RACE, MORALITY, MORAL DISTRESS AND CLINICAL DECISION MAKING AMONG MENTAL HEALTH PROFESSIONALS

Emily Mortimer

A thesis submitted in partial fulfilment of the requirements of the University of East London for the degree of Professional Doctorate in Clinical Psychology

August 2022

ACKNOWLEDGEMENTS

Firstly, thank you to everyone who took part in, shared or encouraged this study. Your generosity, time and willingness to share your experiences is hugely appreciated.

Thank you to my supervisor, Dr Trishna Patel, for sharing some of your never-ending wealth of knowledge. I am extremely grateful for your support, kindness, positivity and patience.

Thank you to all the people who have helped me to begin to understand the intricacies of the world of psychology. It is always a privilege to hear your stories.

And finally, thank you to my family and friends for the laughs, the ears, the feet and the paws.

ABSTRACT

Background: Clinical decision-making (CDM) in mental healthcare is both evaluatively and ideologically complex. Literature has demonstrated that such decisions are often morally challenging; mental health professionals (MHPs) draw on a wide range of values and professional/ personal factors to make decisions. It has further been suggested that dominant discourses and normative attitudes, namely racial attitudes, continue to influence structures and practices within CDM, thus contributing to the racial disparities evidenced across the spectrum of mental healthcare.

Aims: To explore associations between sociodemographic and professional factors and moral values, moral distress and CDM in mental healthcare. In particular, to explore the influence of racial attitudes on CDM processes.

Methods: A cross-sectional design was used. A sample of adults working in UK mental healthcare (n=450) were recruited online through convenience and purposive sampling. Participants were presented with seven vignettes to assess CDM and racial bias, and completed series of measures concerning demographic factors, moral values, moral distress and racial attitudes.

Results: Findings highlighted significant variation in participants endorsement of the seven moral values measured, in moral distress scores and in CDM. The overall level of moral distress was relatively high (mean MMD-HP score = 98.82). A number of professional and sociodemographic factors were found to predict CDM. Colour-blind racial attitudes were most consistently associated with CDM. Additionally, racial attitudes influenced CDM indirectly; greater endorsement of the moral values of deference and group loyalty increased the influence of racial attitudes on CDM.

Conclusions: There is significant variation in CDM processes among MHPs; decisions are influenced by a range of factors and are often morally challenging. While moral distress may be one consequence of the broad and ideologically complex nature of CDM in mental healthcare, another is that this largely enables decisions to be shaped by dominant discourses, namely, racial attitudes. Thus, the whiteness present within society is reflected in mental health CDM.

TABLE OF CONTENTS

LIST OF ABBREVIATIONS

AHP = Allied Health Profession
ANOVA = Analysis of Variance
B = Racialised as Black
BPS = British Psychological Society
CBT = Cognitive Behavioural Therapies
CDM = Clinical Decision-Making
CFI = Comparative Fit Index
CoBRAS = Colour-Blind Racial Attitudes Scale
CYP = Children and Young People
DSM = Diagnostic and Statistical Manual of Mental Disorders
HCPC = Health and Care Professions Council
IAPT = Improving Access to Psychological Therapies
ICD = International Classification of Diseases
M = Mean
MAC = Morality-as-Cooperation
MAC-Q = Morality-as-Cooperation Questionnaire
MHA = Mental Health Act (1983)
MH = Mental Health
MHP = Mental Health Professional
MMD-HP = Measure of Moral Distress for Healthcare Professionals
NHS = National Health Service
NICE = National Institute for Health and Care Excellence
Ref. = Reference category
RMSEA = Root Mean Square Error of Approximation
SA = Racialised as South-Asian
SD = Standard Deviation
SEM = Structural Equation Modelling
SRMR = Standardized Root Mean Squared Residual
UK = United Kingdom

US = United States

V1 = Vignette 1

V2 = Vignette 2

V3 = Vignette 3

V4 = Vignette 4

V5 = Vignette 5

V6 = Vignette 6

V7 = Vignette 7

W = Racialised as white

WEIRD = Western, Educated, Industrialized, Rich, Democratic

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICIES

1. INTRODUCTION

1.1. Overview

An outline of the current context and complexities within mental healthcare decision-making in the United Kingdom (UK) are initially presented. It is subsequently proposed that both the growing complexity and value-laden nature of clinical decision making (CDM) in mental healthcare means that it is an inherently morally challenging, subjective and ideologically driven process. Mental health professionals (MHP) are required to draw on a range of values, principles and resources to make decisions; these are influenced by normative assumptions and dominant discourses, which are often embedded within structures of whiteness. A literature review exploring the relationship between values, CDM and racial bias/ attitudes in mental healthcare is subsequently presented.

1.2. Terminology

1.2.1. Moral Judgements

Moral judgements express a state or belief (Hume, 1978) and may function to preserve the social anchoring of what is ‘right’ and what is ‘wrong’ (Ellemers, 2018). In healthcare, moral judgements may be defined as those which involve a clinical decision which encompasses the healthcare professionals (HCPs) personal and professional beliefs about what is right and wrong, in addition to an overarching goal of upholding ethical practice (Campbell, 2007).

Within the literature, there are instances in which definitions of ethical and moral judgements differ and other instances in which they are used interchangeably. In those which differ, ethical judgements tend to relate to a system of principles used to guide action, while moral judgements concern normative and value judgements (Barker, 2010; Raphael, 1981). The present research is predominantly concerned with the latter.

1.2.2. Moral Distress

Moral distress encompasses the emotions elicited from moral dilemmas which challenge an individual's moral integrity (Fantus et al., 2017; Vacroe et al., 2012). Moral distress occurs when the person feels unable to act according to their personal and professional values, and/ or code of ethics, whilst assuming little power to alter the situation, for instance due to institutional constraints (Bruce et al. 2015; Epstein et al., 2019). This is closely linked to the concept of moral injury, which refers to the psychological, interpersonal and behavioural effects of perceived violations to an individual's deep moral beliefs (Jinkerson, 2016; Litz et al., 2009). Although varying definitions of both concepts have been offered, moral distress and moral injury are thought to be distinct in that moral injury refers to the immediate effect/ harm of an event violating one's moral or ethical code. Moral distress, on the other hand, encompasses the ongoing effects of various violations to one's moral codes, including the impact of continual organisational oppression (Day et al., 2021). The present research is primarily interested in the concept of moral distress.

1.2.3. Race

Race has been defined in numerous ways throughout history. The modern concept of race emerged in the seventeenth century and is linked to colonial and imperial ways of viewing the world; including the justification of violence and oppression against particular groups (Pilgrim & Patel, 2015). The concept arose from white European attempts to gain power and influence science by defining race in terms of skin colour and physical difference (Ryde, 2019). The term has no inherent biological or physical basis (Helms, 1995; Smedley & Smedley, 2005). Rather, race is a socio-political construct used to group individuals who hold similar heritages, physical traits, cultural attributes and historical treatments (Omi & Winant, 1993).

Although conceptually different, race and ethnicity are often used interchangeably. Like race, ethnicity is socially constructed and its meaning has varied depending on time and place (Oni & Winant, 2015). Ethnicity may be understood as encompassing the social group a person associates with or is recognised as belonging to by others, influenced by a range of factors, including cultural identities (Bhopal, 2004).

Within the present report, specific races or ethnicities will be used if this is available within the literature. Alternatively, the term racialised will be used to describe individuals who are not white, and whose identities have been ascribed racial meaning in order to uphold and maintain structures of whiteness (Patel, 2021). The present research is predominantly concerned with the construct of race, upon the understanding that healthcare disparities and associated biases and attitudes are a result of the social process of racialisation, linked to historical, social and political contexts.

