SCoPEd Methodology Update

January 2022

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# 1.0 Introduction

This document sets out the methodological process to develop the January 2022 version of the Scope of Practice and Education (SCoPEd) framework. It describes the process used to consider responses to feedback from members of the original three partners (BACP, BPC and UKCP) on the SCoPEd Framework July 2020 and also the work undertaken as part of widening the partnership to address challenges and feedback raised by the new partners. It should be read in conjunction with the first two methodology documents – SCoPEd Methodology 2018 and SCoPEd Methodology Update July 2020 – which detail the process prior to this stage. A brief summary of stages of the work covered by these two previous methodology documents is given at Appendix 1 with a full list of evidence sources consulted during these two stages given at Appendix 2.

# 2.0 Feedback from members

## 2.1 Independent questionnaire to members in response to revised framework

The revised SCoPEd framework was published in July 2020 and shortly afterwards a questionnaire to draw out views and feedback about the revised framework was sent to all members of the British Association for Counselling and Psychotherapy (BACP), British Psychoanalytic Council (BPC) and United Kingdom Council for Psychotherapy (UKCP). An independent market research company, Critical Research, was commissioned, having conducted the previous SCoPEd member consultation.

**The feedback process consisted of two stages:**

i) A questionnaire sent to all members to gather a general understanding of members’ thoughts on the July 2020 version of the draft framework and the project itself, and to seek participants for the next stage of the feedback process

ii) A facilitated and moderated bulletin board online discussion forum to explore in depth a range of members’ views about SCoPEd and particularly those with neutral or unsupportive views of SCoPEd in order to better understand their concerns

Each stage of the feedback process is presented in turn.

## 2.2 Members’ questionnaire

A quantitative survey was developed which included sentiment statements and a five-point Likert scale (a response scale for people to specify their level of agreement with each statement) to help assess views about the framework. The question, statements and rating scale were as follows:

Could you please indicate the extent to which you agree or disagree with each of the following statements:

• I am familiar with the updated SCoPEd framework

• I understand the aims of the SCoPEd project

• I feel supportive of the SCoPEd project aims

• I can see where I’d fit within the SCoPEd framework

• I feel that my voice as a member is being heard in relation to the SCoPEd project

• I feel positive about the SCoPEd project being able to deliver on its aims

• In its current format I would support this iteration of the SCoPEd framework as a structure for the future of the profession

Statements were rated by respondents on a five-point Likert scale:

• Strongly disagree

• Disagree

• Neither agree nor disagree

• Agree

• Strongly agree

Specific demographic questions were asked to assist with recruitment to the bulletin board stage. These were:

• Professional body or bodies they belong to (could indicate multiple)

• If a BACP member, which membership category

• Career stage ranging from student or trainee to 10+ years qualified

• Country of residence

• Practice setting(s)

• Employed, self-employed, voluntary status

• Title(s) used in practice

The questionnaire also asked a question about willingness in principle to participate in the bulletin board and three open response questions:

• What are your views on the SCoPEd framework so far? Are there any aspects of the framework so far that you particularly welcome?

• Are there any aspects about the SCoPEd framework so far that you are particularly concerned about?

• In your opinion, what impact would the SCoPEd framework have on your work in the profession, and on the wider profession as a whole, if adopted as a structure for the future?

The questionnaire was launched on 27 July 2020 and was open until 31 August 2020. Each of the three partners sent emails to their members and registrants containing a link to the questionnaire (see Table 1), a total of 60,057 members and registrants. Feedback on the previous consultation had suggested that an individual survey link within an email from the independent research company had resulted in many emails going into junk folders. In order to support greater participation and engagement for this questionnaire, a single link was circulated instead to members and registrants of each organisation directly from the organisations themselves.

A limitation of this approach was that the single open link could have potentially resulted in some members completing the survey more than once. However, to ensure the integrity of the data, all responses were checked by the independent research agency and any duplicate responses removed without being included in the analysis.

#### Table 1: Email circulation of questionnaire link

|  |  |
| --- | --- |
| **Total number of members and registrants emailed** | **BACP: 49,511 (number excludes organisational members, blocked emails and those who have unsubscribed)****BPC:** 1,677UKCP: 8,869 |
| **Undelivered** | **BACP: 13****BPC: 1****UKCP: 13** |
| **Reminders and publicity to members** | **BACP: Email reminders 12.8.20 and 25.8.20 E-bulletin reminder 21.8.20****BPC:** E-newsletter reminder 30.7.20UKCP: Email reminder 20.8.20 |

## 2.3 Questionnaire findings

Findings from the questionnaire were used to support recruitment to the bulletin board stage of the feedback process. The independent market research agency running the bulletin board used responses to both scale questions (strongly agree to strongly disagree) and the three open comment questions to select a wide range of participants. The bulletin board could only accommodate a limited number of participants, so the aim was to select a cross section of members that was broadly representative of the full membership and which facilitated discussion of a range of opinions on SCoPEd.

Details of findings relating to the scaled questions can be found at Appendix 3.

## 2.4 Bulletin board: recruitment and composition

The independent research agency ensured bulletin board participants were a representative sample of the broad range of BACP, BPC and UKCP members, by selecting participants anonymously based upon various demographics such as geographical location, length of experience and practice settings (see Table 2).

**Table 2: Demographic composition of bulletin board participants**

| Total participants | 45 |
| --- | --- |
| **Professional membership body** | **BACP: 42****BPC: 4****UKCP: 10****(total is more than 45 as some participants were members of more than one membership body)** |
| **Career stage** | **Student or trainee or newly qualified: 6****Qualified 1-10 years: 20****Qualified over 10 years: 19** |
| **Practice setting** | **Private practice: 35****Charity sector: 19****Education: 12****NHS: 8****Other settings: 6****(total is more than 45 as some participants worked in more than one setting)** |
| **Country of residence** | **England: 38****Scotland: 4****Wales: 2****Outside the UK: 1** |
| **Views about SCoPEd** | **Supportive: 12****Neutral: 13****Not supportive: 20****(participants were weighted towards those unsupportive or neutral to better understand the views of those with concerns)** |

The bulletin board was an online forum, open for two weeks in autumn 2020, facilitated and moderated by the independent market research agency. Discussion points were posted by the research agency and participants were invited to comment and discuss these with each other. Discussion points were chosen to examine participants’ views on:

• whether the framework had incorporated feedback from the previous draft iteration of the framework

• themes which developed from comments received in the member questionnaire

## 2.5 Bulletin board themes and findings

Findings from the bulletin board discussions covered the following themes:

**The need for SCoPEd:** Those who agreed there was a need for SCoPEd (or something like it) generally felt that the profession needs greater clarity and status. They felt that commissioners and employers don’t understand the differentiation within the profession currently. Participants who didn’t agree with a need for SCoPEd questioned why it was needed as there are already professional standards in existence. They also questioned why membership bodies weren’t focusing on other issues, which felt more important to them. Some participants felt conflicted in their views as they were supportive of the concept but feared the implications of a framework.

**Inclusive language:** While some participants felt the language had changed to be more inclusive, others felt the changes in language hadn’t gone far enough. Questions were raised around whether the language was the reason some therapists felt excluded or devalued, or whether the reasons behind this were much bigger. Several participants felt that the language within the draft framework was not useful for clients, patients or commissioners.

**Gateways, mechanisms and recognition of prior learning and experience:** Participants generally felt that gateways were a good idea, but many participants raised concerns over the lack of detail around this, leading to confusion and difficulty commenting on whether they are a positive or negative addition to the framework. Some participants voiced concerns around the impact of the framework, accessibility and rigour of any mechanisms created. Discussions around this theme led to a wider discussion around participants’ lack of knowledge of the professional landscape before and during their initial training.

**Hierarchy:** Discussions often came back to hierarchy within the draft framework, leading in turn to further discussion about the perceived value of one modality over another and the structure of the framework. Some participants discussed privilege within the profession and felt the framework exacerbated and encouraged this. Other participants had opposing views and talked around whether differentiation of training and experience can, or should, enable all therapists to be represented as the ‘same’.

Findings from the open comments on the questionnaire, along with the themes of the bulletin board were presented to the Steering Group (SG) and Technical Group (TG) for consideration. Where the feedback met the criteria for challenging framework content this was added to the TG feedback audit process (see section 4.3 below for details).

# 3.0 Context

## 3.1 Widening the partnership

In July 2020 the original three SCoPEd partners invited professional bodies with a Professional Standards Authority (PSA) accredited register for counselling, psychotherapy or both to join a round table discussion to explore interest and willingness in joining SCoPEd to continue the work towards agreeing a shared framework. Two meetings were held and were independently facilitated to explore what might be possible and agreement was reached to undertake work together. Four additional membership bodies agreed to explore whether it would be possible to work together as part of SCoPEd.

The new partners at this stage were:

• Association of Christian Counsellors (ACC)

• Association of Child Psychotherapists (ACP)

• Human Givens Institute (HGI)

• National Counselling Society (NCS)

A third meeting took place to explore draft Terms of Reference for the group and to agree a new governance structure for the work. At this point it was agreed that the Technical Group (TG) would be expanded to include representatives from every participating organisation. Additionally, the Steering Group which had oversight of the previous stages of SCoPEd was disbanded and a new governance group, the SCoPEd Oversight Committee (SOC) was formed, consisting of CEOs of the partners, plus members of the TG.

As the collaborative work progressed, ACP reviewed its role in the partnership and in October 2021 decided to step aside from the process because the framework is focused on work with adults and therefore much of the specialist training and practice of ACP registrants falls outside the scope of this work. ACP agreed to continue in the capacity of observer to support the ongoing work of the SCoPEd partnership.

## 3.2 Facilitating the work

To facilitate and support the work between partners, it was agreed that an independent chair should be recruited to the SOC. An external recruitment agency was commissioned to seek applications for this role and interviews were conducted by members of the SOC before an appointment was made in spring 2021.

Additionally, at this stage it was agreed that the involvement of Experts by Experience (EbEs) would be beneficial in order to gain first-hand representation of the views of a diverse range of clients or patients and potential clients and patients, as well as providing a layperson’s viewpoint on technical discussions.

Applications were sought to include two EbEs and applicants were interviewed by members of the SOC. In the event, four EbEs were recruited, though one has since been unable to participate. Brief biographical details of the EbEs can be found in Appendix 4. EbEs have participated in the work of the SOC, the TG (and associated small working groups) and the ERG.

The Professional Standards Authority, which is the body that accredits the registers held by each of the participating partners, was invited to attend SOC meetings as an independent observer.

# 4.0 Undertaking the work

## 4.1 Work of the expanded Technical Group and the Expert Reference Group

From November 2020 the expanded Technical Group (TG) began working together.

## 4.2 Ethical considerations

Throughout its work, SCoPEd has been conducted in accordance with the ethical requirements of each of the collaborating bodies, and with reference to the Ethical Guidelines for Research in the Counselling Professions (BACP, 2019). Formal ethical review of the project is not required since it does not involve data collection from human subjects but instead comprises documentary research looking systematically at sources available within the public domain. Details of the professional body affiliations and theoretical orientation of both TG and Expert Reference Group (ERG) members are listed in Appendix 4. Their professional backgrounds were declared and scrutinised as part of recruitment to the project. Conflicts of interest are asked for at the start of every meeting and none have been declared.

## 4.3 Collaborative working

Each of the new partners shared practice standards that apply to their own organisation and these were incorporated into the collected standards. Any areas of variance or inconsistency were discussed within the full group before agreeing a final version of the practice standards document.

Additionally, new partners to the TG were asked to formally indicate which aspects of the framework needed additional consideration, including details of specific competences (or gaps) and supplying evidence from their own standards or other sources within scope (see previous methodology documents for details of scope) to support discussion and consideration. Appendix 5 shows additional sources provided for consideration by new partners as well as further additional sources that became available during this time. The TG also made use of the existing sources that had previously been consulted when considering the questions and challenges raised (the full list of previous sources is shown at Appendix 2). This represented a considerable amount of work, and was supported by members of the TG (including some EbEs) in small working groups outside formal TG meetings in order to discuss and consider evidence prior to presenting to the full group. Every challenge was discussed in the full group, and outcome decisions are summarised in Appendix 6. Any recommended changes that were agreed were prepared for consideration by the Expert Reference Group (ERG).

After ACP’s decision to step aside from active involvement in SCoPEd, the TG discussed and reviewed the challenges they had raised to consider whether any decisions and recommendations made in response to these challenges were still relevant to the development of the framework. After reviewing, it was agreed that the recommendations from their challenges would be retained as they were relevant to the framework, within scope and supported by appropriate evidence.

In addition to challenges brought by the new partners, feedback was collated via open text comments from the questionnaire, bulletin board, open letters, events and emails. Every item of feedback was read to assess whether it was in scope for consideration by the TG. Where possible, feedback comments were examined in full by the TG, though the volume of feedback from different sources meant that additional work was undertaken to compile feedback into themes for consideration and discussion within the TG (see Appendix 6).

Two particular areas of feedback required exploration of additional evidence, relating to the therapeutic relationship and to competences relating to working with trauma. In order to address these areas the independent Information Analyst (IA) was tasked with searching relevant evidence to bring back to the group for consideration. Additional evidence sources examined by the IA are given at Appendix 7. TG discussion of the feedback audit and of additional evidence consulted by the IA, as well as outcomes and decisions from the discussions are summarised in Appendix 6.

Recommendations from the TG for any potential changes were presented to the reconvened ERG for consideration. Details of discussion and decisions are summarised in Appendix 6. Based on decisions agreed, amendments and changes made to the previous version of the framework have been mapped and are documented in Appendix 8.

