ACP UK

ASSOCIATION OF CLINICAL PSYCHOLOGISTS

Equity, Diversity and Inclusion

Context and Strategy for Clinical Psychology

EDI Committee & Member Consultation Group

Revised March 2024 | Version 2

STRATEGY

www.acpuk.org.uk

Table of Contents

Contributing authors

Dr Nargis Islam
Dr Masuma Rahim
Prof Mike Wang
Dr Leila Jameel
Dr Che Rosebert
Dr Tori Snell
Dr James Randall
Dr Daniel Ruth
Hari Parekh
Manveen Kaur
Claire Lam
Simon Mudie
Dr Penelope Cream

Members' consultative group

Dr. Satbinder Kaur Bhogal
Dr Jules Carlisle
Ronald Dodzro
Dr Kimberley Gin
Abigail Maclellan
Leanne Ong
Dr Meltem Osman
Dr Yvonne Waft

1. Foreword

We are delighted to introduce the ACP-UK EDI Strategy which has the unanimous and enthusiastic support of the Board.

ACP-UK was born in July 2017, in the context of rising societal concern about racism and minority discrimination. ACP-UK's EDI Committee was formed in December 2019 with a specific remit to develop an EDI strategy which we always envisaged would be central to our organisation, objectives and priorities. We created an EDI Director post to lead this work and Dr Masuma Rahim was elected in June 2020. Since then we have had to contend with the pandemic which has highlighted gross inequalities of healthcare, mortality and morbidity, specifically as a result of coronavirus infection. The EDI Committee commissioned Dr Nargis Islam to lead the complex process of strategy development, with support from Dr Rahim. The entire membership was consulted on a preliminary draft, which received widespread support and constructive suggestions for improvement: these were acted upon.

The Board is determined that this EDI strategy will be a manifesto for change and the foundation for ACP-UK's future direction and objectives.

We are grateful to Dr Nargis Islam and Dr Masuma Rahim as well as the EDI Committee for all their efforts and, at times, challenging work, resulting in such a major milestone in the history of ACP-UK.

Prof Mike Wang
Chair, ACP-UK

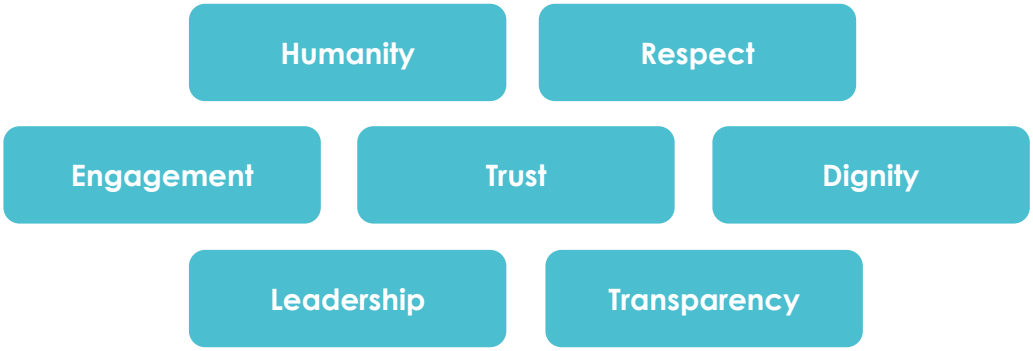
Simon Mudie
Director for Involvement, ACP-UK

2. Executive Summary:

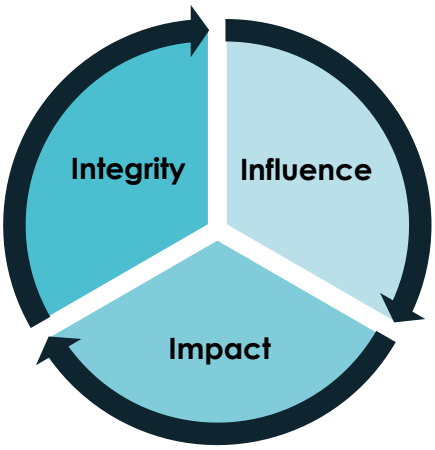
i. ACP-UK Strategic Approach

ACP-UK is committed to expanding, developing and promoting equality, diversity and inclusion in all aspects of the organisation's activity. The organisation's commitment is to existing and future members, associates, affiliates, staff and visitors across all ACP-UK activities, and in the wider profession and population. The strategy presents a forward-thinking approach that promotes and advocates for equality and inclusion in all aspects of professional activity for ACP-UK members, the profession of clinical psychology and for the public.

ii. ACP-UK Equity, Diversity and Inclusivity Strategy: Guiding Principles



iii. ACP-UK Equity, Diversity and Inclusivity Strategy: Strategic Commitments



Integrity: to maintain a congruence to equity, diversity, and inclusivity principles and values across and within all ACP-UK activity.

Influence: to maximise the influence of the ACP-UK's equity, diversity and inclusivity initiatives across the profession and professional activity.

Impact: to provide progressive and impactful guidance and leadership for the profession in equity, diversity, and inclusion work, that has a positive and continuing impact.

iv. Context for Strategy

- ACP-UK recognises that inequality and discrimination remain deeply embedded in all social structures within the UK[1],[2].
- Current workforce and leadership structures are not representative of the diversity in the population, yet evidence highlights that teams and professional groups that are diverse are more effective, adaptive and productive[3].
- ACP-UK strategy is conceptually and practically positioned within an intersectional approach to systems of inequality, e.g., sexism, racism, classism and ableism interact with, generate and perpetuate complex patterns of privilege and oppression.
- The strategic aims target key areas of systemic, structural and institutional inequality from this conceptual position.

v. British Clinical Psychology

- British clinical psychology continues to recruit and be comprised primarily of members of the socially dominant group.
- The profession has a lack of representational diversity in cohorts, programme staff and senior leadership[4] on training courses and in services, with an over-representation of white, able-bodied, heterosexual people in key leadership and decision-making processes within the profession[5].
- The profession of clinical psychology continues to face challenges with barriers for people from marginalised groups to be selected on training[6], and in the progression to senior leadership and executive posts[7] [8] [9].
- ACP-UK strategy provides a set of strategic aims that recognises and addresses these challenges.

vi. Origins of Institutional Inequality in Psychology

- Understanding the historical context of the 'psy-professions' (psychology and psychiatry) is important when considering their contributions to current inequalities.
- There exists an interconnection between the emergence of imperialism and colonisation, slavery, capitalism, the influence of the eugenics movement and the development of the psy-professions as scientific disciplines. These factors resulted in unethical and harmful practices in mental health that focused the control of 'difference' on non-European and marginalised groups[10].

---

[1] Salter, P. S., Adams, G., & Perez, M. J. (2018). Racism in the Structure of Everyday Worlds: A Cultural-Psychological Perspective. *Current Directions in Psychological Science*, 27(3), 150–155. https://doi.org/10.1177/0963721417724239

[2] Phillips, C. (2011) Institutional racism and ethnic inequalities: an expanded multilevel framework. *Journal of Social Policy*, 40 (01). pp. 173-192.

[3] *Ibid (PHE 2020), pg 8*

[4] Scior, K., Wang, M., Roth, A., & 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

[5] Patel, N. 2021. Dismantling the scaffolding of institutional racism and institutionalising anti-racism. *Journal of Family Therapy*. https://doi.org/10.1111/1467-6427.12367

[6] Clearing House, 2019 & 2020

[7] Adetimole, F., Afuape, T., & Vara, R. (2005). The impact of racism on the experience of training on a clinical psychology course: Reflections from three Black trainees. *Clinical Psychology Forum* (Vol. 48, pp. 11- 15)

[8] Wood, N., & Patel, N. (2017). On addressing 'Whiteness' during clinical psychology training. *South African Journal of Psychology*, *47*(3), 280–291. https://doi.org/10.1177/0081246317722099

[9] Spence, N. (2012) Cultural competence: Social class – the forgotten component. *Clinical Psychology Forum 230*, 36-39.

