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Racial and social inequalities: Taking the conversations forward

DCP Racial and Social
Inequalities in the Times
of Covid-19 Working Group

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Division of
Clinical Psychology

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Introduction

This position paper is intended to begin conversations and engagement with stakeholders to co-produce a change strategy to counter racial and social inequalities. It offers initial thoughts on the risks and impact of Covid-19 on pre-existing racial and social inequalities and structural racism. It takes up an inward and outward facing approach to considering barriers to change at individual, professional, social and institutional levels. It also starts to develop an understanding of why this is happening. It outlines an urgent call to action to centre, support, and learn from at risk communities. A framework for change, informed by the literature, our experiences and consultation with others is put forward for the profession, organisations and policy-makers.

We acknowledge that every person has been impacted by the pandemic, but there is an inequity in the impact that it has had on individuals and groups of people. We aspire to ensure that recovery and transformation plans will tackle the socioeconomic and societal injustices that have led to Black, Asian and Minority Ethnic (BAME) groups being disproportionately affected by Covid-19 (Public Health England, 2020). This requires working in partnership with communities to understand and co-create solutions.

These lost lives are situated within a social context. That social context is one in which simply asserting that 'Black Lives Matter' is a radical statement challenging the institutional and structural racism of government, education, the police, the NHS, mental health services and of clinical psychology. Racism is also a virus, but it is within our control and requires us all taking responsibility. It has spread throughout our society and the world, and has caused extreme harm to many individuals and communities. Whilst, our focus has been on the impact of Covid-19 on BAME people, this can't be separated from the wider issues around stigma, discrimination and racism. This was highlighted very clearly at our listening and engagement event including where misgivings exist in our own profession. The message was clear – We need to put our house in order. We seriously need to consider what part we have played in keeping the status quo, what we can do individually and collectively in our roles in organisations and institutions to open our eyes, understand, validate, apologise, forgive, work towards change and be stronger together.

We want to acknowledge the difficulty and emotional labour involved in thinking about inequalities, power dynamics and racism. However, we all have to embrace this to move towards change. Working on this paper has had a significant emotional impact on each of us, which may also be the case for readers. There is a content and length warning. We decided not to cut short the paper to share the emergent process of our thinking to understand this complex subject and facilitate an open dialogue.

We want to hear from as many people as possible, especially those with diverse perspectives to further build upon the foundation we have begun to set in this paper. This will shape and inform the Division of Clinical Psychology's Equality, Diversity and Inclusion and Anti-racism work going forward. We will be setting up a listening post to take this work further. You can contact us through dcp-racial-social-disparities@bps.org.uk and a member of our working group will get back to you.

DCP Racial and Social Inequalities in the Times of Covid-19 Working Group

Understanding race

Before we can understand racial and social inequalities, we must first understand how we (society) conceptualises race. Defining race in itself can become contentious, and the Oxford English Dictionary has almost 100 definitions. The categorisation of people based on their skin colour and physical features developed from a colonial history, where social hierarchies enable groups of society to be discriminated against both consciously and unconsciously. It has long been understood that the term ‘race’ has no biological basis but continues to operate within a social-political context (Smedley & Smedley, 2005). Race is utilised within society to enable racial inequality and racism. We also need to critically look at psychology’s role in the creation and promotion of racial thinking and practices.

CONSIDERING A BIO-PSYCHO-SOCIAL APPROACH TO ‘RACE’

Race needs to be understood *not* as a biological difference with biological consequences, but as a categorisation of people, which has social consequences. There is emerging debate about the impact of genetics and environment and how they explain vulnerability to contracting and dying from Covid-19. The impact of Covid-19 on BAME communities in UK/US seems different from its impact in the African and Asian continents. The disparity can’t be understood as a result of a genetic difference, but as an interaction between biological, psychological and social factors, which create inequalities in health outcomes for BAME groups. Once we understand these factors, we can fully understand how to take action to address these disparities, and create meaningful change.

People use language in multiple ways in discussions about ‘race’. For the purposes of this paper, we used the term BAME (Black, Asian and Minority Ethnic¹), in line with the research emerging related to Covid-19. We acknowledge that many people do not like this broad label, as the varying experiences can be lost and prefer different language use.

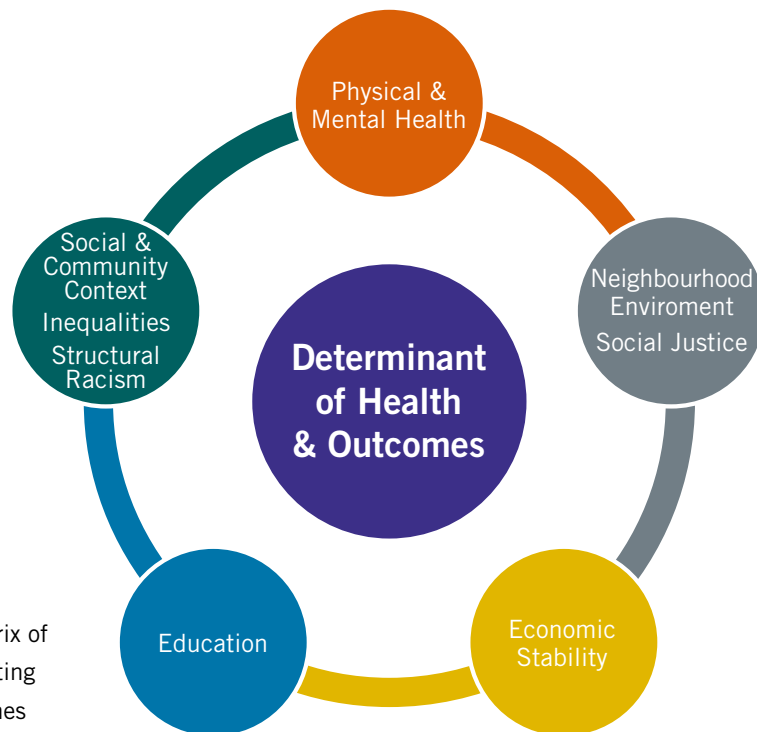


Figure 1. Matrix of factors impacting health outcomes

¹ The authors considered the roots of the disapproval of the word BAME, and acknowledged that it is an umbrella term that does not distinguish between the nuance of the experience of being from Black, Asian and other ethnically minoritised groups living in the UK.

Covid-19 is far from an equaliser – it exposes inequalities

‘It is vital for people of diverse backgrounds to just acknowledge that we are in an unprecedented time and name the real toll and disparate impact that our world’s drastic changes have had on us in order to begin the coping and adjustment process,’

Alfiee Breland-Noble,

(Researcher on mental health disparities and founder of the [AAKOMA Project](#))

EXISTING INEQUALITIES

The Covid-19 pandemic has highlighted the disparity of privilege, protection and power, as well as access to resources (Figure 2). We know that social inequalities in housing, healthcare, employment and education, shape every aspect of life from cradle to grave (Kahn, 2020). Far from ‘all being in it together’, we know that structural racism allows an environment where BAME populations are more likely to experience health and social inequalities.

