Partner Policy: Clinical Engagement

Introduction

Any individual wishing to access the EAP service will need to engage in a clinical conversation with a clinician who will provide them with support, establish their needs and agree an appropriate way forward. The EAP's guidelines for holding these conversations are regularly reviewed and updated according to current clinical standards. This conversation is the foundation of all further counselling-related services WPO will provide to participants. For partners this conversation is generally provided via telephone/video when the participant initially contacts the service, though there are circumstances (e.g. when the partner does not provide a clinical service) when it is agreed that participants will be transferred straight to WPO to arrange an in-person conversation with an appropriate provider. The aim of the conversation is to engage with the participant such that they are provided with an empathic, supportive environment where they can collaboratively work with the clinician to establish the most beneficial way forward for them; be that Single Session Therapy, Transitional Support, short-term EAP counselling (delivered in-person or via telephone/video), cCBT, Aware, Group Counselling, Elevate, Pathways or a referral to a longer-term intervention; depending on what is available under their benefits package. The standard EAP session model WPO uses (regardless of the medium through which it is delivered; in-person, telephonic, or video) is aligned with EAP core philosophy and offers participants a short-term intervention based upon Solution-Focused Brief Therapy. Essentially, this approach involves basic problem-resolution, empathic support and skill development.

From the outset, the EAP approach focuses on the participant's present circumstances and on solutions as opposed to a detailed investigation of the past and the complexity of problems. While past experience may be useful in identifying patterns for context, the focus should be on changing for the future, not on analysing the past. The initial call is often a reframing exercise; critical in the path of change, where clinicians guide the participant into understanding what change they would like to see in their current situation and what steps they need to take to accomplish it.

When engaging in that initial conversation, the clinician is capturing the impetus or inertia of the participant as that individual makes an important step toward change. Clinicians always offer a professional and compassionate response, immediately affirming the participant's desire to change and accepting responsibility as a facilitator of that change process. The quality of that initial engagement is key to that process as it allows the clinician to gather the information required to establish the way forward that is likely to deliver the most beneficial results for the participant.

Policy

The primary task of a clinician is to establish the participant's needs, gather details for follow-up, and determine which EAP service would be most clinically appropriate given the presenting problems.

Participants cannot be referred to ongoing EAP clinical services (e.g. EAP sessions or the cCBT programme) unless the initial clinical conversation is completed telephonically or via video. The only exceptions to this are participants with disabilities which prevent them from engaging via telephone/video, those rare participants who are unwilling or unable to discuss their issues over telephone/video and need to be referred to an in-person assessment and participants who initially access the service via a partner who does not provide a clinical service who need to be referred to an in-person assessment via WPO directly.

Clinicians will approach participants in a calm and compassionate manner, using their own words to present the process as naturally as possible. WPO understands that making that initial outreach for help may have been a difficult choice for the participant to make and may have taken some courage; it is the clinician's responsibility to build rapport and put the participant at ease. The principles of the 'Power of a Good Conversation' will be upheld during the clinical engagement such that participants feel heard, cared for and helped.

With the exception of those identified as abusive or frequent users of the service, First Serve services are available to all individuals accessing the EAP service. Where eligibility has been confirmed and the organisational benefit is understood, clinicians will be mindful of what options are available to the participant under their benefit and ensure their recommendation of the best way forward for the participant is consistent with what is available to them.

Clinicians will approach all calls, whether telephonic or video, as potential, Single Session Therapy working clinically in the moment with the participant to identify the most beneficial way forward.

Participants who are persistent or abusive users of the service will be managed via the Partner Management of Challenging or Resistant Participants or Partner Management of Frequent Users of the Service policies and as such may potentially not be offered a full clinical conversation, First Serve or Single Session Therapy services.

Participants can only be referred to one EAP clinical intervention at a time; they cannot be referred for different EAP interventions (e.g. Individual and Couples/Family) to run concurrently. Engaging in multiple counselling engagements simultaneously is not recommended and can become confusing and/or overwhelming for the participant. If a participant is concurrently engaged in a different type of intervention than that requested with another agency (e.g. they are engaged in Couples Counselling elsewhere and are seeking individual sessions from the EAP) clinical appropriateness must be reviewed with the Partner's Clinical Management who will decide whether it is appropriate to proceed with the EAP intervention requested.