[10] Joseph, A. (2015). The necessity of an attention to Eurocentrism and colonial technologies: an addition to critical mental health literature, *Disability & Society,* 30:7, 1021-1041

- ACP-UK recognises the need to acknowledge the historical foundations, the influence, and the damage that this history has had to the present day.

vii. Critical Positioning of 'Equality' Initiatives: Language and Power

- This strategy recognises that language is powerful and is constantly evolving, particularly in relation to describing social categories such as race and ethnicity and sex and class. Meanings can change depending on how words are used, and who is using them over the course of time.
- Descriptors and terminology developed to describe certain experiences of marginalisation can be used to maintain the social dominance and status quo of dominant groups, so careful consideration is required.
- Power and privilege are integral to maintaining inequality, including how language and terminology have developed over time.
- ACP-UK recognises that within and across its activity the dynamics of power and privilege exist within all social experiences, including within the organisation, the profession and in wider society.

viii. Intersectionality

- The ACP-UK strategy adopts an intersectional approach to addressing inequality, diversity and inclusion in its activity.
- An intersectional approach recognises that human beings are shaped by the interaction and intersections of different social locations (e.g., 'race'/ethnicity, Indigeneity, sex, class, sexuality, geography, age, disability/ability, migration status, religion).
- Intersectionality recognises that within social institutions and experiences, those from marginalised social groups are discriminated against because their experiences are not represented and therefore are rendered invisible.
- ACP-UK outlines in this strategy the importance of understanding how structures intersect to marginalise and obscure the experiences of certain groups.

ix. Social Mobility

- ACP-UK recognises that equality and inclusion are fundamentally linked to social mobility.
- In the profession, inclusive education, inclusive recruitment into employment, stretch development opportunities and career progression structures all provide the means for social mobility and therefore social influence for marginalised groups[11].
- This strategy outlines a commitment to recognising, dismantling and redressing the institutional barriers embedded in the organisation, the profession and in social institutions such as education, employment and policy.

[11] Gazeley, L., (2019) *Unpacking 'disadvantage' and 'potential' in the context of fair access policies in England. Educational Review*, 71 (6). pp. 673-690. ISSN 0013-1911

x. Inclusive Leadership

- Clinical psychologists from marginalised groups (e.g., ethnically minoritised, female, people with a disability) are under-represented in leadership, and over-represented in lower levels of organisational hierarchies.
- People from marginalised groups continue to experience covert and overt discrimination in career and leadership progression opportunities[12].
- Teams are more inclusive when they have effective processes that include a clear vision and values of equality, and leadership that represents the diversity within the population and which is actively committed to supporting a representative workforce and leadership group.
- Through this strategy, ACP-UK articulates its commitment to creating and embedding a culture of inclusion within senior and executive management as well as throughout the organisation[13].

xi. ACP-UK Organisational and Member Consultation – the member consultation identified areas that require specific attention over the next 3-5 years:

- A more representative workforce
- EDI issues embedded in clinical training
- Sustainable funding for EDI-focused research
- Guidance for training courses to implement the above
- Increased leadership opportunities for minorities
- Review of the clinical psychology training application form and process

xii. Strategic Aims

- Strategic Aim 1: Philosophy, approach, and engagement
- Strategic Aim 2: Developing and establishing inclusive culture
- Strategic Aim 3: Evidence, education and training
- Strategic Aim 4: Supporting the profession and professionals
- Strategic Aim 5: Evaluation and revision

[12] Yardley, E. (2020). How minority identity can influence performance through well-being. In *Free to Soar: Race and Well-being in Organisations*, Oxford: Pearn Kandola Publishing
[13] Kline R. (2019) Leadership in the NHS *BMJ Leader*; 3:129–132.

3. Glossary

Ableism: the discrimination and oppression of disabled people from a societal belief that being abled is "normal" and is preferred.

Class: a group of people within a society who possess the same socioeconomic status.

Classism: the systematic oppression of subordinated class groups to advantage and strengthen the dominant class groups. Classism is maintained by a system of beliefs and cultural attitudes that ranks people according to economic status, family lineage, job status, level of education, and other divisions.

Culture: 'the beliefs, customs, arts… of a particular society, group, place, or time'[14]. Culture is a dynamic and complex social phenomenon, dependent on context and applies to all human experience.

Disability: any condition that makes it more difficult for a person to do certain activities or effectively interact with the world around them (socially or materially). These conditions, or impairments, may be cognitive, developmental, intellectual, mental, physical, sensory, or a combination of multiple factors.

Diversity: the recognition of the benefits of different values, abilities and perspectives, and celebrating people's differences. This means promoting an environment that welcomes and values diverse backgrounds, thinking, skills and experience.

Epistemic: of or relating to knowledge, knowing or the study of knowledge, and/or the conditions for acquiring it. From 'epistemology' which is the theory of knowledge, especially about its methods, validity, and scope, and the distinction between justified belief and opinion.

Ethnic/Ethnicity: associated with or belonging to a particular race or group of people often defined as those who have a culture that is different from the main culture of a country[15]. It is a poorly defined but complex social phenomena that influences personal identity and group social relations and becomes a reductionist term for the nuance of different cultures across the global population.

Ethnocentrism: the overvaluing of one's own culture in relation to other cultures[16]

Equality: making sure that everyone is treated fairly and with dignity and respect. Equality means challenging discrimination and removing barriers, so that everyone has opportunities to achieve their desired outcomes.

Equity: where each individual or group of people is given the same resources or opportunities. Equity recognizes that each person has different circumstances and allocates the exact resources and opportunities needed to reach an equal outcome.

[14] *Merriam-Webster Dictionary*
[15] *Merriam-Webster Dictionary*
[16] Schouler-Ocak et al. (2021), see note 25.

Gender: often expressed in terms of masculinity and femininity, gender is largely culturally determined and is assumed from the sex assigned at birth.

Gender diverse: a descriptor for identities that are not "male" or "female" and is intended as an overarching term under which individuals within the population remain free to choose their own identifier[17].

Gender identity: a person's innate sense of their own gender, whether male, female, or non-binary, which may or may not correspond to the sex assigned at birth.

Heteronormative: denoting or relating to a world view that promotes heterosexuality as the normal or preferred sexual orientation.

Inclusion: the provision of a space where everyone has equal access to opportunities and resources, and where everyone feels valued and accepted. Everyone should be able to contribute and have a voice. This may mean making reasonable adjustments to facilitate participation.

Intersectionality: the interconnected nature of social categorisations such as race, class and gender, regarded as creating overlapping and interdependent systems of discrimination or disadvantage. Intersectionality is the acknowledgement that everyone has their own unique experiences of discrimination and oppression and therefore requires an understanding of structural context.

LGBTQ+: an acronym used to represent a range of sexualities and gender-identities, including lesbian, gay, bi, trans and queer.

Non-binary: an umbrella term for people whose gender identity does not sit comfortably with "man" or "woman". Non-binary identities are varied and can include people who identify with some aspects of binary identities, while others reject them entirely.

Power: a complex process, defined as the ability to set standards, create norms and values that are deemed legitimate and desirable[18], and is the capacity or ability to direct or influence the behaviour of others or the course of events[19].

