



Final Report on the Impact Assessment of the SCoPEd Framework

December 2022

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Key Points

1. In our opinion the prospective impact of the SCoPEd Framework on the therapy profession is positive and important.

The framework will make substantial contributions to: clarifying for those who train therapists what that training must cover if it is to qualify the trainee for entry into the profession; clarifying for those who wish to become therapists which courses will provide the training they require for the role they wish to fulfil; making explicit the ways in which therapists may advance their professional development; facilitating commissioners and employers to understand more fully the mix of competences that they require in relation to the therapy needs of the intended beneficiary group; and ultimately facilitating clients, patients and service users to understand more fully the different competences that therapists offer.

2. These transformative contributions are contingent on the way in which the work is taken forward.

The strategic objectives that the Partners set for SCoPEd draw our attention to the dependency of its success on equality, diversity and inclusion (EDI) considerations. Choice and access to high quality practitioners are to be delivered 'regardless of location or circumstance' (Objective 1). Success in advancing the EDI agenda in relation to the profession provides: a route into engagement with the framework for those therapists who remain open to it; a focus on equality about which there is broadly shared agreement across the profession; the creation of a constructive challenge for the Partners in relation to the process through which they will establish measurement metrics that are 'owned' by all; putting in place the architecture to ensure appropriate regular monitoring and periodic evaluation of data carried out with high quality evidence; reassurance and transparency on the progress being made, and entry points, progression routes, grandparenting arrangements etc. that are being processed across the Partnership in meaningfully standardised ways, which respect the shared understanding of the framework and still allow for individual organisational requirements.



3. An important space can remain for those therapists who are unconvinced of SCoPEd's desirability if the framework is taken forward.

If such a space is not available, then it remains unclear how their views are to be channelled into the adoption and implementation of the framework. Leaving these critical voices outside the process runs the risk of reproducing the current confrontational and oppositional debate in the future. Our consultation suggests that some of those who maintain their critical position remain open to the possibility of engagement with the process. One possibility would be that a 'what works' group might serve as a space for therapists, regardless of their SCoPEd position, to engage on how the practice of therapy would best advance the EDI agenda in the profession and, more generally, how the profession may be developing as a result of SCoPEd. As the focus will be on practice, we intend that the debate may shift towards the realist's questions of 'what works, for whom, in what respects, to what extent, in what contexts, and how?'

4. The continuing buy-in of external stakeholders, both commissioners and employers in public and private sectors, and training agencies, both in further, higher and postgraduate settings, university, and private sectors is fundamental to the likelihood of success in bringing about the intended changes.

One idea, which external stakeholders received positively, was the proposal that there should be a 'stakeholder forum' that would create a space for deliberation by representatives of these agencies and Partners on the challenges and opportunities that the changing context offered. It would be essential that the terms of reference for the forum would make explicit that its function was deliberative. It would operate alongside the SCoPEd Oversight Committee (SOC), to which it would report, but without decision-making authority. It will be important for the SOC to listen to any stakeholder forums created, as well as share with them to create ongoing helpful dialogues. How stakeholder forums work and who participates would be an ongoing area for reflection.

5. A document that positions 'what this means for me' would make explicit the mechanisms through which the framework is to deliver value to stakeholders.

It would sit alongside and guide the Partners' implementation plans.



Executive Summary

Our consultation with institutional stakeholders, including training providers in both higher and vocational education settings and those working in commissioning and purchasing of therapeutic services, suggests they are confident in the positive benefits for those seeking therapy from the establishment of a competency framework for the profession. Commissioners noted that a preference for recruitment from one column was not a given and that the availability of guidance from a trusted source would be welcomed in order to assist with workforce planning.

There was general agreement across all those whom we interviewed that a competency framework could make a significant contribution to the profession. A minority of those we consulted were less convinced of this framework making that contribution, especially in relation to the unresolved issue of titles. This issue remains core to the opposition of some we consulted in groups from outside the Partnership.

The majority of interviewees were therapists. Many were interviewed for a role or knowledge in addition to their practitioner experience or status (e.g. trainers, membership body personnel, professional community voices) and are discussed within the report as 'stakeholders' alongside the non-practitioner stakeholders such as commissioners. Another subset was interviewed solely on the basis that they were active practitioners. For the most part these therapists welcomed the idea of a framework but had some varying reservations about the SCoPEd Framework, especially in relation to the issue of titles.

Clients, service users and patients were highly receptive to the logic underpinning the framework and immediately grasped how the framework facilitates choice.

Below we comment on the findings in relation to the primary aims and objectives of SCoPEd, and additional issues on which the impact assessment was to comment:

- Does the framework provide stakeholders with the required clarity on the standards and competences of therapists?

Stakeholders typically reported that the framework does provide this clarity.

A few stakeholders noted that they perceived the framework as informed by a 'medical model' that downplays the social construction of distress; one reported that clarification of the use of the term 'ability' in the Glossary would be helpful; and another, while finding it initially 'daunting' did welcome the specification the framework contains.



- Does the framework ensure that clients, service users and patients can make informed choices and have better access to high quality practitioners regardless of location or circumstance?

Noting that the framework is not a public-facing communication, our interviews with a small sample of 12 individuals who are in or have recently completed therapy, suggests that, for the most part, the core ideas of the framework appeal intuitively to them, and they would welcome a 'plain English' single page that would summarise and tailor the content for the audience.

