integration of the trainee's process as a psychotherapist in the work. It is my opinion that supervision as a key element of training as a psychotherapist must remain within the context of the training programme, is deeply embedded in the orientation and modality of the training programme and is not just a feature of the placement. There is of course, a way in which some form of case management may be undertaken and remain within the placement, but this should not have any evaluative or assessment aspect to it.

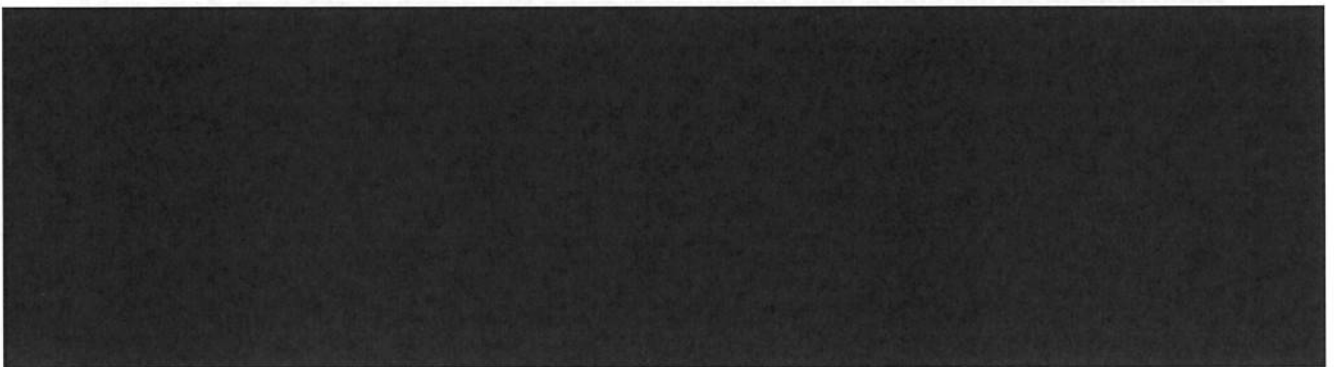
On site supervision as outlined in the CORU criteria appears divorced from the main training forum and seems to be almost a stand alone form of assessment. It takes no cognisance of the integration of theory and practice and of how the trainee responds to and develops understanding and containment of clinical practice. The key proficiencies which are necessary for development within a training supervision process include a) awareness of own process in clinical practice b) understanding the therapeutic relationship c) application of counselling and psychotherapeutic skills d) professionalism and ethics e) evidence of the integration of theory and practice of specific modality f) understanding of the function of supervision (this can include both individual and group supervision).

Supervision must be modality specific and supervisors must be trained within the orientation and framework of each modality. Supervision and its core assessment function of clinical practice should remain within the Training context, in co-operation with placements and with appropriate Professional Supervision according to modality.

Finally, proposed criteria for CPD should make specific reference to on- going advanced Supervision post –training, as a mandatory part of a CPD process .

I am advocating for the retention of the very high standard of post graduate education and training espoused by the EAP/ICP current standards and wish to express my disappointment at the draft proposals, which I see as a significant diminution of standards already in existence in Ireland .

I continue to support and advocate for a threshold of Level 9 for entry to any register for psychotherapists.



Dear CORU

I am writing to you as a member of the Public & as a practicing psychotherapist with 18 years experience working with Children, Adolescents & Adults. This letter in my submission to CORU and brings to your attention my grave concerns regarding the Draft Standards of Proficiency for Psychotherapists & the Draft Criteria for Education & Training Programs as recently proposed by CORU. I believe they pose a significant & serious risk to the Mental Health & Wellbeing of members of the public and undermine the profession of psychotherapy as a whole profession. Of more significant concern is the risk such inadequate criteria would present to the personal Safety, Welfare & Wellbeing of vulnerable members of the public, such as children, adolescents, vulnerable adults and their families if such deficient standards were enacted.

The Irish Association of Humanistic and Integrative Psychotherapy (IAHIP), of which I am a member, is the largest Member Organisation of the Irish Council for Psychotherapy (ICP), and the largest accrediting body of psychotherapists in Ireland. We are accredited to the European gold standard approved by the European Association of Psychotherapy (EAP). This is the most exacting standard in Europe, and guarantees the integrity of our profession in Ireland. The EAP standard requires that Psychotherapists must meet the following criteria:

- Seven years of training, ending in a postgraduate qualification (level 9 in Ireland).
- Have personally undergone a minimum of 250 hours of Psychotherapy.
- An appropriately trained and qualified supervisor must have supervised their training.

In contrast, under the new CORU proposals, Psychotherapists would be required to only have a three- or four-year primary degree. Personal participation in therapy would not be a required part of their training, nor would their training need to be supervised by a supervisor who is appropriately trained and qualified. My specific concerns are for the following reasons.

- i) The absence of a Personal Therapy component establishes poor professional practice & significantly deviates from sound clinical governances, customs & traditions within psychotherapy and the existing minimum standards of training & practice presently for psychotherapists in training. The absence of rigorous minimum requirements for Personal Therapy places members of the public in danger of being exploited & misled by misguided and/or poorly trained & inadequately experienced therapists.

ii) The minimum Level 9 must be the required NQL entry requirement as a fundamental prerequisite for students psychotherapists who need to have evolved to the peak of their personal capacity for human development & maturity so that students have the required personal & profession insight necessary for sound clinical governance & practice . This is of particular relevance when working with children, vulnerable adults & their families.

iii) Onsite observations as presently outlined in the Draft Standards of Proficiency for Psychotherapists & the Draft Criteria for Education & Training Programs do not comply with present GDPR requirements for sound clinical governance. As presently described these standards are a direct violation of all members of the Irish public's inherent right to the privacy & confidentiality of their Medical Records . By their very nature these standards contravene present EU legislation & are exclusionary by design in that they engender anxiety & fear of exposure at a critical juncture when members of the public engaging in psychotherapy are trying to bring about significant change through personal development.

iv) All Psychotherapy Supervisors as described in the standards are not required to be of equivalent standards to the present accredited supervisors within IAHIP as a professional body. From a psychotherapy perspective this demonstrates a gross absence of robust clinical governance & oversight of student therapists. This practice seeks to overwhelmingly neglect the most vulnerable members of the public (children & vulnerable adults). To implement the present Draft Standards of Proficiency for Psychotherapists & the Draft Criteria for Education & Training Programs for psychotherapists as these relates to the supervision of trainees & to implement these draft Standards into a legally prescribed framework would be a profound misuse of public funds, seek to significantly reduce present psychotherapy standards of training, clinical practice, clinical governance and would establish the opposite of what the regulation under The Health and Social Care Professionals Act, 2005 (HSCP Act 2005) overarching principals seeks to achieve i.e. the safety & welfare of the Irish Public.

vi) IAHIP is the largest Member Organisation of the Irish Council for Psychotherapy (ICP) and our standards are accredited to the European gold standard approved by the European Association of Psychotherapy (EAP). The European Association of Psychotherapy (EAP) is the gold standard of practice in nine of the present EU Members states (Austria, Belgium, France Germany, Greece, Italy, Netherlands, Poland & Spain). To put the Draft Standards of Proficiency for Psychotherapists & the Draft Criteria for Education & Training Programs as recently proposed by CORU on a statutory footing would mean that Ireland's statutory regulation of psychotherapy practice will not be of equivalence standards & is critically less rigorous than those in nine other EU Member states.

This is in direct contravention of the common EU principal of all EU members having a common set of minimum knowledge, skills and competences that are needed to pursue a given profession through a Common Training Framework in each of the member states.

vii) CORU's regulations as presently presented represent a gaping dilution of present professional clinical practice. It is incumbent on CORU to alter these regulations if minimum standards are to be prescribed that seek to take care of all members of the public. Of particular concern are the members of public who are under 18 of age and vulnerable adults. For Psychotherapists present Irish Legislation states that as a profession we have statutory & mandatory obligations to work in the best interests of our clients & to keep members of the public safe at all times. These regulations do not seek to fulfill these mandatory obligations & are in stark contravention & a violation of existing Irish Legislation in this regard (The Children First Act 2015; Child Care Act 1991 & Children First National Guidance for the Protection and Welfare of Children 2017

For the above reasons I have very real & genuine concerns with regard to the absence of overarching Sound & Robust Clinical Governance of Psychotherapy as a profession as it is presently described in these CORU regulations for psychotherapy.

I believe strongly that CORU's/these proposed standards will undoubtedly weaken the efficacy of psychotherapy as a practice; diminish and negatively impact the rigour of training; while ultimately undermining public trust and safety in psychotherapy and psychotherapists as professionals, all of which are contrary to the purpose of statutory regulation.

Yours Sincerely,

[REDACTED]

For the urgent attention of Coru strategy and policy makers.

We, the undersigned, are a group of experienced and committed psychotherapists and supervisors, writing in response to the recent webinar on the draft standards of proficiency in psychotherapy/counselling and the draft criteria for education and training programmes.

Based on what we have heard and read here, we feel great concern for the future of our professions and the safety of those who might have a need to use them.

Regulation is, we agree, a good and necessary step towards raising and upholding standards of practice across the board in both professions. However, we strongly believe that any standards of proficiency and practice, which do not include a requirement for a personal psychotherapy or counselling experience of significant duration, are in fact dangerous. Basing proficiency of practice solely on academic and skill-based standards, is a move we feel strongly opposed to. This unfortunately, is merely following the current trends, which have already put our professions at risk. Regulation was, we hoped, a move towards amending this. Towards making our professions safer for the clients who avail of them. The absence of any reference to the absolute necessity for a personal psychotherapy/counselling process experience, is very worrying indeed. Its absence suggests an absence of understanding on the part of the policy makers, of what psychotherapy and indeed counselling actually are. Again, that is very worrying and as dedicated members of these professions, we do not accept it.

