Good Practice in Action 063
Clinical Reflections for Practice

Equality, diversity and inclusion (EDI) within the counselling professions

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Context

This resource is one of a suite prepared by BACP to enable members to engage with BACP's *Ethical Framework for the Counselling Professions* in respect of equality, diversity and inclusion.

Purpose

The purpose of this resource is to stimulate ethical thinking in respect of equality, diversity and inclusion issues that may be encountered within therapeutic practice.

Using Clinical Reflections for Practice resources

BACP members have a contractual commitment to work in accordance with the current *Ethical Framework for the Counselling Professions*. The Clinical Reflections for Practice resources are not contractually binding on members, but are intended to support practitioners by providing information, and offering questions and observations practitioners may need to ask themselves as they make ethical decisions within their practice in the context of the core ethical principles, values and personal moral qualities of BACP.

Specific issues in practice will vary depending on clients, particular models of working, the context of the work and the kind of therapeutic intervention provided. As specific issues arising from work with clients are often complex, BACP always recommends discussion of practice dilemmas with a supervisor and/or consulting a suitably qualified and experienced legal or other relevant practitioner.

In this resource, the terms 'practitioner' and 'counselling related services' are used generically in a wider sense, to include the practice of counselling, psychotherapy, coaching and pastoral care. The terms 'therapist' or 'counsellor' are used to refer to those trained specifically as psychotherapists and counsellors.

1 Introduction

It may appear a simple task to define how equality, diversity and inclusion (EDI) are encountered in practice, but EDI bring an expectation for us to not only be mindful of the overall concepts, but also to develop a holistic view of the person we are working with and the unique relationship which is being formed. If we as practitioners want to avoid the risk that some aspects of our clients may go unseen, we need to look beyond appearance and physical capacity, beyond gender and cultural backgrounds as the concept of EDI genuinely encompasses all of our lives. For example, think back over your life, have you ever felt unseen by the world around you? Or that you were being treated differently from others? Or blocked from doing something you really wanted to do? While these are often normal experiences of living, they can also be the manifestation of discrimination and exclusion.

The concept of EDI has been entwined within a changing society for decades, with the pace of change slowly building as the structures needed to support an inclusive society evolved and discrimination began to be challenged. While steps were taken to tackle discrimination in some specific contexts, it was not until the Equality Act of 2010 was passed that a unifying piece of legislation was instigated.

The Equality Act introduced a working definition of EDI with the aim of enhancing inclusion within society through the identification of different specific characteristics where discrimination could be experienced within society. These protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation are at its core and provide a clear scope of its application.

While these characteristics encompass the totality of life, it is important to remember that their application and relevance will vary depending on the individual concerned. For example, while age is a consistent characteristic, its application will vary depending on the age of the individual concerned, as the manifestation of discrimination around children and young people will differ from people past retirement. Additionally, while some of the characteristics have consistent relevance, others may vary depending on the events of a person's life and their choices. You can find further information about the Act's definition and application at the Equality and Human Rights Commission website: www.equalityhumanrights.com/en/equality-act-2010/what-equality-act or the Equality Advisory Service www.equalityadvisoryservice.com/app/help. Full contact details can be found at the end of this resource.

The other key responsibility, which the Equality Act introduced was the obligation to make reasonable adjustment to ensure accessibility for disabled people. In this case the decision of what comprises a reasonable adjustment is not specified by the legislation or determined by either party but is subject to negotiation if legal precedent does not exist.

While these overarching themes cover the whole of the UK their application can vary in England, Scotland, Northern Ireland and Wales and local guidance should be sought where necessary.

It should be remembered, however, that while the Equality Act has been vital in enhancing awareness of EDI, its structure around certain protected characteristics does risk facilitating the development of a 'silo approach' where the characteristics are viewed and addressed in isolation. This approach can result in a presumed need and detract from relating to the person holistically. For example, are we being genuinely mindful of EDI when engaging with a client who has a physical disability, if we are unaware of their sexuality or gender? In addition, focusing solely on the protected characteristics can result in other barriers to inclusion and equanimity such as disparity in wealth or the availability of support services going unseen.

In light of the Equality Act's differing application across the UK, the following vignettes focus on two overarching themes: the protected characteristics, and our obligation to make reasonable adjustment and what this may look like within therapeutic relationships. This resource does not provide specific guidance, rather its aim is to increase our awareness of how EDI can be present in practice. To this end, these vignettes feature fictional composite characters drawn from the experiences of a range of BACP members working in settings from private practice to the NHS and voluntary organisations. They are all written from the client perspective. All the therapeutic sessions take place in a fictional counselling service and should not be perceived as the only way in which EDI may be encountered in practice. Following the vignettes there are some questions which you may wish to consider, together with some general observations, which are included at the end of the resource to support further reflection. Other resources in respect of EDI include: Good Practice in Action 062 Commonly Asked Questions about EDI, and 108 Legal Resource on EDI.