1.2.4. Racism

Racism stems from the conceptualisation of the term race and the seventeenth century ideologies promoting a social hierarchy based on skin-colour (Roy, 2001; Saini, 2019). Broadly, racism relates to the exclusion, marginalisation or inferiorization of individuals or groups as a result of supposed physical, cultural or symbolic difference (Golash-Boza, 2016). Racism has evolved with the changing socio-historical and political contexts; it is understood that different groups have been racialised throughout history, though, the effects of racism are consistent (Delagado & Sefancic, 2000; Garner, 2017). Racism operates across multiple levels and takes many forms; it operates both overtly and covertly, institutionally and structurally (Berman & Paradies, 2010; Saini, 2019).

1.2.5. Whiteness

Whiteness pertains to the socialisation processes and practices, laws and privileges which favour white racial groups over others (Helms, 2017). Racial power is upheld and reproduced by systems, structures and practices through the normalisation and centralisation of whiteness (Guess, 2006; Neely & Samura, 2011). Whiteness is ubiquitous, yet remains somewhat invisible whilst enabling both the privileging of those who are racialised as white, and the othering of those who are not (Patel, 2021). It maintains and perpetuates inequality, injustice and structural power (Baima & Sude, 2020), and intersects with various axes of inequality (Crenshaw, 1989).

1.3. Clinical Decision Making in Healthcare

The National Health Service (NHS) Constitution states that those accessing services should expect decisions about their care to be made rationally, systematically and consistently. Decisions should be underpinned by evaluation of available evidence and care provided equally and rationally, across patient groups and in light of competing demands (NHS, 2013; NHS Constitution for England, 2021). HCPs are expected to uphold ethical practice at all levels of CDM, drawing on the four key principles of autonomy, non-maleficence, justice and beneficence (Beauchamp & Childress, 2001) and relevant guidance, such as the HCPC Standards of Conduct Performance and Ethics (HCPC, 2018).

Indeed, the National Institute for Health and Care Excellence (NICE) was established in 1999, with the aim of creating more equal care by recommending the most effective clinical practices across England and Wales through the use of evidence-based practice (Rawlins & Culyer, 2004). NICE guidelines are continually updated, derived from the judgement of available evidence, and can be used to guide treatment decisions on the basis of an individual’s presenting difficulties or diagnoses (NICE, 2021).

In addition to the evaluation of the growing evidence-base, the concept of shared decision making, a process in which the HCP and client work together to reach a clinical decision, has gained substantial traction in healthcare policy. Shared decision-making hinges on the ethical principle of autonomy and is consistently named as a fundamental tenet in healthcare decision making and forms a key part of the NHS Long Term Plan (NHS England, 2019).

1.3.1. Complexity in Mental Health Decision-Making

Decision-making in mental healthcare is becoming ever more complex and various factors, including a growing demand for services and competing needs, pose threats to the notions of rational systematic and shared decision making. A selection of these factors will be explored below.

1.3.1.1. Resource prioritisation

A significant influence on healthcare decision making is resource prioritisation. The NHS has been significantly impacted by years of under-funding, with cuts to most departments' expenditures being evidenced over the last ten years (Marmot et al., 2020). Mental health services specifically, have been consistently underfunded and current funding commitments are insufficient to meet demand (O'Shea, 2021). As a result, healthcare decisions often involve rationing, operating at multiple levels – individual, departmental, organisational, societal and commissioning levels.

In light of resource prioritisation, various ethical frameworks have been drawn upon to facilitate decision-making processes. For instance, in line with both shared decision-making and the four principles of clinical ethics, outlined above (Beauchamp & Childress, 2001), MHPs often attempt to uphold deontological ethical philosophies, endeavouring to minimise harm and maximise autonomy by involving clients in their treatment planning. In practice, however, clinical decisions are often driven by utilitarian ethical practices; those which understand the moral choice to be that which benefits the greatest number (Mandal et al., 2016). Utilitarianism approaches have been subject to various criticisms, including that decisions based solely on a cost-benefit analysis have little moral bearing and can therefore justify potentially unjust or unfair decisions on the basis of maximising utility (Buchanan, 2009). In addition, these approaches tend to favour those with greater socioeconomic and medical advantage and therefore, often maintain inequity by disparately impacting multiple already disadvantaged groups (Allwood & Bell, 2021).

1.3.1.3. The law

The intersect between CDM and the law also warrants consideration. All public functions, including the NHS are required to abide by the Human Rights Act (1998). Yet, the various ways in which this has been interpreted and applied across mental health systems, considerably influences the priorities and conditions under which clinical decisions are made. For instance, under Article 2, everyone's right to life should be protected by the state. The Mental Health Act (MHA; 1983) is consequently used to justify the detainment of those deemed to be at risk of harm to themselves or others. Contending with this, however, is the right to liberty, security and personal freedom (Article 5), as under the MHA, mental health remains the only area of healthcare in which people can be treated against their will, regardless of their assessed capacity (DoH, 2008).

In order to combat this discrepancy, notions of capacity and consent are drawn upon to facilitate CDM. For example, the Mental Capacity Act (2005) was designed to protect individuals who may have difficulties in making decisions about their care, and support them to uphold a level of autonomy and empowerment. All of the above Acts and Codes however, rely on subjective judgements of impairment and adequate resources to carry out appropriate assessments (Coggon & Kong, 2021; Scott et al., 2020). Indeed, in a largescale UK-based review, it was suggested that there is a limited understanding of how to promote and apply statutory guidance amongst providers. As a result, the use of this guidance to facilitate CDM is inconsistent, often at the detriment of the empowerment and involvement of clients regarding decisions about their care (CQC, 2019).

1.3.1.4. Diagnostic classifications

The creation of psychiatric classification frameworks is based upon logical-empiricist ideology. Using the same ideals as medical theoretical frameworks, they aim to map symptoms of disorders onto corresponding diagnoses (e.g. Regier et al., 2011). Diagnostic classifications, including the International Classification of Diseases (ICD; WHO, 1993) and the Diagnostic and Statistical Manual of Mental Disorders (DSM; APA, 2013) frame and present concepts of mental illness and are generally used to make clinical diagnoses and subsequent clinical decisions. These manuals are not only used by MHPs, but also shape the way in which individuals, public institutions, policy and the law understand and interpret concepts of mental illness (Sadler, 2002).

However, in the absence of underlying pathology, mental health diagnoses were created through a process of observation and tend to consist of subjective beliefs, experiences and appraisals of behaviour (Boyle & Johnstone, 2014; Porter, 2002). There exists therefore, a contention between the positivist-empiricist theories of science, upon which these manuals are based, and the descriptive and evaluatively-complex nature of the diagnostic categories (Proctor, 1991). More specifically, mental health disorders are abstract entities which cannot be directly observed and therefore, understandings of these disorders will always be shaped by human interpretation and the imposition of values (Sadler, 2005). Indeed, diagnostic categories have failed to attain widespread consensus, despite the extensive use and research into their proposed concepts (Phillips et al., 2012). Arguably, the ontological and epistemological issues present within mental health diagnoses means that achieving widespread consensus is not conceptually possible (Phillips et al., 2012).

1.3.2. Principlist and Values-Based Approaches

One way of responding to the challenges and complexities of CDM in mental healthcare is by adopting a principlist approach, as proposed by Beaucham and Childress (2001). This approach draws on the ethical principles (autonomy, non-maleficence, justice and beneficence) as a framework for resolving moral dilemmas, and has been widely used within various healthcare fields, including mental health. It is argued that these principles are reflective of common morality and are correlative to human rights. Equally however, it has been suggested that focusing on general ethical principles alone is not sufficient to manage the moral complexities present in mental healthcare (Clouser & Gert, 1990; Morgan et al., 2015; Nimmagadda et al., 2017).

An alternative approach to responding to the challenges of CDM in mental healthcare is using a values-based approach (Fulford, 2004). Values are understood to be broader that ethics, in that they encompass one’s needs, preferences and wishes, as well as the diverse ways in which these are expressed (Von Wright, 1963); they are action-guiding attitudes or dispositions which are fundamental to decision-making (Sadler, 1997).

