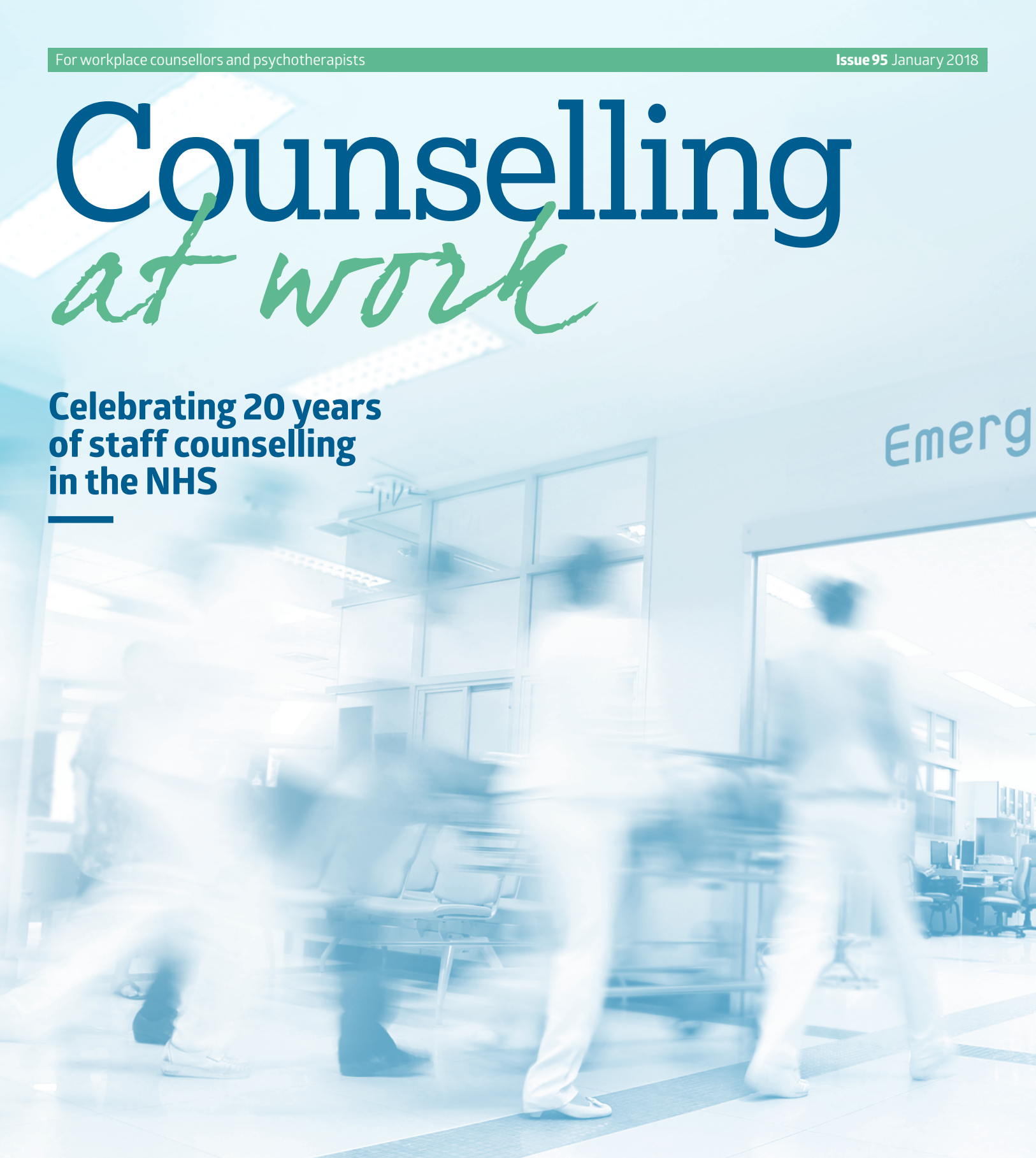
For workplace counsellors and psychotherapists

Issue 95 January 2018

Counselling *at work*

Celebrating 20 years of staff counselling in the NHS



Twelve years of trauma: why employers need to plan

We mean business: talking about mental health is not enough

A changing legal framework: what does it mean for you?

A watershed moment: post Weinstein, what is OK at work?

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Contents

Features

Regulars

First words

I'd like to press the 'pause' button. Creating moments to stop, reflect and regulate, is what we help our clients with. And, often they don't want to; they want answers, solutions and 'to do something'. The pause I'd like to create is to the momentum of the mental health at work agenda juggernaut. Ideally, it would be before another report lands in my inbox making recommendations to improve the mental health of the UK workforce through low-cost or no-cost means.

Much as I welcome the world beyond the therapy profession waking up to the reality that mental health is something that we all have, (and that how we treat each other makes a difference), I fear that the expertise and knowledge that already exist in our profession, are being overlooked.

Missing from much of what I've read and heard, is sufficient content and understanding of the role of counsellors and counselling in supporting good mental health at work. No surprise that it features prominently, as it always does, in this issue of *Counselling at Work*. 'Leading by example' is the story of the work of Cindi Bedor, a counselling service manager, and her team, at the Royal United Hospitals, Bath, where they support an NHS workforce of 5,000.

'What's missing in too much of what I've read and heard, is sufficient content and understanding of the role of counsellors and counselling in supporting good mental health at work'

This year, the service marks its 20th anniversary. It's some achievement, and poignant in the wider climate of a continued lack of resources in the NHS, strained relations between health professionals and the Government, and with the growing demands of an ageing society. In 2013, when Sir Robert Francis published his report into the appalling levels of abuse at Mid Staffordshire Hospital, causing patients to die suffering, dehydrated, unfed and lying in excrement, a culture lacking in care was cited as the context for the neglect and cruelty. It spurred an interest in the compassionate mind and those at the forefront of good practice in healthcare to develop a wider understanding of neuroscience and how compassion is nurtured.

A recent letter to *The Guardian*, led by Professor Paul Gilbert, on the science of compassion, challenged the view that threats can make healthcare workers more compassionate. It said: 'As the Francis report notes, NHS services can be time-pressured, accounts-driven, and job-threatening, whereas compassion grows in compassionate, supportive environments.'[1] This is what the service which Cindi leads offers to stretched NHS staff; a space in which they are supported, with a direct consequence for the quality of patient care.

But to secure proper funding, our therapeutic work needs to be understood and valued at the top. Communicating this to employers and stakeholders remains a crucial part of what we all need to do. But, I think we might need to do more of it. In the recent Stevenson-Farmer review, *Thriving at Work*, there is much mention of the need for the public sector, employing 5.4 million people to lead in fostering good mental health at work.

What's striking, is that there's little mention of the counsellors and counselling that are already doing exactly this across the public sector, in the NHS, education, and the emergency services. You can read our thoughts on page 28.

Welcome back to Peter Jenkins, who provides a helpful guide to navigating the changing legal framework surrounding the General Data Protection Regulation and explains the implications for therapists and organisations. It comes into force in May 2018, so there's time to get your house in order.

'Twelve years of trauma', by Fiona Dunkley, explains why organisations need a trauma management programme. The terrorist attacks in London in 2005 sparked a need for organisations to better respond, both to support first responders and frontline services and to employees caught up in the atrocity. Yet, it's the personal testimony that powerfully demonstrates how individual traumas are exacerbated by organisational neglect or ineptitude, and why a plan is vital.

There's an opportunity to hear Fiona speak at an event which BACP Workplace has helped plan, in April, 'Working with critical incidents – prepared not scared; are you ready for a critical incident?' BACP Workplace is committed to supporting the professional development of workplace practitioners – and so a reminder to book your place if this interests you. We're excited that Anne Scoging, who leads the counselling service at the London Fire Brigade, will be speaking, and reflecting on her organisation's learning from the Grenfell Tower fire.

It's a moment to pause, to hear from our sector's experts about how therapists and a therapeutic presence in an organisation make a profound difference to how employees feel they are supported in their working lives, whatever trauma or horror unfolds. For counselling to change more lives, it needs to be valued more, understood more and funded more.

Reference

1 https://www.theguardian.com/society/2013/apr/01/threats-healthcare-workers-more-compassionate

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News from the world of work

Our round-up of the latest events, news and resources

Event

Working with critical incidents – prepared not scared: are you ready to respond?

Edinburgh, 17 April 2018, Hilton Grosvenor

From terrorist attacks in our cities, the fire at Grenfell Tower, or a suicide at work, critical incidents happen to us and around us. We know that being prepared improves our capacity to respond. But as a therapist, how prepared are you for the crucial role that you could play in responding to a critical incident? This BACP event will develop your understanding of how therapists work with critical incidents, before, during and after an event.

Speakers come from frontline services, including the emergency services, humanitarian and aid work organisations, as well as those involved in providing counselling support following recent terror atrocities in the UK. Anne Scoging, who leads the staff counselling service at the London Fire Brigade, will be reflecting on the Grenfell Tower fire and its aftermath.

The event will aim to cover the following areas:

- Explain what a critical incident is and how you can plan and prepare for the event.
- Explore how organisations and employers prepare for a critical incident and how trauma affects an organisation during and after an event.
- Develop your knowledge and competencies to be able to assist clients, organisations and therapists before, during and after a critical incident.
- Consider what employee assistance providers (EAPs) are looking for in their therapists who respond to critical incidents.
- How to manage the impact of social media when a critical incident occurs.
- Share self-care skills for you and others to aid recovery and sustain resilience.

Early booking is recommended.
If you would like to book a place, visit **http://bit.ly/2jpySep**

If you know of any programme or resource that would interest readers, please email **counsellingatwork@bacp.co.uk**

Radio

How can we overcome the forces that divide us?

We may be more connected than ever, but we are, in many ways, strangers to each other. How many of your close friends have radically different politics, values or life experiences from you? And when did you last share a meal with someone from a totally different background? In this programme, Douglas Alexander tries to find out why we've become so polarised as a nation and what we can do about it. His time as a politician convinced him that government alone cannot mend Britain's divisions. So, what can we do as a society and as individuals? Douglas seeks advice from those who've studied Britain's fault lines and traced their causes – from political and economic forces to neuroscience and psychology.
http://bbc.in/2icEVCC

Resources

Did you know that BACP produces a treasure chest of resources that are freely available to members to support you in your practice?

Change is omnipresent in our society, but the BACP *Good Practice in Action* resources offer a clear, accessible and engaging way to help therapists keep up with what's happening in society that could impact on our practice.

Good Practice across the counselling professions 01: gender, sexual and relationship diversity:
Written by Dr Meg-John Barker, this resource explains that gender, sexual and relationship diversity are likely to be of great significance in our clients' lives, and it's important that therapists have a good working knowledge of the diversity of forms they can take.

Informative and practical, it is available on the website at: **http://bit.ly/2AEkh60**

Resources

A changing legal framework

This issue, Peter Jenkins writes 'An upgrade for data privacy' on the changes to the General Data Protection Regulation (page 22) so practitioners are prepared. In readiness, BACP has also produced a *Good Practice in Action* resource with an update on the General Data Protection Regulation. It is available now and will be reviewed every three months and updated as needed. You can access it at: **http://bit.ly/2j39kXC**

Reports

Improving lives: the future of work, health and disability

This paper sets out plans to transform employment prospects for disabled people and those with long-term health conditions over the next 10 years. It comes after figures revealed that some 80 per cent of non-disabled people are in work, compared with under 50 per cent of those with disabilities.
http://bit.ly/2kbwOtG

Reports

Psychology at work

How often do you define yourself by what you do? Work can be a key part of our social identity and good for our health; but it is not a universally positive experience. Poorly designed jobs, work that is not well organised and challenging work environments can create or exacerbate mental health conditions. Successive UK governments have attempted to address issues around work, health, and disability, but this has yet to achieve real traction. The British Psychological Society's (BPS) report, *Psychology at Work: improving wellbeing and productivity in the workplace*, brings together evidence from across the disciplines to demonstrate how policy makers can tackle the challenges. **http://bit.ly/2BluMoo**

BACP Workplace in the news

Working with the dead

Do funeral directors believe they and their colleagues would benefit from access to professional counselling? This was the question that *Funeral Service Times* asked a selection of funeral directors and counselling organisations. BACP Workplace Chair, Nicola Neath said: 'Staff working for funeral directors have regular exposure to vicarious trauma from those around, which, by the nature of the job, is continuously unexpected. They provide support to the bereaved during the most difficult time of their lives, putting others before their own mental wellbeing, and, like emergency service personnel, they can be affected by the trauma of fatal accidents or incidents they are called to. All funeral businesses need to foster an environment where employees feel that they are able to disclose if they are suffering, and counselling should be readily available when the need arises.'

