When work causes harm: Supporting recovery and work participation after bullying and harassment

Webinar transcript

Assoc Prof Caroline Johnson (00:08:04):

Good evening. Welcome to When Work Causes Harm Supporting Recovery and Work Participation After Bullying and Harassment. Next. So the Mental Health Professional Network would like to acknowledge the traditional custodians of the lands, seas, and waterways across Australia upon which our webinar presenters and participants are located. And we pay our respects to the elders past, present, and acknowledge the memories, traditions, culture, and hope of Aboriginal and Torres Strait Islander people. So I'm Associate Professor Caroline Johnson, and I'll be facilitating tonight's session. So I work at the University of Melbourne as a teacher and a researcher in mental health, but I also work as a general practitioner here on Wurundjeri land And I'm really excited to hear this presentation tonight because it's a big part of the work that I also do. We're going, of course, to be exploring some strategies to really understand the health impacts of workforce bullying and harassment to help you to apply evidence-based clinical management approaches, and also to engage in ways to support client and patient recovery and engagement to get them back to safe and sustainable work.

(00:09:28):

You'll hear from each of our panellists in tonight's discussion, and we'll work through the learning outcomes that you can see here on the screen. Next.

(00:09:40):

So I'd now like to introduce our wonderful panel. You can certainly check their full biographies because they're available below in the video stream. And I'll just ask each panellists to briefly introduce themselves and just share in one sentence, what do you really love about working in the psychosocial safety space? So welcome and we'll start with Louise.

Louise Rabbone (00:10:03):

Good evening, everyone. Thank you for attending tonight. I think I've seen a significant psychological harm and bullying and other psychosocial hazards, what they've caused clients that I see individually. And so as a result of that over the years, I've become very passionate in being involved in the preventative side as well, working in organisations, understanding that we can prevent and make healthier and safer workplaces for employees. So that's myself tonight. Look forward to participating.

Assoc Prof Caroline Johnson (00:10:36):

Thanks, Louise. And I'll move on now to Summer.

Summer Bland (00:10:40):

Thanks, Carolyn, and hi everyone. I'm coming to you from Myanjin Brisbane. And when people say that they try and change the system from within, I tried to do that and it didn't work. And so what I really love about working in the psychosocial safety space now is that, well, my background is actually in performing arts and rock and roll. And I have actually been able to go back and work with some peak music bodies to help them to develop better systems, to create safer and fairer workplaces.

Assoc Prof Caroline Johnson (00:11:18):

Wonderful. Well, hopefully you'll share a bit of rock and roll with us tonight as well. Great to hear. And I'll move on to Chris.

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Chris Foley (00:11:27):

Yes. Hello everyone. I'm here 40 years working in mental health and working workplace health and safety. Certainly for me, it's about ensuring that people have a means in which to actually live their lives and to help their families as well. So it's whatever we can do to actually make that happen.

Assoc Prof Caroline Johnson (00:11:48):

Fantastic. So for the audience, you can see we've got expertise in organisational psychology, organisational development consultant through summer, and Chris's role as an occupational therapist. But what I think you're hearing is that everybody here, like most of us in clinical practise, like to make a difference, and it's very rewarding if you can make a difference. And certainly in this space, your skills and your ability to impact people's journey when they've experienced workplace harassment or bullying is really important. So we'll move now into the content and we're going to start really with a little bit about what are we talking about? What is bullying? And we're going to get the audience to do a little bit of work here because we know in our conversations that the four of us had in preparation for this webinar is defining bullying can be quite complex. It's quite context dependent.

(00:12:40):

So we'd like you to just use this QR code on the screen or there's a polls tab you can see just below your screen. And please put in your response to this question of what is bullying? Which of these options do you think are consistent with the description or definition of bullying? And you'll be able to see each other's responses come together as you answer.

(00:13:05):

So as you're submitting your responses, we also want to acknowledge that tonight's discussion may impact those who have had direct or indirect experience with this subject matter. And we ask that attendees try and keep their comments respectful and relevant, as I'm sure you will. And if you feel affected by tonight's discussion, support is also available via the resources in the chat. Okay. So I think we're going to see some of those responses now.

Summer Bland (00:13:37):

Drum roll?

Assoc Prof Caroline Johnson (00:13:38):

Yes. I'm not sure if we've got some of them coming through. Okay. I can't see them yet, but we do have some coming through. I can see from our facilitators that results are coming through. Maybe give people a little bit more time.

Summer Bland (00:14:00):

It's a tricky one.

Assoc Prof Caroline Johnson (00:14:02):

While people are answering, feel free to let the panellists join in. Do they have any sort of thoughts or things they think about when they think about the term bullying?

Summer Bland (00:14:19):

Well, I think it's a very big term. Oh, there's our - Fantastic. I'll let you lead.

Assoc Prof Caroline Johnson (00:14:28):

Have a look some at those responses and feel free to comment.

Summer Bland (00:14:33):

Yeah. So it looks like most of them are quite highly rated as including bullying. The interesting one is that 30% of people say it always involves deliberate intent to cause harm. And also that there's a bit of discrepancy around whether it's a fair and transparent process, I think the wording was, whether or not bullying can be involved there too. So certainly bullying can exist, I think, even where a process is perceived to have been conducted fairly. We have regulation and legislation around the wording of reasonable management practises conducted in a reasonable way, but that can be fairly subjective. And so I think what those results are showing there is that really bullying exists in so many different ways. It can be subtle, it can be overt, but it's systematic. It can include unreasonable performance management. There seems to be a fair bit of agreement around that.

Assoc Prof Caroline Johnson (00:16:04):

Yes, that's great. So can you talk a little bit more about other things that help us define bullying and harassment in particular in relation to the impact it has on the people, clients and patients that we might work with?

Summer Bland (00:16:17):

Yes. Well, I think that bullying is a bit of a catchall term that people rightly use to describe when they've been treated unfairly. And so these days we now talk about psychosocial hazards and a lot of what we call bullying can actually be categorised as one of these hazards. So maybe if you report to two bosses, there's a role clarity issue there and maybe there's different instructions coming from each of those bosses. And that might also intertwine with another hazard, like I suddenly can't think of any of them, like organisational change. And when we look at psychosocial safety hazards, they intersect and build and there's a cumulative effect. And that is often what I think a lot of people refer to as bullying, but they just don't have the language to say specifically what it is that's happening. We get all tongue tied around regulation that says it must be repeated.