Some of the examples include:

Poverty & Deprivation: BAME people in the UK experience greater poverty and deprivation, are less likely to have access to public space (CABE, 2010) and are likely to bear the brunt of the recession and the economic impacts of government responses to Covid-19. Early restrictions in lockdown affected people in poverty disproportionately. For example, online shopping relies on access to digital equipment and Wi-Fi.

Education & Employment: Multiple barriers in society impact BAME people’s educational and employment attainment. As a result, BAME people are more likely to be precariously employed (TUC, 2016), or in key worker roles as carers, shop workers or health care transport staff, risking greater exposure to the virus.

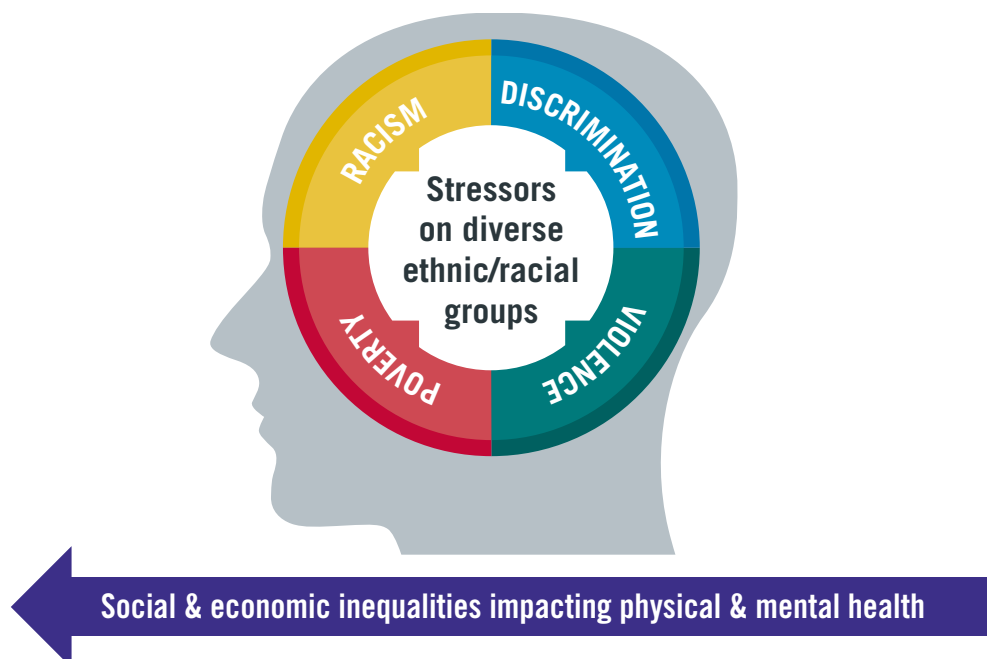


Figure 2. Disparities of privilege and power impacting physical and mental health. Adapted from U.S Surgeon General, [Project LETS](#).

Housing: 30% of Bangladeshi families and 15% of Black people experience overcrowding, compared to 2% of white people (Gov.UK, 2018).

Discrimination, Racism and Moral Injury: BAME people are being targeted by discriminatory actions and aggression in public and virtual spaces in multiple ways.

- Experiences of micro aggressions and discrimination would discourage people from BAME groups from going for walks and exercising near their homes in the initial phases of lockdown.
- Penalties and restrictions imposed as part of the Coronavirus Act have been applied through the prism of police racism, for example the tasing of Ziggy Mombeyarara.
- BAME groups are more likely to report personal experience of discrimination; more likely to have formal disciplinary processes and experiences of bullying and harassment from staff, patients and relatives. There are a fewer BAME leadership role models; reduced career progression, promotion and CPD, and recruitment opportunities (Workforce Race Equality Standard, 2020).
- Racism itself has been shown to have negative psychological and health outcomes. The psychosocial stress of stigma and racial discrimination contributes to poorer health quality and higher rates of chronic health conditions for BAME communities (Williams & Mohammed, 2013; Williams, Lawrence, Davis & Vu, 2019)
- People from BAME experience exclusion, bullying and harassment that may not always be so overt. Covert racism/prejudice can be very subtle yet powerful enough to impact deeply at psychological level and may lead to more serious and enduring emotional health difficulties including PTSD. Moral injuries can be experienced at varied grades, intensities and levels.

Engagement and Access to Mental Health and Psychological Services: Racial discrimination impacts both physical and mental health. Providing inclusive, culturally sensitive mental health services is something many NHS trusts are still working to get right.

- Community groups are reporting wide scale distrust of statutory institutions and alarming levels of unmet mental health need.
- The language of the NHS is of the ‘hard to reach’ – locating the problem with the communities rather than questioning their own ethnic background or middle class culture and values.
- People from BAME communities are more likely to be diagnosed with mental health problems, (Mental Health Foundation, 2019) experience a poor treatment outcome and to disengage from mainstream mental health services – leading to social exclusion and a deterioration in their mental health.
- One third of people aged 35 and under and a quarter of those aged 35 and over have experienced racial discrimination using mental health services (Mental Health Foundation, 2016).
- Ninety per cent of BAME respondents said it was not easy to find information about mental health services in their local areas, almost half said mental health services were not culturally sensitive, while one in four said they were asked questions that were not acceptable to their culture or faith (Healthwatch, 2018).
- Detention rates under the Mental Health Act in 2018 were four times higher for people in the ‘Black’ or ‘Black British’ group than those in the ‘White’ group, creating fear and mistrust (Mental Health Foundation, 2016).
- Socially distanced communication and the digital world: The changing rules of the pandemic from day to day are publicised primarily online. The digital world of government and health messaging is predicated on an assumption of white, middle class, values of the reasonably solvent, and those who can read and speak English. It is important to understand how these privileges may have impacted on people from BAME background’s ability to work from home and keep their children engaged with learning.

The psycho-social impact of the Covid-19

Major crises like wars and pandemics activate individual and collective anxieties at multiple levels such as fear of the invisible, unfamiliar and unknown. Prolonged and dynamic conditions surrounding them draw out uncertainty, deep fear of dying, anguish and helplessness. They interrupt the routine and normality by challenging social, occupational and economical structures. Xenophobia and stigma can be activated through entrenched social processes impacting the social order through the interplay of individual, groups and societal factors. Ebola, MERS, and now the Covid-19 pandemic, all follow similar patterns. Strong (1990) points out how spreading of high-risk health problems can be followed by psycho-social epidemics of fear, suspicions, stigmatisation, strong moral and ideological debates across cultural and religious groups around causes, responsibilities and solutions.

We acknowledge the commonality of human experience during this crisis and that Covid-19 has impacted all groups of society across the world by creating immense psychosocial disturbances. However, it is having a disproportionate impact on those who are already faced with health and social disparities. Covid-19 health risks, experiences, burden and outcomes are not the same for everyone as the virus has exposed many racial and social inequalities. It has highlighted the reality and dire consequences of stigma, discrimination and structural racism. These are exacerbated by the lack of understanding, turning a blind eye, and ignoring the undesirable alongside entrenched prejudiced practices.

