Counselling for staff in health service settings

A guide for employers and managers
Acknowledgements:

This document originated from the work of a group of RCN staff and representatives in the RCN’s Northern and Yorkshire and Humber regions who have been central to the process throughout. In particular the RCN would like to thank:

RCN contributors
Carol Bannister
Shane Buckeridge
Sandra Bullock
Claire Cannings
Janet Daniel
Karen Doherty
Kath Fawcett
Lynne Jackson
Gordon Lees
Dorothy Madine
Barry McInnes
Janet Mortimer
Anita Murray
Cathy Taylor
Sue West
Gerrie Witney

Other contributors
Participants of the RCN Wales consultation seminar, March 2001
Trudy Chapman, Guy’s Hospital
Ali Jesson, St George's Hospital
George Leach, St Bartholomew’s Hospital
Roz Rome, St Thomas’ Hospital
Miranda Whyte, Royal Free Hospital

2006 Amendments
Shane Buckeridge
Head of Counselling
Royal College of Nursing

Hickman - a registered trademark of C. R. Bard, Inc. applied to a central venous catheter.
Counselling for staff in health service settings

A guide for employers and managers

Contents

1 Introduction and context 3
2 What is counselling and how is workplace counselling different? 5
3 Counselling’s contribution to staff health and organisational effectiveness: the evidence base 7
4 Getting started: core elements and key principles 10
5 Counselling services and their role in wider staff support and organisational culture 16
6 Audit and evaluation of counselling provision 18

Appendix A: Human resources, legal and health and safety considerations 20
Appendix B: Key indicators of service quality 21
References and further reading 22
Resources 23
COUNSELLING FOR STAFF IN HEALTH SERVICE SETTINGS

working well
This guidance has been developed as part of the Royal College of Nursing’s (RCN) Working Well Initiative and outlines the role of staff counselling within health service workplaces. This specialised field of counselling is known as workplace counselling. This document is intended to help health service employers and managers have a more informed view of how to provide staff counselling services and the resources that are needed.

The RCN has a long-standing interest in the psychological health of nurses and other health service staff, and has been at the forefront of initiatives aimed at both preventing and alleviating unnecessary distress and psychological ill-health to staff involved in the delivery of health care to patients. This includes the identification of work factors that contribute to workplace stress, the promotion of good employment and management practices, and the provision of appropriate and timely intervention for staff affected by their work.

For many years the RCN has recognised the value of counselling in health care settings, providing a counselling service to RCN members for more than 20 years. Indeed, it is the only professional body in the UK to provide such a service using staff directly employed for that purpose. In addition, it has encouraged health service employers to provide counselling directly for their staff, believing that they have an obligation to address the human and organisational consequences of stress and that it is in their financial interests to do so.

A large-scale study into stress in the NHS conducted by Leeds and Sheffield Universities established a clear link between stress and sickness absence (Borrill et al, 1998). More recently, these findings have been echoed in the RCN’s own Working well survey of 6,000 members, which identifies that staff experiencing significant levels of psychological distress report twice the mean level of shifts taken off sick than other colleagues (RCN, 2002a).

This guidance also aims to raise awareness of the legal standards to be met in relation to the Health and Safety at Work etc Act 1974, which states (section 2(1)) that: “It shall be the duty of every employer to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all its employees.” Employers must also take account of the risk of stress-related ill health when meeting their legal obligations under the Management of Health and Safety at Work Regulations 1999, which includes the requirement to conduct risk assessments.

The Health and Safety Executive (HSE) has established targets for reducing the incidence of both work-related ill-health and working days lost to work-related ill-health by 20 per cent and 30 per cent respectively by 2010 (HSE, 2000). The HSE has also produced Tackling work-related stress – guidance to assist managers in improving and maintaining employee health and well-being (HSE, 2001).

More recently the HSE has produced Management Standards for Tackling Work-Related Stress (2004). The Standards identify six key areas (or risk factors) that can be causes of work-related stress. These are:

- the demands of your job
- your control over your work
- the support you receive from managers and colleagues
- your relationships at work
- your role in the organisation
- change and how it’s managed

The target proposed by the standards is for all organisations to match the performance of the top 20% of employers that are successfully minimising work-related stress.

Counselling is not a panacea, and should not be regarded in itself as an adequate response to addressing stress in the workplace. Nonetheless, there is a clear and growing evidence base demonstrating that counselling is highly cost-effective, helping to reduce work-related symptoms and stress and lowering sickness absence.

“Staff experiencing significant levels of psychological distress report twice the mean level of shifts taken off sick than other colleagues.”

Working well survey 2002
However, not all counselling provision is equally effective and the RCN is currently involved, together with other partners, in developing a quality evaluation framework for counselling in workplace settings. This will enable health service organisations to assess the quality and effectiveness of their provision against benchmark data for other services, and identify ways in which they may be enhanced.

The value of counselling for staff is increasingly being recognised in the health service. The human resources frameworks for both England and Scotland make explicit the need for counselling provision. Working together – securing a quality workforce for the NHS (NHSE, 1998) goes further and states that all NHS staff in England should have access to counselling services by April 2000. The NHS Executive’s The provision of counselling services for staff in the NHS (2000) describes the types of services that should be available. The Welsh Assembly’s strategic plan, Improving health in Wales (National Assembly for Wales, 2001), states that: “As good and caring employers, health organisations will ensure that staff who suffer injury, trauma or distress at work are fully supported at all stages.” See Appendix A for more details on the impact of human resource and occupational health strategies and the relevant legal, health and safety considerations.

The RCN wants nurses and other health service staff to be able to access appropriate, high quality counselling provision wherever they work. This guidance describes the range of counselling that best offers professional support to health service staff. It builds upon the existing guidance, and evidence of effectiveness and good practice, to help inform and guide managers and employers in developing and evaluating counselling provision.

How this document is structured

Section 2
offers a broad definition of counselling, how it differs from the use of counselling skills, and outlines some of the main features of counselling in workplace settings. The key standards for safe and effective practice are identified.

Section 3
examines the developing evidence base for counselling, in terms of staff health and organisational effectiveness, showing the contribution that counselling makes to improved psychological health and productivity and reduced sickness absence. Financial issues, like cost benefit, are also addressed.

