A Personal Experience of Regulation under the Health and Care Professions Council, and the Perils of Institutional Professionalization

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SYNOPSIS

This is a personal account of my experience of regulation under the Health and Care Professions Council (HCPC). Back in the 1990s the profession I belonged to was invited to vote as to whether we should join the then HPC. My profession overall voted 'yes' to joining. What happened next was a tightening grip on our abilities to help, of oppression of professional experience, and a change in the climate of care as a forgetting of the client, of subscribing to something political, and playing into the cost-effectiveness movement. This experience is considered with reference to the profession of counselling and psychotherapy, and the dangers of its increasing professionalization and institutionalism.

I'd like to invite counsellors and psychotherapists to visit the Health and Care Professions Council (HCPC) website and read through the reports on some of the 3,000+ Allied Health Professionals (AHPs) who have been investigated, suspended or struck off from their register. I have read through many, and what struck me throughout was the sense of a lack of humanity within each report. Not once did I find an acknowledgement of the context within which these AHPs had found themselves: the reality of working in care sectors, especially those supported by public funding. Where, for example, was the mention of the many contributing factors involved in the everyday effort to assure 100 per cent care? – the staff shortages, resource cuts, challenging family members, difficult patients, the non-conformity of other colleagues and clients, irrational and impractical expectations, bullying by peers and/or managers – and the inevitable depression, anxiety and fear that come from working in sectors where more and more is expected of workers, despite there being less and less resources. I worked as an Allied Health Professional for almost 20 years within the National Health Service (NHS) and came across the aforementioned realities of working in public service on a daily basis.

I left my AHP practice before I stopped managing well due to the factors described above but I left because I could see that it was on the cards. For example I was trying to

manage a caseload three times the ideal size for the hours I worked. I could see it happening to my colleagues, and I do wonder now why not more of them found themselves before the HCPC. Why do some health and care workers get 'found out' for being human and imperfect, and not others? I suspect it may have something to do with the fact that our department still managed to maintain some semblance of in-house peer and line manager support. However, I chose to leave before all of the above and more could create a work environment that I would not manage, in the process becaming not good enough in the eyes of the regulating government-supported quango, the then HPC. My experience is that the ethos of the HPC contributed to that decision. For me, they took the humanity out of human care. Here is my experience.

As an AHP I loved helping people. I loved increasing their quality of life through shared ideas, shared care, shared support. Mostly, I loved identifying, with clients' help, what they needed, and then finding the necessarily innovative ways to achieve that. I worked for a profession that was pretty impressive in terms of its workers' and clients' care. It had its own Royal College which, with the help of staff and clients, provided ethical guidelines, audit and quality checks, approved training and training guidance, supervision, and a fully audited service which introduced care pathway guidelines. We were also one of the few professions which practised reflective Continuing Professional Development (CPD), recording it in diaries and submitting it as evidence of our continuing skill base.

If you look at what the HCPC claims to provide to AHPs for their ever-increasing subscription price, it's very similar. So why, then, many years ago, did I find myself asking questions about the then HPC, and what its benefits to us would be? I know the history of its inception. I know of the people who evoked it and steered it. I believe they were misguided, and that its inception should never have occurred.

HPC was sold to us in strange ways, not as a body for protecting clients but more as something that would protect us, validate us, and give us more clout amongst other health professions. For example, 'The HPC will protect your professional title' was a big deal for many in my profession. For some reason there was always this sense that our skill base wasn't taken that seriously. Mostly this was due to referring agencies not understanding what we did, or how hard we trained and how useful and vital we were. Yet surely that was up to us as a profession, with our Royal College, to do more about? However, the HPC's invitation to protect our title, so as only those trained on approved courses could register to use the title, seemed like an approval, like some invitation-only party for VIPs. This is what the HPC was sold to us as – our protector. The rest was essentially swept under the carpet.

Our union, quite rightly so it appears, had other ideas. They talked of increased fees on a regular basis, of a Big Brother mentality, of a tightening grip on our abilities to help – even of oppression of the profession. They talked of a scenario where we would find ourselves doing more paperwork, seeing fewer clients, and constantly ticking boxes and looking over our shoulders in fear. So I voted 'no' to HPC registration. My subscriptions to my Royal College were doing all of the things the HPC proposed, ensuring we continued to learn and reflect so as to protect our clients.