Values-based approaches are grounded in the recognition of the diversity of values held by MHPs, clients and others involved in decision-making processes (e.g. Moyo et al., 2016), which means that logically, conflicts over values will be the norm. The approach suggests that CDM often fails to account for the fact that MHPs own values play a considerable role in determining the most appropriate course of action (Inguaggiato et al., 2019; Woodbridge & Fulford, 2004).

A key difference between principlist approaches and values-based approaches with regards to issues of morality, is that values-based approaches assume that we cannot rely on evidence and quasi-legal regulatory ethics to solve moral dilemmas and differences of values. Rather, a crucial skill in CDM is acknowledging and working with these differences in order to foster genuine, collaborative communication that is sensitive to the diverse values at play; particularly in situations eliciting moral uncertainty (Fulford, 2004; Woodbridge & Fulford, 2004). The current research focuses on moral values in particular, although it is acknowledged that the notion of values as a whole encompasses a far wider set of principles and belief-systems.

1.3.3. Moral Distress

The numerous competing values operating within various levels of mental healthcare, as well as the difficulties MHPs may face when attempting to address the complexities of mental health CDM through existing ethical frameworks and guidelines alone may elicit moral distress. Indeed, moral distress frequently occurs when HCPs feel unable to practice in accordance with their values (Jameton, 1984; McCarthy & Gastmans, 2015).

The considerable prevalence of moral distress in healthcare settings has been well documented, including within mental healthcare (Austin, et al., 2008; Ohnishi et al., 2019; Lomis et al., 2009; Lützen et al., 2010). In line with the various factors associated with the complexity in mental health CDM, as above, moral distress has been shown to relate to a lack of resources; professional, ethical and legal conflict; observing cultural harm; working within structures which inhibit the ability to work by one's moral values; and ideological/ professional differences in conceptualisations and treatments of mental distress (Austin et al., 2003, 2008; Deady & McCarthy, 2010; Jansen et al., 2019; Sprigings, 2021; Morgan et al., 2019). Moreover, attending to moral distress within CDM is important as it can significantly impact on staff wellbeing (Konttila et al., 2021), has been associated with the intention to leave a position (Hamric et al., 2012), and can affect client care; particularly if it results in MHPs distancing or disconnecting from the work (Deady & McCarthy, 2010).

1.4. Moral Judgements in Mental Healthcare

In accordance with the concept of moral distress, various moral dimensions exist within mental healthcare CDM – for instance, decisions frequently concern the intersect between moral decision making, individual values, healthcare ethics and the law (Popescu, 2015; Schulberg & McClelland, 1981).

Moral judgements are commonly thought to involve: the recognition of the moral rules attached to the given situation, the retrieval of appropriate moral schemas and the development and evaluation of possible moral responses (Cohen, 2004; Garrigan et al., 2018; Kohlberg, 1984; Vaughn, 2008). Moral judgements therefore differ from other forms of reasoning because they are driven by moral schemas and frameworks, including moral rules, values and knowledge. CDM often involves moral judgements and is influenced by moral values (Campbell, 2007; Grace et al., 2003; Tjeltvet, 2016). Accordingly, associated theories of morality are explored below.

1.4.1. Conceptualising Morality

Early rationalist theories of morality support the notion that moral judgements can be applied universally, in a logical and deductive manner (e.g. Kohlberg 1969; Piaget 1932). They suggest that a developmentally ordered set of strategies are used to interpret moral scenarios and subsequently to make a moral judgement (Kohlberg, 1981). More recently however, literature has highlighted the role of emotions, culture, norms and values in predicting social and moral behaviour (Haidt & Graham, 2007; Greene 2015; Kahneman, 2002). In line with the latter body of work, the Moral

Foundation Theory (MFT; Haidt & Graham, 2007), and associated Moral Foundations Questionnaire (MFQ; Graham et al., 2011) has been extensively used to measure and study domains of morality. However, the proposed five-factor model of morality has not been widely supported by empirical studies (Graham et al., 2011; Kim et al., 2012; Nilsson & Erlandsson, 2015). Furthermore, the MFT is not explicitly based upon an underlying theory meaning that making principled predictions about morality and its effects are considerably limited (Curry, 2016).

1.4.1.1. Morality-as-Cooperation

A recent alternative theory of morality is the morality-as-Cooperation (MAC; Curry, 2016). The MAC posits that morality functions to promote cooperation. Social, cooperative and altruistic behaviour develops through biological and cultural mechanisms, motivating individuals to value and actively seek out mutually beneficial outcomes. The various ways in which individuals do this, influenced by human instincts, institutions and inventions, represents human morality (Curry, 2005; Curry, 2016).

As such, the MAC uses game-theory to explore discrete problems of cooperation and associated resolutions in order to generate a moral framework and develop novel predictions about various facets of morality (Curry, 2016). The theory assumes that there are multiple ways of resolving cooperation problems, and presents seven widely-recognised forms of cooperation: helping family, helping group, social exchange, conflict resolution through 1) hawkish and 2) dovish displays, division of resources and respecting possession. Subsequently, these forms of cooperation give rise to seven types of morality: family values, group loyalty, reciprocity, heroism, deference, fairness and property rights. Solutions to each of the problems of cooperation are thought to result in mutually beneficial outcomes, helping to explain why we value certain traits, viewing them as morally good. Unlike previous theories, such as the MFT, the MAC includes distinct domains relating to group loyalty, deference and fairness, all of which are arguably, relevant to CDM in healthcare.

In relation to how these moral values influence CDM in mental healthcare, it might be considered that clinical decisions often involve multiple competing interests, including the best interest of the client, limited resources and pressures from various levels of the system. In order to solve these problems of cooperation/ conflicts of interest, MHPs may draw on their moral values to appraise situations. There is however, no standardised way of doing this nor is there a single set of moral principles which guide CDM. Rather, the facets of morality are thought to be functionally and psychologically distinct and the degree to which an individual endorses each type of morality can vary independently (Curry et al., 2019a).

In addition, the moral values proposed by the MAC can be observed across a range of cultures and societies (Curry et al., 2019b). However, the way in which one appraises situations, balances between societal and individual interests, and consequently resolves conflicts/ problems of cooperation (makes moral decisions) are likely to be influenced by more than simply the presence or endorsement of particular moral values.

1.4.2. Variation in Moral Judgements

Indeed, various factors, including cultural and relational circumstances, may influence the concerns, interests and motivations which fundamentally drive moral decisions, including those operating within healthcare contexts (Berg et al., 2021; Grace et al., 2020; Weidman et al., 2020). A selection of factors influencing moral judgements within CDM in mental healthcare are presented below.

1.4.2.1. Values

Value priorities have been shown to influence the factors used to appraise clinical situations (McCabe et al., 1992; Moyo et al., 2019). For example, one United States (US) study found that medical students who prioritised values of universalism showed greater moral decision making than those who prioritised values of power (Helkama et al., 2003). There are however, very few studies directly exploring the relationship between values and CDM. None of these directly explore moral values and all have been conducted within medical settings outside of the UK. A potential reason for the limited research here is that there is considerable variation in whether MHPs believe that values (moral values specifically) influence decision-making. One study, which was conducted in the UK, suggested that only half of those asked believed moral values to be important in CDM. The majority felt that patients' rights and MHPs legal duties took precedence over moral values (Armstrong et al., 2000).

1.4.2.2. MHP-related factors

A number of MHP-related factors have been shown to impact on moral judgements and CDM. There tends to be an agreement among MHPs that decisions should be grounded in the client's best interest (Buckloh & Roberts, 2001; Gonyea et al., 2014). Yet, in practice, MHPs assessment of the presenting problem and subsequent treatment decisions often differ between MHPs (Garb, 2005; Kuyken, 2006).