(00:17:48):

It must fit into this very tiny definition that regulators have brought in, in order to be able to assess bullying and say, yes, it has happened or no, it hasn't. But with psychosocial safety regulations, there's now this element of, okay, we want to understand specifically what is happening to you.

Assoc Prof Caroline Johnson (00:18:09):

So talk us through a little bit about that ability to understand. So I hear what you're saying is maybe it's not as important to get fixated on the legal definition of bullying, but more to understand the experience of the person in a way that can help them. What are some of the things they would be experiencing?

Summer Bland (00:18:26):

Yeah. So just being able to identify some of those things. I think poor support from supervisors is a hazard and that can be perceived as bullying. I've come up with a really great, I think, a really great idea for something that we can implement, but my manager in the meeting says, "No, I'm not interested in that." And then on a different day, maybe there is some exposure to a traumatic event or something like that. These things, they align.

Assoc Prof Caroline Johnson (00:19:09):

Yeah. What would other people say about that? Louise and Chris, what's your experience of trying to help work out when someone's describing an experience, whether you need to go down that path of seeing this as a psychosocial hazard? What are some other things you do to help you decide?

Chris Foley (00:19:29):

Well, some of the things that pop into my mind at the present point in time is the way in which workplaces is changing. So we see a lot of instances where people are working from home, working using Microsoft Teams. I have a vague concern that that's actually contributing to people misunderstanding each other. If we go back to before working from home was the standard, we used to clear things around the water cooler, whereas what I'm certainly seeing now is that something might happen on a Teams call or it might happen at work, but the person's not at work the next day. So they contact one of their friends and say, "Hey, did you see that? What do you think about it?" And so suddenly it becomes a split within the team where some people are talking about it and it never really gets back to that base of what actually happened and did the person who said it have an opportunity to actually say, "Oh, hang on.

(00:20:31):

No, that's not how I meant it." I mean, there is certainly bullying and harassment going on, but I see lots of confusion around it where people are. They're just not as connected as they were. And as a species, we're supposed to be, I think.

Louise Rabbone (00:20:48):

I definitely agree with that, Chris, because I think people's ability to communicate in real time is diminishing and not just with our younger sort of generation, but across the board because we're using more and more texting, working from home, emailing. And as a workplace mediator, I see a lot of disconnect with exactly what you're saying, people understanding what the intent is and maybe shying away from actually communicating as well. So it can be quite difficult to pinpoint where all that's coming from. Yeah.

Assoc Prof Caroline Johnson (00:21:28):

Thank you. So I'm hearing a little bit around it is a thing that might be understood differently by different people. And you've also spoken a bit about people's perception. So people's perception of what's happening sounds to be pretty important and the environment or the context, whether it's due to ways of working is also important. Maybe could we talk a little bit more about the factors that you as a clinician can influence in these conversations? What can you influence and what can't you influence? Maybe Chris, I'll hand over to you initially.

Chris Foley (00:22:00):

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Yeah. So I think some of the time it is about how do you access the workplace? How do you actually talk with the manager? What is the intent of the manager? I see a lot of instances where it becomes difficult to really understand what's going on. It might be that the changes within an organisation are such where the manager has great difficulty in expressing the fact that, hey, we're about to go through a round of retrenchments and so therefore they're short in their language or they're anxious themselves. And so because they're being fired off with their fight flight freeze of themselves, they don't recognise how they're interacting with people around them. I think sometimes, as I said, there's this mixture of what is it really that's happening? And people don't... Often a manager will rise to being a manager because they're really an expert technician, but they really haven't had any training in the background about how do you manage people.

(00:23:11):

And so directing people becomes a thing that the person who's actually wanting someone to explain to them doesn't happen. And so then that person starts to think, oh, I'm being seen as stupid and way it goes.

Assoc Prof Caroline Johnson (00:23:25):

Yeah. It's really helpful to have your insights into the perception from the other side. And I guess for a lot of us in the room working, for example, in private practise, we might not get the perspective of the manager and we might not have access to it all. We might only have access to what the client in the room tells us. Can one of you talk a little bit about things that you can do in that context to try and help you have a more broad perspective?

Chris Foley (00:23:59):

Good question.

Assoc Prof Caroline Johnson (00:24:04):

When you're talking to the client, is it helpful to encourage them to think about other perspectives when they're describing what they perceive as

Chris Foley (00:24:12):

Happening? Yeah. I think it's really important to actually explore how the person interprets the bullying and helping them to sort of actually think about what might be a different explanation. Yes, that sounds like bullying, but is there another explanation? Is there something else that's going on within the workplace that might actually be affecting the people around you? Where is the space for people to actually clarify about what is meant? As I said, often people are immediately, depending on their level of assertiveness and what have you, immediately shrink back and go, "Well, that must be what it is." Sorry, go on.

Louise Rabbone (00:25:04):

I was just going to say sometimes people's mental health can skew their ability to look at things objectively, not always. And I think that could be another issue that could be occurring that their mental health is impacting their sensitivity, but we need to have that balanced perspective and give the clients obviously the opportunity to describe exactly what's happening and then gently get them to look at

other perceptions and other, is there repeated things occurring and look at the whole situation, a holistic perspective.

Assoc Prof Caroline Johnson (00:25:42):

Yeah. I think that's very good advice, isn't it? It's important not to assume that just because as a GP, I might be treating someone for 10 years and I might know they've had anxiety, but if they come in worried about a workplace situation that they perceive as unsafe, I'd have to be careful not to assume, oh, it's just because they're anxious. I have to actually explore it in a little bit more depth. I wonder, Sama, would you have any comments around that because you did raise this issue of the person's perception of what's going on?

Summer Bland (00:26:12):

Yes. I guess I hesitated from responding because I'm not a practitioner as yet, but I do do workplace investigations into these kinds of things. And my experience is that it's been really important to validate the individual. And I think what you were just saying about not assuming because they have a history of anxiety that maybe their perception is skewed. And I think when I was using the term their perception, I meant it more as just because what I was saying before, that it's about not having the language or the knowledge to accurately describe what is actually happening. So something I should have said earlier, an example would be being asked to do things that are constantly outside of your job description or having high work demands or being given menial tasks, all of these sorts of things. I think a person's perception might be, I'm being bullied, but that doesn't mean it's not bullying, but it also doesn't mean that nothing is happening.

