Irish Association for Counselling and Psychotherapy

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

30th November 2023

Via email to strategyandpolicy@coru.ie

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

Dear Ms Griffin,

The Irish Association for Counselling and Psychotherapy is writing to you to submit feedback on the CORU Standards of Proficiency and Criteria for Education and Training Programmes and Standards of Proficiency and Criteria for Education and Training Programmes for Counsellors and CORU Standards of Proficiency and Criteria for Education and Training Programmes and Standards of Proficiency and Criteria for Education and Training Programmes for Psychotherapists.

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

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

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

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

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

Should you require any further information, please do not hesitate to contact us via email at chair@iacp.ie and ceo@iacp.ie .

Yours sincerely,

Séamus Sheedy

IACP Cathaoirleach

Lisa Molloy

IACP Chief Executive Officer

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Introduction

About the IACP

The IACP was established in 1981, to identify, develop and maintain professional standards of excellence in Counselling and Psychotherapy.

Our work promotes best practice and the development of the profession as well as safeguarding the public. As a registered Charity (CHY 6615) representing over 5,700 members, the IACP is the largest counselling and psychotherapy association in Ireland.

What we do

The IACP has dedicated itself to promoting and advancing the profession of counselling and psychotherapy for more than 40 years. We will continue to achieve this through the promotion and provision of high-quality education, training and professional development. We lobby and advocate for increased investment in counselling and psychotherapy with the aim of creating universal access to these essential supports. We also raise awareness of the value and benefits of Counselling and Psychotherapy and support members to work to the highest possible standards, for the benefit and the protection of individuals seeking therapy.

Protection of the public is at the core of the mission of the IACP. We achieve it through the IACP accreditation process, which is instrumental in guaranteeing that practitioners possess suitable qualifications and adhere to acknowledged standards of professional capability. It also provides clients with the assurance that practitioners operate within an established ethical framework. The IACP Accreditation establishes rigorous minimum criteria for entry into the profession, supported by robust governance oversight to maintain and uphold these standards continually. The IACP has a comprehensive Code of Ethics and Practice that members must adhere to, strict supervision and CPD requirements as well as a robust Complaints Procedure.

We accredit individual members as well as Level 8 and 9 Training Programmes in Counselling and Psychotherapy. The details of the IACP Membership structure are provided at Appendix 1 and for the list of IACP Accredited Courses, please see Appendix 2.

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

Methodology

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

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

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

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

The IACP welcomes the opportunity to make this submission. Our organisation was established in 1981 to set and monitor professional standards for counselling and psychotherapy, with the purpose of protecting the public. As the IACP is a self-regulating body, it holds the interests and safety of the public at its core. You will see from our submission that all the concerns raised, and suggestions put forward have been articulated in response to significant identified risks to the public.

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

Secondly, there is the risk that due to the onerous requirements being applied to placements that an unintended consequence could be a reduction in the number of training placements available and indeed training providers. This would have a detrimental effect on future recruitment to the profession and a negative knock-on effect to mental health service provision. At a time when Government has committed to invest in mental health supports and, in the profession, it would undermine the significant progress that has been made and reduce accessibility for those in need of counselling and psychotherapy supports, directly conflicting with the "Vision for Change[1]," a national policy aiming to enhance mental health care across Ireland.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Lack of a Specific Personal Therapy Requirement in Training

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

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

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

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

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

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

International Best Practice

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

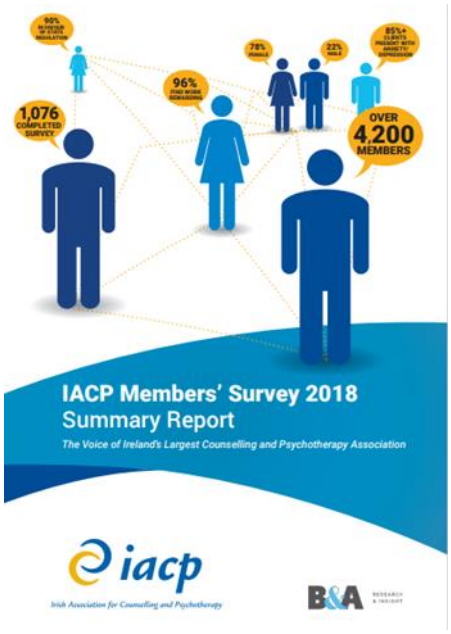
"We recognise that personal therapy is a crucial part of any training. Without having engaged deeply with our own process through ongoing personal therapy, we cannot provide the necessary holding necessary to support our clients with their process work."