Privilege: defined as the societal benefits and the implicit and systemic advantages awarded to the dominant group, "white" people[20], with an emphasis on unexamined, implicit and hidden benefits that such positions hold.

Racism: "a distinctive doctrine cause or theory" or an "oppressive and discriminatory attitude or belief"[21].

---

[17] Thorne, N., Yip, A. K., Bouman, W. P., Marshall, E., & Arcelus, J. (2019). The terminology of identities between, outside and beyond the gender binary - a systematic review. *The International Journal of Transgenderism*, *20*(2-3), 138–154. https://doi.org/10.1080/15532739.2019.1640654, pg 155

[18] van Ham, Peter. (2010). Social Power in International Politics. 1-257. Routledge 104324/9780203857847.

[19] *Oxford English Dictionary*

[20] Neville, H., Worthington, R., Spanierman, L. (2001). Race, Power, and Multicultural Counseling Psychology: Understanding White Privilege and Color Blind Racial Attitudes. In Ponterotto, J., Casas, M, Suzuki, L, and Alexander, C. (Eds) *Handbook of Multicultural Counseling*, Thousand Oaks, CA: SAGE.

[21] *Merriam-Webster Dictionary*

Social construct: an idea or notion that appears to be natural and obvious to people who accept it but may or may not represent reality, so it remains largely an invention or artifice of a given society.

Social mobility: the movement of individuals, families, households or other categories of people within or between social strata in a society and is integral to an equal society.

4. ACP-UK Organisational Values and Commitments

4.1 As a professional membership organisation, ACP-UK is committed to expanding, developing, and promoting equity, diversity and inclusion in all aspects of the organisation's activity. The organisation's EDI commitment is to existing and future members, associates, affiliates, staff and visitors across all ACP-UK activities, and in the wider profession and population.

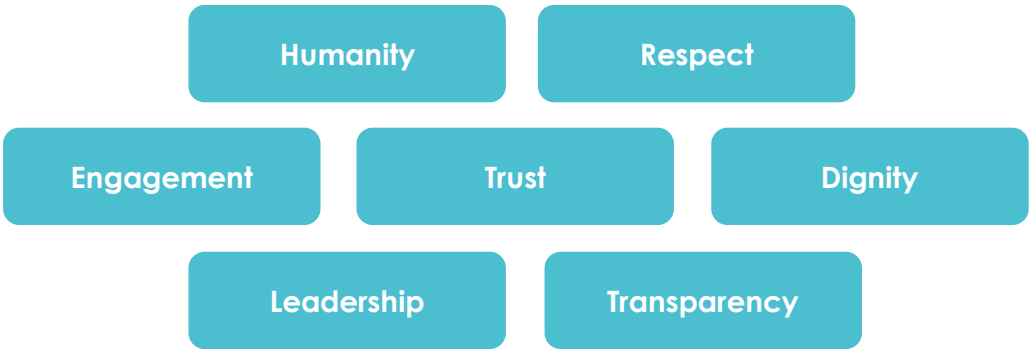
4.2 The aims of the organisation were to develop a strategy that is forward thinking and promotes and advocates for equity and inclusion in all aspects of professional activity for ACP-UK members, the profession of clinical psychology, and for the public that they serve, with particular emphasis on:

- Establishing and sending a clear message of the centrality of equity, diversity and inclusion processes across all streams of ACP-UK activity.
- Actively advocating for, and supporting, equality of access, experience and outcomes for all members and through clinical psychology activity, for the populations they serve, individuals, families, communities, organisations and institutions.
- Establishing an understanding of where, when and how issues in fairness and equality arise and drive forward tangible action and change in a timely way.
- Strengthening and developing effective equity, diversity and inclusion activity and partnerships across stakeholder groups.
- Enhancing transparency and accountability in the implementation of the strategy.

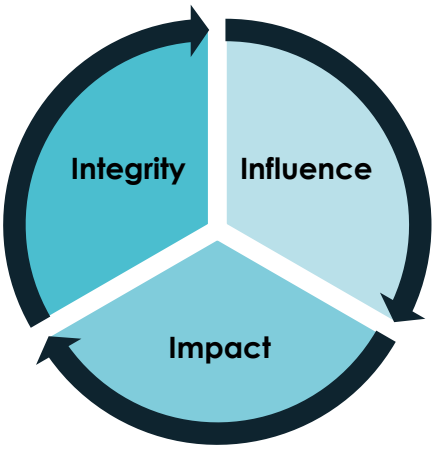
4.3 The EDI Strategy has been developed based on the ACP-UK values of being **Bold, Ethical and Member-led** and a pledge to:

- Act resolutely, offering leadership to clinical psychologists and speaking out on behalf of our members
- Act with integrity for the benefit of our clients and communities, promoting clinical psychology and standing up to prevent its misuse
- Be accountable to our members, responsive and transparent in our communications, and guided by their concerns
- Provide a national psychological voice and promote not only the discipline but also the profession of clinical psychology.

5. ACP-UK Equity, Diversity and Inclusion: Guiding Principles



6. ACP-UK Equity, Diversity and Inclusion: Strategic Commitments



Integrity: to maintain a congruence to equity, diversity, and inclusivity principles and values across and within all ACP-UK activity.

Influence: to maximise the influence of the ACP-UK's equity, diversity and inclusivity initiatives across the profession and professional activity.

Impact: to provide progressive and impactful guidance and leadership for the profession in equity, diversity and inclusion work, that has a positive and continuing impact.

7. Context for Strategy

7.1 The moral obligation to build fair and inclusive professions, organisations and healthcare services is clear. Regardless of identity, background or circumstance, it is a basic human right that all people in society have opportunities to thrive, develop skills and live their lives in structures and systems which are safe, supportive and inclusive. This includes the right to live and work without fear of marginalisation, discrimination and/or harassment, to have their worth recognised, to be justly rewarded and recognised for their work, and lead meaningful lives. This position and approach underpin and guide the *ACP-UK Equity, Diversity and Inclusion - Context and Strategy for Clinical Psychology*.

7.2 ACP-UK recognises that discrimination and racism remain deeply embedded in all social structures within the UK, despite longstanding policies and priorities to tackle, social, structural and institutional inequality in education, housing, the criminal justice system, and healthcare[22,23]. The effects of social inequality in these institutions are well documented, shaping all aspects of social experience[24]. These include discrimination on the basis of sex, class, disability and those from ethnically marginalised groups.

7.3 Current geo-political events, George Floyd's murder, the Black Lives Matter movement and the global pandemic have highlighted how structural inequality and discrimination continue to have a negative impact on marginalised social groups[25]. Austerity policies, the "hostile environment" immigration policies and the Brexit vote have further contributed to the significant rise in racism, prejudice, discrimination and xenophobia[26]. Britain has been shown to be institutionally discriminatory, with the recent and controversial Commission on Race and Ethnic Disparities Report (2021) suggesting that social and institutional systems are "no longer rigged against ethnic minorities". ACP-UK published a statement in response to the report outlining its failure "to build a coherent and frank picture of the continuing scale and impact of racial disparities in the UK, and the ways in which structural and systemic factors perpetuate these disparities"[27].

7.4 Structural discrimination towards socially marginalised groups (which encompass race/ethnicity, disability, sex and socio-economic status) exists in individually held prejudices and biases, as well as in the structure of laws and policies that embed these attitudes in the UK's economic, social and cultural norms[28]. As a society and profession, the moral responsibility for equality resides alongside the necessity for the collaboration and the cognitive diversity that defines functional, adaptive and effective systems[29].