First and foremost, the language used is jarring to us in the psychotherapy/counselling professions. We are not professions that use the term "service users". This term is suggestive of a medical treatment model, which we do not offer. Neither psychotherapy or counselling use a medical model of practice. Unlike the doctor/patient relationship in which a patient seeks a cure from the doctor who prescribes, the psychotherapy and counselling relationship rests on the premise that the client is the authority of and in their own life. We use a process model of practice. We work with clients, who employ us not as experts who fix what hurts, but as psychotherapists/counsellors who explore in a collaborative relationship with them, the source of what's hurting and how they might best find healing. That may be through a short-term solution focused counselling experience that offers tools and support for living or a longer-term psychotherapy experience depending on the depth at which the pain lies, how early in life the pain was experienced and the strength of the adaptations and defences the person has had to create in their life, in order to avoid the pain. Counselling and Psychotherapy both offer a facilitative process to people, whereby they can be helped to understand themselves in their lives a little more. Medical models of treatment and healing aim to attempt to fix what is broken. Our professions, which are based on the process model of healing, believe that there is nothing broken. That emotional pain is in fact a natural response to experiences in life and that suffering is the agony that occurs, when we develop and maintain adaptive strategies to avoid feeling this pain. Our model believes, and hopefully our practitioners know from their experience of their personal psychotherapy process, that to move towards the source of the pain, express it in a healthy way in the presence of a competent psychotherapist who offers a caring and non-judgemental relational experience, is how the healing/therapy begins. What follows is an untangling of

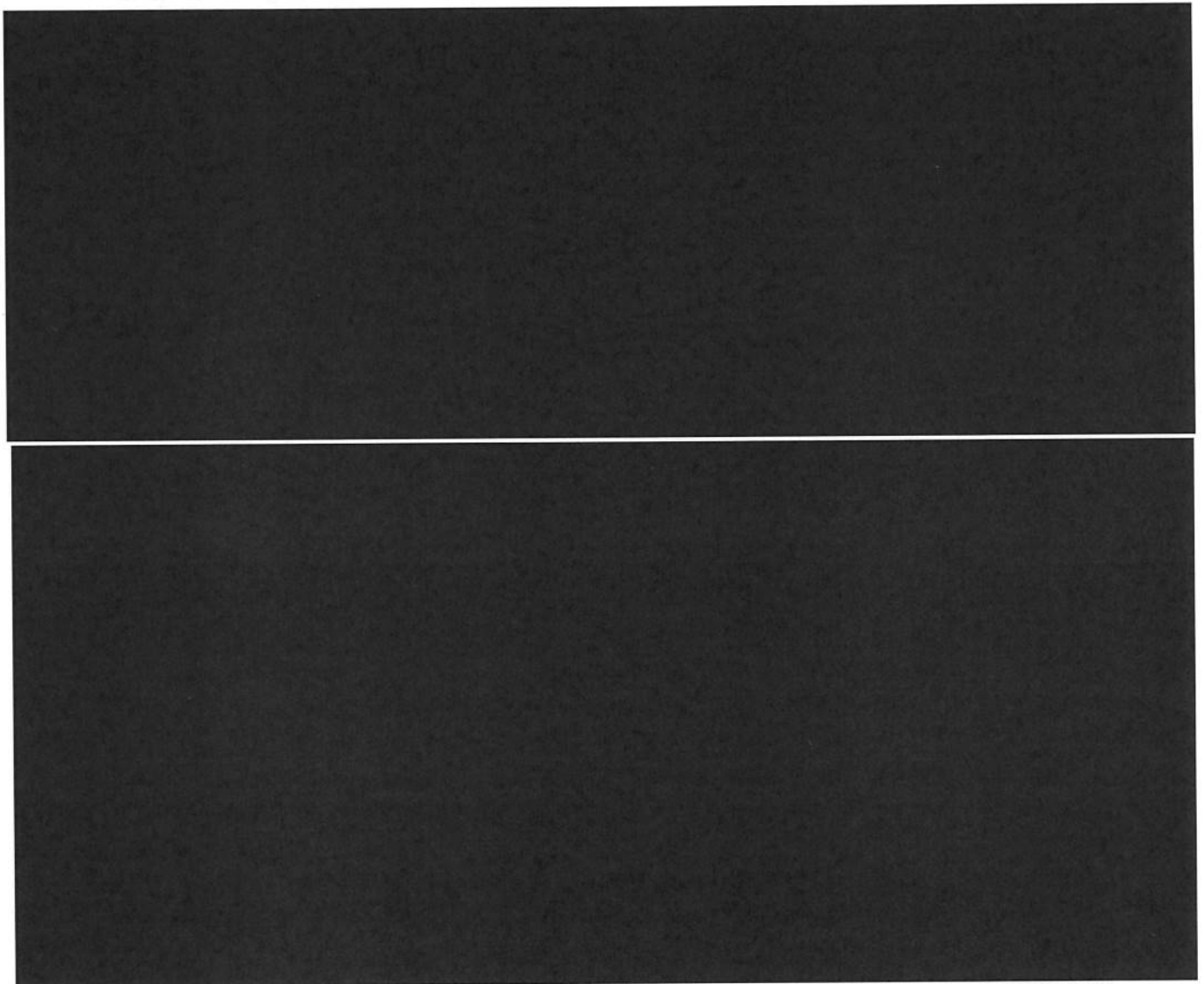
the many patterns of defence that wrap around the pain and can severely impact a person's quality of life. Clients, through this facilitated experience of feeling met with compassion in their pain, over time learn to understand themselves and their complexities more. They begin to feel for themselves, adjusting their own relationship with themselves to one of compassion - this is therapy.

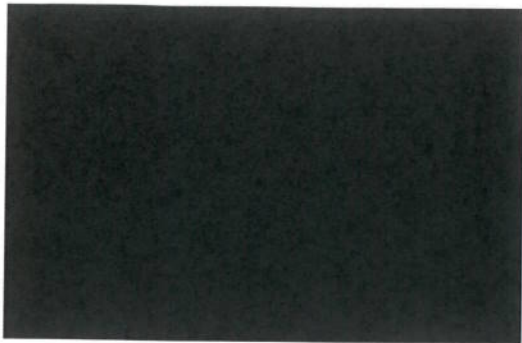
This is not a simple process. It is not a process one can facilitate having qualified with a masters, a Fetac level 8 or a four year degree course, which does not include group process work and a requirement for many hours of personal psychotherapy. 20 sessions of occasional counselling hours is just not sufficient. Weekly psychotherapy over at least the four years of training, may give a student psychotherapist/Counsellor a basic level of understanding of the process involved and how to facilitate it. It requires great relational awareness on the part of the psychotherapist, of how to manage relationally, the impact of a client's defences, many of which will engage when getting closer to the source of pain. Without an experience of getting to know and manage their own defences through their own in-depth psychotherapy process and of course support in supervision, there is a danger of the psychotherapist acting out of unconscious hurts, prejudices and patterns. Also, a psychotherapist or counsellor cannot support a client to explore that which is difficult and painful in themselves, if they, the psychotherapist/counsellor have not explored that which is difficult and painful in their own beings and lives. This is why psychotherapy for the psychotherapist is so vital. To keep the clients safe from that which is unprocessed in the psychotherapist. This necessary depth in a psychotherapy process does not happen in a few short sessions. It must, as stated earlier, begin as weekly individual psychotherapy over the four years of an intensive training and be supported by group therapy at training level and it must extend beyond training in dedicated forms of self-exploration.

Please - a body who is looking at regulation of this field of psychotherapy and counselling, do not make the very big mistake of classifying them as you might, professions using the medical model approach. These professions are not and never should be viewed as such. They are process models, needing people who are first and foremost, prepared to commit to a deep exploration of their own personal process. Theory, practice and skills are of no value without it. In fact, you refer often to "safety of the service user" in your drafts. There is no safety in a psychotherapy or counselling relationship where the therapist has not completed many hours of self-reflection in a psychotherapy relationship and uncovered and explored some of the many relational patterns that result from adapting to experiences in their own early environment. Without this process whereby unconscious hurts, prejudices and patterns are opened up, felt and made visible, these will hide in the shadows and infect the relational space with clients. This makes for unsafe and incompetent psychotherapy/counselling practice.

In conclusion, we want to state in the strongest possible terms, that you put the requirement for a personal psychotherapy experience at the core of any future drafts in relation to both of our professions - Psychotherapy and Counselling. We must show recognition that the quality of the work with clients is totally dependent on the depth of

personal work the psychotherapist/counsellor has done, which deepens their relational capacity. We insist that you reconsider this draft and engage in depth with members of our professions, in order to fully understand the complexity and depth of the processes of *psychotherapy* and Counselling. We also advocate that you recognise the necessity for including significant hours of **personal psychotherapy** in training and the commitment to **ongoing** psychotherapy/reflexive practice in any future draft. This is of critical importance and ultimately impacts the safety of our which is really at stake here. Ethically we cannot support any future drafts, which do not include recognition of this.





23rd November 2023

Submissions Section for Psychotherapists
CORU Board, Infinity Building,
George's Court, George's Lane,
Smithfield, DUBLIN 7 D07 E98V

Dear Board Members,

Please find enclosed Submission from  in response to CORU's invitation to submit on behalf of Psychotherapists.

I regret I am at an age where your very detailed Online Form is inaccessible to me as a senior member of society but very active in the training of Psychotherapists.

This is a critical and important time for the work of your Board in preparation for regulating our Profession.

I consider our Submission important and essential in your deliberations for the standards of Psychotherapy regulating. It's obvious there are two pathways for registration, namely Counselling and Psychotherapy. I was at the first Inaugural Meeting of QQI when this was recommended and agreed.

Our Submission, I know details the need that Psychotherapy regulating be at entry level 9.

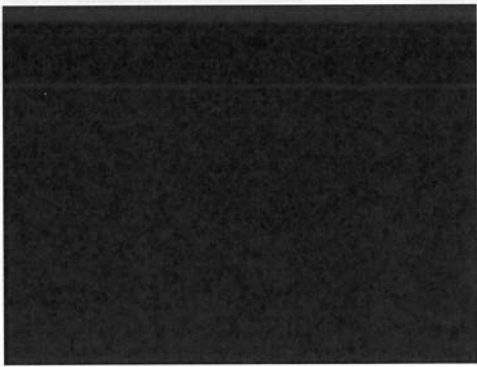
The Submission is in hard copy duly signed by me.

I know that you will respectfully acknowledge there are existing high standards criteria well documented by the accrediting bodies for Psychotherapy, namely:

- Irish Association of Humanistic and Integrative Psychotherapy
- Irish Counsel for Psychotherapy
- European Association of Psychotherapy

I am more than available if you wish to meet with me in the interest of our Psychotherapy Profession.





Response to CORU Criteria for Education and Training Programmes

Introduction

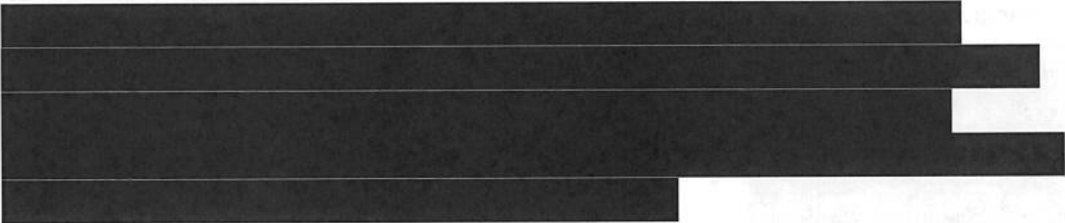
This submission is in response to a recent request from CORU - the regulatory body of Health and Social Care Professions to respond to the contents of the following *draft* documents:

- Counsellors and Psychotherapists Registration Board
Criteria for Education and Training Programmes for Psychotherapists
- Counsellors and Psychotherapists Registration Board
Standards of Proficiency for Psychotherapists

 Institute intends to challenge and present their views in relation to proposals circulated in the above documents.







Position

■ believe it is beneficial that the professions of Counselling, Psychotherapy along with related Education and Training Programmes, be regulated and registered with CORU.

However, ■ are concerned about the standards and proficiencies that have been put forward in the above documents. ■ believe the proposals do not reflect the existing robust and rigorous training criteria, which are already in place in many Psychotherapy Training Institutes. These are criteria for best practice, aligned with standards of best practice, accredited and acknowledged, by the professional organisations nationally and within Europe.

It is equally important that the profession of Psychotherapy be seen as being different to that of Counselling.

Psychotherapy and Counselling are divided into two separate registration pathways, undergraduate and postgraduate. They require a different number of clinical hours, and they have defined differences in principles and proficiencies.