(00:27:33):

It doesn't mean that situation's normal.

Assoc Prof Caroline Johnson (00:27:35):

Yeah. No, I think that's really helpful to sort of say that it's your role then to tease that out a little bit in the conversation with the person you're helping. Really helpful. So let's move on for the next 10 minutes or so. I want to talk about that early contact. When first of all, you suspect something's wrong and you want to help a person to disclose what's going on. So really talking about how can you support a client or a patient to talk about it in a way to help you understand, but also then to maybe help them raise it in the workplace setting, which obviously often needs to happen for things to get better. Louise, could you maybe comment a little bit about that?

Louise Rabbone (00:28:17):

Look, I think this is a really important point and it's not just for clinicians. I know we have a lot of psychologists, counsellors and social workers and so forth who would be directly involved in this type of thing, but it's also for people like GPs or HR of health and safety, even managers who will be the first person that that person might contact. So one of the first things I say is ensure the response is trauma informed. And really in that context, understanding that sometimes as a mediator, I can get a referral coming through for mediation and it's saying there's conflict occurring and bullying and harassment's not simply workplace conflict. So it can often be miscategorized. And obviously if it is bullying, then mediation isn't the appropriate response. But from a trauma informed, we have to be aware that clients actually experience bullying and harassment as a genuine threat.

(00:29:20):

And that is linked to mental health issues like depression, anxiety, burnout, post-traumatic stress symptoms. And there's some research that I've put in at the end that people can read if they want to look at some of those linkages, what the research is showing. So we need to approach the disclosure as we would any trauma disclosure. We need to ground it in making the client feel safe, building trust, giving them choice and empowerment. So that means pacing that conversation, watching for shame that might be coming through, any hypervigilance and self-blame. A disclosure, if we're hearing that disclosure, And we meet that with invalidation, it adds to the trauma. So our first job is to not be another invalidating response. And I'm very, very firm on that one and quite passionate about taking that stance.

Assoc Prof Caroline Johnson (00:30:15):

That's really helpful. Can I ask Samer or Chris, do you have anything to add around what you think trauma informed care looks like in that early phase of trying to encourage disclosure?

Summer Bland (00:30:31):

I often try to put things into, if this was a physical issue, how would someone respond? Because often the client I think would already be coming in, or I see a lot of people who are already gaslighting themselves, maybe I'm not resilient, maybe I am terrible at my job, this is all my fault, and really seeing that they are the ones to blame. But sometimes I try and put it into perspective for people that if this was a physical injury, like if you fell into a pothole at work and you broke your leg, would we be looking at how porous your bones are? I don't know, maybe you do, Carolyn, you might be able to respond to that, but do we blame our brittle bones or do we blame the pothole? And I think that's that part of that validating that you were saying, Louise, that we don't need to second guess people necessarily when they are talking about their experience.

Assoc Prof Caroline Johnson (00:31:43):

Those things are really helpful. Sorry, go ahead, Louise.

Louise Rabbone (00:31:46):

I think it's also important to realise that the bullying may be happening for some time. It's very rare that I get a client come in after a few weeks or even a few months. It's six to 12 to 18 months and sometimes even more. So I think that's an important thing to be aware that when they're disclosing to us, they might be exhausted, there's a lot of self-doubt, there's a long layered story and we've got to make room for all of that. So our first interaction is very key. We might see them, they've already broken trust with people in authority that they've gone to. So the therapeutic relationship carries significant weight in that regard because the interaction that they have with us or even someone in the workplace tells the client whether they're going to be believed, are they going to be judged, are they safe?

(00:32:37):

So it's a sense of feeling a warmth, don't hurry the unhurried listening, reinforce that confidentiality with them. And that lays the foundation for the whole therapeutic journey that you're bringing the client on. So I think where possible, if you can have an extended session, I know that's not always possible, but don't rush that first initial session. If you find that there's a lot of information and also you need to do some assessment as well, then follow on very quickly with another session close rather than leaving it

too far apart. I find that very helpful. And also letting that client be in control of what they disclose. By the time they've reached us, they haven't had a sense of control at all. That's been eroded by what's happened to them in the workplace by the bullying and harassment. So we need to be very client centred and let them decide what they share, how much and when.

(00:33:37):

We know it can be very damaging to force that disclosure too quickly and let them feel they're in control of that. We offer a gentle structure. Don't push for detail before they're ready and give them choice at every opportunity because we need them to reclaim their voice. If you're being subjected to bullying and harassment, you've lost your agency, you've lost your ability to have a voice, and that's part of the therapeutic response that we need to really reinforce. And then finally, I think it's very important to normalise the difficulty of that disclosure. A client will come in, they're quite unsure. They're going, "I don't know if this is really important. Does that really count? Maybe I'm overreacting or maybe they haven't been believed before. There's been an investigation. They've said no, everything's fine." So they're just afraid they won't be believed and they're ruminating. And so I think it does help to name directly to that client that it can be hard to talk about, but their reactions do make sense.

(00:34:42):

And given all the things I've been through, normalising help reduce shame as we know, and it signals that it's a safe place to tell this story. So we know that impact from bullying can range from mild annoyance to very severe trauma in some sexual harassment cases. And so the client's response, every client's response is valid. As we're saying, it doesn't have to be always a significant trauma, but it can start with some more milder symptoms. So just a few things there to consider.

Assoc Prof Caroline Johnson (00:35:18):

Well, it's very helpful for those of us who are working at the coalface. So certainly as a GP, when someone comes in, what I'm taking from what you're saying is maybe the emphasis shouldn't be so much on making that decision. Does this person have a work cover claim or have they met a legislative diagnosis? It should be about validating their concerns, trying to give them back some control and not treating it as the first thing is the diagnosis, but the first thing is establishing that trust because those decisions about whether it meets any threshold can certainly be made a little bit further down the track if needed. Is that kind of what you're saying there, Louise?