# 5.0 Final agreement and publication

Upon completion of these steps, the latest version of the framework was ratified by the Expert Reference Group before final sign off by the SCoPEd Oversight Committee and preparation for publication.

# Appendix 1: Summary of methods and stages from the first two methodology documents, October 2016-July 2020

[Full details can be found in the SCoPEd Methodology 2018 and SCoPEd Methodology Update July 2020 documents]

• Agreement to base the work on Roth and Pilling methodology (Roth, A.D. and Pilling, S. (2008) Using an Evidence-Based Methodology to Identify the Competences Required to Deliver Effective Cognitive and Behavioural Therapy for Depression and Anxiety Disorders. Behavioural and Cognitive Psychotherapy 36: 2: 129-147), adapted to include evidence sources from published competence frameworks and other sources from grey literature such as textbooks, curricula and codes of ethics

• Systematic scoping and mapping of sources

• Initial organisation of evidence into working header themes followed by a group summary analysis process, informed by thematic analysis and nominal group technique. The Technical Group (TG) produces an initial consensus summary from this analysis. Sign off by the Steering Group (SG) ready for presentation to the Expert Reference Group (ERG) and further analysis

• Recruitment and formation of the ERG. Initial consensus summary presented to the ERG for consideration. Eleven additional areas for research highlighted by the ERG with recommendations for additional evidence sources to search. Literature searching within these areas was undertaken by an Information Analyst. Results of searching considered by both the TG and ERG and any recommendations agreed incorporated into the framework

• All competences drafted into the working header themes then given a thematic sort in order to develop a more appropriate structure to present the framework. Competences then analysed thematically into these themes. Additional data search to cover any outstanding gaps or questions. TG completes framework for agreement, ratified by the ERG

• Framework and first methodology document published by partners (January 2019)

• A four-week consultation process for members of all three organisations launched with the framework by an independently commissioned research agency, consisting of a quantitative survey focussed on members’ views of the potential impact of the framework, and an open-ended question asking for views on gaps or omissions in the framework and any other comments

• Analysis of responses. Themes from the qualitative analysis presented to the TG and ERG. ERG membership expanded and concerns about methodological limitations revisited in light of feedback received

• Additional themes from feedback systematically considered by the TG and ERG to further develop the framework. Wider and more comprehensive mapping of practice standards undertaken. Revised framework and practice standards mapping agreed, ratified by the ERG

• Small group clarity check of the framework and practice standards by critical readers identified by each of the partners. Final revisions made from this feedback to improve clarity and formatting, and agreed by the TG; ratified by the ERG and SG

• Revised framework published (July 2020)

# Appendix 2: Full list of sources, stages one and two, October 2016-July 2020

ABC Awards Level 4 Diploma in Therapeutic Counselling: Unit Title: Self-awareness for Counsellors

ABC Level 4 Diploma in Therapeutic Counselling: Counselling in a Diverse Society

Agenda4Change: Profile – Level 5, 6 and 7 Counsellor

AIM Awards Level 4 Diploma in Counselling Practice

AIM Awards Level 4 Diploma in Counselling Practice: Unit Title: Counselling: Embarking on Practice

BACP Accreditation of Training Courses: Criteria for BACP Course Accreditation

BACP Competences – working online and by telephone

BACP Core Generic Competencies for Counselling and Psychotherapy

BACP Course Accreditation Criteria (‘Gold Book’)

BACP Ethical Framework for the Counselling Professions

BPC Standards

BPC Training criteria: Psychoanalytic psychotherapy, psychoanalytic and Jungian analytic trainings

BPC Training criteria: Psychodynamic Counselling

BPC Training criteria: Psychodynamic psychotherapy trainings and Jungian psychotherapy trainings

COSCA Counselling Skills Certificate Course Module 1: Advanced Communication Skills Module 3 – Review & Reflection

CPCAB Level 4 Diploma in Therapeutic Counselling

CPCAB Level 5 Diploma in Psychotherapeutic Counselling

European Association for Counselling (EAC), Training Standards (2013)

European Association for Psychotherapy (EAP): The Professional Competencies of a European Psychotherapist

IAPT Band 7 CBT Therapist role profile

Level 4 and Level 5 counselling courses: learning outcomes – (CPCAB), (AIM Awards), (ABC), (OCN), (BTEC)

National Occupational Standards (NOS) Framework (counselling and mental health), particularly:

– NOS SFHMH100 Establish and maintain the therapeutic relationship

– NOS SFHMH97 Identify models of personality and mind development in relation to the client in counselling and develop appropriate intervention

– NOS LSICLG8 Demonstrate equality and diversity awareness when working in counselling

NCS Training Standards

Open College Network Level 4 Diploma in Counselling: Unit Title: Personal Development

Open College Network PS1/4/NQ/013 Professional, Ethical and Legal Issues in Counselling

QAA Subject Benchmark Statement Counselling and Psychotherapy

Revised Cognitive Therapy Scale (CTSR) Manual

University College London competence frameworks:

– Cognitive and Behavioural Therapy

– Counselling for Depression

– Couples Therapy for Depression

– Dynamic Interpersonal Therapy

– Humanistic Therapy

– Interpersonal Psychotherapy

– Psychoanalytic/Psychodynamic Therapy

– Systemic Therapy

UKCP Ethical Principles and Code of Professional Conduct (2009)

UKCP Guidelines for Mental Health Familiarisation

UKCP Professional Occupational Standards

UKCP Standards of Education and Training

# Appendix 3: Combined questionnaire findings – quantitative questions

A total of 8,364 members responded to the July 2020 questionnaire, a response rate of 14% across the three partners.

**I am familiar with the updated SCoPEd framework:**

• 60% strongly agreed or agreed (6% strongly agreed, 54% agreed)

• 23% were neutral

• 16% disagreed or strongly disagreed (12% disagreed, 4% strongly disagreed)

**I understand the aims of the SCoPEd project:**

• 66% strongly agreed or agreed (7% strongly agreed, 59% agreed)

• 18% were neutral

• 14% disagreed or strongly disagreed (10% disagreed, 4% strongly disagreed)

**I feel supportive of the SCoPEd project aims:**

• 46% strongly agreed or agreed (8% strongly agreed, 38% agreed)

• 31% were neutral

• 22% disagreed or strongly disagreed (13% disagreed, 9% strongly disagreed)

**I can see where I’d fit within the SCoPEd framework:**

• 48% strongly agreed or agreed (7% strongly agreed, 41% agreed)

• 27% were neutral

• 24% disagreed or strongly disagreed (17% disagreed, 7% strongly disagreed)

**I feel that my voice as a member is being heard in relation to the SCoPEd project:**

• 30% strongly agreed or agreed (3% strongly agreed, 27% agreed)

• 39% were neutral

• 26% disagreed or strongly disagreed (14% disagreed, 12% strongly disagreed)

**I feel positive about the SCoPEd project being able to deliver on its aims:**

• 31% strongly agreed or agreed (3% strongly agreed, 28% agreed)

• 39% were neutral

• 28% disagreed or strongly disagreed (16% disagreed, 12% strongly disagreed)

**In its current format I would support this iteration of the SCoPEd framework as a structure for the future of the profession:**

• 34% strongly agreed or agreed (4% strongly agreed, 30% agreed)

• 31% were neutral

• 31% disagreed or strongly disagreed (16% disagreed, 15% strongly disagreed)

Percentages do not add up to 100% as the ‘Do not wish to respond’ option has not been included.

# Appendix 4: Membership of Technical Group and Expert Reference Group, and Experts by Experience

| Name | Theoretical orientation | Membership body | Role or group membership | Representative of SCoPEd for which membership body |
| --- | --- | --- | --- | --- |
| **Independent roles** |
| **Professor Alessandra Lemma** | **Psychoanalytic** | **BPC, Institute of Psychoanalysis** | Independent Chair of ERG |  |
| **Dr Alan Dunnett** | Humanistic Integrative | BACP | Information Analyst |  |
| **Expert Reference Group (ERG) and Technical Group (TG) Members** |
| **Dr Heather Churchill** | Integrative | ACC, BACP | ERG, TG | ACC |
| **Fiona Ballantine Dykes** | Humanistic Integrative | BACP | ERG, TG | BACP |
| **Dr Sally Beeken** | Psychoanalytic | BPC | ERG, TG | BPC |
| **Ms Fiona Biddle** | Hypno-psychotherapy | UKCP | ERG, TG | UKCP |
| **Lindsay Cooper** | Humanistic | NCS | ERG, TG | NCS |
| **Ms Ani de la Prida** | Person-Centred and Pluralistic | BACP | ERG | [None – recruited subsequently as additional ERG member] |
| **Ms Maxine Dennis** | Psychodynamic, Psychoanalytic | BPC, Tavistock Society of Psychotherapists, Institute of Psychoanalysis | ERG | BPC |
| **Professor Lynne Gabriel** | Pluralistic | BACP | ERG | BACP |
| **Dr Jan McGregor Hepburn** | Psychoanalytic | BPC | ERG, TG | BPC |
| **Claire Hopkins** | Psychodynamic | ACP | ERG, TG [until October 2021 after which took observer role] | ACP |
| **Keri Johnson** | Humanistic Integrative | BACP | ERG, TG | BACP |
| **Kathryn Marlow** | HG practitioner | HGI, NCS | ERG, TG | HGI |
| **Professor John Nuttall** | Integrative | UKCP, BACP | ERG | UKCP |
| **Ms Katy Rose** | Psychodynamic | UKCP | ERG, TG | UKCP |
| **Professor Alistair Ross** | Psychodynamic | BACP | ERG | BACP |
| **Kathy Spooner** | Integrative | ACC, BACP | ERG, TG | ACC |
| **Dr Clare Symons** | Psychodynamic | BACP | ERG, TG | BACP |
| **Dr David Vincent** | Freudian, Foulksian | BPF (BPC), IGA | ERG | BPC |
| **Dr Brinley Yare** | Psychoanalytic | UKCP | ERG [Resigned from ERG effective from 18.10.21] | [None – recruited subsequently as additional ERG member] |

**Administrative support:**

Miss Debbie Delves, Project Manager (BACP)
Ms Kathy Roe, Senior Administrator (BACP)

| Experts by Experience (membership of SOC, ERG and TG):**SCoPEd’s Experts by Experience have consented to sharing their first names and brief biographical details that they have each written.** |
| --- |
| **Alex** | Alex is new to the lived experience field, having been encouraged by peer support in London. He hopes to see geographical disparities in publicly-funded talking therapies addressed, particularly for LGBT+ communities. A service user for 19 years, Alex combines his life experience with an academic interest in the field. |
| **Emily** | Emily is a long-time service user and survivor who has experienced mental distress since her teenage years. She currently works full time in the user-led mental health world, and is deeply passionate about social justice, involvement, and the political nature of mental health. She has been a client or patient in a number of different settings. She has had Dialectical Behaviour Therapy (DBT) and Cognitive Behavioural Therapy (CBT) on the NHS, seen counsellors, and was in analysis for several years. She brings with her both a passion about the benefits of psychotherapy and counselling and an academic interest in the subject. |
| **Julian** | Based in Leicester, Julian works both as a freelance Equality and Diversity Consultant and in mental health – his diagnosis is clinical depression, OCD and Anxiety Disorder – for various projects and areas of work that require a lived experience perspective. The latter involves work with universities, within the NHS and for mental health organisations locally and nationally. He is also an author and has published three books – on rugby league, on the Holocaust and on living with mental illness.He has had a number of experiences of different forms of counselling and psychotherapy – as an individual and in groups – and has found every single context and type of work to be beneficial and, in some cases, inspirational. The opportunity to work at such close hand with professionals is so valuable in mental health recovery. |

# Appendix 5: Additional sources consulted

APPG prescribed drug dependence: Guidance for Psychological Therapists. Enabling conversations with clients taking or withdrawing from prescribed psychiatric drugs (revised 2021)

ACC application for the Christian Content Recognition of a Counselling Training Course by ACC

ACC Waverley BA curriculum

ACC London School of Theology, Theology & Counselling
Programme Handbook 2020-2021

ACC Level 5 Diploma in Integrative Therapeutic Counselling; mental and spiritual health content

ACC The Churchill Framework (2021)

ACP Competence map for Child and Adolescent Psychotherapists
at the point of qualification (revised, 2020)

ACP Quality Assurance Framework for Training in Child and Adolescent Psychoanalytic Psychotherapy

BACP Online and phone therapy (OPT) competence framework (2021)

BACP Supervision competence framework (2021)

BACP Workplace counselling competence framework (2021)

HGI Ethics and Conduct Policy

HGI Observed Therapy Sessions Assessment Criteria

Human Givens Diploma Guidance for students

Human Givens Diploma Supervisors’ Handbook

NCS Standards for Education and Training for accredited
Courses 2020 with addendum

NCS accreditation full application form

QAA leaflet Qualifications can Cross Boundaries. A guide to comparing qualifications in the UK and Ireland