2 Therapeutic setting for vignettes

Fictional Charlotte House was built in the early 1920s as a care home for wounded servicemen, surrounded by gardens and allotments to feed the home's residents. Since World War II, the outdoor space has gradually been reduced, being re-developed to provide much needed local housing and only a small paved seating area and six staff parking spaces remain. In the mid-1960s the building was transferred to the NHS and had a variety of uses before becoming the local base for mental health services in 1973.

In the years following the millennium, the local Clinical Commissioning Group has implemented a rolling review of its service provision, and it was decided that it would be more appropriate for mental health services to be contracted out to an independent provider. As the staff were keen for the service to be retained, ABT Community Engagement was created and secured the contract in 2005, at which point management of the service's 60 volunteers was transferred to ABT.

ABT became a social enterprise the following year and raised the funding it needed to complete essential maintenance and modernisation works to ensure Charlotte House would meet the needs of all service users, and it now has two distinctly separate spaces. The ground floor being the community space including a café, large rooms for clubs and groups to meet in, along with the office space for ABT, main reception, two rooms used by the Community Mental Health Team for mental health assessments and ABT's drop-in advocacy service along with stairs to the first floor.

The first floor comprises the protected counselling space with four one-to-one rooms, two couples' rooms and a family room along with the private waiting area. From the outset, ABT's fundamental goal was to make free counselling services as accessible as possible providing open-ended interventions for adults. Sessions could take place by appointment between 9am and 9pm Monday to Friday and from 9am to 5pm on Saturdays and Sundays.

In accordance with the terms of the original contract, the service provision has recently been reviewed and following a reduction in funding, it is no longer viable for ABT to have these extended hours. Following an independent consultation with all stakeholders a restructure in the service provision has had to be implemented. At the start of the current financial year, services were revised and there has been a reduction in ABT's opening hours for counselling to 9am to 5pm Monday to Friday and Saturday between 9am and noon. Free counselling was capped at 18 sessions per intervention; however, following objections from both clients and counsellors, it was agreed that the 18-session limit could be exceeded but it was conditional on the client making a contribution of between £5 and £20 per session depending on their circumstances.

The service has also responded to requests from its counsellors and now makes the counselling rooms available for rental on an hourly basis by private practitioners in the evenings and weekends. In order to make the separation between private and ABT clients clearer, a separate entrance has been created providing direct access to the counselling rooms for private clients.

2.1 Referrals and service remit

Referrals to ABT can be made by any medical or social care professional within the Clinical Commissioning Group's geographic remit who considers that someone they are working with would benefit from counselling. All ABT referrals are assessed by one of ABT's three paid counsellors before being allocated to one of the volunteer counsellors primarily on the grounds of counsellor availability, unless a specific type of intervention has been identified. Following allocation, practitioners are given a summary of the assessment prior to seeing the client. Those counsellors who are either registered or accredited with BACP are able to liaise directly with their clients to confirm appointments etc., but all client contact for other counsellors (such as trainees) takes place via the office staff.

Any requests for counselling which fall outside ABT's service remit, such as self-referrals, are referred to the 'Other Services' section of their website where clients can register by providing basic details about themselves, availability and reason for seeking counselling. They will then be contacted by one of the private practitioners registered with ABT to arrange an assessment.

3 Clinical vignettes

The following series of fictional vignettes are intended to enable you to reflect on how issues relating to EDI may present themselves in practice. As you read through them, be mindful of the protected characteristics and the potential need to make changes in how services are provided for the person. After you have read the last vignette about Tanith, there are questions for you to think about (and for discussion) in respect of all the vignettes.

3.1 Vignette 1 – Bert

Bert was referred to ABT by his GP following the death of his second wife, Dorothy or Dot as her family always called her, shortly after celebrating their 30th wedding anniversary. They met and married following the difficult, bitter break up of his first marriage; when comparing his marriages Bert said, 'but it's all right though, I loved this one'. He asked to be referred to ABT at the encouragement of his children, as he appeared unaware that his angry outbursts were becoming more intense and being directed at them, often in the presence of his grandchildren, and they felt they were being pushed away.

The assessment was comparatively brief, confirming the above information; the primary presenting conditions being sadness and loneliness, that he had no specific access needs and that he had been made aware of the terms and conditions relating to the service's scope.