The EAP does not provide EAP sessions for those reporting they have been ordered to engage in counselling by a Court.

The primary aim of clinical engagement is to achieve an overall understanding of a participant's situation including but not limited to: their current physical, mental and emotional presentation, the dynamics in their personal and working lives (family, romantic relationships, friends, colleagues etc.) and current support systems, as well as any factors that may be causing or exacerbating distress. The participant must be given the opportunity to present their reason(s) for contacting the service at this particular time in their own words, so that informed decisions can be made on whether the services the EAP provides match up appropriately for their needs. The clinician will never assume that everyone who contacts the service is in need of counselling.

An appropriate risk assessment covering potential risk of harm to self, risk of harm to others, child protection or vulnerable adult issues, abusive relationships and any risk arising out of substance use, will be completed for all participant's during the clinical engagement. On the very rare occasions where a clinician judges that asking a particular risk question is not appropriate, the clinical justification must be recorded in the documentation.

Clinicians will, at all times, provide culturally sensitive participant-centred care, recognising and respecting the participant's beliefs, values, experiences and care-seeking behaviours.

The Outcome Rating Scale (ORS) should be asked of all participants looking to engage in adult, individual EAP counselling sessions or cCBT, to provide the baseline against which the effectiveness of the future intervention can be measured. The ORS is not collected for those referred to an in-person assessment for Minors, Couples or Family Counselling, longer-term resources or the Aware, Elevate or Pathways programs and are optional for Single Session Therapy and referrals to Transitional Support.

Clinical Practice

- The clinician's approach to all participants will be conversational in manner and clinicians should take care not to sound like they are reading from a script or list of questions. During this initial conversation clinicians should take care in gathering information to be able to understand the participant's difficulties, presentation and support systems and at the same time validate their emotions, acknowledge the effort they are making and provide strategies that might aid the participant in getting a better understanding of how they can move forward.

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- The conversation should not be referred to as an 'assessment' as this can lead the participant to believe that they are being tested and have 'failed' in some way if it transpires that EAP sessions are not appropriate for them. Good opening statements could be:

    - 'What led you to call us today?'
    - 'If you have the time to talk now, we can take a look at how best to help you'.
    - 'Are there any particular difficulties that you are dealing with at the moment?'

- Statements such as the following may be problematic:

    - ‘We now have to assess you for short-term counselling.’
    - ‘If you have the time for an assessment now, we can then refer you to an in-person Counselor.’
    - ‘We have the following options: in-person, STC, etc. Which one do you think would be suitable for you?’
    - ‘I can offer you immediate in-the-moment support.’

    They may increase the participant’s anxiety and contribute to feelings of confusion and helplessness. They also tend to point the outcome of the conversation in the direction of a referral to short-term counselling before appropriateness has even been discussed. Making more positive, open statements allows the participant to state the issue as they perceive it and gives the clinician the opportunity to meet the participant where they are and keep all options open. Importantly, all of this should happen conversationally and naturally as the clinician engages the participant and develops rapport.

- Participants must be heard empathically and the counsellor’s responses to them should reflect that they have properly heard the participant’s presentation.

    - How does the participant define or identify the problem?
    - Is there a precipitating event or trigger?
    - How is it affecting the participant physically, emotionally, and mentally? Identify symptoms: mood, appetite, sleep patterns, anxiety levels, energy levels, and so forth.
    - What changes would the participant like to see take place in their life.

- Clinicians should always check whether there are any previous cases for this participant as they may provide valuable background to the participant’s presentation and what may be appropriate for this participant going forward. However, the clinician must not jump to conclusions based on information collected previously, or indeed from the participant’s initial statements on the call, but keep an open mind throughout the call and have a meaningful conversation with the participant which leads to an appropriate way forward for this participant, in this moment.

    - Has the participant previously received counselling or treatment for emotional or psychological problems?
    - Is there a psychiatric history that needs to be taken into consideration?
    - Does the participant report any specific medical condition? If so are they taking any prescribed medication(s)?
    - Is it a recent problem or a recurring one?

- What in the participant's background or history is relevant to the presenting problem?
- Does the participant report any history of abuse or trauma?
- What is the participant's support system?
- Is the problem affecting the participant's job performance and if so in what way?
- What coping strategies does the participant use and how successful are they?
- What are the participant's strengths which they can build on?

