

Statutory Regulation and the Future of Professional Practice in Psychotherapy & Counselling:

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Statutory Regulation and the Future of Professional Practice in Psychotherapy and Counselling

Evidence from the Field

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Introduction

This report is based on a research project funded by the GMC/ESRC Public Services Programme entitled 'The Visible and Invisible Performance Effects of Transparency in Professional regulation'. The research compared the effects of regulation for doctors with developing regulation for psychotherapists and counsellors (as outlined in the 2007 White Paper 'Trust, Assurance and Safety: The regulation of health professionals'). We summarise here some of the key findings in our study focusing on issues that are relevant to the HPC consultation on the regulation of counsellors and psychotherapists.

We conducted 50 formal interviews and 22 informal scoping interviews with regulators and other officials, representatives of professional bodies, patient representatives, doctors (GPs and psychiatrists), psychotherapists and counsellors. In addition we observed Health Professionals Council (HPC) Professional Liaison Group (PLG) Meetings for Psychotherapists and Counsellors, as well as for Psychologists. We also observed four professional conferences on the regulation of counselling and psychotherapy. Finally we conducted a stakeholder workshop where we presented our provisional findings to a group including those involved in regulating psychotherapy and counselling at the national level and practising psychotherapists and counsellors, to validate our results.

We present our findings as follows. First we examine the way that doctors (GPs and psychiatrists) said that current forms of regulation affected their practice. Although their practice and context differ from those of psychotherapists and counsellors, their experience highlights a number of issues and questions about professional regulation, which we believe should be considered in the future regulation of psychotherapists and counsellors.

Second, we examine the experiences of psychotherapists and counsellors working in the NHS, voluntary and independent sectors. In particular, we focus on a large, integrated NHS mental health service, whose work is influenced by the local development of an Improving Access to Psychological Therapies (IAPT) service.

Again, although these experiences do not reflect the wider contexts of psychotherapists and counsellors per se, they do shed light on the effects of a more regulated mental health context.

Third, we briefly highlight what we regard to be an emerging assemblage of regulatory processes in the field of psychotherapy and counselling. Whilst the question of regulation is ostensibly restricted to the present focus of the HPC PLG, we draw attention to what we believe are important wider forces shaping this process.

Finally, we draw conclusions and make some recommendations designed to inform the development of future regulation.

Our research is a relatively small scoping study based upon a limited number of interviews and observation. We do not claim that the findings outlined in this report are representative of the whole field of psychotherapy and counselling. However our research does reflect how regulation is perceived in different contexts, it may indicate how future regulation would be interpreted and implemented in practice, and suggest some of its potential visible and invisible effects.

1. Doctors' perceptions of regulation in practice

i. Doctors: "Guilty until proven innocent"

Although we interviewed only a small number of doctors, the proportion that had been through (and exonerated in) independent reviews or disciplinary hearings was surprisingly high. Those who had not gone through a review were very aware of colleagues who had, so complaints affected the practice of all doctors.

Doctors described reviews as "hell", "very distressing" and "deeply upsetting", as fundamentally challenging their core identities, and causing anxiety and depression. Reviews led to doctors feeling isolated, unsupported and "ostracised" by colleagues. GP practices and PCTs did not seem to have adequate support process in places. This reflects the 2008 National Audit Office report 'Feeding Back?'¹, which described support for those being complained about as 'variable'. Our findings also reflected in research on medical complaints in Canada². So independent reviews and complaints processes, which doctors suggested sometimes took years to resolve, were seen as punishments in themselves in which doctors felt "guilty until proven innocent".

Doctors suggested that complaints were commonly "not [about] criminal activity, they're things that have gone wrong" or "vexatious". This problem was exacerbated in mental health where "false allegations... malicious or based in psychosis... are institutional hazards". Given the nature of their practice many doctors felt that complaints were inevitable. Clearly some complaints do relate to issues of serious malpractice but unsubstantiated complaints could also have serious knock-on implications. They could end professional careers, particularly for junior professionals who were seen to be at greatest risk: "they just disappear, even if the allegation is investigated and found to be empty... [Regulation] often falls most heavily... on those who are least securely held within their... institution, so agency nursing, locum doctors, trainees." Doctors under investigation could also be so

¹ National Audit Office (2008) Feeding Back? Learning from Complaints Handling in Health and Social Care.

