

From: "PCO Enquiries Mailbox" <enquiries@pco.gov.uk>
Subject: Thank you for your email to the Privy Council Office Re: Fwd: The Privy Council's production via regulation of the one treatment, excluding all others from the area known as Mental Health
Date: 28 September 2021 at 16:44:14 BST
To: je.lacanian@icloud.com

Thank you for your enquiry. If this matter is within the Privy Council Office remit, you should hear back from us within 15 working days.

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For the attention of the Privy Council, 1 Horse Guards Road, London, SW1A 2HQ.
(enquires@pco.gov.uk)

Copy : Mr Craig Mackinlay MP, Member of Parliament for South Thanet
From : Julia Evans, Lacanian Psychoanalyst, Kent

27th September 2021

NOTE this is also published [The Privy Council's production via regulation of the one treatment, excluding all others, from the area known as Mental Health : 27th September 2021 : Julia Evans](#) or [here http://www.lacanianworks.net/?p=12962](http://www.lacanianworks.net/?p=12962)

The Privy Council's production via regulation of the one treatment, excluding all others from the area known as Mental Health,

The purpose of this message is to draw your attention to the clash between the aspirations of the Privy Council in implementing the Health Professions Order 2001 onto practitioners providing treatments to subjects, defined by the Government's NICE clinical guidelines, as having mental health issues, and what practitioners trained in many different perspectives & traditions bring to this clinic. There is no one correct solution.

Further, the pretence contained in HPO 2001, and driven by Privy Council power, that there is one safe way of practicing which always produces a standard result, prevents many experienced practitioners from being within the Government's provision of mental health services. This limits availability of treatments.

My message adds to a Public Briefing Paper from the UK Association for Humanistic Psychology Practitioners. It should be attached or is available <https://ahpp.org.uk/wp-content/uploads/2021/08/BRIEFING-PAPER-PSA-Changes-V3-Aug-2021.pdf> This Public Briefing Paper explores : Concerns about proposed regulatory changes to the ethos of the voluntary Accredited Registers Programme and impact on the accessibility of psychotherapy and counselling and service user choice in the UK

I, Julia Evans, have been raising concerns about the Privy Council operating the clinic for those subjects defined as having Mental Health issues, within Parliament since 2005. My involvement commenced in 2000, prior to the promulgation of the Health Professionals' Order 2001. At issue is the object of the Order & the use of Privy council power to obtain this perverse end:

From Health Professions' Order 2001 :

Section 3 (4) The main objective of the Council in exercising its functions shall be to safeguard the health and well-being of persons using or needing the services of registrants.

(5) In exercising its functions, the Council shall—

(a) have proper regard to the interests of all registrants and prospective registrants and persons referred to in paragraph (4) in each of the countries of the United Kingdom and to any differing considerations applying to the professions to which this Order applies and to groups within them; and

(b) cooperate wherever reasonably practicable with— (i) employers and prospective employers of registrants, (ii) persons who provide, assess or fund education or training for registrants or prospective registrants, or who propose to do so, (iii) persons who are responsible for regulating or coordinating the regulation of other health or social care professions, or of those who carry out activities in connection with the services provided by those professions or the professions regulated under this Order, (iv) persons responsible for regulating services in the provision of which registrants are engaged.

What, about safeguarding the mental health and well-being of subjects, is possible?

When does safeguarding become perverse, as with for example the Inquisition who guarded your soul from hell?

How do you know when you are operating a perverse system of regulation?

What does this form of megalomaniac control add to the use of legislation on financial abuse, physical abuse, sexual or physical assault, grooming or stalking.

So what HPO 2001 sets up is rules, regulations and codes with the force of Privy Council power behind them, to ensure that only procedures agreed by the Privy Council's agents, can be used. There is the one, Privy Council-guaranteed way of giving talking treatments to subjects categorised as in need by NICE clinical guidelines, so they can be returned to an acceptable standard of humanness (presumably as defined by Privy Council agents or maybe using the Government's economic definition of not receiving benefits).

I have been deconstructing this position for 20 years, as it devalues what it is to be a human subject & supports treatments which actually do not work, though they register well on your/the Government's evaluation procedures.

Further the Privy Council approach to regimenting practitioners, produces Professionals, plastered in certificates allowing them to apply permitted procedures (usually cbt) to unique subjects defined as 'ill' or suffering substandard mental health. This is based on the medical model, with the difference being that in medicine, usually symptoms can be verified by physical examination or x-rays or ... & the intervention is directly onto the subject's body. In the area of mental health, there are problems of definition. Is how I perceive an anxiety state the same as your perception? Is my definition of well-being (sitting in a gutter drinking a bottle of vodka) the same as yours? So the Privy Council, in HPO2001, assumes that wellbeing can be defined, that mental health can be defined, that it can regulate practitioners and prevent harm (the Privy Council should tell their secret to the Police, so they too can prevent all crime), and can measure all this up using a standard of normal mental health.