We need a therapy profession that reflects the diversity of our society

BACP Workplace Executive Committee members, Nicola Banning and Nicola Neath, contribute to the debut issue of *BAME: The Educational & Careers Guide*, published by the Black Solicitors' Network, on why a career in the counselling and psychotherapy profession could be for you (pp58–59). The aim of the guide is to provide young people from Black, Asian, and minority ethnic (BAME) background with the information and confidence to think of themselves as the leaders of tomorrow. You can read more at: **http://bit.ly/2iZ8nQ1**

Notes from the Chair

All change
Nicola Neath

I was surprised to find myself standing, tearfully, in the metropolis marvel that is Grand Central at New Street Station in Birmingham, last November.

I had travelled to Birmingham to attend a BACP event for volunteers, 'Valuing your involvement', and to attend the AGM. I was emotional, not because of these events, I hasten to add, but because nothing around me was familiar. I grew up in Birmingham, and spent hundreds of hours of my youth passing through New Street Station on my travels around the city and beyond.

What really got to me was not having any reference points to relate to. The station and surrounding shops have been so transformed, that nothing of what I knew all those years ago remains. I was struck by the loss of an environment once familiar to me and experienced a destabilisation in my own narrative. At the same time, the architectural beauty of the redesigned Grand Central area spoke to me; I felt proud to be a Brummie.

'It is important that BACP and our profession continue to lobby and educate to influence the debate about mental health at work here in the UK'

It all made me think about those at work who may have lost various reference points in their own lives, impacting on their health, family, jobs, colleagues, security, role or sense of place. It made me think of ever-shifting working environments, of people who come to the UK as refugees, from war-torn countries, or who have simply moved away from their roots of origin. Change can be destabilising, even if the change is welcome.

Birmingham is an ever-evolving city and perhaps its nature flows in my blood and helps me manage some changes; but without any reference points, it was almost too much to take in. We know our mental health fluctuates as it constantly tries to absorb our inner and outer narrative, and to manage metamorphoses in self and in health. At the end of last year, the Stevenson Farmer review, *Thriving at Work*, was published, addressing the changing mental health at work agenda, the impact of work on our health and the need for workplaces to alter their attitude towards supporting employees. You can read our thoughts on page 28. It is important that BACP and our profession continue to lobby and educate to influence the debate about mental health at work here in the UK, as it matures.

The BACP event was designed to help volunteers like me to tune in to what is happening across the divisions and centrally at BACP. While some changes we may welcome, others we may not. As ever, we will need to express ourselves to be heard and to influence the conversation. We are in a new age, where BACP engages with members and our peer organisations.

The sessions covered work that BACP is involved in with the four nations, ethical practice, research, customers, governance, older people's mental health and the new website. However, it was the session on differentiated practice which really caught my attention. BACP is looking to define a training path of qualifications, and in the proposal is the idea of separating out what it means to describe yourself as a 'counsellor' or a 'psychotherapist'. I am not yet sure what any kind of differentiation might mean for our members. But one thing I know for sure, whether you're a 'counsellor' or 'psychotherapist', it's your skills and experience that will qualify you to work with employees and organisations, and it's those skills that we will continue to prize and get recognised across all our diverse practices. We will, of course, welcome your thoughts on this as plans unfold.

I'd like to thank Pam Ludlow and her Volunteers team, who are working so hard to bring the volunteers and BACP core staff closer together; it's a positive shift. Finally, we are really excited about the 'Working with critical incidents' day, which we have planned with BACP's Events team, and wish to thank Richard Smith and the team who have helped us to navigate our way through planning and structuring the day. It will be held in Edinburgh on 17 April and it is shaping up to be an impressive opportunity to hear from some of the expert voices in our community. The interest we have received so far from delegates is fabulous, so we advise booking your place as soon as possible. We are really looking forward to seeing you there.

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Workplace matters

A watershed moment

Sandi Mann

The Harvey Weinstein scandal at the end of last year was not merely an indictment of one boss or even one industry, but a veritable can of worms that led to revelations across the globe from women (and some men) who claim to have been sexually harassed or abused by people they have worked with.

Yet the defence of many of the accused is a common one: it was just a joke; office banter. According to a tweet by *Los Angeles Times*' Matt Pearce, in response to two separate accusations against George Bush for molesting women during photo shoots: 'To try to put people at ease, the president routinely tells the same joke — and, on occasion, he has patted women's rears in what he intended to be a good-natured manner.'[1] Later it emerged that the 'joke' revolved around his favourite magician being 'David Cop-A-Feel'. According to the ex-President's spokesperson, Jim McGrath, in a statement to CNN about the allegation, 'President Bush would never — under any circumstance — intentionally cause anyone distress, and he most sincerely apologises if his attempt at humour offended.'[2]

I suspect that many historical 'gropers' would offer up this defence and claim that it was a joke that, in the context of the times, was acceptable. But times have changed and what may once have been considered as a bit of benign workplace 'pestering', is now, quite simply, sexual assault. And anyone in today's workplace who doesn't get that message is entitled to be thrown to the wolves over their behaviour.

The potential downside is that there could be a danger of creating a culture of fear for employees, who may worry that their comments or banter might be misconstrued. In a changing landscape over what's OK or not OK at work, I've considered some of those more common 'fine lines'.

Is it OK to comment on the clothing or appearance of a colleague? Well, that depends if they are sexual comments or not; telling someone they look smart, or the colour suits them etc is OK; using descriptors like 'sexy' is not and nor is making comments in relation to chest or buttocks. This goes for women too; admiring a man's tie is OK but remarking that their shirt shows off their pecs nicely is not.

Is it OK to refer to Kim Kardashian's bottom in the workplace? Probably not if said in an overtly sexual way; discussion of whether she is a good role model for women might be OK but commenting on the sexual allure of her assets is not.

> '...what may once have been considered benign workplace 'pestering', is now, quite simply, sexual assault'

Male employees viewing pornographic images on the internet in an office where a female colleague is present constitutes sexual harassment.[3] But what about the popular trend for charity calendars featuring naked firefighters, rugby players and even knitters? Can these be displayed at work? They should probably be regarded as no different from any other pictures of semi-naked people. If it makes anyone uncomfortable, then the answer is no.

Jokes or banter with sexual content is a definite no nowadays (shame no one told Bush that). Of the 1,553 women who took part in a TUC survey in 2016,[4] 32 per cent had been subject to unwelcome jokes of a sexual nature. Sexual jokes that may be considered harassment can include descriptions of sex acts, sexual language or sexual innuendo ('David Cop-A-Feel)'. This includes jokes or cartoons sent by email, commenting or 'liking' such jokes on social media or forwarding such material at work or using work resources.

Is it OK to ask a colleague out on a date? Yes – as long as there is no compulsion on one party to accept in order to further their career. And, the person asking has to immediately accept a 'no' or else risks straying across that fine line.

The Harvey Weinstein affair may well prove to be a watershed moment in how sexual harassment is recognised and treated at work, but it should not leave ordinary employees feeling confused. An article in *The Guardian*[5] points out that the common litmus test of sexual harassment ('how would I feel if this happened to me?') is inappropriate, since different people have different views on what they deem offensive, hostile or degrading. But if employees exercise a bit of common sense, thought and respect, then the risk of crossing that line can be minimised.

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Talking purple

Telling purple stories

David Caldwell

Humans are natural storytellers. We've told stories for as long as we've been around: from cave paintings to Shakespeare; from fairy tales to Harry Potter; from TV advertising to Instagram and Snapchat. Storytelling has been used for years by marketing companies to sell us a vision of our future selves, and by journalists to tell us what's going on in the world; but it's only recently become a medium for telling our lived experience in society and the workplace. It's paying huge dividends. Take one of the UK's most successful storytelling campaigns as a perfect example: Time to Change is a partnership between Mind and ReThink Mental Illness and was established to end the stigma surrounding mental health. It uses storytelling as a key medium to drive cultural change right across the country. In the last decade, we have seen a significant change in attitudes towards people with mental health issues, and the reporting of discrimination has dropped significantly.[1]

> '...storytelling can lead to culture change and can be a powerful tool to help people with disabilities and mental health issues to face less discrimination'

So, what does the success with Time to Change mean for the rest of the disability agenda? For me, it's proof that storytelling can lead to culture change and can be a powerful tool to help people with disabilities and mental health issues to face less discrimination, get access to more opportunities and help more people to better understand mental health issues and disabilities in the workplace.

It's led me to spend the last few years working in a number of ways to unlock the stories that exist within the financial services industry and to help other organisations to find ways of unlocking stories in order to change their cultures. In 2014, I helped to launch 'This is me' at Barclays, which was the start of a mini-revolution within the industry. It resulted in a city-wide campaign introduced by the Lord Mayor of London and has seen many colleagues across the industry step up and share their own stories of mental health issues, caring and disability.

Rather than recount everything about the campaign, I wanted to share some top tips for helping people to unlock their own stories. While this is primarily for diversity and inclusion (D&I) professionals, I think the same approach could be used by anyone looking to help others to share their stories:

Provide structure and guidance

Helping people to tell their story in a logical, well-structured way is important, not only to help them articulate what they want to say, but also to ensure that what they say is valuable for those reading their story. Think about the audience, where their story will be told, whether it will be part of an existing communications campaign, an internal blog, at an event, or on their own social media.

Create a support network

Ensure that storytellers can connect with each other and that they understand what support is available for them. Knowing people who are going through the same thing is an important part of feeling comfortable telling their story.

Enable storytellers to become signposters

Storytellers often become magnets for others with lived experience. Ensuring they know where to signpost people who need support, is important to avoid dealing with other people's issues alone.

Practice makes perfect

It helps to ensure that the story being told is the right story to tell. Ensure that storytellers draft and redraft their story and then share it in different ways to hone the key messages.

Be a thoughtful sounding board

Challenge storytellers constructively, listen empathically and offer guidance and support about what is appropriate information to share, or not.

The great thing about storytelling is that it encourages openness, honesty and a culture built on trust. From what I've seen and heard from other organisations, storytelling has the power to change the way people work, how they respond to people of difference and equips them to better support those around them.

For many people, starting the journey towards unlocking the lived experience stories is scary, and can feel too hard or too big a mountain to climb; but it doesn't need to be that way. When I started back in 2014, there was almost no advice or support out there, but now there's loads. Over the years, I've contributed to some of these platforms, but the one I'm most proud of and recommend is Purple Stories from PurpleSpace. It's a free resource and is focused on how individuals tell their stories of difference. Whether you're looking to tell your own story at work or want to help others share their stories to help change the workplace culture, I'd encourage you to take a look at **www.purplespace.org/purple-stories.**

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1 https://www.time-to-change.org.uk/news/less-mental-health-discrimination-and-sea-change-public-attitudes-during-ten-years-time-change

David Caldwell is Digital Accessibility Manager at Barclays and a Founding Ambassador of PurpleSpace. Follow David on Twitter at **@cfunn** and PurpleSpace at **@MyPurpleSpace**

Cyberwork

Beyond words

Sarah Worley-James

Have you ever used a smiley face when communicating with your clients? Probably not, if you work face to face with clients. But working predominantly as I do with young people, I've found the sparing and considered use of emoticons can help the development of a therapeutic relationship, particularly in IM sessions. However, it can be fraught with difficulties, and I suspect that many therapists will avoid their use to limit the potential for cultural misunderstandings arising, or offence being taken.[1]

> 'I consciously limit my use to a smile emoticon, as I feel that, as one of the most commonly used, it is most likely to be received in the way I intend'

I deliberately choose to use an emoticon rather than an emoji, as I feel that its simplicity is more likely to add, rather than distract from the session. Just to be clear, an emoji, is an image with colour and sometimes animation. It's an intrusion into the text, drawing the eye away from the words and meaning conveyed in them.[2] It is a crude representation of emotion and within therapy could be seen as diminishing the client's experience. That said, for some young people the use of an emoji can be an easier way to express those emotions that are difficult to access or articulate.