Louise Rabbone (00:35:53):

Yes. I would agree. Don't be in a rush in that first session because usually they just want to get it all out and it's important to let them lead that when they're ready and you can be collecting information as you go. But I do find a longer session is required to put all the information together as well as do a thorough assessment with them. So longer session or couple of sessions close to back to back.

Assoc Prof Caroline Johnson (00:36:23):

That's great. Well, I'm going to move in a minute into management, but I just want to touch base with Chris there. Do you have anything to add about that early support around disclosure? Is there anything else you'd add? Have you seen situations where disclosure's taken too long, for example, in terms of talking to the workplace about those kind

Chris Foley (00:36:40):

Of things? Yeah. Look, I think sometimes it is that and we're going to talk about it a bit later, but I think it's also about thinking about who else is involved in this. Sometimes an organisation will throw things like this out to HR where the person doesn't have any connection with the person experiencing the bullying and what have you. And so it's really about the how do you actually get everybody on the page really to actually make a difference. Some of the things that we see now is that when someone claims bullying, the manager shuts up and disappears into the background, everyone becomes defensive. And of course with the defensive, you've got walls going up and then that just reinforces for people that yes, they are being bullied or no, they are being singled out. So I think it is important to actually help the person and to be thinking also about, is this a person who has naturally assertive qualities?

(00:37:48):

Because if they don't, then throwing them back into the work or getting them back into the workplace early is probably going to just undermine them further.

Assoc Prof Caroline Johnson (00:37:59):

Yeah, that's really helpful. So that's a beautiful segue into the next 15 minutes of this webinar, which is really talking about the management of suspected bullying once you've got to that point. So when we get to management, I think what you're talking there, Chris, is a bit about a shared language between what the client talks about and what the workplace talks about. So I wonder if you can talk about how we in the clinical space can support that shared language to occur.

Chris Foley (00:38:30):

Yeah. Look, I think often because people are isolated, it's about talking with the person about who supports them, who it is in the workplace that they trust. I think it's also useful to be thinking about what are the support structures that you can bring in. So obviously it's a bit of self-interest in this, but certainly I see where the role of oc rehab providers in coming in and being able to be talking with the manager at the same time as the clinical work is going on with the person concerned. Because often you'll find that people run their own narratives and so it becomes harder and harder for the person to come back into the workplace. You can also get confusing narratives. I know in the past I've had situations where the GP has one story, the psychologist has another story, the HR department has a different story.

(00:39:32):

And so with all of those becomes a confused communication that just adds to the trauma of what's going on. Yeah.

Assoc Prof Caroline Johnson (00:39:43):

So other than advocating to bring in an independent occupational rehab person, which obviously isn't always possible, but I absolutely agree. Sometimes I wish we could do it earlier because it almost seems like you only bring someone in when all those problems have gotten worse. But talk us through what are some of the things that we as clinicians could do to prevent that kind of, if you like, these different stories emerging that don't fit together and don't make sense and don't help a person move ahead in their recovery?

Chris Foley (00:40:15):

Yeah. Look, I think some things like people learning a little bit about their values and how their value systems get trodden on by people around and how do they then communicate. So rather than withdrawing or getting angry back and things like that, being able to say something along the lines of one of my values is fairness. And when you did that, Joe, it doesn't feel fair to me. Helping the person find what alternative language they have rather than you did me wrong. Because as soon as you get that, organisations then get into defending. The times that I've seen organisations immediately throw it into an expert who then immediately goes, oh, this is all the defensive stuff that we've got, rather than sort of going, hang on, step back and understand what's happened within that. And so I think clinicians helping the person explore what might be alternative explanations for what happened, what's going on.

(00:41:19):

Not to say that they're wrong, but to actually explore that because as I said, sometimes you'll find that it's been a line of bullying. The executive directors are riding the back of the manager, riding the back of the supervisor, and the supervisor's actually sitting there going, well, the only thing I can do is push this button. And so helping the person think about there may well be other things that they know about but haven't really connected in.

Assoc Prof Caroline Johnson (00:41:45):

So there's that interesting tension. It's really helpful. There's that interesting tension between really validating a person's distress, really saying that you understand and that it's not okay what they're experiencing, but at the same time not feeding into creating more adversarial language. Of course, sometimes as a GP you can feel you're doing that because you have to let people know they have a right to make a claim, for example, under work cover. But in so doing it, you don't want it to be adversarial, you want it to be something collaborative. And I think that idea of looking at values is really good. Louise or someone, would you add anything to that, particularly around is there a point where you should talk to the manager yourself or how do you make a decision to up the ante versus just working with the individual in the room?

Louise Rabbone (00:42:33):

I think as a psychologist, we can't approach directly the manager or the organisation without the employee if they're coming to us privately. But if I'm consulted by the organisation and they are bringing me in to help sort that through and then also equally getting the client's permission, then we can navigate that discussion a little more clearly. But I think it is important. I just want to get across that when we are looking at the diagnosis and how it all fits together, there can often be two injuries from the client, the injury from the actual bullying itself. But then this is where I'm finding it becoming more acute, is that it's how the organisation responds to that claim of bullying. And I think we can call that institutional betrayal. Now I've got some information also in the references for people to read through a little bit of that.

(00:43:34):

So I think we need to understand the full scope of the injury. And when I say institutional betrayal, it's not often that it was the organisation were deliberately betraying the individual in that way or not preventing the harm or being supportive. And this is the education piece that we can as clinicians provide the organisation now with the advent of all the psychosocial legislation who are more open to receive this type of information on how to prevent the institutional betrayal and institutional harm. I'm not sure, Chris, you would find or someone that that's more of an education piece. So it's not always the

organisation being a bad organisation, but they're actually making the situation worse by how they're managing the claim or whatever.

Chris Foley (00:44:27):

Sorry. One of the things that certainly I'm finding now is that we've got a lot of organisations that are reaching out to organisations like ourselves to say, "Come and teach me."

Louise Rabbone (00:44:37):

They want to learn.

Chris Foley (00:44:39):

And speaking with managers to talk through what's their stresses and how do they react when timeframes are getting blown out and people are taking sick leave and all of that sort of thing. How do they actually manage that in a way that sort of says, "Let me take a step back and understand this from a different perspective." Finding that happening more and more and people actually leaning into, "Oh gosh, I didn't realise that's what I was doing."