# Appendix 6: Summary of feedback and decisions

|  |  |
| --- | --- |
| **Feedback** | The definition of ‘worldview’ is not broad enough with regard to spirituality |
| **Action taken** | Framework definition of ‘worldview’ extended. See glossary |
| **Rationale** | Evidence established precedent for use of religion and spirituality – TG accepted that spirituality was not included and (or) was implied to be understood within ‘religion’ |

|  |  |
| --- | --- |
| **Feedback** | The framework competences surrounding mental health should be revisited with regard to differentiated competence of column A and B therapists and to ensure consistency over terminology |
| **Action taken** | • Competence 2.1 column B wording enhanced• Competence 2.2 column B removed, with 2.2 column A enhanced to reflect therapists’ ability to work within appropriate limitations• Competence 2.4 column A wording enhanced to mirror appropriate content in column B (psychological distress an understanding of cultural norms)• Competence 2.4 column B wording enhanced to mirror appropriate content in column A (mental health problems)• Mental health problems used as a singular term in place of various others (common, chronic, enduring, conditions etc) |
| **Rationale** | • Evidence suggests differentiation is in the ongoing strategy that is coherent, consistent, in-depth with theoretical approach• Revisiting the evidence to refine the criteria resulted in further lack of differentiation. Autonomy and therapist limitations can be addressed within one criterion• Mirroring language showed differentiation more clearly• Glossary work picked up inconsistencies within the use of terms and variable understanding of terms |

|  |  |
| --- | --- |
| **Feedback** | Ability to establish and maintain emotional contact with those worked with not represented in column A |
| **Action taken** | Technical Group (TG) discussed and felt this was covered implicitlyNo further action |
| **Rationale** | Evidence of implied competence found in primary source |

|  |  |
| --- | --- |
| **Feedback** | Ability to draw on knowledge that enactments are inevitable and will require the therapist to work to regain a reflective stance to be added to column B and (or) C |
| **Action taken** | TG considered definitions of enactmentsNo further action |
| **Rationale** | Speaks to themes already covered in 3.12 columns B and C |

|  |  |
| --- | --- |
| **Feedback** | Ability to be aware of, and respond to, emotional shifts occurring in each session, with the aim of maintaining an optimal level of emotional arousal (i.e. ensuring that the patient is neither remote from nor overwhelmed by his or her feelings) to be added to column B and (or) C |
| **Action taken** | Competence 3.9 column B had a further competence added |
| **Rationale** | TG discussed and agreed that this wasn’t about what therapists do, but what was assessed within training and the evidence was found to be in column BWording of optimal and arousal were amended due to variable understanding |

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| **Feedback** | Ability to distinguish countertransference feelings from feelings with other origins, and to identify and make use of the countertransference as a source of information and understanding to be added to column C |
| **Action taken** | No further action |
| **Rationale** | Speaks to themes already covered in those referencing ‘unconscious’ or ‘out of awareness’ processes and within applying your own model as outlined in 4.2 |

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| **Feedback** | When discussing assessment does the framework mean just initial or ongoing monitoring? |
| **Action taken** | TG discussed potential for expanding the definition of assessment within the footnote (footnotes now housed in glossary for accessibility purposes)• TG recommend ‘initial and ongoing’ be added to competences 2.1, 2.7, and 2.10 |
| **Rationale** | Amending wording of specific criteria was more suitable than overall definition due to other competences already containing similar language |

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| **Feedback** | Ability to be aware of possible transference responses and meanings for the patient if the therapist takes external action, to be added to column B and (or) C |
| **Action taken** | TG discussed with regard to competences referencing both suicide and unconscious processes• An additional bullet point added to existing competence 3.14 in column A |
| **Rationale** | Group agreed that this was something that spoke to all modalities when removing the concept of transference, that all practitioners would discuss what it means to break confidentiality, and that it fell more thematically within the relationship suite of competences |

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| **Feedback** | Addition to column A: Ability to follow legal, organisational, local, and professional guidelines and procedures in relation to the assessment, management and monitoring of risk |
| **Action taken** | TG discussed this within a safeguarding perspective as it was raised by those working with childrenNo further action |
| **Rationale** | Group agreed unnecessary to specify range of relevant sources for safeguarding as in challenge as existing 2.7 states: comply with safeguarding guidance, appropriate to the therapy setting |

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| **Feedback** | Addition to column B: Ability to make balanced and informed judgments and decisions about when matters of risk can safely be managed and contained within the therapeutic frame and relationship, and when they require discussion, consultation or action involving colleagues, other professionals, or other agencies |
| **Action taken** | TG discussed whether evidence existed as to ability to ‘do’ something before or instead of referralNo further action |
| **Rationale** | Evidence was not specific enough to warrant ‘more’ or ‘different’ than expressed in enhanced 2.7 (column A) and NEW 2.7 column C – see below |

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| **Feedback** | Does 2.7 sufficiently cover depth and complexity of risk? |
| **Action taken** | TG discussed depth and complexity of risk associated with different level therapists and management of high-risk clients or patients generally • Competence 2.7 column A enhanced to reference therapist’s level of competence• Competence 2.7 added in column C to reference ongoing work with high-risk and complex clients or patients |
| **Rationale** | • Need to capture working with high-risk clients or patients generally, as it is already noted specifically within technologically mediated context• Capturing the elements of ongoing work and appropriate action was needed for differentiated column C via EAP source evidence |

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| **Feedback** | Addition to column C: Ability to draw on countertransference as a source of information about risk |
| **Action taken** | TG discussed whether there was evidence for something more or more specific than already covered that wasn’t modality or setting-specificNo further action |
| **Rationale** | Themes already covered by ‘unconscious’ or ‘out of awareness’ process and general ability to make risk assessments (e.g. 4.3, 2.7) |

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| **Feedback** | Addition to column B: Ability to draw on knowledge of methods for monitoring change resulting from treatment, with the aim of identifying the impact (positive or negative) of an intervention |
| **Action taken** | TG discussed whether and how well the framework captures ongoing evaluation as opposed to just end outcomes• Competence 4.4 enhanced |
| **Rationale** | Process of change is implied throughout therapy and not just outcomes. However, framework could be strengthened by explicitly noting the ability to ‘track change’ as part of therapeutic process in column A |

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| **Feedback** | Addition column C: Ability to draw on one’s own countertransference experiences for assessment |
| **Action taken** | TG discussed with regard to ongoing and ending assessments• Competence 5.1 column C enhanced |
| **Rationale** | The use of ‘therapeutic process’ in 5.1c could more sufficiently cover assessment and endings by adding the word ‘throughout’ for clarity |

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| **Feedback** | Addition column B: Ability to identify changes within the psychotherapy that have generalised to other settings and contexts |
| **Action taken** | TG discussed with regard to whether a marker of change or progress is a generic competence and whether the theme of the feedback was already sufficiently coveredNo further action |
| **Rationale** | Sufficiently covered by enhancement of 4.4 ‘tracking’ change |

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| **Feedback** | Addition column A: Ability to draw on knowledge of other psychological therapies as a basis for considering more suitable alternatives or choices for the patient |
| **Action taken** | TG discussed with regard to purpose of initial assessment• Competence 2.1 enhanced |
| **Rationale** | Group consensus that initial assessment is not just about suitability for therapy but for that specific therapy |

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| **Feedback** | Addition to column C: Ability to draw upon conscious and unconscious communications that the process of referral and assessment conveys about the supportive environment in deciding upon an approach |
| **Action taken** | TG discussed with regard to generic support structures and whether already sufficiently covered in the frameworkNo further action |
| **Rationale** | Group consensus that theme already covered by competence 3.4 |

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| **Feedback** | Addition column C: Ability to help the patient to be aware of, and where possible reflect on, his or her conscious and unconscious experience of the assessment |
| **Action taken** | TG discussed with regard to differentiated competences 3.6 and 4.7No further action |
| **Rationale** | Group consensus that themes already covered by competences reacting to unconscious processes throughout therapy including assessment |

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| **Feedback** | Addition column C: Using knowledge of client’s external systems and (or) dynamics to inform thinking |
| **Action taken** | TG discussed in line with earlier challenge on ‘supportive environments’ and also with relevance to professional communities and multiagency working etc.No further action |
| **Rationale** | Group consensus that themes already covered in competences 3.4 and 1.12 |

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| **Feedback** | Addition column C: Ability to apply the formulation of internal dynamics to an assessment of risk with regard to: Acting out and self-harm; Suicide; Vulnerability to abuse or neglect or injury; Danger to others |
| **Action taken** | TG discussed with regard to assessment, unconscious processes and working within own therapeutic modelNo further action |
| **Rationale** | Group consensus that themes already covered in competence 4.2 |

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| **Feedback** | Addition column B: Ability to communicate the formulation to others in a coherent and appropriate language and manner, both verbally and in writing, taking into account: Who it is addressed to, the purpose of the assessment, issues of consent, confidentiality, risk and child and (or) adult protection |
| **Action taken** | TG discussed with regard to whether specifics of formulation were required and (or) coveredNo further action |
| **Rationale** | Previous TG discussions were referenced around lack of agreement across approaches for ‘formulation’ and that evidence suggested this was sufficiently covered by ‘conceptualise’Group consensus that theme already covered in competences 2.1 and 2.2 |

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| **Feedback** | Addition column B and (or) C: Ability to distinguish between factors of severity, chronicity, complexity, and comorbidity that may have implications for treatment duration and intensity |
| **Action taken** | TG discussed with regard to whether this was more than determining whether a client or patient was right for therapy at this time and (or) this therapy being offeredNo further action |
| **Rationale** | Group consensus that this was sufficiently covered by enhancement to competence 2.1 |

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| **Feedback** | Confusion and (or) ambiguity around what ‘Levels’ mean on practice standards table |
| **Action taken** | TG discussed the difference of Level 4s in Further and Higher Education in terms of diploma and certificateAgreed to add the word ‘diploma’ to Level 4 in column A of practice standards table to ensure it covers full practitioner trainings not entry certificates |
| **Rationale** | QAA leaflet: Qualifications can cross boundaries |

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| **Feedback** | Do minimum Guided Learning Hours (GLH) need to be added to practice standards? |
| **Action taken** | TG discussed this in regard to Total Teaching Hours• Definition agreed and added to glossary• Total Teaching Hours added to each column within practice standards table |
| **Rationale** | • Group consensus that terminology and definition needed consideration due to changes to the landscape i.e. following pandemic and move to online • Group agreed this was a suitable inclusion given membership bodies have this as a requirement for registration |

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| **Feedback** | Do new competence frameworks etc. have a place in the framework? |
| **Action taken** | TG discussed that though the project is a mapping of what is (as opposed to what might be in the future or what should be), there is a requirement for additions and updates to be taken into consideration as standards change and evolve• Agreed members of TG should submit any new or recent frameworks as evidence via the proforma review process to enable discussion within competence mapping items at the TG meetings |
| **Rationale** | Group agreed that standards change and evolve and cited previous evidence of this being taken on board within the SCoPEd framework when the self-harm and suicide prevention framework was looked at in the previous round of feedback and revisions |

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| **Feedback** | The framework should be revisited in line with updates to the Online and phone therapy (OPT) competence framework published in February 2021 |
| **Action taken** | TG discussed new evidence source with regard to ways of training and (or) working under the pandemic restrictions• Competence 1.11 wording enhanced• Competence 2.3 wording enhanced• Competence 2.10 wording enhanced• Competence 2.10 column B reworded to show differentiated competence more clearly |
| **Rationale** | Group consensus that this source constituted evidence of updated and evolving standards in the current landscape • Group considered that current framework criteria reference only ‘online’ working but the OPT noted more than this via technologically mediated therapy which would encompass e.g. phone, text etc. |

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| **Feedback** | Current wording does not show meaningful differentiation between column A and B with regard to clinical and comprehensive risk assessment, and the wording of ‘competent’ in column B is problematic |
| **Action taken** | TG discussed with regard to competences 2.1 and 2.7 • Competence 2.1 column B amended• Competence 2.7 column A enhanced |
| **Rationale** | • Group consensus was to remove the word ‘competent’ from column B as numerous pieces of feedback evidenced that readers were interpreting the presence of it in B along with the absence of it in A as implying that column A therapists were not deemed ‘competent’ • Group discussed evidence for differentiated competence in item 2.7 and use of term ‘comprehensive’ in column B, and agreed to enhance column A criteria with initial and ongoing, but that the differentiated aspect of the competence held and was in relation to the use of ‘strategy’ – comprehensive risk assessment strategy relates to the deeper understanding and risk and overall strategy whilst column A evidence is focused on risk associated with a particular client or patient |

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| **Feedback** | Current wording does not show meaningful differentiation between column A and B, and the wording of ‘interpersonal risk’ in column B is problematic |
| **Action taken** | TG discussed with regard to competence 2.10No further action |
| **Rationale** | Group consensus that evidence showed a differentiated competence, but that wording was not currently showing this, had now been addressed after reviewing the competence under the OPT evidence source suite of challenges |

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| **Feedback** | Current wording does not show meaningful differentiation between column A and B, and column C appears to be about organisations and (or) not relevant to therapists in private practice |
| **Action taken** | TG discussed with regard to competence 3.6No further action |
| **Rationale** | Group discussed and agreed that competences found in evidence cannot be removed, that they are additional competences whether or not people do them. Trainings mapped to column C do expect people to apply issues of power dynamics to organisational settings and this is very important in some settings. It may not be relevant to or evidenced by someone who solely works in private practice and did not complete a column C training, but it remains an evidenced additional competence beyond column A and B trainings. Many therapists may have these competences and work in private practice while others may not. The context of therapy is not a feature of the frameworkGroup agreed that shared communications, website FAQs etc. should better address the idea of relevance and training content, onward evidence of further training and experience (where this may be gained) and the idea that not everyone has to evidence meeting criteria or being in a column if it is not relevant to their work |

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| **Feedback** | Differentiation between column A and B appears limited and more about noting the importance of transference and therefore privilege one modality over others |
| **Action taken** | TG discussed with regard to competence 3.12• Competence 3.12 column B wording enhanced |
| **Rationale** | Group discussed original source as being BACP Core Competences, which is degree level training so both higher than Level 4 and not biased towards a psychodynamic modality, however it was noted this issue had been raised in the previous round of feedbackGroup agreed that the work on evidencing and wording ruptures in column A had perhaps diluted the differentiation in B so the group would reword B to reflect that A is about managing ruptures and B is about using them, understanding the meaning of them, and getting a therapeutic outcome from themUCL source used for rewording |