You have been working with Bert for three months and his attendance has generally been good, but the reduction in the family income following his wife's death now means that he no longer drives and is dependent on public transport, or community transport services, which he finds demeaning. In his early sessions he was often angry in the room with you, focusing his aggression on the unfairness of his life. Over time though he has begun to trust you, becoming slowly more candid and you have formed an effective working relationship with him.

It has gradually become clear that in addition to the loss of his wife, his anger stems from his own practical struggles. While you were always aware that he used a walking stick to get around he is now struggling to make his way up the stairs when he thinks nobody is looking. He is also clearly in pain when it is cold, rainy or windy outside.

In recent sessions Bert has been talking about how he now just feels lonely and unhappy all the time and has picked up a couple of the leaflets for the groups which meet on the ground floor; while accepting the possible benefit they could bring he isn't really sure whether he would want to be that involved as, 'that was Dot's job'. He is also concerned about what people might think when it gets out that he is coming to see you. Running in parallel with his loneliness, he has also recently been acknowledging the benefit which talking to you is having for him but he is starting to become anxious as to what will happen when his sessions run out.

3.2 Vignette 2 – Lilly

Lilly was referred for counselling by her Rehabilitation Worker as she is experiencing growing anxiety over some unavoidable and significant changes in her life.

At present, she still lives at home with her mother, her father died before her first birthday and she has no memories of him. She was born deaf blind as her birth was extremely premature due to her mother's severe pre-eclampsia. Her mother has empowered her by making sure that all her close family learned to hands-on sign to ensure her home life was as inclusive as possible. Sadly, her mother is now developing dementia and it is no longer felt safe for them to keep living together. Lilly has decided that it is time to move out to supported housing, but she is increasingly anxious over the practical challenges this will present.

Despite her fears over what the future holds, Lilly sees the real benefit of counselling and wants to come as she knows her life is changing forever. As this was her initial assessment session, she brought her younger brother, Danny, to 'hands on' sign for her, but feels it would be inappropriate for her siblings to attend her sessions.

From the outset it was apparent that this style of communication would take longer than usual and two further appointments were needed to complete her assessment. Lilly was adamant that she did not want to have any existing connection with the translator and, as the deaf blind community is comparatively small, it took two months to find somebody she felt able to work with.

The signer was articulate and engaging, but 'hands on' signing proved very time consuming and tiring with sessions being broken into two 20 to 25-minute slots with a short break in the middle. Lilly finds the interruptions irritating but her commitment remains undimmed as she has begun to explore parts of her life she has always felt unable to look at. Whilst progress is slow, Lilly begins to risk considering how she sees herself, and the experience of being loved, but she also acknowledges her fears that with only three sessions left, and without the financial resources to pay for more sessions, she will not have enough time to think about it properly.

3.3 Vignette 3 – Rani

Rani was referred for counselling by her GP as her children were becoming increasingly concerned over her reaction to the death of her first great grandchild. The inference from the referral was that she had been able to spend time with the baby but at assessment it was confirmed that the baby, a boy, was stillborn.

The GP's covering letter confirmed that the referral was being made following a discussion with her oldest son Belwinder, a doctor working in orthopaedics. Since the baby's death, he was aware that his mother had become less active and was reluctant to engage with her family. In her assessment, it was noted that although she communicated easily with the assessor, her son had also attended, often interrupting to correct her response if he saw things differently; Rani always deferred to his perspective.

While a family member would bring her to ABT for her sessions and take her home afterwards, they always waited in reception. In her early sessions Rani focused on the losses in her life, starting with her parents' deaths in India over 40 years ago whose funerals she was unable to attend, two miscarriages and the loss of her husband who she described as being her 'support and protector'.

Rani is engaging in her sessions, welcoming any observations you make, acknowledging them as being 'so powerful in helping me understand and start trying to change'; at the end of her fifth session you note that she has always deferred to your perspective. As Rani's sessions progress, she often ends her sessions by commenting on how much better she feels from seeing you.

Unusually, Rani's session was cancelled today but the clinical lead at ABT checks in with you as Belwinder had called to express his, and his siblings concerns, that despite seeing you for 12 sessions, their mother remains as detached as she was prior to starting counselling.

3.4 Vignette 4 – Tanith

Tanith was referred to ABT by her GP as she has been becoming increasingly detached from family and friends, culminating in the recent separation from her partner of four years. Her referral confirmed her medical history providing summary information across a range of health conditions, including four counselling referrals during the last 15 years since coming under the remit of the adult mental health team.