The perspectives of those working on the training of therapists suggest that this enhancement should flow from the greater clarity on what is meant by (and therefore mapped by the framework) competences and standards, and how they do or do not relate to issues (not mapped by the framework), such as therapy outcome measures and an individual practitioner's specific capability, qualities or specialisms. If the adoption and implementation of the framework addresses the EDI agenda, we anticipate that the ability to access a broader range of appropriately trained, knowledgeable and skilled practitioners will increase for those currently under-served by the profession.

- Does the framework provide clear, accessible, jargon-free information on core training, practice and competence requirements for informed choice?

For the most part feedback from training providers suggests this is the case.

- Does the framework champion high-quality practitioners to policymakers and service providers?

At the current time, it is not possible to analyse this in a statistical way, however working towards an impact measurement system will enhance the capacity to evidence and progress on this objective. Interviews with commissioners during the consultation suggest that the evidencing of highly trained therapists across the framework is seen as useful and impacts on their understanding of what they need for workforce planning. The fuller the clarification the Partners are able to provide on the quality of all column therapists, the greater the use commissioners and employers will make of it.

- Does the framework provide vision and structure for professional development and progression?

Entry points and progression routes seemed reasonably clear to practitioners, but the costs of training generally, and a perceived need for more advanced training because of SCoPEd remained a concern.

- Does the framework create clarity for current and potential employers?

Feedback from employers was highly positive about the clarity the framework brings.



- Does the framework strengthen and enhance the benefits of the Professional Standards Authority (PSA) Accredited Register programme?

The framework offers the future prospect of understanding the shared standards across the registers of the Partners, and any other bodies that may map their membership to SCoPEd in the future.

- Titles

The dispute over the 'titles' represented by or attributed to the framework columns continues and is part of a wider issue within the profession. Those opposed to the framework remain convinced that it reduces the status of counselling and privileges that of psychotherapy, and link this to the titles issue of what applies to the columns and who may or may not be able to use which.

Some interviewees suggested their own possible solutions e.g. all should be termed 'psychotherapist', a new, singular title, 'mental health and wellbeing practitioner', proposed differentiation according to training and experience and or specialism. We note that none of the conversations addressed the perceived denial of professional identity, which seems to be an important part of what is at stake for some therapists, nor did they acknowledge the current position of the framework, which notes that research found no evidence of psychotherapy trainings in column A. More significantly the conversation did not meaningfully move the current discussion on the issue of titles beyond the realm of opinion, preference or more siloed understanding.

- Withdrawing from SCoPEd

The report acknowledges that the framework is already in the public domain and that the Partnership sees value and opportunity in their collaboration. Our commentary on the broad characteristics of the field in the absence of the framework being taken forward (as in adopted and implemented), points to the centrality of advantage and disadvantage for entry into, and progression within, the profession. We make the case that the success of the framework should be seen in relation to the EDI agenda and that Partners' data systems must transform from where they are currently in order to monitor and evaluate performance in relation to EDI. The report also highlights the strategic and professional risks of non-adoption and implementation of SCoPEd.



- Availability of data

The data the Partners were in a position to share were varied and, in some cases, extremely limited. The request for line-by-line data including membership category, postcode and any protected characteristic collected was met by three Partners, although the collection of protected characteristics data by these Partners was limited. The report's quantitative analysis therefore relates to three Partners with a focus on socio-economic factors. With regard to socio-economic features, there is little apparent difference between the membership categories (and the framework columns to which they map) on the one hand, and the relative advantage or disadvantage of the places in which therapists live, on the other hand. All tend to live in those areas that are on average among the 40% of the most advantaged neighbourhoods. A 2022 survey by one of the Partners (whose membership categories currently map to columns A and B) provided data from approximately 4,000 qualified and training therapists. This survey suggested some modest differences in the reactions to the framework of people sharing a particular 'protected characteristic'. Gender, disability and sexual orientation all correlate with reactions to the framework – men are less supportive, people with a disability were less clear on which column they mapped to, and LGBTQ+ members were less likely than others to endorse any supportive opinion statements.

As noted above, evidence of SCoPEd's impact on accessibility within the profession will require a more robust collection and analysis of data.



Overview of Findings

Commentary on the implications of one or more Partners not adopting the SCoPEd Framework

Strategic implications

In the event that the Partners do not take the project forward, we expect that the therapy field will continue to operate in ways similar to those currently.

The shift towards establishing collaborative relations among the Partners, and the greater levels of trust and willingness to work towards shared objectives, will continue. However, without the practical goal of agreeing the competences and standards, these relations may weaken over time. It would seem likely that the appetite of the Partners for another significant professional development initiative, for the collective benefit of the field as a whole, would decrease. Publication and adoption of the SCoPEd Framework has proved to be a much more drawn-out process than originally anticipated. The process of reaching agreement on the framework itself has not been the only task, and this report was conducted during a period where each Partner was following their own processes to determine whether they will agree to adopt and implement SCoPEd within their own organisation, and was working in partnership to determine how mechanisms for and shared principles about movement throughout the framework will work. The work has been complex, and involved considerable interaction and attention across the Partnership. The decision to embark on a comparable collaborative intervention would likely be taken only with considerable reservation.