Within the context of racial and social inequalities, the resulting psychological, physical and social impact of the pandemic on BAME communities and marginalised groups is likely to be disproportionate further enhancing their vulnerability. Below are some of the examples. It is not an exhaustive list.

Key material highlighting the impact of discrimination and poorer life chances was omitted from the PHE review (Moore, 2020). The lack of any concrete action was criticised, which was put forward two weeks later. There has been a call for a full public inquiry.

Instances of stereotyping, harassment and bullying directed at BAME people.

A pandemic can further heighten anxiety for people with pre-existing health conditions. Disrupted support and social isolation can result in flaring up of previously managed physical and mental health symptoms.

People can hide symptoms of illness to avoid discrimination and stigma. Lack of trust has built up over the years in marginalised communities in the medical, social care and criminal justice system and wider society due to experiences of institutional and systemic racism. This may result in reduced help-seeking, which can be further exacerbated by linguistic barriers and feeling disempowered.

Disproportionate exposure to infections, increased illness, subsequent health complications and death toll put BAME communities at increased risk of stigma and heightened stress and trauma. Some may not be able to isolate physically, due to unstable housing, limited access to healthy food, or low or precarious income, e.g. zero hours contracts or job losses. The choice of working from home and access to digital resources is not available for all.

Public Health England guidance and information on public health messages, including washing hands and the importance of ‘coughing etiquette’ was not always translated with the speed and accuracy needed to support communities where English is not spoken or read.

Non-documented migrants may fear accessing public health and social care services and may fear detention and deportation due to the ‘hostile environment’. Many people of the Windrush generation have been too fearful to seek care and treatment, contributing to the increased deaths of BAME people from Covid-19 (Dropkin, 2020).

A membership tracking survey by [Royal College of Psychiatrists](#) has highlighted on-going issues with access to PPE, slow progress on access to testing and testing turnaround time. 48% of respondents said they were either concerned or very concerned about their health. For those from BAME backgrounds, this rose to 76%.

There is a danger of a single narrative in the media about heightened risk marginalised communities face solely due to underlying conditions without much acknowledgement of the impact of structural racism. There have been incidents of racist media representations criticising Black Lives Matter protestors defending the right to life of black people for increasing the risk of Covid infection, whilst tourists on beaches were not similarly attacked.

**COVID-19 HEALTH RISKS,
EXPERIENCES, BURDEN AND
OUTCOMES ARE NOT THE SAME
FOR EVERYONE – THE VIRUS
HAS EXPOSED MANY RACIAL
AND SOCIAL INEQUALITIES.**

Where we are in the profession: Representational diversity, equity, open dialogue

Change will require taking responsibility, self-examination, humility, honesty, mindful listening and commitment to a long-term process and action. It has to start from us all.

Within clinical psychology there is a lack of representational diversity (Longwill, 2015; Scior, Wang, M., Roth, & Alcock, 2016; Smith, 2017). The profession does not represent the communities it supports. Higher education institutions pay the BAME people working in psychology and the behavioural sciences less (Advance HE, 2019). Undergraduate psychology programmes perpetuate an attainment gap and create a sense of imposter syndrome (Miller, 2016). Selection processes for clinical training are making little impact on improving diversity. The most recent data shows that the number of BAME applicants has gone up but the number getting selected has gone down. The methodologies, curricula and research base of clinical psychology are centred on the individual, white, European, hetero normative experience (Guthrie, 2004) and need 'decolonising'. Providing inclusive, culturally sensitive mental health services is something many psychologists working in NHS trusts are still striving for.

Within such a context, [Health Education England](#) announced an increase in clinical psychology training places and 'targeted action to increase the diversity of new entrants to these professions in order to build a workforce that reflects the communities they serve'. Following an initial [statement of intent on anti-racism](#), the Group of Trainers in Clinical Psychology (GTiCP) Anti-Racism working group is reviewing current training practices to work towards diversity and anti-racism. The key areas of attention are: (1) Curriculum & teaching practices; (2) Evidence production (including research); (3) Trainee-staff selection; (4) Placements and supervision; (5) Assessment practices; and (6) Experiences of and relationships amongst the training community.

Within the Covid-19 context, it is important that trainees from marginalised communities impacted by Covid-19 have access to meaningful and tailored support. Alongside this, we encourage thoughtful and respectful adaptations to be made to teaching and training programmes to ensure training content addresses the existing racial and social disparities highlighted by Covid-19. Training courses need to commit to changes to create a safer and richer learning environment, whilst scaffolding and preparing trainees for their clinical work on placement.

Given the wider societal injustices influencing the pandemic, psychological professionals need to consider their own positioning, challenge and shift themselves for sustained development². Workforce strategies need to consider how the impact of the pandemic will shape our work within services for the foreseeable future. It will be important that development opportunities are available and well supported to enable psychologists in taking up roles at various levels (Figure 3) to address inequalities emphasised by Covid-19. This is further elaborated in later sections.

² Potential areas of development are to be included in a separate paper.

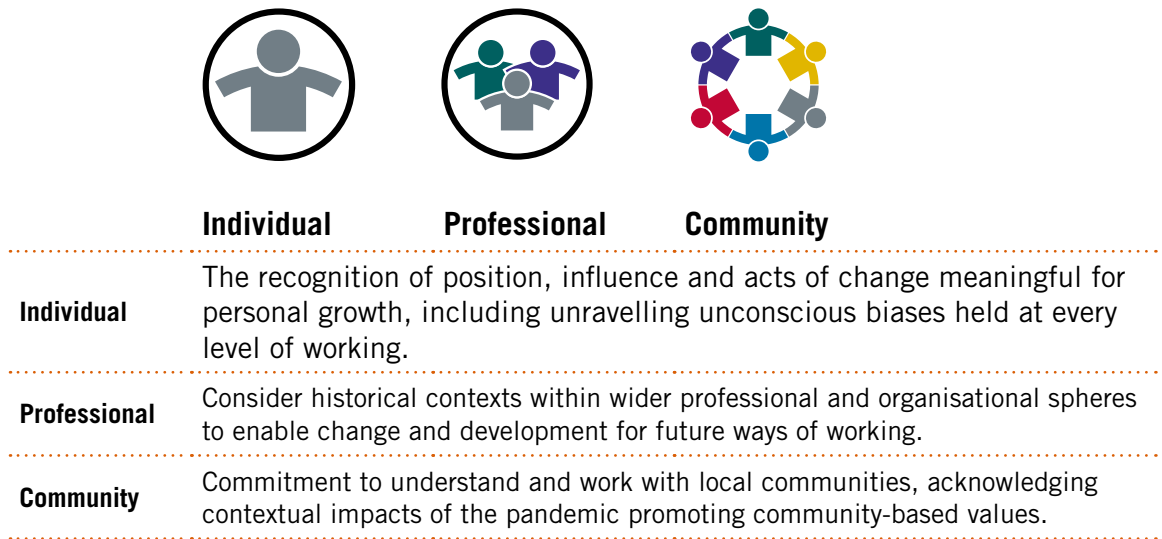


Figure 3. Reflective stance and commitment to change pandemic, at multiple levels

THE METHODOLOGIES, CURRICULA AND RESEARCH BASE OF CLINICAL PSYCHOLOGY ARE CENTRED ON THE INDIVIDUAL, WHITE, EUROPEAN, HETERO NORMATIVE EXPERIENCE AND NEED ‘DECOLONISING’

Tackling inequalities and racist practice

To be antiracist is a radical choice in the face of history, requiring a radical reorientation of our consciousness.
 Ibram Kendi 'How to be an Antiracist' (Kendi, 2019)

Pandemics are not just physical problems. They imply social, cultural, political and psychological processes, which are further complicated by existing social disparities and longstanding systemic and structural racism.