This generic difference has not been identified nor outlined clearly enough in the draft CORU documents.

1. Existing Training Standards:

Many training Institutes have been in existence for the best part of four decades. The training profession has developed high standards in terms of its regulation and accreditation, along with University validations.

In addition, ■ as a member of the Irish Counselling of Psychotherapy (ICP) and the European Association of Psychotherapy (EAPL) subscribe to the 1990 Strasbourg Declaration on Psychotherapy, *which recognised Psychotherapy as an independent scientific discipline, the practice of which represents an independent and free profession.*

The Strasbourg Declaration acknowledges that training in Psychotherapy takes place at an *advanced qualified and scientific level.*

In Ireland, this represents postgraduate level 9. [REDACTED]

[REDACTED] has also successfully met quality standards and attained accreditation from the following professional organisations:

- Irish Association of Humanistic and Integrative Psychotherapy (IAHIP)
- European Association of Psychotherapy (EAP}
- European Association of Integrative Psychotherapy (EAIP}
- Irish Association of Counselling and Psychotherapy (IACP}
- European Association of Psychotherapy Training Institutes (EAPTI}

2. Level 8 Qualification for Entry to the Register

- Level 8 is too low a threshold for entry into Psychotherapy Training. [REDACTED] strongly recommends that entry to the profession of Psychotherapy be set at (level 9), post graduate level
- Prior to commencing professional psychotherapy training at (level 9), level 8 qualification or equivalent, should be the minimum level of attainment for entry into Psychotherapy training
- All Psychotherapy students who apply to [REDACTED] for Psychotherapy Training are interviewed. There is an expectation and a requirement, that prospective students will demonstrate the following:
 - o Life experience
 - o Emotional maturity
 - o Academic standards
 - o Communication
 - o Critical thinking
 - o Capacity to engage in deep self-reflection
- Level 8 is not an acceptable standard by the European Association of Psychotherapy, to which [REDACTED] and the Irish Council for Psychotherapy adheres. This will result in Ireland having a lower standard in Psychotherapy Training which is not acceptable

- Unless Psychotherapy Training is maintained at (Level,9), it *will not* be possible for [REDACTED] to attract European students for Psychotherapy Training. Students *will not* be eligible to be awarded a European Certificate of Psychotherapy by the European Association of Psychotherapy
- The adoption of Level 8 for Psychotherapy Training will result in Ireland having the lowest standard of Psychotherapy training in Europe

3. Non-inclusion of Personal Therapy

- There is no requirement for personal therapy in either of the draft documents.
- [REDACTED] considers the non-inclusion of personal therapy as a requirement for Counselling and Psychotherapy Training in the draft document, as a serious omission.
- [REDACTED] requires that each student, on the commencement of their training, engages in weekly personal therapy for the duration of their training

4. Clinical Supervision

- Clinical supervision is currently embedded in training at [REDACTED]
- There is no requirement for clinical supervision in either of the draft documents
- [REDACTED] require that placements have an accredited psychotherapist who screens clients for their suitability to engage in therapy sessions
- [REDACTED] insists, when all students commence clinical practice in placement, that they have regular supervision of their work, by qualified and experienced supervisors, contracted by [REDACTED]
- The sole responsibility for assessing students must lie with the Training Institute. This has been well documented through Quality and Qualifications Ireland (QQI). To change this could have serious implications for the

relationships that training institutes have with the organisations that validate them

5. Duration of Training

The Registration Board does not appear to have included a minimum threshold for the duration of training.

Currently, [redacted] training is aligned with European requirements and with [redacted] for (level 9) for a duration of four years. This allows for a two year lead in, consisting of personal development, theory and putting theory into practice.

[redacted] currently do not allow students to progress to seeing clients until the third year of their training. [redacted] recommends that this be the required minimum threshold for recognised training in Psychotherapy.

Education providers will require time to align their trainings before registration begins. [redacted] recommend that seven years be allowed for this.

Conclusion

The profession of Psychotherapy unlike any other; is not suitable and cannot be accessible to all in society.

[redacted] is a unique collaboration.



This ensures highly validated, academically educated and clinically, trained professional graduates (Level 9), who then go on to sustain the lives of others whom they counsel.

The profession of Psychotherapy carries enormous responsibility.

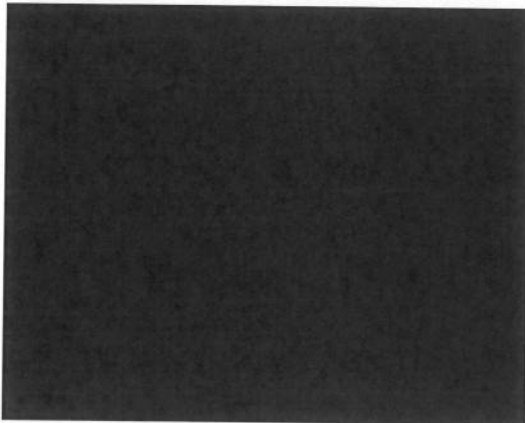
The profession is dependent on the maturity of its applicants. Their work is always as skilled practitioners. Such work demands the trust; the protection and the confidentiality of their clients at all times.

Psychotherapy is a young profession.

- [REDACTED] has set standards
- [REDACTED] has set standards
- [REDACTED] Psychotherapy Training organisations have set standards
- [REDACTED] intend to keep and maintain those standards
- [REDACTED] intend to build on those standards
- [REDACTED] intend to promote those standards
- [REDACTED] intend to continue to deliver those standards at Level 9

It is regrettable that providers of training such as [REDACTED] with long standing, experience, expertise, vision, incisive knowledge, professional skills, capacity and capability, was not consulted in the CORU drafting process for Psychotherapists.

[REDACTED] looks forward to closer collaboration in the future.



Submitted November 2023

Public Consultation, CORU

Infinity Building

George's Court,

George's Lane,

Smithfield,

Dublin 7,

007 E98

24th November 2023

Re: National consultation for Stakeholders on CORU Draft Standards of Proficiency and Education Criteria for Counsellors and Psychotherapists.

Dear Sir/Madam,

I wish to make a formal submission in relation to the above.

I am a Psychotherapist, working in private practice in [REDACTED] for almost 20 years. In addition I run the counselling service for the members (and their families) of a [REDACTED]. I also Lecture in Counselling and Psychotherapy with teaching students at both undergraduate and postgraduate level.

I hold an undergraduate qualification in Counselling and Psychotherapy from the Tivoli Institute, Dublin and a MSc (Hons) in Psychotherapy Studies from the University of Sheffield, UK. I have undertaken regular additional training over the past 20 years to broaden and deepen my knowledge to enhance my client and teaching work.

I have reviewed the Draft Standards of Proficiency and the Criteria for Education and Training for both Counsellors and Psychotherapists and I wish to propose some inclusions/amendments to these:

Counsellors v Psychotherapists

Differences are made between the role of Counsellors and Psychotherapists and, as outlined in the Standards of Proficiency for both, these distinctions lie in the depth of the work, with Psychotherapists working at greater depth, including understanding and managing the unconscious aspects of the therapeutic relationship.

I believe it would be ideal that Psychotherapists attain the level of knowledge and self awareness required to work with the complexity and at the depth needed for this work through attaining a Level 9 qualification.

I also believe however, that it is more important that both Counsellors or Psychotherapists attain their qualification through relevant study over a period of no less than 4 academic years. Whether the qualification is Level 8 or Level 9 is of less importance in my view.

As well as attaining the standards of proficiency as outlined in your draft documents, a high degree of self awareness is required in order to develop the capacity to hold those clients in emotional distress and to avoid doing harm to those most vulnerable. I do not believe this can be cultivated over a timeframe of any less than 4 years of relevant study along with personal therapy, suitable clinical placement and a robust supervision process.

Personal Therapy as a Client

At present personal therapy is not included in the Draft documents as a requirement for either counsellors or psychotherapists. While as proposed, the education providers may provide this, there is no specific requirement or standard set out in the Draft criteria. This, I believe, needs to be addressed.

Personal therapy is a fundamental part of training as either a Counsellors or Psychotherapist. There are a number of aspects of the work that this supports and enhances: sensitivity towards clients/patients, capacity for empathy, presence, engagement at a more human/personal level, strengthening of self knowledge and thus ability to be authentic, build trust, stability, safety, ability to 'hold' another in deep emotional distress. All of this can not be achieved without engaging in a considerable amount of weekly 1:1 (face to face) personal therapy and with a suitably qualified (registered) therapist. I believe this should be no less than 120 hours of personal therapy, to be undertaken throughout a programme of minimum 4 years at Level 8 standard.

In addition, I believe there should be a further profession specific criteria for education and training programmes around minimum 60 hours of Group Therapy/Process Group to be undertaken during the minimum 4 year Level 8 programme. Group Therapy/Process invites the student to reflect on group behaviour and dynamics informed by their own experiences in teams, family and society generally and this further enhances self awareness and self understanding which ultimately benefits the client work.

Practice Placements

I support the practice placements as proposed however I recommend some further stipulations:

Practice placements should not begin before Year 3 of a 4 year Level 8 programme. In my own experience and also as a Lecturer/Trainer, I do not believe students are ready to begin client work prior to Year 3 of a 4 year programme. Thus both the wellbeing of the student and the care for the client is at issue here. We have a duty of care to both and we must ensure that we harm neither.

Supervision

At present the Draft Criteria for Counsellors and Psychotherapists does not stipulate any requirement around student engagement in Clinical Supervision. In addition there are no guidelines/standards/requirements set out for ongoing supervision of client work, post registration. Also, no standard have been set down for Supervisors. All of this, I believe, needs to be addressed, and specific requirements set out.

Supervision is an essential component of therapist training and is a key support for therapists in training as well as a vital part of client care. Ongoing supervision helps to maintain a high standard of clinical practice and care of both client and therapist.

I believe there should be no dilution of the existing standards of supervision during the training process. While this currently varies across the current profession bodies, in my view is:

- min 200 hours of face to face supervision during training.
- 50% of supervised practice should be by way of individual supervision - minimum monthly.
- 50% of supervised practice can be group supervision but subject to minimum standard of Ratio 1:5 (1 hour's supervision for every 5 hour's client work) and in a max supervision group of 4 students.

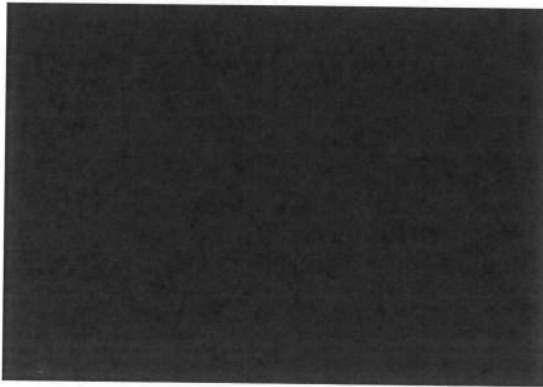
Supervision post Registration should be provided By a therapist who has attained a suitable supervision qualification.

Minimum monthly supervision - Ratio 1:50: ie Ratio of 1 hours supervision for every 50 hours of client work.