I consciously limit my use to a smile emoticon, as I feel that, as one of the most commonly used, it is most likely to be received in the way I intend:[3] to convey warmth at the beginning of the session; in response to a described pleasure at a change or progress; as encouragement; in response to a moment of humour; to convey a more human response; and to say 'good bye'. I am mindful that the client may not like or appreciate the use of emoticons, or it could be read as dismissive or patronising. I note how the client responds, and cease if they object.[4]

I use an emoticon as an alternative and an enhancement to using brackets to say what I am thinking. For example, I might type: 'I can hear how pleased you are at how you handled that situation (and I'm smiling as I type this)', or I can simply add a ☺. Interestingly, in synchronous IM sessions I tend to use emoticons more freely than in an email, as the immediacy of the relationship enables a readjustment or holding back if it appears that emoticons are not welcome.

Venturing into online work, I was mindful of the range of ways that people communicate via text-based media, as well as style and use of punctuation. Interestingly, my experience of working with young adults in a university is that they rarely abbreviate in a counselling session, have less typos than me, and are very forgiving of mine!

The advent of Twitter, Instagram and Snapchat, with their limited characters, provides another medium where people use ellipsis. And I find that people write in the style of the medium they are using, rather than adopting a 'one-size-fits-all' approach to online communication.

I use the smile emoticon alone, as I am conscious of wanting to communicate the smiles I would naturally use in face-to-face work. In contrast, I choose not to use a sad face (☹) in response to an expressed trauma or painful emotion, because in a face-to-face session, I would be keeping my response as neutral as possible (while still being human), to convey a steadiness and an ability to hold the feelings in the room. The use of a sad emoticon has the potential to convey sympathy rather than empathy, and risks the client believing I am getting overwhelmed . And, of course, my choice to convey sadness may not relate to the predominant emotion the client is feeling in the moment. Perhaps anger, hurt or numbness are more apt, while, of course, an angry emoticon (>:( ) brings into the session a strong sentiment that could be misinterpreted as my displeasure or anger.

As IM can be a more focused experience, for both client and counsellor – with a shared sense of time being more precious – emoticons can add to the expression of immediate feelings, just as a fleeting facial expression or body movement can enhance or express a depth or contrasting emotion to the verbalised one, in a face-to-face session.

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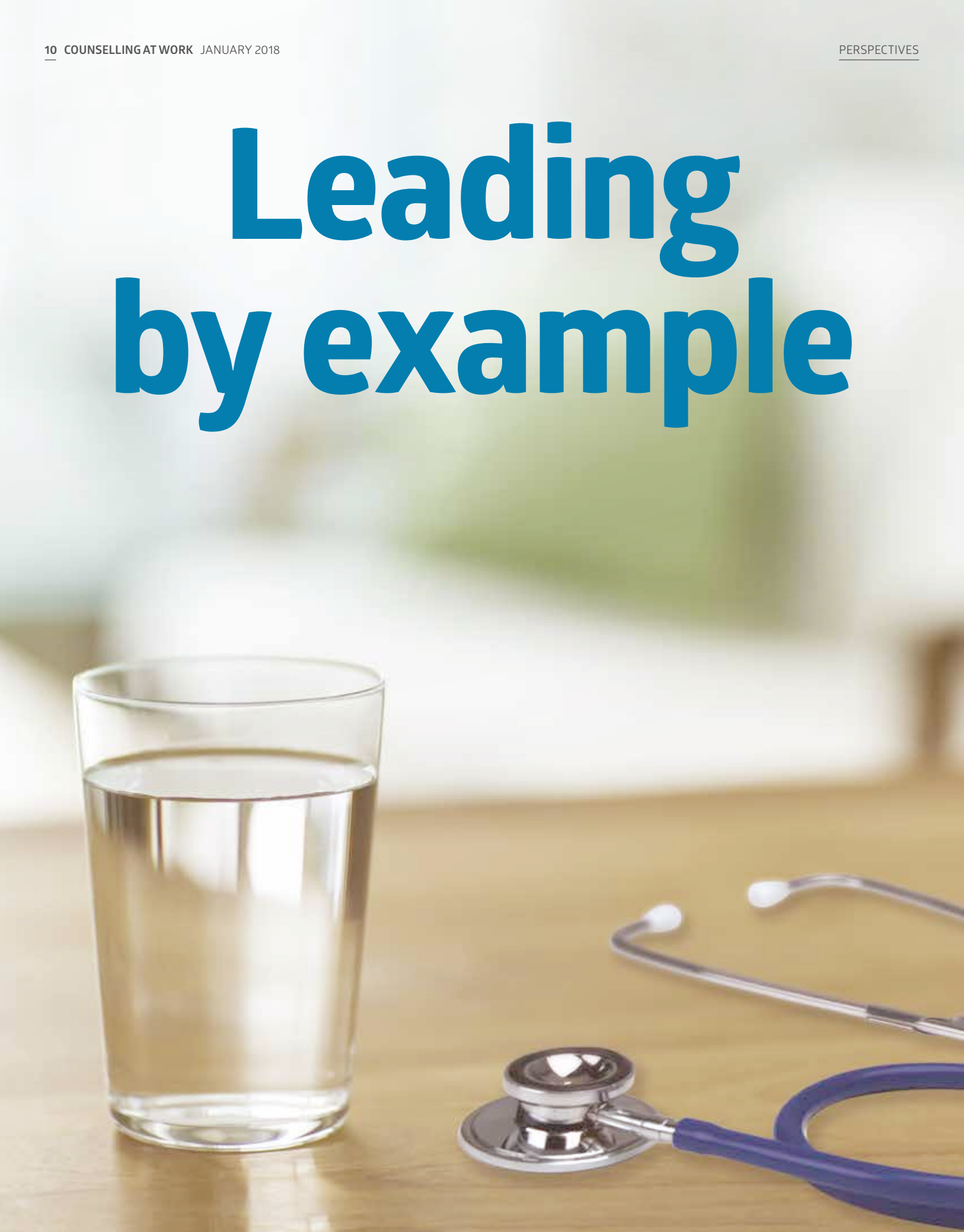
Leading by example



How can we mark our 20th year anniversary as a counselling service? This was the question that Cindi Bedor, head of staff counselling in an acute NHS hospital, asked *Counselling at Work* editor, **Nicola Banning**. Short of ideas, Nicola tells the story of the service, from surviving to thriving

If you've visited an NHS hospital recently, you'll know that the squeeze on resources can be felt even while parking the car. Arriving at the Royal United Hospitals Bath before visiting hours, I'm relieved to find a space and make my way towards the staff counselling service. Situated in one of the hospital's older buildings, it's discreetly positioned away from the busyness of the main hospital entrance.

'Anyone who's ever managed a service will know what I mean when I talk about the amount of energy and work that goes into fighting for our continued existence'

I'm here to meet Cindi Bedor, who leads the counselling service, for coffee and to talk to members of her team before the first clients of the day arrive. If, like me, you've worked in some rather drab and neglected public sector buildings, you'll understand why entering through the doors of this counselling service felt like a far cry from my usual experience. I'm soothed by the calm, the soft light, the plants and colour palette. Art on the walls, classical music for the soul and a carefully considered choice of self-help literature. It's understated, professional and therapeutic.

'One of the most consistent pieces of feedback we have is about the quality of the waiting room and how staff feel when they arrive here,' Cindi explains. I'm not surprised. It's carefully tended to and designed to give stretched NHS staff something that is in short supply in their working lives: a feeling of quiet. 'Hospital staff experience overload in every way, including sensory demands, so we try to avoid further overloading them with too many leaflets, unkempt therapy rooms, waste bins full of tissues, or even a radio station with commercials that intrude into the waiting room.'

The sound of sirens is a reminder that this in-house counselling service is actually part of an acute hospital. Established in 1987 and only the second of its kind in an NHS hospital, the service is now well embedded in the organisation. The reality of the day-to-day life of health professionals in the NHS is never far away, I'm told, and winter always brings a greater strain on the NHS. 'The pressure within the hospital always comes into the counselling room', explain Alison Lock and Sophie Pickering, two members of the counselling team. 'High escalation levels occur when there is unrelenting pressure on beds and everyone is working flat out. There's a different energy in the hospital and we can just feel it.'

Working flexibly

Responding to this pressure, Cindi explains how the service holds the context of its clients' work in how it contracts. 'Our flexibility with missed or cancelled appointments allows us to remain engaged with our clients, and we try to balance this with a consistent approach, through our warmth and approachability, our systems and procedures and our boundaries. We are sensitive to the nature of the work, the shifts, and the huge pressures on staff. Being on site means that we have a strong sense of the demands

healthcare workers face and we are easy for them to access when they can.'

There's pride in how Alison and Sophie speak about their work, their team and its integral role within the hospital. 'We are an informal presence and we're accessible to those who need us, regardless of their role in the hospital. People see us as being available and that we're here for them.' They are clear that Cindi's style of leadership is pivotal to the reputation of the service and to how highly regarded it is across the hospital. 'Cindi's work focuses so much on building relationships and working with teams and managers. Much of our work is hidden, but our presence is felt as a safe place.'

Understanding the culture

Organisations are notoriously difficult places, and the distinct cultures of therapy, medicine and business are not natural bed fellows. It means that whoever leads the service, must be able to communicate the value of therapy to the organisation and to understand how therapists can offer it. 'The proof for me of our value in the organisation is when staff contact us,' says Cindi. 'They are busy, they don't like to concede what they perceive as weakness, they often don't know themselves what they want, but they do know they are struggling, and I feel privileged each time a manager or clinical specialist contacts me. Our service has been invited to work with some of the most senior teams in this hospital, including the consultants, to provide reflective supervision for the whole team. This shows an enormous display of trust, which has grown out of staff feeling psychologically safe enough to work with us.'

Alongside leading the service, Cindi's clinical work keeps her connected to her own passion for and belief in therapy: 'I've seen extraordinary therapy happen: it's short term, often appointments have to be fitted around shifts or hospital pressures, and sometimes we have to be very creative in the way we keep our clients engaged. But, I have come to truly believe in the power of therapy with and within organisations, and it is good to see a growing movement of compassion in healthcare, which we are very much a part of.' This culture shift has come as a result of the Francis Inquiry into abuse at the Mid Staffordshire Foundation Trust Hospital and following Paul Gilbert's work on the compassionate self. It's a shift that Cindi has built on, keeping a focus on how the service can continue to support staff to deliver their best under enduring pressure; and how to share what we've learnt as therapists from attachment theory and neuroscience about how humans function.

Connecting and reconnecting

Healthcare professionals, by the very nature of their work, are trained to put the needs of others above themselves. They tend to have a strong sense of vocation, duty and passion to give the best possible care to their patients, and for them to go the extra mile to achieve this is not unusual, explains Cindi. But it's a vocation that comes with inevitable risks: 'Much of our work is about connecting and reconnecting. It's important for all of us to have a passion for our work, and so often we are helping NHS staff to reconnect with what's brought them into their work, because they can lose this when they become tired, exhausted and burnt out.'

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There are potentially 5,000 clients working in the hospital and the service sees between 10–11 per cent of the workforce for one-to-one work. Clients are provided with up to four sessions and careful attention is given to endings, Cindi tells me. 'When we end with our clients, it's standard practice as part of our package to write to each and every person to acknowledge the work has ended and to remind them that they can use the service again. Clients are also offered a follow-up session, and we have a 20 per cent take-up rate for those. With some of our clients, especially those we know are facing enormous pressures, we email them a few weeks later to see how they are. Sometimes my emails are strategically written to arrive in the recipient's inbox when I know there's a maximum chance they will see it.'

'Through our work in organisations, we potentially reach thousands of clients and we have the opportunity to model what therapy stands for and to spread the word of its potential'

In addition, the service provides relationship counselling for couples, coaching, specialist addiction and PTSD therapy, workplace mediation and clinical supervision. Working upstream with hospital staff, trainings are delivered by members of the service and include training managers about mental health, working with anxiety at work, and self-care and resilience for staff across the workforce. Cindi tells me that the service also gained funding to provide eight-week mindfulness training to all staff, which it has done for the past two years, as well as running courses specifically for doctors, and it will begin mindfulness training for leaders in the spring.