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

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

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

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



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

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

Assessment of Personal Therapy in Training

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

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

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

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

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

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

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

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

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

Counsellor Proficiencies:

Autonomy & Accountability:

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

Professional Development:

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

Knowledge & Skills:

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

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

Psychotherapist Proficiencies:

Knowledge & Skills:

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

Knowledge & Skills:

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

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

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

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

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

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

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

Feedback Regarding Supervision in Training

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

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

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

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

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

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

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

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

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

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

Professional Development

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

Skill Enhancement

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

Ethical Decision-Making

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

Emotional Support

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

Self-Reflection

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

Accountability

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

Quality Assurance

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

Continuing Professional Development

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

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

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

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

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

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

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

As per the HSE's Clinical Supervision in Mental Health Nursing FAQs[4] , clinical supervision is seen as an essential requirement for the profession:

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

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

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

[3] https://www.hcpc-uk.org/news-and-events/blog/2019/reflect-discuss-develop-the-value-of-supervision/
[4] https://healthservice.hse.ie/filelibrary/onmsd/clinical-supervision-in-mental-health-nursing-frequently-asked-questions.pdf

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

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

Looking again to other health and social care professions, the British Journal of Wellbeing Vol. 2, No. 6 Clinical Supervision - Separating clinical and line management supervision in occupational therapy[5] shows differences (Table 1) between clinical supervision and line management supervision. In the occupational therapy profession comparisons can be drawn between line management supervision and onsite placement supervision and those proposed by CORU for counselling and psychotherapy. As both forms of supervision differ greatly it is our view that one cannot replace the other:

Table 1:

Table 1. Clinical supervision and line management supervision

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

[5] Published Online:20 Feb 2014 https://doi.org/10.12968/bjow.2011.2.6.18

The IACP requires all our members, including students, to attend clinical supervision.

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

As per the IACP Accreditation Policy:

Supervision of Students

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

Ratio: The student is required to have a minimum of one hour of individual supervision for every five client contact hours.

The IACP advocates for clinical supervision to be included in the CORU's training standards and frameworks for both counsellors and psychotherapists.

IACP Members' Feedback in relation to Clinical Supervision:

"Supervision is so multidimensional - care of the client, care of the therapist, CPD, minimising burnout or risk escalation issues, ethical issues, feedback space, client challenges space. In most of the other healthcare professions, it's more about Supervising - case management or Supervising - organisational issues or protocols."

"Supervision should be an essential element to be considered as a standard of proficiency. For me it is an essential part of the counselling process, both as a safeguard for me as a practitioner, and for the clients."

"Supervision is the heart of your development and best practice. It must be a part of this set of standards to protect our clients and provide the most ethical standards of work."

"I could not find any references to supervision in this draft. Supervision is necessary for the safety of both counsellors and clients. Beyond safety, it is also essential for enhancing practice. None of us are perfect and we all experience blind spots. Due to the confidentiality required in this work, it is very helpful to have support from another, suitably qualified and experienced supervisor."

"With no criteria in place and recognition of Supervisors and Supervision as part of growth and development of a Counsellor my concern is that blind-spots; transference and counter-transferences, bad habits, judgements and bias may become embedded without the challenges and capacity for self-reflection, deeper learning and meaning-making that Supervision creates an opportunity to engage in. Where might the slippery slide into burnout be explored? CORU may end up being busy processing Fitness to Practice cases, particularly

for Counsellors in Private Practice who may descend into burnout unimpeded if they lack professional support that regular supervision provides."