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| **Feedback** | Differentiation between column A and B appears limited |
| **Action taken** | TG discussed with regard to competence 4.6• Competence 4.6 column B wording enhanced |
| **Rationale** | Group considered previous evidence and decision making document to ascertain that it was the modification element that gave the differentiation, and in discussing further noted that the higher order skill was better represented as being about adaptation given it is more responsive to process |

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| **Feedback** | Communicating ‘both in writing and verbally’ is problematic for therapists with dyslexia, or visual impairments |
| **Action taken** | TG discussed with regard to 4.13• Competence reworded |
| **Rationale** | Group discussed that there would be accessibility considerations likely covered in the individual interpretation of this competence, and suggested removing the explicit clarification and stipulations |

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| **Feedback** | Any movement through these columns is a function of experience rather than training or academic achievement. Dividing this spectrum into discrete gradations of competence gives a false impression of the reality of practice. It is also implied that column A therapists are not competent of doing ‘potentially taxing work’ due to the wording presence in column B and absences from column A |
| **Action taken** | TG discussed with regard to 5.1 and self-awareness generally• Competence 5.1 column B reworded |
| **Rationale** | Group consensus was that this competence was about self-awareness more specifically and how this increased over time (via longer trainings and (or) experience). Previous decision and evidence documents were consulted which reaffirmed the differentiation, however the point was noted about understanding of ‘taxing work’ and group agreed to remove |

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| **Feedback** | Is this not discriminatory in terms of differing levels and degrees of health? |
| **Action taken** | TG discussed with regard to 5.4 and the themes of psychological and physical health, self-care, and wellbeing• Competence 5.4 reworded |
| **Rationale** | Group consensus was to reframe to be more inclusive and found evidence of more appropriate wording referencing self-care and wellbeing in key sources |

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| **Feedback** | Differentiation between column A and B appears limited |
| **Action taken** | TG discussed with regard to 5.5No further action |
| **Rationale** | Group discussed previous decision-making and evidence documentation and agreed differentiation was in the responsibility for adaptation of supervision. Group consensus was that column B use of supervision was more proactive and referenced higher reflection on needs |

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| **Feedback** | What does ‘maximise therapeutic outcomes’ mean? |
| **Action taken** | TG discussed with regard to 1.12• Competence 1.12 column B amended |
| **Rationale** | Group agreed that ‘maximise’ raised questions as to meaning and quantifiability, and that the context (working in teams) was about enhancing outcomes, so ‘enhance’ was deemed a more accurate reflection of the competence being described |

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| **Feedback** | Wording such as ‘critically appraise’ and ‘understand discourses’ relates to academic criteria rather than vocational competences and isn’t relevant to clinical work. Understanding of diagnosis, pathology and mental disorders does not fit with person-centred experiential modality |
| **Action taken** | TG discussed with regard to 2.4• Competence 2.4 column B amended |
| **Rationale** | Group discussed previous evidence and decision-making documents and – as with challenges relating to organisational power dynamics – evidence showed that training in column C does contain this content, further discussion reached consensus that although some modalities may not need, use or agree with something doesn’t mean that it doesn’t exist, and a competence is required to be able to understand it in order to work with professionals who doGroup however agreed that the wording of ‘critically appraise’ was unhelpful and that the skill was to take account of and hold in mind, so could be reworded to reflect this |

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| **Feedback** | 3.6b seems relevant only to those in a managerial role |
| **Action taken** | TG discussed 3.6No further action |
| **Rationale** | As with above and previous on organisational dynamics, this is a competence found within column C trainings so cannot be removed. However, it was noted again that stronger shared communications, website FAQs etc. are needed to deal with understanding issues of relevance and evidence |

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| **Feedback** | Critical awareness is an academic competence rather than vocational |
| **Action taken** | TG discussed with regard to 3.12• 3.12 column B reworded• 3.12 column C amended |
| **Rationale** | Group considered previous evidence and decision-making documents as well as other current feedback challenges relevant to themes here. Consensus was reached that evidence for differentiation from A to B existed, but wording could be strengthened to reflect this – using UCL source, and that removing ‘critical’ in column C left the practical skill whilst removing the implication of academic attainment |

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| **Feedback** | Are ‘Ability to describe the philosophical assumptions’ and ‘integrate relevant theory and research’ academic competences, rather than vocational ones? |
| **Action taken** | TG discussed with regard to 4.8• 4.8 column B amended |
| **Rationale** | Group agreed this had academic-sounding connotations and that the differentiated competence was about recognising and exploring assumptions more generally to reach understanding |

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| **Feedback** | Academic language in column B and the requirement to do a Masters to enter column C |
| **Action taken** | TG discussed with regard to 4.12• 4.12 column B amended• 4.12 column C amended |
| **Rationale** | Group consensus that differentiation between columns B and C were ranges from looking at research to actually conducting research, but that a Master’s degree wasn’t a requirement – that for example a literature review at L6 would satisfy or ‘a systematic case study’. Similarly, L4 courses do look at research – the differentiation is in being able to integrate research which is a higher-order skill. Group agreed that academic-seeming language could be amended but that the level of engagement with research is still differentiated |

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| **Feedback** | If you can ‘understand the impact of something’ does it not follow that you are capable of critically challenging it? |
| **Action taken** | TG discussed with regard to 5.3No further action |
| **Rationale** | Group agreed that column A counsellors develop the habit of self-awareness and how this impacts on their work, but that a next order competence is about challenging beliefs etc. Similar themed challenges were found within the decision-making documents and applied here – differentiation is about focus on self as therapist shifting to greater ability to challenge self and be aware of impact on client or patient |

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| **Feedback** | This describes a way of working familiar to psychodynamic and process-based practitioners. It does not fit with an autonomy-based approach in which therapy takes place in a collaborative context, not one of treatment by an expert |
| **Action taken** | TG discussed with regard to 1.5No further action |
| **Rationale** | Consensus was that this was a perception of the word ‘framework’ meaning this was psychodynamic working, but group agreed no issue with the word. Group suggested again this was a case for stronger communication around the work and specifically here that the terms used are not associated with an approach |

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| **Feedback** | Wording is modality specific and should not be in column C due to relevant conditions and ways of working being covered at diploma level |
| **Action taken** | TG discussed with regard to 2.1No further action |
| **Rationale** | Group agreed that not all would consider the wording modality specific and that whilst for example L4 CBT diploma students might cover this, there was no evidence that all column A trainings assessed competence around the differentiated aspect of chronic and enduring |

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| **Feedback** | Wording is modality specific and private practitioners cannot access column C |
| **Action taken** | TG discussed with regard to 2.4No further action |
| **Rationale** | Group discussed in line with previous challenges of being able to understand certain modalities in order to work in multidisciplinary teams in mental health settings. Being able to understand different discourses does not imply agreeing to that discourse which might be more associated with another modality. Private practice is a ‘setting’ not a competence. Therapists in private practice may or may not have these competences or work in other settings too. Group again noted importance of relevance, settings, etc. for communications and FAQs |

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| **Feedback** | Unclear with whom collaboration is meant |
| **Action taken** | TG discussed with regard to 2.8• Competence 2.8 amended |
| **Rationale** | Group discussed original evidence sources and issues with interpretation in terms of settings, and agreed to be more explicit and inclusive in the wording |

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| **Feedback** | Is suicidal ideation always ‘conflictual and paradoxical’? |
| **Action taken** | TG discussed with regard to 4.3• Competence 4.3 amended |
| **Rationale** | Group discussed original wording source as being a distillation, and the base of the competence being about the complex nature of suicide ideation so amended to better reflect this |

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| **Feedback** | These competences describe a way of working familiar to psychodynamic and process-based practitioners |
| **Action taken** | TG discussed with regard to 4.7No further action |
| **Rationale** | Group discussed and agreed that all could interpret the progression regardless of modality |

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| **Feedback** | Differentiated competence is role-specific, relevant only to a team leader or practice manager and not relevant to private practice |
| **Action taken** | TG discussed with regard to 4.11No further action |
| **Rationale** | Group discussed original source material and decision-making documents and agreed it held |

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| **Feedback** | Is this not modality specific? |
| **Action taken** | TG discussed with regard to 5.1No further action |
| **Rationale** | Group discussed along with other challenges on concerns over the use of ‘unconscious’ and ‘out of awareness’ |

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| **Feedback** | Are the equality and diversity provisions in SCoPEd sufficient? |
| **Action taken** | TG discussed with regard to 1.9, 3.4, and 4.9, and went on to review new evidence source on EDI, resulting in:• Amended footnote wording on Equality Act (and moved all footnotes to glossary for accessibility purposes)• Amended 3.3• Added NEW between 3.3 and 3.4• Amended 3.4• Amended 3.14• Amended 4.8• Amended 4.9• Amended 5.2 |
| **Rationale** | See individual entries for each criterion |

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| **Feedback** | Is ‘reflecting upon impact’ sufficient? |
| **Action taken** | TG discussed with regard to 3.2• Competence 3.2 amended |
| **Rationale** | Group agreed there was more expected, and amended wording of criteria to reflect the shared exploration and use of this |

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| **Feedback** | Should the ability to critically appraise and (or) conceptualise symptoms be evidenced in column A? |
| **Action taken** | TG discussed with regard to 2.1 and 2.4No further action |
| **Rationale** | Group agreed the themes of the challenge had been addressed already via wording amended in 2.1 and 2.4 |

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| **Feedback** | Should knowing how to refer on be evidenced in column A? |
| **Action taken** | TG discussed with regard to 2.2 and 2.6No further action |
| **Rationale** | Group agreed the themes of the challenge had been addressed already via wording amended in 2.2 |

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| **Feedback** | Should devising a comprehensive risk strategy be evidenced in column A? |
| **Action taken** | TG discussed with regard to 2.7 and 2.8No further action |
| **Rationale** | Group agreed the themes of the challenge had been addressed already via wording amended in 2.7Group agreed suggested changes are not around differentiation or being evidenced in column A because consensus held that assessing an individual client or patient is different from having a comprehensive risk assessment strategy |

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| **Feedback** | Is there not an inconsistency here concerning monitoring, recognising and responding? |
| **Action taken** | TG discussed with regard to 3.10• Competence 3.10 column A amended• Competence 3.10 column B amended |
| **Rationale** | Group agreed there was evidence that column A do not simply monitor but manage responses to clients or patients and that differentiated competence is seen in the active use of self in this process. Column A and B wordings amended to reflect |

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| **Feedback** | Are column A counsellors really unable to ‘find ways of making progress’? |
| **Action taken** | TG discussed with regard to 3.14• Competence 3.14 column A amended• Competence 3.14 column B amended |
| **Rationale** | Group agreed that the differentiation in column B required more explicit language to reference the ability to analyse and address in the moment and move past difficultiesGroup agreed column A would be addressed via slight amending to wording, which would be further strengthened by other additions and amendments to the same competence via other challenges |

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| **Feedback** | Should we acknowledge that column A counsellors can critically reflect? |
| **Action taken** | TG discussed with regard to 3.9• Competence 3.9 column B amended |
| **Rationale** | Group agreed that evidence showed a differentiation but that current wording was unhelpful in showing thisDue to other feedback for 3.9 in column B, the group suggested two competences would reflect all challenges, with this specific challenge being addressed via the outcome of enhancing the client’s or patient’s self-awareness and understanding of themself in relationship |

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| **Feedback** | Should we acknowledge that using our own responses to the client in a way that is therapeutic is a competency which is exhibited in column A? |
| **Action taken** | TG discussed with regard to 3.10No further action |
| **Rationale** | Group agreed the theme of this challenge had been addressed in previous wording amendments |

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| **Feedback** | Should we acknowledge that analysing difficulties and making progress in therapy are competences exhibited in column A? |
| **Action taken** | TG discussed with regard to 3.14No further action |
| **Rationale** | Group agreed the theme of this challenge had been addressed in previous wording amendments |

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| **Feedback** | Should the ability to consider the potential issues arising at the end of therapy be acknowledged as a competency widely exhibited in column A? |
| **Action taken** | TG discussed with regard to 3.15• Competence 3.15 column B amended |
| **Rationale** | Group agreed evidence of differentiation was present but not well captured |

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| **Feedback** | Is the ability to understand and apply the Equality Act and other relevant legislation (at entry level) necessary to ensure safe and ethical practice within the law? |
| **Action taken** | TG discussed with regard to 1.2 and 3.2No further action |
| **Rationale** | Group agreed that evidence sources say you must work within the law |

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| **Feedback** | Is responding to practical and ethical demands of online therapeutic provision an ‘as is’ requirement of most courses or simply something of greater importance following the pandemic? |
| **Action taken** | TG discussed with regard to 1.11No further action |
| **Rationale** | Group agreed that this area represented a gap that needed strengthening and that evidence sources existed to do so |

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| **Feedback** | It is not a requirement of some training to recognise, understand and work with issues of power |
| **Action taken** | TG discussed with regard to 3.6No further action |
| **Rationale** | Group discussed the modality-based challenge and agreed that though the terminology is not recognised the concept is |

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| **Feedback** | Sense checking what is captured as critical reflection on client processes as being – understanding and reflecting to what extent a client’s emotional and physical needs are met, what attempts are being made to meet these needs, and whether the attempts would be viewed as balanced and healthy? Their capacity to utilise innate resources and skills in a healthy way to aid the meeting of needs and to recognise neurological processes such as pattern-matching and patterns of behaviour |
| **Action taken** | TG discussed with regard to 3.9 and 5.1No further action |
| **Rationale** | Group discussed the modality specific interpretation and confirmed the understanding, citing also 4.2 as the application of theory and practice from your model |