It has been suggested that workplace setting may impact CDM processes, for example by influencing views around the acceptability of utilitarian practices (Buckloh & Roberts, 2001). A selection of research, predominantly conducted in the US, has found associations between years working in mental health and moral judgements (Haas et al., 1988; Tarvydas, 2001). With regards to theoretical orientation, it might be considered that different mental health disciplines will have different understandings and teachings regarding how to apply the fundamental ethical principles of healthcare, therefore influencing CDM processes (Peay, 2003; Stone, 2019). Equally, it has been suggested that professional background alone, cannot account for the variation in MHPs moral values/ judgements (Stone, 2019) and one study found that over half of MHPs asked believed that MHPs from differing professional backgrounds require the same values to make successful clinical decisions (Armstrong, 2000). Furthermore, the influence of MHPs own sociodemographic factors on CDM has been noted in studies conducted in both the US and UK, particularly in morally challenging situations (Buckloh & Roberts, 2001; Quirk, 2003).

1.4.2.3. Cultural and contextual factors

The context in which CDM takes place has been shown to influence moral judgements (Ferencz-Kaddari et al., 2016). This may be influenced by the organisational culture (Luke et al., 2017) or by high-pressure environments (Hinkeldey & Spokane, 1985; McGuire et al., 1995). In addition, family values, cultural and societal norms and religious teachings may influence the endorsement and expression of particular moral values (Knapp & VandeCreek, 2007). For example, it could be argued that individualistic cultures, such as WEIRD (Western, Educated, Industrialized, Rich, Democratic; Henrich et al., 2010) societies, are more likely to endorse individualistic moral values, whereas collectivist or community-based cultures may endorse moral values relating to the protection of social order or group interests (Graham et al., 2016; Li & Vermillion, 2006). Drawing on ideas from the MAC, balancing individual vs. group interests in order to promote cooperation underpins morality (Curry et al., 2019a). It follows that differences in cultural understandings regarding how to achieve this balance may result in differing moral judgements and thus, differing CDM.

1.4.2.4. Power

It has been argued that power is inextricably linked to ethical and moral issues (Lerman, 1994). Therefore, any approach to understanding moral and ethical healthcare practice should consider the imbalances of power present in our mental health systems (Morgan et al., 2015). At the individual level, moral dilemmas involving threats to autonomy, through the use of coercion or restraint, generally involve expressions of power (Arnold, 2001).

In terms of epistemic power, the dominance and reliance on evidence-based practice in mental healthcare and CDM should be considered. Returning to the NHS's application of the NICE guidelines, outlined in Section 1.3, the epistemological position under which these guidelines are produced should be explored. Research and evidence are largely grounded in positive epistemology and are concerned with objective fact (Bryman, 2008; Hyman, 2010). NICE, as well as many other influential research bodies, employ a hierarchy of evidence, in which randomised controlled trials are thought to be 'gold standard'. However, this research tends to privilege certain models and methods of conceptualising mental health and is often based on WEIRD populations, which account for merely five percent of the population worldwide (Arnett, 2008). Therefore, CDM directed by the current evidence-base is a potentially compromising practice, supporting epistemic and moral authority (Kerridge, 2010). That is not to suggest that the evidence-base does not have some utility, but it is to say that using it to create standardised, prescriptive guidelines obscures the distinction between fact and value. In doing so, this largely silences alternative views, conceptualisations and opinions which may otherwise be used to facilitate meaningful and ethical CDM.

Considering ideological power, the value-laden nature of mental health diagnosis and associated treatment should be explored. For example, many mental health diagnoses require normative judgements of behaviour. The DSM-V criterion for schizophrenia and psychotic disorders for instance includes the presence of disturbances which cause an 'impairment' to the person's functioning (APA, 2013). Therefore, in order to make a diagnosis, MHPs are required to form a value-judgement regarding whether the behaviour is indeed an impairment. Similarly, when judging the perceived suitability for psychological treatment, MHPs may assess a client's capacity to reflect and think, their communication skills and their enthusiasm (Nakajima et al., 2021). These judgements are all arguably, value-laden and based on the MHPs normative assumptions of how a 'suitable' client presents. A particular concern here, is that normative assumptions are largely influenced by individual values and wider contexts (Okasha, 2000); subsequent CDM is therefore, inherently linked to the socio-political contexts (Fernando, 2014; Moncrieff, 2010; Spandler & Anderson, 2015; Thakker & Ward, 1998). Moreover, diagnostic criterion and clinical judgements are not in themselves, wholly invalid, for example if they validate individual experiences or aid access to relevant support (Norman & Ryrie, 2018). However, a failure to acknowledge the conceivable diversity of values present in mental health diagnosis and treatment means that clinical judgement and interpretations of behaviour are largely based on Western norms and ideals.

In addition, the mental health field holds significant power in relation to its influence on determining concepts of mental ‘dysfunction’, or, alternatively determining optimal ways of being human. Thus, an ignorance of the pervasiveness of Western ideals within these conceptualisations is in itself, a form of cultural imperialism (Christopher & Hickinbottom, 2008; Stam et al., 2015; Summerfield, 2013). This is likely to simultaneously disadvantage those who do not ascribe to the dominant culture, and maintain disparities by masking the inequalities of power in supposedly neutral concepts and ideas of mental health and impairment (Eagleton, 2007; Szasz, 1974).

Furthermore, both the enactment of cultural imperialism and the consequential inequalities within our mental healthcare systems may be less apparent to those who ascribe to the dominant culture. Thus, the power and pervasiveness of whiteness evident both in various mental health disciplines (e.g. clinical psychology; CHPCCP, 2020) and in professional hierarchies (e.g. Ross et al., 2020) can preclude even the recognition of various power and race inequities.

1.5. Racism in mental healthcare

The epistemic injustices discussed above have allowed and continue to allow various axes of inequality to exist and persist (Fricker, 2007; Spivak, 1998). The present research will focus on racial disparities specifically, although it is acknowledged that these disparities are inherently intersectional (Crenshaw, 1989).

1.5.1. Brief History and Context of Racism in Mental Healthcare

Considering the ideological power operating within our mental health system, a brief overview of the history will be explored. Race and racism are entwined in the history and origins of our current mental health system. From the 17th Century, eugenicists used theories of biology and genetics to create racial diversions within society, including ideas relating to moral and psychological character and intellect (Fernando, 2017; van den Berghe, 1967). Racist ideologies were absolute and influenced the way in which mental health and distress were conceptualised (Fernando, 2017). Whiteness, has subsequently contributed to the persistence of racial discrimination, through the privileging, ‘normalisation’ and centralisation of whiteness (Guess, 2006; Neely & Samura, 2011). While these ideas are rooted in scientific racism, they continue to prevail in today’s society across multiple levels – individually, institutionally and structurally (Patel, 2021; Saini, 2019).

A recent example of this includes the government report of the Commission on Race and Ethnic Disparities (2021) and their subsequent response (HM Government, 2022). While the response does go further in acknowledging racial disparities than the initial report, which wholly denied the existence of systemic and institutional racism, it continues to largely neglect institutional, systemic and socio-economic issues, focusing on micro-level approaches to addressing racism. Thus, the current socio-political context continues to largely disadvantage racialised people through the masking and silencing of the very real experiences of racism at multiple levels.

In mental healthcare specifically, attempts to address racial equity and racial justice are by no means novel, and have been made numerous times throughout history. For example, in 1970, Sabshin et al. (1970) established actionable antiracist recommendations for psychiatry, acknowledging the influence of history, social structures and how every day practices enable racism in psychiatry. Nonetheless, little has changed since this time and the field of mental health has arguably, not yet gone far enough to address the systemic and institutional power dynamics which sustain racism in our mental health systems (Mensah et al., 2021; NHS Confederation, 2012).

1.5.2. Disparities in Mental Healthcare

As such, racial disparities continue to prevail across the spectrum of mental healthcare, including in mental health prevalence, access, assessment and treatment (Bignall et al., 2019).

Underlying these disparities is the pervasive presence of whiteness and institutional racism. This relates to the way in which institutions, ideologies, systems and processes interact to uphold racism, both overtly and covertly, either through the acceptance of racist actions or the exclusion of those which might rectify the situation (Patel et al., 2000). Also, to the operations of power within institutions and society which seek to normalise, minimise or omit the centrality and benefits of whiteness (Assari, 2018). Whiteness and racism function within various mutually reinforcing systems, including health, social, economic and judicial systems (Flacks, 2018; Joseph-Salisbury, 2021; Nussbaum, 2019).