We see the need to highlight the divergence between the CORU draft standards proposed general model of supervision and the distinct needs of counselling and psychotherapy as a profession.

In summary, we see the need to highlight the divergence between the CORU draft standards proposed general model of supervision and the distinct needs of counselling and psychotherapy as a profession. While CORU's framework aligns with established practices in regulated health and social care professions, it overlooks crucial nuances specific to our professions. The intensity of our therapeutic work and the risk of burnout demand a robust model of clinical supervision that goes beyond proposed on-site placement supervision. This supervision model isn't just about meeting regulatory standards, it is about fostering deep reflection, ensuring ethical practice, and safeguarding the public.

There are several reasons why the proposed on-site supervision model by CORU is unsuitable for our profession. Existing placement providers lack the infrastructure to support this form of supervision, and the block placement structure doesn't align with the non-traditional sessional working hours characteristic of our field.

Also, the proposed approach doesn't account for the unique nature of counselling and psychotherapy work, where therapists assess their own limits, which is crucial to prevent burnout and ensure client safety. The critical role of clinical supervisors is undermined in CORU's draft, posing risks to both client and therapist safety. We insist that clinical supervision, an indispensable aspect of our training, isn't interchangeable with on-site supervision.

Feedback regarding Clinical Placements

IACP members and accredited course providers expressed concerns over the proposed number of placement hours for both registers as well as the proposed structuring of placements:

Main issues listed:

- Demand for 450-500 hours of clinical practice during the program, coupled with a high number of directly observed service user contact hours, poses infrastructural, ethical and public safety issues and financial burdens on education providers and students. Also, high volume of required placement hours could require students to engage in client work prematurely, which could pose a significant risk to the public.
- Course providers expressed a concern that there are currently no placements in Ireland that would be in a position to adhere to the placement conditions described by CORU.
- Financial burden might lead to increased course fees, limiting accessibility for students and reducing the number of qualified counsellors and psychotherapists. This is turn could have a negative impact on future recruitment, thereby limiting access for the public to essential therapeutic services.
- Excessive direct observation hours can be intrusive, impacting the client's confidentiality (GDPR), safety, and the overall quality of therapy.
- No other CORU profession has a requirement for directly observed placement hours.

Observed Hours

The inclusion of direct observation in the Criteria for Education and Training for Counselling and for Psychotherapy needs careful consideration due to its potential negative impact on clients.

The level of direct observation is seen as excessive and intrusive on vulnerable clients, primarily in low-cost counselling with few alternatives

The level of direct observation is seen as excessive and intrusive on vulnerable clients, primarily in low-cost counselling with few alternatives. It risks taking advantage of these vulnerable clients for the purposes of trainees, where a significant power imbalance is in place, and a client is likely to feel pressured to either accept the level of intrusion or leave

therapy where they have little to no alternative options for low-cost counselling without this intrusion on their privacy.

The requirement for observed hours goes against the Principle 1 of the IACP Code of Ethics and Practice:

"Respect for the rights and dignity of the client. Practitioners are required to treat their clients as persons of intrinsic worth with a right to determine their own priorities, to respect clients' dignity and to give due regard to their moral and cultural values. Practitioners take care not to intrude inappropriately on clients' privacy. They treat as confidential all information obtained in the course of their work. As far as possible, they ensure that clients understand and consent to whatever professional action they propose."

The heightened vulnerability experienced by some potential clients, stemming from feelings of shame or inadequacy, may lead to reluctance to engage in therapy if subjected to observation or recording. This vulnerability, more prevalent in disadvantaged cohorts, could result in the exclusion of clients from more vulnerable sectors of society. Studies, such as those by Tangney and Dearing (2002) and Ó Braonáin (2013), suggest that shame and a sense of inadequacy are significant barriers to engagement in counselling, with many participants expressing aversion to being recorded.