I draw your attention to further texts by Julia Evans [Index of texts by Julia Evans](#) or [here http://www.lacanianworks.net/?p=12365](http://www.lacanianworks.net/?p=12365)

& two recent texts

[The Royal College of Psychiatrists & Lacanian in the UK : Comments following Éric Laurent's 'The Culture of Abusive Treatments' \(LQ 930/LRO 308\) \(8th January 2021\) : Julia Evans : 3rd July 2021](#) or [here http://www.lacanianworks.net/?p=12941](http://www.lacanianworks.net/?p=12941)

[Alliance for Counselling & Psychotherapy Newsletter : SCoPed & a new APPG?](#) by Julia Evans on 31st October 2019 or [here http://www.lacanianworks.net/?p=12364](http://www.lacanianworks.net/?p=12364)

Further I strongly recommend a Public Briefing Paper from the UK Association for Humanistic Psychology Practitioners. It should be attached or is available <https://ahpp.org.uk/wp-content/uploads/2021/08/BRIEFING-PAPER-PSA-Changes-V3-Aug-2021.pdf>

Julia Evans

www.LacanianWorks.net & www.LacanianWorksExchange.net

a Lacanian

– member of the London Society of the New Lacanian School, which is part of the New Lacanian School of Psychoanalysis, which is a member of the World Association of Psychoanalysis. (<https://www.wapol.org/en/Template.asp>) I practiced as a Chartered Psychologist for 20 years, then in the Lacanian field for 30 years – having trained for 10 years. Your Privy Council rules & regulations forbid me from practicing with your stamp of approval, registration, on the grounds that I am a dangerous charlatan. What is your, the members of the Privy Council, evidence for defining me thus?

PUBLIC BRIEFING PAPER: Concerns about proposed regulatory changes to the ethos of the voluntary Accredited Registers Programme and impact on the accessibility of psychotherapy and counselling and service user choice in the UK

Background

The purpose of this paper is to highlight how proposed regulatory changes to the *Accredited Registers (AR) Programme* under the *Professional Standards Authority (PSA)* will potentially impact on the accessibility of psychotherapy and counselling in the UK.

The PSA which is accountable to the government via the *Privy Council* is responsible for overseeing ten statutory bodies regulating health and social care in the UK. The *Accredited Register Programme* was launched in 2012 to promote best practice and good governance for voluntary professional registers and over two million unregulated health and social care providers.

To date the AR programme has accredited **23** voluntary registers, accounting for **102,330** registrants over a wide range of professions including counselling and psychotherapy (see *Appendix 1*). Organisations have joined the programme for different reasons, some registers see it as a way of gaining recognition and access to the *National Health Service (NHS)*; some see it as a stepping stone toward statutory regulation, whilst others see it as vehicle for expanding market influence – all registers are committed to enhancing public confidence in the programme through the maintenance of high professional standards.

There has been an abundance of enthusiasm and goodwill in support of the AR programme since it was launched in 2012. However, following the first *Coronavirus* lockdown in 2020 the PSA published a consultation paper in which it mapped out its vision for the future. This vision is not, as it could have been, the product of collaborative enquiry with register holders about how the programme could evolve. In essence the PSA is proposing a departure from the fundamental ethos of the programme as a government endorsed voluntary registration assurance scheme.

The PSA's vision for the future is based on the understanding that 'patients' have difficulty in navigating multiple registers and that for a voluntary assurance scheme to be effective there must be greater standardisation and consistency between registers. The measures the PSA intends to implement include:

- **Financial Self-Sustainability of the Programme:** Following the withdrawal of funding by the *Department of Health and Social Care (DHSC)* the programme will have to be financially self-sustainable by 2022.
- **Efficacy of Treatments and Therapies Covered by the Programme:** The introduction of a mechanism in alignment with the *NHS Commissioning Frameworks* and the *National Institute of Clinical Excellence (NICE)* for assessing the risk posed to the public by health care occupations and the treatments and therapies provided by registrants.