Making the business case

The culture shift that's occurring in the nation's psyche around mental health means that there's a growing understanding of what Cindi's service is providing. 'When I completed my training over 20 years ago, counselling wasn't in the mainstream as it is now,' she tells me. 'I joined an in-house team of counsellors, and we always had to defend our work and justify our presence in the organisation and to argue the business case. This has continued throughout my career and while I've been running this service. Anyone who's ever managed a service will know what I mean when I talk about the amount of energy and work that goes into fighting for our continued existence.'

But there was a turning point some years ago which has had profound consequences for Cindi's leadership: 'I realised that I didn't have to keep fighting and selling the service. I never received an explicit statement to say our service is safe, and I still don't take that for granted. But I realised that I didn't need to sell the value of the service anymore. We were being integrated more and more into the organisation, and at all levels there was interest in the information, insights and advice we could offer. That said, we can only do what we do because the Trust has shown its continued commitment to offering our service to their staff.'

Service managers often talk of needing to have the evidence for the efficacy of an in-house service readily available for stakeholders, and I'm wondering how important this remains as the service marks its 20th year. 'I still have the evidence base and I believe outcomes are very important,' Cindi says, 'but I am now much more confident about defining the outcomes I believe are important, rather than acquiescing to what other people (who are not in the fields of psychology) think are good outcomes but are either not realistic or meaningful.'

Engaging a team

Leading a service also means being responsible for recruiting and engaging therapists, whose livelihoods depend on your capacity to defend your service. Does Cindi recognise these layers of responsibility that rest with her? 'It does feel quite a responsibility. We have an amazing team of therapists who are very committed to the service, and it is important to me to create a strong sense of

teamwork and to support their ongoing development as workplace counsellors. I also believe that service leaders have much to contribute to our profession. Through our work in organisations, we potentially reach thousands of clients and we have the opportunity to model what therapy stands for and to spread the word of its potential.'

It's no surprise that this is a place where therapists want to work and where retention is good. Alison and Sophie explain: 'We have a low turnover of counsellors because we're very well supported and we work well together. We network and gather twice a year for CPD, for socialising and lunch. We're not micro-managed and we are trusted and respected for our different ways of working,' they both tell me. Appointments take place onsite, which means the team create the environment, manage appointments and maintain sound clinical governance. Cindi describes the therapists who work in the service as all being good team players: 'We enjoy learning from each other's practice and having a consistent source of personal and professional support.'

Often, service leaders tell me that they are inundated by applicants when posts are advertised but can narrow down a shortlist quickly, because too few therapists understand what it means to work in an organisational context. I wonder if this is Cindi's experience? 'I'm looking for therapists who've done their own therapeutic work and who really understand their own transference around authority and power. We need practitioners with maturity, and that's not the same as not being young. I have just engaged our first trainee in our service, who is very mature with lots of life experience. But on the whole, we're a mature team and we welcome some new blood to challenge our thinking. Interestingly, the trainee approached me and said, 'everyone told me to come and speak to you.' I take it as a compliment. I think that's a role that I, or we as service managers, can take more seriously: how do we mentor a new generation of workplace counsellors?'

Looking ahead, Cindi sees workplace counselling as a growing area that is deserving of more discussion, understanding and promotion by BACP and in society. 'The therapy that this service does is touching a lot of ordinary people's lives who would never access therapy privately, and surely there are enormous possibilities for our profession to expand this work.'

Working creatively

Therapy is a term that Cindi uses in its broadest sense and it goes beyond the conventions of two people in a room. It often happens during her corridor conversations, while walking the hospital, coming across staff and making connections. She tells me how one day she bumped into the hospital's Arts Officer, and between them they developed 'the sleep project'. Tapping into an internal innovation fund, together they developed a plan to make 100 sleep packs for shift workers to encourage them to go home and get some proper sleep. This gem of an idea pooled the creativity of staff right across the hospital, who were all invited to volunteer their needlework skills, and to reuse unwanted fabrics.

Staff came up with their own unique design for small bags, (much like the inflight bags you have on long-haul flights, only nicer, and each one individually designed), in a range of recognisable fabrics, including: a man's pyjamas; a winceyette nightie; and an old pair of scrubs. The 100 sleep packs were then handed out to the matrons to distribute to sleep-deprived shift workers to encourage self-care, rest and sleep. Each sleep pack contained an eye mask, earplugs, a lavender sachet, one herbal sleep teabag and an information leaflet on sleep. The response Cindi received from the matrons speaks volumes: 'What

'It is embedded into the working life of the hospital and is led by a practitioner who's learnt how to take the best from therapy and make it make sense to people right across her organisation'

surprised me was how much this gesture meant to them, to be given something that they in turn could give to their staff, when so often they are struggling with such a scarcity of resources.'

Closing thoughts

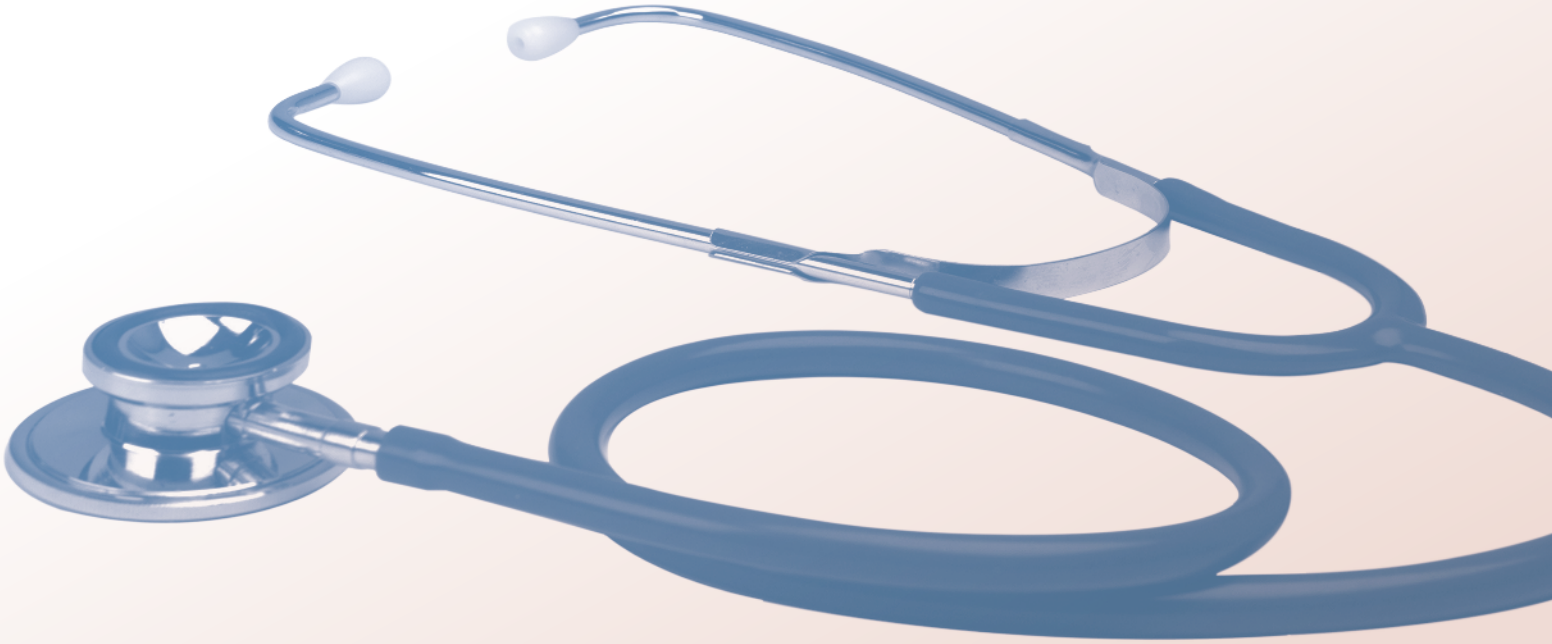
The clock ticks, and it's time for the team to begin to prepare for the first client to arrive. As we pick up our coffee cups and straighten the room, Cindi tells me: 'We have rituals for how we begin and end with the room. We make the space; it doesn't make itself.' The sense of collective responsibility in this service, is clear. So too is my overwhelming sense that this is what leading by example looks like.

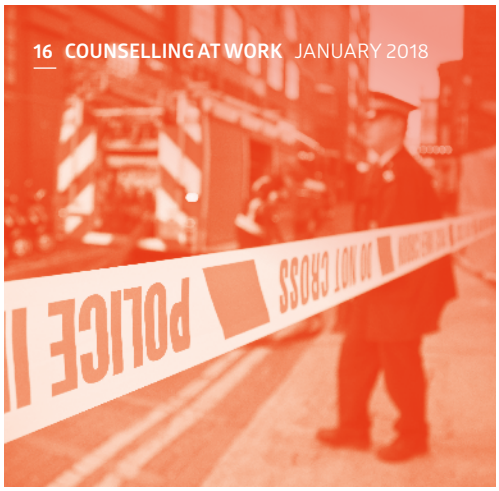
There is nothing ordinary about this counselling service. It is embedded into the working life of the hospital and is led by a practitioner who knows how to take the best from therapy and make it make sense to people right across her organisation. I've edited this journal for five years and witnessed internal services being dismantled and outsourced, resulting in colleagues losing their livelihoods, and organisations losing years of therapeutic expertise, knowledge and good working relationships. There is much that our profession needs to learn from the success story of this in-house service supporting NHS staff; it is part of one of the nation's most important institutions, and as it marks its 20th anniversary, it is thriving.

Nicola Banning is a BACP accredited counsellor specialising in working with individuals and organisations, and is editor of this journal. She has a background in broadcasting with the BBC and writes on counselling, mental health at work and professional development.

Your feedback please

Counselling at Work is dedicated to our community of workplace practitioners and is committed to best practice and to a wider understanding of the role of counsellors in organisational life. If you have a story you'd like to share, the editor would like to hear from you. **counsellingatwork@bacp.co.uk**





Twelve years of trauma

From the 7/7 bombings (2005) to the Grenfell Tower fire (2017), **Fiona Dunkley** explains why organisations need a trauma management programme

In the last 12 years, working as a trauma specialist psychotherapist, I have seen an increase in the demand for trauma therapy. The most poignant incidents where I have supported organisations and individuals include the London 7/7 bombings (UK, July 2005); Syrian civil war (Syria, ongoing since 2011); Ebola outbreak (West Africa, from 2014); Search and Rescue refugee crisis (Mediterranean, from 2015); Nepalese earthquake (Nepal, July 2015); Westminster terrorist attack (London UK, March 2017); London Bridge terrorist attack (UK, June 2017); Brussels bombing (Belgium, March 2016); anti-government protests, Istanbul (Turkey, July 2016); Juba attacks on aid workers (South Sudan, July 2016); and the Grenfell Tower fire (London UK, June 2017).

This is not an exhaustive list of major incidents, but as I composed it with a heavy heart, it reminded me just how much trauma has become part of our daily lives. As well as these high-profile cases, I support individuals with other traumas, including sexual violence, childhood abuse, bullying, transport accidents, domestic violence and medical health issues, which also impact individuals and families, with devastating effect. We are exposed to trauma continuously in the media, as images become more graphic and stories more personal, and we are all vulnerable to vicarious trauma (sometimes named 'secondary trauma' or 'compassion fatigue'). Vicarious trauma is the cumulative impact of indirectly witnessing trauma or hearing stories of traumatic content. *The Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), for post-traumatic stress disorder (PTSD), recognises that individuals can be impacted by trauma symptoms whether they experience a traumatic event indirectly, directly, or as a witness.[1]

Background

My passion is caring for the carer, and a great deal of my work is supporting emergency first responders, including the police, fire brigade, medical staff, and humanitarian aid organisations internationally. A previous article I wrote for *Counselling at Work*, 'Caring for the Carers',[2] highlighted the psychological risks of working with trauma and explored coping strategies for the carers of our world. It's an area I know well, having worked in the NHS offering crisis support in The Havens' forensic sexual violence units. I went on to join the counselling and trauma service, as the lead counsellor, at Transport for London (TfL), after the London 7/7 bombings. Later, I moved into the field of humanitarian aid work, offering psychosocial support to organisations including the Red Cross, Save the Children, Oxfam, Plan International, and Voluntary Services Overseas (VSO). I currently have a private practice, work internationally and undertake consultancy work, supporting individuals and organisations at risk of being exposed to trauma.