Power differentials in the therapy room, coupled with potential stigma, may disadvantage diverse groups in therapeutic outcomes (Arthur & Collins, 2013; Guggenbuhl-Craig, 1971). The likelihood that higher-functioning individuals may be more accepting of observation raises questions about the meaningful purpose of direct observation, particularly if it results in a skewed sample of clients. This raises concerns about upholding values of equality, diversity, and inclusion within the counselling and psychotherapy professions.

In addition, there are also significant privacy, confidentiality, and ethical concerns. Issues related to informed consent, GDPR compliance, and the potential for misuse of recorded material pose risks to client well-being. Brown, Moller, and Ramsey-Wade (2013) emphasise the ethical challenges of clients not fully understanding the purpose of recordings, raising questions about informed consent.

Research on observer effects indicates changes in behaviour among those being observed, with potential negative consequences for clients, such as declining engagement and delayed disclosures. The potential for harm to clients, including exacerbation of shame and exploitation, raises ethical concerns about the requirement for direct observation. The Hawthorne effect is a psychological phenomenon where individuals modify their behaviour or performance in response to being observed or knowing that they are being studied. (Gale EAM. The Hawthorne studies—a fable for our times? Q J Med 2004; 97:439–449.)

Notably, clients with lower financial means often access low-cost counselling, where trainees frequently provide therapy and direct observation may occur. This setting could trigger shame, potentially leading to the selective exclusion of disadvantaged clients from services. The fear and distrust of authority among disadvantaged populations, as highlighted

by Dew et al. (2007), further underscore the potential negative impact of direct observation, potentially impeding disclosure and access to mental health support.

In terms of the cost of the observation hours, the assumption is that clients with lower financial means will be unable to bear this cost, nor should they be expected to. Therefore, without government/HSE funding, the burden of this cost will fall to students. A simple lower bound estimate of the cost of this would be as follows. The observer needs to be a qualified and registered counsellor or psychotherapist so the hourly rate will be one-to-one with observed hours, plus at least 25% additional hours for developmental feedback. This excludes any additional costs of observation process.

If we take a sample rate of €75 per hour, the additional training costs are:

- Estimated Counsellor Observation Cost: 75 hours of observation - €7,031;
- Estimated Psychotherapist Observation Cost: 100 hours of observation - €9,375.

From a practical standpoint, the infrastructure of counselling and psychotherapy placements in Ireland poses challenges to the implementation of direct observation, as described by CORU.

The organisations receiving funding have openly acknowledged that the allocated funds fall considerably short of the actual costs required to provide the essential services (Samaritans and Aware, as referenced in Dwyer, 2023).

Dwyer (2023) highlights the government's heavy reliance on charitable organisations to deliver community mental health support in Ireland, which suffers from inadequate funding. Notably, there has been minimal financial commitment towards offering counselling/psychotherapy in Ireland (as reported by Dwyer, 2023, only 5.1% of the 2022 budget was allocated to mental health).

The feedback from IACP accredited course providers is that it will lead to many placement centres closing, training courses not being able to secure student placement opportunities, with the effect of less and less students being admitted to counselling and psychotherapy training.

Many non-profit organisations, crucial for community mental health support, lack government funding and would not be able to provide placement structures as described in CORU draft documents. The requirement for on-site placement supervisors for direct observation is deemed impractical, creating barriers to student access to placements and hindering the provision of low-cost services to the public. The feedback from IACP accredited course providers is that it will lead to many placement centres closing, training courses not being able to secure student placement opportunities, with the effect of less and less students being admitted to counselling and psychotherapy training.

In the long-term, there is a risk that this will result in a deficit of counsellors and psychotherapists and create future recruitment issues in relation to counselling and psychotherapy roles, in the same way other health professions have been impacted. This is a risk to public safety and will lead to an increase in untreated mental health conditions and mental health related emergencies, overprescription, and increased overreliance on medication.

Also, imposing a high amount of placement hours in blocks rather than sessional, as these happen currently, might create a shift towards full-time programmes, which could markedly diminish the attraction and access for students with relevant prior professional or life experience, who require flexibility for a multitude of reasons, e.g. personal, health, caring or financial commitments.