- **Access to the AR Programme:** Restricting access to the AR programme through the establishment of conditions for the amalgamation, merger or takeover of registers, so as to pave the way for single profession monopolies and a single register for all non-statutory health care professions.
- **Change of Ethos:** Shifting the ethos of the programme from an *organisational perspective* to an *occupational perspective* with greater emphasis on determining what service users can and cannot access.
- **Raising Awareness about the Programme:** A campaign to raise awareness and recognition about the AR programme and to deter service users, employers and service commissioners from accessing the services of any health care professional whose name is not included on a statutory or accredited register.

Without consultation with register holders and other stakeholders, the PSA gave notice of its intention to abandon all but the first of the five design principles the programme was founded upon and which all registers holders signed up to:

1. *Ensure that any restrictions developed through the creation of the Standards, or the operation of the programme, would reflect the potential risks of harm to the public.*
2. *Not unfairly or unnecessarily restrict the market by creating monopolies. It should be open to any eligible register, including those relating to the same occupation.*
3. *Be affordable for applicants, and not price small registers out of the market, making it open to registers clustering under umbrella organisations.*
4. *Should not set the education and training requirements for entry onto a register.*
5. *Would not make any judgement about the effectiveness of any therapy or health or care practice.*

The redesign of these principles suggests that the programme as originally envisaged as a voluntary assurance scheme will cease to exist and be replaced with a framework for regulating professional occupations and the delivery of health care provisions in the independent sector (charities, voluntary services, private practice, commercial etc.).

If left unchallenged the consequences of these measures will have far reaching effect within the wider field of counselling and psychotherapy. Diversity of care and service user choice will be further diminished and the employment/livelihood of many health care professionals who remain committed to upholding high professional standards will be threatened.

The following sections consider some of the consequences the PSA's decisions are likely to have on the wider field of counselling and psychotherapy and service user choice.

1. The Efficacy of Counselling and Psychotherapy and continued access to the AR programme

In order to establish greater governance consistency across registers, the PSA has revised its professional standards to include a mechanism for assessing the efficacy of treatments and therapies provided by registrants and the risks posed to the public by health care occupations.

On the basis that service users have the right to exercise free choice and determine what treatments and therapies are in their best interests, assuming that they are not harmful or illegal, the PSA originally took the position that it *'would not make any judgement about the*

effectiveness of any therapy or health practice'. The PSA has now decided to introduce criteria for registers to provide clear and objective evidence in support of the efficacy of treatments and therapies carried out by registrants and that service users derive benefit from such activities.

At face value having a professional standard that accounts for the efficacy of treatments and therapies covered by the programme is a measure most professionals would wish to uphold. Safeguards need to be in place to protect the public from mavericks, charlatans and those intent on exploiting the vulnerable. Thus it is not the standard that is under question here, it is the method the PSA intends to utilise to determine efficacy.

The PSA has stated that it is not equipped to assess the efficacy of treatments and therapies and that to only accredit occupations where there is a recognised evidence base may exclude occupations that are beneficial to the public and that whilst some disciplines are subject to randomised trials others are based on qualitative research and evidence-based practice. The PSA now seems to be abandoning inclusivity in favour of a universal research paradigm applicable to all health care treatments and therapies. The PSA goes on to say:

'Not all the benefits of the activities of registrants can be evidenced through scientific means. Not all treatments will be able to meet the commonly agreed definitions of efficacy, which is the ability to produce a desired or intended result.'

The assumption here is that all therapies and treatments are concerned with producing predetermined outcomes, akin to the medical model, such as symptom relief, whereby the client is a passive homogenous recipient of prescribed interventions. This is not the case for many counselling and psychotherapy approaches, where client and therapist are unique heterogeneous individuals engaged in an unfolding relationship where the client's individuality, self-healing capacities and resourcefulness may emerge. Constructive personality change unfolds over time, often long after therapy has been completed. It is a process unique to each individual – it is not predetermined or orchestrated by external forces.

The PSA says that although the burden of proof will initially rest with register holders, it will draw on the recommendations and expert opinion from authoritative bodies and legal advice when determining the efficacy of professions and the activities of registrants. The authoritative bodies cited by the PSA include: *The National Institute of Clinical Excellence (NICE)*, *Cochrane*, *Scottish Intercollegiate Guidance Network of Clinical Excellence* and the *NHS*. It is doubtful if the PSA will consult with eminent scholars and researchers who are opposed to NICE guidelines such as those active within the '*NICE Stakeholders Campaign*'.

The involvement of NICE in determining the efficacy of counselling and psychotherapy is of great concern. NICE, the guardians of randomised control trials as the gold standard for determining the effectiveness of all health care treatments and therapies considers the majority of counselling and psychotherapy approaches to be insufficiently evidence based. As a result NICE has been instrumental in the decline of counselling and psychotherapy diversity within the NHS and mental health reduced to the elimination of anxiety, stress and depression.