Section 4
highlights the major issues that need to be tackled in identifying a model for service delivery that is appropriate to the needs of both employers and staff. The relative merits of providing counselling internally and externally are considered, and a quality framework for service delivery is outlined.

Section 5
explores the contribution of staff counselling to the overall health of the organisation, suggesting a range of additional functions to improve staff support.

Section 6
emphasises the importance of audit and evaluation of the service and outlines a framework to enable this to take place. The benefits of a standardised system of audit and evaluation are highlighted, and specific standards and recommendations are proposed.

Appendix A
looks at the potential impact of human resources and occupational health strategies in each of the four countries of the UK on the development of counselling services. It goes on to examine the relevant health and safety and legal considerations.

Appendix B
details the key indicators of service quality.
What is counselling and how is workplace counselling different?

What is counselling?

Numerous definitions of counselling exist, but one of the more succinct and helpful descriptions is that by Burks and Stefflre (1979): “Counselling denotes a professional relationship between a trained counsellor and a client. This relationship is usually person-to-person, although it may sometimes involve more than two people. It is designed to help clients understand and clarify their views on their life space, and to learn to reach their self-determined goals through meaningful, well-informed choices and through resolution of problems of an emotional or interpersonal nature.”

Counselling may focus on both work related and personal problems, which can include coping with crisis, conflict with others, development of personal insights and improving relationships. Sessions usually last for between 50 and 60 minutes and take place within a confidential setting. Frequency and duration varies, depending on the client’s needs, availability and the model of counselling employed. Traditionally, counselling happens face-to-face but alternatives – such as telephone, video-conferencing and online counselling – have emerged in recent years.

Counselling is increasingly recognised as a specific professional discipline, as distinct from the use of counselling skills, which are employed routinely by most health service professionals in the course of their work. It is likely that the area of psychological therapies will become legally regulated within the next few years, with titles such as ‘counsellor’ and ‘psychotherapist’ being protected. The minimum level of training that is generally recognised by the professional bodies for counselling and psychotherapy (see Counselling and psychotherapy professional bodies information, page 6) is a diploma, which includes both theory and practice components.

Here are some of the main requirements of professional counselling practice.

**Accountability**
- Counsellors should be properly trained and experienced for the work they carry out.
- They should belong to a recognised professional body, with a code of professional practice and a complaints procedure.
- Clinical supervision is vital and counsellors should receive at least the minimum level required by their professional body.

**Responsibility**
- The primary focus of the counselling is the needs of the client.
- Counsellors should avoid situations that give rise to conflicts of interest between their responsibilities to their clients and other parties. This usually means they do not have any other role with their clients.
- Counselling takes place in an appropriate setting that ensures the confidentiality of the relationship between the client and the counsellor.

What is workplace counselling?

Workplace counselling is a specialised field, whereby the employer either provides a service or access to one. Over the last decade it has become one of the fastest growing fields within counselling. Most of the growth has taken place in the private rather than public sector, with many large corporate companies now offering this service.

In most cases, the health service has been slower to recognise the benefits for its staff, but in many areas this...
is now beginning to change. The growing problems facing NHS managers in recruiting and retaining nursing and medical staff has raised the importance of having a working environment that is supportive to the needs of health service staff.

Counselling for staff can either be provided internally – through a service located in the organisation and by staff employed by the organisation – or externally, where an external provider is contracted to provide the service.

Wherever the service is located, the issue of accountability for counsellors can be complex. This may be to either the employer or to an intermediate provider, depending on whether the service is provided internally or contracted out. In addition, legal, commercial and health and safety considerations may impinge on the counselling relationship. Given these complex factors, it is recommended that newly qualified counsellors should not be employed in these settings unless they can be adequately supported and that, ideally, counsellors should have a minimum of three years' post qualification experience.

Staff perceptions of the service’s confidentiality are crucial and if employees remain unconvinced, it will not gain the trust necessary to succeed. Whether provided internally or externally, the boundaries between counselling and other functions – such as human resources and occupational health – should be clearly defined.

Occasionally staff may be involved in disciplinary processes at work and use the counselling service for support. However, counselling as described within this guidance should not form part of or be confused with any disciplinary process. Counselling should only be undertaken voluntarily and staff should not be coerced into using the service.

Managers and colleagues acting out of concern may suggest contact with a counselling service, but essentially staff should self-refer, free of pressure. Managers should also be sensitive to the needs of staff using the service, for example in enabling them to use the service during work time, and also respect their right to confidentiality.

The following points identify some of the principle features of counselling practice as it applies to the workplace:

- most counselling provision is short-term, with services offering between six and eight sessions, including an initial assessment
- in addition to the minimum professional level qualification of a diploma, counsellors need to be able to work within a short-term counselling framework
- counsellors work with an understanding of the organisational culture – in this case the health service – and of organisational factors which impact on psychological health in the workplace
- counsellors work with an awareness of the interests of different organisational stakeholders and of the potential for conflicts of interest between the needs of the client, the service and other stakeholders.

Counselling and psychotherapy professional bodies

The main national bodies are the British Association for Counselling and Psychotherapy (BACP), the British Psychological Society (BPS), the UK Council for Psychotherapy (UKCP) and the Confederation of Scottish Counselling Agencies (COSCA). See the Resources section at the end of the publication for details.
Standards for health service staff counselling

Counsellors should:

✦ be qualified to a minimum of diploma level
✦ be additionally trained to a level appropriate to their role and setting
✦ be members of a relevant professional body, with a code of professional practice and complaints procedure
✦ be supervised to the minimum level required by their professional body
✦ not have any other role with clients with whom they work
✦ be accredited or eligible for accreditation by their professional body
✦ be trained and/or experienced in short-term work
✦ have an understanding of organisational culture and its impact on staff.

For counselling services settings

✦ Staff using the service should do so voluntarily, by self-referral, and free of pressure.
✦ Counselling should be provided in a setting that protects the confidentiality of the client.

Recommendations

✦ Given the complexity of workplace counselling, counsellors should ideally have three years’ post qualification experience.
✦ Staff should be enabled to use the service during work time if necessary.

Counselling’s contribution to staff health and organisational effectiveness: the evidence base

A range of evidence exists supporting the idea that workplace counselling helps to reduce the level of psychological distress in staff, improves work functioning and lowers absenteeism. Some key studies are outlined here.