As we know, mental health services in Ireland are underfunded, relying in part on voluntary sectors to supplement their delivery, including counselling services provided by students. Heightening financial burdens for training courses, placements and students could potentially reduce the number of students in training programmes. This in turn could create a barrier to access, for those from low-income backgrounds, impacting diversity and equality in the sector and impacting the inclusive nature and identity of the profession.

In addition, feedback from a number of placement providers raises concerns that as placement providers have limited interaction with students compared to college lecturers, it would be unrealistic to expect placement providers to validate specific competencies.

Please see below examples of feedback received from IACP members and course and placement providers in relation to CORU's proposed clinical placements and observed placement hours:

"I believe that this is not practical and achievable. The academic workload during the training, current placement hours are a struggle for students who are often in full time employment. Second, direct observation does not uphold the boundary of confidentiality and compromises the client's sense of safety. I believe it would prevent a client from being able to be vulnerable and held safely."

"I believe that some community projects will not be able to operate due to increased financial pressure placed on them to adhere to this regulation."

"How will a trainee manage to complete 300 hours in 2 years of clinical practice. The focus will shift from quality to quantity. 75 hours of directly observed client work- unless these hours are part of course simulated counselling sessions observed by a course tutor...there isn't a placement in Ireland equipped to provide this for trainees, and who will pay observer to observe...will they have to be accredited supervisors...and what about client's autonomy... It does not seem to be thought out for part time training courses and seems to be more in line with medical model."

"This is not realistic on the assumption that students do not start their placement until end of year 2/beginning year 3. In the context of placements, it will not be possible (or

appropriate for the client/service user) that 75 hours are directly observed. Counselling placements are quite different from other social care/medical environments and are not done 'in block'."

"The client's trust and feelings of safety within the therapeutic relationship with their therapist are developed over time. The inclusion of a third party either in person or by observation would at minimum, lead to a stilted, inauthentic interaction that may not accurately reflect the reality of a normal session. This is an unnecessarily intrusive practice which only serves the therapist's benefit, not the clients. Which is in direct conflict with the primary ethical consideration of always acting in the client's best interest. The imbalance of power is also a consideration. If the client agrees to the observation, it may be due to their fear of affecting the therapeutic relationship."

"I already undertake student placements at my practice. I coordinate placing low acuity clients with these student therapists. I am in the background should they need to consult on areas such as a risk or mandatory reporting. I liaise with the college as required. That being said, I personally would not have the time or resources available to become an 'on site supervisor' assessing students, signing them off. I would wager that most in my position would not. We would also be seeking to be remunerated if this had to be done. Who will fund this? CORU/Dept of Health? The college? Otherwise practices simply won't be prepared to take on students and there will be few options out there for those seeking placements. We are not in the room with these student therapists. We do not have the degree of contact that the college lecturers have with them. It does not make sense to ask us to sign off on competencies etc. In fact, it would be a totally inaccurate assessment and therefore represents another failing of the proposed regulations to protect the public. I urge you to strongly reconsider what has been set out and to place the responsibility with the college for this task."

"As a Placement manager I find the proposed CORU guidelines in relation to placements and assessments of students alarming. I am not sure how we would be able to continue providing a placement to students with the demand for in-house supervision and direct observation. While we are happy to provide non mandatory group supervision once a month as an addition to students' external clinical supervision, to be expected to take over both full supervision and assessment of students seem untenable. Assessment is in the hands of the training colleges and to expect us to do this seems to diminish rather than add to how students are assessed.

The ethics of direct observation are at odds with our code of ethics respecting the dignity of the client. Our focus is always on client safety and best practise and these suggestions by CORU seem to fly in the face of this.

I fear that many placements including our own will have to close their doors to students if CORU continues with its current set of proposals."

"The key pillar of the CORU proposals assumes the active collaboration and involvement of the placement organisations used and relied upon by colleges for student client practice.