7.5 Addressing health and mental health inequalities is not a new focus[30]. However, the COVID-19 pandemic and its social and economic impacts has highlighted the disproportionate impact on the most disadvantaged in society. Specific socially vulnerable groups included ethnically minoritised communities, those from socially and economically deprived groups, older adults, women, children and those in a range of caring occupations [31] [32],[33].

---

[22] Salter, P. S., Adams, G., & Perez, M. J. (2018). Racism in the Structure of Everyday Worlds: A Cultural-Psychological Perspective. *Current Directions in Psychological Science*, 27(3), 150–155. https://doi.org/10.1177/0963721417724239

[23] Phillips, C. (2011) Institutional racism and ethnic inequalities: an expanded multilevel framework. *Journal of Social Policy*, 40 (01). pp. 173-192.

[24] Michael Marmot, Jessica Allen, Tammy Boyce, Peter Goldblatt, Joana Morrison (2020) *Health equity in England: The Marmot Review 10 years On*. London: Institute of Health Equity

[25] Michael Marmot, Jessica Allen, Tammy Boyce, Peter Goldblatt, Joana Morrison (2020) Health equity in England: The Marmot Review 10 years on. London: Institute of Health Equity

[26] *European Commission against Racism and Intolerance Report*, 2016.

[27] Rahim, M & Jameel, L. (2021). *ACP-UK Rapid Response to Commission on Race and Ethnic Disparities Report*, ACP-UK, https://acpuk.org.uk/rapid_response_race_ethnic_disparities_report/, accessed Dec 2021)

[28] Bailey, Z.D., Feldman J.M., Bassett M.T. (2020) How Structural Racism Works - Racist Policies as a Root Cause of U.S. Racial Health Inequities. *N. Engl. J. Med*. 2020 Dec 16

[29] *Ibid (PHE 2020), pg 8*

[30] *Five Year Forward View for Mental Health and the NHS Long Term Plan*

[31] http://www.instituteofhealthequity.org/resources-reports/ethnicity-and-mortality-from-covid-19/ethnicity-and-mortality-from-covid-19-comment.pdf, accessed Dec 20th 2020

[32] Marmot, M., Allen,J., Goldblatt, P., Herd, E., & Morrison, J. (2020). *Build Back Fairer: The COVID-19 Marmot Review. The Pandemic, Socioeconomic and Health Inequalities in England*. London: Institute of Health Equity

[33] Public Health England (2020), *Beyond the data: Understanding the impact of COID-19 on BAME groups*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf. Accessed Sept 2021

7.6 Additionally, and predating the pandemic

- Service user experience of discrimination is widespread in mental health services[34]:
- Older people are a fifth as likely as younger age groups to have access to talking therapies but six times as likely to be on medication.
- Children and young people from ethnically minoritised communities are less likely to be able to access services which could intervene early to prevent mental health problems escalating;
- People from Black-African and Caribbean communities are 40% more likely than White-British people to come into contact with mental health services through the criminal justice system;
- Mental health inequalities disproportionately disadvantage women across their lifespan[35].
- Rates of mental health difficulties are rising more quickly for women, with many facing barriers because of their gender, including within relationships with staff, and a lack of voice or control.
- Women experience disproportionately higher levels of sexual assault, violence, trauma and exploitation[36].
- Transgender people frequently experience prejudice, financial barriers, discrimination, lack of cultural competence by providers, health systems and socioeconomic barriers when attempting to access services[37].
- Transgender people experience a combination of exclusion and marginalisation, and are particularly vulnerable to human rights violations[38].
- LGB patients are far less likely to feel they had been treated with dignity and respect by NHS mental health services[39].
- People in lower income households are more likely to have unmet mental health treatment requests compared with the highest.
- Many socially disadvantaged groups face barriers to accessing healthcare services, including those sleeping rough, sex workers and migrants[40].
- People with disabilities are are at greater risk of violence than people without disabilities[41].
- Perceived disability-related discrimination is linked with poorer well-being[42].

[34] HEE (2020) Advancing mental health equalities strategy
[35] World Health Organization (2016). *Gender, equity and human rights, making a difference: vision, goals and strategy*, https://www.who.int/gender-equity-rights/knowledge/GER-biennium-report.pdf (accessed 20/8/21).
[36] Dept of Health and Social Care (2018) *The Women's Mental Health Taskforce Final Report*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/765821/The_Womens_Mental_Health_Taskforce_-_final_report1.pdf (Accessed
[37] Safer, J. D., Coleman, E., Feldman, J., Garofalo, R., Hembree, W., Radix, A., & Sevelius, J. (2016). Barriers to healthcare for transgender individuals. *Current Opinion in Endocrinology, Diabetes, and Obesity*, *23*(2), 168–171. https://doi.org/10.1097/MED.0000000000000227
[38] UN Human Rights, Office of the High Commissioner (nd) *The struggle of trans and gender-diverse persons*. https://www.ohchr.org/EN/Issues/SexualOrientationGender/Pages/struggle-trans-gender-diverse.aspx
[39] House of Commons, Women and Equalities Committee (2019), *Health and Social Care and LGBT Communities*. https://publications.parliament.uk/pa/cm201919/cmselect/cmwomeq/94/94.pdf
[40] Equality and Human Rights Commission (2016). *England's most disadvantaged groups: Homeless people. An Is England Fairer? Review spotlight report.* https://www.equalityhumanrights.com/sites/default/files/is-england-fairer-2016-most-disadvantaged-groups-homeless-people.pdf
[41] Dammeyer, J., Chapman, M. A national survey on violence and discrimination among people with disabilities. *BMC Public Health* **18,** 355 (2018). https://doi.org/10.1186/s12889-018-5277-0
[42] Hackett, R. A., Steptoe, A., Lang, R. P., & Jackson, S. E. (2020). Disability discrimination and well-being in the United Kingdom: a prospective cohort study. *BMJ Open*, *10*(3), e035714. https://doi.org/10.1136/bmjopen-2019-035714

- The lived experience of mental health difficulties in health professionals and clinical psychologists is far more common than previously recognised[43], but continues to be an area of significant need.

7.7 Despite equality policies and initiatives, health services and health professions recognise the immediate need to address structural and institutional inequality and discrimination within their systems and disciplines. This strategy is conceptually and practically positioned within an intersectional approach to systems of inequality, e.g. sexism, racism, classism and ableism, interact with, generate and perpetuate complex patterns of privilege and oppression. The strategic aims target key areas of systemic, structural, and institutional inequality from this conceptual position.

8. British Clinical Psychology

8.1 British clinical psychology continues to recruit and be comprised primarily of members of the racially dominant group. According to the British Psychological Society (BPS) demographics, 88% of psychologists are[44], a demographic which has shaped the profession and remained largely unchanged since the 1970s[45].

8.2 Clinical psychologists from ethnically and socially marginalised groups continue to experience discrimination, including overt and covert racism, sex-based discrimination, classism and ableism, throughout training and their qualified life, including opportunities for career progression to leadership and executive decision-making roles.

8.3 Clinical psychology is also criticised for a lack of representational diversity in cohorts, programme staff and senior leadership46, with an over-representation of white, able-bodied, heterosexual people in key leadership and decision-making processes within the profession47. Leadership in the profession is predominantly male, with people from socially marginalised groups experiencing racism, sex-based discrimination, ableism, and classism, in their efforts to progress to leadership roles.

8.4 The profession faces challenges in addressing the continued barriers for people from marginalised groups to be selected on training[48]. Ethnically minoritised people, people who are disabled and those who identify as being from working class backgrounds report experiences of marginalisation, overt and covert discrimination, and being stereotyped within training[49] [50] [51].