Moreover, whiteness operates across all systemic levels and thus, racialisation does not function as a discrete entity, but as a dynamic process, scaffolded through historical and ideological processes. Through whiteness, these processes continue to influence the way in which individuals experience the mental health system (Bhui et al., 2018) and often reinforce discriminatory beliefs, practices, values and ideas (Bailey et al., 2017). While the processes by which whiteness operates remain relatively unspoken, its effects can be seen across various levels of our mental health system, as below.

1.5.2.1. Access

Numerous studies have highlighted racial disparities in accessing mental health services in the UK. Studies have shown that clients from racialised backgrounds are less likely to be referred for psychological therapies compared to their white counterparts (Karlsen, 2007; Mental Health Foundation, 2016; Toleikyte & Salway, 2018) and are more likely to be dismissed by mental health services (Rethink, 2004). More specific examples from studies investigating UK mental healthcare include evidence that Pakistani women are less likely to be referred and treated by IAPT services (Kapadia et al., 2017). Also, that within maternity mental health services, Black African, African Caribbean and Asian women are likely to be asked about their emotional health and therefore are less likely to be offered psychological treatment (Redshaw & Henderson, 2016). These differences however, are largely in contention with the disproportionate rates of mental health diagnoses in various racialised groups (discussed below; section 1.5.2.2.). This brings to question whether CDM regarding treatment access is at least in part, influenced by value-judgements. This includes normative judgements about the perceived suitability for treatments which are predominantly based upon Western, Eurocentric models and concepts (e.g. Nakajima et al., 2021). Arguably, both the pervasiveness of Western ideals within current mental health systems, as well as the influence this has on the normative assumptions and discourses which play out in CDM, can create disparate barriers to accessing mental health services.

1.5.2.2. Assessment

With regards to mental health assessment, studies conducted in the UK have consistently found that Black Caribbean and Black African clients, particularly Black men, are up to three times more likely to be diagnosed with a psychotic disorders and schizophrenias, compared to their white counterparts (Bhui, 2016; Fearon et al., 2006; Lawrence et al., 2021). Additionally, a systematic review of empirical studies conducted in the UK suggested that diagnoses of depression and anxiety are higher amongst Black and South Asian groups (Rees et al., 2016). In consideration of these disparities, the potential influence of social and historical contexts within current conceptualisations of mental health should be acknowledged (Cromby et al., 2013). For example, with regards to diagnoses of psychotic disorders and paranoia, it should be considered that for racialised clients, a mistrust of services in light of the history of systemic racism in mental health and ongoing experiences of discrimination (both overt and covert; Combs et al., 2006; Read, 2004), is an adaptive and appropriate response. However, diagnostic criterion tends to be based on Western assumptions of normality and rarely takes such contexts into account. Therefore, these behaviours are often pathologized and judged as a symptom of a mental health disorder (see Mills & Fernando, 2014; Read et al., 2004), thus contributing to the maintenance of racial disparities in mental health assessment.

In addition, Adams et al. (2014) suggested that MHPs tended to make a greater number of inferences for racialised compared to white clients when making decisions regarding the assessment and diagnoses of depression. It was suggested that the increased number of inferences may reflect greater clinical uncertainty. Here, the ideological power within the UK's mental health system, which largely centers white, Eurocentricity and operates within assessments/ conceptualisations of distress and diagnostic categories should be considered (Eagleton, 2007; Kline, 2014; Szasz, 1974). For instance, it may be suggested that the systemic underrepresentation of racialised groups and associated forms of cultural imperialism results in greater clinical uncertainty within MHPs judgements when working with racialised clients. There is however, limited research in this area, all of which has been conducted in the US.

1.5.2.3. Treatment

The use of psychiatric drugs and the depot injection have been shown to be higher amongst Black, Asian and racialised clients, compared to white clients (Das-Munshi et al., 2018). In addition, evidence suggests that in some areas of the UK, Black African and Black Caribbean clients are twice more likely to be sectioned under the MHA and are likely to be detained for longer periods of time (Mohan et al., 2006; NHS Digital, 2021; Singh et al., 2014). One reason for the increased frequency of more aversive/ less autonomous treatments may be that the systematic disadvantaging of racialised clients with regards to service access and assessment creates disparate barriers to accessing early support.

Going further than this, the applicability and generalisability of mental health treatments across cultures should be considered. For instance, most of the dominant models of mental health in the UK adopt the Eurocentric idea that social problems and mental health difficulties can be treated through individualistic therapies (e.g. David et al., 2018). This may not reflect the realities or practices held across cultures (Afuape, 2016) and may influence clients experiences of services and of therapy (e.g. Devonport et al., 2022; Yasmin-Qureshi & Ledwith, 2020). Yet, the Western cultural underpinnings of current mental health treatments are rarely acknowledged within services. Instead, explorations of these disparities often focus on the groups or communities who are underrepresented within mental health treatments, rather than on the applicability of services to meet various cultural needs; for instance, by labelling groups as 'hard to reach' (Islam et al., 2021; Lightbody, 2017). In turn, such narratives do little to address disparate experiences occurring within treatment and furthermore, can prevent the cultural imperialism often present within CDM processes, from being acknowledged and/ or acted upon (Mensah et al., 2021).

1.5.3. Clinical Decision-Making and Racial Disparities in Mental Healthcare

As noted above, number of these disparities may be driven by the impact of ideologies, assumptions, bias and healthcare systems which reproduce and maintain structures of whiteness, yet which situate themselves under a guise of neutrality (Eagleton, 2007). At the individual level, whiteness can manifest in the decision-making processes and underlying assumptions of MHPs, though often implicitly. For instance, failing to recognise the normative sociocultural standards under which these ideas and judgements are made risks essentialising and pathologizing difference (Mills & Fernando, 2014; Patel, 2021).

In terms of assessing racial bias in CDM, the implicit nature of whiteness means that understanding the ways in which racial disparities arise using empirical methods is inherently challenging. A predominant method used to empirically assess clinical-judgement bias is the vignette method. This method presents short hypothetical depictions of clinical scenarios to participants and can be used to study potential biases by manipulating variables of interest (Aguinis & Bradley, 2014; Evans et al., 2015). Indeed, a systematic review of the utility and validity of vignette methodologies concluded that vignette studies can be a useful tool for identifying bias in clinical scenarios (Evans et al., 2015). They may, for example, reflect behavioural intentions or decision-making processes more accurately than interviews or data extracted from clinical records (Peabody et al., 2004; Shah et al., 2010).

A number of vignette studies attempting to capture the racial disparities present within the UK mental health system have been conducted, indicating differences in MHPs judgements of the hypothetical client by race. Several of these studies found that clients from a racialised background were less likely to be offered intensive or direct psychological treatments in comparison to their white counterparts (Jones & Williams, 2020; Chaudary, 2017; Currin et al., 2007). These clients were also being underdiagnosed for some mental health difficulties, including diagnoses of antisocial personality disorder (Mikton & Grounds, 2007) and the attribution of pain (Jones & Williams, 2020). One study further suggested that this relationship varied by the ethnicity of the MHP; MHPs from racialised backgrounds did not appear to show the same bias (Mikton & Grounds, 2007). A number of studies have however, found that vignette studies were not sensitive enough to pick up on racial bias in hypothetical CDM (Conolly & Taylor, 2016; Currin et al., 2007; Lewis et al., 1990; Littlewood, 1992).