Tackling inequalities require radical orientation and critical interrogation. We encourage the consideration of psycho-social interventions at multiple levels. There are no easy solutions. It requires embracing complexity and commitment to long term process and action. We are putting forward a safeguarding framework shaped as five R's (Recognise, Review, Respond, Refresh, Respect) as a starting point to tackle underlying inequalities and racism shown to light by pandemics. In writing this framework we are bringing our own experiences and what we have heard from others. However, it is a starting point, as we do not want to be directive. This framework could be one way of saying what is needed. However we recognise that there will be many others. We hope that this will help to frame questions and open up conversations. The areas listed below overlap and are interrelated.

Covid-19 pandemic shines a light on a new kind of class divide and its inequalities calling for urgent change. (Reich, 2020)



Figure 4: Framework to tackle inequalities and racism – Recognise – Review – Respond – Refresh – Respect

1. RECOGNISE RACISM AND INEQUALITIES

- Acknowledge that stigma and structural racism are real.
- Social inequalities, prejudice and racism can be both subtle and explicit. They are often overlooked as dynamics associated with difference are powerful and challenging to work with.
- Recognise the impact of systemic and structural racism on health and social inequalities.
- Pay attention to disproportionate grief, bereavement, trauma impact, moral injury and mortality burden.
- People may not feel able to share concerns due to fear of discrimination. Speaking out involves taking a risk, which inevitably places the person in a vulnerable position.
- Engage in meaningful conversations and provide multiple confidential routes for feedback.
- Actively value diverse lived experiences.

2. REVIEW POSITIONS

- Racial and social inequalities are everyone's business.
- Individuals and organisations need to reflect and examine their own unconscious biases and prejudices.
- Those in positions of leadership and management need to consider the impact of advantage blindness and power dynamics.
- Barriers to change in the implementation of [NHS Workforce Race Equality Standards \(WRES\)](#) need to be urgently addressed.
- Learn about the research evidence on how diversity is associated with team and organisational effectiveness and innovation. Involve people with lived in experiences in training and organisational development.
- Consider systemic impact of placing BAME in a vulnerable and at-risk category and mindfully prioritise them for Covid-19 testing and support measures. Risk assessment can have unintended consequences of magnifying prejudice and discrimination.

3. RESPOND WITH COMMITMENT

RAISE AWARENESS AND ENGAGE WITH COMPASSION

- Raising awareness and engagement is everyone's responsibility. It is a journey, which requires humility, respect and compassion.
- Enhance understanding of the health and mental health needs of marginalised groups.
- Raise awareness how bias, stigma and discrimination impact the pandemic response and how to mitigate this at individual, organisational and societal level.
- Educate self and others (policy-makers, commissioners) regarding equity enhancing practices.
- Expand your circle of influence at social, political and professional level.

TAKE RESPONSIBILITY – IT IS A POWERFUL CHANGE AGENT

- Don't be a bystander but intervene. Encourage the use of bystander intervention against stigma, xenophobia and discrimination to circumvent and prevent escalation (Sue et al., 2019).
- Reflect upon and understand history and your place in it, recognising how your identity affects your work / relationships with diverse groups..

- Consider the power of language and privilege, as well as the diversity of beliefs around familial, social, religious and political values and discourses.
- Advocate for equity and anti-racist approaches in policy making. Take them forward assertively to change work practices.

FOSTER A CULTURALLY SENSITIVE WORKFORCE

- Training and teaching practices to (a) adopt antiracist education and learning (b) consider adaptation and addition in curriculum (c) address impact of inequity and power relations on learning and assessment (d) promote diverse learning styles (e) develop capacity to reflect and engage with difference (Kehoe, 1994).
- Support trainees and learners from marginalised communities specifically impacted by Covid-19.
- Develop resources to support culturally competent teaching, placement and research activity.

DEVELOP PSYCHOLOGICALLY SAFE WORKPLACES – TACKLE RACISM AND DISCRIMINATION

- Stigma and lack of sense of belonging and mistrust can adversely affect psychological safety.
- Invest in building up psychologically safe work cultures. Racial and social inequalities, racism and prejudice impact on organisational outcomes and workforce wellbeing.
- Embed diversity and inclusion within the service/organisational structure not as a separate project.
- Stop looking to your BAME colleagues to fix the problem. Combating racial and social disparities is a collective problem and requires meaningful co-production.
- Recognise linguistic barriers and cultural variations in expressive language, social interactions and attire.

DRIVE SOCIETAL CHANGE – COMMUNITY INVOLVEMENT AND RESILIENCE HOLD POWER FOR CHANGE

- Acknowledge the inherent resilience of the communities to build up social cohesion and tolerance.
- Reach out, engage, listen to and learn from at risk communities to enable (1) knowing/ understanding identities and (2) relationship building, empowerment and involvement in co-produced planning and delivering change (Drury et al., 2019).
- Engage with the political systems and community groups to build on culturally sensitive models of prevention, public health, community psychology and social action against structural racism.
- Communities need to be involved in service development, pathway design and commissioning with better integration of social and health care systems.

4. REFRESH PERSPECTIVES

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- Stock takes and reflective practice are necessary for learning and addressing barriers to change.
 - Step back and reflect on the impact of racism and capitalism in all aspects of your life.
 - Refresh perspectives, moral stance and relatedness with BAME communities beyond your circle of familiarity and comfort zone.
 - Listen out and consider what change looks like from an antiracism stance morally and structurally.
 - Evaluate impact – how well, and what difference?

5. RESPECT AND VALUE DIFFERENCE

- Recognise stigma and counter racism and bias at all levels.
- Examine values and confront racist and prejudice within and outside.
- Support and recognise the value added by the BAME communities.
- Practice anti-racism and counter policies, which disadvantage vulnerable groups.
- Engage with difference and vulnerability with respect and humility.
- Champion antiracist ideas and non-discriminatory practices.
- Talk about inequalities – Silence is not an option.