---

[43] Kemp, N., Scior, K. & Clements, H. & Mackenzie-White, K.. (2020). *Supporting and valuing lived experience of mental health difficulties in clinical psychology training*. British Psychological Society.
[44] BPS, 2015,
[45] Wood, N., & Patel, N. (2017). On addressing 'Whiteness' during clinical psychology training. *South African Journal of Psychology*, *47*(3), 280–291. https://doi.org/10.1177/0081246317722099
[46] Scior, K., Wang, M., Roth, A., & 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
[47] Patel, N. 2021. Dismantling the scaffolding of institutional racism and institutionalising anti-racism. *Journal of Family Therapy*. https://doi.org/10.1111/1467-6427.12367
[48] Clearing House, 2019 & 2020
[49] Adetimole, F., Afuape, T., & Vara, R. (2005). The impact of racism on the experience of training on a clinical psychology course: Reflections from three Black trainees. *Clinical Psychology Forum* (Vol. 48, pp. 11- 15)
[50] Wood, N., & Patel, N. (2017). On addressing 'Whiteness' during clinical psychology training. *South African Journal of Psychology*, *47*(3), 280–291. https://doi.org/10.1177/0081246317722099
[51] Spence, N. (2012) Cultural competence: Social class – the forgotten component. *Clinical Psychology Forum 230*, 36-39.

8.5 It is also recognised that the methodologies, curricula and research base of clinical psychology are centred on the individual, white, European, able-bodied, heteronormative and neurotypical experiences and need 'decolonising'52. There are fewer data on experiences of discrimination post qualification for clinical psychologists, but NHS reports of workforce experiences of marginalised ethnic groups, as well as disabled, sex and age discrimination, suggest that this pattern of overt and covert discrimination continues and creates barriers to career progression and social mobility53.

9. Origins of Systemic and Institutional Inequality in Psychology

9.1 Understanding the historical context of the 'psy-professions' (psychology and psychiatry) is important when considering their contributions to current inequalities. A comprehensive summary is beyond the scope of this document and has been discussed in detailed elsewhere 54 55 56 57 58. What is important is the connection between the emergence of the psy-professions as scientific discipline, the historical legacy of slavery, neoliberal capitalism, imperialism and colonisation, and the control of 'difference' through diagnostic mechanisms, coercion and unethical harmful practices in mental health59. Ethnocentrism has been fundamental to the historical complicity of psychiatry and psychology in continuing narratives of disempowerment and oppression60.

9.2 The imperialist ideology driven by colonial occupation in the late nineteenth and early twentieth centuries led to Europeans occupying approximately 85% of the globe. This expansion corresponded with the development of a 'scientific base' of the superiority of the white European amongst global populations, with European and American psychiatry, psychology and medical professionals developing 'scientific proof' of this 'innate superiority'. This self-serving pseudo-science61 included a 'moral dimension' that justified the control of those deemed to be inferior.

9.3 The 'psy' professions, strongly influenced by social Darwinism, advocated eugenics62, a [16] pathologising categorisation of human differences according to supposedly innate and fixed 'traits' (such as race or intelligence) while significantly minimising or dismissing the role of social context. Through the development of intelligence and personality testing, the eugenics-based research aimed to develop an 'evidence base' of the biological and social inferiority of certain

[52] Guthrie, R. V. (2004). *Even the rat was white: A historical view of psychology* (2nd ed.). Pearson Education.
[53] 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*. Middlesex University Research Depository
[54] Mills, C. (2014*). Decolonizing Global Mental Health The psychiatrization of the majority world*. Routledge. ISBN 978-1-135-08043-3.
[55] Bhui, 2021, Race, ethnicity, and disparities in mental health experiences and outcomes #AntiRacistMHResearch, *National Elf Service* https://www.nationalelfservice.net/populations-and-settings/black-and-minority-ethnic/race-ethnicity-disparities-mental-health-experiences-outcomes-antiracistmhresearch/, accessed Aug 2021
[56] Wood, N., & Patel, N. (2017). On addressing 'Whiteness' during clinical psychology training. *South African Journal of Psychology*, *47*(3), 280–291. https://doi.org/10.1177/0081246317722099
[57] Fernando, S. (2017) *Institutional Racism in Psychiatry and Clinical Psychology: Race Matters in Mental Health*. Palgrave McMillan
[58] Schouler-Ocak, M., Bhugra, D., Kastrup, M. C., Dom, G., Heinz, A., Küey, L., & Gorwood, P. (2021). Racism and mental health and the role of mental health professionals. *European Psychiatry : the Journal of the Association of European Psychiatrists*, *64*(1), e42. https://doi.org/10.1192/j.eurpsy.2021.2216, Pg 2
[59] Joseph, A. (2015). The necessity of an attention to Eurocentrism and colonial technologies: an addition to critical mental health literature, *Disability & Society,* 30:7, 1021-1041
[60] Byrd, C. M. (2021). Cycles of development in learning about identities, diversity, and equity. *Cultural Diversity and Ethnic Minority Psychology.* Advance online publication. https://doi.org/10.1037/cdp0000389
[61] Bhui. K. (2021) (see note 22)
[62] Galton, 1904, pg 1, in Fernando, 2018 (see note 24), pg 26.

groups, such ethnic groups, those with physical and mental health disabilities, and women[63] [64].

9.4 Within intellectual disabilities, using their conceptualisation and testing of 'intelligence' Galton (1881) and Spencer (1884) advocated that certain groups in society were inferior. These theories provided the scientific and moral basis for policies and practices which in actuality dehumanised and brutalised not just those with intellectual disabilities but also those from ethnically marginalised groups, and those marginalised based on gender, sexuality and lower socioeconomic class[65]. The influence of eugenics ideology, together with the influence of the medical model of disability, provided the foundation for the continued discrimination and prejudice towards people with disabilities[66].

9.5 It is this history and context that present-day clinical psychology rests within, with an undeniable link and influence of eugenic ideologies in relation to human differences, some of which became central to practices of psychotherapy. British clinical psychology continues to be influenced by this within the central tenets of 'evidence-based practice'. As such, the psy-professions have been criticised for being complicit in systems of marginalisation and oppression[67] [68].

9.6 While times have moved on and the ethos and value base of the profession has significantly shifted, the legacy of the history continues in current structural and systemic discrimination. Such historical and [17] pathologising narratives of difference have resulted in certain types of difference from the 'norm' being stigmatised, resulting in structural and individual discriminatory attitudes and behaviours. The profession of clinical psychology needs to recognise and acknowledge its historical foundations, and the influence and damage that this complicity has had to the present day.

9.7 To this end, ACP-UK acknowledges that the history of British clinical psychology is rooted in a misogynistic, colonial, ableist and Western worldview, and that the profession has a long history of complicity in oppressing those with less structural power.

[63] Brigham, 1923; Goddard, 1912; Hall, 1909; McDougall, 1914; Terman, 1916; Thorndike, 1909; Watson, 1914, 1919, Hall, 1909, 1917; Terman, 1916; Thorndike, 1909; Watson, 1919, 1928; Yerkes, 1918

[64] Yakushko, O. (2019). Eugenics and its evolution in the history of western psychology: A critical archival review. *Psychotherapy and Politics International*.

[65] Patel, N. (2021). Dismantling the scaffolding of institutional racism and institutionalising anti-racism. *Journal of Family Therapy*.

[66] Dirth, T. P., & Branscombe, N. R. (2017). Disability models affect disability policy support through awareness of structural discrimination. *Journal of Social Issues*, *73*(2), 413-442.