1.5.4. Colour-Blindness

In addition to studies exploring racial bias in CDM, the influence of MHPs racial attitudes should also be considered. A further ideology which has supported the maintenance of whiteness and therefore, racial disparities is the colour-blindness movement. The concept of colour-blindness gained traction in the 1990's as an attempt to avoid racism by treating everyone equally, for instance, proposing that race should not be considered in decision making (Apfelbaum et al., 2012; Bonilla-Silva, 2006). Instead however, it obscured experienced of racism and failed to provide racially sensitive responses and services by treating everyone according to white-British norms. These attitudes have been shown to influence screening and treatment decisions in healthcare. For example, Okah et al. (2021) found that physicians who endorsed more colour-blind racial ideologies were more likely to use race-thinking in healthcare decision making.

Additionally, colour-blind ideologies have been associated with lower multicultural awareness and less racial sensitivity amongst predominantly white therapists (Burkard & Knox, 2004; Chao et al., 2011). A major concern with colour-blind approaches is that they allow racism to persist at multiple levels – at the systems level, they remove the discussion of whiteness, allowing institutional and structural racism to remain unchallenged (Gallagher, 2003). At the individual decision-making level, they prevent racist narratives, which might skew decision making processes, from being acknowledged and therefore acted upon (Mensah et al., 2021).

1.6. Literature Review

A scoping review was conducted to examine the current understanding of the relationship between values, CDM and racial bias/ attitudes in mental healthcare. Peters et al.'s (2020) guidance on scoping reviews was used to guide this process.

To identify relevant papers, the following databases were searched: EBSCO (including Academic Search Ultimate, CINAHL, PsycArticles and PsycInfo), Scopus and PubMed. Google scholar and reference lists were also utilised. Various alterations to the search strategy were made based on examinations of relevant search results. Initially, the search explored associations between CDM, race/ racism and moral values specifically. However, only four results were obtained, none of which were relevant to the present topic, so the inclusion criterion was expanded to include studies relating to all/ any values. Here, limiting the search to UK-based studies only resulted in only two relevant papers, therefore, the geographical limit was removed. Finally, there are significant limitations to combining the terms race, ethnicity and culture. However, given the limited research in this area and upon examination of various search results, it was thought that this would allow for a more in-depth understanding of the proposed topic. Included studies directly explored the effects of MHPs values on CDM and referred to whether MHPs consider the client's ethnicity, race or cultural factors in this process. The final search resulted in six relevant papers; four US- and two UK-based studies. Details of the searches conducted, including search terms, limiters, inclusion and exclusion criteria and a flow diagram are included in Appendix A.

1.6.1. US Studies

Four US studies exploring the influence of MHPs values on CDM in mental health, and referring to the influence of race or cultural factors in this process were retrieved. Schwartz (1975) examined the influence of racial bias and moral values amongst a sample of psychiatrists, using vignettes. Findings suggested that both racial bias and moral values individually influenced CDM. For some clinical decisions (vignette scenarios), an interaction effect between participants moral values and racial bias was also found. Specifically, participants holding less traditional moral values were more likely to recommend a less aversive treatment when the hypothetical client was described as white, compared to when they were described as Black, whilst those with more traditional values did not show the same bias.

Similarly, Chih (2001) used vignettes to explore the effects of racial bias and clinician values on CDM amongst a sample of counsellors. Values were measured using the Self-Construal Scale (assessing collectivist/ individualistic cultural values). Like Schwartz (1975), findings highlighted a significant effect of values; counsellors who held more collectivist values were more likely to draw upon clients contexts and worldviews when making decisions. No significant findings relating to the hypothetical clients race (described as Asian/ white) were found. Here, it was suggested that cultural factors related to the counsellors, rather than clients, were significant in CDM processes. For instance, participants identifying as Asian were more likely than white counsellors to endorse collectivist values, and therefore take contextual factors into account.

Again, Littleford (2007) employed vignettes to explore the influence of various factors, including participants values and multicultural awareness, on CDM. Participants provided both quantitative (Likert scale) and qualitative responses (rationale for their responses) to the vignettes and completed the Multicultural Counselling Knowledge and Awareness Scale (MCKAS). Findings suggested that participants relied mostly on their own values, immediate interests, personal feelings or judgement calls –above the use of formal guidelines and policy, and rarely considered the clients cultural background within CDM. In addition, regression analyses found that those who did consider the clients culture had more cultural knowledge and awareness (higher MCKAS scores).

In the fourth identified study, Stampley (2008) qualitatively explored the influence of social workers values and culture-based transferences on CDM. As with the above studies, findings suggested that participants values and internal conceptual frameworks were predominant in CDM. With regards to racial and cultural issues, the study identified a presence of negative cultural stereotypes within the counselling process.

Within clinical practice, participants tended to avoid topics which made them feel uncomfortable, including race, sociocultural and socio-political issues. Equally, participants described distancing or avoiding clients (referring away from counselling) if a presenting complaint did not fit with their conceptualisations of mental health and support.

Moreover, the above studies all suggest a significant role of both MHP values and racial attitudes within CDM. Nonetheless, the methodologies and potential limitations of these studies must be considered. Three of these studies used vignettes to operationalise CDM (Chih, 2001; Littleford, 2007; Schwartz, 1975), thereby allowing the highly complex process of CDM to be quantified and various factors associated with CDM to be explored quantitatively. With regards to the assessment of racial bias/ attitudes, two studies varied the race of the vignette-client and analysed differences in participants CDM (Chih, 2001; Schwartz, 1975). The validity of using this design as a method of detecting bias alone has however, been questioned. For instance, some have suggested it can inadvertently reveal the aims of the study, thereby leading to socially desirable responding and potentially underestimating the effects of racial bias (Evans et al., 2015). An alternative approach to assessing racial bias/ attitudes was taken by Litlleford (2007). Here, the MCKAS was used to assess the influence of participants cultural attitudes/ knowledge on CDM. A strength of this is that directly measuring participants knowledge/ attitudes potentially shifts the focus of the research towards the processes by which racial disparities occur (e.g. normative attitudes/ knowledge), rather than solely assessing the presence of bias, thereby holding greater clinical utility. It is also less likely to be affected by social desirability (Ponterotto et al. 2002). However, this scale focuses specifically on cultural factors relative to the counselling processes. This may not capture the extent to which wider societal discourses and worldviews influence CDM, as suggested by the above studies. Further research into CDM, employing scales which tap into participants more general attitudes and worldviews regarding issues of race and racism would therefore be of value.

Furthermore, the notion of values remains conceptually vague and methods of assessing values are considerably heterogenous. Stampley (2008) used solely qualitative methods to capture the role of MHPs values, whilst Lillteford (2007) attempted to code participants open-ended responses in order to quantify factors (including values) influencing CDM. Two studies explored the effects of specific values; Chih (2001) considered culture orientation, whilst Schwartz measured moral traditionalism. However, results of these scales were dichotomised and therefore analyses and interpretations were limited to considering the influence of either individualistic/ collectivist values or traditionalist/ non-traditionalist moral values, respectively. Dichotomisation considerably limits the statistical analysis by reducing the power to detect effects (Altman & Royson, 2006), and further, may have risked over-simplifying interpretations of the influence of values on CDM. Assessing the influence of values on CDM quantitatively has therefore been fairly challenging; such studies may benefit from the use of validated measures specifically designed to assess a wider range of values.

Moreover, the generalisability of these studies should be examined. The aforementioned studies predominantly included mental health professionals from a sole professional grouping; Schwartz's study included 102 psychiatrists, Stampley's (2008) study included 17 social workers, and both Chih (2001) and Littleford's (2007) studies included 82 and 787 counsellors/ psychotherapists, respectively. Comparisons by mental health profession were therefore not possible and consequently, it is not known whether the findings can generalise to MHPs from all professional backgrounds. Finally, given that all studies were conducted in the US and that the UK arguably represents a distinct healthcare context, further research in this area, concerning MHPs practicing in the UK, and from a range of professional backgrounds is needed.