Assoc Prof Caroline Johnson (00:45:07):

Yeah, that's helpful. So Summer, you also have some experience there, I think, don't you, in helping organisation?

Summer Bland (00:45:13):

Yeah, I was going to say that's very encouraging, Chris, that you see that the organisations are trying to improve in this area because a lot of the work that I do is really I'll be upfront about is often at the very far end where someone has experienced negative behaviours to the point where they have developed a psychological injury and they've gone through work cover, they're seeking legal advice. And that's usually when I, well, that's a large part of the work that I do is then investigating those. And so my experience is really that a lot of investigative processes are actually aligned more with organisations trying to avoid insurance premiums, increases in their insurance premiums, which is a very cynical view. And certainly I do acknowledge that I probably see the worst of organisations.

(00:46:21):

But I think it's important to know that, that when you're being approached by an organisation as part of an investigation into a claim is that they're often looking for reasons why they... It is that defensive aspect, but they're really looking for fuel for the insurer so that the insurer does not have to pay out and then later drive up their insurance premiums. And I've been asked by organisations, "We have bullying complaints. Someone's threatening to go to work cover and we can't afford that. So can you come in and do an investigation?" And I have to tell them that's not the approach. As you were saying, Louise, it is a workplace right that people have to go down that process and it's about giving them financial security while they heal. It's not just about money grabbing, but unfortunately that seems to be the line of sight that I see in a lot of investigative processes.

Assoc Prof Caroline Johnson (00:47:33):

Well, that's really helpful to know that there are those pressures from an organisational lens, whether it be right or wrong or cynical or not. I can imagine people don't want their insurance premiums to go up. And I guess for us in the initial clinical space, when we want someone to go back to work because we know we've been taught that more time away from work actually makes things worse, but then we've got to try and help them do it in a way that's safe. And we talk about person-centered care, making reasonable adjustments. Can we maybe just spend the next five minutes or so talking about how do you negotiate that? And I want to leave a little bit of time to say, well, what does that look like and what if it breaks down to the point that you really don't think you can send someone back to work?

(00:48:19):

Maybe Chris, you could start here.

Chris Foley (00:48:22):

Yeah. Look, I think it's reasonable to suggest, and certainly I think more clinicians are doing this, is to find a space where the person might return to work, not immediately in line with the experience that they've had. So where there's an alternative, say, job that they can take on. As I said, I'm finding, yes, there are some organisations that will fight tooth and nail, we didn't do it. Yes, I know I've got my fingerprints all over it, but I still didn't do it. That sort of stuff is becoming less and less. So organisations, particularly larger ones, do have the capacity to look at how they might create alternative work that gives the person the space to do it. And I'll give you an example. I had many years ago, a person at Centrelink who was feeling really distressed by the bullying that she was receiving from a supervisor who every Friday would sit down and say, "Well, you haven't done this and you haven't done that and you haven't done something else and not do it from an educative place." Cutting it short, she left work, put in a claim.

(00:49:32):

We ultimately were involved in it and we organised for her to come back in a support role to the job that she was doing. And because she'd actually been in the front line as it were, she was actually quite an extraordinarily good administrator and suddenly she felt empowered in the job that she had. There's a bit of luck involved in it because the person whose job she was replacing was on leave and decided not to come back. So just by having an alternative entry point, it gave the person the courage and the experience of going, "I can do this job. I don't have to be sitting in front of a supervisor every Friday saying why I did this and why I did that." So it's helping the person find alternative ways to get back in there. And more often than not, it's also having done that, how does the person then get back into their job?

(00:50:33):

Or is there a conversation that needs to be that, "Hey, this is really not a job that a person..." And Centrelink, for instance, that job was the person was put in a job where every day they would bring up as many people as they had to and say, "You haven't been doing your work. You're not getting payment anymore." Which of course was leaving lots of abuse and lots of, "Oh, thank you for that. I don't need the money," conversations. And so then being on the receiving end of what was essentially abuse by her supervisor because she wasn't doing the 90 odd calls you had to make or whatever it was. Yeah.

Assoc Prof Caroline Johnson (00:51:13):

Those situations can be very tricky, can't they? Because you don't want to send someone back to an unsafe workplace, but you also, I guess what you're saying is you really need to get the experts involved and you can work with your client in your therapeutic role, but you need to get some expertise in, which

is some of the things. We might talk a little bit more about that now because I'm just conscious of the time. I want to move on for the next minutes to talk a little bit about, as we're having this conversation about can someone go back to work or is it unsafe, what can we as clinicians do to support the people who we're seeing to work out whether it's psychosocially safe and what are the structures? I mean, Chris, you've mentioned a little bit around it, around kind of moving people out of a role and taking the heat out of it a little bit, but what are some of the other things that we can suggest that would help the client or the patient to do some of that themselves, particularly in that early phase before we've escalated it to the point that we have a claim, an insurance claim or a rehab provider involved?

(00:52:21):

Maybe some of you could start with this because I think you'd have some experience here.

Summer Bland (00:52:25):

I think being able to identify when it is safe is really important for a clinician because the individual won't necessarily be able to do that themselves. So the sorts of things that I would be looking for is, are the managers having a meaningful process with this person to try and talk about accommodations that might need to be made? If there are meetings planned with that person, are there agendas? Have they been offered the opportunity to have a support person or have they just been told your first day back is the 30th of September and there'll be a meeting at 9:00 AM to talk about your return to work?

(00:53:14):

That happens a lot and there's not actually a lot of information there. And sometimes when people ask for a agenda for that meeting, they're not given one. And part of the reason is because the employer thinks that the person won't turn up for that meeting, which is actually, I think, very sound because sometimes those return to work meetings are actually an ambush. So while they've been absent and people have been looking into their claims, they've been counterbullying allegations or allegations of poor performance have come up and these things are then presented to them at their return to work meeting. And worst case scenario, they're put on a performance improvement plan and all those sorts of things, which is, you can imagine if you're returning from a place of hurt to a place of employment is going to be re-traumatizing. So I think being able to identify where it is safe is really important.

(00:54:24):

And so I'd be looking for those kind of structures and a genuine commitment from management to explore accommodations.