Tanith carefully planned her lengthy journey to ABT for her assessment, but it was less time consuming than she had anticipated and she arrived 30 minutes early. While waiting in reception she became visibly uncertain and uneasy as it was busy with excited people attending a community event and she struggled to access any of the information displayed. Her assessment notes confirmed that throughout her assessment Tanith was disconnected, responding primarily mono-syllabically and refusing to sign the contract provided saying, 'I can't read that, don't you know I'm dyslexic?' before threatening to leave; her referral had only described her as having a 'learning difficulty'.

Tanith cancelled her first session when she arrived and learnt that a contract which she could read, still had not been provided and that no one was available to work through it with her.

Following a brief telephone conversation with the administrative team, a reformatted contract was produced, which was discussed in detail at the start of Tanith's next session, when she focused on ensuring that she had correctly understood the meaning of the language used.

During her first few sessions Tanith swayed from mono-syllabic responses, avoiding eye contact and fidgeting, often crossing and uncrossing her arms and legs, to a more relaxed posture with a continual, uninterrupted narrative being recounted about all aspects of her life. She often appeared oblivious to your presence. As she spoke Tanith often misinterpreted your observations and interventions, necessitating clarification and re-phrasing a number of times to make sure that the language meant the same to both of you. As her sessions progressed, a reasonable working relationship started to form, and she began to become more candid over some of the experiences of her life.

3.5 Questions for reflection

Some questions for you to consider when thinking about Bert, Lilly, Rani and Tanith:

- which of the Equality Act's protected characteristics is applicable to each of them?
- do you think that any adjustments might be needed to make it easier for them to attend their sessions with you?
- when you are in the room, might you need to make any changes to how you work?
- is there anything which you feel may need to be considered/reviewed by ABT?

4 Observations for practice

4.1 Equality, diversity and inclusion (EDI)

When considering the vignettes, all of the clients fall under the scope of a number of the protected characteristics including age, gender, disability and race but the profile and potential issues vary.

In relation to the protected characteristics relevant in each of the vignettes, we can see that Bert's and Rani's ages should be considered, Lilly and Tanith's disabilities need to be recognised and Rani's race noted to ensure that no one is disadvantaged on any of these grounds.

The vignettes show that there are differing levels of willingness to acknowledge the need to request adjustment to improve service access. Lilly and Tanith are both able to articulate what they need in order for them to engage with counselling; a sign language interpreter was found for Lilly and an accessible contract provided for Tanith. Bert seems reluctant to acknowledge his challenges and hence to consider whether things can be improved; in this case a counsellor might need to give some thought as to how to explore what changes may be appropriate with him. Finally, in the case of Lilly, it may be appropriate for further adjustment to be considered. Thought could be given as to whether it is necessarily appropriate to apply the requirement of payment for additional services to Lilly given that the slowing of progress has stemmed from things beyond both the client and counsellor's control.

The counsellor working with Lilly will have had to adjust their way of working to accommodate the use of the signing interpreter, allowing time and space for the interpretation and the break during sessions which became necessary. Tanith's counsellor began using more clarification to ensure that both they and Tanith were experiencing a shared understanding of the therapy. For Rani, a recognition that her more submissive way of being could potentially be due to a cultural difference in relation to her Indian heritage means that the counsellor might have to take this into consideration within the therapeutic relationship.

From these four vignettes, it seems that ABT maybe need to revisit their policy regarding charging people for sessions beyond the original 18, as this could potentially discriminate against clients like Lilly and Bert who have financial concerns. Thinking about Bert's difficulty in climbing stairs, the organisation may need to consider providing a counselling room downstairs for such clients. When thinking about Tanith's anxiety in the waiting area downstairs, consideration may need to be given to making this area more accessible.

In all of these cases, the need to actively consider the totality of the client, and a willingness to address possible changes to enhance the effectiveness of the intervention, are essential in order to provide genuinely inclusive services.

4.2 Ethical Framework

Throughout its evolution, an underlying theme of the *Ethical Framework* has been to make service accessibility a reality. Historically, this has predominantly been articulated through its ethical principles, values and personal moral qualities.

The *Ethical Framework for the Counselling Professions* (2018) however, commits members to 'respect our clients as people by providing services that:

a. *endeavour to demonstrate equality, value diversity and ensure inclusion for all clients*

b. *avoid unfairly discriminating against clients or colleagues*

c. *accept we are all vulnerable to prejudice and recognise the importance of self-inquiry, personal feedback and professional development*

d. *work with issues of identity in open-minded ways that respect the client's autonomy and be sensitive to whether this is viewed as individual or relational autonomy*

e. *challenge assumptions that any sexual orientation or gender identity is inherently preferable to any other and will not attempt to bring about a change of sexual orientation or gender identity or seek to suppress an individual's expression of sexual orientation or gender identity*

f. *make adjustments to overcome barriers to accessibility, so far as is reasonably possible, for clients of any ability wishing to engage with a service*

g. *recognise when our knowledge of key aspects of our client's background, identity or lifestyle is inadequate and take steps to inform ourselves from other sources where available and appropriate, rather than expecting the client to teach us*

h. *are open-minded with clients who appear similar to ourselves or possess familiar characteristics so that we do not suppress or neglect what is distinctive in their lives.* (Good Practice, point 22a-h.)