² Canadian Medical Protection Agency (1999) Stress and the College Complaints.

preoccupied by the process that they put other patients at risk: “It’s like when you have a pile up on the motorway, you’re so busy looking at the pile up, you’re going to crash your car yourself. It puts me more at risk and it puts other patients more at risk.”

ii. The Blame Society

Doctors felt that professional and NHS regulation was driven far more by high profile ‘media spectacles’, and what we describe as a ‘blame society’, rather than the actual practices of most doctors: “People who are a serious danger to themselves and others... I just want to stress that they’re a tiny part of my job. Of course that different place is the only thing the papers... the courts... [and] regulators are interested in.” Regulation also appeared to be associated with increasing defensive legal bureaucracy, which did little to improve care. And doctors were conscious of a proliferation of agencies regulating healthcare (which a psychiatrist suggested totalled 37) and a regulatory climate “reminiscent of ... the Inquisition.”

This wider climate of the ‘blame society’ is not conducive to creating the ‘blame free culture’, recommended by the Department of Health in ‘An Organisation with a Memory’³ to improve patient safety. The NAO’s ‘Feeding Back’ also suggests that a substantial number of complainants simply wanted an acknowledgement of a mistake, an apology and to know that measures had been taken to prevent similar mistakes happening again but many were driven to litigation through frustration with the complaints process. So there appears to be a vicious circle associated with current healthcare regulation, with NHS professionals and organisations trying to defend themselves against complaints but in doing so frustrating complainants to the point of driving them to litigation. Intervening in this vicious circle could save time, money, improve the experience of complainants and professionals, patient safety and learning.

iii. Reactivity

Reactivity is a term used in research to describe the way subjects can react and change their behaviour if they know they are being studied; so researchers can play an active role in creating the behaviour that they wish to observe undisturbed. Similarly, some doctors appeared to have reacted to the prevalence and consequences of regulatory complaints by developing a new model of consultation: “there are two people in the consultation. There’s you and the patient - safeguard yourself first. It’s a different consultation model... Everything that you do and say in a consultation can be used against you”. This model undermined the relationship between doctors and patients and meant that doctors were practising to minimise the risk of a complaint rather than doing what was best for the patient. The defensive model affected, for example, end of life care where doctors were less prepared to allow a patient to die at home for fear of a complaint. A GP described how colleagues had not addressed the poor practice of a colleague for fear of a harassment charge.

³ Department of Health Expert Group (2000). An organisation with a memory: Report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer.

iv. Formative spaces

Doctors commented on the difficulty of spotting “bad apples” and some believed that preventing a future “Harold Shipman” was impossible. One of the reasons why some doctors are reluctant to acknowledge their mistakes may be the serious implications of doing so and a lack of support. Most people we spoke to suggested that the best way to reduce malpractice was to ensure that safe, “formative spaces” existed in which doctors could openly discuss and address difficult issues: “Good supervision is a different space, not quite therapy and not quite case discussion, that could stop boundary areas becoming boundary violations. You’ve got a group that can spot them... without turning them into a patient or a criminal.”

We found formative spaces to exist in a variety of places such as in clinical supervision, in psychoanalytic case discussion or reflective practice groups, and in certain mentoring relationships. They combine support and challenge in a high trust environment, which is backed by a strong professional ethos. Although such ‘spaces’ exist in a number of settings, they are predominantly experiential, phenomenological spaces in which participants feel safe enough to bring personal and professional dimensions together. As one senior doctor put it, to “connect” to their professional selves: “I tell them that it’s good if they fail with me... for me to see the warts and all... because we can change behaviours and turn things around. I preserve their confidentiality and get them feeling... it’s possible to have the support of colleagues, and it’s possible to show one’s vulnerabilities”.

v. Implications for counselling and psychotherapy regulation

So how are our findings in relation to doctors relevant to the regulation of counsellors and psychotherapists? First, we suggest that psychotherapists’ and counsellors’ experiences of complaints and reviews may be similar to those of doctors. Some complaints may be valid, others may be unfounded, and yet psychotherapists and therapists may feel punished by their participation in an investigative process regardless of the outcome. So people need to be better supported during investigations and treated as innocent until proven guilty (where there is a serious risk to clients they may need to be prevented from practicing and/or their case made transparent).

Second, we suggest that regulation for psychotherapy and counselling needs to balance its response to high profile but rare ‘media spectacles’ with its effects on the majority of practitioners’ day-to-day practice.

Third, we need to defuse the effects of the ‘blame society’ for psychotherapist and counsellors too. In 2008/9 the NHS spent £89m on handling and reviewing complaints⁴ and paid £769m in compensation⁵. So could more effective local mediation processes prevent complaints developing into complex, time consuming and expensive litigation? The NAO report ‘Feeding back’ and the Healthcare Commission’s ‘Spotlight on Complaints’⁶ (2007) point out that many people simply want their complaints to be acknowledged; they consequently recommend local

⁴ National Audit Office (2008) Feeding Back? Learning from Complaints Handling in Health and Social Care.