Most of my colleagues in my profession didn't even vote. We sadly had, and still do have, this tendency to believe that these political-type matters aren't actually relevant to us on a daily basis. For that is what the HPC was and is to me – a political, neo-liberal, capitalist agenda to make money out of public health service workers. Its design is to control and oppress workers so as to ensure that political agendas, based on control of the economy in health care, are met.

The vote to join was inevitably a 'yes', as those colleagues who did pay a modicum of attention were beguiled by the idea that they might be taken seriously by their colleagues and the public if they had a protected title and accredited training programmes. I remember sitting with my colleague (who also voted 'no') on hearing the result, as he quoted from Orwell's 1984: 'If you want a picture of the future, imagine a boot stamping on a human face – for ever'.

He wasn't wrong. Progressively I found our innovative and creative ways of supporting clients eroded by the HPC and, increasingly, so-called evidence-based care pathways came in to being. Big Brother was watching, and he would disapprove if the 'approved' (i.e. cheapest) way of doing things was not working, despite our years' of experience knowing another way. At the back of our minds we began to worry about being reported to the HPC. The stifling of professional experience had begun.

I trained 20 years ago, for four years at university, in a way which was practical, and strongly supported by experiential learning. I went into my profession with a respect for practical experience as a way of learning and sharing knowledge. This continued as my profession encouraged reflective learning in continuing professional practice journals. We were encouraged to ask ourselves: what am I doing, who does this benefit, what have I learned, and do I need to change anything?

The nature of my work involved the complexities of human skills which were context bound and thus unhelpful to

observe in isolation. As such we were encouraged to see our assessment results not as a diagnosis but as a hypothesis which could be supported or not via our treatment proposals. Creating these highly imaginative plans within contexts of functionality ensured that each plan was unique (within a general theoretical framework) and, for me, celebrated the 'human-ness' of the client I was working with. As such I am influenced by the idea that we should be careful of universality in our findings, and in our knowledge when dealing with humans, and not apply it rigidly. My experience and continuing research of the HCPC leads me to believe that they do not apply any of the above.

I left my profession, disappointed in how far it had fallen in terms of human care, not only for clients, but for colleagues too. I left oppressed and fearful, frustrated at being stifled when wishing only to help clients function.

I became interested in counselling but refused to go any further into training with the realities of professionalization and institutionalism rearing their ugly head. I have chosen instead to specialize in the politics of counselling, particularly in the power which manifests within the current neoliberal, capitalist ideology, seeping into how we offer up counselling support.

I am searching for alternatives to the conventional counselling approaches currently on offer. My own personal experience and research tell me that conventional counselling is not necessarily meeting the needs of those marginalized by society. Yet these are the very groups, let down by society, who need a break from the chaos of life, to feel un-judged, heard, contained and held, to learn how boundaries are useful but flexible, that compromise can be achieved, that being part of someone else's life can be a good thing, to see themselves mirrored in another as 'good enough', to paraphrase Winnicott (e.g. 1960).

Counselling can do all that. Yet I fear its ever-increasing professionalization and institutionalism prevent it from doing this in a way that puts the client first. Conventional counselling now seems to be about individualism, about encouraging the client to look inside themselves and to change themselves, a position that is not dissimilar to neoliberalist ideology. Yet we don't live in vacuums, we live in society, full of external power: culture, class, politics, race, sexuality, difference.

In my own studies I reflected and wrote extensively about my experience of being marginalized and counselled. This culminated in an auto-ethnographic exploration of my experience of oppression caused by the boundary of the counselling hour within conventional face-to-face counselling (Anderson, 2013). I was stunned by my own oppressive reaction to the hour boundary of a conventional approach. On deeper examination of my reaction to the boundary, I discovered themes of power, politics, social class and shame. The conclusion I considered was that external influences are echoed in the controlling aspect of the boundary of the therapy hour, and when the hour boundary is offered up for mutual discussion between counsellor and client, as it was with me, it can lose its oppressive and controlling nature. I proposed that counsellors need to be more aware of the external influences exerting power over clients and not necessarily focus internally all the time. I argued that counselling cannot be an a-political dynamic, that marginalization continues to be ever increasing in UK culture, and that a consideration of a client's social and political history, plus their current external context, can have a positive impact on mental health improvement. I also considered the dangers of an increasingly professionalized culture for counselling which demands the utilization of only economically viable options, and exacerbates the holding of internalistic views and an attitude of individualism.