[67] Wood, N., & Patel, N. (2017). On addressing 'Whiteness' during clinical psychology training. *South African Journal of Psychology*, *47*(3), 280–291. https://doi.org/10.1177/0081246317722099 pg x

[68] Goodley, D. Lawthom, R., Liddiard, K. & Runswick-Cole, K (2019) *Provocations for Critical Disability Studies, Disability & Society*, DOI: 10.1080/09687599.2019.1566889

10. Critical Positioning of 'Equality' Initiatives

10.1 A note on language and terminology:

10.1.1 In the UK, age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation are 'protected characteristics' covered by the Equality Act 2010, and which are protected from unlawful discrimination. The Act places a pro-active responsibility on public authorities and institutions to eliminate discrimination, advance equality and foster good relations.

10.1.2 This strategy recognises that language is powerful and is constantly evolving, particularly in relation to describing social categories such as race and ethnicity and gender and class. Meanings can change depending on how words are used, and who is using them over the course of time. Descriptors and terminology developed to describe certain experiences of marginalisation are often used to maintain the social dominance and status quo of dominant groups. Power and privilege are integral to how language and terminology has developed over time. For example, the term 'minority' suggests numbers within a national population, rather than an experience of marginalisation. Groups may be a minority within the UK, but are in a global majority and, as such, the experience is based within a context of disempowerment, not numbers.

10.1.3 In this strategy, it is recognised that 'race' is not a biological category but, rather, is a social construction of ideas and beliefs about human difference and is often erroneously presented as a biological fact. Race and ethnicity are often used interchangeably and are how powerful structures populate these social categorisations[69]. Language and terminology are particularly relevant to how ethnically marginalised groups are described. 'BME' and 'BAME' acronyms (often pronounced as a word and not an acronym) have been noted as being meaningless and homogenising and allow socially dominant groups to pathologise while avoiding and sanitising racism. In this document, the descriptor 'ethnically minoritised' will be used in recognition that these are social constructions of race and ethnicity with the limitations and challenges therein.

10.1.4 The term LGBTQ+ used in this strategy recognises and acknowledges that words, meanings, and terminology continue to evolve over time. The purpose of the acronym which includes '+' is to represent and fully capture the significant diversity of people who are same/similar sex or gender attracted and transgender. In this document, the descriptor LGBTQ+ will be used with the recognition that it represents a diverse range of experiences and perspectives. At the same time, we recognise that not all LGBT people identify as 'queer' and that many regard it as a term of offence.

10.1.5 Discussions and references to the experience of disability and ableism in the profession and in the population recognise and acknowledge that language reflects how society situates, perceives and understands disability. There is also an

[69] Aspinall, P.J. (2020). Ethnic/Racial Terminology as a Form of Representation: A Critical Review of the Lexicon of Collective and Specific Terms in Use in Britain. *Genealogy, 4,* 8

acknowledgement that 'disability', of all the protected characteristics, is defined in a 'negative way by default'[70]. Definitions and terminology inform operationalisation of inclusivity initiatives, and these can directly impact those with a disability, in addition to how social institutions and organisations engage with the many social problems disabled people face.

10.1.6 This strategy recognises the importance of including class, with the acknowledgement that there is no specific protection for social class discrimination in the Equality Act 2010 and therefore does not extend to protection against discrimination or experiences of marginalisation. The strategy recognises, however, that power and inequality affect a person's social experience, and impact on social mobility. Evidence strongly indicates that being from a working class background has a detrimental impact in access to social opportunity and social mobility within the profession and in the general population.

10.2 Power, privilege and epistemic injustice

10.2.1 The unequal distribution of social and economic power in society is one of the fundamental causes of health and social inequality. Power, privilege and institutional discrimination are interlinked concepts, where the social and economic power held by individuals within dominant social groups maintains widespread structural inequality [71]. As such, power exists in the relationships between people and groups and is both overt and covert. This strategy recognises within and across its activity that the dynamics of power and privilege exist within all social experiences, including within the organisation, the profession and in wider society.

10.2.2 Inherent within structural inequality, power and privilege are the related concepts of 'epistemic violence' and 'epistemic injustice'. Epistemic violence represents an imperialist and colonial strategy of using structural power to eradicate and erase indigenous knowledge, beliefs, traditions and language to be replaced by the dominant coloniser's knowledge and beliefs[72]. It can be meaningfully applied to experiences of the discrimination of all marginalised groups, where the experiences of the dominant group, e.g., white, male, heteronormative, neurotypical, able bodied, middle class, are set as the representational ideal for all experiences.

10.2.3 The concept of epistemic injustice describes how the only valid knowledge is that which reflects the perspective and agendas of the socially dominant groups[73]. The experience of marginalised groups and communities is therefore made invisible and invalid. Epistemic injustice recognises the marginalisation and silencing of marginalised experience and violates the respect human beings owe one another[74] [75].

[70] Wolbring, G., & Lillywhite, A. (2021). Equity/Equality, Diversity, and Inclusion (EDI) in Universities: The Case of Disabled People. *Societies*, *11*(2), [49]. MDPI AG. Retrieved from http://dx.doi.org/10.3390/soc11020049, pg 20
[71] Anthias, F. (1999). Institutional Racism, Power and Accountability. *Sociological Research Online*, 4(1), 143–151. https://doi.org/10.5153/sro.239, paragraph 4.1
[72] Spivak, G. Chakravorty (1988). Can the Subaltern Speak? *Die Philosophin* 14 (27):42-58
[73] Fricker, M. (2007-06-01). *Epistemic Injustice: Power and the Ethics of Knowing*. Oxford University Press.
[74] Herzog, L. (2016). Basic Income and the Ideal of Epistemic Equality. *Basic Income Studies*, *11*(1), 29-38. https://doi.org/10.1515/bis-2016-0009
[75] Patel, N. (2019). Human rights-based approach to applied psychology. *European Psychologist*, 24, 113–124. https://doi.org/10.1027/1016-9040/a000371.

11. Intersectionality

11.1 This strategy adopts an intersectional approach to addressing inequity, diversity and inclusion in its activity. An intersectional approach recognises that human beings are shaped by the interaction and intersections of different social locations (e.g., 'race'/ethnicity, Indigeneity, sex, class, sexuality, geography, age, disability/ability, migration status, religion). These interactions occur within a context of connected systems and structures of power, for example, laws, policies, housing, state governments and other political and economic unions.

11.2 When social structures and institutions have developed from and been normed for a particular (and narrow) social group, other experiences of the world are not represented in such structures. Intersectionality recognises that within social institutions and experiences those from marginalized social groups are discriminated against because their experiences are not represented and are therefore invisible, through a process of epistemic injustice. Inaccurate assumptions about representation are often based on restricted standards and norms (e.g., middle class represent all classes, white women represent all women). Through such processes, interdependent forms of privilege and oppression shaped by colonialism, imperialism, racism, homophobia, ableism and patriarchy are created[76]

11.3 The relevance of intersectionality for this strategy lies in the importance of understanding how structures intersect to marginalise and obscure the experiences of certain groups. This includes the lack of structures and opportunities to contest or question the status quo, which maintains the legitimacy of dominant social narratives. This strategy sets out an initial plan for addressing and dismantling the structures and narratives that perpetuate inequality within all ACP-UK activities.

11.4 In this strategy, ACP-UK recognises that creating structural equality requires interrogating and dismantling dominant systems of structural discrimination, which includes an examination of intersectional factors. Located in the intersectional experiences of historic and current epistemic injustice, ACP-UK strategy aims to address discrimination and equality by recognising and actively addressing where power is exerted, and where and how disempowerment is maintained and perpetuated by organisational and institutional structures.