The British Association for Counselling and Psychotherapy commissioned a rigorous and independent research review of the evidence to date into the effectiveness of workplace counselling (McLeod, 2001). The results are important pointers to some of the successes within the field of workplace counselling. McLeod systematically reviewed all published English language studies within the field and the report summarises and evaluates in excess of 80 separate studies between 1954 and 2000, reflecting the experiences of more than 10,000 clients. The review concludes that, beyond doubt, workplace counselling is a highly effective intervention.

How counselling benefits the individual

Individuals can refer themselves to psychological support at a time of crisis and distress. Acknowledgement of a problem can be the psychological turning point for the individual. Many staff wait too long before accessing help and the availability of immediate psychological support can reduce distress, helping the individual maintain their role at work.

The McLeod study found strong evidence of the individual benefit from workplace counselling, concluding that: "People who make use of workplace
counselling typically report high levels of psychological distress, equivalent to that found in out-patient psychiatric populations… Significant benefits for clients can be achieved in three to eight sessions of counselling; only the most severely disturbed clients appear to require long-term counselling help or referral to a specialist service… Counselling interventions are generally effective in alleviating symptoms of anxiety, stress, and depression. Two-thirds of studies have shown that, following counselling, levels of work-related symptoms and stress return to the normal range for more than 50 per cent of clients.”

The study by Leeds and Sheffield Universities (Borrill et al, 1988) evaluated two NHS trust staff counselling services, finding a significant reduction in the proportion of clients with significant levels of psychological disturbance (87 per cent at intake to 27 per cent after an average of five sessions). And a study by Cary Cooper (1991) into counselling provision in the Post Office found marked reductions in symptoms of depression and anxiety, as well as significant organisational benefits.

It is also clear that counselling at work is well received by staff. McLeod (2001) states that: “Over 90 per cent of employees who make use of workplace counselling are highly satisfied with the service they have received, would use it again if necessary, and would recommend it to colleagues.”

The study by Leeds and Sheffield Universities (Borrill et al, 1988) evaluated two NHS trust staff counselling services, finding a significant reduction in the proportion of clients with significant levels of psychological disturbance (87 per cent at intake to 27 per cent after an average of five sessions). And a study by Cary Cooper (1991) into counselling provision in the Post Office found marked reductions in symptoms of depression and anxiety, as well as significant organisational benefits.

It is also clear that counselling at work is well received by staff. McLeod (2001) states that: “Over 90 per cent of employees who make use of workplace counselling are highly satisfied with the service they have received, would use it again if necessary, and would recommend it to colleagues.”

The McLeod review also found evidence of very considerable benefits for organisations in having counselling provision. The study concluded that: “Counselling interventions have been found, in the majority of studies to have reduced sickness absence rates in clients by 25-50 per cent… Counselling interventions have a lesser, but still significant, positive impact on job commitment, work function, job satisfaction and substance misuse.”

In a study of Lothian Regional Council Education Department’s Advice, Support and Counselling Unit, absence in the three months after counselling showed a mean reduction of 35.6 per cent compared with the preceding three months (Goss, 1995). Absence in the six months after counselling showed a reduction of 62.5 per cent and changes in absence over the three-month period were calculated as saving £2,000 per employee counselled, rising to £4,000 over six months.1

---

1 Based on previous studies, a figure of £2,000 for every ten days absence was used as indicator of the scale of the cost to the Education Department of any changes in absenteeism.
There is also some evidence that the provision of counselling positively influences staff perceptions of the employer. Smewing (1995), in a study of a NHS based Employee Assistance Programme (EAP), found that even staff that had not used the counselling service felt more valued by the organisation, which led to a 'feel good' factor about their employer.

Case study

Bassetlaw hospital is an example of an organisation that has worked hard to develop an open and informative style of management. In 1994, the hospital faced a major crisis when a member of its nursing staff was arrested and subsequently tried for murder. The court case lasted a number of weeks and many of the staff from the intensive care unit had to go to court to give evidence. The Trust worked with the newly formed staff counselling service, ensuring that the counsellor was included in all the discussions about this difficult incident. Senior managers attended training in critical incident debriefing and utilised these skills with every member of staff that attended the court case. This allowed the nurses involved to express their feelings of anxiety, while the senior managers were viewed as supportive and caring. As a result of their approach, Bassetlaw hospital survived the incident in a way that other hospitals facing similarly devastating incidents had not.

Financial implications

Cost issues are important because counselling provision for staff is essentially competing for resources with other priorities. The more effectively it can demonstrate its value, the more successful it is likely to be in attracting resources.

In addition to the Lothian study already cited, McLeod examined a range of studies looking at the cost effectiveness of workplace counselling and EAP provision. His conclusion is that: “Even the most rigorous economic analyses show that workplace counselling and EAPs cover their costs, in terms of economic savings that are generated by employers.” There is strong evidence that counselling has a positive impact on organisational health and a properly targeted intervention will at least pay for itself. However, not all counselling interventions are equally effective and clearly there is a link between service quality and outcomes. Service evaluation is crucial in determining the effectiveness of individual services and how it may be enhanced. The issue of service audit and evaluation is explored in Section 6.
Currently, access to counselling for staff in the health service is far from universal and, where it is provided, is extremely varied in its range and quality. Provision ranges from single – and often part-time – counsellors engaged for limited hours and providing only counselling, to well-resourced services employing a number of staff and providing a range of additional services. The majority of services appear to be either internally provided, or purchased on a contract basis from other health services providers who already have internal provision.

Given that health care is delivered in a range of widely differing settings and by a range of professional and support staff, the manner in which counselling is provided will inevitably need to reflect this. However, the RCN believes that there are some core elements of service provision that should be available for all staff. This section outlines the RCN’s view on what should constitute the core elements of any service and the key principles underpinning how the service should be delivered.

While most services usually offer between six and eight sessions, there should be the option of additional sessions where the counsellor makes a clinical judgement that the client needs extra support. Counsellors should be trained or experienced in short-term work. The service should have links with local mental health services and other agencies to enable referral where needed.

Support for staff exposed to traumatic incidents

Traumatic incidents may include physical or verbal assault, a drug error, involvement in a critical incident inquiry – for example, suicide or homicide – or witnessing a fatal accident. It is quite common for staff who have been exposed to traumatic incidents to develop a range of reactions and post-trauma symptoms, some of which may be distressing and disabling. Both in the short and longer term, the individual’s well-being and performance may be severely affected.