Some of these organisations are community-based, others are operated, by necessity, on a more commercial basis and have various sources of funding, mostly via client fees. These organisations are not in any way under the control of or even formally affiliated to the training colleges. They are entirely independent service-providers and have no obligation to adapt in any way to the 'requirements' or standards of CORU.

There is no incentive for them to do so. There is no current provision for additional State funding in order to provide such incentives. The onerous responsibility of assessing students would be unprecedented for them and would carry little attraction. Student assessment is also a sensitive area in terms of potential litigation. They are not trainers or educators or assessors. They see other important roles for themselves as independent service-providers to the public.

Arguably they could be encouraged to 'hire-in' additional staff (presumably funded by colleges) who would be suitably qualified to carry out the assessment etc tasks envisaged, but there is no reason this unprecedented and extensive degree of co-operation by independent and variously constituted organisations could be relied upon as part of responsible future planning. "

In summary, our position informed by our members and our accredited course providers, is that the insistence on 450-500 clinical practice hours, alongside an excessive focus on directly observed service user contact hours, presents significant concerns in terms of infrastructure, ethics, public safety, and financial strain for education providers and students. The lack of placements in Ireland that align with CORU's stipulated conditions is a significant concern voiced by course providers, placement providers, and IACP members.

Financial burdens could escalate course fees, limiting access for students, and potentially reducing the number of qualified counsellors and psychotherapists, impacting future recruitment and public access to crucial therapeutic services. Another concern is that the sheer volume of required placement hours would require students to engage in client work at an early stage of their training, and this could pose a significant risk to the public.

The requirement for direct observation within counselling and psychotherapy training is a matter of deep concern for us at the IACP due to its potential repercussions on client well-being. Research shows that the level of direct observation, especially in low-cost counselling settings, may intrude upon the privacy and dignity of vulnerable clients, creating an uncomfortable power imbalance and leaving little choice for clients seeking affordable counselling options.

The impact of direct observation could be particularly detrimental to individuals from disadvantaged backgrounds, as studies have shown that shame and a sense of inadequacy are significant barriers to counselling engagement. This requirement risks excluding these vulnerable individuals from accessing much-needed mental health support, contradicting our commitment to equality and inclusion within the counselling and psychotherapy professions.

Furthermore, ethical concerns related to informed consent, confidentiality, and potential harm to clients' well-being due to changes in behaviour under observation deeply trouble us. The financial burden of meeting these observation requirements, especially for those accessing low-cost counselling, is concerning, as it would reduce access to services and hinder diversity in our profession.

Practically, implementing extensive direct observation hours within our current counselling and psychotherapy infrastructure poses significant challenges, impacting placement provision and limiting opportunities for future professionals. Feedback received from both course providers and placement providers indicates that a high proportion of placement providers will be unable to meet the requirements of CORU. Placements are integral to course provision and training cannot be completed in the absence of quality placement opportunities. The overly onerous requirements being imposed on placement providers, in the absence, we understand, of any consultation with said providers, are unrealistic and unimplementable. The knock-on-effects of this will be the inability of course providers to meet CORU requirements, thereby, leading to closure of colleges and in turn, significant reduction in qualified professionals.

In the long run, there's a potential for a shortage of counsellors and psychotherapists, which could generate future recruitment challenges similar to those experienced by other healthcare professions currently. This poses a risk to public safety, potentially leading to a rise in mental health conditions and related emergencies. Additionally, it may result in overprescription and increased dependency on medication to address mental health issues in the absence of access to therapeutic supports.

Overall, the proposed requirement for excessive placement hours coupled with the requirement for direct observation hours, raises ethical, practical, and financial dilemmas that would compromise our clients' safety, access to mental health services, and the inclusivity of our profession.

In light of our concerns highlighted above, the IACP is not in a position to support the requirements for observed hours as outlined in the draft proposals, and is therefore obliged to oppose them.

Conclusion

Regulation will introduce a statutory basis for mechanisms similar to those already in place within the IACP, such as those related to accreditation and fitness to practice. Regulation aims to safeguard the public, especially those who are most vulnerable, by enforcing agreed standards of training and competency, as well as introducing a legal framework to ensure visibility and accountability. It should also lead to a better understanding and recognition of counselling and psychotherapy.