Although mental health currently has a high media profile, the accessibility of counselling and psychotherapy in the NHS is still limited to manualised outcome-oriented approaches,

provided by psychologists, *cognitive behavioural therapists* (CBT) or *Improving Access to Psychological Therapies* (IAPT) workers – the latter initiative being an initiative to reduce the number of working days lost to the economy due to depression and anxiety. Such therapies are often offered in conjunction with psychotropic medication.

Personalised care tailored to the needs of the individual aims to empower service users to make decisions about their ‘treatment’ in partnership with their NHS health care provider, but if there is no diversity of counselling and psychotherapy in the NHS how can this be empowering – clients/patients have little or no choice! The diversity of counselling and psychotherapy should be accessible within the NHS and free at the point of delivery.

The majority of counselling and psychotherapy approaches embrace research paradigms different to those advocated by NICE. Humanistic and psychoanalytic approaches which have served the public well for generations barely have a foothold within the NHS, yet there are decades of extensive qualitative research to support the effectiveness of these approaches. NICE refuses to accept such research insisting that the efficacy of all health care provision must be assessed in accordance with the methodology of randomised control trials – this is not adequate for understanding individuality and the significance of human relationships.

The meta-analysis of qualitative and quantitative psychotherapy outcome research, since the 1950’s, has repeatedly demonstrated that clients who receive psychotherapy benefit more than clients who do not. The utilisation of the client’s frame of reference, rather than techniques, the preoccupation of predetermined outcomes and the elimination of unpleasant symptoms, is central to positive psychological change. Lambert’s (1992) work is repeatedly validated:

- Techniques account for 15% of outcome variance [this is the factor NICE places so much emphasis on]
- 15% of outcome variance is attributed to expectancy and the placebo effect [the same as techniques]
- 30% of the effectiveness is accounted for by common factors unique to the client-therapist relationship such as responsiveness to intra/interpersonal resonance, empathy, genuineness, unconditional positive regard – this is also the domain of transference and countertransference.
- 40% of variance is accounted for by extra therapeutic change variables – factors unique to the client as an individual and their personal circumstances.

The importance of the therapeutic relationship and factors unique to the client as an individual is best summarised by Yalom (1989):

‘The drama of age regression and incest recapitulation (or, for that matter, any therapeutic cathartic or intellectual project) is healing only because it provides therapist and patient with some interesting shared activity while the real therapeutic force - the relationship – is ripening on the tree’.

There is compelling evidence that Humanistic Psychotherapy has a robust research tradition and that Humanistic practice built on empathy, acceptance, collaboration and a genuine therapeutic relationship supports the premiss that the client is the driver of therapeutic change:

'Meta-analyses of Humanistic therapies, as a whole, support the hypotheses that they are efficacious and effective forms of therapy, with a large average pre-post effect size of 0.90, reducing down to 0.89 when compared against waiting-list or no-therapy controls'.

(Elliott, Greenberg et al., 2004 cited in Cooper, 2008: 162).

As a consequence of NICE's influence on the NHS the burden of counselling and psychotherapy provision in the UK has shifted to the independent sector, primarily voluntary services and private practice. Unfortunately access to such therapy is only available to those who can afford to pay and individuals who endure long-term mental health distress and whose needs are often the greatest fall through this safety net. The PSA's measures would seem to do little if anything to expand the availability and diversity of counselling and psychotherapy – to the contrary it would seem they erode good therapy and ration what remains.

It is unlikely that NICE will approve treatments and therapies in the independent sector that it has prohibited in the NHS and as a consequence the restrictions inherent in the NHS will be replicated in the independent sector. Diversity will be curtailed and specialist registers will be marginalised within the AR programme or cease to exist.

The PSA believes that being on an accredited register may lend credibility to practitioners whose practice has no evidence base. It therefore intends to develop a hierarchy of care competence, with statutory occupations at the *'higher'* end and non-statutory (unregulated) occupations being tiered into *'intermediate'* and *'lower'* end. It is anticipated that the accreditation of *'intermediate'* registers may include a *'licensing'* arrangement allowing register holders to grant permits to registrants and the power to exclude registrants whose practice does not comply with efficacy requirements (NICE). The independent sector is pulled further within the regulatory orbit of the PSA and the professional standing of counsellors and psychotherapist whose names are not a statutory or voluntary register is likely to be undermined.