Most symptoms generally diminish over a few weeks, but where they persist they may indicate the presence of Post Traumatic Stress Disorder (PTSD) or another psychological disorder. While only a small proportion of staff exposed to critical incidents develop PTSD, support following a traumatic incident at work should be available to all staff. Although this is a specialist area of work, which requires appropriate training, staff counselling services are in a good position to provide post incident support.

The National Institute for Health and Clinical Excellence (NICE) has produced Management of Post-Traumatic Stress Disorder in Adults in Primary, Secondary and Community Care (2005). This states that debriefing should not be routine practice when delivering services. The RCN has also produced Guidance on traumatic stress management in the health care sector (2005) which outlines the recommended approaches in response to and treatment of PTSD based on current research evidence.
### Case study

Sally was a staff nurse working nights on a medical ward. Two weeks after her brother was killed in a road accident, she gave a patient a lethal dose of a drug, via a Hickman® catheter. Both Sally and those colleagues working with her that night were traumatised by this devastating incident. Before they went home, all the staff asked for a debriefing session and three of the seven requested further support. Their feelings encompassed shock, numbness, guilt and fear of the police inquiry and legal proceedings. Debriefing helped the group understand these reactions and also enabled them to face the coming months, including the inquest. Meanwhile, Sally received continuing support throughout the trial, including help to face the hearing where she was struck off the UKCC register.

### A framework for establishing and reviewing services

The way in which services are established is critical to their success. To ensure that services fulfil their potential, careful consideration of their purpose, structure and resourcing is required. A framework for considering key stages in the process of service development is outlined in Figure 1 and elaborated on in the following sections.

Central to establishing a successful service is organisational ownership and the involvement of key stakeholders. A development or advisory group can help to ensure that the interests of the various stakeholders are taken into account. This should include senior management – for example the director of nursing or human resources – and the views of staff and unions, with their active involvement if possible, enabling users to have confidence in their service.

![Figure 1: A framework for the key stages in the process of service development](image-url)
Determining overall aims

The broad aims of the service should be informed by human resource issues – like levels of stress and sickness absence, staff attitude surveys and critical incident records – but they must be realistic. For example, don’t assume that establishing a counselling service will result in an immediate fall in sickness absence or reduce the threat of litigation. These can only be achieved if counselling is offered as part of a wider organisational response, specifically addressing the work factors that give rise to these concerns.

More achievable aims might include:

✦ providing timely psychological support to staff experiencing stress or distress, preventing further deterioration of symptoms and an adverse impact on work performance
✦ contributing to the return to work of staff whose psychological health has resulted in absence from work
✦ effectively managing critical incidents and providing appropriate support to staff affected.

Setting objectives

The key objectives and functions of the service can be determined from the overall aims. Objective setting is important in that it provides the subsequent basis for evaluating the overall effectiveness of the service. Objectives will be specific to each organisation but should capture the contribution that services can make to staff as clients and to the wider organisation. Here are some examples:

✦ providing professional, short-term, confidential counselling to all staff
✦ providing counselling, both face-to-face and by telephone
✦ offering training and consultancy to managers to help staff who are experiencing distress
✦ providing post incident support to staff, including debriefing as appropriate
✦ contributing to organisational policy and practice in critical incident management.

Additional service objectives or functions may also be identified, for example:

✦ providing training for staff in counselling and communication skills, managing stress and psychological responses to traumatic situations
✦ offering mediation or conflict resolution
✦ giving careers advice.

Determining the model for service delivery

Both internal and external models of service delivery have their benefits and problems and a number of issues need to be considered before making a choice. These include the size of the organisation and whether it can sustain its own provision, or whether it would be better to contract with an external provider with an existing service. Geographical area may be a deciding factor and, if an external private provider is selected, you will need to ascertain whether it can provide what it claims.

However the service is provided, it should be based on a set of clear quality criteria that form the basis for monitoring and evaluating its quality and effectiveness. The principle components of a quality framework are outlined in ‘A quality framework for staff counselling provision’ page 15.

Meanwhile, here we assess the key features, advantages and issues for each model.

Internally provided services

Key features

With internal or in-house provision the service’s staff are employees of the organisation and provision is usually on site. Some larger NHS based services also provide services on a contract basis to neighbouring trusts and other organisations.
Advantages
Within this model the counsellors are more likely to understand the organisational culture, its ways of working and the roles that staff perform. In terms of staff as clients, it can be important that they feel the counsellor understands the nature of their role within the organisation. Through its understanding of the organisation, the service can be highly responsive to need and also contribute to and inform the wider human resource agenda by, for example, advising on the management of major organisational change. This model can be very successful where the organisational culture is open to the contribution that counselling services can make.

Key issues for consideration
Accountability/management: Clear frameworks should be established for overall accountability and for the management of the clinical work of the service. Within the NHS, services are commonly located and line managed within a department or directorate such as human resources or occupational health. However, there should be clear functional boundaries between the counselling service and human resource and occupational health departments.

In order to protect the confidentiality of staff using the service, responsibility for clinical work should reside with the service. To support this, services should have formal access to psychotherapy/psychiatric consultancy. Clinical supervision of the work of counsellors is normally external and this is considered good practice in most workplace and other organisational settings. Provided the service is of a sufficient size, a service manager who is experienced in workplace counselling can be appointed to have responsibility for the clinical work of the service.

Physical location: The service needs to be located so as to protect the confidentiality of service users. Where the organisation covers a wide geographical area or is delivered from a range of different locations, thought should be given to ensuring that staff are able to access the service easily.

Resourcing: The appropriate level of resourcing for services will depend on a range of factors, including the size of the organisation, the anticipated uptake by staff, and the functions that the service is expected to provide. The NHS Executive guidance (NHSE, 2000) suggests a ratio of one full-time counsellor per 2,000 staff, where counsellors have no role other than counselling, and where they work from a single site. More staff may be needed if the service fulfils additional functions or operates from different sites.

An alternative model for assessing the level of counselling resources required can be based on anticipated staff uptake and the optimum caseload capacity of counsellors. While usage cannot be predicted in advance, studies of workplace counselling provision suggest that an assumption that up to 10 per cent of staff may use the service in any one year is not unreasonable. The resource requirements from this level of usage are outlined in the following box.