However, to ensure that the regulatory standards applied to both professions, are effective in protecting the public, it is the view of the IACP that the Registration Board must amend the proposed standards to address the significant and valid risks to the public and to the profession we have raised in this submission.

Firstly, we firmly advocate for the necessity of personal therapy in training programs. It serves as a cornerstone for ethical and professional growth, aiding therapists in managing their emotions and potential triggers during client work, ultimately safeguarding clients from harm.

Secondly, our perspective on clinical supervision underscores its indispensable nature, extending beyond regulatory compliance. The proposed on-site supervision model by CORU lacks alignment with our profession's unique needs for clinical supervision, posing risks to client and therapist safety, also due to infrastructure limitations and incompatibility with the non-traditional working hours.

Lastly, the issue of clinical placements and observed hours presents significant concerns. The demand for excessive observed hours creates infrastructural, ethical, and financial burdens, potentially leading to compromised client safety, diminished therapy quality, and heightened risk of burnout among therapists.

The IACP has been self-regulating the professions for more than 40 years and is the largest and longest established professional body for counselling and psychotherapy. We are extremally well positioned to say that standards proposed by CORU in the current form, pose a risk to both – therapist's and client’s safety.

We cannot support the qualifications of practitioners, who do not complete mandatory hours of personal therapy and have no clinical supervision in training.

Also, clinical placement as proposed by CORU will have a detrimental impact on the future of the profession, leading to many placements' closures, which in turn will impact on the student numbers and future recruitment.

For these reasons, the IACP is not in a position to support these aspects of the Standards of Proficiency and Criteria for Education and Training Programmes for Counsellors and Psychotherapists in their current form and, as a result we are compelled to oppose them.

For these reasons, the IACP is not in a position to support these aspects of the Standards of Proficiency and Criteria for Education and Training Programmes for Counsellors and Psychotherapists in their current form and, as a result we are compelled to oppose them. However, the IACP fully supports the proposal to establish the academic threshold for entry at NFQ Level 8 for both counsellors and psychotherapists. Entry at Level 8 aligns with the requirements to ensure that practitioners exhibit exceptional performance, robust critical thinking skills, a deeper understanding of the subject matter, and the capability to conduct independent research.

IACP members are highly experienced, qualified, and ethical professionals. The vast majority of the IACP membership is made up of fully accredited members or supervisors (72%) while student and pre-accredited members make up just over a quarter (26%). The organisation enjoys a loyal, long-standing, well established, and trusted membership. Almost a quarter have been members for between six to 10 years, more than a quarter have been members for between 11-20 years and almost a tenth have been members for more than 20 years (IACP Member Survey 2021). Our members together with our 22 accredited degree Level 8 and Level 9 course providers have given us invaluable feedback, insights and suggestions, which demonstrate the depth and breadth of professional expertise, skills, knowledge, and experience contained within our membership. The IACP trusts that the Registration Board will listen to the voices of our profession and address their well-founded and evidenced concerns.

The IACP is keen to support the Registration Board in any way that the board would find helpful and would be very happy to engage further in relation to any aspect of this submission.