Our understanding is that the sector expects the profession to present a reasonably clear prospectus of what the profession wishes to offer, and our consultation suggests the framework would deliver on these expectations. In the event the Partners were not in a position to offer this, stakeholders would not have available to them the benefits that the framework should deliver, and the likelihood of the deployment of the profession at scale inside the NHS, for example, seems likely to be lower than it would be were the project taken forward. At the time of writing an NHS pilot of a fully funded training programme for psychotherapeutic counsellors whose curriculum is mapped to the SCoPEd Framework and is intended to be accredited by the SCoPEd Partnership has recently commenced. Non-adoption of the framework and dissolution of the SCoPEd Partnership would remove the opportunity to inform and accredit such training pathways now and over time.

EDI and accessibility implications

There is of course uncertainty about how the characteristics of therapists (and how these might be represented in different areas such as work and training settings) might change if the project is not taken forward. Our assumption is that there will be little change in the current composition of the profession unless we intervene.



Our assessment of the quantitative features of the two dimensions was constrained by the availability of data. The lack of data generally and synthesisable data in particular was an unfortunate theme when considering how we might analyse the make-up of the profession. Again, we emphasise the need for a new approach for the profession in relation to collection and monitoring of data, building on the success of EDI-centred development in the public, voluntary and private sectors.

Three Partners were able to provide postcode data that enabled us to use the Index of Multiple Deprivation (IMD) as a measure of the geographical distribution of social advantage and disadvantage. It is important to note that IMD describes the areas in which people live, not the people themselves, and that this is not a mapping or equivalent to protected characteristics. Nevertheless, the data does bear on the geography of social class and the advantage that flows from it with one interviewee stating that ‘social class is [a] variable’ when considering the profession in relation to equality, diversity and inclusion, and likely has some impact on the experiences that therapists support clients and patients to manage.

The data from the IMD are described by deciles, which are the population divided into 10 equal groups. The groups range from the top 10% deprived areas to the top 10% least deprived areas. The lower the score of decile, the more deprived the area.

Analysis showed therapists tend to live in areas that are among the 40% most advantaged in relation to income (including income deprivation affecting children), employment, education, skills and training, health (morbidity, disability and premature mortality), and among the most advantaged 50% of the population in relation to victimisation through crime, barriers to housing and other services, and the quality of the ‘living environment’ in which they live. None of the median scores (that is the ‘middle’ score) fall in the most deprived half of the areas, where (roughly) half of the population lives.

We also noted that from analysing the data received, which contained membership categories across each of the three framework columns, no difference in IMD decile was seen across the A, B or C columns, indicating that the socio-economic circumstances of where a therapist lives is not strongly related to their current membership category.

Table showing median scores for therapists’ overall IMD decile and age

| | Membership categories mapping to Column A | Membership categories mapping to Column B | Membership categories mapping to Column C |
|------------|---|---|---|
| IMD decile | 7 | 7 | 7 |
| Age | 52 | 58 | 56 |



Table showing the advantage/disadvantage of the places where therapists live

| Factor | Median of therapists' postcodes |
|--|--|
| Overall IMD decile | 7 |
| Income | 7 |
| Income deprivation affecting children decile | 7 |
| Income deprivation affecting older people decile | 6 |
| Employment | 7 |
| Education and skills | 7 |
| Health and disability | 7 |
| Crime – risk of victimisation | 6 |
| Barriers to housing and services | 5 |
| Living environment | 5 |

The chart above shows that the median score (that is the middle score) of therapist postcodes is in the middle to top end of the IMD distribution. The financial, educational, cultural, environmental and social assets and resources located in these places are substantially different from places at the other end of the IMD's distribution.

However, higher median scores on the income and employment factors may have an effect on who can afford to undertake costly training and CPD (noting that therapists 'tend' to live in the higher decile areas does not mean all therapists do, or that they do when they commence training). Similarly, higher median scores generally may be seen to put therapists as having had a different lived experience than people at the disadvantaged end of the distribution.

Of course, socio-economic disparities are not the only dimensions of inequality that play a part in choice of those seeking to enter the profession, which types of training they may be able to afford, how they view onward development opportunities. Nor are they the only dimensions of inequality that play a part in choice and accessibility of therapists for those clients and patients who will have to fund their own therapy. However, in this report both the data we were able to access and the chief concerns raised in interviews focused on socio-economic factors.

In our view, should one or more Partners not adopt and implement the framework the current 'Business As Usual' model of advantage will continue. The limits on the accessibility of the profession to people from less advantaged social positions cements this association. This, in turn, denies the profession the insight into the lived experience of the less advantaged third of the population. Health inequalities (including mental health and wellbeing) will likely continue to be core concerns for public policy. If the profession is unable to make credible moves towards becoming a more inclusive occupation, its relevance to policy will decrease.



Number of People Accessing Therapy

The Health Survey for England shows considerable uptake of therapy across the adult population. The most recent material NHS Digital made available is from 2019, covering the year before the pandemic. There is widespread agreement that the negative effects of COVID and the cost of living crisis increased levels of emotional distress. The table shows estimates of the uptake of different therapies. We assume these numbers will have been higher since 2019.

Table showing whether adults received counselling or therapy during previous 12 months

| Received counselling or therapy | % |
|--|-------|
| Counselling, including bereavement counselling | 2.95 |
| Psychotherapy or psychoanalysis | 1.52 |
| Cognitive behavioural therapy | 2.49 |
| Mindfulness therapy | 1.14 |
| Alcohol or drug counselling | 0.40 |
| Couples or family therapy | 0.33 |
| Social skills training | 0.22 |
| Art, music or drama therapy | 0.16 |
| Sex therapy | 0.04 |
| Another type of therapy | 1.43 |
| None of these | 91.81 |
| Any therapy in the last 12 months | 8.19 |
| Base is all adults – weighted | 8,197 |

Source: Health Survey for England 2019, NHS Digital, Copyright © 2021 Health and Social Care Information Centre.