⁵ <http://www.nhs.uk/home.htm> (accessed 31st July 2009)

⁶ Healthcare Commission (2007) Spotlight on Complaints: A report on second-stage complaints about the NHS in England.

mediation close to the point of grievance, instead of escalating to legal processes. Can lessons be drawn from other legal proceedings such as mediation in the case of divorce, or restorative justice between criminals and their victims, where attempts have been made to address grievances, and reduce the burden on the legal system?

Finally it is important that psychotherapists and counsellors have what we describe as 'formative spaces', such as supervision or reflective practice groups, in which to discuss difficult issues. Addressing and preventing problems that arisen in what one doctor described as the "amber zone" of potential malpractice may be a more effective way of tackling poor practice without practitioners "being turned into either a patient or a criminal". Only the most serious issues of malpractice would then fall into a "red zone" in which professionals are prevented from practising and caught up in long and complicated regulatory processes.

2. Psychotherapists' and counsellors' perceptions of regulation in practice

i. The effects of performance management on therapy

In the mental health service we examined, the organizational requirements for IAPT led to a clinical performance system being introduced across the wider psychological therapies service. Some junior mental health workers and CBT practitioners appreciated the clear structure and model of accountability that the IAPT model provided. The IAPT model may also enable more people with mental health problems to be seen. More senior therapists, however, described this producing a marked change to the nature of their therapeutic practice: "It moved from being an individual/client relationship to (organisational) productivity. The measure was starting to overshadow... clients saying, oh no, not these measures again..."

Quantifying clinical outcomes, whilst useful for managers and commissioners, was described as decontextualising the complexities of therapy. Therapists described how representing therapy in simplified and numerical terms affected clinical practice and decision-making. Some aspects of clinical practice can be quantified but measures were experienced as having "a life of their own" which "bullied" therapists into changing their practice to comply with these measures. A senior therapists described how colleagues had been "in tears" and had to "wrestle with themselves" in complying with this new mode of therapy which they felt was undermining good therapeutic practice. Simplified, second-order representations (for example numerical data) were perceived to be transforming first order practice. For example, one therapist described how he could not longer make decisions based upon clinical intuition because he may have been accused of disregarding data, even if he felt the data was inaccurate. So therapists spoke of "losing a clinical mindset" and "something precious" about the nature of their practice.

ii. Reactivity

Therapists spoke in private about how they reacted to the new way of managing the service, "covering themselves" in case things went wrong. This was less about practising safely than of being seen to adhere to protocols - which could sometimes be detrimental to good clinical care. Some therapists described having to select

clients who would be “easy wins”, or superficially “patching them up” before they could consider any deeper therapeutic work with harder cases, because they needed to achieve reasonable clinical outcome measures. One therapist commented: “It’s mistaking the figures... for the thing itself. The distinction [doesn’t] matter anymore... Putting your work into boxes and numbering it conceptualizes it in a particular way, despite your best intentions, and will change it.”

iii. Formative spaces

Therapists, like doctors, commented on the importance of formative spaces, such as clinical supervision or reflective practice groups. However, some therapists described how organisations were reacting to the risks associated with mental healthcare in ways that could undermine practice and transfer risks from the organization to individual therapists. For example, an IAPT team leader described how in supervision they discussed each case, rather than devoting time to more complex or difficult cases, so that “at least it’s written down and it’s all formalized. If there’s an incident, there’s a claim in the future... that would have been an opportunity for it to be discussed but if it wasn’t discussed, that’s a practitioner’s [responsibility]”. So here the representation of second order (organisational) risk management practices was also beginning to overshadow actual first order clinical risk management. Although there are differences between the IAPT and psychotherapy and counselling in their models of delivering care, there is a risk that supervision may develop in the same way in both.