1.6.2. UK Studies

Indeed, two relevant studies based in the UK were retrieved. Quantitatively, King et al. (2009) conducted a pilot study to consider participants values, conceptualisations of mental health and various professional models used to make clinical decisions. The study identified a wide range in the values and models participants endorsed. It further highlighted a potential shift in the models and values participants would ideally use (when presented with Likert questions) compared to those they would select in practice (when presented with a clinical vignettes). It was suggested that this may reflect participants adopting the values or culture of the professional organisation when faced with a professional scenario. However, due to the limited availability of data and statistical tests conducted (descriptive statistics) it was not possible to ascertain whether particular workplace settings or professional groups did indeed, influence participants values and subsequent CDM. Furthermore, the study identified considerable variation in whether participants believed that attending to cultural factors was important for understanding mental distress, and in the endorsement of various stereotypical beliefs about young Black males, including beliefs about service use/ access and resilience. Though again, due to the design of the study (CDM was not operationalised), it was not possible to ascertain the influence these views/ beliefs had on CDM overall.

Qualitatively, Buckland (2016) explored factors participants (10 Approved Mental Health Professionals) drew upon when making decisions to use compulsory powers under the MHA. Again, findings indicated that participants drew on a range of values and conceptual frameworks to make decisions and were aware of the way in which their own value system often operated alongside or above the Code of Practice. Similar to King et al.'s (2009) findings, participants described feeling a tension between their own personal values and those they adopted in order to carry out their professional role. The study further suggested that the way in which participants conceptualised clinical situations in relation to race was often influenced by their own experiences and attitudes, therefore concluding an implicit role of sociocultural factors, including race, in CDM.

Whilst these studies offer insights into the relationship between CDM, values and racial bias/ attitudes within the context of UK mental healthcare, the generalisability of these study samples were again, fairly limited. Only 57% of King et al.'s (2009) sample were made up of MHPs and the qualitative design of Buckland's (2016) study meant that the sample was naturally small. In addition, due to the nature of the studies (qualitative/ pilot study, respectively) directly exploring associations between variables and/ or predictive relationships was not possible. Further larger-scale research which can quantitatively explore relationships between CDM, MHPs values and racial bias/ attitudes would therefore be of interest.

1.6.3. Summary of Review

Both qualitatively and quantitatively, these studies have demonstrated that MHPs draw on a wide range of values, attitudes and worldviews to make decisions, largely contending with the notion of universal human values and rational CDM. Given the influence of the above factors, it follows that socio-political attitudes, including racial attitudes, influence MHPs clinical judgements (including through their influence on individual beliefs and values). The current review however, only identified two studies based in the UK; whether studies can generalise to the specific contexts of UK mental healthcare warrants further consideration.

In addition, conceptualising and quantitatively assessing CDM, values and racial bias/ attitudes, respectively, has been fairly challenging. The notion of values remains conceptually vague and the influence of MHPs racial attitudes on CDM processes requires further consideration. Moreover, neither of the UK studies attempted to quantify CDM and therefore multivariate analyses were not conducted due to the methodological design of the studies or a limited sample size and subsequent power to detect effects. Overall, the above limitations support the call for larger-scale UK-based studies, including a range of MHPs, which can quantitatively explore associations between CDM, moral values and racial bias/ attitudes.

1.7. Rationale and Aims

Decision making in mental healthcare is an increasingly complex and value-laden process. MHPs draw on a range of values, beliefs, attitudes and worldviews to make decisions. Whilst research has evidenced wide variation in CDM and in the values

MHPs draw upon to make decisions, the notion of values has proved difficult to quantify. The present study aims to do so by using a standardised measure to assess moral values. Moral values were chosen due to the increasing recognition that many mental healthcare decisions are inherently morally challenging and often elicit moral distress. As such, in relation to these values the present study aims to firstly, explore the potential range in MHPs moral values. Secondly, to consider the prevalence and factors associated with moral distress and thirdly, to explore whether moral values are implicated in CDM. Furthermore, the research discussed above suggested that various sociodemographic and professional factors influence CDM. The current research further aimed to investigate the influence of these factors on both CDM and moral distress.

In addition, studies discussed throughout this chapter have suggested that the values, beliefs and worldviews MHPs utilise to make clinical decisions are influenced by socio-political contexts. CDM and mental health ideologies are not simply linked to professional training or prescriptive guidelines. Instead, they are entwined in the historical and social contexts under which the mental health system was constructed; thus, they continue to be upheld by whiteness and Western norms. Accordingly, as evidenced in the scoping review, racial biases, attitudes and MHPs worldviews considerably influence CDM. This continues to systemically disadvantage those who do not ascribe to the dominant culture and ultimately, serves to maintain the stark racial disparities present in mental healthcare. Arguably, this provides a strong rationale for considering not only the presence of racial bias, but to directly consider the influence of MHPs attitudes on CDM, for instance, by assessing MHPs racial attitudes using standardised measures. Furthermore, the majority of the studies identified in the scoping review were not sufficiently powered to assess the range and interactions of various factors influencing CDM and only two identified studies were conducted in the UK. The present study aimed to address these gaps by exploring various associations between MHPs values, racial attitudes and bias within the context of mental health CDM in the UK.

1.8. Research Questions

Research Question 1 (RQ1): Moral Values

a) What is the range in participants MAC-Q moral value scores?

b) i) Are there significant differences in the endorsement of the MAC moral values by sociodemographic (gender, ethnicity, religion, education level) and professional factors (training route, workplace setting, workplace urbanicity)? ii) Are there significant associations in the endorsement of the MAC moral values by sociodemographic (age) and professional factors (years working in mental health)?

Research Question 2 (RQ2): Moral Distress

a) What are the characteristics of moral distress among MHPs?

b) Do sociodemographic (age, gender, ethnicity, religion, education level) and professional factors (training route, years working in mental health, workplace setting, workplace urbanicity) predict moral distress?

Research Question 3 (RQ3): Clinical Decision-Making

a) Are there a significant differences in CDM scores by the hypothetical client's race?

b) Are racial attitudes significantly associated with CDM?

c) Which factors (racial attitudes/ bias, sociodemographic/ professional factors and moral values) predict CDM?

d) Do racial attitudes mediate the relationship between moral values and CDM?

Research Question 4 (RQ4): Factors Influencing CDM Processes: Content Analysis

a) i) Which factors influence participants agreement/ disagreement with CDM processes? ii) Are participants judgements of these factors influenced by the race of the hypothetical client?

b) Is the number of qualitative comments participants make influenced by the race of the hypothetical client?

2. METHODOLOGY

2.1. Overview

This chapter begins by presenting the epistemological position of the study, in order to consider both the scope and limits of the research design. Key ethical considerations and a description of the study design are then presented, followed by an outline of the analytic strategy.

2.2. Epistemology

The current research is underpinned by a critical realist epistemological approach. Epistemology is concerned with the origin of knowledge and how it is acquired (Burr, 2003). This is closely linked to ontology, which refers to assumptions about the nature of reality and its entities (Bhaskar, 2008). Epistemological and ontological frameworks help to inform the research paradigm and to consider key questions regarding the context of knowledge production, including the distinction between fact and value (Khatri, 2020). Critical realism sits between positivism, a paradigm which considers reality to be directly observable; and social constructivism, which assumes that reality is constructed through discourse, history and culture (Burr, 2003; Pilgrim, 2015). As such, critical realism assumes realist ontology, considering there to be real processes underpinning knowledge and observable phenomena. Crucially, critical realism acknowledges that scientific investigation is intrinsically linked to historical, social, cultural and political contexts (Bhaskar, 1998). Our knowledge of reality is therefore bound to social systems and power and is limited to the conceptual frameworks available and the methods used to study these concepts (McEvoy & Richards, 2003).