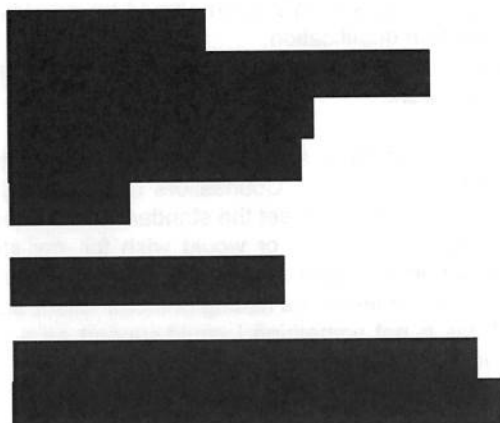
Overall, while there are many positive aspects to the Draft Standards of Proficiency and Education Criteria for Counsellors and Psychotherapists, as they have been presented they are not sufficient to meet the standard of care for clients and therapists that I as a practicing professional aspire to or would wish for my students entering the professions.

I am deeply concerned that the standards as currently presented would result in a dilution of standards rather than a raising of them. Client safety and care would be negatively impacted and this is not something I could support as a practitioner or a teacher in a profession I am proud of and care deeply about.

I would ask that you give all of the points I raise above careful consideration as you proceed towards regulation.



Letter received from 12 respondents



Public Consultation,
CORU,
Infinity Building,
George's Court,
George's Lane,
Smithfield, Dublin 7,
D07E98Y.

November 22, 2023

Dear CORU

As an experienced psychotherapist, I have critical concerns about the standards and criteria proposed by CORU for Psychotherapists because I believe they pose a risk to public safety and undermine the profession of psychotherapy.

The Irish Association of Humanistic and Integrative Psychotherapy (IAHIP), of which I am a member, is the largest Member Organisation of the Irish Council for Psychotherapy (ICP), and the largest accrediting body of psychotherapists in Ireland. We are accredited to the European gold standard approved by the European Association of Psychotherapy (EAP). This is the most exacting standard in Europe, and guarantees the integrity of our profession in Ireland. The EAP standard requires that Psychotherapists must meet the following criteria:

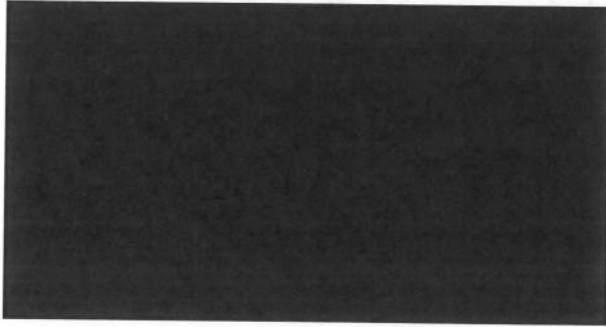
- Seven years of training, ending in a postgraduate qualification (level 9 in Ireland).
- Have personally undergone a minimum of 250 hours of Psychotherapy.

- An appropriately trained and qualified supervisor must have supervised their training.

In contrast, under the new CORU proposals, Psychotherapists would be required to only have a three- or four-year primary degree. Personal participation in therapy would not be a required part of their training, nor would their training need to be supervised by a supervisor who is appropriately trained and qualified.

I believe strongly that CORU's/these proposed standards will undoubtedly weaken the efficacy of psychotherapy as a practice; diminish and negatively impact the rigour of training; while ultimately undermining public trust and safety in psychotherapy and psychotherapists as professionals, all of which go against the purpose of statutory regulation.

Kind regards,





27 November 2023

To: CORU

As an experienced psychotherapist, I have critical concerns about the standards and criteria proposed by CORU for Psychotherapists because I believe they pose a risk to public safety and undermine the profession of psychotherapy.

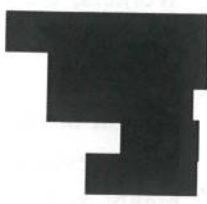
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23rd November 2023

CORU
George's Court,
Infinity Building,
George's Ln,
Smithfield,
Dublin, D07 E98Y

RE: Submission on the Regulation of Counsellors and Psychotherapists in Ireland

To whom it concern,

I am writing to you to make a submission in regards to the standards to be set for the registration of Psychotherapists on CORD register. I am a registered Family/Systemic Psychotherapist with Family Therapy Association of Ireland (FTAI), Irish Council for Psychotherapy (ICP) and European Association of Psychotherapy (EAP) and employed by 

I am concerned that in assessing the standards against the NFQ Level Descriptors the Board considered Level 8 as the threshold for Psychotherapy rather than level 9. Psychotherapists work with some of the most vulnerable people in society and as an organisation the FTAI & ICP have worked hard to set the highest standards to our profession to ensure the safety and wellbeing of the public. It is important for public safety and accountability that the standard of training is maintained to ensure continued safe practice into the future.

It should also be noted that the pay scales for grade of Family Therapist (3959) & Psychotherapist NCS (3028) both reflect level 9 NFQ.

The standard for psychotherapy qualification across the European Union is Level 9 for this reason. It is important that Irish residents have the same level of protection and professional expertise as our European counterparts. Not to do so would prevent Psychotherapists being able to work abroad in other EU countries. The FTAI also has a MOU with Association of Family Therapy (AFT) which is based on their current standards and allows a reciprocal arrangement where Registered Family Therapists with FTAI are able to register with AFT and work in UK. NFQ being set at level 8 could undermine this MOU. Of note, Social

Workers, Occupational Therapists and other disciplines already registered with CORU have standards of proficiency and criteria for education that fall in line with European standards.

In light of recent high profile cases where those providing psychological interventions were misrepresenting themselves the public are more aware of the importance of contracting with highly qualified professionals. As a result, our members have experienced growing scrutiny of the level of their qualifications and comparison with that of other disciplines and professionals.

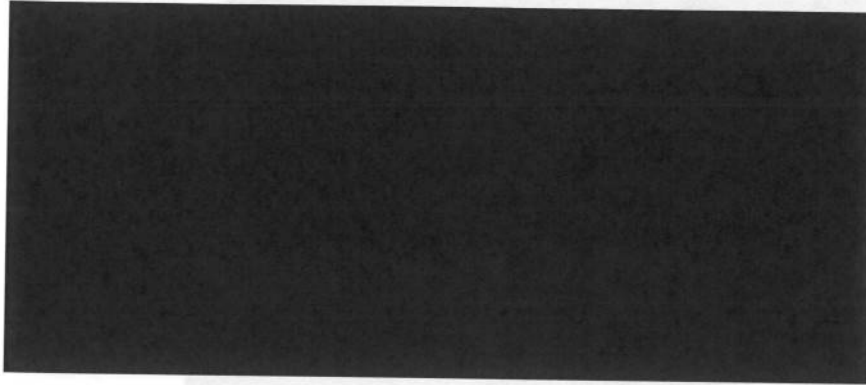
CORU have clearly set out fitness to practice processes for all registered professionals. Given the complexities of providing psychotherapy to vulnerable persons, it is imperative that graduates are prepared to meet the fitness to practice requirements by being trained to a very high standard of proficiency. This can only be achieved if a Level 9 entry requirement is upheld.

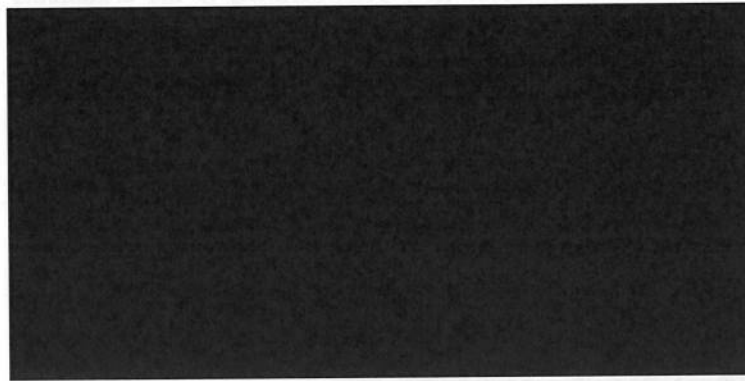
It is important that CORU understand and accept that there is a distinct difference between a counsellor and psychotherapist on this basis, and the entry level of qualification needs to reflect this by maintaining a Level 9 standard.

In regards to Boards proposal around supervision I believe that it is also crucial that supervisors must have modality-specific clinical supervision training, in order to adequately supervise trainees to meet the professional and ethical standards of the profession. I also believe that supervision should be a requirement of CPD to ensure the highest standards of people working in the profession are maintained.

I also note that the Board's view is that Personal Therapy is not connected with the assessment of the student and does not contribute to an assessment of whether a student has achieved the standards of proficiency. Therefore the Registration Board is not in a position to set any requirements around personal therapy. I believe that Personal Professional Development (PPD), is a core pillar of systemic psychotherapy and embedded in systemic psychotherapy training, both in Ireland and across Europe. This is because the importance of self-awareness as a key aspect of psychotherapy practice cannot be stressed enough. PPE/PPD is undertaken within a group setting, as a systemic approach to psychotherapy training, for each year of the four-year training. This aspect of training facilitates a deep engagement with the self of the therapist and the self in context throughout training. This is an essential element of systemic psychotherapy training, which along with the other pillars of training leads to competent skilled professional upon qualification. It is an essential part of Family Therapy Training Programmes and must be maintained as a core part of a clinician's personal/clinical development and as an approach to safeguarding and reflective engagement with clients.

I would respectfully ask that the Board give consideration to the arguments put forward for inclusion at level 9 LFQ, the need for modality specific supervision, the need for PPD as part of training standards and distinction between counselling and psychotherapy.





Submission to CORU

in response to

**Draft Criteria for Education and Training
Programmes for Psychotherapists**



This submission highlights 6 areas of concern:

1. entry level criteria,
2. placement supervision requirement,
3. lack of attention to the particular context of Irish provision,
4. lack of a pre-clinical training requirement,
5. blunt 'one size fits all' approach,
6. general lowering of training standards with concomitant risk to the public.

1. Entry level for psychotherapists

Ireland is on course to become an outlier in terms of psychotherapist training and qualification level within the EU and more widely. Given that Ireland is a committed and enthusiastic member of the EU, it is difficult to see how this departure from the European standard can be justified in terms of the status of Irish psychotherapists or the service provided to the people of Ireland. There are therefore political as well as quality and safety implications for the Irish government.

The level of training required for psychotherapists across Europe is postgraduate and the entry level specified is, at a minimum, a primary degree. To qualify as psychotherapists in Europe students are expected to complete a minimum four year postgraduate specialised training. This means training as a psychotherapist takes a minimum of seven years with an entry level designed to ensure students possess sufficient ability, maturity, life experience and ego strength to manage the intellectual, emotional and psychological demands of training as well as the complex decision making involved in the practice of the profession.

Contrary to the declared aims of CORU the lack of a specified entry level for psychotherapist training will:

- reduce the duration of training,
- fail to protect public safety,
- downgrade the level and quality of training and therefore of subsequent professional practice with the further implication that some organisations might choose to merely meet minimum standards,
- downgrade Ireland's status within Europe as a country that no longer supports rigorous training standards.

The differential in hours of practice in no way makes up for the difference in training duration and therefore depth and quality. It is neither in the interest of public safety nor the reputation of Ireland as a provider of high standards of professional training and practice.