Assoc Prof Caroline Johnson (00:54:33):

So that's really helpful. So certainly as a GP, I've often been in a situation where I've had the same doubts that you've just described that I haven't seen any evidence reported to me from the patient I'm seeing that the organisation has created psychological safety. So one thing I've tried is to write a letter to the employer saying, "This person's on leave and in preparation for return to work, here are five things that would really help a safe return to work." I mean, is that the kind of strategy that you think we out in trenches can use or can it also create risks in terms of escalating things unintentionally when we advocate for our patients?

Summer Bland (00:55:12):

I think there's always a risk of that. Oh, sorry, it's just lagged a bit, but I think there is a risk of escalating things when people have to put themselves out on a limb, but unfortunately it does rely on the individual to stand up for themselves with their support network. So with you as a GP or with whatever other specialists they have. So it is a necessary part of the process, but then it's just being prepared for what may be a negative response. So a lot of people, they put a lot of hope in that kind of a process. So we don't want them not to have hope, but we want them also to be going in with their eyes open and understand that a list of things that may help them will be presented. But if the organisation is not addressing those or they're just dismissing it, we don't have resources, why should we bother?

(00:56:14):

Or just no response at all, then that then is not safe. You know then in fact, you have your evidence to say this is not a safe place for you to go to. And hopefully that person is able to take the time away from work to plan the next steps.

Assoc Prof Caroline Johnson (00:56:30):

And I have to say in that regard, when I have correspondence back from a therapist, for example, a psychologist that says to me, "Caroline, I've been working with this client and this is what they're telling me. And I think it's psychologically unsafe." I find that really helpful as a GP to say, "Okay, I have to up the ante here. I have to actually call it out and say, No, you're not going back to work. So again, it links into this interprofessional communication for those in the audience, really important to think who's on the patient's team and making sure that those ideas are shared. So we avoid the problem Chris was talking about, which is everybody has a different version of the story because it sounds like that can create more risk for the client rather than increasing safety. Anything you could add there, Chris?

Chris Foley (00:57:14):

Yeah, look, I think it is important to actually, and this is where Oc rehab I think actually plays a significant part because it almost becomes the interpreter for all of the parties that are involved. So certainly a good Oc rehab provider will talk to the employer and say, "This is something that's actually impacting negatively on this person, so probably other people within your workplace as well." And more and more of the work cover authority, for instance, engages us to actually help translate that. And so help do things like, "Hey, let's not go back full time. Let's start with come back half a day, three days a week. So Monday, Wednesday, Thursday, catch up with all the things that you need to escalate that to then three days a week with a gap in between where you can stop and actually have a chat around that this is what I'm finding difficult, this is what's there." Even engaging someone who they feel safe with in the workplace to be the support person for them that they can go to when they're feeling a little bit anxious about what's going on.

(00:58:27):

You can actually put in quite significant scaffolding for people so that they do feel safe. They know what to do when it starts to raise for them. I'm not saying that every workplace is willing to do that, but we're finding more and more are because they do recognise and we certainly try to convince workplaces that if people around see someone coming back successfully for work, they're more likely to actually raise their hand when they're feeling unsafe or unwell and things like that. And so that improves the morale of the workplace and it improves their bottom line. Their premiums don't go up because people are prepared to say, "I've got a problem." Yeah, that's great to

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Assoc Prof Caroline Johnson (00:59:13):

Hear. Louise, you're nodding there too. Is there anything you'd like to add to that advice? I

Louise Rabbone (00:59:19):

Guess just adding to the one-on-one therapeutic sort of model, we talk about work focus CBT. So in that process, we bring work into therapy right from the beginning, sort of recognising there is a graded return to work plan because what we know is that the longer the person is, if they have been bullied, the longer they are away from the workplace, the more fear they develop and the more resistance they develop to going back. But if we bring work into the therapy, and maybe it's not necessarily going back in, we don't want to push them back into harm, but Want to keep the client's working life and identity central. I have someone at the moment who is devastated. They love their job, but they just cannot imagine going back into that workplace. And perhaps that might be the case that they may not be able to, but I think it's about still keeping their identity and what work means for them that they can actually work somewhere else if that's going to be their choice because people can get broken to the point where they can't work anywhere.

(01:00:27):

I mean, that's an extreme, but I think that's something that we need to look at as well.

Assoc Prof Caroline Johnson (01:00:34):

That's an excellent point. So I think you're now talking about it's important to ensure that the person you're working with has the resilience to move on, even if they decide to leave that workplace, that they don't become unemployable, which is so powerful. It's a nice segue into we're going to move in a minute to the questions from the audience. So encouraging people in the audience to keep those questions coming, that's really helpful. Before we move into that question time, I just want to spend a couple of minutes on a kind of a skills checkpoint, I'll call it, Chris, where I would just love it if you could just give an example of how to handle that first conversation someone gets back to work. So the patient and I have agreed they're going to go back to work, we've done the groundwork, but they've got to go back to work and it's starting next week.

(01:01:20):

What are some things I as a clinician can tell them or rehearse with them so that they feel ready to do that?

Chris Foley (01:01:27):

Yeah, I think one of the things to be able to say to people like this is really, "Hey, who in the workplace do you want to know that they know about what's happened to you?" But also about understanding the sort of questions that might come. So inevitably, particularly in a large workplace, there'll be people that come up to the person and say, "Well, how was your holiday? What have you been up to? Where did you go?" And things like that, which again, then trigger the person even further. So helping them work through what might be some of the things that happen on day one in the workplace and having some sort of, well, this is the strategy to manage that. Is it a discussion with the workplace? Is it a discussion with someone who supports you? Can we have some structured time when you go back to work and if there's things that have triggered you on day one, is there someone who's going to debrief with them at the end of the day and say, okay, how do we manage that now rather than wait till a month later or whatever it is?

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Assoc Prof Caroline Johnson (01:02:37):

Fantastic. So that's a really helpful skill point. And I love the idea of rehearsing with someone what they might say in certain situations because then you can really see, are they ready to do it? If they can do it with you confidently, they've got a better chance of being able to do it. That's really helpful. Okay. So you've all shared really useful things and we're coming now to the question and answer time. And we have received some good questions both live during the webinar, but also ones that people sent in during registration. So we're going to try and answer as many as we can, but obviously we can't answer everything. We've got 15 minutes for this part of the webinar. So bear with us if we don't get to your question. Maybe we could start with something that's come through in the chat, which is, first of all, I just want to check, is there anything else that you would suggest in the framework of building resilience?