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| **Feedback** | The use of own responses as part of the therapeutic process is not a recognised competency within some modalities |
| **Action taken** | TG discussed with regard to 3.10No further action |
| **Rationale** | Group discussed the modality-based challenge and agreed that though the terminology is not recognised, the concept is and that for some modalities this may not be something you explore, it is about what is consistent with your therapeutic approach |

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| **Feedback** | Our approach is solution focused and predominantly short-term, where sessions are booked one-session-at-a-time. Discussions regarding holidays and breaks on both sides are addressed on a session-by-session basis. The seeking of support in case of emergency is considered best practice in the management of risk between sessions regardless of time frames and would be in competences associated with risk management and client safety |
| **Action taken** | TG discussed with regard to 3.11No further action |
| **Rationale** | Group discussed that as the modality is not longer term or pre-arranged, the competence does not affect their model and their argument for risk, best practice covers this |

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| **Feedback** | Feedback from partner that their members do not work specifically with ‘unconscious’ processes, rather behaviour based on pattern-matches relating to previous experiences and would seek to highlight these to clients |
| **Action taken** | TG discussed with regard to 3.12No further action |
| **Rationale** | Group discussed the modality-based challenge and agreed that though the terminology is not recognised the concept is with evidence of identifying patterns in sources at Level 4 |

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| **Feedback** | Feedback from partner that their members are trained to work with both suicidal risk and self-harm, and to recognise how it is possible for clients to feel conflicted due to the potentially paradoxical nature of these experiences |
| **Action taken** | TG discussed with regard to 4.3No further action |
| **Rationale** | Wording around ‘conflictual’ and ‘paradoxical’ removed as part of other discussion – evidence of differentiation remains |

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| **Feedback** | The competences referencing ‘unconscious’ and (or) ‘out of awareness processes’ shaping perceptions and experiences are taught at entry level within our framework as ‘trance vs observing self’, pattern matching and other neurological processes |
| **Action taken** | TG discussed with regard to 4.7No further action |
| **Rationale** | Group agreed that pattern matching was equivalent to unconscious etc., and recognised that though this is included in core training at column A for some approaches, it is not included in column A training for all |

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| **Feedback** | There is a gap in terms of referencing blind sessions and commitment to engaging with research for newly qualified practitioners |
| **Action taken** | No further action |
| **Rationale** | Group discussed and agreed blind sessions were an assessment method as opposed to a competence itselfGroup agreed that higher-level engagement with research is not expected at column A for all |

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| **Feedback** | Is the framework missing psychoeducation with the client? |
| **Action taken** | No further action |
| **Rationale** | Group agreed that evidence is required in order to add but consensus was that this didn’t exist. It may be a by-product of what happens alongside therapy as opposed to an actual competence and can be best described in other ways e.g. 3.5, 3.7 and 3.8 |

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| **Feedback** | Is ‘advance competence’ the same as ‘advance practice’? |
| **Action taken** | No further action |
| **Rationale** | Group discussed and agreed there were issues with perceptions of column A in comparison to column C, understanding of longer and deeper trainings, and progressions without hierarchy. Group agreed this should be picked up in better communication |

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| **Feedback** | Is there a gap around ability to tolerate uncertainty? |
| **Action taken** | TG discussed with regard to QAA benchmark statement• Group agreed to add NEW competence |
| **Rationale** | Group discussed and agreed this was a competence found across modalities and within column A |

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| **Feedback** | Is there a gap around ability to introduce a new perspective? |
| **Action taken** | No further action |
| **Rationale** | Group discussed and agreed there were issues with the challenge in terms of it not being client or patient led and potential for pre-setting the agenda, and considered whether this might already be sufficiently encompassed within 4.2’s generic wording on model of change |

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| **Feedback** | Is there a gap around reflecting on the client’s or patient’s verbal and non-verbal behaviours? |
| **Action taken** | TG discussed with regard to UCL Core• Group agreed to add NEW competence |
| **Rationale** | Group discussed multiple evidence sources and agreed this was a column A competence |

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| **Feedback** | Is there a gap around the use of the client’s or patient’s imagination? |
| **Action taken** | TG discussed with regard to imagination and imaginative life• Group agreed to add NEW competence |
| **Rationale** | Group discussed and agreed beneficial to be explicit around the competence within column A |

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| **Feedback** | Is there a gap with regard to focus on the transference relationship within a session and over time? |
| **Action taken** | TG discussed with regard to patterns and work ‘in the room’• Group agreed to add NEW competences in column A and B |
| **Rationale** | Group discussed and agreed transference and countertransference were modality specific and higher-level competences but that the theme of the challenge offers opportunity to be more explicit around the issue of patterns, which had been previously raised and agreed within column A |

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| **Feedback** | Is there a gap around avoiding excessively protracted or interminable treatment which is an avoidance of ending? |
| **Action taken** | TG discussed the issue of proposing something in the negative (i.e. what one shouldn’t do as opposed to what one should know or do)No further action |
| **Rationale** | Group discussed and agreed this was an ethical framework issue, not a competency framework issue |

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| **Feedback** | Is there a gap with regard to setting limits or boundaries in the moment? |
| **Action taken** | TG discussed with regard to if client or patient behaviour threatens injury or damage or underlines the viability of therapy• Competence 1.5 amended |
| **Rationale** | Group agreed to add something about protecting oneself as therapist as well as the client or patient |

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| **Feedback** | Is there a gap with regard to recognising and managing disinhibition? |
| **Action taken** | TG discussed in line with updates following Online and phone therapy framework• Group agreed to add NEW competence |
| **Rationale** | Group agreed there was a column A competence in recognising and understanding disinhibition in technologically mediated therapy |

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| **Feedback** | Is the footnote referring to the Equality Act 2010 sufficiently inclusive? |
| **Action taken** | TG discussed with regard to EDI good practice• Group agreed to enhance footnote wording (footnotes now housed in glossary for accessibility purposes) |
| **Rationale** | The group noted that the current framework wording does not make direct reference to protected characteristics, yet the footnote is based upon this and does not include the full list and that there are areas of discrimination and equality that impact upon EDI (e.g. class, socio-economic background and geography) |

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| **Feedback** | Is a new competence required to sufficiently capture the establishing and maintaining of an effective therapeutic relationship? |
| **Action taken** | TG discussed with regard to trust, rapport, acceptance and humanity• Group agreed to add NEW competence |
| **Rationale** | Group reviewed evidence captured in a summary paper from the sources listed on the therapeutic relationship compiled by an independent analyst |

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| **Feedback** | Does competence 3.3 need to better reflect its relational focus? |
| **Action taken** | TG discussed with regard to the content being more thematically covered by similar in theme 5, and opportunity to focus on the more relational aspects of diversity within theme 3• Competence 3.3 reworded |
| **Rationale** | Group reviewed evidence captured in a summary paper from the sources listed on the therapeutic relationship compiled by an independent analyst |

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| **Feedback** | Does the framework need to add something to reference intersectionality? |
| **Action taken** | TG discussed intersectionality as crucial to current conversations and work around EDI• Group agreed to add NEW competence |
| **Rationale** | Group reviewed an EDI competence in the Supervision competence framework as a new source of evidence |

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| **Feedback** | Does the existing competence reference the ability to view the needs of the client or patient need to be expanded to cover wider context and better reflect the sense of the client’s or patient’s own identity? |
| **Action taken** | TG discussed coverage and positioning of 3.4• Competence 3.4 amended |
| **Rationale** | Group agreed new source of evidence offered open language which includes systemic context and focus on the uniqueness and client’s or patient’s own sense of identity |

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| **Feedback** | Does the existing competence require an additional bullet point to address how EDI issues might impact upon therapy? |
| **Action taken** | TG discussed coverage of 3.14• Competence 3.14 amended |
| **Rationale** | Group agreed further wording was required as to how ruptures that relate to EDI issues, as opposed to therapeutic issues, might impact upon therapy |

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| **Feedback** | Does the framework need to add a competence which explicitly references a practitioner’s ability to adopt a trauma informed approach? |
| **Action taken** | TG discussed various feedback challenges on the absence of trauma from the framework• Group agreed to add NEW competence |
| **Rationale** | Group considered a paper by an independent analyst to determine if, how, and where trauma could be referenced within the framework. It was agreed to add a column A competence which referenced the key themes of recognising trauma and importance of working to own competence at each level |

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| **Feedback** | Does existing competence 4.5 need to move themes from 4: Knowledge and skills to 3: Relationship? |
| **Action taken** | TG discussed theme of 4.5 • Competence 4.5 moved, and wording enhanced |
| **Rationale** | Group agreed when looking at the overarching work on the therapeutic relationship that ability to understand and respond to emotional content was better aligned with the new and revised competences in theme 3 |

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| **Feedback** | Does a new competence need to be added to reference a practitioner’s ability to respect client or patient autonomy? |
| **Action taken** | TG discussed an agreed key outcome for therapy as being client or patient autonomy and empowerment• Group agreed to add NEW competence |
| **Rationale** | Group reviewed evidence captured in a summary paper from the sources listed on the therapeutic relationship compiled by an independent analyst |

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| **Feedback** | Does the existing competence need to be strengthened in terms of communication and anti-oppressiveness? |
| **Action taken** | TG discussed coverage of 4.8 and the difference between inclusion, anti-oppressiveness, and non-oppressiveness• Competence 4.8 amended |
| **Rationale** | Group reviewed an EDI competence within the Supervision competence framework as a new source of evidence which suggested that the inclusion of ‘non-oppressive communication’ is an additional, important distinction to non-discriminatory behaviour |

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| **Feedback** | Does the existing competence need to mirror EDI awareness outcomes of valuing and respecting and using difference (as opposed to defining it)? |
| **Action taken** | TG discussed wording of 4.9 with regard to what was important• Competence 4.9 amended |
| **Rationale** | Group agreed that defining difference is not the important skill, rather the focus on difference and the impact it can have are |

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| **Feedback** | Does the existing competence, referencing therapist ability to communicate, need to be more explicit in terms of aspects of communication? |
| **Action taken** | TG discussed wording of 4.13 with regard to therapist’s ability to take into account a number of aspects to ensure clear communication with clients or patients • Competence 4.13 amended |
| **Rationale** | Group reviewed evidence captured in a summary paper from the sources listed on the therapeutic relationship compiled by an independent analyst |

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| **Feedback** | Does the existing competence need strengthening to mirror the EDI competences that suggest the skill is not in understanding your preconceptions and biases, but in challenging them? |
| **Action taken** | TG discussed wording of 5.2 with regard to need for therapists to work on their own bias as opposed to simply understanding its relevance• Competence 5.2 amended |
| **Rationale** | Group reviewed an EDI competence within the Supervision competence framework as a new source of evidence |

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| **Feedback** | Can we draw upon findings to say more about the therapist’s ability to bring trust and connection into the therapeutic relationship? |
| **Action taken** | TG discussed wording of 3.9 with regard to need for therapists to work on their own bias as opposed to simply understanding its relevance• Competence 3.9 amended |
| **Rationale** | Group reviewed evidence captured in a summary paper from the sources listed on the therapeutic relationship compiled by an independent analyst |

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| **Feedback** | Is the specific ability around being responsive to the client’s or patient’s agenda adequately covered by the current framework? |
| **Action taken** | TG discussed with regard to client or patient needs • Group agreed to add NEW competence |
| **Rationale** | Group reviewed evidence captured in a summary paper from the sources listed on the therapeutic relationship compiled by an independent analyst |

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| **Feedback** | Is the specific ability around being able to help the client or patient express their emotions adequately covered by the current framework? |
| **Action taken** | TG discussed with regard to the enablement of client’s or patient’s emotions and in the importance of discussing their emotional reactions, and in relation to the theme of responding appropriately to emotional content, as noted in existing competence 4.5 which was earlier moved to theme 3• Group agreed to add additional content to competence 4.5 |
| **Rationale** | Group reviewed evidence captured in a summary paper from the sources listed on the therapeutic relationship compiled by an independent analyst |

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| **Feedback** | Is the specific ability around being able to work with client’s or patient’s emotions sufficiently covering the potentially differentiated or higher-order skill competence of working with intense emotions? |
| **Action taken** | TG discussed with regard to potential for column C competence within theme 3 but agreed this addition was not helpful beyond that already covered in the moved 4.5No further action |
| **Rationale** | Group reviewed evidence captured in a summary paper from the sources listed on the therapeutic relationship compiled by an independent analyst |

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| **Feedback** | Is the specific ability around being able to note an unspoken client’s and (or) patient’s agenda sufficiently covered within the current framework? |
| **Action taken** | TG discussed with regard to the potential of unspoken material ‘in the room’• Group agreed to add NEW competence |
| **Rationale** | Group reviewed evidence captured in a summary paper from the sources listed on the therapeutic relationship compiled by an independent analyst |

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| **Feedback** | Does the existing competence require strengthening to note the relationship must be rooted in courtesy and respect? |
| **Action taken** | TG discussed wording of 3.5 with regard to working in collaborative and boundaried ways with clients or patients • Competence 3.5 amended |
| **Rationale** | Group reviewed evidence captured in a summary paper from the sources listed on the therapeutic relationship compiled by an independent analyst |

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| **Feedback** | All competences should replace binary gender pronouns ‘his’ or ‘her’ with ‘their’ |
| **Action taken** | TG discussed in relation to a proposed competence which was ultimately not agreedNo further action |
| **Rationale** | Group agreed given work and conversations arising out of EDI source, however no binary gender pronouns were subsequently found throughout framework, methodology or narrative |