Proposed solution: Specification of a postgraduate threshold for entry to psychotherapy training is essential to safeguard public safety and the value and status of Irish qualifications across Europe.

References:

1990 Strasbourg Declaration on Psychotherapy,
European Certificate for Psychotherapy (Version 8) adopted in March 2023).

2. Placement 'supervision' as opposed to external specialised clinical supervision

External supervision and mentoring of the professional development of student practitioners by highly qualified, experienced practitioners approved by training organisations has been a crucial and extremely valuable part of psychotherapist training for decades. Supervisors are selected because they are familiar with the particular developmental criteria which must be met in order to ensure progress and competence in the modality practised.

Clinical supervisors are required to have completed a minimum of five years practice in the profession plus a minimum one year specialist training in supervision skills. The current high ratio of clinical supervision to practice hours required by the professional associations ensures that students have sufficient time for reflection on their cases and are not simply ticking a box of competencies in the immediate aftermath of a client session.

The level of 'supervision' required for other professions recognised by CORU is minimal in comparison with the levels demanded from QQI level 9 psychotherapy training programmes and the professional bodies in the field. The frequency and quality of specialised external supervision currently provided to students on psychotherapy programmes ensures that both conscious and unconscious material is explored and understood. Substituting a focus on the achievement of learning criteria coupled with a reduction in the high ratio of supervision to practice hours will lead to client safety being compromised. As has been recorded in complaint cases in Ireland and the UK, lack of rigorous clinical supervision which is frequent enough and of a quality to ensure that transference and countertransference phenomena are addressed in depth at very frequent intervals results in therapeutic boundaries being inappropriately breached.

Proposed solution: that there is no reduction in the current levels of clinical oversight for students. That this level is maintained by retaining external supervision in the ratio required by the professional bodies which for years have accredited psychotherapy training. This would ensure that public safety is protected.

3. The particular context of provision in Ireland is disregarded.

CORU states that it wants to take account of the particular context of provision in Ireland however the placement criteria fly in the face of this declared aim.

The placement supervision model suggested (which currently operates in areas like social work) is completely inappropriate in psychotherapy as it fails to take into account the nature of the vast majority of placements available. These are frequently located in self-funded services provided by charities. Students on placement make a significant contribution to the provision of these low cost/free services. Their presence is much appreciated by managers who avail of the freely provided services of competent, closely supervised third and fourth year students to the benefit of their service users.

Given the particular nature of most student placement organisations and their wide distribution across the country, ensuring a suitably qualified on-site supervisor is present at all times when students are working would not be possible or practicable. Most psychotherapy trainings are part time and enrol mature students with considerable professional experience in other fields. Part time programme students do not complete block placements because they are already in employment which precludes this option. This is a very different situation from professions such as social work, psychology etc. which are usually based in statutory settings where staff are full time and available on a permanent basis. Psychotherapy students complete their placements at times which fit with their

working lives and in any one placement different students might be working at different times and on different days/evenings. Providing an on-site supervisor (as opposed to a mentor) to accommodate the different schedules would be prohibitively expensive, inefficient and extraordinarily difficult. The CORU document says the training of placement supervisors is the responsibility of training organisations. It is simply not practical or feasible to train placement supervisors to the current high standard in the numbers required by the CORU proposal.

Currently placement mentors/managers are responsible for overseeing all operational aspects of students' work in the placement e.g. administrative responsibilities, public protection protocols, booking appointments, providing on-site support etc. The division of responsibility between mentors/managers and external clinical supervisors has been proved to work well for decades. The level, nature and amount of 'supervision' required by CORU involves a serious reduction in both the quality and quantity of oversight. This does nothing to improve client outcomes, safety and well-being and is therefore counter to CORU's explicit aim of protecting the public. Given that it will prove very difficult, if not impossible, to provide sufficient on-site supervision, a serious reduction in the services available to the public will inevitably occur. The official waiting list for mental health services provided by the HSE already exceeds 4,000. The loss of the many therapy hours provided by students in local low cost counselling and psychotherapy centres will have a devastating effect on services throughout Ireland.

In summary, the reality is that provision of easily accessible, community based services will be seriously affected by this requirement for on-site supervision. This will be particularly so in rural areas with their lower population levels and concomitant lack of large, well-funded service providers. How such a potential diminution in provision contributes in any way to public safety and mental and physical health is, to say the least, problematic. Indeed, the on-site placement criteria have the potential to strip counselling/psychotherapy services from all areas of Ireland outside major cities.

Proposed solution: that mentors/managers remain responsible for administrative matters but specialist external supervision in the current ratio and to current standard remains mandatory for psychotherapy training.

4. Pre-clinical training period

Currently, students on IAHIP recognised programmes are not allowed to begin a clinical placement until they have completed at least two years of training. This pre-clinical placement period is essential to ground students in the theoretical basis and practical application of the discipline. It affords time for students to gain valuable experience working as therapist on the training programme under the observation of tutors and peers.

CORU's current proposal makes no mention of a mandatory pre-clinical training period. Without such a mandatory period students would be able to move into working with clients with minimal theoretical understanding and insufficient time to develop the professional skills necessary. A substantial preparation period before beginning clinical placement is crucial to ensure safety for both the client and the therapist. This period needs to comprise theoretical learning, skills development and demonstrated evidence that students have developed sufficient self-awareness and ego strength to enable them to engage with vulnerable, and frequently traumatized, clients.

Proposed solution: that a minimum pre-clinical training period of not less than two years remains mandatory for psychotherapy training.

5. Recognition of specialist routes and public information to allow choice.

There are distinct differences in philosophy, theory and clinical approach subsumed under the term 'psychotherapy'. This has been totally ignored by CORU whose insistence on a 'one size fits all' approach fails to take into account the nature of the service offered to the public.

The different approaches are:

a) Systemic therapies which work with groups/systems as opposed to individuals. These therapies focus on interactions and relationships between group members (e.g. families) and are often based in statutory settings or larger organisations.

b) Strategic, solution-focused therapies which provide individual therapy most frequently on a short-term basis. These approaches use cognitive and behavioural strategies and focus on immediate symptom reduction and practical problem-solving.

c) Psychodynamic and Relational therapies work with both individuals and groups. The work is medium to long-term and the relational dynamic between therapist and client is central to the process. In this form of psychotherapy unconscious process is engaged in an intentional way. To provide safety in this form of in-depth therapy a high level of personal awareness on the part of the therapist combined with high levels of specialist supervision is required.

It is absolutely essential that students training in these specialisms have personal therapy. Personal therapy has been a vital part of all forms of psychotherapy across Europe and further afield for decades. CORU's omission of any requirement for students to attend individual therapy with an approved therapist as part of their training programme takes no cognisance of this important element of training.

The failure to address the different modality-specific criteria and proficiencies required in training will inevitably lead to a flawed and inadequate regulatory framework. The concomitant lowering of standards for training in psychodynamic and relational approaches will compromise the safety of practitioners and service users alike.

Proposed solution: that CORU establishes three sections within the register. Common proficiencies would apply in all three sections with further distinct proficiencies for each of the three routes.

This would provide a more inclusive and comprehensive framework for registration and ensure that the robust structures and rigorous training standards already in place for each of the modalities are not undermined.

It would further enhance client choice by ensuring that the public has continuing access to different forms of psychotherapy tailored to their particular needs. The register needs to make this information clear to the public.

6. Lowering of the existing rigorous standards of training.

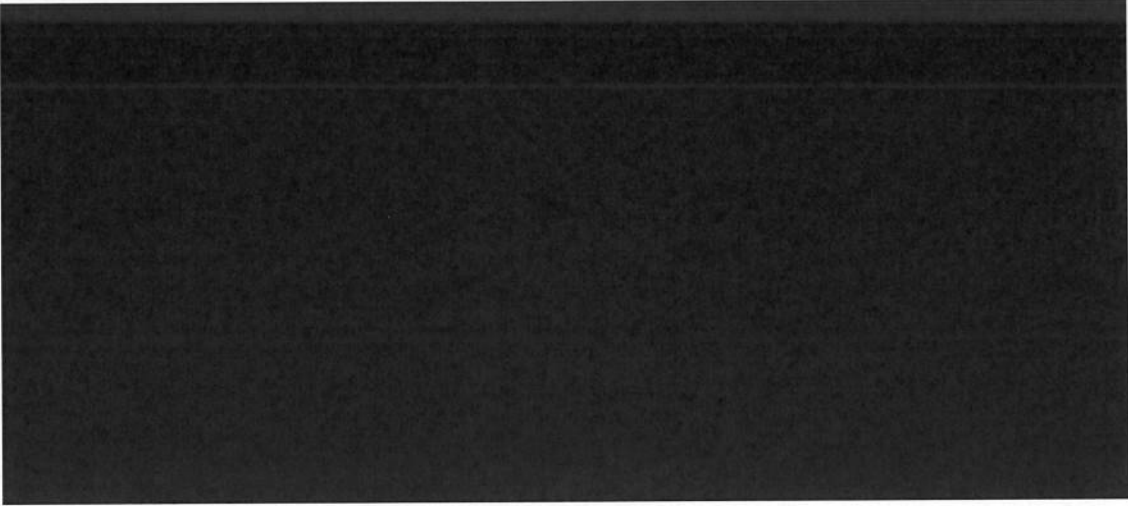
The proposed standards and proficiencies are set much lower than current professional association accreditation standards. Failure to set the European standard entry level to psychotherapy training, lack of recognition of the need for personal therapy, complete disregard of the necessity for specialised clinical supervision, lack of a specified mandatory pre-clinical training period – all threaten the quality and level of training. This would inevitably reduce the quality and level of service provided to the public.

The number of therapy hours available to the public is going to be reduced as a result of the demand for on-site 'supervision' in placement settings at all times when students are working. Given the huge HSE waiting list, and the full appointment books of many voluntary service providers, such a reduction will compromise the safety and well-being of the Irish population.

If CORU's aim is to increase public safety and provide a better, more accessible service across Ireland these proposals totally fail to meet these aims.

Signed





FAO: Board of Directors
CORU

Re: Draft framework: Statutory registration for counselling and psychotherapy

Dear members of the board

Thank you for your work in putting together the draft framework for the regulation of counselling and psychotherapy.

It has been a lengthy process to have finally got to the stage of government regulation after many years of endeavour . I am delighted to see where we have got to and i hope regulation will happen soon.

However I hold grave reservations on a couple of matters put forward in the draft framework.

1. The proposed suggestion that students would not have to undergo their own personal therapy
2. That supervision would not be a requirement for counsellors and therapists in their practice.

I would as a matter of grave concern, request you to reconsider the above proposals.

My reasoning :

Safe and effective counselling and psychotherapy are very much based on the persona of the therapist delivering such a service it is a unique profession where the interventions delivered are at and in the hands of the practitionerit is a commonly held understanding that the therapist is the instrument of the intervention.

When is the therapist delivering such a service from their own frame of reference and not in the interests of the client ?? This can only be mitigated by the therapist being aware of their own lens and bias as well as their blind spots. A therapist not being aware of their own frame of reference and transference can lead to client harm rather than

support. Undergoing our own therapy and being in supervision helps us as practitioners to be aware of and monitor our own blind spots and 'psychological lenses'.

Having been an [REDACTED] and a [REDACTED]

[REDACTED] I have been privy to many such harmful transgressions ... and this is by therapists who have undergone some personal counselling themselves !!

