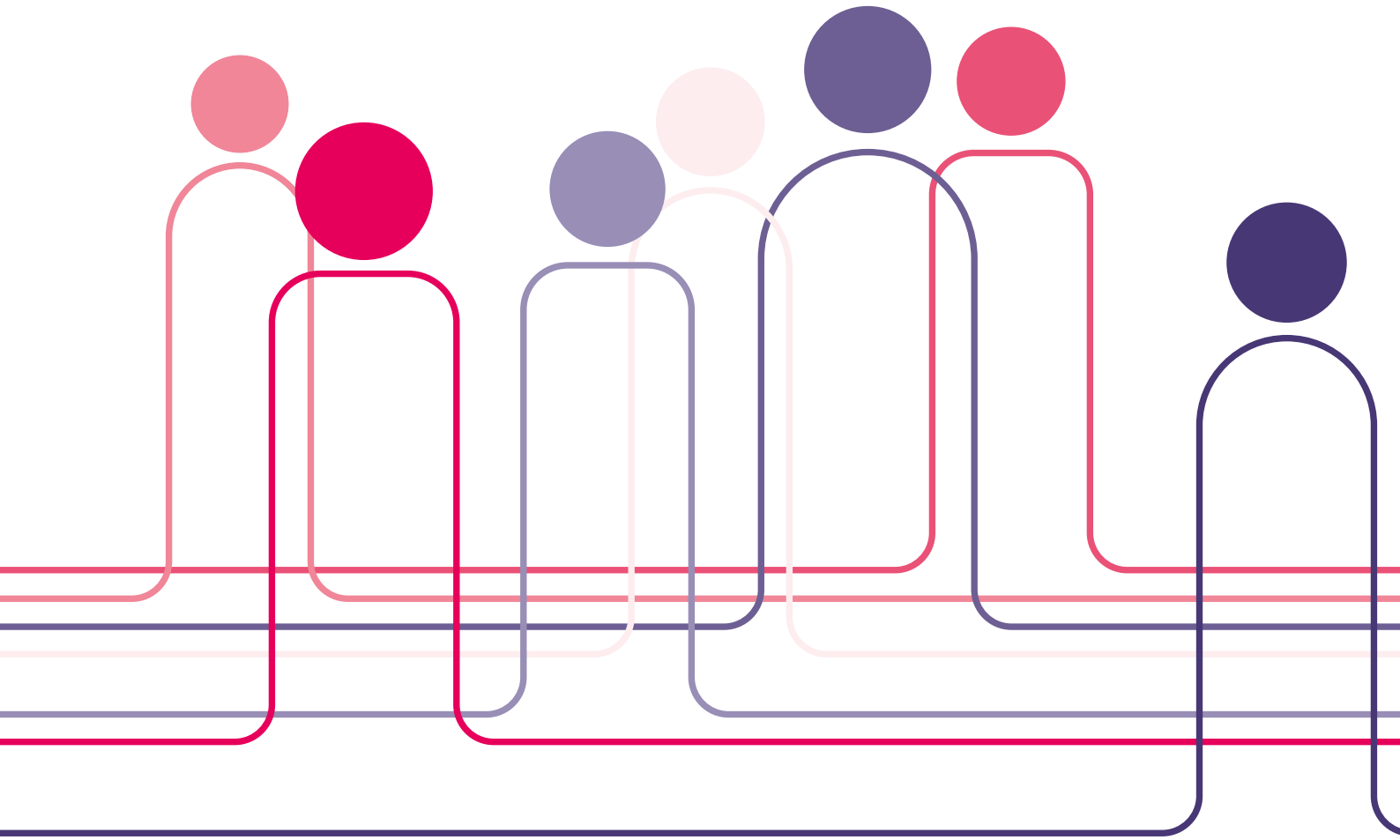
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A quick guide: Lone working Part 2



Checklist

Ethics Essentials

Client considerations

Introduction

In a recent survey of BACP members, 79% (n=694) said they work alone; 15% said they'd experienced violence or aggression while working with clients and or colleagues; this figure is significantly higher than the national average of 1.3% (BACP and Suzy Lamplugh Trust 2019).

The survey found that 92% of violent or aggressive incidents were carried out by clients or ex-clients and nearly 10% said it was perpetrated by a colleague or ex-colleague. In some cases, respondents experienced violence or aggression from clients and colleagues.