I also think that our reliance on registration and evidence-based practices which promote economic effectiveness towards the service, and registration's effect of the continuing institutionalism of counselling, are marginalizing the already marginalized. I think we have to step outside of conventional practice in order to step outside of our lives, to then see back inside with wider clarity. However, I believe and my experience suggests to me that HCPC membership would not allow this.

> ...on occasion, moving beyond the limits that we have come to impose on ourselves through our training... can liberate our therapeutic potential and provide a response that is more truly and lastingly helpful to the client than would be the case if we merely stayed within safe and familiar constraints (Woskett, 1999: 164).

Exploring power in therapy activities which put the counsellor in charge, e.g. the setting of boundaries, led me to the increasing professionalization of counselling services. As a client, I find this a dangerous route for counselling to take. There is a sense in what I read that the creation of many of the ideas, ethics and 'rules' indicates a lack of trust in clients, which is so at odds with what counselling claims to be about. To quote Abernethy:

> Insistence on accreditation, registration and the move towards professionalisation is all supposedly being done to protect the client... to fob me off with the notion that an accredited certificate proves anything other than that the person has undergone that particular training.... It is one of the most disempowering things I have heard of, to be force-fed the fallacy that the more 'respectable' one is or

> the more letters one has after one's name, the less likely one is to abuse one's position. (2011: 335)

It is argued that professionalization leads to institutionalism and a loss of each person as an individual (Mearns and Thorne, 2007). I can certainly relate to this on a professional level in my time as an AHP. Shortly after my profession joined the HPC, I sensed a change in the climate of care as a forgetting of the client, of subscribing to something political, and playing into the cost-effectiveness movement.

Professionally my career developed against a backdrop of changing health initiatives such as the introduction of evidence-based medicine, soon to become universally accepted as standard practice, the creation of care pathways, and the establishment of institutions which researched and promoted evidence-based practice. I could acknowledge the positive developments regarding patient care (Berwick, 2005; Clark, 2011; Parry, 2000). Suddenly, the medical profession was being encouraged to ask, 'Why are we doing this?' – realizing in many cases that the answer was '...because this is the way it is always done', only to realize they then needed to ask the question, 'Is it the most effective way?' However, this felt like it was accompanied by a reduction in attention to the individual needs of people.

Unfortunately I can look back on my career and see that these questions were frequently asked from a top-down process of power through government initiatives via the natural science communities and institutions. I saw so-called effective treatments becoming about cost, not best. Working in the NHS, my sense was that the questions were institutionally biased towards what was best for the purse strings. I found my treatments becoming extremely prescribed – a 'one shoe fits all' mentality using care pathways which generalized treatments. This led to clients leaving programmes of therapy before they were ready because their care pathway had come to an end. It led to a deskilling of the professionals and a conveyor belt like 'quality' of care.

I left as I was tired of being forced to put my own 'career safety' first by ensuring I followed the rules, rather than support the client in what they really needed. I was tired of the conveyor-belt philosophy which had built up as a result of care pathways and as evidence-based practice attempted to fold everyone neatly into tidy prescriptive flow-charts. I do not wish to ever enter another profession oppressed by this corrupt ideology. I realize too that in my personal counselling experience, the setting of that hour boundary without mutual discussion of how it met my needs, or otherwise, has echoes of all that felt wrong for my career as it 'professionalized'. It became stifled and oppressed, and about protecting the institution. It forgot that at its heart were human beings in need of voices.

Catriona Anderson was an Allied Health Professional working for the National Health Service in Scotland for nearly 20 years. During this time she was a member of her profession's Scottish Committee, a departmental audit and quality co-ordinator, worked as a Child Protection Trainer, and developed a respect for the protection which unions and workers' rights afforded employees against top-down management styles. She left the NHS frustrated by the politics of economy over need, which prevented her practising well. Three years studying for a Masters In Counselling Theory found her studying politics, power and class, and she now spends her time immersed in the research and writing of politics, class, marginalized groups, and mental health.

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