Around one in 12 adults (8.19%) accessed some form of therapy over the previous 12 months (within and or outside of the NHS). Just over half (55%) of these adults accessed counselling, psychotherapy or psychoanalysis. Twice as many accessed counselling as psychotherapy or psychoanalysis (2.95% compared to 1.52%). Women tended to outnumber men in accessing the services by two to one. Comparable data from the other nations are not available.



Protected Characteristics of Therapists

The Equality Act 2010 sets out nine 'protected characteristics' (age, gender reassignment, being married or in a civil partnership, being pregnant or on maternity leave, disability, race including colour, nationality, ethnic or national origin, religion or belief, sex and sexual orientation). The Act makes discrimination illegal on the basis of these characteristics. There is widespread acceptance that it is unfair to discriminate against people on the basis of these characteristics but that equality issues are much broader than these characteristics. Nevertheless, they provide a benchmark against which we may calibrate the attention, which current data systems accord to this important legislation.

The data the Partners were in a position to share on the protected characteristics of members were limited. Three Partners were able to supply membership data in relation to some, but in no case, all nine protected characteristics. Typically, the data supplied covered age and gender but also religion in one case. The same three Partners were able to supply membership data in relation to postcodes, which we used to explore socio-economic factors. (We understand that the process through which the membership data and or customer relationship management systems do or could incorporate 'protected characteristics' fields differs across Partners. The data that the three who were in a position to supply material were in a variety of formats. This, in turn, gave rise to additional data cleaning tasks as we integrated the data from each into a common format. There would be considerable efficiencies in the Partners adopting the same software solution should they wish to produce a more robust and effective method for capturing and monitoring these data. This would help build the confidence of stakeholders that the evidencing of competences was equivalent across Partners).

The median age across the three is 52 and 16% are men. The median age of the UK adult population is 40 and men account for 48%. The age difference may be understood, as therapists often tend to be in second careers. If there is a pronounced growth in therapist employment inside the NHS, as some stakeholders anticipate, it will be important to ensure that any gender differential is monitored so that women are not inadvertently disadvantaged if a more gender-balanced workforce is recruited meaning proportionately more men than women secure those positions. Please note that when we report here using the male or female binary that reflects the differing approaches to data collection and reporting within the Partnership.

One of the three Partners supplying membership data also stated their institutional members had additional data on the members' status in relation to the 'protected characteristics' however those data were not available for analysis here.



Protected Characteristics and Perceptions of the Framework

One Partner was in a position to provide recent survey data on perceptions of the January 2022 framework alongside therapists' status on protected characteristics.

The table shows the average score on a 5-point Likert scale item.

All six average scores are above the mid-point (2.50) on each scale item. More members agree rather than disagree that they are familiar with the framework, perceive it to be a positive development on the earlier version, feel they understand its aims, understand the mapping of membership category to framework column and believe in the delivery of SCoPEd's aims.

Table showing the average score on attitudes towards the framework

| Attitude towards... | Average score |
|--|---------------|
| Familiar with framework | 3.25 |
| Perceives positive development from previous framework | 2.90 |
| Understands aims | 3.34 |
| Supports aims | 2.84 |
| Understands membership category maps to column | 2.99 |
| Believes aims can be delivered | 2.59 |

Our analysis of these data suggests there is an influence of the status on protected characteristics on the attitude to the framework. The tendency is reflective across membership categories: members in column A are less supportive across all questions, than column B.

The analysis of the survey data aimed to establish if there is any significant difference in opinions of groups of members who have protected characteristics. This has been done by using two-sided t-test to assess if the average response scores between different sub-sets of responses were significantly different (at 95% confidence level).

Age. Overall, age is not a significant factor in supporting the SCoPEd Framework. There is some significant variance, however. A younger cohort of members (under 35 years old) are less supportive of the aims of the framework compared to their older peers. Similarly, there is also a significant difference in whether they see the framework as a positive development on the previous version (younger members on average see it as a less positive development).

Gender. There is a significant difference in how members of different genders see the framework. Female members are more likely to support the aims of the framework and feel positive about the framework achieving its aims. There is no significant difference across other questions.

Disability. There is a significant difference in opinions between those members who have a disability and those who do not. Members with a disability less frequently agree that 'I can see where I would fit within the SCoPEd Framework' in terms of Membership Category mapping to column Status (A, B or C).



Religion and belief. There is no significant difference in opinions between those who are religious and those who are non-religious.

Sexual orientation. Sexual orientation is an important factor in the difference between some of the opinions. LGBTQ+ members were less supportive on the following statements, compared to the heterosexual members, showing a significant difference in opinions:

- 'I am familiar with the updated SCoPEd Framework'.
- 'I think the January 2022 Framework is a positive development on the previous version'.
- 'I feel supportive of SCoPEd's aims'.
- 'I understand where membership categories map to the SCoPEd Framework'.
- 'I feel positive about SCoPEd being able to deliver on its aims'.

Marital status. There is also a significant difference in opinions of members who are single and who are married. Members who are single are less supportive of all the statements apart from 'familiarity with the statement'. The difference between opinions of single members and married members is statistically significant.

The data show that some of the members' status on protected characteristics does correspond to differences in the perceptions of the framework. There are two important features of the data that readers should bear in mind – the sample size was large and so even small differences on the 5-point opinion scale will be statistically significant.