It alarms me to think of the liability of practitioners who haven't become aware of some of their own blind spots.

Supervision

One of the functions of supervision is to help therapists monitor their own effectiveness as well as continuing to be aware of their blind spots and work within an ethical framework. This monitoring function is part of the supervision process and allows for a safer and more effective intervention structure that might enhance the client's benefit.

In my 33 years working as a therapist. .. and in my many years as a supervisor and trainer I am acutely aware of supporting therapists as they come to understand their own undiscovered issues of power, sexuality and coercion as well as the impact of the work that could seriously unhinge safe therapeutic practice.

[REDACTED]

Supervision is an important layer in maintaining client and practitioner care and safety. Eroding the necessity of supervision would in my opinion leave client safety and therapeutic endeavour severely compromised.

I refer you to Jeffrey Masson's writing on the danger of therapy (Against therapy 1988)

As such I urge you to reconsider the above proposals as per your draft framework.

Yours sincerely

[REDACTED]

This submission has been collated by student representatives, following consultation with counselling and psychotherapy students from around the country. The submission is organised under two themes that arose from the issues arising during the student consultation. Recommendations for action around the themes are then presented and an appendix of relevant student quotes is included for reference.

THEME 1: PLACEMENTS

It is our understanding that a motion was passed at the AGM of one of the professional bodies in 2021. The motion referred to the securing of allocated placements for all students offered a place on counselling courses. We fully endorse this motion, given the struggles of students securing placements as detailed below in anecdotal evidence.

Exploratory discussions with student therapists to gain insight into their lived experience of sourcing and securing suitable placements revealed several issues, as detailed below, with full accounts included in Appendix 1:

- Confusion in relation to students' role/responsibility in accessing placements.
- Inequity of access to placement opportunities.
- Students receiving out-of-date lists of placements, some of which are inappropriate and/or inactive.
- No set criteria in relation to accessing, negotiating, and securing suitable placement. It appears that it is the students' responsibility to source and secure the suitable placement. This would question the role of the placement co-ordinator.
- Lack of duty of care from some colleges when students encounter difficulties accessing placements.
- Ensuing stress experienced by students as a result of all of the above placement issues.
- Concerns were raised by students that not all counselling services cover supervision costs for students and pre-accredited therapist, which students feel should be a mandatory requirement for those in placement.

In the light of all of the above, we recommend the following:

1. An external independent review to be undertaken of student experiences across all colleges. More specifically, to conduct a quantitative survey to ascertain the challenges faced by students in sourcing and securing a suitable placement.
2. That colleges ensure that placements meet these requirements and standards to provide a quality learning environment. To ensure that a formal written agreement or Memorandum of Understanding be in place that clearly sets out the responsibilities of all involved parties, so that these standards of proficiency are achieved.
3. That colleges maintain a thorough and effective system for approving and monitoring the quality of all placements. Students, the college, placement providers and all relevant stakeholders to have a role in this review process including mechanisms for obtaining regular feedback.
4. That each CORU accredited college submit an annual audit of the quality of the learning environment of student placements to the accreditation committee.
5. That there be a more robust governance structure for placement providers and clear, ongoing communication structures and processes in place between the college, placement provider and student.
6. A **student centred**, operational pathway must be established that clearly sets out the process of sourcing and securing an appropriate placement.
7. There must be a clear and explicit process in place for students to raise concerns in relation to their practice placements and where to access appropriate supports.
8. Each college to have a full listing of active, quality learning placements for students.
9. Each CORU accredited college must have a designated Placement Co-ordinator. A review of the remit of the placement co-ordinator should take place which would facilitate a clear operational pathway.
10. Colleges must not offer a place to a student on their programme until there is an appropriate placement available.
11. Placements counselling services should cover supervision costs for students and pre-accredited therapist and consider payment for students and/or pre-accredited therapists.

THEME 2: PROFESSIONAL TRAINING

➤ Inconsistency of academic support within colleges

Students report inconsistencies in academic support with final dissertations at Degree and Master's level within college classes and between different colleges. This means that some students receive much more structured and reliable support than others when conducting and writing up research, which means that the academic potential of all students may not be subject to a level playing field.

Recommendation: Regular governance around academic input

➤ Overemphasis on academia on some college courses

Some students report large class sizes and an overemphasis on academia at the expense of personal development, with one Master's program reported to have no personal development or group process modules throughout its two year program, nor any group supervision on offer for students as per requirements of some professional bodies.

Recommendation: Regular governance around need for adequate personal development

➤ Deficits in training in the field of mental health

Some students report a deficit in training in the field of understanding mental health presentations as part of core training for therapists. This lack of training can impact on clinical practice, particularly with the high percentage of clients presenting with mental health issues.

Recommendation: Inclusion of additional training in the field of mental health

➤ More emphasis on Assessment and Case Conceptualisation

It is our understanding working within certain services, that there is a high emphasis on assessments, however our overall experience of being students is that there is a limited focus or training within colleges on the importance of clinical assessment and case conceptualisation.

Recommendation: Inclusion of additional training in the area of Assessment and Case Conceptualisation

➤ **Private Practice Establishment/Self-Employment Start-up and Skills**

Given the fact that the majority of qualified psychotherapists go into private practice, we recommend that there would be guidance in the area of business startup and supports available.

Recommendation: Inclusion of additional training in this area

➤ **Accessibility of Counselling Courses**

Students raised concerns about the lack of availability of grants in private colleges, similar to the SUSI model that is available for public colleges and universities. This is an inequitable situation which limits accessibility for many sections of society to pursue a career in counselling. Furthermore, the historical background of counselling courses in Ireland is one of private organisations which could lead to the business model superseding the importance of the therapeutic model.

Recommendation: Students attending private counselling colleges to be eligible for grant assistance

➤ **Potential for trainee welfare issues emerging in private practice placements**

Some students report working unpaid in placements where the private practice is charging the client. This practice is considered unethical for both client and student and impacts on the morale of student.

Recommendation: Strict governance and accountability in this area

Appendix 1

A variety of difficulties were encountered by students across the country in securing placements. Students who shared their experiences did not wish to be identified due to *fears of repercussions on their appraisals and grade allocation.*

See quote from student A:

I think there is a reluctance on some students in certain places to talk of any issues. There is an air of just keep your head down keep quiet and get your degree.

The experiences shared speak to a variation in practice across colleges. Dublin based students placed in inappropriate settings, for example Addiction treatment centres which were extremely challenging placements with minimal supports.

See quote from student B:

Placement given in Dublin in a centre totally unsuitable for student starting out, serious addiction and prison related clients. Apparently, a previous student had informed the college of this but was still listed as a placement and given to a student in the next year. Placement options given for some northwest students by college from there supposed vetted database included ..a place that was not taking students , a number incorrectly given as a placement but was a private counsellor number and never a placement.

Students experiences of being unable to secure a placement and being told that they may have to repeat the year.

See quote from student C:

One of my fellow students was told by the college that she couldn't progress to 2nd year of her master's without a placement and yet they know she has been struggling since the start of 1st year to secure a placement. Again, she was given a list that wasn't up to date and left to her own devices. I have actually stepped in to advise her, based on the experience I had and the coordinator of my centre has agreed to help the coordinator in her centre to advise on setting up a suitable environment for students. This is all work that the college should have done in advance.

General experiences of students being handed a list of possible placements to try and access with:

- No prior discussion on their respective training and learning need.

- No contractual arrangements with the relevant college in place.
- Inaccurate contact information about placement provision.
- Listed Placements no longer being available.
- Lack of empathy/compassion experienced by students.

See quote from student D:

I suppose my struggle was that no organisation details were supplied to me by the college. I had to call various centres asking for information about their policy on students. I sourced a placement and never got any clients! I am currently travelling 1hr 15min to provide free counselling as there is no chance of me having my 450 hours done within the time frame for accreditation.

See quote from student E:

The college confirm a placement for all students in Dublin, but that is just not practical for me. The college provided me with a list of suitable places in my region, but most of them were no longer operating or didn't take on students anymore.

I had to seek out new places and then the college had to determine if they were suitable and then I had to go ahead setting up the new arrangement. I managed to get a placement an hour away from my home that I set up myself and have had to work at putting policies in place for referral and assessments. I felt I was doing the college's job.

Students experiences of being advised of placement availability at course intake interviews and then subsequently having to travel further afield to secure a placement which incurred additional expenditure and travel.

See quote from student F:

The difficulties I experienced were:

Travelling long distances, 220 km and 130 km. Reduced admissions due to isolation and distancing requirements and therefore on occasions some of the clients failed to show for counselling.

Searched unsuccessfully for student placement hours [in a number of towns]. All centres either did not have facility to accept student placement or their student quota was full.

December 1st 2023

Dear Sir or Madam,

I am an experienced, accredited psychotherapist, accredited clinical supervisor, and trainer of psychotherapists, and I have been working since 2000. I am accredited to or registered in the following professional bodies as a psychotherapist and with IACP as a supervisor.

The Irish Council for Psychotherapy (ICP).

The Irish Association for Body Psychotherapy (IABP).

The Irish Association for Counseling and Psychotherapy (IACP).

The Irish Association for Humanistic and Integrative Psychotherapy (IAHIP).

The European Association for Body Psychotherapy (EABP).

The European Association for Psychotherapy (EAP).

I have strong concerns about the draft standards and criteria for Psychotherapists proposed by CORU, which I will state below and which I believe undermine both public safety (our clients) and the profession of psychotherapy itself.

All of the above associations support the inclusion of requirements for personal psychotherapy and clinical psychotherapeutic supervision for trainee psychotherapists. This is, I believe, critical for the safety of all involved in the therapeutic relationship. Under Coru proposals I believe Ireland would be the only country in the world to forego these vital and essential requirements for trainees and practicing therapists. This is very worrying.

These requirements are approved by the European Association of Psychotherapy's (EAP) Europe-wide standards, which guarantee the integrity of the psychotherapy profession in Ireland. The EAP standards are supported by:

- the Irish Association for Humanistic and Integrative Psychotherapy (IAHIP)
- the Irish Council for Psychotherapy (ICP)
- the Irish Association for Body Psychotherapy (IABP)

Similar standards are upheld by the Irish Association of Counseling and Psychotherapy (IACP).

The EAP standard requires that Psychotherapists must meet the following criteria:

- They must have undergone a minimum of 250 hours of personal psychotherapy.
- They must have been supervised for a minimum of 150 hours by qualified psychotherapy supervisors during their training.

- They must have undergone seven years of training, ending in a postgraduate qualification (level 9 in Ireland).

However, as I understand it, under the current CORU proposals, Psychotherapists:

- Would not be required to participate in personal therapy as part of training.
- Their work with clients during training would not need to be supervised by an appropriately trained and qualified supervisor.
- They would only be required to only have a three- or four-year primary degree. Personal participation in therapy would not be a required part of their training, nor would their training need to be supervised by a supervisor who is appropriately trained and qualified. Quite frankly this is shocking to me and I believe it will undermine the quality of the work, the safety of clients and indeed therapists, as in my experience a lot of learning, support and growth happens within the holding space of both personal therapy and clinical supervision.