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| **Feedback** | Is it convoluted or necessary to use ‘respond therapeutically’ (and similar) as opposed to a simpler ‘respond’ etc.? |
| **Action taken** | TG discussed in relation to 2.10, extending to others also including ‘respond appropriately’• 2x competences had unnecessary terminology removed• 3x competences no further action, remain as drafted |
| **Rationale** | Group agreed phraseology helpful in some cases when it may relate to situations when it might be easy to respond untherapeutically |

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| **Feedback** | Is there a gap relating to therapist ability to reflect and (or) learn from when things go poorly, and they can’t be repaired? |
| **Action taken** | TG discussed the framework in regard to ‘learning from’• Competence 5.1 amended |
| **Rationale** | Group discussion of the additional bullet point for 3.14 wording (of when therapists work to repair relationships) raised the question of where the framework addressed what therapists do when they can’t. Group agreed existing content should be strengthened to show ability to learn via practice and supervision |

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| **Feedback** | Is there anything else that needs to be addressed in competence 1.12 in terms of strengthening wording? |
| **Action taken** | TG discussed with regard to issues of differentiation, relevance and language• No further action with regard to use of professional community in columns B and C• Competence 1.12 column C wording amended |
| **Rationale** | Evidence shows working in multidisciplinary teams is a skill gained in higher-level trainings often connected to specific placement |

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| **Feedback** | Does the group need to revisit competences containing mental health criteria in light of changes already made, outstanding feedback to be processed and standardised wording? |
| **Action taken** | TG returned to discuss competences 2.1, 2.2 and 2.4 as a suite following several individual challenges• Competence 2.1 amended• Competence 2.2 column A enhanced using appropriate wording from column B competence• Competence 2.2 column B removed• Competence 2.4 column A amended• Competence 2.4 column B amended |
| **Rationale** | In compiling the glossary, the group recognised issues with interchanging terms and the loss of clarity and consistency post amends |

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| **Feedback** | Does 2.7 sufficiently cover depth and complexity of risk? |
| **Action taken** | TG discussed competence 2.7 with regard to all therapists facing complex and high-risk clients or patients• Competence 2.7 amended• Competence added to 2.7 column C |
| **Rationale** | Group discussed and agreed that all therapists need to work within own levels of competence, and that therapists having completed training for entry to column C would work to higher thresholds in terms of continuing therapy with high-risk clients or patients |

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| **Feedback** | Is a third-party harm and risk to therapy sufficiently covered within the current framework? |
| **Action taken** | TG discussed with regard to context of assessing risk to therapy when clients or patients are at risk outside of the therapy room• Competence 2.8 enhanced |
| **Rationale** | Group agreed that there was a gap in covering assessment of clients or patients who may be at risk of ongoing third-party harm |

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| **Feedback** | Does language need to be included in competences relating to culture? |
| **Action taken** | TG discussed with regard to competences referencing identity, culture, values, and worldview• Competences 1.9, 3.2 and 5.3 enhanced |
| **Rationale** | Group agreed that language be added in relation to competences whereby the list referred to working with the client or patient |

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| **Feedback** | Does the framework need to address working with third parties in the room? |
| **Action taken** | TG discussed third parties may be in the room in roles as carers, signers, translators etc. and that this can impact on the work• Group agreed to add NEW competence |
| **Rationale** | Group identified the gap during discussion on language when the issue of translator’s and interpreter’s presence was noted. Evidence found suggesting a column A competence |

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| **Feedback** | Wording relating to ‘unconscious’ and ‘out of awareness’ working implies expert and patient, and prizes psychodynamic ways of working |
| **Action taken** | TG discussed with regard to 3.12, 4.3, 4.7 and 5.1No further action |
| **Rationale** | Group agreed the theme of the feedback has been sufficiently discussed throughout various challenges (e.g. patterns) and that there are other techniques (e.g. Gestalt) which bring things into awareness without being psychodynamic |

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| **Feedback** | Does the framework sufficiently cover the concept of time with regard to ability to ensure interventions fit the time constraints? |
| **Action taken** | TG discussed the competence of adapting interventions with regard to time and skills of the therapist comparing to criteria 1.3, 2.1, 3.7 and 3.8• Group agreed to add NEW competence |
| **Rationale** | Group agreed evidence showed this was an additional competence not already covered |

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| **Feedback** | Is there a gap within the framework when it comes to review of progress? |
| **Action taken** | TG discussed with regard to 1.3 which talks about ‘review’ but only in terms of the contract, not review of progress or goals• Group agreed to add NEW competence |
| **Rationale** | Group agreed this was an important gap to capture, as evidence indicates review of progress does enhance therapy and provide opportunities for client or patient to feed back to therapist |

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| **Feedback** | Is there a gap in the framework with regard to explicit consent? |
| **Action taken** | TG discussed with regard to lack of noting the client or patient is being ‘informed’ or establishing consent• Competence 1.3 enhanced |
| **Rationale** | Group agreed that 1.3 could be strengthened to go beyond the negotiation of contract by explicitly naming informed and freely given consent |

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| **Feedback** | Does the framework adequately cover what is expected of referrals? |
| **Action taken** | TG discussed with regard to lack of acknowledgement that therapists may do more than simply ‘make’ referrals• Competence 2.6 enhanced |
| **Rationale** | Group agreed 2.6 could be strengthened to reflect that therapists may need to manage the process of referral |

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| **Feedback** | Does the framework adequately cover the required therapist knowledge of legislation (beyond the Equality Act)? |
| **Action taken** | TG discussed the lack of explicit note of therapist working to legal frameworks (beyond the Equality Act) • Competence 1.1 enhanced |
| **Rationale** | Group agreed that there was a need to ensure the framework covered working to legal frameworks as well as professional and ethical |

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| **Feedback** | Should theme 3 be renamed as Therapeutic relationship (as opposed to current ‘Relationship’)? |
| **Action taken** | TG discussed with regard to extent of feedback provided and IA research on the theme of the therapeutic relationship • Theme 3 title enhanced |
| **Rationale** | Group agreed that the original theme name came out of a thematic sort and so the additional work provided evidence for a rename |

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| **Feedback** | Does the framework adequately cover an entry level skill of use of self? |
| **Action taken** | TG discussed evidence with regard to strengthening content within theme 5: Self-awareness and reflection• Group agreed to add NEW competence |
| **Rationale** | Group reviewed evidence captured in a summary paper from the sources listed on the therapeutic relationship compiled by an independent analyst |

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| **Feedback** | Is empathy sufficiently covered? |
| **Action taken** | TG discussed evidence with regard to strengthening the communication of empathy• Group agreed to add NEW competence |
| **Rationale** | Group reviewed evidence captured in a summary paper from the sources listed on the therapeutic relationship compiled by an independent analyst |

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| **Feedback** | Challenge to definition of assessment as believed it should be about the counsellor’s ability to work with the person, as much as the state the person is in |
| **Action taken** | TG agreed themes of the challenge – rapport and trust – are key to relationship and thus successful outcomes, however believed to be covered by new work elsewhere in the frameworkNo further action |
| **Rationale** | Group agreed this was covered by new criteria relating to therapeutic relationship |

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| **Feedback** | Counsellors have written essays critically appraising psychological ideas, cultural and socio-political concepts [4.2] in their work in columns outside column C, and lower education levels than L7. This [4.2] implies that (column) A and B practitioners are oblivious to – and so cannot engage with – the history of ideas and their social context |
| **Action taken** | TG discussed in line with other thematically similar challenges (e.g. 4.8 and 4.12)No further action |
| **Rationale** | Group agreed issue is not that column A and B practitioners are not able to engage with ideas and social context, but the evidence is that there is differentiation in terms of what is expected and assessed in different levels of training and practice |

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| **Feedback** | There is a false differentiation in competence 4.3 |
| **Action taken** | TG discussed after processing a reword in 4.3 column BNo further action |
| **Rationale** | Group agreed differentiation in evidence sources existed and rewording made this clearer |

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| **Feedback** | There is a false differentiation in competence 4.11 |
| **Action taken** | TG discussed 4.11 content overall during earlier feedback challenges on relevance to settings No further action |
| **Rationale** | Group agreed differentiation was clear in evidence with regard to understanding, use of, and wider engagement |

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| **Feedback** | There is a false differentiation across the whole of theme 4: Knowledge and skills whereby column B competences are the same as column C competences (except for 4.12) |
| **Action taken** | TG discussed with regard to the competences in theme 4, noting there had been earlier discussions and individual revisions made prior to this overarching challengeNo further action |
| **Rationale** | Group discussed false differentiation as a concept and via individual competences extensively throughout this framework version’s feedback stage and made revisions where appropriate and where evidence existed |

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| **Feedback** | There is a gap with regard to organisational culture and how this can impact on counselling services and individual counselling sessions |
| **Action taken** | Out of scopeNo further action |
| **Rationale** | Group agreed this is beyond therapy itself |

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| **Feedback** | There is a gap related to embodiment |
| **Action taken** | TG suggested this might be covered more broadly within non-verbal communicationNo further action |
| **Rationale** | Group agreed there wasn’t evidence to warrant a separate competence |

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| **Feedback** | There is a gap related to social justice |
| **Action taken** | Out of scopeNo further action |
| **Rationale** | Group agreed this was important but that it could not be said to be a competence |

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| **Feedback** | Is this relevant and using input from Northern Ireland? |
| **Action taken** | TG not aware of any specific standard for NI as standards are UK wideNo further action |
| **Rationale** | Group agreed this may be an issue for communications on relevance |

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| **Feedback** | Does criterion 2.1b [chronic and enduring mental health conditions] mean BACP accredited counsellors will no longer be able to work within NHS IAPT services [as the competence has been taken to be understood]? |
| **Action taken** | TG agreed that the framework does not prevent people working within their competence, so this does not prevent accredited counsellors working in IAPT services. However, not all accredited counsellors will have had this level of training as it sits in training standards at column C |
| **Rationale** | Group agreed this is a communications issue |

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| **Feedback** | Various comments on framework accessibility |
| **Action taken** | TG discussed and made various changes and recommendations to framework, methodology and narrative documents including:• Plain English• Inclusive language• Adding a glossary• Framework re-numbering• Accessible versions of all documents |
| **Rationale** | Group agreed that various issues existed with understanding and ability to access the July 2020 version of the framework |

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| **Feedback** | Layout suggests a linear progression and academic template |
| **Action taken** | TG discussed and made various changes and recommendations to framework, methodology and narrative documents including:• Graphic interpretation of entry and transition points• Language within practice standards table |
| **Rationale** | Group agreed that various issues existed with understanding and interpretation of the July 2020 version of the frameworkGroup agreed this is also broadly within the scope of communications |

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| **Feedback** | The framework is suited to a clear understanding of the employment of practitioners across generic roles. However, this would be strengthened further by giving some examples of existing roles and job titles that the framework maps onto |
| **Action taken** | TG discussed more broadly during earlier feedback the issues with applying settings and roles to specific columns or competences, as this is both too prescriptive and out of scope of the workNo further action |
| **Rationale** | See Action |

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| **Feedback** | Various concerns and comments on perceived access to employment (including impact on current work) |
| **Action taken** | Both TG and SCoPEd Oversight Committee (SOC) have discussed this and see both the increased partnership and clearer and joint communications as helpful to addressing this in the future, however noting that the framework is not changing therapists’ current training, knowledge and skills nor the requirement to work ethically within their competence |
| **Rationale** | See Action |

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| **Feedback** | Various concerns and comments on the value of specialisations |
| **Action taken** | The current framework remit is to map generic shared minimum standards across core training, practice and competence requirements for therapists working with adults, specialisms are out of scope No further action |
| **Rationale** | See Action |

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| **Feedback** | Various concerns and questions on gateways, including your individual circumstances and where you ‘fit’ and issues related to access, cost and privilege related to progression |
| **Action taken** | The SOC agreed that work on gateways will fall into phase two of this work, to be commenced after publication of the current framework |
| **Rationale** | See Action |

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| **Feedback** | Various concerns and questions on titles |
| **Action taken** | The SOC agreed that work on titles will fall into phase two of this work, to be commenced after publication of the current framework, however noting that in an environment without regulation or legal protection of titles, this is an issue relating to ethics and representation rather than membership body policing |
| **Rationale** | See Action |

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| **Feedback** | Various comments on use of CPD |
| **Action taken** | CPD is typically a requirement of membership bodies and not within the remit of current mappingNo further action |
| **Rationale** | See Action |

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| **Feedback** | Various comments on bodies outside the PSA and different trainings (e.g. BPS, doctoral study, psychology degrees) |
| **Action taken** | Out of scopeNo further action |
| **Rationale** | See Action |

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| **Feedback** | Various comments on use of personal therapy |
| **Action taken** | The current framework remit is to map shared minimum standards. The TG and SOC have discussed and agreed that there are no shared minimum agreements on personal therapy at present, and the current framework remit is not to set a standard for personal therapyNo further action |
| **Rationale** | See Action |

|  |  |
| --- | --- |
| **Feedback** | Various comments on the evidence and work completed and need for transparency |
| **Action taken** | The methodology contains all information on the sources and processes used to produce the current frameworkThis documentation has been agreed and signed off by the TG, Expert Reference Group (ERG) and SOCNo further action |
| **Rationale** | See Action |

|  |  |
| --- | --- |
| **Feedback** | Various concerns about negative attitude towards SCoPEd, threat of fragmentation, social media behaviours |
| **Action taken** | Both TG and SOC have discussed this and see both the increased partnership, and clearer and joint communications as helpful to addressing this in future |
| **Rationale** | See Action |

|  |  |
| --- | --- |
| **Feedback** | Various opposition related to themes of seniority, hierarchy, access to column C, power, devaluing of vocational qualifications, perceptions of medicalised model, conflation of competence and competences |
| **Action taken** | Both TG and SOC have discussed and agree not everyone will support the work in ideological or practical terms, but hope the increased partnership, and clearer and joint communications will be helpful in addressing this for those whose views or understanding are less philosophically opposed |
| **Rationale** | See Action |

|  |  |
| --- | --- |
| **Feedback** | Various comments on audience benefit, rationale, scope etc. |
| **Action taken** | Improved communications agreed within extended partnership |
| **Rationale** | See Action |

|  |  |
| --- | --- |
| **Feedback** | Various comments on regulation and professionalisation |
| **Action taken** | Improved communications agreed within extended partnership |
| **Rationale** | See Action |