Interviewees also described how the pressures put upon the IAPT service to produce outcomes were causing therapists considerable anxiety, but managing the emotional aspects of mental health work did not appear to have been considered within the IAPT model. A lead CBT therapist commented that they were “not CBT robots. Supervisors are on the receiving end of all the anxiety and insecurity [which has] been dismissed within IAPT.” A senior therapist in the wider mental health service described “clinical supervision... where you can in a fairly relaxed way, actually talk about... I made a real hash” as “very precious oases in a sort of desert of figures and processes and procedures.” Yet the pressures of achieving IAPT outcomes were resulting in clinical supervision being missed altogether, or being seen as “operational management”. Our findings highlight the crucial role that supervisors play in mediating between the demands of performance management and effective clinical practice.

iv. Independent psychotherapists and counsellors

Independent therapists’ views of statutory regulation were mixed. Many were less aware of the possibility of statutory regulation or wider ‘blame culture’ than their NHS colleagues, so this may be one advantage of the independent sector. In general, those who had trained more recently were more optimistic about statutory regulation than those with more experience who, like the NHS therapists described earlier, were concerned about modes of therapy “losing their essence”. Their concern was that statutory regulation would not be sensitive to the nuanced but important aspects of their practice relating to feelings and relationship: “[W]hat’s going to be lost... [is] subtlety... my practice is about feelings and emotional relationship... I want [regulation to] be supportive... rather than suffocat[ing]... The relationship is alchemy; it’s not dead, it’s not a thing that’s fixed.”

An independent counsellor, like therapists in the NHS service, described how the regulation of independent sector counselling based on quantified data could affect the nature of practice and result in therapists “colluding in the system” and being “nice” to clients to look good on paperwork, rather than addressing uncomfortable areas that should be addressed by therapy. This counsellor added: “[the] agency I worked for was brilliant at getting funding... it simply manipulated [outcome reporting].”

v. Implications for the design of future regulation

How might our research contribute to the design of effective regulatory systems in the future? We have four main concerns about the potential effects of expanding and imposed regulation.

First is that second-order representation of practice (for example outcome measures) may become more important than practice itself, and begin to change first-order practices in ways that could undermine their efficacy and public protection. In policy terms, this is the old problem of bureaucratic and regulatory systems expanding unless checked. Instrumental rationality (for example, following bureaucratic procedure) becomes more important than substantive rationality (whether the procedure is helpful).

Secondly, high-impact but low frequency ‘bad cases’ – amplified in the media – have a tendency to drive system-wide escalation of regulation. We would caution against the potential over-proliferation of regulatory and risk management systems, not only given their time and resource consequences, but also because of their unintended consequences for practice, as described in this study.

Thirdly, there is a danger that a regulatory system driven by transparent, second-order representations of practice could crowd out what we describe as ‘formative spaces’ which we argue are crucial to safe and effective practice. Where these formative spaces exist, they combine support and challenge in a high trust environment for reflective practice, backed by a strong professional ethos. However, we found evidence that the longstanding tradition of clinical supervision was being eroded by the demands of greater transparency, audit and increasingly “contractual relationships”.

Fourthly, we found evidence that an internalised ‘regulatory mentality’ was beginning to undermine practitioners’ awareness of the importance of formative spaces such as clinical supervision. Some professional representatives actively argued for formative spaces to become more transparent, stating that NHS therapists had “little right to privacy because they’re a public servant”. However, our study suggests that increased transparency may make practice less safe and less effective, because it changes therapists’ willingness to disclose problems.

3. Wider pieces of the regulatory puzzle

The regulation of psychotherapy and counselling ostensibly rests with the HPC, but our observations of the field overall suggest that a far wider process of regulatory assembly is taking place. While the HPC PLG process was generally described in positive terms, (with some respondents describing “impressive” levels of transparency and consultation), this wider process was felt to be significant

because it situates regulation within a wider political agenda in which the Care Quality Commission, “IAPT, Skills for Health, NICE and regulation... become the pieces of the puzzle.”

Although we found no evidence of an overarching political agenda, this wider political assemblage is relevant to the future regulation of psychotherapy and counselling. Many therapists we spoke to were suspicious of what they saw as an elite group of senior psychologists steering wider assemblages in their own interests. How representatives were appointed to committees making decisions about the future of NHS talking therapies was described as “deeply opaque”. Some felt that, especially with the rise of an evidence-based discourse, regulation could be subjected to ‘regulatory capture’, in which partisan interests are furthered, while undermining the nature of psychotherapy and counselling overall.

In particular, some psychotherapists and counsellors saw the development of IAPT and NICE guidance as a way for clinical psychology to achieve dominance across the entire field of psychology, psychotherapy and counselling. A senior representative we spoke to acknowledged the link between NICE guidance and IAPT funding but argued that therapists were naïve to resist outcome measures: “The government was not going to invest in psychotherapy unless there was good evidence; it wasn’t going to give £173 million for all flowers to bloom.” He argued that the quantification of each therapy session (through performance measures) was inevitable because for the first time the NHS was able to “commission for outcomes.” Those who refused to participate would not be funded, so “that’s a sort of genie that’s come out of the lamp, which no one can put back.” Some NHS psychotherapists agreed, one commented: “For about 20 years I’ve been saying... this would happen one day... there is a need for [psychotherapists and counsellors]... to take seriously the need for evidence.”