Voices of Therapists

A market research firm recruited a sample of six therapists for interview. The market research firm was provided with a brief to recruit interviewees who represented, as far as was practicable, demographics and characteristics within the therapist and general population. Some communities (such as those identifying beyond the gender binary) are not represented due to factors, such as not responding to the invitation to interview or not meeting the survey criteria in some way, such as not being a member of a registered professional body.

The sample was equally split between male and female and covered all four home nations. One interviewee was a member of a minority ethnic community, one identified as disabled. There was an equal split of over and under 40 years of age. Two interviewees were in employment in the third sector, four were in private practice.



Our interviews suggested that:

1. The decision to enter the profession followed from their own personal experience of therapy, an introduction to therapy as part of their higher education, a desire to enter a caring profession, or a path that followed another career that flowed easily into therapy. One recalled little awareness of the different training programmes on offer until after they had embarked on a training course delivered in a further education college.
2. All had completed formal training, and the cost of course fees was deemed high, especially by those at earlier stages in their career, with financing relying on personal debt and savings or parental support, and a common perception that the 'woman, middle aged and middle class' cliché still rang true, with the social class dimension being important for those entering the profession from other backgrounds. One of the participants suggested that an apprenticeship scheme and bursaries could ease the financial barriers. The latter would be particularly important for people with greater 'lived experience' wishing to enter the profession. For the most part, these therapists viewed their professional practice as part of an activist stance in relation to social justice issues.
3. All reported some level of familiarity with the framework, ranging from it being brought to their attention during training, to an in-depth familiarity with the framework and the titles debate. Two reported having read the framework document in depth and a third reported following coverage in membership bodies' publications. The therapists, for the most part, broadly welcomed the collaboration among the Partners, and noted that joint-working was an opportunity for learning across the different bodies.
4. All shared support for the underlying rationale of specifying the competences that professional practice required. There was general agreement that some form of differentiation as regards training and experience was appropriate but little on the issue of titles, although most did think that naming the different levels of competence was more appropriate than the current lettering. For one, they felt this was helpful to communicate more clearly to potential clients. For another they perceived an issue with the Partners themselves reaching agreement through debate and compromise on naming. Commonly, the participants drew on their own professional development experience to highlight the importance of greater clarity on the competences of therapists.
5. Without disputing the bona fides of the Partners, those who were more familiar with the framework, for the most part, shared one or more of the following criticisms of the project – a perceived diminishment of counselling and humanistic perspectives, a perception of diminishing of column A therapists especially in regards to value of their experience and accomplishments, a perception of more generally privileging of expensive formal training over other training routes and experience.



6. The relationship of trust between therapist and client or patient was a core element that was important to all six, and for those more critical of the framework, there was a perception that it was driven by the needs of employers of therapists and their professional bodies than by the desire to deepen or protect this relationship.
7. Within this group of therapists there was a perception that the framework's content would result in the need for practitioners to invest further in costly training and that accessibility to the columns will become dependent on people's backgrounds.
8. When discussing titles in relation to SCoPEd and more generally within the profession, the group broadly shared a consideration that statutory regulation of titles was desirable, and provided an alternative route to address the rationale for the framework.

Voice of Clients, Service Users and Patients

The same market research firm recruited a sample of 12 clients, services users and patients for interview.

The sample was equally split between male and female and covered all four home nations. Four were members of minority ethnic communities. There was an equal split of over and under 40 years of age. There was an equal split of those completing therapy in the last six months, the last seven to 12 months, and the last 13 to 18 months.

Our interviews suggested that:

1. Ease of access to therapy was important, with many stating that waiting for a referral from a GP was typically not feasible.
2. For those seeking out therapists rather than waiting for referrals, this was often via their own networks of family and friends, Google, and great attention paid to claims on therapists' web presence. None mentioned Partners' websites.
3. Those with strong heritage and faith community backgrounds tended to believe that cultural competence was an important factor, in that it would equip the therapist with an understanding of the norms common in their community. However, this was not always noted as requiring the therapist to share the same background as them.
4. The perception of the skills and abilities of the therapist were very important in decision-making about which therapist with whom to work, but personal recommendation was also a strong factor.



5. In the large majority of cases, they believed that the skills' levels of therapists varied, and they tended to give equal weighting to education and experience credentials. When considering the idea of a framework to help with this they felt that the 'ABC' headings could be as useful for them as any other headings, when combined with a 'plain English' summary on a single page that outlined the competences each would bring.
6. Choice of therapists was important, but those whose choice was limited (due to access via GPs or EAPs) reported as positively about their experience as those independently accessing therapists, with one specifically noting they felt sourcing their own therapist would have been a challenge and that in their case they trusted the EAP to refer them to the right person.
7. For those accessing therapy via a referral, the ending tended to be initiated by the therapist, whilst for those accessing therapy privately, cost was a major consideration in bringing work to a close.
8. None of the clients, service users or patients reported that they perceived their therapists were ever working outside of their competence, and all felt that if a major issue arose, they would have felt confident in knowing how to have the issue addressed by a third party.



Risk Commentary

We adopt the three-way classification of risk proposed by Kaplan and Mikes. (Managing Risks: A New Framework - Smart companies match their approach to the nature of the threats they face. Robert S. Kaplan and Anette Mikes, HBR, 2022).