Responding in a crisis

It is essential that organisations have a thorough and well-rehearsed critical incident plan, which needs to incorporate a trauma management programme. This should clarify what psychosocial support is available for staff throughout every stage of a critical incident, including early intervention, specific treatments for trauma, follow-up and recovery. A well thought-through critical incident plan saves lives and helps people recover quicker. Staff need training, guidance, knowledge and clear policies. The reality is that major incidents almost always catch us unaware; therefore, forward planning is essential.

As the lead on InterHealth Worldwide's Responding in a Crisis (RIC) service between April 2014–April 2017, I gathered a significant amount of crisis response data. During that time, InterHealth managed 188 critical incidents for 89 client organisations. The prevalence of each type of incident is shown in percentages, and the findings are below:

- Ill mental health (21 per cent). This refers to an individual suffering from the severe end of the spectrum of mental ill health, such as psychotic episodes or suicidal attempts or ideation.
- Civil unrest and terrorism (16 per cent). The data show that civil unrest and terrorism have increased by 37 per cent over the last two years. Many more countries have become targets of terrorist attacks over the last few years.
- Sexual violence (nine per cent). The data record that sexually violent crime has increased by 25 per cent over the last two years.
- Death of a member of staff due to accident/illness or murder (8.5 per cent).
- Kidnapping and hostage-taking (five per cent), with an increase of 33 per cent over the last three years.
- Other incidents recorded: robbery, mugging, assault, vehicle accidents, carjacking, natural disasters, accidents and illnesses (non-fatal) and disease epidemic.

It is noticeable that incidents of both sexual violence, kidnapping and hostage-taking have increased over the last three years. These figures could be impacted by increased numbers of individuals reporting incidences, and more organisations having systems in place to encourage reporting. However, unfortunately, the research is demonstrating that the overall risk to aid workers of being involved in a traumatic event has increased.[3]

Organisations need to give careful consideration to how they will implement the stages of a trauma management programme; and to illustrate this, I turn now to two high-profile cases. Both Peter Moore, who was held hostage for just under three years in Iraq, and Megan Nobert, who was raped while working in South Sudan, agreed to speak to me in detail about their experiences. They both hope that some of the learning points that came out of their own horrific experiences will be taken forward and implemented into organisations' critical incident policies.

Megan Nobert – case study

Megan Nobert (former director of Report the Abuse), a Canadian aid worker, was deployed to South Sudan in 2015, where another humanitarian worker sexually assaulted her. Megan shares some of her story with me below.

'When I was drugged and raped while working in South Sudan, I expected my organisation to provide medical and psychosocial support. Instead, the opposite happened... When I asked for a week off to return home – to see some friends and tell my family what I had experienced in the field – I was told it would be disruptive to programming and if I wanted to go home, I should quit. So, I quit, to go home and heal. There were many traumatising moments: when I was asked to go from room to room and relive my experience for senior management. When I was told that, if I wanted to be evacuated post-rape, it was my responsibility to make it happen. Beyond all of this though was the moment when I was told by senior management that I wasn't allowed to speak about my experience. If there had been policies or procedures in place, perhaps things would have been handled better... The wounds from how I was treated by my former organisation run deep, though; in some ways, even deeper than those from the rape itself.'

'The wounds from how I was treated by my former organisation run deep, though; in some ways, even deeper than those from the rape itself'

A clear trauma management programme for managers to refer to in the early stages after a critical incident is essential. How individuals are treated by their organisation directly after a crisis is fundamental to their recovery process; the 'stuck moments' in therapy can often be an unsupportive comment made by a manager or colleague. Individuals are highly sensitive and vulnerable to being retraumatised in the early stages after an incident.

'Working within the field of crisis response, it's not unusual to receive calls from managers or HR personnel, anxiously demanding that: "we need counsellors here, now!" My role is to contain the anxiety and to manage the situation by grounding and stabilising the individual at the end of the phone'

Peter Moore – case study

Iraqi militia held Peter Moore hostage for two years, seven months and one day. Peter worked as an IT consultant, training local staff in Baghdad, Iraq. On 29 May 2007, Peter and four British guards were kidnapped while at work. He describes his first year as *'pretty rough'*, including *'mock executions, being hung over the door and regular beatings.'* By 2008 Peter describes his conditions as *'better'*. He was *'blindfolded and handcuffed, kept in a lying down position for six months and separated from the other four guards'*. He later found out that all four guards had been shot and killed. At this point Peter was released from his chains, for the first time in two years. Peter felt that at this time he hit his *'all time low'*, and considered using the chains to hang himself. In 2009 he was *'given a laptop, was able to exercise, and had the use of a toilet.'* This was the year he was released, on 30 December 2009, 946 days after he was first taken hostage.

When I asked him what psychosocial support he was offered on his return, Peter informed me, *'My organisation did not have any, but after I was released from being a hostage, the UK Government had a military psychologist appointed to me.'* Peter struggled to get back into a day-to-day routine: *'my company wanted to send me to Afghanistan within a few months of being released. My only option was to quit the job, so I was not impressed with their lack of flexibility.'*

One way that is helping Peter to recover is to share his experience through presentations to humanitarian organisations and the military. He ends one of his talks with the quote from the German philosopher, Friedrich Nietzsche: 'That which does not kill us makes us stronger', and, at the same time, he also shares that his recovery has been seven years to date, and is still ongoing.

A trauma management programme

Having worked with organisations for as long as I have, I appreciate that trying to design an organisational trauma management programme is no easy task. Even as an experienced psychotherapist, I'm aware that the information surrounding early intervention is confusing and controversial. Further research is essential in this crucial early stage of trauma support. Below, I have attempted to decipher the confusion and explain, briefly, some of the controversy. Drawing on my experience, I recommend that an organisation's trauma management programme should include the following:

Immediate crisis management

The situation is often chaotic in the initial stages of a critical incident, and therefore the immediate stage of any crisis is all about practical support, and de-escalating and defusing the situation.

Screening

Most people will recover from a traumatic event naturally, but having an evidence-based screening process, (and one that is culturally and ethically appropriate), can help to monitor individuals who may need further support. Ideally, trained and professional clinicians would conduct the screening sessions using evidence-based questionnaires, which need to be comprehensive, and explore physical, psychological, and social needs.

Family liaison support

Family liaison officers are necessary when a member of staff has died or if they are unable to speak for themselves, perhaps because of a kidnapping incident or because they are unconscious. Ideally, organisations will have in-house volunteers trained as family liaison officers; alternatively, some organisations may use an external source.

Peer support

Several organisations have implemented a peer support programme into their organisation. These can be a great resource to support staff as they are versatile, cost-effective, and can be accessed by staff who are harder to reach due to the environment or circumstances. Peer supporters are volunteers within the organisation who have been trained in trauma and stress awareness.

Psychological first aid (PFA)

PFA was first developed by the Australian psychiatrist Beverley Raphael[4] and has become the foundation of psychosocial responses to a major incident. PFA can be delivered to individuals or a group, and encompasses safety, information, emotional support, psycho-education and access to further services.

Psychological debriefing

Psychological debriefing[5] was developed 30 years ago for use in organisations where employees were exposed to traumatic material. However, after the Cochrane review into psychological debriefing for preventing PTSD, psychological debriefing was labelled 'harmful'.[6] Since then, many clinicians have argued that the original research was flawed,[7] as the research evaluated was conducted on individuals for whom psychological debriefing was not originally designed, by inexperienced clinicians, and was too short, both in length of session and time frame. Today, organisations such as emergency first responders, the fire brigade, the police, employment assistant providers (EAPs), NHS foundation trusts, various non-government organisations (NGOs) and United Nations departments, are all continuing to use various forms of psychological debriefing. It is an intervention that needs to be facilitated by specialist clinicians, in an appropriate time frame, and once a traumatic event is over.

Initial trauma assessments

A trauma assessment needs to include identifying symptoms, normalising of the individual's responses, and enabling the individual to recognise and develop coping strategies. It creates a space for the individual to talk through their experiences, and can offer a monitoring process and follow-up appointments, if necessary.

➔

Specialist trauma counselling

The National Institute for Health and Care Excellence (NICE), the World Health Organisation (WHO) and the American Psychological Association (APA) recommend two specialist trauma models: trauma-focused cognitive behavioural therapy (TF-CBT) and eye movement desensitisation and reprocessing (EMDR). Both TF-CBT and EMDR have been culturally adapted to be effective globally, although many countries do not have access to therapists who are trained as specialists in these approaches.

Closure/follow-up

It is good practice to offer follow-up appointments, as it is helpful if staff feel that it is acknowledged that they have been through a distressing situation, and important that they feel supported and valued by their organisation. I supported a team of staff who had lost one of their team members in a car crash. They were a close team and were great at supporting one another. They requested that I come back a year later to facilitate a group event for the one-year anniversary of their colleague's death. Anniversaries and specific dates of events are important to note, and can be triggering for individuals. If it was a high-profile incident, the media may rerun footage of the event and produce documentaries, which can also be triggering. Recognising triggers and enabling events that can create closure to an event, can help healing.

Summary

Working within the field of crisis response, it's not unusual to receive calls from managers or HR personnel, anxiously demanding that: 'we need counsellors here, now!' My role is to contain the anxiety and to manage the situation by grounding and stabilising the individual at the end of the phone, by offering clear support and advice, and explaining the appropriate trauma interventions. Typically, I create a pause moment and give the caller permission to take a deep breath and reflect on the situation, so individuals become informed and responsive, rather than anxious and reactive. This is the challenge of managing a crisis call, as anxiety is highly contagious: 'Well-intentioned, mental health practitioners should not "parachute" uninvited into a disaster zone, particularly if they have no knowledge of the local culture, language, mores and religious sensitivities.'[8] Counsellors or peers trained in trauma awareness, PFA and crisis response can be helpful in these early stages, but general counsellors or counselling are not.

In short, it is essential for all organisations to have a critical incident plan, which includes a trauma management programme that is tested yearly through a simulation training programme. Assessment and triage need to be carried out early on after an incident takes place, and administration processes are important to set up during the immediate response. Psychological first aid can be a useful model to offer as well as providing psycho-education, normalisation and resourcing for staff after an incident. The benefits of PFA are that it can be facilitated by appropriately trained peers, and can be useful even during a long-term crisis incident (such as working and living in war zones). Peer support programmes are also worth considering, so appropriately trained staff are available and at hand immediately during a crisis to support their colleagues. Psychological debriefing should not be activated until the incident has ended, and needs to be facilitated by mental health professionals, and is time sensitive. If individuals are identified as having ongoing psychological difficulties four weeks after an incident, there are excellent trauma specialist therapies available. Support for families needs to be included in the critical incident plan, providing information sheets as required, and family liaison support when necessary. This includes having access to specialist trained family support officers.

Megan and Peter did not receive good quality trauma care, and were often retraumatised by their post-incident experiences. Organisations need to incorporate a clear trauma management programme into their critical incident plan that supports staff through each stage of their recovery process and eventually enables staff, not only to recover, but to experience post-traumatic growth.

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Fiona Dunkley is a senior accredited BACP psychotherapist, supervisor and trainer. She manages FD Consultants, offering psychosocial support and trauma specialist services to humanitarian aid organisations. Fiona's new book, *Psychosocial Support for Humanitarian Aid Workers: A Roadmap of Trauma and Critical Incident Support*, is published in spring 2018 by Routledge. The case studies in this article are extracts from the book and are republished with permission. For further details, visit **www.routledge.co.uk**
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Your feedback please

If you have thoughts about any of the issues raised in this article or would like to write an article of your own, we would like to hear from you. Please email the editor: **counsellingatwork@bacp.co.uk**

Q&A

What are the issues that you face in your client work with employee assistance providers (EAPs) and organisations? A member of the BACP Workplace Executive Committee responds here to your workplace queries

Q

Sometimes at work, I bump into clients in the corridor or at lunch and it's always an uncomfortable encounter. How would you recommend workplace practitioners deal with these situations?

A

Nick Wood, BACP Workplace Executive Committee

You certainly aren't alone in experiencing these kinds of encounters when working with employees and employers. It's most likely to occur in an in-house setting, but even EAP affiliates when visiting a customer organisation can end up seeing former or existing clients. Bumping into clients in lifts, at lunch, in reception or while delivering training, is very much part and parcel of our work with employers.