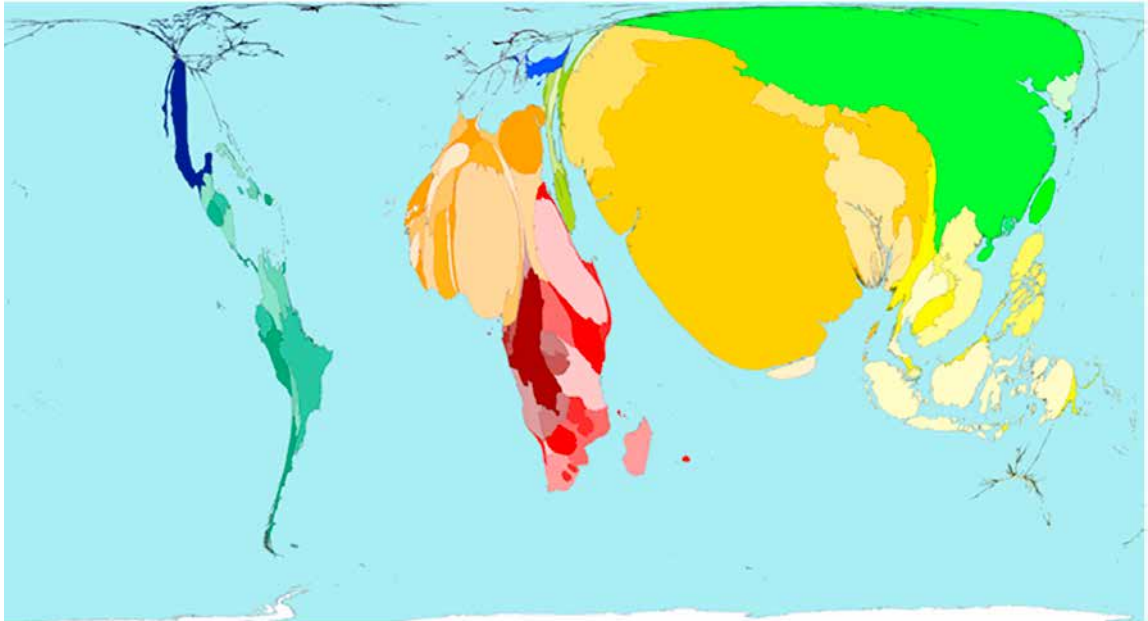


Figure 5: Living on the equivalent of under \$2 per day. Territory size shows the proportion of all people living on less than or equal to Purchasing Power Parity US\$2 in a day (2002). Source: Barford, A. (2017). Emotional Response to world inequality. *Emotion, Space and Society*, 22. Image from www.worldmapper.org.

SOCIAL INEQUALITIES LEAD TO HEALTH INEQUALITIES AND THEY CAN'T BE SEPARATED FROM STRUCTURAL RACISM

Suggested recommendations: What we can do to make changes

CHANGE CAN'T HAPPEN WITHOUT THINKING NOR WITHOUT ACTION

The suggested recommendations below are informed by the discussion in the working group and through the consultation and listening events. They follow the approach taken within this document, that social inequalities lead to health inequalities and that they can't be separated from structural racism. Where possible, we have distinguished Covid-19 specific required changes from actions to address structural racism separately for ease of reading. We view these as inextricably linked. We encourage that all actions need to start with understanding the varying experiences of people from minoritised groups... not just a 'one size fits all'. Addressing inequalities and inclusion needs to be an ongoing, 'moment-by-moment' activity that engages with and responds to people's lived experiences (The Kings Fund, 2020).

FOR ALL

- Assert that health and equality is a human right, which does not depend upon citizenship.
- Go beyond acknowledging the impact of events and translate this into meaningful action.
- Engage with the five R's (Recognise, Review, Respond, Refresh, Respect) safeguarding framework.

FOR THE PROFESSION

COVID-19 SPECIFIC ACTIONS

Training and support

- Support psychologists in developing community based approaches and organisational competencies to work with communities, organisations and policy-makers to counter inequalities and aftermaths of Covid-19.
- Incorporate impact of discrimination, bias, prejudice and stigma in all Covid-19 resources. Covid-19 recovery strategies to include inequalities and anti-racism training (specifically in relation to working with 'difference', 'conflict' and 'power dynamics'), mentoring and learning opportunities.

Working together

- Help key stakeholders (politicians, policy-makers, community leaders, media) understand psychological factors affecting the health and mental needs of marginalised group and how bias, stigma and discrimination impact on the pandemic response and ways to counter them in developing services post Covid-19.

Strategic influence

- Gather evidence on the broad psycho-social sequelae of emergency measures causing educational and social disadvantage to feed into the **parliamentary inquiry** on the impact of Covid-19. Include issues such as home education requirements, language barriers, literacy rates, internet accessibility, data on police stop and search, inequalities in housing, and income shortfalls.

ACTIONS TO ADDRESS STRUCTURAL RACISM IN PROFESSIONAL BODIES³

Antiracism and inclusion require more than acknowledgement

- Address repetitive cycle of reactive stance and proactively engage, listen and take action.
- Include BAME psychologists in the decision-making processes / planning / writing up of policies and strategies.
- Embed and resource Equality-Diversity-Inclusion-Anti-racism into the core business. Language of ‘minorities’ without a reference to the above can be disrespectful.
- The core elements of the DCP’s Inclusivity Strategy (2016–2018) need to be reviewed and developed further in the light of the work taken by the DCP. We support the calls in the DCP inclusivity strategy to (a) enable a mechanism for demographic data capture across the profession (b) create an Inclusivity Outreach Champion position/s with a systemic focus (c) increase BPS network links (d) develop an accessible inclusivity resource (e) increase opportunities for CPD and mentoring support (d) create inclusivity recognition processes and awards (f) resource activity on inclusivity issues.
- Foster psychological safety and bring more diversity across the committees and leadership roles.

Commitment to Culturally Competent Workforce Development⁴

- Change selection processes, to manage unconscious bias at the short listing stage, curriculum adaptation, support during training and setting out safer and richer learning environment.
- Critique current practice to challenge unconscious bias and set out a review to look at achieving a diverse and representative workforce at all levels including senior leadership.
- Ensuring that training on cultural competence is offered and advocated.
- Set out Accreditation Standards that address cultural competence in training.

Show support for equality and antiracism

- Support calls by the Royal College of Midwives, BMA and Association of Medical Royal Colleges to scrap the migrant charges scheme. Effective track and trace requires a public health approach, which is accessible for all (Dropkin, 2020).
- An open letter from BPS/DCP condemning hostile environment and its psychological impacts. DCP to set out its support for the campaigns being led by the Lancet and Medact against NHS data sharing with the home office in relation to immigration enforcement.
- Offer proactive support for psychological professionals impacted by prejudice and antiracism.
- Consider setting up roles such as ‘speak up guardian’ as part of enabling psychological safety for those who have experienced/witnessed prejudice and racism.

³ This section refers to DCP & BPS within the context of this paper. However, there are recommendations which are relevant for other professional organisations.

⁴ IAPT has set out an example in its *Black, Asian and Minority Ethnic Service User Positive Practice Guide* (Beck, A, Naz, S, Brooks, M Janowska, 2019)

FOR ORGANISATIONS

Research highlights that how organisations respond to large-scale diversity-related events receiving media coverage can have an impact on psychological safety at work. If organisations do not handle these well, they can contribute to level of threat and mistrust of institutions of authority amongst BAME people.