The types of incidents included verbal abuse, threats, sexual harassment and stalking. This highlights a potential risk for therapists when working alone. Forty-three percent of those affected said it had impacted their ability to do their job and had had a long-term effect on their confidence.

In the survey, 22% said they hadn't reported the incidents. Some of the reasons they gave included feeling unclear about the procedures and policies in place, what evidence they needed to report, and that they were anxious about breaking confidentiality. Some were fearful of the therapeutic relationship breaking down and consequently ending work with the client. They were worried this could cause a loss of the relationship and loss of earnings.

How to use this resource

Members have a contractual commitment to work in line with the *Ethical Framework for the Counselling Professions 2026*. This lone-working resource isn't contractually binding on members, but it's intended to give support by condensing relevant information and guidance into practical recommendations, which are valid at the time of publication. Recommendations given are in the context of the core ethical principles, values and personal moral qualities of BACP.

Specific issues in practice will vary depending on clients, models of working, the context of the work and the kind of therapeutic intervention provided. Specific issues that emerge from client work are often complex and we always recommend discussing practice dilemmas with a supervisor or consulting a qualified and experienced legal or other relevant practitioner.

In this resource, we use the word 'therapist' to describe counsellors and psychotherapists, and 'therapy' to describe counselling and psychotherapy. We use the term 'practitioner' to include those working in the practice of counselling, psychotherapy, coaching and pastoral care.

Potential clients, including offenders – safety considerations

In therapy, risk can be restricted to the risk that the client is to themselves, or to other people outside the therapy room. It might be usual for you to assume the client doesn't present a personal threat to you.

In some cases, this could potentially put you in a risky position if there's a lack of awareness that you need to include yourself when assessing the client's 'risk to others'. Storey, Hart & Lim (2017) highlight the prevalence of stalking for those that work within the mental health professions. The recent survey conducted by BACP indicated that one in six of the respondents had experienced violence or aggression in their practice (BACP and Suzy Lamplugh Trust, 2019).

Risk assessments should start at the initial contact with the client or if you have received information as part of a referral.

Previous behaviour can provide a useful indicator to potential future behaviour, so it's vital that you take a detailed history from the client.

For the purposes of risk in lone working:

- try to establish the genuineness of each new client before you agree to meet them, for example, take their full address or ask how they heard about you
- be clear from the start that the first session or two will be assessment sessions, before committing yourself to ongoing sessions
- be prepared to say no to offering therapy if you feel too uncomfortable, and don't succumb to financial (or any other) pressure to take on every potential client
- have GP details, client's name, address, DOB, phone number before agreeing to meet (standard practice before meeting any new client irrespective of location)
- conduct a detailed history of the client, specifically look for any indicators of violence to professionals or within interpersonal relationships, including fixated or obsessional thinking and behaviour
- be inquisitive about offending behaviour, particularly regarding offences for violent or aggressive behaviour
- are there particulars about their previous behaviour that suggest a risk of harm to others?

- can they explain the circumstances around any aggressive or violent incidents? This may be useful information to understand the factors that increase their risk, you will need to discuss these with your supervisor
- ask about their relationship history, are there any indicators of obsessional behaviour?
- if they've accessed professional mental health assistance previously – how did their last therapy end? This may hold indicators about 'red flags' that could mean they potentially pose an increased risk to other professionals who work with them
- what do they think of their previous therapist or mental health professionals they have worked with before?

Knoll & Resnick (2007) offer an overview of the factors that increase the risk of violence.

Historical

- Previous violence
- Criminal history of violence
- Previous threatening behaviour.

Clinical

- 'Rejected' (behaviour following the end of relationship) or 'predatory' (linked to sexual offending) stalking behaviour
- Substance use
- Narcissism
- Mental health issues.

Behavioural

- Access to weapons
- Proximity of victim
- Impulsive behaviour.

Stalking

Understanding stalking and harassment are key parts of developing a risk-awareness strategy but might be particularly important for lone workers. This type of behaviour isn't limited to clients and, given our recent research findings, this can also apply to colleagues and ex-colleagues. You should be made aware of the issues around what constitutes stalking and harassment and how to manage this.