(01:03:38):

I know a lot of us think of resilience as a dirty word in the bullying space because the bullying should be stopped rather than making the person strong, but there might be some things you can do. Chris's example of rehearsing what to say when you get back to work might help someone feel more resilient in that setting. Any other tips that you would have, particularly if you know someone's going back to a workplace where you're not a hundred percent confident that it's going to go smoothly?

Chris Foley (01:04:04):

One of the things that I get people to do is to think about what are the things that they can do that actually helps them maintain their equilibrium. If they, for instance, like art, make sure they continue to go to art, make sure they actually do things outside of work that actually helps them de-stress from that work experience. I mean, often people withdraw from a lot of things in their life which just escalates that stress. So encouraging them to meet with friends and all of those sorts of things is certainly one of the things that I try and get people to do so that they actually do have a sense that they have a scaffolding, that they are a human being, that they are okay.

Assoc Prof Caroline Johnson (01:04:52):

They're very helpful. Louise and Summer, would you add anything to that? Things that you think can help people build that strength to go through these difficult times?

Louise Rabbone (01:05:02):

Just working on their overthinking and catastrophizing and getting them to reformat the way that they approach their return to the workforce. Maybe if they do have an excessive amount of those types of questions that they can contact someone in the workplace prior to them going back into the workplace can help calm some of those overthinking thoughts. Summer?

Summer Bland (01:05:30):

I don't know if there's any evidence base for this. I only have my own anecdotal evidence to go on, but sometimes just helping people to identify an exit strategy doesn't mean they have to leave, but sometimes just knowing that they have options or being able to talk through options seems to just take the pressure off a little bit in having to return, I'm going to return to this role and it's going to be awful and I've got no future if I'm not there. So sometimes just arming people with a bit of those kind of things that they may actually have some level of control over.

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(01:06:16):

So yeah, an exit strategy, I tend to call it, involves being able to look at what your options are while you're still healthy because the risk of going back of being further bullied or having some other related trauma involved means that their mental health may get worse. So sometimes being able to plan an exit strategy in advance of it getting worse can be a protective factor. Again, I don't know if there's actual evidence for that, but I would think that anything that can give people a little bit of hope that this isn't the end would be useful.

Assoc Prof Caroline Johnson (01:07:05):

I think what you're talking about there is both hope, but also linking back to what Louise said earlier about people often feel they have no control in a situation, but what you're doing is giving them a sense that they do have some control, which links very nicely to one of the questions that's come through is what happens if you do speak up and you say this is a psychosocial hazard and things get worse for you as a result, like you get punished for it or we talked about that, you go back to work and they say, "Well, no, we want to performance manager. It's your problem, not ours." What advice you would give a clinician who's trying to support someone in that setting?

Summer Bland (01:07:43):

I think pointing them to other specialists as well, whether that be, or other avenues like is it a fair work issue? Is it something that's worth investigating what your legal options are? And work cover itself. These are all really scary ideas for people, but again, it's really good just to sometimes scope out what options are available to you if things go really badly. Another thing I tell people to do is to see what their superannuation covers. Are they covered for, what is it, total permanent disability and those sorts of things. And again, it just gives people a little bit of insight into what tools they might be able to draw on if things do go bad. And hopefully they don't, but I think that's a really important factor.

Chris Foley (01:08:51):

They can also engage with their union. So a lot of unions actually have people who are specialised in being able to support the person, particularly in larger organisations, but that can also have a balancing effect on how the organisation responds, can have the opposite. That's

Assoc Prof Caroline Johnson (01:09:12):

A good suggestion for people who have access to it. I'm wondering, that kind of fits with one of the questions coming from the audience about organisational accountability. I'm a clinician and I'm kind of hearing from my patient that something really bad's happening at work and I'm outraged and I think they should know that they're actually... So one thing I can do, I guess is fill in paperwork for a work cover claim, which is sort of signalling to the workplace that actually what I'm hearing is a concern. But are there any other things that clinicians can do other than involving the union that would increase the accountability of the workplace for your patient

Louise Rabbone (01:09:49):

Or client? I think most organisations would have some form of bullying and harassment policy and steps to take and contact officers and other avenues, particularly the bigger ones, but link them into that process and build the confidence that they can actually approach that type of accountability that

organisations... I know some of them do have a policy and they don't always implement it, but that is an avenue that they have. It's their right. And I've found that a good approach. A good HR practitioner will not send one away if they're saying, "This is what I've got happening to me and this is part of the bullying policy. Can you help me explain that?"

Assoc Prof Caroline Johnson (01:10:37):

Yeah. So empowering people to look at the bullying policy and speak to it is a very practical suggestion. One of the questions coming through is something that I deal with all the time. When should you raise that maybe this is something they should consider under workers' compensation? Which kind of comes down to that thing of how do you know when a person maybe has unreasonable expectations versus the workplace really is doing something unreasonable? You only got the client in the room and I know we've touched a bit on you can try and gather some more information, but do you have any tips around when to draw the line and mention that it might be a compensable injury?

Summer Bland (01:11:28):

How you would draw that distinction, except in terms of how functional they are.

Assoc Prof Caroline Johnson (01:11:38):

So severity of the distress, the impact on function, the clear ability to articulate a relationship between the alleged bullying and the emotional distress, those kind of things might help. Is that true? Any other tips?

Chris Foley (01:12:00):

Yeah. I think it is sort of ensuring that people do understand the impacts so that within the workplace, the impacts of it. Again, probably it's a function of the people that we interact with, but certainly a lot of workplaces now are more than happy to actually sit down and talk through what it is that they can do differently. I don't think anyone... Most people actually gets that people who get into that state, it actually has a flow on effect to that person's family and to the community at large. So as I said, I'm finding more and more places are willing to actually step in and go, "What can we do differently?"

Louise Rabbone (01:12:48):

I think I'd agree with that, Chris, because with the advent of the psychosocial code of practise, it's bringing all those sorts of things to the forefront and the legislative and legal requirements that organisations have now compared to say five years ago. Would you agree that it's more willing to come to the table, more willing to change, and it's a cultural change. And if it's happening once, it'll happen again and then it causes a major disruption in the workplace. Well, that's great

Assoc Prof Caroline Johnson (01:13:22):

To hear those.