Assessing resources

In an organisation employing 2,000 staff, an uptake of 10 per cent would mean 200 new clients per year. Assuming that each has an average of four to five sessions, this would indicate a requirement for some 800 to 1,000 sessions.

It is recommended that counsellors conduct no more than five sessions per working day and 20 sessions per week if employed full-time. Based on a 46-week year, a full-time counsellor with no other role could expect to provide some 920 sessions per year.

Two further key points should be addressed when considering resource requirements:

✦ provision needs to be made for resourcing the continuing professional development needs of staff, and the external supervision of counsellors. Frequency of external supervision should be in line with the requirements of their professional body. It is likely to cost between £35 to £45 per hour, depending on the supervisor’s qualifications and experience

✦ it is also strongly recommended that the point of contact with the service be staffed during advertised operating hours. Some existing services require staff to leave messages on an answerphone, and there is considerable anecdotal evidence to suggest that this significantly discourages uptake.
Externally provided services

Key features
Here the organisation contracts with an external service provider for a specific service or range of services. Broadly, there are two models within the health service – the first being NHS based workplace counselling services. These are located in one organisation, but also provide services to neighbouring trusts and other employers. This model tends to be the most popular amongst health service organisations without their own service. The second is the large number of commercial providers that offer a range of counselling and other services, usually known as Employee Assistance Programmes (EAPs). They mainly work off-site and their counsellors (sometimes called associates) are usually self-employed and may work for a number of EAP providers.

Advantages
External provision may be appropriate for smaller organisations that cannot sustain their own internal provision, or where the organisation simply wants to provide counselling and nothing else. Larger EAPs cover a wide geographical area, offer 24-hour access to services and can provide a range of additional services, such as critical incident support and legal and debt advice.

Key issues for consideration
Contract specification: Assuming the objectives of the service have been clearly defined, then a contract specification can be drawn up as the basis for identifying potential providers. The standards for professional counselling practice in the workplace outlined in this document should be specified in the contract and used as a benchmark for assessing potential providers.

NHS or EAP? NHS based providers will have a good understanding of the health service context and experience in delivering counselling to health service staff. Depending on how important this is to the purchasing organisation, this could form part of the specification.

EAP providers may offer very comprehensive packages that the organisation does not require. For example, there is no evidence to suggest that 24-hour cover is more effective than 12 hours. Anecdotal evidence over a four-year period from one large NHS based service showed that reducing the service from 24 hours to 12 did not affect the number of calls.

Contract monitoring and quality assurance: One of the limitations of external provision is a lack of direct control over quality. For that reason, organisations that are purchasing services externally should ensure that the standards outlined in this document are being met and that there is evidence of this. This should include ensuring that counsellors are qualified and experienced in workplace counselling and understand the organisational context. The organisation should also satisfy itself that counsellors are adequately supervised and the premises in which staff are seen are suitable. A contract manager should be appointed to manage the contract and provide a central point of contact between the organisation and the provider. Preferably this should be a senior manager within the organisation.

Monitoring/evaluation
Whether services are provided internally or externally, a system for routine monitoring and evaluation should be developed that addresses the quality criteria outlined in this chapter. The focus of monitoring and evaluation should be twofold: to provide routine data on service usage and a mechanism for enhancing the quality of the service. A system is outlined in Chapter 6.

Reporting
A clear system for reporting of service activity should be established at the outset. Reporting should enable the organisation to determine whether the service is achieving its aims and deal with any resource issues that may arise. The process should also seek to identify areas of concern that may need to be examined by the wider organisation, for example, a high proportion of service users experiencing bullying and harassment.
A quality framework for staff counselling provision (adapted from Bower, Foster and Mellor-Clark J, 2001)

**Accessibility**

A standard should be set for an optimum waiting time for first appointments. Evidence suggests a relationship between longer waiting times and non-attendance at first appointments. Ideally, an individual should receive an appointment within five to 10 days. Provision should also be made to respond to staff in crisis on a priority basis if required.

To enhance accessibility, the point of contact with the service should be staffed within advertised hours. Access that is restricted to an answer phone is likely to significantly discourage take up. The hours of access and counselling provision should reflect the needs of staff and their working patterns.

The means by which counselling is delivered should reflect both client preference and the setting in which health care is delivered. Most clients prefer seeing a counsellor in person but other means of service delivery – for example telephone counselling – may be appropriate to the needs of staff in remote areas.

**Appropriateness**

Are the client's assessed problems appropriate to the service offered? Assessment procedures should be in place for determining the suitability of clients for counselling. In addition, the service should be provided by appropriately qualified and experienced staff who receive adequate supervision, support and development.

**Acceptability**

Services should strive to be as acceptable as possible to potential users. A significant number of clients drop out of counselling and it is likely that a proportion of these feel that the service has not met their needs. Data should be collated on the clients’ experiences of the service, including looking at the reasons why clients withdraw from counselling without notification.

**Equity**

The service should be sensitive to gender, ethnicity, sexuality, disability, religion and culture. Language may also be a consideration in some circumstances – for example, employers in Wales may wish to take account of the spirit of the Welsh Language Board’s guidance on Welsh language provision (Welsh Language Board, 2000). Service usage should reflect the demographic make up of the organisation and routine monitoring can help to identify groups that are under-represented, helping to tackle equity issues.

---

**Standards**

- Organisations should provide general counselling on a range of work related or personal issues of concern to staff, and support for staff exposed to critical incidents at work.
- Face-to-face counselling should be available to all staff, wherever possible.
- Services should be based on clearly stated aims and objectives that are informed by the organisation’s human resources context, and a set of clear quality criteria.
- A system for routine monitoring and evaluation should be developed that addresses these quality criteria.
- A system for reporting of service activity should be established to determine whether the service is achieving its aims and identify areas of concern that may need to be considered by the whole organisation.

**Internally provided services**

- Responsibility for clinical work should reside within the service.
- Services should have formal access to psychotherapy/psychiatric consultancy.
- The service should be located to ensure the confidentiality of its users.
- Resourcing of services should take account of a range of factors, including the size of the organisation, the anticipated uptake by staff, and the functions that the service is expected to provide.
- Provision should be made for the continuing professional development needs of staff and the external supervision of counsellors.
- Counsellors should conduct no more than five sessions per working day (20 sessions per week if employed full-time).