I believe and indeed fear that CORU's proposed standards go against the purpose of statutory regulation, and will:

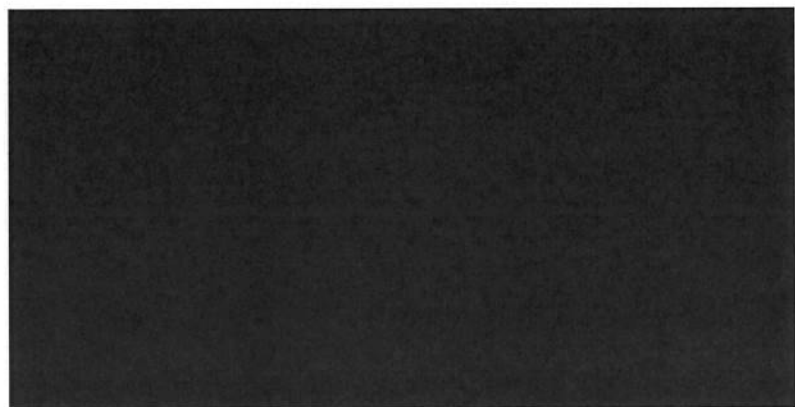
- undermine the safety of the public.
- distort and undermine the practice of psychotherapy,
- significantly diminish the value of psychotherapy training,
- will also undermine public trust in psychotherapy and psychotherapists as professionals. Indeed, if your proposed measures are brought in it could ultimately be the end of the psychotherapeutic alliance as we know it.

As stated I have grave concerns about all of these issues for the professions of counseling and psychotherapy going forward.

Yours faithfully,

[Redacted signature]

[Redacted contact information]



Hello,

My name is [REDACTED]. I am in private practice in [REDACTED]. I am an accredited therapist with IACP. I have all my qualifications up to Masters.

I am very concerned that you are placing the training of student therapists with Placements. [REDACTED] a very badly run low cost counselling centre which charge some members of the public [REDACTED] plus they are reeling in huge money through Charity and ask the therapists who work for free to go out and shake the bucket at Christmas and other times of the year to bring in more money. This Centre is approved by yes none other than the HSE, in fact the HSE send referrals some with severe mental illness to [REDACTED] to work with student therapists. It's people like myself clinical supervisors that keep these students and clients safe.

Simon Harris wrote in his letter to me that "it will be unlawful for anyone (including student therapists) to work with members of the public without full qualifications (accreditation certs)". Now this important ethos is being pushed aside and student therapists will now be able to work with the public without full qualifications and who will be their supervisors none other than the likes of the owners of badly run Placements like [REDACTED]. I'm sure the owners of these Placements will get supervision certificates so now they can rake in more money from not alone getting therapists to work for free but now they can charge them for supervision.

I am urging you if you are serious of not hurting the public to hand over the training to IACP and allow us clinical supervisors who are doing a good job to continue our work. Please do not give

this power over to Placements. If you do so, the government will find themselves being sued by the public. Give the training up to 200 hours to the Colleges to provide in house supervision and then let us Clinical Supervisors continue our work which is working at the moment. Don't break what isn't broken and allow these Placements to continue being Fat Cats charging huge money to the public without any overheads as their employees (student therapist) are working for free and the government are also helping them out by giving huge money by way of grants. It's a total disgrace.

I say to you get rid of these Placements either get Colleges to do their in house training (Colleges could easily train their therapists by having exchange days or workshops where students would get to work with other students from other Colleges). Iacp or iahip could do this work if Colleges do not want to take it on.

I do hope you take my concerns for the public and change what you are setting up.

Thank you for reading my email.

Regards

[REDACTED]
[REDACTED]
[REDACTED]

1 December 2023

RE Public Consultation: Psychotherapists – Standards of Proficiency and Criteria for Education and Training Programmes for Psychotherapists

Dear Members of the Counsellors and Psychotherapists Registration Board

We are writing as Psychotherapists and members of the Irish Council for Psychotherapy and the Irish Forum for Psychoanalytic Psychotherapy. We have extensive experience of providing clinical Psychotherapy, training, and supervision. We bring our specialist clinical expertise to organisations and work in private practice. We are deeply concerned by the proposals set out in the 'Standards of Proficiency and Criteria for Education and Training Programmes for Psychotherapists'.

Psychotherapists are specialists in the therapeutic treatment of emotional distress and mental health difficulties. Psychotherapists are trained to work with people with complex and long-standing difficulties and psychiatric diagnoses over long periods of time; years rather than weeks or months. It is significantly different than counselling, which provides short-term treatment for specified issues, usually over a number of weeks. Thus, Psychotherapy training needs to be at postgraduate level, which is the appropriate and internationally-recognised educational level for specialisation. An undergraduate degree, which is a foundation in basic knowledge and skills, is not an appropriate level for training Psychotherapists.

As part of Psychotherapy training, personal Psychotherapy and one-to-one clinical supervision are required. They are the cornerstones of Psychotherapy training and practice. They, along with further professional development training, are essential to the integration of training and ethical practice throughout a Psychotherapist's clinical career. Without them, people would be practising in the absence of the requisite skills and capacities required for working therapeutically in depth with patients presenting with long-standing and complex difficulties and psychiatric diagnoses. This would be both unethical and dangerous.

Psychotherapy includes a number of specialist modalities. In a specialist discipline like Psychotherapy, Psychotherapists train in a particular modality, which requires an emphasis on different theories and skills. A failure to acknowledge and ratify these specialist modalities would be akin to sending a thoracic surgeon into an operating theatre to do a knee operation.

The current proposals will impact in a significant way on public safety and will put patients at risk of harm and in danger.

We are requesting that the regulation process be paused pending significant research being carried out on current Psychotherapy training standards, and how and why they have to meet international standards.

Yours sincerely

A large black rectangular redaction box covering the signature and name of the sender.

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Concerns regarding CORU draft submissions regarding the training and ongoing development of Psychotherapists.
Date: Thursday 30 November 2023 11:46:33

Dear Sir,

I wish to comment on some of the suggested draft Standards of Proficiency and Criteria for Education and Training.

The key areas of concern to me are:

1. No requirement for Clinical Supervision for entry to the Register. Clinical Supervision of placements by suitably trained clinical supervisors in a variety of settings is much more appropriate for the complexity of issues arising.
2. No requirement for Personal Therapy for entry to the Register. An experiential understanding of the therapeutic process such as therapist countertransference is an important component of training. Not requiring extensive personal therapy for a trainee psychotherapist is a fundamental misunderstanding of the psychotherapeutic relationship and client safety.

I have also completed the feedback survey.

Regards

[REDACTED]

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Re; the draft proposals for Psychotherapy training in Ireland.
Date: Friday 1 December 2023 16:20:35

Dear CORU,

I am a Counsellor, Psychotherapist and Clinical Supervisor whose career spans over 30 years and I am an accredited member and an accredited Clinical Supervisor with the 'Irish Association for Counselling & Psychotherapy' (IACP) and the 'Irish Association of Humanistic & Integrative Psychotherapy' (IAHIP) and I am also a registrant with the 'Irish Council for Psychotherapy' (ICP).

I have many concerns about the CORU proposed standards of training for Psychotherapy in Ireland and at what seems to be a lack of understanding at the differences between counselling & psychotherapy. If psychotherapy training is set at level 8 rather than level 9 this will be a serious drop in standards of the present standards in psychotherapy training in Ireland which are set by The Irish Council for Psychotherapy (ICP) which is in line with the European Association of Psychotherapy (EAP). These are the 'gold standard' of European guidelines for psychotherapy training in Europe.. <https://www.europsyche.org/training/eapti/> This would be detrimental for future graduates from Ireland if the present standard of a post-graduate level 9 four year training were scrapped. We would no longer be on a par with the rest of Europe, the USA, Canada and other jurisdictions. This would leave Irish graduates in the vulnerable position of not being adequately qualified to apply for work in other parts of the world which would be a great loss. The standards already in place in psychotherapy training institutions in Ireland are set at level 9 four year trainings of either a higher diploma or masters of science (MSc) or an arts masters (MA). The concerns which CORU mentioned in relation to the accessibility of entry to psychotherapy training could be managed in a similar way to places on Clinical Psychology doctorates and ultimately there would be lots of counselling graduates to take up front line positions in mental health services. There is a place for counselling within a healthcare system but there is also a necessity for a more specialist, long term and deeper therapeutic engagement which is provided by Psychotherapists.

Counselling and psychotherapy are two different mental health professions just as clinical psychology or psychiatry are distinct professions. The profession of psychotherapy has been around for 100 years and it is rooted in the deep exploration of the human psyche and the need for the practitioner themselves to have engaged in lengthy and deep journeying of their own processes. They need to have explored their own family-of origin and its influence on the person they've become and their own early developmental attachments. One of the reasons that it's crucial that trainee psychotherapists enter their training at a postgraduate level is that neuroscience now tells us that the adolescent brain is continuing to develop up to the mid 20's and doesn't complete in the late teens as was previously believed to be the case. Therefore it's necessary that the psychotherapy student is developmentally an adult so that they have the capacity to have created enough distance from their childhood and teen years and especially where there was a lot of developmental trauma. Ultimately my concern is for the safety of the public and I would have serious reservations about client safety if the suggestion of an undergraduate level 8 training was the new standard of psychotherapy training in Ireland. This would be completely out of step with the rest of the world and the standards we already have in place here in Ireland and it fails to recognise the history of what psychotherapy is and its distinctiveness from counselling. Counselling like a general degree in Psychology is appropriately set at an undergraduate level 8 degree and an excellent precursor to post-graduate training as a psychotherapist just as the undergraduate degree in psychology is likewise appropriate for further training as either a clinical or educational psychologist at level 9 or 10.