PSYCHOLOGICAL SAFETY

- Offer physical and psychological safety: It is important not to keep silent, act defensively and overgeneralise. Avoid adopting strategic colourblindness due to the fear of being seen as prejudiced and be aware of white fragility.
- Acknowledge the impact of disproportionate infections, deaths and impact of systemic racism. Affirm and support employees' right to safety and protection.
- Create safe spaces to have meaningful conversations and learning.⁵

GOVERNANCE

- Avoid tokenistic approaches. Put things in practice at all levels – up and top down and sideways.
- Think critically and bring meaningful action to bring governance of inclusivity and equality.
- Research local and national data: Collect reliable and comparative equality data in line with fundamental rights and data protection standards to look at how BAME employees are impacted.
- Policies & Strategies: Supportive, compassionate and inclusive leadership enhances work satisfaction and outcomes. Bring antiracism policies and measures that recognise structural racism and inequalities with targeted objectives for the inclusion and equality of outcomes for different groups affected by Covid-19 & racism.
- BAME staff need to be included in the higher decision-making processes / planning / writing up of policies.
- Develop culturally competent HR and OH services. Invite BAME staff feedback to allow concerns about the risk assessment/or work in general associated with Covid-19 and discrimination.

PSYCHOLOGICALLY INFORMED & CULTURALLY COMPETENT SERVICES

- Develop culturally sensitive, accessible, and translated advice and information about the services.
- Develop psychologically informed support services during and post crises.
- Encourage innovative practice to build evidence base for more culturally diverse interventions.

ENGAGEMENT & WORKING TOGETHER

- Consult with BAME staff about the impact of Covid-19 and develop **psychologically informed risk assessments and interventions** including mental health and wellbeing support.
- Work alongside BAME grassroots organisations to co-produce Covid-19 recovery strategies.
- Support Community group and psychological services to co-lead on educating the health sector to reduce future health inequalities ensuring there is representation of a breadth of perspectives to prevent barriers to accessing health services.
- Risk assessment of workplace, workforce and individuals assessments need to consider impact of stigma, discrimination and racism at individual, interpersonal, institutional and structural levels. Risk appraisal need to be carried out sensitively with key emphasis on developing a psychologically safe, compassionate work culture.
- Risk assessments and mitigation protocols need to be developed in consultation with BAME workforce at individual and organisational level with a culturally sensitive, bi-directional bottom up approach. Managers need to be supported in managing conflict and discussing cultural issues and the existence of underlying health conditions.

⁵ <https://www.inclusivetherapists.com/resources>

TRAINING & DEVELOPMENT

- Offer choice for learning and development such as mentoring and coaching, including opportunities for reverse mentoring.
- Training should be evaluated to erase bias from an assumed position of white privilege and to interrogate the contributions from diverse perspectives to ensure that participation from BAME backgrounds (whether trainees or staff) are not additionally disregarded or further disadvantaged.

FOR POLICY MAKERS

- Monitor progress to overcome the obstacles to racial and social equality.
- Recognise the interplay between integration, social inclusion, community cohesion and equalities. Adopt a intersectional approach centering BAME communities to mitigate severe consequences of Covid-19 by addressing health inequalities and racism; reviewing emergency measures and legislation; addressing risk of destitution; and countering hostile environments (Charity So White, 2020).
- Adopt a **holistic approach** to policy development. Adopt a psycho-social perspective to tackle psychological impact of Covid-19 in all polices targeting the recovery and restoration phase.
- BAME staff inclusion in the higher decision making processes and writing up of policy guidance.
- Mandate comprehensive and quality ethnicity data collection and recording in NHS and social care data collection systems, including at death certification.
- Improve access, experiences and outcomes of NHS, local government and Integrated Care Systems commissioned services including equity in workforce and workforce wellbeing.
- Invest in development of culturally competent occupational risk assessment tools.
- Set out culturally competent Covid-19 education and prevention campaigns in partnership with local BAME and faith communities
- Ensure that Covid-19 recovery strategies actively target inequalities caused by the wider determinants of health to create long term sustainable change.
- Mainstream non-discrimination and anti-racism into all public policies, incorporating the principle of co-production with community groups across culture, faith and class.
- Release the PHE report including recommendations and implementation planning.
- Commit to the outcome of the **public inquiry** into the disproportionate death of at risk communities.
- Consider areas in the country that have a much smaller BAME representation, it is often those areas that have the biggest negative impact on BAME staff.
- Withdrawal of all NHS charging for migrants, in particular the National Health Service Overseas Visitor Charging Regulations 2015 and 2017 and the Immigration Health Surcharge.
- Ensure all advice and public health guidelines are as accessible to people from every community paying attention to languages used, infographics, placing of information, e.g. letters to houses, hoardings, TV adverts.

We would like to end this position paper with acknowledgement of those people and their families who lost their lives and have bereavement through Covid-19 and racism.

Key readings

KEY WEBSITES

<https://keepournhspublic.com/>
<https://patientsnotpassports.co.uk/>
<https://migrant.health/>

<https://www.cnn.com/2020/06/15/what-it-means-to-be-an-anti-racist-company.html>
www.healthwatch.co.uk
<https://charitysofwhite.org/covid19>

KEY REFERENCES

Beck, A., Naz, S., Brooks, M. & Jankowska, M. (2019). *Black, Asian and minority ethnic service user positive practice guide*. Retrieved from <https://www.babcp.com/files/About/BAME/IAPT-BAME-PPG-2019.pdf>

Eddo-Lodge, R. (2018). *Why I'm no longer talking to white people about race*. London: Bloomsbury Publishing.

Kendi, I. X. (2019). *How to be an antiracist*. London: One world.

Myers, B. (2014). *Acknowledging your biases* (Ted Talk). Retrieved from https://www.ted.com/talks/verna_myers_how_to_overcome_our_biases_walk_boldly_toward_them?utm_campaign=tedsread&utm_medium=referral&utm_source=tedcomshare

References and resources

REFERENCES

BMA (2019). *Delayed, deterred, and distressed: The impact of NHS overseas charging regulations on patients and the doctors who care for them*. <https://www.bma.org.uk/advice-and-support/ethics/refugees-overseas-visitors-and-vulnerable-migrants/bma-view-on-charging-overseas-visitors>

Butler (2008, 18 June). How migrants helped make the NHS. *The Guardian*. <https://www.theguardian.com/society/2008/jun/18/nhs60.nhs2>

CABE (2010). *Community green: Using local spaces to tackle inequality and improve health*. Retrieved from <https://www.designcouncil.org.uk/sites/default/files/asset/document/community-green-full-report.pdf>

Dropkin, G. (2020). Covid-19: Contact tracing requires ending the Hostile

Environment. *British Medical Journal* (Rapid Response). *BMJ* 2020, 368, m1284. Retrieved from: <https://www.bmj.com/content/368/bmj.m1284/rr>

Drury, J., Carter, H., Cocking, C., Ntontis, E., Tekin Guven, S., & Amlôt, R. (2019). Facilitating collective resilience in the public in emergencies: Twelve recommendations based on the social identity approach. *Frontiers In Public Health*, 7, 141.

Guthrie, R.V. (2004). *Even the rat was white: A historical view of psychology*. New York: Pearson Education.

Kline, R. (2014). The 'snowy white peaks' of the NHS: A survey of discrimination in governance and leadership and the potential impact on patient care in London and England.

REFERENCES CONT.