One of the vehicles the PSA intends to use to achieve this objective is to launch an awareness campaign directed at the public, employers and service commissioners. If this campaign is successful and service users boycott the services of unregulated health care professionals, the diversity of counselling and psychotherapy and consumer choice will be diminished within the independent sector. Practitioners who do not comply with the PSA's notion of efficacy will be marginalised, forced underground and in some instances will have to rebrand the services they provide in order to survive. It cannot be in the public interest to allow such measures to restrict market conditions and limit service user choice.

The imposition of a common efficacy standard aligned with NICE guidance will stifle innovation and place the diversity of service user choice in the independent sector in great risk. Such imposition contravenes the first AR programme design principle, the one the PSA says it wants to retain. This imposition is clearly not in the public interest!

2. The Financial Self-Sustainability and Affordability of the AR Programme

This section illustrates the interaction between the PSA's new ethos, implementation of a new model and market conditions, in ways that are not conducive with the public interest or development of AR programme.

On the basis that the effort required for assessing a register is the same regardless of registrant size the PSA have charged all registers a similar standard fee since the onset of the programme – **£10,414**. As the largest register has a turnover of several **£million** and registrant size in excess of **41,000**; whilst the smallest register has a turnover of less than **£50K** and a registrant size less than **200**, many have considered this model to be unfair and disproportionate. An additional **10 pence** per-registrant levy was recently introduced but did nothing to address this disparity.

In 2020 the *Department of Health and Social Care* (DHSC) gave the PSA notice that it will be withdrawing funding and that the AR programme, with forecasted expenditure in the region of **£504,000** and a deficit of **£90,000**, will have to be financially self-sustainable by 2022.

The PSA made a welcome announcement in its consultation paper published at the end of 2020. Alongside the introduction of a three years re-accreditation cycle it proposed changing the current *Annual Re-Accreditation Model* to a *Full Per-Registrant Fee Model* of approximately **£6** per-registrant annually in line with statutory regulators.

According to the PSA the overall response to the proposed funding model agreed that moving to a full per-registrant fee model is a reasonable way to achieve financial sustainability. Of the **33** register holders and associated organisations consulted, **12** agreed that a per-registrant fee model is reasonable, **7** larger registers disagreed.

On 31 March 2021 the PSA *Chief Executive* announced that the proposed per-registrant fee structure would not be implemented and that an alternative model based on *minimum and maximum capped contributions* plus a *per-registrant fee* would be introduced instead. The reason given for this decision change was to accommodate the budgetary interests of larger registers. No reference was given or provision made to accommodate the budgetary needs of smaller registers. To the contrary, subsequent communications acknowledged that some registers may be priced out of the programme (regardless of their commitment to continue) but this was of no great concern to the PSA as any lost revenue will be recouped from newly accredited registers. The PSA also informed register holders that if they did not confirm their intention to renew accreditation within 26 days of the 31 March 2021 the PSA will assume they are not intending to remain on the programme – the tone and style of this type of communication is indicative of the PSA's change of ethos.

The PSA's communications about the implementation of the new fee structure were confusing, leading to considerable misunderstanding. On 28 May 2021 the Chair of the Authority confirmed in writing to the UKAHPP that the PSA is '*not introducing a full per-registrant fee model, as was proposed*' and instead has '*decided to introduce a minimum and maximum cap, in combination with the per-registrant fee model*'. On 1 July 2021 the PSA finance department issued invoices that took no account of any capped *minimum contribution*. In effect the original hybrid fee model still applied. Except for the introduction of a capped *maximum contribution* there is no change – and there is no capped *minimum contribution*:

- The *standard base rate fee* of **£10,414** was increased by **£86** to **£10,500**
- The **10p per-registrant levy** was increased to **£5.70** per-registrant.
- A *maximum contribution* capped at **£60,000** was introduced
- There is **NO minimum contribution** capped at **£10,500** as was stated.

The spreadsheet below (see *Appendix 2*) base on PSA data at 31 May 2021 provides a breakdown of the fees payable by each register holder under the newly introduced fee model and the previous *Annual Re-Accreditation Fee* model. Calculations for three full per-registrant options are also included for comparison.

The old *Annual Re-Accreditation Model* equated to a per-registrant fee of **35 pence** for the largest register and **£64** for the smallest register, with actual fees paid ranging from **£10,430** for the smallest register to **£14,657** for the largest register.

The new fee model equates to a per-registrant fee of **£1.44** for the largest register and **£70.51** for the smallest register, with actual fees paid ranging from **£11,423** for the smallest register to **£249,945** for the largest register, the latter being reduced to **£60,000** with the introduction of the capped *Maximum Contribution* – that is a saving of **£187,945**.