12. Social Mobility

12.1 ACP-UK recognises that equality and inclusion are inherently linked to social mobility. In the profession, inclusive education, inclusive recruitment, stretch development opportunities and career progression structures all provide the means for social mobility and therefore social influence for marginalised groups[77].

[76] Hankivsky, O., Grace, D., Hunting, G. *et al.* (2014). An intersectionality-based policy analysis framework: critical reflections on a methodology for advancing equity. *Int J Equity Health* **13,** 119 . https://doi.org/10.1186/s12939-014-0119-x pg 2

[77] Gazeley, L., (2019) *Unpacking 'disadvantage' and 'potential' in the context of fair access policies in England. Educational Review*, 71 (6). pp. 673-690. ISSN 0013-1911

Institutional and structural barriers in education and employment have restricted the mobility and influence of people from marginalised groups.

12.2. This strategy outlines a commitment to recognising, dismantling and redressing the institutional barriers embedded in the organisation, the profession and in social institutions such as education, employment and policy.

13. Inclusive Leadership

13.1 ACP-UK recognises that tackling inequalities within the workforce and public services will need organisations, professional bodies and each person to recognise how their own biases, beliefs and behaviours contribute to and perpetuate existing inequalities. This requires both individual and systemic change. While the terms diversity and inclusion are widespread in organisations, the tokenistic and performative implementation of diversity and inclusion initiatives present ongoing challenges for the profession.

13.2 Clinical psychologists from marginalised groups (e.g., ethnically minoritised, female, other gender identities, people with a disability) are under-represented in leadership and over-represented in lower levels of organisational hierarchies. People from marginalised groups continue to experience covert and overt discrimination in work and in career progression opportunities[78]. Data on the experiences of clinical psychologists working in non-NHS settings and the private sector are lacking, but it is plausible to assume that there are parallel experiences of discrimination and inequality in work experience, opportunities and career progression in these sectors. It is also possible that clinical psychologists working in these sectors, particularly private practitioners, are less likely to have supportive systems around them and may be at more risk of the psychological impacts of discrimination. ACP-UK is committed to developing support systems for this group.

13.3 Tackling inequality and inclusion within organisations is complex, but opportunities to bring about change are most likely to be effective at team level, where most discrimination occurs. Teams are more inclusive when they have effective processes that include a clear vision and are connected to the values of equality. In addition to this, having leadership that represents the diversity within the population and which is actively committed to supporting a representative workforce and leadership group is crucial. Within organisations, effective diversity management policies, practices and procedures that can shape and reinforce equal employment are vital.

13.4 Through this strategy, ACP-UK articulates its commitment to creating and embedding a culture of inclusion within senior and executive management as well as throughout the organisation, which has been shown to be a successful approach[79].

[78] Yardley, E. (2020). How minority identity can influence performance through well-being. In *Free to Soar: Race and Well-being in Organisations*, Oxford: Pearn Kandola Publishing
[79] Kline R. (2019) Leadership in the NHS *BMJ Leader*; 3:129–132.

14. ACP-UK Organisational and Member Consultation:

The member consultation identified areas that required specific attention and work over the next 3-5 years:

a. A more representative workforce
b. EDI issues to be embedded in clinical training
c. Sustainable funding for EDI-focused research
d. Guidance for training courses to implement the above
e. Increased leadership opportunities for minorities
f. Review of the clinical psychology training application form and process

These areas include particular focus on the following stages of the clinical psychology career trajectory:

1) Priorities for graduates

a. Mentoring and outreach to school pupils to increase awareness of the profession, along with clear and transparent information about the training pathway and expected timescales of progression
b. Mentoring and outreach to undergraduate programmes to enable admission to clinical training programmes
c. Career pathways with greater financial security
d. Review of selection processes (evidence for improved processes to be provided, and audits to be done to demonstrate problems with the current and evolving process)
e. A greater focus on disabled, working-class and male applicants
f. Abolish unpaid posts which are not supported by an academic programme

2) Priorities for trainees

a. To decolonise the curriculum
b. Development of part-time and flexible routes for clinical training
c. Improved teaching on gender and sexual diversity (more and of better quality)
d. The provision of confidential 1:1 support for minoritised trainees
e. Training on EDI issues for placement supervisors and programme staff
f. EDI to be meaningfully embedded in placements and research (and increased flexibility regarding provision of placements specifically working with minoritised people)
g. Training on the history of the profession, EDI and decolonisation as part of the teaching programme, with an appreciation for the fact that there will be dissenting views on the impact of colonialism, and that such views must not be repressed

3) Priorities for qualified clinical psychologists

   a. Mentoring for qualified staff
   b. Improve supervisor training and competencies in respect of EDI
   c. Improved processes regarding recruitment
      i. EDI principles to be embedded in the selection process, including criteria for interview and appointment
      ii. 'Diversity champions' – when used – to be clinical psychologists
   d. Facilitating networking for support and professional development
   e. Development of EDI-focused competencies and CPD
   f. Representative leadership
   g. EDI-focused reflective practice opportunities within services
   h. EDI to be prioritised in services and individual practice
   i. Supporting service development in the area of EDI

15. Strategic Aims

Strategic Aim 1: Philosophy, approach and engagement

To recognise and acknowledge that structural discrimination operates in all structures, given the historic roots of the phenomena, and that it operates in everyone's systems and everyday actions. As such, the ACP-UK directors and members commit to open self-reflection on personal complicity and responsibility in enacting such inequalities.

To espouse, operate within and advocate for a structure that recognises their history of cultural dominance.

To advocate for and operate within systems and processes that are committed to addressing structural, implicit and personal biases.

To operate and embody a culturally congruent, valuing, respectful and compassionate ethos in all ACP-UK activity.

This strategy would operate internally within the organisation as well as in outward-facing activity to support the membership, the profession, health and mental health care organisations, service users and carers and the public.

Goals:

1. Recognition of the institutionalised power of the socially dominant group – intersectionality and reparatory actions
2. Addressing structural, implicit and personal biases – it is imperative that this occurs within the organisation of ACP-UK as well as in external activity.
3. 'Decolonisation' – recognising philosophies, training, research, practice and institutional structures that have influenced our current position

4. Developing leadership skills, support and networks for marginalised groups, getting 'a seat at the table' and strategies for social mobility
5. Engaging membership in consultation and ongoing activities
6. Engaging with service user groups and experts by experience, e.g., co-production of activity, statements and guidelines
7. Leading and lobbying within structures and power – developing activity within membership and external partnerships, to be able to support members to engage in advocating for change in power structures, supported by ACP-UK, either in partnership or through mentoring, for example. This could be at local NHS/public sector level, regional or national (e.g., Government, Parliament and similar institutions)
8. To ensure impact, influence and integrity across all activity in this strategic aim

Strategic Aim 2: Developing and establishing inclusive culture

To inform, empower and support the organisation, from the Board of Directors to all members and associates, to embody and espouse the principles and activity of the EDI strategy.

To support the membership, the profession, health and mental health care organisations, service users and carers and the public with research evidence, dissemination, information, guidelines and position statements about key events nationally and globally.