- Lingayah, S., Wrixon, K. & Hulbert, M. (2020) Home Truths, Undoing racism and delivering real diversity in the charity sector. London, Acevo.
- Longwill, A. (2015). *Clinical Psychology Workforce Project*. Division of Clinical Psychology UK. Leicester: British Psychological Society.
- Mental Health Foundation (2019). *Black Asian and minority ethnic communities*. Retrieved from: <https://www.mentalhealth.org.uk/a-to-z/b/black-asian-and-minority-ethnic-bame-communities>
- Miller, M. (2016). *The ethnicity attainment gap: literature review*. University of Sheffield Widening Participation Research and Evaluation Unit. Retrieved 22 December 2017 from: https://www.sheffield.ac.uk/polopoly_fs/1.661523!/file/BME_Attainment_Gap_Literature_Review_EXTERNAL_-_Miriam_Miller.pdf
- Moore, A. (2020). Exclusive: Government censored BAME covid-risk review. *Health Service Journal*. Retrieved from <https://www.hs.j.co.uk/coronavirus/exclusive-government-censored-bame-covid-risk-review/7027761.article>
- NHS workforce (2020, 6 January). *Ethnicity facts and figures*. Gov.uk. Retrieved from: <https://www.ethnicity-facts-figures.service.gov.uk/workforce-and-business/workforce-diversity/nhs-workforce/latest>
- Public Health England (2020). *Disparities in the risk and outcomes of Covid-19*. London: Crown Copyright. Retrieved via <https://www.gov.uk/government/publications/covid-19-review-of-disparities-in-risks-and-outcomes>
- Royal College of Psychiatrists (2020). *Covid-19 workforce*. Retrieved via <https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/staff-and-workforce>
- Scior, K., Wang, M., Roth, T. & Alcock, K. (2016). Underrepresentation in the profession: What's been done and what are the priorities going forward? Commentary on Celia Grace Smith's Ethics Column. *Clinical Psychology Forum*, 280, 12–13.
- Smith, J. (2017). The representation of minority ethnic groups in the clinical psychology profession. *Clinical Psychology Forum*, 298, 38–47.
- Smedley, A. & Smedley, B.D. (2005). Race as biology is fiction, racism as a social problem is real: Anthropological and historical perspectives on the social construction of race. *The American Psychologist*, 60, 16–26. doi:10.1037/0003-066X.60.1.16
- Stevenson, B. (2012), We need to talk about an injustice, https://www.ted.com/talks/bryan_stevenson_we_need_to_talk_about_an_injustice?language=en
- Strong, P. (1990). Epidemic psychology: a model. *Sociology of Health and Illness* 12(3), 249–259.
- The King's Fund (2020). Workforce race inequalities and inclusion in NHS providers, The King's Fund, July 2020, <https://www.kingsfund.org.uk/publications>.
- Trades Union Congress (2016). *Insecure work and ethnicity*. Retrieved from: https://www.tuc.org.uk/sites/default/files/Insecure%20work%20and%20ethnicity_0.pdf
- Workforce Race Equality Standard (2020). *NHS Workforce Race Equality Standard: 2019 Data Analysis Report for NHS Trusts*. London: NHS.
- Williams, D.R. & Mohammed, S.A. (2013). Racism and Health I: Pathways and Scientific Evidence. *American Behavioral Scientist*, 57(8), 1152–1173. doi.org/10.1177/0002764213487340
- Williams, D.R., Lawrence, J.A., Davis, B. A. & Vu, C. (2019). Understanding how discrimination can affect health. *Health Services Research*, 54 (S2), 1374–1388

Barr, C., Kommneda, N., McIntyre, N. & Voce, A. (2020, 22 April). Ethnic minorities dying of Covid-19 at higher rate, analysis shows. *The Guardian*. Retrieved from: <https://www.theguardian.com/world/2020/apr/22/racial-inequality-in-britain-found-a-risk-factor-for-covid-19>

Bola, G. (2020, 13 April). I'm a public health expert. I know the hostile environment is making the coronavirus outbreak far worse. *The Independent*. Retrieved from: <https://www.independent.co.uk/voices/coronavirus-covid19-outbreak-deaths-bame-hostile-environment-immigration-a9462221.html>

Blow, C.M. (2020, 1 April). The racial time bomb in the Covid-19 Crisis. *New York Times*. Retrieved from: <https://www.google.co.uk/amp/s/www.nytimes.com/2020/04/01/opinion/coronavirus-black-people.amp.html>

Channel Four (2020). New research shows migrant & BAME communities excluded from the #NHS during coronavirus. <https://www.facebook.com/watch/?v=682375059268348>

Croxford, R. (2020, 18 April). *Coronavirus cases to be tracked by ethnicity*. The BBC. Retrieved from: <https://www.bbc.co.uk/news/health-52338101>.

Deeny, S. & Saunders, C. (2020, 27 March). *International migrants use NHS services less frequently than non-migrants*. The Health Foundation. Retrieved from: <https://www.health.org.uk/news-and-comment/blogs/international-migrants-use-nhs-services-less-frequently-than-non-migrants>

Farrah, W. (2020, 23 April). *Institutional racism in the NHS intensifies in times of crisis*. Institute of Race Relations. Retrieved from: <http://www.irr.org.uk/news/institutional-racism-in-the-nhs-intensifies-in-times-of-crisis/>

Ford, M. (2020, 17 April). Exclusive: BME nurses 'feel targeted' to work on Covid-19 wards. *Nursing Times*. Retrieved from: <https://www.nursingtimes.net/>

[news/coronavirus/exclusive-bme-nurses-feel-targeted-to-work-on-covid-19-wards-17-04-2020/](https://www.theguardian.com/news/coronavirus/exclusive-bme-nurses-feel-targeted-to-work-on-covid-19-wards-17-04-2020/)

Goodfellow, M. (2020,30 March). The hostile environment is creating a coronavirus crisis for Britain's migrants. *The Guardian*. Retrieved from: <https://www.theguardian.com/commentisfree/2020/mar/30/hostile-environment-covonavirus-crisis-britain-migrants>

Haque, Z. (2020, 26 March). *Coronavirus will increase race inequalities*. The Runnymede Trust. Retrieved from: <https://www.runnymedetrust.org/blog/coronavirus-will-increase-race-inequalities>

Kahn, S. (2020, 19 April). More BAME people are dying from coronavirus. We have to know why. *The Guardian*. Retrieved from: <https://www.theguardian.com/commentisfree/2020/apr/19/bame-dying-coronavirus-sadiq-khan>

Johnson, A. & Buford, T. (2020, 3 April). Early data shows African Americans have contracted and died of coronavirus at an alarming rate. *Propublica*. Retrieved from: <https://www.google.co.uk/amp/s/www.propublica.org/article/early-data-shows-african-americans-have-contracted-and-died-of-coronavirus-at-an-alarming-rate/amp>

Nagpaul, C. (2020, 20 April 20). The disproportionate impact of covid-19 on ethnic minority healthcare workers. *British Medical Journal*. Retrieved from: <https://blogs.bmj.com/bmj/2020/04/20/chaand-nagpaul-the-disproportionate-impact-of-covid-19-on-ethnic-minority-healthcare-workers/>