**Externally provided services**

- The contract specification should address the standards for professional workplace counselling practice outlined in this document.
- Contract monitoring should ensure that the standards outlined in this document are evidenced.

**Recommendations**

- The interests of key stakeholders – including management, staff and unions – should, with their active involvement if possible, inform the establishment and development of services.
- To maximise accessibility, the point of contact with the service should be staffed during advertised operating hours, wherever possible.
- Where the organisation covers a wide geographical area or is delivered from a range of different locations, consideration should be given to ensuring that all staff are able to access the service.

---

**Efficiency**

Any planned sessions that are not attended without notice potentially undermine efficiency. It has been estimated that the level of unattended sessions may contribute to an increase of some 25 per cent in waiting times for a first appointment. While 100 per cent attendance is an unrealistic goal, services should try to minimise non-attendance through the development of monitoring mechanisms that aim to identify and tackle any service issues that may have an adverse affect on efficiency.

**Effectiveness**

Counselling will not be equally effective for all clients. Services should assess the relative effectiveness of counselling for different clients, groups and circumstances and use this data to enhance the quality of the provision. Such data may suggest development or training needs for practitioners, either individually or as a service. It may also lead to the conclusion that clients with specific issues need to be referred to services more appropriate to their needs. It is recommended that services use a valid and reliable measure to determine effectiveness. This issue is explored in Section 6 – Audit and evaluation of counselling provision.

---
Counselling services and their role in wider staff support and organisational culture

Services that are purely reactive, only providing counselling for distressed employees, miss an important opportunity to help create a healthier organisation. For example, organisational change is now increasingly commonplace within the health service and is one area where staff counselling services can make a vital contribution. Services routinely work with clients who are affected by victims of poorly managed change. They have a valuable role to play in discussions at management or board level about how proposed changes may impact operationally and the best way to implement them.

Many organisations fail to recognise this contribution and need time to embrace this new way of working. If counselling services are provided internally, experience shows that most will need to be established for between two and three years before their role and functions are fully understood and they are able to contribute to the wider organisation.

There are a number of basic prerequisites for a successful integrated service. The organisation needs to recognise the potential contribution services can make to both individual staff and the wider organisation. The service needs to maintain its profile within the organisation and seek opportunities for contributing to the organisational agenda. It requires counsellors who are comfortable about operating in an organisational context and can manage any tensions that may arise in meeting the needs of both the client and the organisation.

Most counselling and staff support services within health service settings, particularly those that are more established and integrated, offer a range of additional services that contribute to a more comprehensive model of employee support, with overall staff well-being at their core. Here, we highlight a number of possible additional services to be considered when establishing and reviewing provision. It should be noted that counsellors with appropriate training and experience could undertake some of these, such as training and groupwork. Others, such as careers and debt advice, are specialised functions that should only be undertaken by staff with specific expertise. This list is not exhaustive and the precise role and function of services will vary, dependent on the needs of the organisation and its staff.

“Counselling services have a valuable role to play in discussions at management or board level about how proposed changes may impact operationally”

Training and education

Services have an important role to play in destigmatising issues of psychological distress. This may include educating others about coping with stress or understanding the psychological effects of trauma. Services can also provide training on issues like managing distressed staff, counselling skills and handling stress. This kind of educational activity provides opportunities for staff to meet counsellors in a different capacity, raising the profile of the service.

Careers advice

Providing confidential and objective career guidance through workplace counselling services can reap enormous benefits for both the individual and the organisation. Supporting staff to make career decisions helps to ensure a more motivated workforce and will ultimately increase retention rates. Services provided by career advisers include support with job applications and interview techniques, feedback on self awareness exercises and psychometric tests, guidance on educational and career options in the health service, support with personal development planning and access to a range of career resources. RCN Member Support Services provides a telephone-based careers advice service for RCN members.
Debt advice

Financial problems can impact on other aspects of life and, if not dealt with early, can have devastating results, even leading to the loss of a home. A preoccupation with financial difficulties can easily spill over into the work place and giving staff the opportunity to talk to an independent adviser, in confidence, can alleviate some of the stress and provide practical options for dealing with debt. At a minimum, services should have a list of resources for local debt advice, although in some areas arranging an appointment can take several weeks. The organisation should assess whether their staff would benefit from the services of an employed welfare adviser, or dedicated hours bought in from a local service such as the Citizens Advice Bureaux. RCN Member Support Services is able to provide a telephone advice service for RCN members.

Legal advice

Legal difficulties are also likely to affect the well-being of staff and may impact on their work. Some counselling and staff support services have been successful in making arrangements with local firms of solicitors or Citizens Advice Bureaux to offer a free half-hour of legal advice. The RCN provides a free 30 minutes of legal advice for members on non-employment issues, while employment law advice is free to all members, via the RCN’s network of offices.

Links to other agencies

The counselling service should establish effective good links with the local statutory and voluntary sector mental health services to enable referral to alternative or additional sources of psychological or practical support. These may include other counselling and psychotherapy services, Citizens Advice Bureaux, law centres and and other agencies that offer support, such as GP practices and unions. Development of these links should be considered from the outset.

Groupwork

Staff experiencing difficulties at work may benefit from group sessions to help them express their anxieties and concerns within a safe environment. For example, as the following case study illustrates, staff who are facing organisational change may benefit from attending a group workshop where they can articulate their hopes and fears, enabling them to find a constructive way forward at a time of uncertainty.

Case study

In 1990, Groby Road Cardiac Unit faced a move to a new sit at Glenfield Hospital. The decision was made to initiate workshops for staff at both sites, to help everyone focus on their fears and hopes about the change. More than 100 workshops, called ‘Moving Forward…Carrying On’, took place and were viewed as highly successful by all those involved. When the outcomes were assessed, the results showed that staff at both sites shared the same fears and many of each other’s hopes, thereby helping to bring down the barriers to working together. A year on, a follow-up questionnaire demonstrated that the staff continued to feel valued by the Trust.
Audit and evaluation of counselling provision

From an employer’s perspective, the rationale for providing staff counselling is likely to be to improve psychological well-being, performance and attendance. All services should try to determine how effective counselling is in achieving these aims. Audit and evaluation should be integrated into service planning and development, ideally incorporating three key areas:

✦ routine audit of service utilisation
✦ routine audit of aspects of service quality, including effectiveness
✦ the overall objectives of the service.