# Appendix 7: List of sources consulted by the Information Analyst

**Representations of the therapeutic relationship:
List of sources accessed July 2021**

ACC Core Competence Framework

ACP Competence Map for Child and Adolescent Psychotherapists (2020)

ACP Quality Assurance Framework for Training in Child and Adolescent Psychoanalytic Psychotherapy

Agenda for Change Band 5 (Counsellor Entry Level) (2005)

Agenda for Change Band 6 (Counsellor) and Band 7 (Counsellor Specialist)

AIM Qualifications Level 4 Diploma in Counselling Practice

AIM Qualifications Level 5 Diploma in Psychotherapeutic Counselling

AIM Qualifications Level 6 Diploma in Psychotherapeutic Counselling (informed by research)

American Counseling Association Code of Ethics 2014

American Psychological Association Ethical Principles of Psychologists and Code of Conduct

Australian Counselling Association Scope of Practice (2016)

BACP Generic Core Competences (2007)

BACP Ethical Framework for the Counselling Professions (2018)

BACP Counselling Skills Competence Framework (2020)

BACP The competences required to deliver effective counselling in further and higher education

British Psychoanalytic Council: Accreditation Criteria: Psychodynamic Psychotherapy

CPCAB Level 4 Diploma in Therapeutic Counselling

CPCAB Level 5 Diploma in Psychotherapeutic Counselling

CPCAB Model of helping work and counselling practice (2015)

EAC Training Standards (2013)

Elliott, R., Bohart, A.C., Watson, J.C., & Murphy, D. (2018). Therapist Empathy and Client Outcome: An Updated Meta-Analysis. Psychotherapy, 55, 4, 399 – 410

ENTO National Occupational Standards for Counselling (2007)

European Association for Psychotherapy: EAP Quality Standards

Everall, R.D. & Paulson, B.L. (2002). The therapeutic alliance: Adolescent perspectives. Counselling and Psychotherapy Research., 2, 2, 78 – 87

Farber, B.A., Suzuki, J.Y. & Lynch, D.A. (2018). Positive Regard and Psychotherapy Outcome: A Meta-Analytic Review. Psychotherapy, 55, 4, 411 – 423

Gelso, C.J., Kivlinghan, D.M. Jr & Markin, R.D. (2018).
The Real Relationship and Its Role in Psychotherapy Outcome. Psychotherapy, 55, 4, 434 – 444

Hayes, J.A., Gelso, C.J., Goldberg, S. & Kinvlinghan, D.M. (2018). Countertransference Management and Effective Psychotherapy:
Meta-Analytic Findings. Psychotherapy, 55, 4, 496 – 507

HCPC Standards of Proficiency: Practitioner Psychologists (2015)

HCPC Standards of Education and Training (2017)

HCPC Standards of Conduct (2016)

National Counselling Society Standards of Training and Education for Accredited Courses (2020)

National Occupational Standards (NOS) for Psychological Therapies (Skills for Health)

Norcross, J.C. & Lambert, M.J. (2018). Psychotherapy Relationships
That Work III. Psychotherapy, 55, 4, 303 – 315

Noyce, R. & Simpson, J. (2018). The Experience of Forming a
Therapeutic Relationship from the Client’s Perspective:
A Metasynthesis. Psychotherapy Research, 28, 2, 281 – 296

Open College Network Level 4 Diploma in Counselling

QAA Subject benchmark statement Counselling and
Psychotherapy (2013)

SEG Awards ABC Level 4 Diploma in Therapeutic Counselling

Skills For Health (NOS) MH100 Establish and maintain the
therapeutic relationship (2010)

UCL Generic Therapeutic Competences

UCL Basic Analytic Dynamic Competences

UCL Basic Competences for Humanistic Psychological Therapies

UCL Assessing Competences against the Cognitive Behaviour
Therapy Framework (2007)

UCL CBT Basic Competences

UKCP Guidelines for Mental Health Familiarisation

UKCP Professional Occupational Standards

UKCP Standards of Education and Training (2017): The Minimum
Core Criteria: Psychotherapy with Adults

UKCP PCIPC Standards of Education and Training for
Psychotherapeutic Counselling

**Trauma: list of sources accessed October 2021**

APA work on trauma-informed counsellor competences
<https://www.ncbi.nlm.nih.gov/books/NBK207194/box/part2_ch2.box7/?report=objectonly>

APP training for psychoanalytic psychotherapy
<http://psychotherapytraining.co/training/psychoanalytic-psychotherapy-training>

BACP information for clients on what to expect when being counselled for trauma and post-traumatic stress disorder: Information for clients – August 2017 (Authors: Stephen Joseph, Steve Regel, Belinda Harris and David Murphy)
<https://www.bacp.co.uk/about-therapy/trauma-and-ptsd>

BACP Supervision competences 2021

Cert and Diploma in trauma therapy delivered by The Grove – private psychotherapy centre

Cook, J. M.; Newman, E. & Simiola, V. (2019) ‘Trauma training: Competencies, initiatives, and resources.’ Psychotherapy (Chicago III) 56: 3: 409 – 421

European Association for Psychotherapy: EAP Quality Standards

NHS Education for Scotland <https://transformingpsychologicaltrauma.scot/media/cuzhis0v/nesd1334-national-trauma-training-programme-online-resources_0908.pdf>

**Sources of further information on trauma in counselling and psychotherapy:**

Herman, J.L. (1992) Complex PTSD. In G.S. Everly Jr and J. M. Lating (Eds). Psychotraumatology. New York: Plenum. pp 87 – 100

Horowitz, M.J. (1986) Stress Response Syndrome. (2nd edn.) New York: Aronson

Spiers, T. (ed.) (2001) Trauma: A Practitioner’s Guide to Counselling. Hove: Brunner-Routledge

Wastell, C. (2005) Understanding Trauma and Emotion. Maidenhead: Open University Press

Wilson, J. and Družđek, B. (Eds). (2004). Broken Spirits. The Treatment of Traumatized Asylum Seekers, Refugees and Torture Victims. New York: Brunner-Routledge

Yule, W. (Ed.) (1999). Post-Traumatic Stress Disorders. Concepts and Therapy. Chichester: Wiley

# Appendix 8: Changes to the framework

### Theme 1Professional framework

| ****Column**** | Revisions to Competences |
| --- | --- |
| A, B and C Therapists | ****July 2020 version****1.1 Knowledge of and ability to operate within professional and ethical frameworksJanuary 2022 version1.1.A Knowledge of and ability to operate within professional, legal and ethical frameworks |
| A, B and C Therapists | ****July 2020 version****1.3 Ability to negotiate, maintain and review an appropriate contract with the client or patient, taking account of timing, practice setting and duration of therapyJanuary 2022 version1.3.A Ability to negotiate, maintain and review an appropriate contract with the client or patient, taking account of timing, practice setting and duration of therapy, ensuring that the client’s or patient’s consent is explicitly informed and freely given |
| A, B and C Therapists | January 2022 versionNEW: 1.4.A Ability to create regular opportunities for the client or patient to review and feed back their experience of the therapy |
| A, B and C Therapists | ****July 2020 version****1.5 Ability to provide and maintain a secure framework for clients or patients, in terms of meeting arrangements and the therapy settingJanuary 2022 version1.6.A Ability to provide and maintain a secure framework for both therapist and clients or patients, in terms of meeting arrangements and the therapy setting |
| A, B and C Therapists | ****July 2020 version******1.9 Ability to incorporate equality awareness and consideration of diversity of client’s or patient’s identity, culture, values and worldview into ethical decision-making**January 2022 version**1.10.A Ability to incorporate equality awareness and consideration of diversity of client’s or patient’s identity, culture, language, values and worldview into ethical decision-making** |
| A, B and C Therapists | ****July 2020 version******1.11 Ability to manage and appropriately respond to the practical and ethical demands of online therapeutic provision and all forms of technologically mediated communication**January 2022 version**1.12.A Ability to manage and respond appropriately to the practical and ethical demands of all forms of technologically mediated therapy and communication** |
| B and C Therapists | ****July 2020 version******1.12.b Ability to work in multi-disciplinary teams with other professionals to maximise therapeutic outcomes**January 2022 version**1.13.Bii Ability to work in multi-disciplinary teams with other professionals to enhance therapeutic outcomes** |
| C Therapists | ****July 2020 version******1.12.c Ability to take an active role within the professional community locally and nationally. Be able to communicate effectively with other professionals in imparting information, advice, instruction and professional opinion**January 2022 version**1.13.C Ability to take an active role within the professional community locally and nationally. Be able to communicate effectively with other professionals in sharing information, advice, instruction and professional opinion** |

### Theme 2Assessment

| ****Column**** | Revisions to Competences |
| --- | --- |
| A, B and C Therapists | ****July 2020 version****2.1 Ability to make an assessment of the client’s or patient’s problems and suitability for therapyJanuary 2022 version2.1.A Ability to make an initial and ongoing assessment of the client’s or patient’s problems and suitability for therapy being offered |
| B and C Therapists | ****July 2020 version****2.1.a Ability to undertake a competent clinical assessment that is consistent with own therapeutic approachJanuary 2022 version2.1.B Ability to use an initial and ongoing clinical assessment strategy that is informed by a consistent, coherent and in-depth theoretical approach |
| A, B and C Therapists | January 2022 versionNEW: 2.2.A Ability to establish agreement on the therapeutic work which attends to the needs of the client or patient, the skills of the therapist and the time available |
| A, B and C Therapists | ****July 2020 version****2.2 Ability to collaboratively manage the process of referral with clients or patients and (or) other professionals during assessment and throughout therapyJanuary 2022 version2.3.A Ability to recognise own professional limitations, and in collaboration with clients or patients and other professionals as appropriate, manage the process of referral during assessment and throughout therapy |
| **Previously:**B and C Therapists**Now:** A, B and C Therapists | ****July 2020 version******2.2.a Ability to recognise more significant mental health symptoms and difficulties, and know when and how to refer on**January 2022 version**Incorporated into 2.3.A** |
| A, B and C Therapists | ****July 2020 version******2.3 Ability to assess client or patient suitability for online therapy**January 2022 version**2.4.A Ability to assess the** client’s or patient’s **suitability for technologically mediated therapy** |
| A, B and C Therapists | ****July 2020 version******2.4 Ability to draw upon knowledge of common mental health problems and their presentation during assessment and throughout therapy**January 2022 version**2.5.A Ability to draw upon knowledge of common mental health problems and symptoms of psychological distress (with due understanding of cultural norms) during assessment and throughout therapy** |
| B and C Therapists | ****July 2020 version******2.4.a Ability to critically appraise and conceptualise a range of symptoms of psychological distress, functioning and coping styles (with due understanding of cultural norms), during assessment and throughout therapy**January 2022 version**2.5.B Ability to conceptualise, evaluate and take account of a range of mental health problems, symptoms of psychological distress, functioning and coping styles (with due understanding of cultural norms), during assessment and throughout therapy** |
| A, B and C Therapists | ****July 2020 version******2.6 Ability to work within own scope of practice and professional limitations and make referrals where appropriate**January 2022 version**2.7.A Ability to work within own scope of practice and professional limitations and manage the process of referrals where appropriate** |
| A, B and C Therapists | ****July 2020 version******2.7 Ability to make risk assessments regarding clients’ or patients’ and (or) others’ safety, and comply with safeguarding guidance, appropriate to the therapy setting**January 2022 version**2.8.A Ability to make initial and ongoing risk assessments regarding clients’ or patients’ and (or) others’ safety, and comply with safeguarding guidance, appropriate to the therapy setting taking into account own limits of competence** |
| C Therapists | January 2022 versionNEW: 2.8.C Ability to make complex judgments about ongoing work with high risk clients or patients and take appropriate action as needed |
| A, B and C Therapists | ****July 2020 version******2.8 Ability to undertake a collaborative assessment of risks, needs and strengths when working with imminent and ongoing: a) suicidal ideas and (or) behaviour, and b) self-harming ideas and (or) behaviour**January 2022 version**2.9.A Ability to collaborate with clients or patients and (or) others as appropriate to assess risks, needs and strengths when working with imminent and ongoing:*** **suicidal ideas and (or) behaviour**
* **self-harming ideas and (or) behaviour**
* **risk of harm to clients or patients from third parties e.g. situations of domestic abuse**
 |
| A, B and C Therapists | ****July 2020 version******2.10 Ability to assess the risks for both parties specific to the online environment**January 2022 version**2.11.A Ability to make an initial and ongoing assessment of the risks for both parties specific to the environment of technologically mediated therapy** |
| B and C Therapists | ****July 2020 version******2.10.a Ability to identify and respond to the interpersonal risks that are specific to working online as they impact on the therapeutic process or interaction with a client’s or patient’s presenting problems**January 2022 version**2.11.B Ability to identify and respond to the impact of the technologically mediated environment on issues of identity and presence, including fantasies and assumptions about the therapist and client or patient** |