Chris Foley (01:13:25):

So one of the things that we encourage employers to do is to actually go, "Did this person ever do the work that was required for them? Yes, they did. So what's happened to make it change now?" Because

rarely does an employer actually stop and ask that question, because if they could do it before, what's different now?

Assoc Prof Caroline Johnson (01:13:45):

That's a helpful question. And it's nice to, as we get to the close of this webinar, it's nice to hear some optimism that employers are seeing this is important, that there's now much more clarity around what their obligations are. There's one more question that I think is a really good one that's come up from the audience, which is more about what do you do in a situation where someone's sort of stuck in the middle? So the scenario that's been shared is what if a client reports being bullied by their next in line, and so they go higher up to complain about it, but then it puts them in a delicate position because they might still have to work under that person that's bullying them. So this is kind of internal in an organisation. Is there anything that we as clinicians can do to help set them up for a better outcome when they feel like they're at that meat in the sandwich to a certain extent?

(01:14:40):

Any suggestions?

Louise Rabbone (01:14:42):

Look, I think really it's about working on their mental health. If we're building that additional capacity to manage their anxiety or depression and sense of self and rights, then they're a little bit more robust to manage that. So sense of increasing their sense of agency, that they've got a voice, they've got options, they've got a pathway to move, is a therapeutic response in itself.

Assoc Prof Caroline Johnson (01:15:14):

And I guess also Chris's suggestion about values might be useful, exploring the person's values in that situation.

Chris Foley (01:15:21):

Yeah, helping the person become so assertive around it. So being able to say to your manager, "Hey, look, I don't know why you're talking like that. One of my personal values is fairness and this really doesn't seem fair to me. I know that's not what you want to do, but that's how it feels to me." So again, it's sending a warning signal back to the employer about the, "Hey, what you're doing is impacting upon me around my fairness," or whatever that core value is. Where a person can do that, you certainly start to see a shift in the manager in terms of either they're going, "Oh gosh, I'm stepping over the line here, so what do I need to know?" And hopefully that's where they get a good HR person in who says, "Yeah, that's not the way to deal with it, but there are some places that don't."

Assoc Prof Caroline Johnson (01:16:12):

Now, I guess that's the other bit about it is we know that bullying can happen even when it's not intended to be bullying. And so how do we deal with that when someone really doesn't think that what they're doing is bullying or don't intend to be bullying, but it still meets that definition that we were talking about before? What are some strategies there if they want to change?

Chris Foley (01:16:38):

So facilitated discussions and mediation is one of the ways, provided the person's strong enough and has support through it. It becomes a neutral space where people can actually say, "This is how I experienced what happened," and for the manager to disclose what's going on for them.

Louise Rabbone (01:16:59):

Also, some manager coaching can be helpful in specific cases, getting them to recognise how their communication style can impact other people and greater self-awareness for the manager so they can grow through that.

Assoc Prof Caroline Johnson (01:17:17):

So these have been really helpful pieces of advice, and I'd like to thank everyone in the audience for putting in such excellent questions. They've certainly helped me a lot in understanding this problem in a more nuanced way. I think what we've heard is that people need to have their experiences heard, they need to be validated, they need to have the help seeking experience normalised, but at the same time, they also need to be able to talk about it in a way that's helpful for them to get a result, which might be about thinking about their values and maybe helping them build a bit of resilience so that they can go into the workplace with a bit more confidence with some of the skills that'll help them, but also finally helping them to have a plan for exiting if the things can't be solved. And that might look like preparing them in advance for what they might do instead, but it might also look like advocating that they get some proper independent occupational health and rehabilitation before they make any major life altering decisions.

(01:18:19):

So there's a lot of richness in what you've shared. And I guess having gone through that tonight, what I'd really like now is to get the audience to think about what they might do differently if they meet someone that they're helping who has reported experience of bullying and harassment. What is something you might do differently after tonight's session? You don't have to tell us necessarily, but I really encourage you, if you've just spent now all this time with us on a webinar, the real strength of the webinar will be your ability to reflect afterwards and do one thing a little bit differently as a result of what you've learned tonight. It's certainly been a very valuable discussion. I think we probably can close it. Are there any final words that people want to say before we move to concluding the session? I hope you've all had a chance to share -

Summer Bland (01:19:15):

I would probably would just go back to the point that I started on, which is about becoming really familiar with those psychosocial hazards and what that really means. Because while bullying is a psychosocial hazard, sometimes what people are actually describing is high job demands, low job control, poor reporting relationships, confusion around that sort of thing. If a bully doesn't realise that they are a bully, maybe it's because they actually are pushing one of those other things. And so when we get caught up in trying to say on X date, this specific event happened and then on this date, this related event happened kind of takes us away from the situation. So being able to put it into the context of what those psychosocial hazards are really will the clinician, but also the client and being able to specifically identify what's happening to them.

Assoc Prof Caroline Johnson (01:20:22):

Yeah, that's super helpful. Any final words of wisdom from you, Louise or Chris?

Chris Foley (01:20:32):

Find ways for the parties to actually have a neutral space to talk.

Assoc Prof Caroline Johnson (01:20:37):

Yeah, that neutrality, that ability, and that's where the independent provider can sometimes make a real difference. And Louise?

Louise Rabbone (01:20:47):

I think just to anyone out there in private practise or working with someone who's been bullied, don't underestimate how much impact you can have on those individuals to help them pick themselves back up again and move through and get to the other side. And often we are the first person that they speak to and it's very rewarding work. So I'm sure many of you who work in that space would agree. Thank you.

Assoc Prof Caroline Johnson (01:21:16):

Yeah, that's wonderful. I definitely hope that you will all leave this webinar, not thinking of these client interactions as a difficult problem, but as something that's really rewarding and you can help people with that's a really good way to frame these opportunities. So I hope you've all found value in this discussion. As I say, I certainly have. We really welcome your feedback. We do look at the feedback and use it to improve our messaging and also MHPN uses it to help in improving its service. So thank you very much to the panel for the insights, and I'd like to thank you all for joining us this evening and wish you a very good night.

Summer Bland (01:21:55):

Good night. Thank you. Good night.

Louise Rabbone (01:21:58):

Thank you.