- Although identifying any history of trauma is an important aspect of the clinical conversation process, clinicians should always use caution when acquiring any details of a particular event. In general, it is best practice to refrain from probing any details of the traumatic event and instead focus on present problematic symptoms. The clinician's aim is merely to ascertain whether previous trauma could be adversely affecting the participant's response to their current situation and make a short-term intervention inadvisable. However, if the traumatic event was recent, there is no history of previous trauma, the participant's symptoms are mild and functioning is not affected, EAP sessions may be appropriate.

- Clinicians should always explore whether the participant is subject to any addictive behaviour (e.g. gambling, sex addiction, addiction to pornography or compulsive eating) during the clinical conversation. This exploration should focus on the impact of these behaviours on the participant's day-to-day living and be used as key information in the clinician's recommendation of the most beneficial way forward for the participant. The following questions may be useful in establishing whether certain of the participant's behaviours are harmful and may need to be addressed in longer-term therapy:

  - 'Have you ever noticed any behaviours that affect your general wellbeing such as compulsive eating, buying or gambling?'
  - 'What is the nature of the behaviour that causes you concern?'
  - 'Do you, or have you in the past, experienced a lack of control in some area of your behaviour?'
  - Have you ever placed yourself or others at physical risk as a result of those behaviours?
  - 'Do you engage in behaviours that you believe adversely affect your day-to-day life?'
  - Do the behaviours you mention present a financial threat to you or your family?
  - 'Is there any behaviour that you would like to cut back on?'
  - 'When, and how often, do they happen?'
  - 'When was the last time?'

- WPO's approach to assessing risk can be found in the following clinical policies:

    - Partner Risk of Harm to Self.
    - Partner Risk of Harm to Others.
    - Partner Abusive Relationships.
    - Partner Vulnerable Adult & Child Protection.
    - Partner Substance Use.

  Appropriate action will be taken when required (see the Partner Calling Emergency Services Policy).

- Wherever possible, risk will be explored as part of the 'Good Conversation' the clinician holds with the participant during the clinical engagement and only those risks not covered during that conversation will be raised separately towards the end of the call. Where a potential risk is raised separate to the general flow of the conversation, the question must be raised sensitively and in the context of the conversation that has preceded it.

    - 'You told me you lived alone; can I just check whether you have any concerns regarding abusive relationships?'

- Risk must be explored with the participant before any conversation regarding the way forward for the participant takes place, as any disclosure regarding risk could significantly affect the options available to the participant.

- If a participant refuses to answer any of the risk questions this must be taken as an indication that risk could well be present. In these circumstances clinicians will firstly gently explain to the participant that it is important to properly understand what is going on for them so that the EAP can provide the most suitable support for them and that their refusal to answer may impact the options available to them as we will need to proceed cautiously on the assumption that some (unspecified) risk exists.

- Clinicians must check any previous clinical cases held for the participant to ensure any previous risk reported is properly probed and to ensure any safety plan previously agreed is reviewed.

- If Single Session Therapy is not appropriate or feasible, it is essential to determine whether the participant's presenting problems could be adequately addressed in the short-term session model that the EAP offers or alternatively whether access to long-term psychotherapy or specialist treatment is more appropriate. For a participant to be appropriate for EAP counselling services they must be able to achieve some benefit from counselling within the timeframe of the number of sessions allowed under their organizational benefit. In order to refer to short-term EAP sessions, the clinician must be confident that some short-term EAP counselling could not potentially do harm to the participant or further increase the risk to an already vulnerable participant and must be able to identify a short-term focus/goal for the sessions. The problem(s) that the participant presents with should be reasonably expected to be addressed in the time-limited format and the participant needs to be able to remain focused on those problems for the duration of the counselling contract. The focus of the counselling should be aimed at finding solutions to current problems and on assisting the participant in the development of better coping strategies.

    - The indicators for short-term counselling are:
        - Symptoms are acute (sudden onset and short duration)
        - Recent onset of presenting problems (within the last 6 months)
        - Participant's functioning is minimally to moderately compromise
        - Participant is agreeable to the short-term intervention process
        - Participant is able and willing to focus on short-term issues even though there may be long-term issues present.