The PSA indicated that it had considered other funding options but has so far declined requests to share information about these alternatives or provide any rationale about how the **£60,000 maximum contribution** and other calculations were arrived at.

In July 2021 the UKAHPP proposed that an alternative fee structure (not necessarily in its best interests) be put to register holders for consideration:

- To charge all register holders an annual organisation fee not more than **£5,000**.
- A **£6** per-registrant fee chargeable to registrants (not organisations) - organisations have the option to absorb this fee or pass it on to registrants as a tax deductible professional fee.
- As register holders are best placed to collect such fees on the PSA's behalf an administration fee of **30p** per registrant could be deducted.

With **102,330** registrants this would give the PSA an income of **£698,281**. The PSA has declined to put this proposal or any variant to register holders for consideration, stating that the approach the PSA has taken is '*fair and impartial*' and that it has applied common principles to all register holders.

There has been misunderstanding amongst register holders about the difference between the PSA's proposed *per-registrant fee funding model* and the *old annual accreditation per-register fee model*. A *per-register fee* is an *operational cost* charged against an organisation; whereas a *per-registrant fee* is a standard *professional fee* charged to registrants on a universal basis regardless of a register size and which is tax deductible - the burden rests with each registrant not register holders. An organisation may choose to absorb *per-registrant fees* as a membership benefit or pass the burden to registrants as a professional fee in addition to any annual subscriptions. Some register holders viewed the PSA's proposal to introduce a *per-registrant fee model* as a standard fee increase with the burden resting with the register holder. On the assumption that the larger the registrant size the more an organisation would have pay, large register holders protested to the PSA. Fearful of the consequences if a per-registrant funding model was implemented the PSA withdrew the proposal and reverted back

to the old hybrid model consisting of a standard base rate fee plus a nominal per-registrant levy. This is in effect a standard fee increase with the burden resting with register holders. Consequently, although larger register holders are paying substantially higher fees, this funding model remains unfair and disproportionate. Most register holders are discontent with the new funding model, albeit for different reasons.

As the ethos of the programme is designed to regulate the services provided by registrants a per-registrant fee is inevitable and should be applied in line with statutory registers as a fair, equitable and proportionate funding model without further delay - everyone pays the same. A **£6** per-registrant fee would generate an income of **£614,004** which is sufficient to ensure the financial self-sustainability of the AR programme.

3. Restricting Market Conditions and the Creation of Monopolies

As all registers regardless of size have paid a similar annual fee it is difficult to understand why the PSA had introduced a fee model favouring larger registers with a *maximum contribution* but without a comparable *minimum contribution*. At the time of implementation this decision favoured only one register the *British Association for Counselling and Psychotherapy* (BACP). The following statement was posted on the BACP website in response to the PSA's proposed per-registrant fee model and may shed some light on why the PSA has not introduced an honest per-registrant fee:

'The current suggested levy is far in excess of the levels of the statutory regulators. As BACP has over 40,000 registrants, making up almost half of the total of registrants, we would welcome discussion of revised fees when we can assess the benefits of the suggested proposals'.

For reference per-registrant fees for statutory registers include:

- **£120** Nursing and Midwifery Council
- **£480** General Medical Council
- **£680** General Dental Council
- **£257** General Pharmaceutical Council
- **£260-360** General Optical Council
- **£90** Social Work England
- **£180** (2 years) Health Care Professions Council. – including Psychologists

It is documented that the BACP and other register holders met with the PSA *Chair* and *Chief Executive* and have put the PSA on notice that unless their terms of regulation are not improved they will not be signing up to the programme again in 2022. The PSA *Chief Executive* informed the UKAHPP that the proposed **£6** per-registrant fee structure was not abandoned due to pressure from larger registers. The BACP goes on to state that the PSA should maintain the minimum accreditation fee so as to:

'Ensure smaller organisations make the commitment to, and remain invested in, the scheme. We believe this would mitigate the risk of a proliferation of small registers with little or no evidence base or infrastructure applying to join the scheme at a very early stage of their development'.

Assumptions to one side that smaller registers have no evidence base, have no infrastructure or maturity, it would seem the BACP is suggesting that the fees for smaller registers should be kept artificially high in order to 'mitigate the risk' they present to the BACP's ambitions. The PSA's new fee model and change of ethos clearly reflect the BACP's explicit view that a full per-registrant fee should not be applied and that controls should be in place to limit small registers from entering and remaining on the programme.