Service utilisation

Both the employer and the service should be aware of how many staff are using the service, their demographic details and the issues they are presenting. This data can be useful in highlighting any issues that may need to be addressed organisationally – for example, if particular locations, grades or professions are over represented or where instances of bullying or assault appear to predominate. Similarly, if particular groups are under represented, this might indicate that targeted promotion is required or draw attention to a problem in the perception of the service.

Service quality

Routine monitoring should deliver data that can be fed into the development of the service and of individual practitioners. The quality framework, outlined in Section 4, can be used as a basis for measuring particular aspects of service quality and effectiveness while Appendix B details some key quality indicators.

† When reporting patterns of usage, it is vital to balance the level of detail with the need to maintain the anonymity of staff. Any data made available to the employer should not compromise the confidentiality of individual clients. The smaller the organisation, the bigger an issue this will be.

The overall objectives of the service

Routine audit and evaluation are likely to inform the broader question of whether the service is meeting its overall objectives, helping to determine whether they remain realistic or need revision. Depending on the objectives of the service, some specific measures of effectiveness may be required. For example, if one of the service’s objectives is helping staff suffering from stress to return to work, measures of pre and post counselling absence or work functioning will be required. Functions that are offered in addition to counselling may need their own individual evaluation frameworks.

Audit and evaluation: the benefits of a standardised approach

The measurement of service utilisation, quality and effectiveness varies widely across psychological therapy services generally and workplace counselling is no exception. Most services routinely audit service utilisation and some seek client feedback on their experience of the service. A relatively small number have attempted to quantify the outcomes of counselling for their clients.

“Many of the measurement tools currently in use have been developed by individual services, with only a few appearing to use valid and reliable measures to evaluate effectiveness.”

Many of the measurement tools currently in use have been developed by individual services, with only a few appearing to use valid and reliable measures to evaluate effectiveness. While these ‘home grown’ systems undoubtedly yield valuable data, their drawback is that they offer no opportunity for comparing data with other services and no possibility of determining whether the data is representative of the wider workplace counselling sector.

The RCN believes that a standardised approach has the potential to contribute significantly to quality and effectiveness, by:

✦ enabling comparisons across services
✦ providing normative data and benchmarks for service provision
✦ developing opportunities for discussion within and between services to identify best practice.
The primary purpose of collecting this data should be to improve the service quality. The process should be service-led, informing the development of service policy, procedure and practice.

The RCN’s Counselling Service has been using a standardised system since March 1999. The CORE (Clinical Outcomes in Routine Evaluation) system (see box) is the first in the UK to apply audit, evaluation and outcome measurement to counselling and psychological therapy settings. The RCN has been collaborating with the Psychological Therapies Research Centre and other partners to adapt CORE to the needs of workplace counselling, and has been part of a collaborative research project involving seven workplace counselling services using the CORE system.

The findings of this research project build on the conclusions of the McLeod study that workplace counselling is highly effective. The study (Mellor-Clark, 2001) found that the psychological health profile of staff using counselling services is almost identical to that of clients using primary care counselling, and that workplace counselling has the potential to:

✦ improve mental health for 78 per cent of clients
✦ reduce rates of sickness and absence
✦ enhance work functioning.

The RCN believes that the CORE system is the best available tool for measuring and enhancing the quality of counselling provision for health service staff and recommends its use in these settings.

At the time of writing a set of key performance benchmarks have been developed for primary care counselling, based on CORE System data for 35,000 clients from 34 primary care counselling services. The benchmarks, some of which are generic, will provide a valuable reference point for services providing staff counselling, and will be profiled in the anticipated March 2006 special edition of *Counselling and Psychotherapy Research*.

**Standards**

✦ Routine audit and evaluation of counselling provision should be built into service planning and development.
✦ The audit process should be service-led and its purpose should be the enhancement of service quality and effectiveness.
✦ Audit and evaluation should take place within a quality framework that includes effectiveness.

**Recommendations**

The use of the CORE system should be considered to enable service benchmarking and opportunities for enhancing service quality and effectiveness.

**CORE SYSTEM**

The CORE (Clinical Outcomes in Routine Evaluation) system is a standardised system for audit, evaluation and outcome measurement in psychological therapy.

It was developed by the CORE System Group – now the CORE System Trust, a not-for-profit research charity based at the Psychological Therapies Research Centre, University of Leeds – and is the first attempt in the UK to standardise audit, evaluation and outcome measurement to profile and compare service provision across a wide range of counselling and psychological therapy settings.

The system includes a client self-report measure – addressing subjective well-being, problems/symptoms, functioning and risk – and practitioner completed forms that focus on the quality of the service, including access, appropriateness, acceptability, equity, effectiveness and efficiency.

The system has been in use for some years within NHS psychological therapy settings, and a range of national benchmarks exist against which services can compare their own data, enabling them to tackle any shortfalls in service quality and effectiveness.

More recently, the CORE system has been adapted specifically for workplace counselling, enabling the collection of additional data that is particularly relevant to this environment, for example, work factors affecting psychological health, functioning and absence.

**CORE-PC**

CORE-PC is a software application enabling the processing and analysis of CORE system data. It has been developed under license from the CORE System Trust by CORE Information Management Systems Ltd. It is designed as a practical system to allow practitioners and service managers to analyse and interpret their own CORE system data, and provides a comprehensive report structure profiling key service performance indicators including waiting times, clients’ levels of psychological health and risk, session attendance, therapy endings and improvement rates. For further information please see CORE-IMS in the Resources section at the end of this publication.
Appendix A:

Human resources, legal and health and safety considerations

Each of the four countries of the UK has its own human resource and occupational health strategies that potentially influence the development of counselling provision.

England

Working together: Securing a quality workforce for the NHS (1998) requires that all NHS trusts should: “have in place Occupational Health and counselling available for all staff by April 2000.” Building on this, the NHS Executive has published more detailed guidance on the development of staff counselling provision in The provision of counselling services for staff in the NHS (2000).

The Department of Health’s audit instrument for its Improving Working Lives Standard (2001) specifies the availability of counselling services for all staff as one of the indicators that organisations are meeting their obligations under the Standard.