Goals:

1. Culture, policy and process and ACP-UK 'walking the talk'
    a. Individual, institutional and organisational processes – examine and develop an understanding of barriers and implicit biases in personal-professional interface
    b. Addressing and modelling how to work through culture change,
    c. Recognise and change, embody with congruity
    d. Embed formal and informal systems and a culture of accountability and transparency
    e. Constitutional congruency – representation and infrastructural support
    f. Engagement with service user groups and public consultations to be connected to the needs of the populations clinical psychologists serve.
2. Image congruency – website, images, language and accessibility to all reflect the ethos, philosophy and position on inclusivity and diversity
3. Opportunity, recruitment and progression – to consider how ACP-UK internal processes adhere to principles of EDI Also see Roger Kline's (2021) *No More Tick Boxes* report[80].
4. The clinical psychology profession – supporting and influencing an inclusive culture, enriched by diversity at the relevant stages and transition points for members, i.e., pre-training, training, qualified, mid-career and senior leadership,

[80] Kline R (2021a) *No more tick boxes: a review on the evidence on how to make recruitment and career progression fairer*. NHS East of England.

in the form of support, training, position statements and involvement and consultation regarding national changes in the profession.
5. Healthcare systems, staff and service user experiences - supporting and influencing an inclusive culture, enriched by diversity at the relevant stages and transition points for stakeholders and the public, by having direct and indirect impact and influence, i.e., in the form of support, training, position statements and involvement and consultation regarding national changes in the profession.
6. Public and societal safety, education and awareness raising - supporting and influencing an inclusive culture, enriched by diversity at the relevant stages and transition points for stakeholders and the public, by having direct and indirect impact and influence, i.e., in the form of support, training, position statements, and involvement and consultation regarding national changes in the profession.
7. International collaborations – developing partnerships and collaborations to learn from and with diverse cultures.
8. To ensure impact, influence and integrity across all activity in this strategic aim.

Strategic Aim 3: Evidence, education and training

To develop, in line with EDI strategy principles and goals, a research evidence base and the dissemination of progressive and innovative research and practice.
To support the membership through knowledge dissemination and through supporting individual members to conduct their own research, thereby enriching the evidence base with relevant research findings.

Goals:

1. Promoting and developing research and evidence – based on EDI strategy philosophy and targets, e.g., development of a EDI research strategy on the basis of gaps in research on experiences of clinical psychologists across the range of settings and modalities of work.
2. To engage and develop partnerships with service user groups to have involvement in the development and co-production of training, research and education.
3. Development and dissemination of progressive and innovative research and practice
    a. Support for professionals – grant application help (in partnerships with external organisations), a network or stream within ACP-UK, partnership with universities for private/non-institutioned practitioners who want to do research. Support for publication, access to full text journals and similar platforms.
    b. Support for internal research (e.g., 'our stories' project) and membership research aligned to EDI strategy, to include funding opportunity and grant writing support.
    c. Partnership with funding and other organisations – collaborations and funding opportunities.
    d. To provide material, evidence, information on key and current issues through ACP-UK's own work (see 2.a and 2.b) and/or national research.

4. Training and support for all those who work with and for ACP-UK, for the membership body and in the wider profession to maintain and embody alignment with EDI activity (see 'Integrity' commitment)
5. To ensure impact, influence and integrity across all activity in this strategic aim.

Strategic Aim 4: Supporting the profession and professionals

To advocate for and support members in areas of disempowerment and discrimination, to encourage and support the professional membership and profession to espouse and embody the EDI principles and values.

To provide progressive and bold leadership for the profession, through providing clear and timely statements on issues that effect marginalised and disempowered people, in the membership and in the population.

To maximise influence and impact on the future of the profession and clinical psychology activity in all sectors.

To provide a national *psychological voice* and promote not only the discipline but also the *profession* of clinical psychology.

Goals:

1. Statements about key national and professional events – congruent to strategic principles, commitments and aims, e.g., statement on institutional racism
2. Production and dissemination of progressive and innovative practice and research in response to membership consultations and needs.
3. Policy and practice influence – promoting and lobbying for influence and impact on key areas, in line with and congruent to strategic principles, commitments and aims. Partnerships with stakeholders, i.e. membership, national networks and service user groups.
4. Structural support – to develop from research and consultation processes on the nature of structural barriers the members - and all clinical psychologists - experience in the profession, from aspiring psychologists to senior leadership.
    a. Career progression: entry, selection, recruitment, promotion, leadership (e.g., contextual admissions for training, No Tick Boxes, ACP-UK innovations)
    b. Support in professional structures – guidelines, partnership, e.g., a partnership with a union/Unite could develop into a useful structure that addresses intersectional difficulties in professional activity that are discriminatory in nature (such as service user groups), ethical and legal support systems, advocacy and campaigning).
5. To ensure impact, influence and integrity across all activity in this strategic aim.

Strategic Aim 5: Evaluation and revision

To establish accurate, culturally and contextually robust systems of data collections and evaluation practices, benchmarked and measured to establish and develop an evidence base for ACP-UK EDI activity.

To develop a conceptual and research methodology to maximise accurate capture and collection of the range of data from individual, group, organisational and professional activity.

To recognise that inclusivity and equality initiatives represent nuanced and complex social phenomena which are intersectional in nature.

To recognise that current research and evaluation paradigms are located in a colonised and narrow social norm, and, as such, accurate and contextual measures and matrices of the EDI initiatives need to be developed.

Goals:

1. Evaluating EDI strategy aims are dependent on how the streams of work and activity develop, but there are key drivers for the process of evaluation:
    a. Systems of accountability and transparency within organisational functioning and EDI outward-facing activity.
    b. Benchmarking and measurement - decolonised and contextualised measures and paradigms and timelines
    c. Measurement of impact on systems, members, stakeholders and the public.
    d. Critical consideration and review of evaluation
2. Annual review of processes and practices:
    a. Revision and re-calibration
    b. Review strategic goals and aims
    c. Calibration/recalibration to current context and drivers
    d. Revise and enhance aims, goals and outputs

3. To ensure impact, influence and integrity across all activity in this strategic aim.
    a. ACP-UK has committed to review its own policies and practices on an annual basis, to ensure that the values and actions embedded in this document guide its work
    b. The organisation will also work with partners and stakeholders to implement systems-level change

16. Strategy Consultation and Review

This strategy was developed by the ACP-UK EDI Committee working with an EDI consultant, who is an ACP-UK member. We thank all our internal and membership contributors for their valuable input and for their help ensuring that this document is a comprehensive statement on ACP-UK commitment to EDI. This strategy will be

published and publicly available on the ACP-UK website and available in alternative formats on request. The strategy will be revisited and revised as work continues. The ownership of this strategy will sit with the ACP-UK Board of Directors, who will be responsible for ensuring that it is a 'live' and accessible document.

The development and consultation process for developing the strategy was as follows:

Version	Actions	Format	Date of Version
1	Internal Consultation: 1. EDI Committee 2. ACP-UK Board of Directors 3. Internal groups invited to contact for individual feedback to consultant. Consultation activity and outputs: Strategic aspirations, goals and aims developed through consultation discussions with ACP-UK Organisation groups	Large group discussions Individual and representative Written feedback	11.10.21
2	Internal Consultation 1. EDI Committee 2. ACP-UK Board of Directors 3. ACP-UK Organisational Group Members Consultation Group 4. Internal groups invited to contact for individual feedback to consultant directly or written form. Comments and feedback incorporated into Version 2.1	Group feedback Written feedback	19.11.21
2.1	Public Consultation Format of survey and qualitative responses on Ver. 2.1 circulated. EDI committee review and recommendations incorporated into Version 3.	Feedback via Qualtrics EDI Committee review of Public Consultation with recommendations for revisions.	25.11.21
3	Final strategy completed for Board of Directors approval		25.1.22
4	Regular review		12.2.24