### Theme 3Therapeutic Relationship

| ****Column**** | Revisions to Competences |
| --- | --- |
| A, B and C Therapists | January 2022 versionNEW: 3.2.A An ability to demonstrate personal qualities associated with supporting a strong therapeutic relationship including:* showing appropriate levels of empathy, warmth, concern, confidence and genuineness, matched to the client's or patient's need
* experiencing and communicating a fundamentally accepting attitude
* being respectful, non-judgmental, and approachable with an ability to establish rapport
* being flexible and allowing the client or patient to discuss issues which are important to them
 |
| A, B and C Therapists | ****July 2020 version****3.2 Ability to reflect upon the impact that diversity of the client’s or patient’s identity, culture, values and worldview (including protected characteristics) has upon the relationship and use this understanding in ongoing workJanuary 2022 version3.3.A Ability to explore with the client or patient and reflect upon the impact that diversity of their identity, culture, language, values and worldview (including protected characteristics) has upon the relationship and the therapeutic process, and use this shared understanding in ongoing work |
| A, B and C Therapists | January 2022 version**NEW: 3.4.A Ability to reflect on and understand the impact of working with a third party present in the therapy sessions (e.g. as translator, interpreter, signer, carer)** |
| A, B and C Therapists | ****July 2020 version******3.3 Ability to reflect on own identity, culture, values and worldview and the impact of these on the therapeutic relationship**January 2022 version**3.5.A Ability to communicate empathy, sensitivity, acceptance, openness and curiosity towards all aspects of diversity and respond in a way that shows an understanding of the client's or patient's perspective** |
| A, B and C Therapists | January 2022 versionNEW: 3.6.A Ability to work therapeutically with issues of diversity and intersectionality, taking account of the different dimensions of diversity within a person |
| A, B and C Therapists | ****July 2020 version****3.4 Ability to view the needs of the client or patient within a number of contexts including, but not limited to, their family, social and cultural settingJanuary 2022 version3.7.A Ability to value and understand the person within their unique context including, but not limited to, their family, social, community and cultural setting alongside their personal history and sense of identity |
| A, B and C Therapists | ****July 2020 version******3.5 Ability to establish and hold appropriate boundaries and create and maintain a collaborative relationship**January 2022 version**3.8.A Ability to establish and hold appropriate boundaries, creating and maintaining a collaborative relationship rooted in courtesy and respect** |
| A, B and C Therapists | January 2022 versionNEW: 3.9.A Ability to be responsive to the client’s or patient’s agenda, focus, therapeutic needs and pace |
| A, B and C Therapists | ****July 2020 version******3.9 Ability to establish, sustain and develop the therapeutic relationship**January 2022 version**3.13.A Ability to establish, sustain and develop the therapeutic relationship and to engender trust and authentic connection** |
| B and C Therapists | ****July 2020 version******3.9.a Ability to critically reflect upon the client’s or patient’s process within the therapeutic relationship**January 2022 version**3.13.Bi Ability to critically reflect on the client’s or patient’s process to enhance the client’s or patient’s self-awareness and understanding of themself in relationship** |
| B and C Therapists | January 2022 versionNEW: 3.13.Bii Ability to be aware of, and respond to, emotional shifts occurring in each session, with the aim of maintaining a level of emotional engagement appropriate for each circumstance |
| A, B and C Therapists | January 2022 versionNEW: 3.14.A Ability to form an empathic connection which communicates understanding of the client’s or patient’s experience |
| A, B and C Therapists | ****July 2020 version******MOVED: 4.5 Ability to understand and respond appropriately to the emotional content of sessions**January 2022 version**3.15.A Ability to enable the appropriate discussion of and (or) expression of the client**’s **or patient’s emotions, and understand and respond therapeutically to the emotional content of sessions** |
| A, B and C Therapists | ****July 2020 version******3.10 Ability to use self-awareness to monitor own emotional or physical responses to the client or patient**January 2022 version**3.16.A Ability to be aware of and manage own emotional or physical responses to the client or patient** |
| B and C Therapists | ****July 2020 version******3.10.a Ability to use own responses to the client or patient in a way that is therapeutic and consistent with the theoretical model or approach**January 2022 version**3.16.B Ability to actively use own responses to the client or patient in a way that is therapeutic and consistent with the theoretical model or approach** |
| A, B and C Therapists | January 2022 versionNEW: 3.18.A Ability to be open and aware that the client or patient may have an unspoken agenda |
| A, B and C Therapists | January 2022 versionNEW: 3.19.A Ability to reflect on and tolerate uncertainty, responding therapeutically while maintaining appropriate boundaries |
| A, B and C Therapists | January 2022 versionNEW: 3.20.A Ability to attend to, reflect on and respond to the client’s or patient’s verbal and nonverbal communication as part of the therapeutic process |
| B and C Therapists | ****July 2020 version******3.12.a Ability to recognise difficulties or ruptures in the therapeutic relationship and explore with the client or patient similarities with other relationships**January 2022 version**3.21.B Ability to make use of ruptures or impasses in the therapy as opportunities for expanding the understanding of the clien**t’s **or patient’s subjective experience of their difficulties** |
| C Therapists | ****July 2020 version******3.12.b Ability to work therapeutically with ruptures or difficulties within the therapeutic relationship using critical awareness of and skills associated with ‘unconscious’ or ‘out of awareness’ processing**January 2022 version**3.21.C Ability to work therapeutically with ruptures or difficulties within the therapeutic relationship using awareness of and skills associated with ‘unconscious’ or ‘out of awareness’ processing** |
| A, B and C Therapists | ****July 2020 version******3.14 Ability to foster and maintain a good therapeutic relationship, and to understand the client’s or patient’s identity, culture, values and worldview:*** **capacity to recognise and to address threats to the therapeutic relationship**
* **ability to recognise when strains in the relationship threaten the progress of therapy**
* **ability to use appropriate interventions in response to disagreements about tasks and goals**

***continued overleaf*** |
|  | January 2022 version**3.23.A Ability to foster and maintain a good therapeutic relationship including:*** **capacity to recognise and address threats to the therapeutic relationship**
* **ability to recognise and respond when strains in the relationship threaten the progress of therapy**
* **ability to use appropriate interventions in response to disagreements about tasks and goals**
* **being aware of possible responses and meanings for the client or patient if the therapist takes external action (e.g. when needing to implement risk management procedures)**
* **ability to address difficulties related to equality, diversity, and inclusion in order to repair any damage to the therapeutic relationship**
 |
| B and C Therapists | ****July 2020 version******3.14.a Ability to analyse difficulties encountered as part of the therapeutic process to find ways of making progress**January 2022 version**3.23.B Ability to analyse and address difficulties in the immediacy of the therapeutic encounter to find ways to overcome such difficulties** |
| B and C Therapists | ****July 2020 version******3.15.a Ability to consider the potential issues arising when ending therapy in the light of the client’s or patient’s previous experience**January 2022 version**3.24.B Ability to consider and manage complex issues arising when ending therapy in the light of the client’s or patient’s previous experience of endings** |

### Theme 4Knowledge and skills

| ****Column**** | Revisions to Competences |
| --- | --- |
| A, B and C Therapists | ****July 2020 version****4.3 Ability to apply understanding of a) suicidal behaviours, and (or) b) self-harming behaviours, to work collaboratively with clients or patientsJanuary 2022 version4.3.A Ability to apply understanding of suicidal behaviours, and (or) self-harming behaviours, to work collaboratively with clients or patients |
| B and C Therapists | ****July 2020 version****4.3.a Ability to work with suicidal risk and (or) other self-harming behaviours and associated ‘unconscious’, or ‘out of awareness’ processes and perceptions, including the conflictual and paradoxical nature of suicidal ideationJanuary 2022 version4.3.B Ability to work with suicidal risk and the often complex nature of suicidal ideation and (or) other self-harming behaviours and associated ‘unconscious’, or ‘out of awareness’ processes and perceptions |
| A, B and C Therapists | January 2022 versionNEW: 4.4.A Ability to help the client or patient to become aware of recurring patterns in their relationships in order to facilitate therapeutic change |
| B and C Therapists | January 2022 versionNEW: 4.4.B Ability to use the therapeutic relationship to work with the client's or patient's ‘unconscious’ or ‘out of awareness’ perceptions, experiences and distortions of the therapist and the therapeutic relationship to enhance therapeutic change |
| A, B and C Therapists | January 2022 versionNEW: 4.5.A Ability to recognise symptoms of trauma and acknowledge own limitations and level of competence in work with clients or patients showing such symptoms |
| A, B and C Therapists | ****July 2020 version****4.4 Ability to understand the process of change within a core, coherent theoretical framework and adopt a stance as therapist in accordance with itJanuary 2022 version4.6.A Ability to understand and track the process of change within a core, coherent theoretical framework and adopt a stance as therapist in accordance with it |
| A, B and C Therapists | ****July 2020 version******MOVED to Therapeutic Relationship:** **4.5 Ability to understand and respond appropriately to the emotional content of sessions**January 2022 version**Incorporated into 3.15.A** |
| B and C Therapists | ****July 2020 version******4.6.a Ability to demonstrate the capacity, knowledge and understanding of how to select or modify approaches to respond appropriately to the needs of the client or patient**January 2022 version**4.7.B Ability to demonstrate the capacity, knowledge and understanding of how to select and adapt interventions and (or) approaches to respond to the needs of the client or patient** |
| A, B and C Therapists | January 2022 versionNEW: 4.8.A Ability to recognise, respect and work to support and enhance the autonomy of the client or patient |
| A, B and C Therapists | January 2022 versionNEW: 4.10.A Ability to invite the client’s or patient’s use of imagination to facilitate work towards therapeutic goals |
| A, B and C Therapists | ****July 2020 version******4.8 Ability to reflect upon own identity, culture, values and worldview, and have the capacity to work authentically in a non-discriminatory manner**January 2022 version**4.11.A Ability to reflect upon own identity, culture, values and worldview, and have the capacity to work and communicate authentically in a non-discriminatory and anti-oppressive manner** |
| B and C Therapists | ****July 2020 version******4.8.a Ability to describe the philosophical assumptions that underpin theoretical understanding of identity, culture, values and worldview**January 2022 version**4.11.B Ability to recognise and explore with the client or patient the assumptions that underpin understanding of identity, culture, values and worldview** |
| A, B and C Therapists | ****July 2020 version******4.9 Ability to define difference and explore the impact of discrimination, prejudice and oppression on mental health**January 2022 version**4.12.A Ability to acknowledge diversity and explore the impact of discrimination, prejudice and oppression on mental health** |
| A, B and C Therapists | January 2022 versionNEW: 4.13.A Ability to a) recognise when technologically mediated therapy effects a lowering of inhibition in either the client or patient and (or) the therapist and b) regulate and understand the impact this has on the therapeutic relationship |
| B and C Therapists | ****July 2020 version******4.12.a Ability to critically appraise published research on counselling and psychotherapy, and integrate relevant research findings into practice**January 2022 version**4.16.B Ability to draw upon and evaluate published research on counselling and psychotherapy, and integrate relevant research findings to enhance practice** |
| C Therapists | ****July 2020 version******4.12.b Ability to successfully complete a substantial empirical research project, systematic review or systematic case study informed by wide current understandings of the discipline**January 2022 version**4.16.C Ability to successfully complete a substantial empirical research project, systematic review or systematic case study informed by wide current understandings of therapeutic practices** |
| A, B and C Therapists | ****July 2020 version******4.13 Ability to communicate clearly with clients or patients, colleagues and other professionals both in writing and verbally**January 2022 version**4.17.A Ability to communicate clearly, appropriately and using understandable language with clients or patients, colleagues and other professionals providing and receiving information which may be complex, sensitive and (or) contentious** |

### Theme 5Self-awareness and reflection

| ****Column**** | Revisions to Competences |
| --- | --- |
| A, B and C Therapists | ****July 2020 version****5.1 Ability to engage in personal development that includes self-awareness in relation to clients or patients to enhance therapeutic practiceJanuary 2022 version5.1.A Ability to make use of personal development, self-awareness and supervision to reflect on, learn from and enhance therapeutic practice |
| B and C Therapists | ****July 2020 version****5.1.a Ability to be emotionally prepared for intense and complex work, which requires reflexivity, and which is potentially taxing for the therapistJanuary 2022 version5.1.Bi Ability to be emotionally prepared for intense and complex work, which requires sustained reflexivity |
| C Therapists | ****July 2020 version****5.1.c Ability to evidence reflexivity, self-awareness and the therapeutic use of self to work at depth in the therapeutic relationship and the therapeutic processJanuary 2022 version5.1.C Ability to evidence reflexivity, self-awareness and the active use of self to work at depth in the therapeutic relationship and throughout the therapeutic process |
| A, B and C Therapists | January 2022 versionNEW: 5.2.A Ability to use awareness of self during therapy to enhance the therapeutic process |
| A, B and C Therapists | ****July 2020 version******5.2 Ability to reflect on aspects of own identity, culture, values and worldview that have most influenced ‘self’ and understand the relevance of this when working with others**January 2022 version5.3.A Ability to reflect on aspects of own identity, culture, values and worldview that have most influenced ‘self’ and work on own preconceptions and bias |
| A, B and C Therapists | **July 2020 version**5.3 Ability to understand the significance and impact of own identity, culture, values and worldview in work with clients or patients**January 2022 version**5.4.A Ability to understand the significance and impact of own identity, culture, language, values and worldview in work with clients or patients |
| A, B and C Therapists | ****July 2020 version******5.4 Ability to monitor and evaluate fitness to practise, and maintain personal, psychological and physical health**January 2022 version**5.5.A Ability to monitor and evaluate fitness to practise, and maintain own self-care and wellbeing** |

Footnotes from the previous framework have been moved to the glossary in the January 2022 SCoPEd Framework for accessibility.

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