Our team of counsellors will often give talks about the work of the counselling service, run training sessions on stress management or personal resilience, and attend staff events such as mental health awareness-raising days. These are occasions when we will link up with other employee services and it can take both the counsellor and client by surprise to find themselves sitting at the same meetings, planning the event.

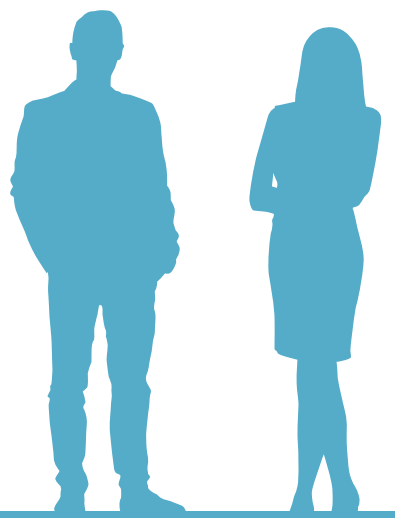
Therefore, it makes sense to be well prepared for this eventuality and to have a plan; but it's also good practice to prepare your clients for this likelihood, too. These encounters can be awkward for both counsellor and client and can have the capacity to impact on the therapeutic relationship.

I find, the key to making what might be a difficult situation for the client more bearable, is to refer to the possibility of this happening during contracting. Openness and transparency are skills we need as therapists to build a good working alliance with the client and, as a rule, I prefer to talk about my role within the organisation, sometimes with a bit of humour, if appropriate, rather than adding additional sentences to the written factsheets I give to clients.

Often in a first session, while I'm covering our confidentiality policy, I'll explain that I'm also an employee in the organisation, and there might be occasions when we could find ourselves in a meeting together, or even in the lunch queue. I'll tell the client that in those circumstances, I probably won't acknowledge or speak to them directly. It helps to point out that this protects client confidentiality; which applies to the content of the sessions and the fact that the client is seeing a counsellor (also subject to confidentiality). If the client wants to initiate a greeting to me, that is fine, but it's their choice.

My intention is that, by discussing this with the client, it will make any future meeting in a different context easier to manage for the client. My golden rule is to ensure that if I see a client, I allow time in the next session to ask the client how they felt about seeing me in a different context. I make sure that I attend to any repair in the therapeutic relationship that might be needed.

Interestingly, on the occasions when I have bumped into clients, I've found that they tend to be far less concerned about the impact of these unexpected encounters than I have ever been.



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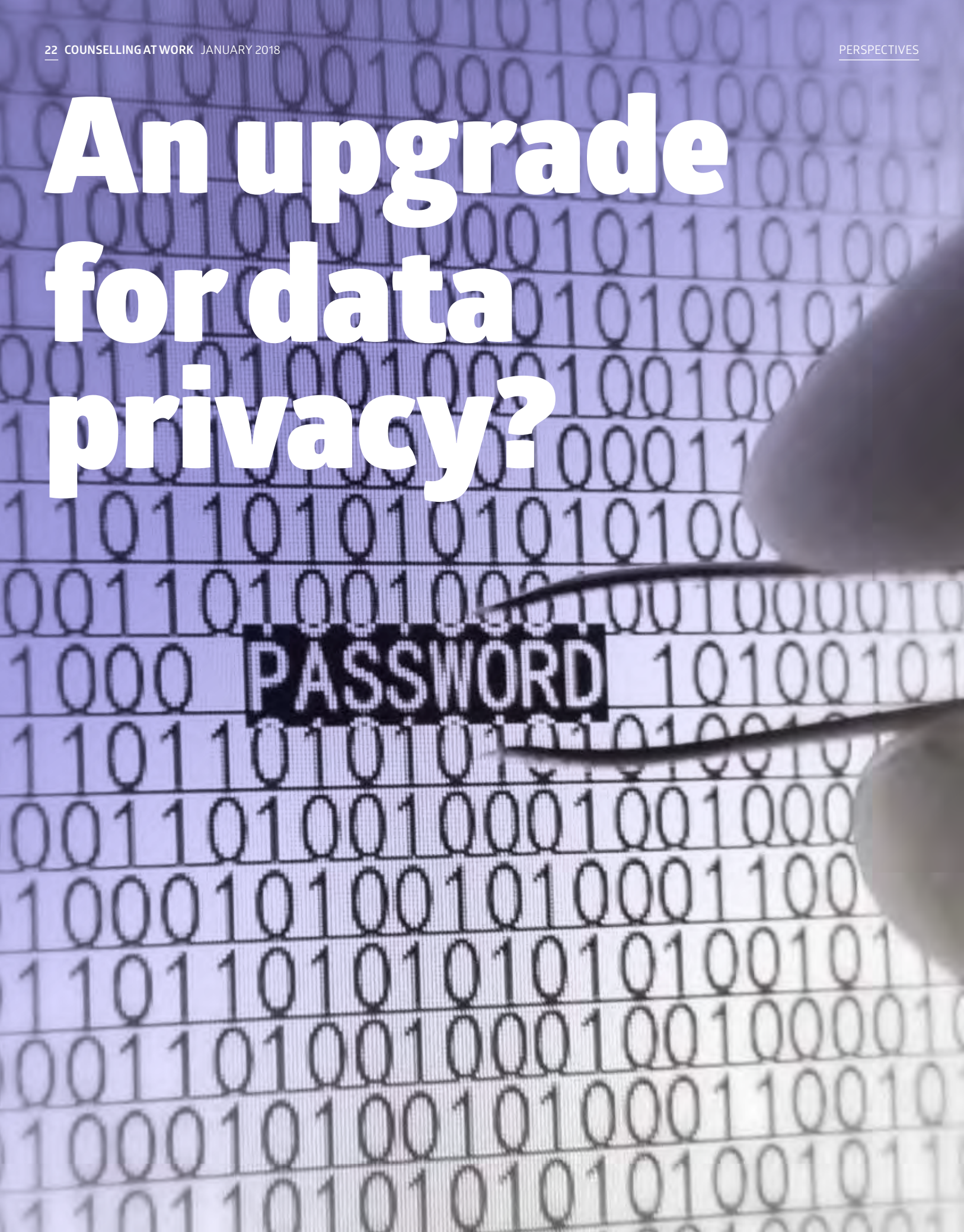
An upgrade for data privacy?



Peter Jenkins examines the changing legal framework surrounding the General Data Protection Regulation and explains the implications for therapists and organisations

The issues of data security, personal privacy and the overarching role of the internet are rarely out of the news. Google is in trouble for seeking access to NHS data.[1] Firms such as TalkTalk have been fined for data breaches,[2] prompting its boss to describe cybercrime as 'the crime of our generation'.[3] The reported epidemic of trolling, cyberbullying and web abuse have sparked even the normally sanguine leader writers of *The Guardian* to lament that 'the internet can be a vile place...'[4]

This changing view of the web, as a dark and troubled landscape, has led to increasing calls for monitoring and policing the internet, to protect personal data and privacy. The Crown Prosecution Service is now seeking stiffer penalties for abuse on Twitter, Facebook and other social media.[5] There is a proposal for an 'internet ombudsman' to police the internet.[6] The normally reticent Information Commissioner's Office (ICO) has lately become more forceful in taking action. Now, the Government proposes to enforce major fines of £17m, or four per cent of global turnover of organisations failing to prevent cyberattacks causing major disruption to transport, health or electricity.[7] This comes as part and parcel of the General Data Protection Regulation (GDPR), which comes into force in May 2018, and is credited with having major effects on counsellors and counselling organisations.

'...there will be a greater focus on data quality and its accuracy, namely the core professional task of recording client notes'

Counselling and data security breaches

Counsellors and counselling agencies might be thought to be less at risk of censure for data protection problems, given our strong professional and ethical commitment to protecting client confidentiality. However, respect for client confidentiality is no guarantee for understanding the fine detail of data protection, either in the past, or in the future under the GDPR. There are examples of counselling agencies losing sensitive client records, eg through the theft of unencrypted memory sticks, in the case of one bereavement agency.[8] The BPAS was subject to an eye-watering fine of 200,000 GBP for systematic failures in its website security.[9] The advice agency, AnxietyUK, was also subject to a recent enforcement notice, following similar concerns over levels of data security on its website.[10] While much writing on the ICO and data protection tends to emphasise its rather scary role as an enforcer, it is clear that, major abuses aside, the ICO sees its role as a 'light-touch' educator, rather than as a heavy-handed regulator. The broad-brush basics of data security are not that complex to learn or to put into practice (see figure 1).

Figure 1: Advice from the Information Commissioner's Office on protecting client data[11]

1. Tell people what you're doing with their data.
2. Make sure you are adequately trained.
3. Use strong passwords.
4. Encrypt all portable devices.
5. Only keep people's information for as long as necessary.

Changes due to GDPR

The changes introduced by the General Data Protection Regulation represent a shift in orientation towards the processing of personal data. Necessarily, this is a key task for counsellors and counselling organisations. In broad terms, the changes operate firstly at the level of *organisational policy* and then at the level of *practice*. At the *policy* level, organisations need to establish appropriate policies, for example, by nominating a data protection lead, with overall responsibility for data protection. Agencies need to develop sufficient levels of awareness among staff about good data security. Clearly, organisations need to notify the ICO of their data processing activities, or to 'register', with it, in everyday language. Where data processing is outsourced, eg by being held in a computing 'cloud', then care needs to be taken that the level of protection is compliant with the high levels already required within the European Community. The GDPR is designed to be Brexit-proof and will not be affected by the outcome of the Brexit negotiations. The Government is fully committed to implementing the GDPR and an updated Data Protection Act will follow on and become law in 2018.

General Data Protection Regulation: main changes from the Data Protection Act 1998

- New requirements on data *processors*, those carrying out data processing activities, ie to maintain records of their work; greater legal liability for data breaches;
- New, broader, definition of personal data, eg to include identifying IP addresses; term 'sensitive personal data' replaced by 'special categories of personal data', to include identifying genetic or biometric data;
- New 'accountability principle', whereby organisations need to show *how* they comply with the data protection principles, eg by recording their activities, and by appointing a data protection officer;
- Enhanced protection of the rights of children with regard to data processing, eg the right to remove material from social media; no requirement for parental consent for data processing related to counselling;
- Information about data processing ('data subject access request') to be *free*, rather than require a fee of 10 GBP;
- Duty to report data breaches, eg loss of client confidentiality, within 72 hours;
- GDPR to provide a 'floor' of EU standards for data processing, with additional UK-specific areas, such as law enforcement and national security, to be covered by the proposed Data Protection Act 2018.

Despite the publicity surrounding the GDPR, there is still a nagging suspicion that there is actually rather less here than meets the eye, at least in terms of a *radical* overhaul of data protection. With the GDPR, however, it does seem that the devil will be in the detail. According to the ICO, 'many data security breaches are accidental and result from insider actions,' rather than from external hacking. Counsellors will already have a keen awareness of the importance of maintaining confidentiality, but can sometimes be hazy on the fine detail of data protection practice, particularly at the more 'high tech' end of things. In terms of the practical application of the GDPR, organisations need to be clearer about how they protect client privacy, ie clarifying *what* client information is kept, *how* it is processed, *how long* it is kept for and *for what purposes* (see below: draft privacy and consent form for counselling clients).

'Under the GDPR, there is a greater emphasis on client rights, such as the right to ask for their records under "data subject access requests"'

Draft privacy and consent form for counselling clients

- State who is the Data Controller and whether they are registered with the ICO
- Set out the purposes and legal basis for processing client personal data
- Clarify the circumstances in which data may be shared with other agencies (eg immediate risk of substantial harm to self or others; or under a legal requirement, eg terrorism, drug money laundering; or via court order for disclosure)
- State how long client records are kept, before being securely destroyed
- Explain client rights under data protection law, ie
  - > to access a copy and explanation of their personal data
  - > to request correction or erasure, in certain circumstances
  - > to request limiting or ceasing data processing, where applicable
  - > to compensation for substantial damage or distress caused by data processing, where applicable.