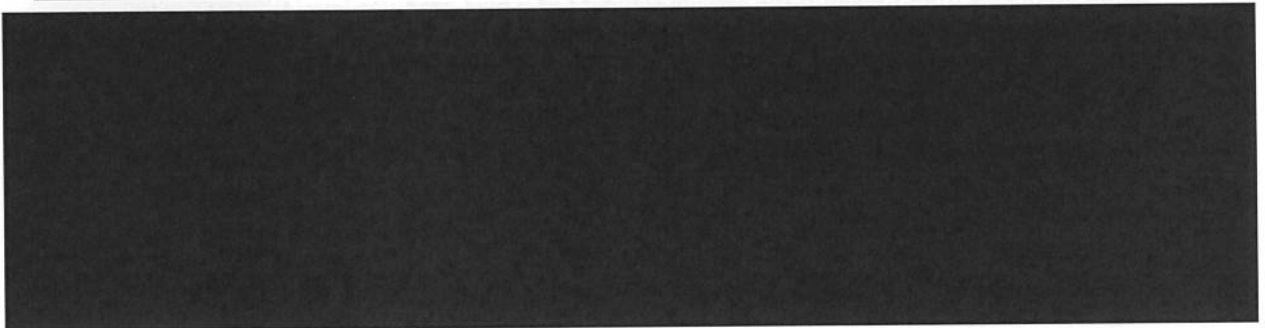
This is a crucial juncture in the recognition of psychotherapy within the Irish mental health professions but also on the world stage and CORU needs the most accurate guidance from the relevant professional bodies on both distinct professions. 'The Irish Council for Psychotherapy' (ICP) are the organisation who provide the gold standard guidance on Psychotherapy training in Ireland whereas the 'Irish Association for Counselling & Psychotherapy' (IACP) were initially an organisation to represent Counselling and only added 'Psychotherapy' to their name in the last 20

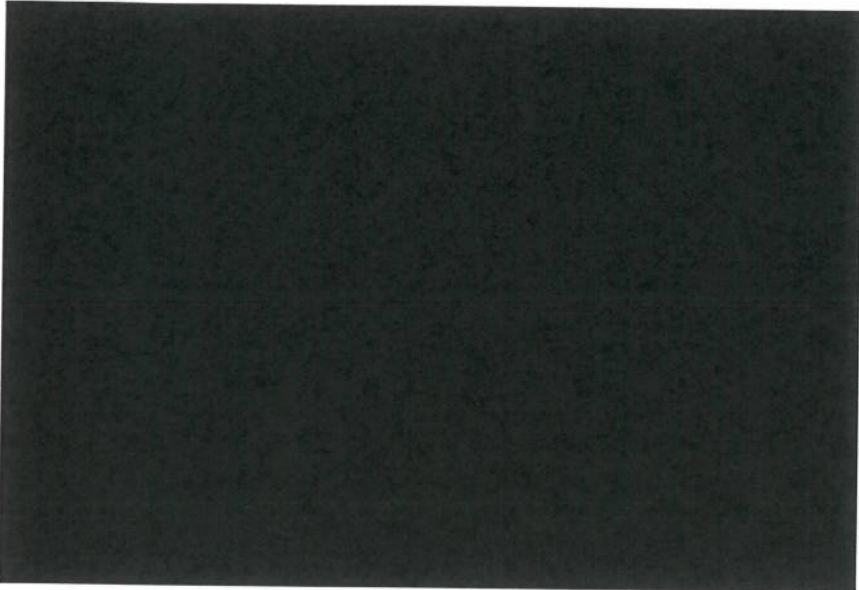
years whereas 'The Irish Council for psychotherapy' (ICP) has been the organisation representing Psychotherapy solely for 30+ years and so are the leading experts on psychotherapy training in Ireland.

Ultimately it is the impact on clients/patients who will seek out psychotherapy in the future after regulation that I'm concerned with because they would no longer have the opportunity to experience the enriching and unique experience of being in therapy with highly trained psychotherapists if these lesser than training standards are approved for psychotherapy training institutions in Ireland. I would urge CORU to be guided by the specialist organisation on Psychotherapy Training in Ireland, ie, 'The Irish Council for Psychotherapy' (ICP) and to reconsider the proposals on Psychotherapy training standards for the greater good of the psychotherapy profession within Ireland and on the world stage but most importantly for the safety and well being of future clients & patients.

Thank you for taking the time to read this.

With kind regards,





30th September, 2023.

CORU

To whom it concerns:

I would like to comment on the proposed standards for registration of Psychotherapists (including counsellors).

I fully understand the impetus for QUANGOs like yourselves to justify their existence and to extend their remit, and I consider that the exercise often involves an attempt to re-invent the wheel. This happens without a lot of evidence that the existing wheel is broken or that the new one will be much improved. I have seen no copious evidence that the public has been harmed by unregulated counsellors. On the other hand, I could provide you with a filing cabinet full of the evidence of harm that has been done by health care practitioners who are strictly regulated both from my own research and that of other health care activists. Indeed the current news broadcasts are full of such instances right now. Regulation is not a guarantee.

I have been involved in counselling (and psychotherapy) since 1993, as a practitioner, a lecturer and an external examiner at different times. For my PhD in Sociology I researched professionalisation in the field, so I do have some knowledge of the processes involved. I could go through your copious literature and offer a critique point by point, but I am tired of fighting creeping bureaucracy so I will confine myself to two points.

1. It would seem to me that degrees in counselling and psychotherapy (I only separate them to suit your taxonomy) which are already validated by established and legitimate universities and other third levels institutions would not need extra validation by CORU. It incurs extra expense, work and personnel, but maybe that is the whole purpose.
2. I want to address the in-person or video supervision. First of all it surprises me, given your strict criteria that the invigilators need not be trained supervisors. More importantly however, is that the resulting observations will probably not be valid. Most scientists know now that an object or person being observed is subject to change in behaviour or impression given. From quantum physics we have Heisenberg whose theory was brought into the ER and

showed that psychiatric patients needed less sedation when they knew they were being observed. Erwin Schrödinger's famous cat in the box experiment provides further evidence of the observer effect as does the equally famous Hawthorne study which looked at psychology in the workplace. Lastly, I will remind you of Jeremy Bentham's invention of the panopticon prison which showed the influence being under constant surveillance had on prisoner behaviour. There is also lots of evidence –if you care to look it up—that observer bias comes into play as well.

In conclusion, I repeat that the proposed in-person supervision method will not produce valid assessment of practitioner skills and will favour the good actors. It will work as a box-ticking exercise and add to your perceived status as regulators and I am cynical enough at my stage of life to know that may be the driving influence.

Sincerely,

A solid black rectangular box used to redact the signature of the sender.

From: [REDACTED]
To: [Strategy and Policy](#)
Subject: Stakeholder Consultation
Date: Friday 1 December 2023 15:09:03

Dear CORU Team

I took a look at the surveymonkey feedback pathway and have decided to email instead.

I agree that Level 8 is an appropriate minimum requirement for the Registration of entrants onto the Register, however, I also feel that setting higher and higher qualification criteria does not necessarily equate to better quality therapists. Psychotherapy is highly pivotal on building a safe, trustworthy relationship with clients, who will not typically talk about their issues without its presence. Over-emphasis on theory, science and the medical model alone misses the point, in my view. The draft document appears to be worded more in line with a Psychology/ Medical framework, particularly when it references the communicating the diagnosis and assessment data to service users, health professionals, carers and relatives. Counsellors/Psychotherapist do not currently have a diagnostic or medical assessment capacity and thus to date have not supplied diagnoses, prognoses or medical data to third parties. I wonder if perhaps there is some confusion or cross-over here between Counsellors/Psychotherapists and Counselling Psychologists? Counsellors are not medically trained nor equipped to formulate definitive diagnoses and no legal basis/credibility to provide medical opinion regarding their clients. Counsellors/Psychotherapists also do not tend to engage with multi-disciplinary treatment planning on a regular basis unless they choose to enter a contract with a HSE post. Many are in private practice and would not routinely be seconded onto multi-disciplinary teams.

What grandparenting criteria is proposed? Persons with Level 7 or similar but extensive experience, what consideration will be placed on assessing their eligibility to join a Register? Also as a supervisor, I encountered a person with a recent Level 7 qualification - who are now seeing clients - would they have to cease practising until they complete a level 8 qualification?

I believe that omission of a mandatory requirement for personal therapy while in education and training is concerning, as is mention of the Course Provider exercising discretion in recommending therapy for student counsellors. This, in my view opens up opportunities for this element to be overlooked, minimised or hidden through a fear of failure to progress on a course, rather than actually addressing emerging issues. Many trainee therapists are juggling work and family commitments and may seize an opportunity to avoid the additional cost of personal therapy if it becomes optional. They may also mask internal struggles as they emerge throughout training which will amount to unresolved issues being taken into the professional therapeutic space at a later stage rather than being addressed at the time.

Currently trainee therapists experience challenges in accruing their mandatory clinical practice hours of 120 for their core course due to shortage of suitable placements. They then are required to secure 450 pre-accredited hours. If they are required to complete their 450 or 500 hours - before being eligible to register, how is this going to be feasible and who will provide placement for the duration of this training period?

Once a trainee therapist completes their required 450/500 hours and joins a Register, there doesn't appear to be a mandatory requirement for Supervision? Why is this the case? Supervision maintains accountability for work, is a forum for identifying the early stages of burnout, awareness of developing transference/counter transference, blind spots,

emergence of judgement or bias which has the propensity to become embedded over time without a formal space of supervision to reflect on work practices etc. Avoidance of the issues if Supervision is optional is a distinct possibility. Does this create a higher incident rate of burnout and thus generate a larger volume of Fitness to Practice cases that CORU will become involved in? Particularly for counsellors/ psychotherapists in private practice where burnout may fester unimpeded if they lack the motivation of professional support in Supervision. How does CORU propose to maintain proficiency and efficacy of therapists, once acquired?

As CORU has identified two separate roles of Counsellor and Psychotherapist, I would be interested to know how you have delineated the two and what exactly defines each separate role? How does 50 extra hours of training practice equip Psychotherapists to undertake their duties for that Register? What if a counsellor encounters a psychotherapy issue, does the work stop and referral made to a different professional and vice-versa? In my view this rationale doesn't make sense other than setting a requirement to pay to be on two separate lists and meet the minimum required standards of proficiency and training?

What structure will be required to improve the quality and availability of clinical placement settings, equipped to the standards outlined in these draft proposals. Currently clinical placement settings are not structured in a way as to provide in person supervision. Students at times even struggle to locate a manager or dedicated professional on site let alone the criteria in these draft educational proficiency documents.

Has any thought been given to client (service user) openness to being observed while opening up about their issues. As previously mentioned Trust is paramount - do service users now have to trust two people if they meet with a trainee therapist? Only a limited number of clients will give consent to being observed or recorded during their sessions and for the trainee there will be an element of performing rather than being real with their clients.

I believe IACP and other professional organisations should have a much closer liaison with CORU (and that CORU take on board what they have to say on the criteria for how the clinical work of trainees is supervised and monitored. E.g the Psychotherapist 500 hours of clinical work, the proposal states 350 must be supervised service user contact experience, of which 100 hours must be directly observed service - there is no ratio of supervision mentioned for the balance of 250 of those supervised hours. Currently trainee supervision is at a ratio of 1 hour supervision for 5 client hours, moving to 1:10 for pre-accredited therapists 450 hours practice. Is the balance of 150 of the 500 hours unsupervised altogether? This doesn't make practical or professional sense.

I do feel CORU has a point regarding setting standards for the training institutions, however, wonder how this will be maintained and monitored by CORU once the institution has been approved by CORU initially? Trainees struggle with inappropriate clinical placement settings, being advised to 'do what you think yourself' if they seek support on a clinical issue, for example, or being mismatched with inappropriate presenting issues for their current skillset and experience of practice. Will trainees be required to work free of charge for the entire 450 or 500 hours?

My comments are not exhaustive and I have also submitted these observations to IACP who have collated all the comments of their members to submit to CORU on our behalf.

My summary understanding is that the draft documents do not represent our profession, and the mechanics of the minimum requirements being proposed will be significantly challenging to implement, thus will need sufficient time to be accurately defined prior to a

formal live register being established. I would be extremely concerned if the Counselling and Psychotherapy job description is assessed and rushed through using a variation of a Psychology or previously established healthcare template. There is no stipulation for personal therapy or supervision, other than therapy deemed necessary by a training institution and directly observed supervision of placement hours. What happens after this? Once a person graduates their formal training, joins a register or registers are they left to their own devices unless a complaint is lodged by a service user that their therapist is not fit to practice? Who might make the observation that a graduate therapist is, in fact, impacted by their personal process - does CORU plan to adopt this duty?

Thank you for taking the time to read my variety of observations on the education and training requirements.

Sincerely

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