Malik, N. (2020, 6 April). After this crisis, remember the NHS is not drained by migrants, but sustained by them. *The Guardian*. Retrieved from: <https://www.theguardian.com/commentisfree/2020/apr/06/coronavirus-crisis-nhs-not-drained-migrants-sustained-died-frontline>

BLOGS AND NEWSPAPER ARTICLES

Smith, J. (2020, 31 March). *Covid-19 and the viral spread of racism in the west*. Stand Up To Racism. Retrieved from: <https://www.standuptoracism.org.uk/covid-19-and-the-viral-spread-of-racism-in-the-west/>

Wright, R. (2020, 21 April). Home Office under fire over visa measures for health workers. *Financial Times*. Retrieved from <https://www.ft.com/content/686c001e-fc55-4a34-a30d-b8bccec3462e>

Younge, G. (2018, 22 June). The NHS, Windrush and the debt we owe to immigration. *The Guardian*. Retrieved from: <https://www.theguardian.com/commentisfree/2018/jun/22/honour-nhs-built-on-immigration-windrush>

Reich, R (2020, 26 April). Covid-19 pandemic shines a light on a new kind of class divide and its inequalities. *The Guardian*. <https://www.theguardian.com/commentisfree/2020/apr/25/covid-19-pandemic-shines-a-light-on-a-new-kind-of-class-divide-and-its-inequalities>

JOURNAL ARTICLES ON COVID-19

Chung RY-N & Li MM. (2020). Anti-Chinese sentiment during the 2019-nCoV outbreak. *The Lancet*, 395, 686–87. doi.org/10.1016/S0140-6736(20)30792-3

Cook, T., Kursumovic, E. & Lennane, S. (2020). Exclusive: deaths of NHS staff from Covid-19 analysed. *Health Service Journal*.

Devakumar, D., Shannon, G., Bhopal, S. & Abubakar, I. (2020). Racism and discrimination in Covid-19 responses. *The Lancet*. doi:10.1016/S0140-6736(20)30792-3

Dyer, O. (2020). Covid-19: Black people and other minorities are hardest hit in US. *BMJ*, 369. doi.org/10.1136/bmj.m1483

Garg S, Kim L, Whitaker M, et al. (2020). Hospitalization rates and characteristics of patients hospitalized with laboratory-confirmed coronavirus disease 2019. COVID-NET, 14 states, March 1–30, 2020. *CDC Morbidity and Mortality Weekly Report (MMWR)* 202, 8 April.

Gilroy, (2020, 25 May). *Visa fears mean Filipino nurses 'feel unable to say no' during crisis*. Retrieved from: <https://www.nursingtimes.net/news/coronavirus/visa-fears-mean-filipino-nurses-feel-unable-to-say-no-during-crisis-25-05-2020/>

Kehoe, J. (1994). Multicultural Education vs Anti-Racist Education: The Debate in

Canada. *Social Education* 58(6), pp.354–358. National Council for the Social Studies.

Pareek, M., Bangash, M.N., Pareek, N., Pan, D., Sze, S., Minhas, J.S., Hanif, W. & Khunti, K. (2020). Ethnicity and Covid-19: An urgent public health research priority. *The Lancet*. Retrieved from: [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30922-3/fulltext#articleInformation](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30922-3/fulltext#articleInformation)

Rose, T.C., Mason, K., Pennington, A., McHale, P., Buchan, I., Taylor-Robinson, D.C. & Barr, B. (preprint, 2020). Inequalities in COVID19 mortality related to ethnicity and socioeconomic deprivation. *British Medical Journal*. doi: <https://doi.org/10.1101/2020.04.25.20079491>

White, A.I.R. (2020). Historical linkages: epidemic threat, economic risk, and xenophobia. *The Lancet*. doi: 10.1016/S0140-6736(20)30737-6

Zhao, H., Harris, R.J., Ellis, J. & Pebody R.G. (2015). Ethnicity, deprivation and mortality due to 2009 pandemic influenza A(H1N1) in England during the 2009/2010 pandemic and the first post-pandemic season. *Epidemiol Infect.* 143, 3375–3383. *British Medical Journal*. medRxiv 2020.04.25.20079491; doi: 10.1101/2020.04.25.20079491

JOURNAL ARTICLES ON RACISM

Alderwich, H. & Allen, L. (2019, 19 November). *Immigration and the NHS: The evidence*. Retrieved from: <https://www.health.org.uk/news-and-comment/blogs/immigration-and-the-nhs-the-evidence#:~:text=First%2C%20migrants%20are%20an%20essential,staff%20groups%20and%20different%20regions.&text=Among%20doctors%2C%20the%20proportion%20is%2028.4%25>.

Johnson, MRD & McGee, P. (2005). Globalising care. *Diversity in Health and Social Care* 2005, 2, 1–4

Khan, O. (2020, 20 April). *Coronavirus exposes how riddled Britain is with racial inequality*. <https://www.theguardian.com/commentisfree/2020/apr/20/coronavirus-racial-inequality-uk-housing-employment-health-bame-covid-19> deprivation. *British Medical Journal*. medRxiv 2020.04.25.20079491; doi: <https://doi.org/10.1101/2020.04.25.20079491>

Martin, D. (2020). *Exploring Migrant Access to Health: Part 1 – The Psychological Impacts*

of the Hostile Environment. <https://www.medact.org/2020/blogs/exploring-migrant-access-to-health-part-1-the-psychological-impacts-of-the-hostile-environment/>

Patel, N., Bennett, E., Dennis, M., Dosanjh, N., Mahtani, A., Miller, A., et al. (2000). *Clinical psychology, race and culture: A resource pack for trainers*. Leicester: BPS Books.

Saunders, C. L., Steventon, A., Janta, B., Stafford, M., Sinnott, C., Allen, L. & Deeny, S. R. (2020). Healthcare utilization among migrants to the UK: cross-sectional analysis of two national surveys. *Journal of Health Services Research & Policy*, 1355819620911392. Advance online publication. <https://doi.org/10.1177/1355819620911392>

Simpson, J.M., Esmail, A., Kalra, V.S. & Snow, S.J. (2010). Writing migrants back into NHS history: Addressing a ‘collective amnesia’ and its policy implications. *Journal of the Royal Society of Medicine*, 103(10), 392–396. doi.org/10.1258/jrsm.2010.100222

STATISTICS AND REPORTS

AdvanceHE (2019). Equality in higher education: Statistical report 2019

Gov.uk (2018). *Ethnicity facts and figures: Overcrowding*. Retrieved from: <https://www.ethnicity-facts-figures.service.gov.uk/housing/housing-conditions/overcrowded-households/latest>

Intensive Care National Audit and Research Centre (2020). *ICNARC COVID-19 study case mix programme*. Intensive Care National Audit and Research Centre, London.

NHS workforce (2020, 6 January). *Ethnicity facts and figures*. Gov.uk. Retrieved from: <https://www.ethnicity-facts-figures.service.gov.uk/workforce-and-business/workforce-diversity/nhs-workforce/latest>



Figure 6: 'Stop the racism – people of all colour are equal'. Artwork by Mahnoor Khalid, aged 11.



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