It is also evident from the calculations in *Appendix 2* that the BACP is the main beneficiary of the capped *maximum contribution* with a **£187,945** rebate. The only other beneficiary to the sum of **£30,956** being the second largest register which was recently formed by the amalgamation of two registers. That is a rebate total of **£218,901 (26% of income generated)**. This equates to almost the total *standard base rate* contributions paid by the remaining 21 registers - $21 \times 10,500 = \text{£}220,500$. Not a single penny of the *standard base rate fee* has been invested in the programme, it has all been used to subsidise two registers and these are not one-off rebates, they will be applied every year until a fair and proportionate fee structure is implemented. It is alarming that the PSA is awarding preferential treatment and conditions to dominant registers and has representation at BACP business meetings.

The PSA's vision for the future sees the amalgamations of registers as a stepping stone towards a single register for each profession and potentially a single register for all health care professions. Amalgamations may be beneficial if they are the product of mutual collaboration, but it is a different matter if they are the product of market manipulation and political manoeuvring backed up with financial incentives in the creation of professional monopolies.

The Society of Homeopaths which joined the AR programme in 2014 issued a statement on 23 July 2021 stating although the society's mission remains to ensure that patients receive the highest standards of care, changes to PSA's fee structure, which favours larger bodies has effectively priced them out of the scheme.

Practitioners on registers priced out of the market who do not comply with NICE guidelines and will be discriminated against by the PSA's awareness campaign even if they remain committed to the programme. Their right to earn a living will be seriously impaired with many having to migrate to larger registers in order to survive – thus boosting the market share and influence of dominant registers in the creation of professional monopolies. It must be remembered that AR programme register holders are not necessarily representative of the profession they are related to, this is clearly the case in the field of counselling and psychotherapy. Many counsellors and psychotherapists have multiple registrations and professional affiliations not all linked to the AR programme. The expertise and professional standing of such professionals should not be placed in jeopardy for the reasons outlined here.

The PSA is aware that amalgamations will threaten the financial self-sustainability of the AR programme. The PSA has lost **£41,455** in revenue with the creation of the second largest register. If this trend continues and the programme is reduced to say six dominant registers each paying a *maximum contribution* of **£60,000** net income will be reduced to **£360,000**. This is not sufficient to cover the forecasted expenditure for 2020-21. The PSA will have to act long before this happens by either increasing fees to six figure amounts, which is doubtful, or by introducing a *per-registrant fee* – so should be implemented without further delay.

Conclusion

This paper has demonstrated that the PSA's vision for the future of the AR programme is seriously impaired and is not in the public interest. The PSA should ensure that the AR programme is discharged in collaboration with all register holders and in accordance with the ethos and standards they signed up to. Instead of abandoning the ethos of the programme the PSA should attend to those objectives it has so far not adequately achieved:

- Encourage as many voluntary health care registers as possible to join the AR programme
- The adoption of a fair and proportionate fee structure that does not price small registers out of the programme or deter new registers from joining.
- Does not restrict market conditions and service user choice through the creation of professional monopolies and cartels.
- Embraces research methodology consistent with the treatments and therapies covered by the programme.
- An awareness campaign promoting the benefits of the programme.
- Provision for the registration of *social care workers* as necessary under the *Health and Social Care Act (2021)* – not funded by the *health care registers*.

At the onset of the programme the PSA made the distinction between small, medium and large sized registers and ensured that at least one of each size was included in the first batch of accreditations. Now the programme is established the PSA is abandoning the principle of inclusivity and introducing measures to marginalise small registers and through a process of attrition price them out of the programme, in the creation of professional monopolies in the form of dominant registers. Assuming the role of professional lead these dominant registers will forge the wider field of health care including counselling and psychotherapy in their own Image. It is an error to assume that any single register or combination of registers, whether self-appointed or through selective collaboration with the PSA, are well placed to be the champions of counselling and psychotherapy or any other profession. It is inconceivable that the PSA would foster special relations with dominant registers and allow the programme to be used as mechanism for manipulating market conditions. All register holders should be active in determining the shape of the programme and their professional destiny. It is not in the interests of the public or the professions to allow the PSA's vision to come to fruition.

The PSA's consultation process could be more transparent and collaborative. The PSA has invited feedback but only in respect of predetermined strategy decisions. There was no consultation with register holders about the decision to abandon the ethos and fundamental design principles of the programme. What started as an invitation for registers to join a voluntary assurance scheme is now being transformed into the standardisation of health care professions within very narrow parameters. The PSA's decision making process is not based on *transparency, respect, fairness, and teamwork* as it proclaims. It is selective about what can be discussed, how it is discussed, who is involved in discussions and what is decided.