The three categories are:

1. Preventable risks, as they originate from inside the Partnership, within Partners' authority. These are in theory preventable, the mitigation options being to avoid or eliminate the occurrence of the risk event. However, the issue may be at what cost?
2. Strategy risks, flow from both the explicit strategy, here treated as the purpose and objectives set out for the framework, but implicitly and informally, from other features, e.g. the influence of organisational history, different understanding of collaboration. These risks are not preventable if one retains the strategy; they are inherent in the strategy. While the analogy to market-based firms should not be pushed too far, the proposition that the risks are proportionate to the (prospective) gains applies in this third sector context as well. The mitigation will either reduce likelihood of risk event or its severity of impact.
3. External risks originate from outside the Partnership, but from inside the broader field in which the therapy profession, the Partners and their stakeholders all operate. This needs to be seen alongside others, e.g. the health policy community distributed across the four home nations, professional bodies not involved in the Partnership, some of these sharing more in common with the Partners than others. All of this goes to make up quite a complex field, in which the uncertainty of mitigation is high relative to the other two categories. With these risks, the opportunities for mitigating through reducing the likelihood of the event may be modest. More attention to reducing undesired impact may be more feasible.

Preventable Risks

There is a risk that Partners' membership data systems do not facilitate EDI-relevant analysis of progress in widening access to and progression within the profession, and so in turn ensuring that the framework does not exacerbate barriers to access and progression. Those critical of the framework continue to raise concerns that it will entrench the differential access to the profession of minoritised communities, there is no way to sufficiently evidence or mitigate these perceptions without robust collection and monitoring of data. As noted earlier there were significant challenges in obtaining useful data from the Partners on the protected characteristics and other data related to the demographics of their membership. In the absence of such data, it will not be possible to demonstrate and strengthen the proponent's aim to use the framework as a means to widen access.



Strategy Risks

In our opinion the presentation of SCoPEd should focus on framing the issues in such a way that the benefits are made explicit for organisational stakeholders, therapists and their clients. 'Telling the story' of how the framework and the Partnership will actually do this may be a more effective response that does not make later re-engagement by the critics even more remote.

There is a significant risk that therapists who are critical of the framework and remain apart from the process (perceiving the development of this as 'behind closed doors') will continue to express their opposition to it amplifying concerns that those in column A with many years' practice will have a diminished professional status. Whilst it's noted that some stakeholders we consulted shared this concern about impact on column A; others disputed it. However, such continued opposition has implications for how and where the storytelling of SCoPEd continues for the therapist audience.

During our consultation we were assured by those critical of SCoPEd that their dispute lay within the specifics rather than the proposal per se. While acknowledging the sustained efforts of the Partners to engage constructively with their critics, it may be useful that a mechanism is in place to create a space in which the substance of criticism and impact may be tested over time. It may not resolve all the issues, but provides a mechanism in which movement towards a reality of exploring what works, for whom, in what respects, to what extent, in what contexts, and how, unites a common goal of improving access and progression within the profession. Putting in place a Stakeholder Forum could provide a space for this constructive dialogue, and thus we propose that the Partners establish this during the implementation phase so that therapists may refer issues that arise as they apply the framework, with the forum focus being on the process through which the framework is put into practice. Stakeholder Forums being in place may also prove useful for addressing 'behind closed doors' perceptions of any future SCoPEd work.

External Risks

Stakeholder forums may also be helpful for building trust, relationships, engagement and understanding with other groups covering e.g. policy, training, commissioning.

Risk and EDI

The framework does contribute to the EDI agenda through making explicit the competences that the profession requires. While it may not change the gradient for differentially resourced entrants, it does clarify for all, what are the required competences. In this sense, the playing field may not be any more level, but at least it is in full view. However, if the progression route requires training for which therapists pay, then these costs will be a disincentive for those with less access to finance. As noted, protected characteristic status will compound the difficulty therapists with lower incomes will experience. The mitigation of this risk would involve ensuring that a variety of pathways would be available to allow therapists to evidence their knowledge, skills and experience, including training and recognition of prior learning (RPL) routes.



While many training providers in regulated agencies will be familiar already with EDI principles, this is not the case for all. The framework adds value for these other providers. However, the reduced participation in the profession of people with lower incomes, compounded for many by disadvantage associated with the protected characteristics, points to the importance of mechanisms that resource training for entry points and progression routes. Making progress on these mechanisms would mark an important contribution of the framework to the EDI agenda. Further work is required to clarify who would be entitled to enter at what column point, and the issues of titles remains important in the minds of some stakeholders. Our sense of this is that the columns are sufficient for the initial implementation period and time is required to revisit this issue, it cannot be resolved simply or quickly, and certainly not at this time. However, a primary goal of clarity may be vulnerable if progress is not made on this issue. It may be helpful in any future work on this to engage with various stakeholder forums.

The quality of data has already been discussed in regard to preventable risk for Partners. However, data will also be important for commissioners and employers in terms of both the therapists they recruit and their clients, service users or patients, and they will have their own ways of capturing and measuring these data. This, and indeed the wider landscape of smaller services and agencies that are beyond the control of Partners, present risk in terms of what data are collected and how they are used in the name of equality and accessibility concerns resulting from adoption of SCoPEd. Certainly, only one of the Partners drew our attention to the way it facilitated and supported members with regard to performance data on issues related to EDI.