    - Possible issues for focus for short-term counselling are:
        - General stress
        - Work-related stress
        - Moderate psychological symptoms: Participant is experiencing acute and/or moderate anxiety or depression and needs support in identifying basic coping skills for managing symptoms
        - Relationship conflict with colleagues
        - Family/partner relationship conflict
        - Bereavement (not complex)
        - Adjustment issues (changes at work, relationships, cultural)
        - Life transitions
        - Caregiving
        - Recent Medical Diagnosis

- Boundary Setting
- Parenting
- Effective Communication
- Increasing self-confidence socially or at work (not, however, self-esteem).

- A participant who's presenting problem(s) cannot be reasonably addressed in a time-limited format, or who has multiple concerns and no clear focus, should be referred to appropriate resources outside the EAP service. The clinician should explain to the participant that a short-term intervention is not likely to be the most beneficial way forward for them and determine appropriate resources that the participant may access outside WPO. This may include a referral to open-ended/long-term counselling with a General Practitioner (GP), insurance provider, or specialist agency. Transitional Support may be offered unless to do so may increase the risk of harm to the participant or others. The rationale about why this participant's situation is not appropriate for short term counselling must be documented.

    - Indicators for long-term psychotherapy
        - Symptoms are chronic (slow to develop and of long duration)
        - Presenting problems have been in existence for a long time
        - Participant's functioning is severely compromised
        - Previous attempts at short-term counselling have been unsuccessful
        - Abrupt ending of sessions could be detrimental to the participant emotionally

    - Possible issues for focus of long-term psychotherapy

        - Evidence of psychosis
        - Suicidal Intent
        - Intent to harm others
        - Severe depression (untreated previously)
        - Personality disorders (e.g. schizoid, borderline)
        - Sexual problems/dysfunction of some duration
        - History of Abuse as a presenting issue
        - Alcohol or drug dependency as a presenting issue and in need of treatment
        - Addictions
        - Abusive Relationships
        - Trauma (affecting the current issue)
        - Eating disorders as a presenting issue and where medical evaluation is needed
        - Complex phobias Impulse controls (e.g., kleptomania, gambling)
        - Those with difficulty verbalising their feelings
        - Those with a psychological difficulty in leaving the home (as a presenting issue)

- Those with multiple, complex and compounded issues
- Those who are self-harming
- Those who present as reluctant to change who are seeking validation and sympathy
- Terminal Illness
- Complex Grief
- PTSD
- OCD
- Those with Head Injuries
- Those with a family situation that is chaotic and influenced by addiction or mental illness Self-esteem.

- As a guideline, an ORS combined score of 25 or over would seem to indicate that the participant would be unlikely to gain much benefit from short-term EAP counselling as it would seem to indicate that they may already possess strong coping strategies and Single Session Therapy may be a more appropriate way forward. If the participant refuses, or is unable, to engage in providing the ORS figures, it should be documented that they were attempted.

- Once all this information has been gathered the most clinically appropriate way forward can be determined and an action plan agreed. The options for the course of action will include but not be limited to the following modalities and are dependent the benefits available to the participant:

    - Single Session Therapy
    - EAP Structured Telephone Counselling
    - EAP In-Person Counselling
    - EAP Video Counselling
    - An EAP In-Person assessment for Couples Counselling (See Partner Couples Counselling Policy)
    - An EAP In-Person assessment for Family Counselling (See Partner Family Counselling Policy)
    - An EAP In-Person assessment for Minor's Counselling (See Partner Minor's Policy)
    - cCBT
    - Aware
    - Transitional Support
    - Elevate
    - Pathways
    - Group Counselling
    - Referral onward to long-term treatment with appropriate follow-up
    - Referral to wellness services if applicable
    - Referral to work-life services if applicable.

- Very occasionally a participant may be resistant to engaging in the engagement process and will insist that they will only share personal information with a clinician in-person. A participant who is reluctant to fully engage in a telephonic/video conversation can be referred to an in-person conversation to discuss their needs as long as they have provided their name, contact and full address details and provided there are no significant presenting safety issues following an appropriate telephonic/video risk assessment. This in-person conversation will constitute the first session of their EAP benefit. It must be made clear to the participant that if, during this in-person conversation, their presenting issue is not considered appropriate for short-term solution-focused counselling, resources will be offered.

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