Under the GDPR, there is a greater emphasis on client rights, such as the right to ask for their records under 'data subject access requests'. The knotty, and still largely unresolved, question, ie of how long client records should be kept for, needs to be tackled by agencies and practitioners, by setting clear timescales for retaining, and then securely destroying, client notes. Generally, staff, including students on placement and volunteers, need to be well briefed and 'on board' with the fine detail of data security. This will apply at the most basic level, as in the form of 'clear desks and clear screens' practices (eg by using 'Ctrl-Alt-Delete' to lock screens). Counsellors will need to comply with minimal good practice in data security, by adopting and frequently changing 'hard to guess' passwords, and by minimising their use of personal smartphones, laptops and tablets for work purposes. Basic data security will involve using passwords and encryption to protect any sensitive client material sent as email attachments. There will also be a greater emphasis on obtaining and recording *explicit client consent* for data processing needed for counselling activities (although this is acknowledged as not necessarily the 'silver bullet' of good practice, according to the ICO).[12]

Data protection and time limits for keeping records

One of the issues raised at every workshop on record keeping is: how long should we keep records? Unhelpfully, there are several different answers to the question, depending on the context of counselling practice. Some records, eg in the NHS, may have statutory time limits set.

Professional indemnity insurance policies may need checking before setting time limits for keeping counselling records, as these often stipulate that records are kept for substantial time periods, as defensive material in the case of professional complaint, or litigation. Access to client records by the police, Crown Prosecution Service, solicitors and courts, for use in legal cases involving clients, seems to be increasing, according to anecdotal evidence, although this need not directly influence the time limit set for retaining records as such. Research into data protection in higher and further education found that many counselling services in this sector applied a time limit of around six years, but often with no clear rationale for deciding on this limit. (Six years is the time limit for bringing legal action for breach of contract, which may be one, if not necessarily the sole, deciding factor here.)[13] However, there is a clear principle under data protection law to keep records 'no longer than is necessary'. This countervailing principle can actually empower agencies and practitioners to set lower time limits for keeping client counselling records, according to their own context, agreed priorities and 'standard industry practice'.[14]

Figure 2: Time limits for keeping counselling records in further and higher education (n: 50)[13]

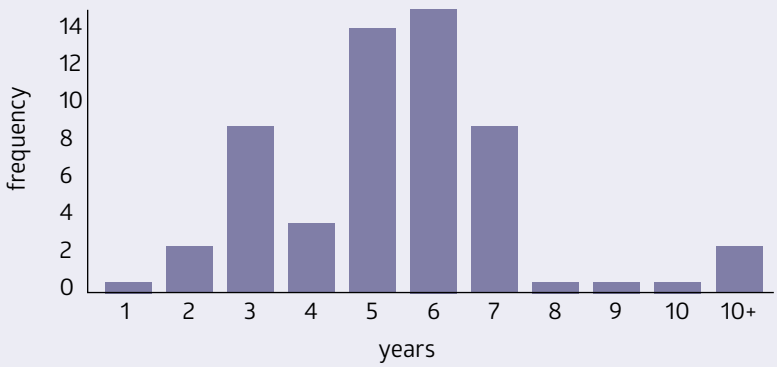


Figure 3: Do I need to register with the Information Commissioner's Office?[10]

Impact of the GDPR

The impact of the GDPR will probably vary, according to the work or practice context of counsellors and counselling agencies. The three main contexts are those, firstly, of working in private practice, secondly, in small voluntary, or third sector, counselling organisations, and, finally, in larger public sector organisations.

Data protection in private practice

Patti Wallace, formerly BACP's professional lead for private practice, carried out an email questionnaire survey of BACP members working in this sector (n: 2,544). She found that 'most respondents use a paper-based system to record client information and notes, although nearly a third (31 per cent) were interested in moving to an online system. However, just 19 per cent were registered with the ICO, and 58 per cent were not aware that they should be registered.'[15] This suggests that there could be a strategic awareness, training and compliance gap regarding data protection in this sector. Clearly, some private practitioners work in a range of settings, so may already have wider exposure to training and updating in data security, which they could easily transfer to their private work. Private practitioners, for example, engaged by employee assistance providers (EAPs), may be more likely to use bespoke electronic recording systems and to be required, via contract, to follow EAP data security policy and practices. Despite the seeming complexity of data protection law, the requirement for private practitioners to register with the ICO is fairly straightforward, that is, if using a smartphone, laptop, tablet or PC, to process *any* client personal data (see figure 3).

Data protection in small third sector organisations

This perception of problematic data protection compliance is also found in smaller, third sector organisations. The ICO has carried out its own small-scale research into policy and practice among victim support services (n: 27)[16] and charitable organisations (n: 32).[14] These agencies are generally characterised by large numbers of volunteers, and consequent high staff turnover, while handling large volumes of sensitive client data, sometimes of a therapeutic nature. The surveys found good physical and building security and high levels of staff commitment to data protection. However, in practice, there were significant weaknesses in terms of a lack of policies for data security regarding staff while working from home, and in using personal electronic devices. This also applied in terms of a lack of basic IT security, such as using strong passwords, encryption and updated virus protection. Where agency work was subcontracted to third parties, contracts often failed to specify data protection roles and responsibilities, such as who was the data controller. Across the board, agencies failed to set out clear data retention policies and security, bearing out apocryphal tales of some manual client records being archived in employees' lofts. Regular staff and volunteer training would thus appear to be critical in overhauling the data security culture in this field.

Data protection in larger public sector organisations

Larger public sector organisations, such as schools, universities, the police and the NHS, will presumably already have data protection officers and policies in place. They may also have less of an immediate problem with the provision of staff training, although it would be good to make less frequent use here of the 'fear factor' as a prime motivator. Much online staff training in data protection in this sector seems incomplete without frequent references to sacked admin staff, or disgraced marketing managers, brought low by lazy email etiquette, or by poor data security. Large public sector organisations are perhaps at higher risk, in terms of the sheer volume of sensitive data they need to handle (eg about mental health, disability), frequently leading to heavy ICO fines when files are lost, or inappropriate information is emailed and systems are hacked. In terms of protecting counselling confidentiality within larger organisations, it has been very useful, in the past, to have sector-specific codes of practice, such as the unfortunately now-defunct JISC Code of Practice for further and higher education.[17] This could often prove useful for protecting counselling client confidentiality and in warding off the enquiring efforts of over-zealous data protection officers.

Privacy as a data protection issue

What is perhaps most striking is the emerging focus on *privacy* as a key data protection issue. As counsellors, we may well pride ourselves on being alert to the need to protect client *confidentiality*, ie the *content* of client-counsellor interactions. *Privacy*, as distinct from confidentiality, 'refers to information *about* the client attending counselling', such as their identity, or other key personal characteristics.[18] Privacy issues are clearly central to counselling as a professional activity. Examples of potential challenges to privacy include, for example, the particularly sensitive issues for trans people, concerning their medical records, which may refer to a previous gender.[19] The increasing use of CCTV in hospitals and in schools raises real concerns about threats to privacy, especially when used in counselling suites.[20] Agencies with a counselling remit may also come unstuck in trying to adapt to new technology. This apparently happened in the case of the Samaritans' use of a Twitter 'Radar' app, designed to alert Sams when service users were 'struggling to cope'.[21]

Privacy issues can be particularly acute for specific client groups, such as children and young people. The campaign group iRights has highlighted the case for young people to have embarrassing and irrelevant material deleted from social media, via 'take down notices'.[22] Thus, in Northern Ireland, a girl aged 14 is currently suing Facebook, in order to remove a 'revenge' naked photo from its web pages.[23] There has also been the recent successful challenge to Scottish government information-sharing policy required for Getting It Right For Every Child (GIRFEC), again on privacy grounds.[24]

Privacy issues are thus being taken more and more seriously within the law generally; witness the recent, perhaps surprising, judgment protecting employees' right of privacy, regarding personal emails at work.[25] The law on privacy is a fast-developing field, in which the GDPR and new DPA 2018 are likely to make an increasingly significant contribution. This is a major legal shift since even the Naomi Campbell privacy case, in 2003. Here, the Data Protection Act 1998 was seen to be of little relevance in resolving the case, compared with the more influential Human Rights Act 1998 (Campbell v MGN Limited [2004] UKHL 22).

Conclusion

If the GDPR, ICO, DPA, and other agency initials, are there to protect client privacy, the real difficulty lies in the growing commercial value now placed on exploiting personal data, whether we choose to call this the new 'data capitalism', or not.[26] In this global marketplace, 'personal data is the "gold" of a new category of companies… that sell this information…'[27] This presents a real tension around the position of counsellors, as custodians of their clients' personal data, given the growing pressures to exploit health data, amidst the mediating role of regulatory bodies, such as the ICO. But maybe we need to look well beyond this, and try also to understand the web at much more of a *symbolic* and *relational* level. On these lines, a *Guardian* journalist, Charles Arthur[28] has referred to the internet in a striking image of the ideal Victorian prison. In what he tellingly calls 'the panopticon of the web', here everything is revealed and nothing is ever forgotten – rather like the unconscious, in fact. The real challenge for therapists, perhaps lies in helping to decode some of the more symbolic meanings of the web, while protecting the privacy of client secrets shared in therapy, and by continuing to explore the implications for our own practice.

Peter Jenkins is a counsellor, trainer, researcher and supervisor. He is the author of *Professional Practice in Counselling and Psychotherapy: Ethics and the Law*, published by Sage.
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Your feedback please

If you have thoughts about any of the issues raised in this article or would like to write an article of your own, we would like to hear from you. Please email the editor: **counsellingatwork@bacp.co.uk**

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Are you looking for peer support?

BACP Workplace Executive Committee has been hearing from members who would like to form peer support groups with workplace practitioners. However, we know that not everyone has other members within their local area.

To help bring members together, our network co-ordinator, Julie Hughes, is looking into the options of holding virtual meetings, for networking, peer support and CPD. If you could be interested in exploring possibilities for new ways of meeting other workplace practitioners, contact Julie Hughes at: **juliehughes@mindmatterscounselling.org.uk**

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BACP Workplace means business

Why is there so little mention of the role of counsellors in the recent *Thriving at Work* review on mental health and employers? Nicola Banning and Nicola Neath argue that BACP Workplace needs to join policy makers at the table

At the end of last year, *Thriving at Work*, the review led by Dennis Stevenson and Paul Farmer, CEO of Mind, was published with much interest in the media as society increases its awareness of the mental health at work agenda. The review into workplace mental health, commissioned by the Prime Minister last January, looks at how employers can better support all employees, including those with poor mental health or wellbeing, to remain in and thrive at work. The report can be found at: **http://bit.ly/2iC9EvH**

In November, members of the BACP Workplace Executive Committee were invited to attend the Westminster Events Forum on mental health in the workplace, with speakers from a range of sectors referencing *Thriving at Work*. It was an opportunity to hear business people discuss the review, and the initiatives that had been in taken in their respective workplace.

Statistics from the Department of Work and Pensions reveal that 300,000 people with a long-term mental health problem lose their jobs each year. Analysis by Deloitte, commissioned by the reviewers, reveals a demonstrable cost to employers, and quantifies how investing in supporting mental health at work is good for business and productivity. Poor mental health costs the UK economy between £74 billion and £99 billion a year. Deloitte's analysis shows that the cost to employers is between £33 billion and £42 billion of this sum, not to mention the individual cost, which we witness daily.

The review focuses on establishing mental health core standards for all employers, including:

- Producing, implementing and communicating a mental health at work plan;
- Developing mental health awareness among employees;
- Encouraging open conversations about mental health and the support available when employees are struggling;
- Providing employees with good working conditions and ensuring they have a healthy work-life balance and opportunities for development;
- Promoting effective people management through line managers and supervisors;
- Routinely monitoring employee mental health and wellbeing.

Broadly speaking, the therapy profession is likely to agree with the aim of moving to a society where all of us become aware of our own mental health, other people's mental health, how it fluctuates and an understanding of how to look after it. We are encouraged that more employers, business leaders and the Government are all beginning to understand what we workplace specialists have known for decades.

At the Westminster Events Forum on mental health in the workplace, the speakers overwhelmingly welcomed the changes in how mental health might be understood in the workplace and addressed the areas where they had made progress towards changing the culture or improving mental health awareness. However, having read the review, and listened to a wide range of speakers on the subject of mental health at work, we are left with concerns about the limitations of the review and the possible implications of some of its recommendations. As a general point, there is a worrying lack of understanding being demonstrated about the existing psychological and therapeutic support systems already working within the public and private sectors, which contribute to cultural change and support good mental health at work.