One commissioner made the point that they would welcome the framework as part of their toolkit they require for commissioning. There was also interest in other parts of a toolkit, and these include clarification of outcomes for the work and governance of the framework. With regard to the titles, one of our sources inside commissioning suggested that it would be helpful to have guidance on the mix of the three that would be appropriate for NHS commissioning at the scale commensurate with its own staffing and the size of the potential level of demand. It was also our understanding that commissioners were not in favour of purchasing long-term, indefinite therapy.

Commissioners also noted that the preference for B over A was not a given, and that in making more nuanced workforce planning decisions, the availability of guidance from a trusted source would be welcomed. This points to one way to champion the high quality practitioners within column A beyond an assumptive preference for column B. Partners would need to facilitate access to expert, independent guidance for commissioners and employers on the mix and ratio of column therapists that would provide the optimal mix related to the achievement of their objectives.



Risk Analysis

A core element in the narrative of many of the framework's critics is the perception that employers and commissioners will exclude column A therapists. The view of those with experience of employing and commissioning is broadly that decision-makers are already making judgments about the mix of skills they want, and that the framework will provide greater clarity for them on this. In the public sector, there is a recognition that it has a responsibility to facilitate skills' development. Another factor that will feature in the decision-making is the duration of the therapy. There is a preference for clarity on the time-limited boundaries of therapy. The same consideration was present for some of the users we interviewed.



Table of Possible Risk, Prospective Impact and Mitigation Actions.

| Possible Risk | Prospective Impact | Mitigation |
|---|---|---|
| [1 Preventable] Uncertainty about whether Partners or training providers have responsibility to assure training curricula align with framework. | Trainees unsure whether their course maps to the framework results in confusion for them and increases queries to Partners and training providers. | The SOC to consider appropriate e.g. 'kitemark' to signify alignment and how this is to be validated. Individual Partners to work with their accredited or approved providers to ensure clear understanding of course alignment. Clear communications to be prepared for trainees. |
| [1 Preventable] Training that does not address the framework's standards remains in place post-transition. | Trainees are left without assurance on minimum standards and whether their courses fulfil criteria for membership bodies aligning their register to SCoPEd. | Partners engaging with approved and accredited course providers during transition period. SCoPEd aligning courses carry a 'kitemark' post-implementation. Partners to consider how best to continue the signposting of potential trainees to appropriately accredited or approved training. |
| [1 Preventable] Training providers and formalised professional networks remain unclear on the implications of the framework for them. | This would reduce the usage of the framework. | Partners maintain a dedicated point of contact for the stakeholder to provide guidance on usage. |
| [1 Preventable] The risk of stakeholders not being engaged or being consulted on the future of SCoPEd. | This could have implications for understanding, engagement and implementation of SCoPEd outside the Partnership and so impacts on prospect of the aims and objectives being met and may impact on future work momentum (e.g. ongoing impact evaluation, titles) | The establishment of an advisory Stakeholder Forum would create a space through which to distil perspectives and updates to the work and communicate these to the SOC. |
| [1 Preventable] The risk of out-of-scope claims for the framework, arising from the misperception of the framework's boundaries e.g. that it covers all forms of talking therapy or relating it to client outcomes. | The over-claiming will jeopardise the receptivity within and outside of the profession. | Consistent communication on the framework's boundaries. |



| Possible Risk | Prospective Impact | Mitigation |
|--|--|---|
| [1 Preventable] The information systems all the Partners use rely on databases that are not capturing the EDI monitoring information in a way that facilitates analysis across Partners' memberships. | EDI data and ability to analyse these remain incomplete. Trust in SCoPEd as a driver for change vs exacerbator of inaccessibility remains unclear. | The SOC to consider their individual organisation and Partnership approach to data infrastructure. The alignment of information systems across Partners would clarify standard treatment of membership criteria at the application stage, validation of training course content and column entry point. |
| [1 Preventable] Partners' communications do not deliver consistent messaging on if, when, how (etc) adoption and implementation may proceed. | Members and registrants remain uncertain about this, giving rise to anxiety for some, and costs for Partners in responding appropriately. | The SOC and Comms Group agree on a protocol for all current Partners on the content and media for messaging on this. |
| [1 Preventable] Anxiety of members and registrants on framework position increases following a potential positive adoption decision. | Gives rise to need for additional resource as members and registrants require one-off clarifications from Partners. | Each Partner to prepare clear adoption, transition and implementation communications. |
| [3 Operational] Accredited and approved training providers with fewer resources may have difficulty in promptly aligning their courses to the framework. | Risks of delay or overall adherence to SCoPEd. | The Partners should proactively engage with accredited and approved training providers post-adoption to reduce risks of delay in adherence. |
| [3 Operational] Training providers do not specify to which column of the framework their course maps. | Trainees will remain unclear about the competences courses offer them. | Training providers to show mapping to SCoPEd framework as part of accreditation and approval processes. |
| [3 Operational] The perception that the coherence of the framework arises from the institutional interests of the Partners rather than those of therapists. | This may reduce the buy-in of those therapists whose support for the framework has a 'wait and see' aspect. | Continued assurance on the current framework (and any other similar work e.g. updates and titles) that these are evidence based. |
| [3 Operational] The perceived costs of standardisation and shared working (including ongoing evaluation of SCoPEd) could be attributed to <i>any</i> increased administrative costs for members and registrants. | The costs of this might be perceived as being borne by therapists. | Communication on how work is financed. |
| [2 Strategic] Training providers reject the framework and move away from accredited relationships or validation with Partners. | This would jeopardise the achievement of the established objectives. | The Partners should proactively engage with appropriate stakeholders post-adoption to show the benefits of mapping to SCoPEd and maintaining relationships with Partners. |