Scotland

In Scotland Towards a new way of working – The plan for managing people in the NHS in Scotland (1998) stipulates that trusts, and where appropriate health boards, should: “Develop a comprehensive and inclusive OH service…and cover as a minimum such areas…as a confidential counselling service.” Towards a safer, healthier workplace: occupational health and safety services for the staff of the NHS in Scotland (1999) elaborates on this guidance and establishes a twelve month timescale for action to “…link closely with the existing counselling services to offer comprehensive counselling and advice services for all NHS staff.”

Northern Ireland

At the time this guidance went to press, the human resources strategy document for Northern Ireland was being finalised. For up-to-date information, contact the RCN Northern Ireland Board on: 02890 668236.

Wales

Although provision for staff counselling is not part of the recommendations contained in the human resource strategy for NHS Wales, Delivering for Patients (2000), the Welsh Assembly’s strategic plan, Improving health in Wales (National Assembly for Wales, 2001) states that:

“As good and caring employers, health organisations will ensure that staff who suffer injury, trauma or distress at work are fully supported at all stages.” By 2003, an enhanced NHS Wales Equality Unit will provide an independent advice service for staff who have been bullied, harassed or threatened by violence in the workplace.

Health and safety and legal considerations

The Health and Safety at Work etc Act 1974, section 2(1) places a general duty on employers: “to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all its employees.” This includes ensuring that employees do not suffer stress-related illness due to their work. While this health and safety legislation applies only to England, Scotland and Wales, legislation in Northern Ireland tends to closely follow that outlined for Great Britain.

The Management of Health and Safety at Work Regulations 1999 place additional requirements on employers that may relate to stress and psychological health. These are to:

✦ make a suitable and sufficient assessment of the risks to the health and safety of employees of the work they undertake (Regulation 3)
✦ apply the principles of prevention (Regulation 4 and Schedule 1)
✦ ensure that employees are capable for the work they are required to do and provide adequate training (Regulation 13)
✦ ensure that young people are protected from risks as a result of lack of experience, awareness or maturity (Regulation 19).

The Health and Safety Executive (HSE) has established targets for reducing the incidence of both work-related ill-health and working days lost to work-related ill-health by 20 per cent and 30 per cent respectively by 2010 (HSE, 2000). The HSE’s Tackling work-related stress provides valuable guidance for employers and managers in improving and maintaining employee health and well-being, including advice on conducting risk assessments for stress (HSE, 2001).

The HSE has also produced Management Standards for Tackling Work-Related Stress (2004). These standards
help employers identify and manage stress at work by providing a framework to pinpoint particular causes of stress as well as solutions. They outline six key areas (or risk factors) that can be causes of work related stress. These are:

✦ The demands of your job
✦ Your control over your work
✦ The support you receive from managers and colleagues
✦ Your relationships at work
✦ Your role in the organisation
✦ Change and how it’s managed

The standards recommend that employees contact their managers at an early stage. If a significant part of the problem is with the manager employees are recommended to talk with their employee representative, HR department or Employee Assistance Programme/counselling service if such a facility exists.

Employers are obliged to assess the risk and potential causes of stress within the organisation and use these to assess how the organisation is performing in relation to the above six risk factors. Furthermore employers need to decide on improvement targets and action plans in consultation with staff or their representatives.

Appendix B:

Key indicators of service quality

**Accessibility**

✦ Service staff are available to respond to enquiries within advertised hours.
✦ Hours of access and counselling provision reflect staff needs.
✦ A mechanism exists to help staff in crisis on a priority basis.
✦ Waiting times for first appointments are routinely monitored against an agreed standard.
✦ The mode of service delivery reflects staff preference and the setting in which care is delivered, for example, telephone counselling in remote areas.

** Appropriateness**

✦ Counsellors are suitably qualified, trained, supervised and supported to deliver service.
✦ Assessment procedures are in place to determine suitability of clients for the service offered.
✦ Staff are referred to other services where assessment identifies that their needs cannot be met by the service.

** Acceptability**

✦ Client feedback on their experiences of the service is routinely sought.
✦ Counselling endings are routinely monitored and the reasons for unplanned endings are examined.
✦ Wider staff perceptions of the acceptability of the service are periodically monitored.

** Equity**

✦ The demographic make up of the client base is routinely monitored to ensure it matches the organisation.
✦ Under represented groups are identified and appropriate strategies are developed to encourage their use of the service.
✦ Service development and training needs identified through this process are addressed.

** Efficiency**

✦ The service routinely uses valid and reliable measures to evaluate counselling outcomes.
✦ Evaluation identifies both service and practitioner strengths and development and training needs.
✦ The results of effectiveness evaluation are fed into service and practitioner development.
✦ If applicable, the service routinely collects data on organisational benefits of counselling, for example, absence data.
References and further reading


Goss S (1995) The value of listening. The final evaluative report on the effectiveness of the Advice, Support and Counselling Unit of the Lothian Regional Education Department. Strathclyde: University Counselling Unit.


Resources

Association for Counselling at Work (ACW)
– a division of BACP
15 St Johns Business Park
Lutterworth
Leicestershire
LE17 4HB
Tel: 0870 443 5252
www.counselling.co.uk

British Association for Counselling &
Psychotherapy (BACP)
15 St Johns Business Park
Lutterworth
Leicestershire
LE17 4HB
Tel: 0870 443 5252
www.counselling.co.uk

British Psychological Society
St Andrews House
48 Princess Road East
Leicester
LE1 7DR
Tel: 0116 254 9568
www.bps.org.uk

Confederation of Scottish Counselling Agencies
(COSCA)
18 Viewfield Street
Stirling
FK8 1UA
Tel: 01786 475140
www.cosca.org.uk

CORE-IMS Ltd
47 Windsor Avenue
Rugby
CV21 3NZ
Tel: 01788 546019
www.coreims.co.uk

RCN Counselling Service
Royal College of Nursing
20 Cavendish Square
London
W1G 0RN
Tel: 08457 697 064
counselling@rcn.org.uk

RCN Direct
Tel: 0845 772 6100
24 hour information and advice for RCN members

UK Council for Psychotherapy
167-169 Great Portland St
London
W1W 5PF
Tel: 020 7436 3002
www.psychotherapy.org.uk