If you haven't had time yet to read the report, please do, and let us know if you have any comments or queries, so that we can be sure to represent your views. In the meantime, we offer some of our concerns.

What is mental health awareness training for?

If mental health awareness training is to help staff to have better conversations at work and to signpost people who need help, to get help, then this is a positive step. It is important that employers can signpost their staff to appropriate support. However, as we know, access to IAPT or other NHS providers can involve long waiting times (up to six weeks), and there is little reference in the review to the access employees have to psychological support and talking therapies via their employers. It's of concern that some employers could see training staff in mental health awareness as a form of treatment or intervention in itself, which we believe is not acceptable; and in the

'...there is a worrying lack of understanding being demonstrated about the existing psychological and therapeutic support systems already working within the public and private sector'

ongoing context of austerity and constrained budgets, this is a very real danger.

How will the new carers and champions be supported at work?

We are concerned too much responsibility for providing mental health support could be placed upon people who don't have any mental health training. Health and safety executives, line managers and senior executives will have greater responsibility for having better conversations to support mental health at work, but there is no mention of what support or clinical care they might need.

Already, there are cases of workplace champions being overloaded with the concerns of others, squeezing their capacity to do their day job and leaving them feeling overwhelmed. This is unsafe and potentially dangerous for those they might wish to support. There is no mention in the review of supporting carers with reflective or clinical supervision, nor mention of the need for workplace competencies in mental health. Our work is complex, multifaceted and often involves the psycho-education of people in organisations to help foster transparency, eradicate blame cultures, manage fear and take reasonable responsibility for complicity and culpability in illness, when work is a factor.

What does it mean to routinely monitor employees?

We are concerned at the suggestion that employers 'routinely monitor employee mental health and wellbeing'. How will staff be monitored? By whom? And for what purpose? We know we need to engender trust in our organisations in order that employees, especially hard-to-reach client groups, are willing to access our services. Consequently, therapists build good relationships at every level of the organisation, and routine monitoring and company disclosures could cause a loss of trust and dissuade employees from accessing help. What also of the right to non-disclosure and the Equality Act, 2010?

What is the quality of support that is being offered?

It is of concern that there is an emphasis being placed upon digital forms of support when employees require help. Potentially lonely and anxious members of staff will remain at risk if the message is that the only support they can expect to receive through their employer will be online.

At the Westminster Events Forum, reference was made to employees making use of digitised-CBT as a good way to support large groups of the workforce. While apps may indeed form part of a therapeutic intervention, it's concerning to increasingly be hearing people who are not clinicians speaking about this alone being a legitimate therapeutic intervention.

What will it really cost?

There is insufficient mention of how employers are going to finance these initiatives to support good mental health or where the experts/trainers will come from. The review claims that the measures will cost 'little or no money', a message repeated by many of the speakers at the Westminster Employment Forum event. This seems at best naïve. In an age of ongoing austerity, it's likely that employers will have to divert money from one place to another to fund support. We know that the NHS needs more funding to adequately provide mental health support, and employers should not be used as an alternative source of funding.

Of particular concern is the lack of acknowledgement in the review of BACP's members, many of whom are supporting employees and employers, working in professional in-house counselling services or via EAPs. These are our colleagues, many of whom have been working in the field of workplace mental health for over 20 years, and whose work is covered regularly in *Counselling at Work*. We are concerned that as the mental health at work agenda is more widely understood, emerging opportunities could arise for unethically minded opportunists, who are neither trained nor skilled, to step in and exploit the sea change.

The review drew on the expertise of a Leadership Panel, an Advisory Group and consulted with over 200 employers and stakeholders, as well as with professional bodies. It's disappointing that BACP was not consulted during the process, and that there is no mention in the review of the extensive evidence base about the efficacy of counselling to support good mental health at work and to reduce sickness absence.

The task ahead

All of the above raises further questions for how we, as workplace specialists across the four nations, can influence and shape what happens in the future; in particular, how we ensure that best practice is offered to our employee and organisational clients.

Looking ahead, the review suggests that the public sector is ideally placed to play a key role, as it employs 17 per cent of those in work. It asks that the Government commit three main employers to take part in implementing 40 recommendations and identifies three main areas: the NHS, the education sector and the civil service. Frontline services and those at high risk of stress trauma are also mentioned as requiring support, including the blue light services, prison staff and social workers.

There is an opportunity now for us to take a lead. BACP Workplace members are actively involved in these sectors and have knowledge and expertise in the context in which employees are working, particularly the context of austerity in our public services. Austerity contributes not just to the poor mental health of our society, but impacts on key personnel who are tasked with supporting those most at risk, at a time of reduced resource, increased demand and with consequences for staff morale, productivity and wellbeing.

Finally, we are committed to ensuring that the work of our sector is more widely understood. We will be requesting that BACP works to ensure that the voice of our profession is represented during any next phases of implementation. We will need to be able to explain in clear language to non-therapists, the value of psychological wellbeing at work and the ways that we support employers every day to maintain the mental health of the workforce. Our work is integral to the health and wellbeing of a healthy economy, and we need to seize this moment to ensure that the services we provide are firmly embedded into the infrastructure of the workplace for the 21st century.

Nicola Banning and Nicola Neath
BACP Workplace Executive Committee

Your feedback please

If you have thoughts about any of the issues raised in this article or would like to write an article of your own, we would like to hear from you. Please email the editor: **counsellingatwork@bacp.co.uk**

EAP MATTERS

It's all in the contract

Julie Hughes

Have you read the contract?' is a question I often find myself asking affiliate counsellors; and it leaves me with a clear sense that contracting needs to be better understood by workplace practitioners. Reflecting on my training, I recall that contracting was given due attention for the therapist setting up in private practice. Unfortunately, there is very little guidance on how to manage a dual contract between an affiliate therapist and an employee assistance provider (EAP), and the contract between the affiliate therapist and the client being referred by the EAP. It's in this spirit that I share my experiences as a case manager, to provide some guidance for those new to EAP work about the importance of reading and understanding the contract.

So, let's be clear, if a client is referred to you by an EAP, there will be a contract that exists between you and the EAP which also embraces the contract between the referring organisation (normally the employer or occupational health company) and the EAP provider. This contract will inevitably impact on the contract that exists between you and the client. It's this important point that is often not understood by affiliates, who are then not prepared for the complexities of managing the dual contracts.

These contracts serve an important function and have been agreed between an EAP and the employer, building in clear boundaries about what services are being offered, where they will be offered, when and how the service will be offered, and what conditions/restrictions are in place to ensure good practice. As an affiliate counsellor, it's essential that you understand what contract you are entering into with an EAP, and that you have agreed that you will work within the remit of that contract.

'Abiding by the contract is a must if an affiliate is to provide good practice to all parties'

Typically, an EAP contract is likely to include the following: cancellation period, reporting on session dates, providing official reports, number of sessions, time periods for when sessions can be completed, restrictions on engaging in a private contract with a client, signing of consent forms, therapeutic model, and costs. Abiding by the contract terms is a must if an affiliate is to provide good practice to all parties; and failing to do so puts not only the client at risk, but the therapist and the EAP too. This might sound alarming, but what follows is not an uncommon example, where veering from the dual contract poses problems for all concerned.

Let's imagine that as a private practitioner you have a 24-hour cancellation period in place for your clients to cancel or change an appointment. However, you are also registered as an affiliate counsellor with an EAP, but their contract states the client must give 48 hours' notice of a cancellation. You see the client through the EAP contract and the client fails to give you 48 hours' notice, but you allow the client to change the appointment anyway, as per your private contract.

Now, just imagine what happens when a client from the same employer who is seeing another affiliate counsellor, referred to them through the same EAP as yours, fails to give 48 hours' notice of a cancellation and they lose that appointment. If the two colleagues (clients) discuss this at work, they may feel disgruntled that they have not been treated equally; they will then report this to management, who in turn report this back to the EAP. As a case manager, I find affiliates often question cancellation times and it will always take us back to the contract, and whether it's been read, understood and adhered to.

I'd recommend avoiding being too helpful or too accommodating, as it can mean that contracts and boundaries are not being held. Remember to hold in mind how the EAP contract varies from your normal contract, because failing to abide by the EAP contract can be detrimental not only to the employer and EAP, but also to the clients who access the service.

Understanding the contract and reading the paperwork are fundamental to good practice in order to deliver a professional service. When working with an EAP, I'd recommend the following: read the contract carefully; ensure that you understand it and the implications; and that you clearly convey this to the client, so that the contract between you and the client is fully understood.

Finally, if in doubt, ask. I'd rather affiliates checked with me than have to pick up the pieces after a contract has been breached.

Julie Hughes is a BACP accredited counsellor and Senior Case Manager at Mind Matters Counselling LLP. She is also a member of the BACP Workplace Executive Committee.
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Practitioner MATTERS

Negotiating the contract

Patrick Quinn

The 'magic number' is often six, but there may be as few as four. I'm referring, of course, to the number of sessions we often work with in the workplace context. Inevitably, some clients arrive with complex long-standing problems, for which we might normally recommend longer-term therapy. Good ethical practice means we can't just launch into a therapeutic relationship that won't go near to meeting the client's needs. And even in the best-judged cases, during the counselling, further stresses and life events can throw clients back into crisis, not long before the arbitrary end date.

'There is a skill to saying "no" to a client whom we decide not to see; a good supervisor should understand the issues and give support and coaching for that difficult task'

At a recent gathering of experienced staff counsellors, it was clear how practitioners had developed various ingenious ways to respond. For example, some EAPs or employers allow for a client to 're-contract' for another course of sessions, providing they return with a different 'identified problem'; or a client may be referred back and see the same counsellor, for a further course(s) of sessions, maybe after an obligatory time lapse. Some agencies allow extra sessions to be negotiated, for example to offer supportive sessions while the client waits for longer-term therapy elsewhere. This could be through local IAPT schemes, but it is always useful for the workplace counsellor to build up knowledge about local voluntary agencies that offer counselling, to refer clients to; for example, Women's Aid, Rape Crisis, and Macmillan, among others.

Skilled assessment is important, and from the first meeting with the client a key factor is the resilience shown by the client, or what psychodynamic practitioners would call 'ego-strength'. In short-term work, I recommend taking a resilience history, whatever your training model says. For example, if the client has been reliably holding down a demanding job, has passed courses successfully, and is managing a family in a stable way, these are pretty good indicators that they might be capable of useful work in a few sessions, even when your assessment reveals serious and early life issues – without danger of mental health breakdown or uncontrolled risk. Be open with the client – tell them your concerns, give them the choice. If the client would rather leave the disturbing things well alone, it might be best to work with a CBT approach. Some short-term training, in brief solution-focused therapy, can help you to identify who is or isn't appropriate for focused short-term work.

For some clients, spacing sessions every two or three weeks may help to reduce the emotional intensity, and allow time to recover stability between sessions. Some clients may develop the motivation to go on to do private work, if they have had a good experience of short-term counselling. However, there are serious ethical issues to be taken to supervision if you wish to take a client from paid-for counselling into private work; and your contract with the EAP will address this issue, too.

And finally, a word of warning: as with doctors, our first ethical duty is to 'do no harm'. Another duty is self-care: an attempt at therapy which causes us undue stress and burnout is not wise. Regardless of how much compassion you feel for a client, you'd be wise to listen to your head, and watch for warning signs that counselling might do more harm than good, to either of you. If the client talks bitterly of relationships with helping agencies that have repeatedly broken down badly, or prolonged bitter conflicts with ex-partners, friends or family, this could indicate that the same pattern will be repeated with you. A client who you feel exhausted by, endlessly worried about and yet somehow you dare not stop seeing, for fear of risk, is a classic pattern which you should ideally identify from the start. Short-term therapy is unlikely to help such a client. Be very clear with the client about boundaries and the limits on sessions, and explore it in depth in supervision. These could be inappropriate clients for short-term work, especially if you are seeing them in a room at your own home.

There is a skill to saying 'no' to a client whom we decide not to see; a good supervisor should understand the issues and give support and coaching for that difficult task. And you may have to inform the EAP or employer, that you do not have the skills for this particular client; an organisation that is not helpful with that, is an organisation that is not safe to work for.

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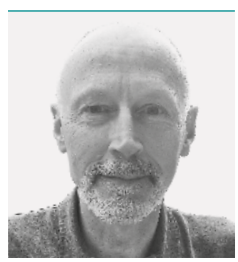

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