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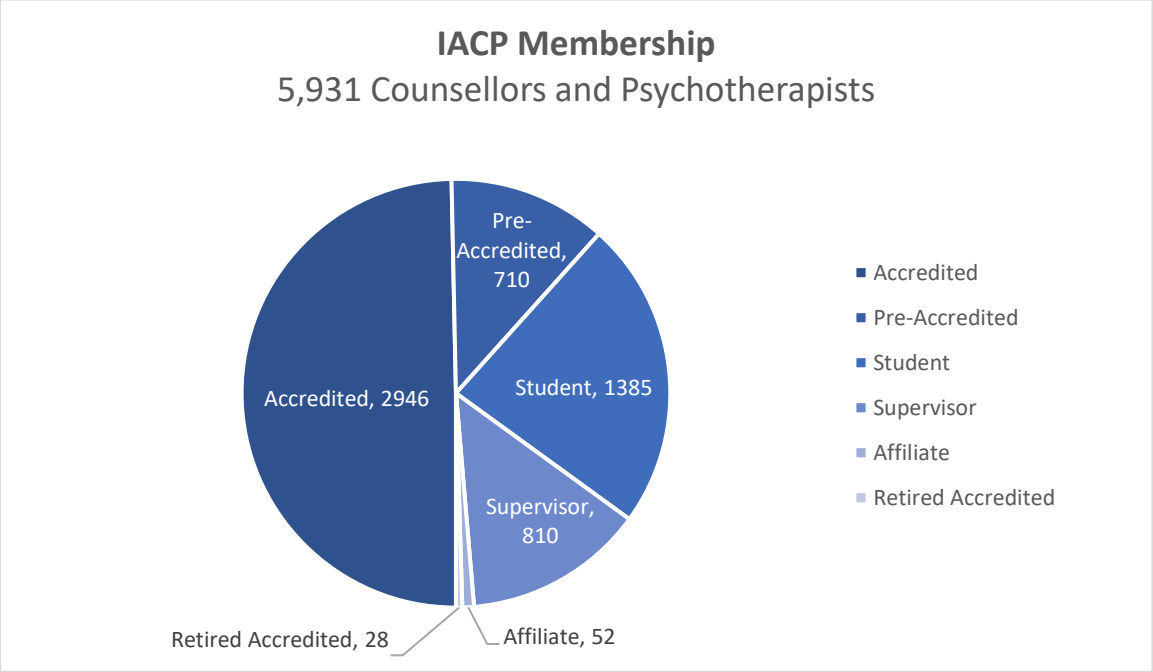
Appendix 1

Membership Numbers



Appendix 2

List of IACP Accredited Counselling and Psychotherapy Training Courses

- BSc (Hons) Counselling and Psychotherapy, Cork Counselling Services Training Institute
- Bachelor of Arts (Hons) In Counselling & Psychotherapy, Munster Technological University (Cork Institute of Technology)
- Bachelor of Arts (Hons) in Integrative Counselling and Art Therapy, Dublin Art Therapy College
- DBS BA in Counselling & Psychotherapy
- DCU MSc in Psychotherapy
- BA in Counselling and Psychotherapy with Addiction, Galilee House of Studies
- MA / PG Diploma in Gestalt Psychotherapy, The Gestalt Institute of Ireland (Irish Gestalt Centre)
- ICPPD BA (Hons) in Holistic Counselling & Psychotherapy (Athlone)
- ICPPD BA (Hons) in Holistic Counselling & Psychotherapy (Galway)
- ICPPD BA (Hons) in Holistic Counselling & Psychotherapy (Dublin)
- IICP BSc (Hons) in Integrative Counselling & Psychotherapy (Weekday Course)
- IICP BSc (Hons) in Integrative Counselling & Psychotherapy (Weekend Course)
- IICP MSc in Pluralistic Counselling & Psychotherapy
- PCI BSc (Hons) Counselling and Psychotherapy, Weekend Course
- PCI BSc Hons in Counselling & Psychotherapy, Weekday Course
- PCI BSc Hons in Counselling & Psychotherapy, Kilkenny, Weekday Course
- PCI BSc Hons in Counselling & Psychotherapy, Cork, Weekend Course
- PCI BSc Hons in Counselling & Psychotherapy, Athlone, Weekend Course
- PCI BSc Hons in Counselling & Psychotherapy, Limerick, Weekend Course
- PCI BSc Hons in Counselling & Psychotherapy, Belfast, Weekend Course
- Professional Diploma in Psychotherapy (Level 8, part of Masters (MA) in Humanistic and Integrative Psychotherapy (Clinical) Tivoli Institute
- Graduate Diploma In Integrative Counselling & Psychotherapy / (MSc) in Integrative Counselling and Psychotherapy), Turning Point Institute (TPI)