The *Ethical Framework* goes on to commit members to:

...take the law concerning equality, diversity and inclusion into careful consideration and strive for a higher standard than the legal minimum. (Good Practice, point 23.)

And that:

We will challenge colleagues or others involved in delivering related services whose views appear to be unfairly discriminatory and take action to protect clients, if necessary. (Good Practice, point 24.)

This brings clear parameters to practice which all members need to be mindful of. Some of these commitments have a clear resonance within the vignettes, such as Lilly and Tanith's need for adjustments to be made in order to make the service accessible. However, is there a need for greater understanding of the possible cultural foundation of Rani's familial dynamics and should Bert's increasing struggles to move around the building be allowed to remain unaddressed? Further relevant GPiA resources to help members think through these, and similar, issues are listed in the 'further resources' section below.

Conclusion

These vignettes have been produced to illustrate how EDI can be evident in our relationships with clients, but this is by no means an exhaustive list. In order for genuinely inclusive and accessible services to be provided, members all need to ensure that they retain a willingness to make adjustments to how they work, where necessary and reasonable, in whatever setting they are working. However, it is more important that we consider our clients holistically and retain the integrity to raise issues that we feel may be impacting on our interaction with them.

Further BACP Good Practice in Action resources are listed below along with other organisations who can provide advice on the interpretation and application of the Equality Act, which informs the need for an holistic view of our clients, whilst acknowledging our individuality as practitioners. This should not be taken as an inference that reading and development opportunities do not exist, rather that their selection needs to be driven by the people we are and our experiences in practice.

If this resource has highlighted an aspect of your client engagement that you would like to increase your awareness of, a good first step would be to reflect on which aspects of EDI you are most uncertain of before reviewing what publications exist and what other developmental opportunities may be provided by organisations focused on this area of public engagement.

About the author

This updated resource was originally authored by Steve Rattray who is a senior accredited counsellor and senior accredited supervisor of individuals, working in an NHS Palliative Care Unit's Bereavement Counselling service. Steve was a member of BACP's Professional Ethics & Quality Standards Committee between 2011 and 2015. Away from his clinical practice, he works collaboratively with a range of third sector organisations, health and social care services to support the enablement, empowerment and rehabilitation of people experiencing sight loss.

Further resources

For information and confidential advice on the application of the Equality Act on an individual level:

Equality Advice Service
Tel: 0808 800 0082
www.equalityadvisoryservice.com (accessed 30 September 2020)

For advice on the interpretation of legislation and its application at an organisational level:

Equalities & Human Rights Commission
Tel: 020 7832 7800
www.equalityhumanrights.com/en (accessed 30 September 2020)

BACP (2018) *Ethical Framework for the Counselling Professions* is available at: www.bacp.co.uk/events-and-resources/ethics-and-standards/ethical-framework-for-the-counselling-professions (accessed 30 September 2020)

Good Practice in Action resources

BACP (2016, updated 2019) Good Practice in Action 056 Research Overview: *Equality, diversity and inclusion within the counselling professions*. (Content Ed. Davies, N.). Lutterworth: BACP.

BACP (2018, updated 2019) Good Practice in Action 080 Fact Sheet: *Reasonable adjustment in the counselling professions*. (Content Ed. Rattray, S.). Lutterworth: BACP.

BACP (2018, updated 2019) Good Practice in Action 091 Fact Sheet: *Working with interpreters in the counselling professions*. (Content Ed. Chaturvedi, S.). Lutterworth: BACP.

BACP (2020) Good Practice in Action 101 Fact Sheet: *Race, religion and belief within the counselling professions*. (Content Ed. Rattray, S.). Lutterworth: BACP.

BACP (2019, updated 2020) Good Practice in Action 108 Legal Resource: *Equality, diversity and inclusion within the counselling professions*. (Content Ed. Whalen, C.). Lutterworth: BACP.

Barker, M.J. (2017, updated 2019) Good Practice across the Counselling Professions 001 *Gender, sexual and relationship diversity (GSRD)*. Lutterworth: BACP.