| Possible Risk | Prospective Impact | Mitigation |
|---|---|--|
| [2 Strategic] The framework does not deliver the benefits on EDI. | The impact arises from the perception that claims for the framework remain theoretical rather than demonstrable. | The SOC tasks a 'What Work's Group' to collate evidence and bring forward innovative proposals on how we meet the EDI aims of SCoPEd. |
| [2 Strategic] The risk of differences in interpretation between Partners on the evidence offered through pathways for credentials of B and C eligibility. | Perception within the profession that the standards of evidence are not being applied uniformly. | Continued Partnership working within the Mechanisms and Technical groups. |
| [2 Strategic] The risk of commissioners and employers favouring column B and C therapists over column A. | Opinion among those interviewed was divided between those who thought this probable, and others thought not. The likely behaviour of commissioners is unclear. The risk makes budget assumptions and available supply of column B and C therapists. These assumptions seem unfounded. | One aspect of the mitigation is clarity on the skills deliverable by column A therapists. This is an important part of the rationale for the Summary for Commissioners we propose. |
| [2 Strategic] The perception of some critics that the process is one that has been carried out 'behind closed doors' reinforces their opposition to the framework. | Diversion of organisational resources from other priorities and collaborative work. | The What Works Group would create a space for dialogue on practical issues that enhances transparency and creates a channel for critics' voices to contribute to the SOC's thinking. |
| [2 Strategic] The mechanisms that facilitate mobility between columns are insufficient (unclear, unrealistic, for other reasons) for those wishing to move columns. | This erodes confidence in the framework and, through time, adds to the critique. | Clear communications on mechanisms required for all appropriate stakeholders. |
| [2 Strategic] The framework fails to reduce the barriers to entry into the profession for people from less advantaged communities. | This would jeopardise the framework's impact on the profession's engagement with EDI. | Partners monitor the changing social profile of members and registrants' entry points and movement across columns and report to the SOC on this. |
| [2 Strategic] The perceived cost of training for movement across columns will impose an additional disincentive on less affluent minoritised communities. | The framework's contribution to the profession's engagement with EDI agenda would fail. | Arrangements for evidencing training, including those linked to demonstrable experience of reflective practice offer alternatives to further high-cost training. |



| Possible Risk | Prospective Impact | Mitigation |
|--|--|---|
| [2 Strategic] The claims made for how the framework advances the profession's engagement with EDI do not materialise. | The current inequalities in the profession remain as they are. | Partner commitment to ongoing tracking of EDI data related to column membership and accessibility of mechanisms to progress through columns. |
| [2 Strategic] Some training providers (not accredited or approved by Partners at present) remain unaware of, or do not understand what, or are against revising their offers to ensure alignment with the framework. | Trainees may graduate without the competence the framework requires for an entry point. | Partners put in place procedures for communicating the benefits of mapping training to the framework. |
| [2 Strategic] Movement of members and registrants from column A to B and B to C does not happen due to unanticipated barriers in mechanisms. | Perception that the framework tends to harden rather than soften barriers to mobility. | The Partners need to agree regular reporting on operation of the pathways becomes a core risk indicator with regular reportage from Partners to the SOC on the mobility they have facilitated. Robust and sustained process required. |
| [2 Strategic] Risk of the framework not delivering increased employment opportunities for column A. | Current position remains unchanged. | Partners need to promote value of column A therapists to stakeholders with demonstrable increased opportunities. |
| [2 Strategic] Continuing dissatisfaction on the part of highly experienced therapists whose column designation is different from their perception of their own competence. | Continuing lack of trust in the categorisation of the competences leads to professional demoralisation of experienced therapists. | Ongoing review of the framework and how it is being used and interpreted with opportunities to adjust as needed. |
| [2 Strategic] A negative reaction follows any decision to adopt and implement the framework. | The harm is that that Partners' resources are divided by dealing with reactions and working on next steps, and that members or registrants (and other stakeholders) may construct their own reaction on the basis of some critics' reactions. | A proactive communication plan in place that presents a strong narrative on the benefits and next steps for all stakeholders, especially members and registrants, and the public. |
| [0 Contextual] The risk of misinterpretation of the framework's content and purpose. | Interpreting the competences in ways unintended may arise for audiences with less familiarity with the profession. While it is reasonable to assume that training providers will interpret as intended, this may not be the case with decision-makers on employing and or commissioning. | The implementation phase should contain a component that would make available to decision-makers, advisory input that would facilitate greater understanding of the mix of competences that clients and patients require. |



| Possible Risk | Prospective Impact | Mitigation |
|---|--|--|
| [0 Contextual] The continued expectation and or practice of some therapists working for free in order to get from column A to B. | This will impact on a perception of the framework's success, and particularly in relation to the profession's engagement with EDI. | Partners to consider monitoring of the distributional effects of this arrangement, and especially how this impacts some therapists more than others and continue lobbying for all qualified therapists to be paid. |
| [0 Contextual] Along with other occupations in health and social care there is a markedly greater attraction of women into the profession. There is a risk that this may give rise to some clients or patients being unable to find therapists with whom they feel comfortable. | As is currently the situation the consequence would be that some clients or patients do not access therapy. | The issue is one that goes far beyond the framework. The SOC may consider how and with whom they share EDI data to aid discussion and inform action with appropriate stakeholders. |