Definition

The Suzy Lamplugh Trust defines stalking as 'a pattern of fixated and obsessive behaviour which is repeated, persistent, intrusive and causes fear of violence or engenders alarm and distress in the victim' (Suzy Lamplugh Trust, 2016). Stalking may not actually entail violence, more often it is ongoing persistent attention that causes such distress. The Trust highlights that anyone can be a victim of stalking. Harassment may consist of many of the same behaviours as stalking; but it is the persistent, obsessional, fixated element of the behaviour that defines it as stalking.

What constitutes stalking?

There can be many behaviours that allude to stalking and harassment. The key factor to consider is repetition and whether the behaviour causes fear, alarm or distress. So 'ordinary' behaviour such as the client walking past the house may become unnerving and distressing should the frequency increase. Behaviour can include:

- following, spying, monitoring, visiting home or place of work (outside session times)
- contact via emails, letters, texts, email hacking, social media, for example cyber stalking or trolling
- sending gifts
- making false complaints
- physical or sexual assault, or threatened assault
- damage to property
- extortion.

What makes a stalker?

Anyone can be stalked, it is not restricted to previous intimate partners. It's not clear why those who work in the mental health professions are at risk of stalking, but research indicates that there is an increasing number of mental health practitioners who are stalked by current or former clients (Miller 2012; Whyte et al 2011). Whyte et al (2011) suggested that clients formed the biggest number of stalkers, followed by colleagues.

It's difficult to accurately predict the personal, biological or cultural factors that result in someone becoming a stalker. Miller (2012) suggests that up to half of stalkers have a mental health issue and that this could be linked to the increased risk. Farber (2015) indicates that clients may present with a level of loneliness, isolation, social incompetence, narcissism and insecure attachment patterns; factors that could increase the likelihood of becoming stalkers. She highlights that as therapists we'll think of our clients with an empathetic, relational mindset but with stalking or harassment, the mindset needs to shift to being more risk aware in order to protect ourselves.

The stalking risk profile

The MacKenzie et al., (2009) stalking risk profile outlines five profile types of perpetrators that can be used for assessing risk:

The rejected stalker: The most common type and most likely to be linked to violence. Reconciliation or revenge will be the motivators.

The resentful stalker: They will have a perception of mistreatment and will intend to cause fear and distress.

The intimacy seeking stalker: They are delusional about the nature of the relationship and desire an intimate relationship with the victim.

The incompetent stalker: They are socially inappropriate in their attempts to instigate a relationship.

The predatory stalker: They are sexually motivated, stalk victims for sexual gratification or in order to commit a sexual assault.

Miller (2012) suggests it's the level of perceived intimacy in the relationship that is a risk factor and most stalkers will know their victim. For practitioners, one of the more challenging and potentially controversial factors that might influence an unhealthy fixation from the client is the use of empathy. While empathy is an essential part of the therapist's work, regardless of therapeutic orientation, it may also be a factor that increases the potential risk of being stalked by a client (Farber, 2015; Storey et al., 2017).

Farber (2015) proposes that stalkers may misinterpret empathy, and so their perception of the therapeutic relationship may become distorted because of their fixated and obsessional thinking.

This can be a challenging thing to manage because empathy is one of our key skills as practitioners. But it is not about you changing your fundamental practice, it's important that you trust your instincts. If the therapeutic relationship feels uncomfortable you can consider the following steps:

- it's good practice to talk these feelings through with your supervisor or with a trusted practitioner, if appropriate
- to aid this, it may be worth preparing for your supervision by reflecting on what it is about the relationship that feels uncomfortable. Does your empathic engagement with the client feel different in some way? Are there any specific examples that can illustrate how you are feeling?
- remind yourself of your client's initial assessment, is there any information you have that may indicate that a risk of stalking behaviour may be raised with this client?
- it could also be helpful to speak to the National Stalking Helpline (0808 802 0300) for advice
- it might be helpful to revisit your personal safety plan and discuss this with your supervisor.

New client checklist

- Made initial telephone contact to establish if client is genuine
- Personal details obtained before agreeing to meet
- Examples of previous aggression and violence:
    - violence or aggression towards professionals
    - violence or aggression within interpersonal relationships
    - previous offending behaviour
    - how previous therapy or mental health services ended
- Do I feel safe working with this client?
- Do I need to make amendments or additions to my current lone-working safety arrangements?
- Do I need to discuss my safety concerns with my supervisor or another trusted colleague?
- Do I need to seek specialist support and advice from the National Stalking Advice line or local police service?

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