A different dimension of the inter-professional politics affecting regulation was the process of distinguishing psychotherapy and counselling in the PLG. Some PLG representatives described this as the unspoken “elephant in the room” which was not settled until the penultimate (May 2009) meeting. The PLG’s decision to separate psychotherapy and counselling into the distinct fields of ‘mental disorder’ and ‘wellbeing’, respectively, was widely seen as a decisive moment for the future of psychotherapy and counselling, with major consequences for the future practices of both.

To summarise, although we found no evidence of an overarching political agenda at the macro level, a far wider process of regulatory assemblage is taking place, in which governmental organisations, professional groups, and a range of interested stakeholders are competing for position and influence. The proposal to regulate counselling and psychotherapy is situated within this context, and there is evidence that the regulatory field overall is being shaped by a far wider group of political assemblages than has been addressed by the PLG

4. Recommendations

- i. Our findings, echoing our earlier research⁷⁸, highlight the continuing important role of professionals in professional regulation and the risks of expanding

⁷ McGivern, G. and E. Ferlie (2007) ‘Playing Tick Box Games: Interrelating Defences in Professional Appraisal’. *Human Relations*, 60 (9) p1361-85.

managerialised regulation, based upon what we have termed 'second-order processes'. We suggest that interpersonal processes within clinical supervision, rather than distant quasi-legal regulation, are the key to protecting the public and ensuring the safety and efficacy of practice. As Prof Christopher Hood notes, face-to-face scrutiny is far less vulnerable to gaming strategies than the "arcane and impersonal process of reporting from one bureaucracy to another in a closed professional world"⁹.

- ii. There is a policy risk of expanding and cosmetic regulatory systems. There needs to be an effective professional regulation framework in place, agreed by the professions, to ensure that poor practice and 'difficult' colleagues are effectively dealt with. This route poses major challenges for supervisors, employing organisations and professional regulators. But our data leads us to ask whether mandatory professional regulation, owned by the profession(s) of psychotherapy and counselling, in practice, may be a more effective way to protect the public than statutory regulation by a quasi-governmental body.

Our concern with statutory regulation is first, whether its processes are sufficiently subtle to regulate the practices of psychotherapists and counsellors, involving complex relationships and emotion, which are difficult to represent in documentation. Our second apprehension is that statutory regulation is more oriented towards a public settlement between politicians, the media and law at macro-level than its effects upon professionals and clients/patients in practice. For regulation to be effectively implemented and interpreted in practice, counsellors and psychotherapists need to believe in it, while maintaining the 'formative spaces' bridging regulation and professional development. We wonder whether the profession(s) of psychotherapy and counselling may be better able to span the macro and micro-level demands of effective regulation.

- iii. In order to be able to own a system of mandatory regulation, we suggest that psychotherapy and counselling would need to become less insular as professions. Psychotherapy and counselling needs to focus more attention on developing evidence for the effectiveness of its practices. Professional bodies have to ensure that they are not seen as self-serving or out of touch with the public, so that they retain the confidence of other key stakeholder groups. This implies micro-level democratisation and strong, rather than tokenistic, lay-involvement in shaping professional bodies, in future regulation, and in fitness to practice cases. Some of the work that NICE has been doing in terms of designing stakeholder consultation exercises¹⁰ may be a useful exemplar.
- iv. Our analysis of data at the micro-level suggests that any system of regulation needs to do more to minimise the often-substantial impact of even trivial complaints. Early mediation between professionals and complainants and more support for those under investigation may be useful in this respect.
- v. Finally, politicians and the public need to be better informed about the micro-level impact of regulations introduced in reaction to high profile 'media

⁸ Exworthy, M. (1998) Clinical Audit in the NHS internal market: from peer review to external monitoring. *Public Policy and Administration*, 13 (2) p40-52.

⁹ <http://www.ethosjournal.com/frontline-focus/item/49-the-numbers-game?showall=&limitstart=> (accessed 6th October 2009)

¹⁰ Davies, C., Wetherall, M. and Barnett, E. (2006) *Citizens at the Centre: Deliberate Participation in Healthcare Decisions*. Policy Press.

spectacles'. Accordingly regulation might be able to balance responding to rare but high-impact malpractice with its often-detrimental effect on the majority of professionals' practice and the enormous financial and social costs of regulation in what we describe as a developing 'blame society'.