If the government is intent on bringing all or some health care professions under statutory regulation and we are not sure that is the case, then the legal mechanisms for implementing this should be implemented allowing all stakeholders to have a voice not just those favoured by the PSA - the manipulation of the professional field by stealth is not acceptable.

The PSA is aware that its vision for the future of the AR programme goes beyond the remit and powers granted under the *Health and Social Care Act (2012)* and that retrospective legislation may be necessary in order to attain its objectives – Parliament will have to catch up with the PSA. However, until such legislation is in place, the PSA remains accountable for the implementation of the programme under existing legislation and the programme’s current design principles, which all registers signed up to. The PSA is exceeding its authority by transform the ethos of the programme on a unilateral basis. *Right touch regulation* is becoming *omnipotent imposition*.

Psychoanalytic and Humanistic Psychotherapy approaches are well established in the UK and have influenced understanding about human nature in all walks of life including education, child development, social work, nursing, business management etc. However, if Sigmund Freud and Carl Rogers, the leading exponents of these approaches were contemporary innovators, it is doubtful if their work would be accommodated within the *problem-centred* rather than *people-centred* parameters of the PSA and NICE. This narrow-minded reductionist imposition must be reformed!

The PSA’s abandonment of the AR programme’s ethos and fundamental design principles; the implementation of a discriminatory funding model; and alignment with NICE guidance is not in the public interest. The application of such measures could have far reaching effect, manifesting in the replication of NHS limitations in the independent sector and the erosion of service user choice particularly for the most vulnerable.

The UKAHPP Board has attempted to address its concerns with the PSA but to no avail, the status quo prevails. The option of submitting a formal complaint has been considered but as PSA procedures do not have provision for independent adjudication and the PSA makes rulings about its own conduct, this does not instil confidence and is not a viable option.

The UKAHPP remains committed to the success of the programme and cannot stand back and watch diversity and service user choice be ripped away from the heart of counselling and psychotherapy and other UK health care professions.

If you share our concerns please forward e-copies of this briefing paper with any additional comments you may have to enquires@pco.gov.uk or mail to:

Privy Council Office
Room G/04
1 Horse Guards Road
London
SW1A 2HQ

and an e-copy to your **Member of Parliament** using the ‘**Find your MP**’ link at <https://members.parliament.uk/members/commons>

It would also be beneficial if you could also send an e-copy of the briefing paper to colleagues and others who may be interested.

Thank you.

John Fletcher - UKAHPP Chair

Derek Lawton - UKAHPP General Secretary

On behalf of the UKAHPP Board of Directors

References:

Cooper, M. (2008) *Essential Research Findings in Counselling and Psychotherapy: The Facts are Friendly*, London: Sage.

Lambert, M.J. (1992) *Psychotherapy outcomes research implications for integrative and eclectic therapists*. In Norcross J.E. and Goldfried M.R. (Eds) *Handbook of Psychotherapy Integration*, New York: Basic Books.

Yalom, I.D. (1989) *Love's Executioner: and other tales of psychotherapy*, London: Bloomsbury.



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UKAHPP is a *Professional Standards Authority Accredited Register Holder* and an *Accrediting Member of the United Kingdom Council for Psychotherapy with the Humanistic & Integrative Psychotherapy College and the Psychotherapeutic Counselling and Intersubjective Psychotherapy College.*

Appendix 1:

List of AR Programme Register Holders as at 31 May 2021

Register Holders	Abbr.	Register Size
British Association for Counselling and Psychotherapy	BACP	41,657
Academy for Healthcare Science	AHS	14,115
UK Council for Psychotherapy	UKCP	8,598
Federation of Holistic Therapies	FHT	7,334
National Counselling/Hypnotherapy Council	NCS/NHS	6,999
Complementary and Natural Healthcare Council	CNHC	6,595
Register of Clinical Technologists	RCT	2,443
Play Therapy UK	PTUK	2,378
British Acupuncture Council	BaC	2,156
British Psychoanalytic Council	BPC	1,785
UK Public Health Register	UKPHR	1,206
Alliance of Private Sector Practitioners	APSP	1,123
British Association of Sport Rehabilitators and Trainers	BASRaT	977
Association of Christian Counsellors	ACC	886
Save Face	SF	833
Association of Child Psychotherapists	ACP	705
COSCA (Counselling and Psychotherapy in Scotland)	COSCA	702
Joint Council for Cosmetic Practitioners	JCCP	454
UK Board of Healthcare Chaplaincy	UKBHC	373
British Association of Play Therapists	BAPT	371
Human Givens Institute	HGI	249
International Federation of Aromatherapists	IFA	229
UK Association of Humanistic Psychology Practitioners	UKAHPP	162