The current study aimed to explore various associations between moral, professional and sociodemographic factors and CDM. In line with a critical realist position, it is assumed that our experiences and decisions as moral agents are real, that they occur within particular social contexts and that humans have the capacity for axiology (Pilgrim, 2019). Additionally, in light of the social, historical and political context, it is considered that society has developed preferred forms of normativity, shaped by both ontological and epistemic power. Thus, beliefs and assumptions and perceptions of normativity, including assumptions about difference and superiority, will influence our judgements, whether this be through conscious or implicit mechanisms (Pilgrim, 2019). Moreover, the current study attempts to quantify and explore phenomena such as moral values, CDM and moral distress, while acknowledging that the exploration is limited to the measures used to define them. Also, that the researcher's own contexts and position will influence the exploration and interpretation of the findings. Therefore, while the data can offer valuable information about aspects of reality, it does not represent an absolute truth. The underlying processes and mechanisms which shape experiences and behaviours will always be influenced by numerous, interconnected contexts, many of which cannot be observed through quantitative measures alone (Bhaskar, 2008).

Additionally, the study holds that race is socially constructed, but that processes relating to power and inequality shape real and observable experiences which can be examined (Harper, 2011). Racism and its impacts are real experiences which can be observed and which have originated from discursive and socially constructed labels. Though again, attempts to measure these experiences are limited to the methods and constructs used to do so. For instance, reducing race and racial attitudes to discrete variables which can be measured largely omits the social, political and intersectional nature of these constructs and the felt experiences of racism and racialisation are considerably neglected. Therefore, the study is not intended to represent an absolute truth or reality. Findings must be interpreted tentatively and in view of the study limitations.

2.3. Ethical Approval and Considerations

Ethical approval was obtained from the University of East London (UEL), School of Psychology Research Ethics Committee (Appendix B). Additional amendment requests were made by the researcher (see Appendix C). Participants were not directly recruited through healthcare services therefore no further ethical approval was required. Ethical considerations with regards to the study design and implementation were informed by the BPS Code of Ethics and Conduct (2018), the BPS Ethics Guidelines for Internet Mediated Research (2021) and the BPS e-Professionalism: Guidance on the use of Social Media by Clinical Psychologists (2012).

2.3.1. Informed Consent

Participants were presented with a Participant Information Sheet (PIS) prior to consenting to participating in the study. This included key information about the aims, entailment, confidentiality and anonymity of the study, and participants were informed of their right to withdraw from the study (Appendix D). Participants were invited to contact the researcher with additional questions at this stage. Following the PIS, participants were asked to indicate their consent by ticking a list of statements for various aspects of data collection, storage and use (Appendix E). It was not possible to commence the survey without providing consent. Non-completion of the full test-battery (stopping mid-survey) was considered as withdrawal of consent so this data was not included in the analyses.

2.3.2. Confidentiality

The survey was completed online using the survey software, Qualtrics. Access was gained through an anonymous link, meaning that IP addresses and location data could not be distinguished. Participants data were stored against a unique identification number (randomly generated through Qualtrics) at the beginning of the survey; participant information collected was not specific enough to identify individuals. Participants wishing to receive a summary of the findings following completion were invited to provide their email addresses. These details were stored in a separate database ensuring survey responses could not be matched to participants. All data was stored on secure password-protected documents, only accessible by the researcher. Email addresses were deleted upon completion of the thesis. All other anonymised data will be retained securely for a maximum of three years. After this time, the data will be deleted, in line with the Caldicott principle and the Data Protection Act (2018).

2.3.3. Possible Distress

While the research was conducted online, and participants were not asked to describe their own personal experiences, a number of the scenarios presented within the vignettes and questionnaires required sensitive and careful ethical consideration. For instance, the vignettes were intended to depict realistic clinical scenarios which may be morally challenging or distressing, particularly if participants had been involved in similar real-world situations (Barter & Reynold, 1999). Nonetheless, hypothetical CDM is likely to be less distressing than that in real-life as the consequences of the decisions are far smaller (Bostyn et al., 2018). The following efforts were made to reduce potential distress: participants were informed broadly of the study aims in the PIS, including that it involved CDM in the context of potentially morally challenging mental healthcare situations, and could make an informed decision about participating in the study. Participants were also provided with a list of support organisations in the PIS.

The study aimed to explore issues relating to racialisation and racism, the presence of which is pervasive yet often subtle, whilst the effects are always harmful. This area therefore required careful consideration. For instance, given the prominence of systemic racism within the UK, vignettes containing depictions of Black and South-Asian clients being treated negatively or inappropriately within mental health systems may be particularly distressing. It may for example, bring up past negative experiences and/ or expose participants to vicarious racial discrimination (Chae et al., 2021; Tao & Fisher, 2022; Williams et al., 2019). In consideration of these issues, participants were assured that they could withdraw from the study at any point without providing a reason and a more extensive list of signposting information was included in the debrief form, which included organisations aimed at specifically providing more equitable services to individuals from racialised backgrounds (Appendix F). In addition, during the vignette consultation phase, consultees were explicitly asked to consider whether they or others may find the vignettes distressing to read, particularly attending to issues relating to race and discrimination. It was also important for the researcher to be aware of their own position as a white researcher. This may for example, allow pertinent issues to be overlooked and is likely to influence the study design and interpretation. In an effort for the researcher to sustain an awareness of their position, a reflective log was kept and discussions were had in supervisions regarding how the researcher's own racial identity, position and discourses may influence different stages of the research.

While participants were not directly deceived about the nature of the study, the extent of the information provided in the PIS was limited and did not explicitly state that the research was exploring racial bias/ attitudes. This was an effort to avoid biases such as social desirability bias within the questionnaires. A risk assessment was completed prior to commencing the study (Appendix G) in view of the sensitive nature of the topic area.

2.3.4. Debrief

Upon completion of the questionnaires, participants were presented with a debrief sheet which informed them of the full nature of the study. Participants were informed that the study was exploring how a number of characteristics, including race, might affect CDM within mental healthcare and were provided with a list of signposting information. The researchers contact details were also provided should participants wish to enquire further about the study

2.4. Design

A cross-sectional, quantitative, factorial design was used; data was collected at a single time-point and associations between a number of factors were examined. The variables included were: clinician sociodemographic (age, gender, ethnicity, religion) and professional information (education level, workplace urban/rural classification, professional training route, workplace setting, time working in mental health), client race, racial attitudes, moral values and moral distress.

In view of the research aims, to explore various associations between complex concepts, including decision-making, moral values and racial attitudes, a predominantly quantitative design was selected. This design was chosen firstly, as many of the processes involved in decision-making are arguably, implicit (including the influence of values and attitudes) and therefore may be difficult to capture qualitatively. Secondly, a number of the constructs being measured (e.g. racial attitudes) are likely to be highly susceptible to social desirability bias; anonymous, online data collection methods, as well as the specific questionnaires chosen (CoBRAS) may reduce the impact of this bias (Joinson, 1999; Neville et al., 2000). In line with the research aims, participants were also given an opportunity to provide comments relating to the vignette or their decision-making process. This qualitative data consequently offered additional, more in-depth, insights into potential factors influencing CDM.

2.5. Participants

2.5.1. Recruitment

Recruitment took place between November 2021 and March 2022. The study employed opportunity, convenience and purposive sampling. Participants were recruited online, through social media sites, including Facebook, Twitter and LinkedIn; also, through online forums and relevant email chains. Here, a general advertisement containing a brief description of the study and a URL link to the survey was posted (Appendix H). Purposive sampling, in which the study advert was posted to social media groups, forums and mailing list specifically aimed at MHPs was also employed. This included forums such as ClinPsy and the Social Psychology Network, as well as mailing lists accessed through university courses related to mental health. Permission to advertise was sought where necessary. It should be noted that these sampling methods can affect the generalisability of the sample. For instance, the resultant sample may only hold small numbers of particular underrepresented sociodemographic groups, resulting in limited power to detect subgroup differences (Bornstein et al., 2013). However, these methods were deemed appropriate in order to support the collection of a relatively large amount of data from a specific group of individuals (MHPs), in a short-time frame (Sharma, 2017).

2.5.2. Inclusion Criteria

Given that the study aimed to explore how a number of factors may affect CDM across mental health care, and that CDM often involves staff members from various disciplines, the inclusion criteria were kept broad. Participants were required to be over the age of 18 and to be a MHP working in the UK. MHPs were considered to encompass anyone working within a mental healthcare setting and did not require specific qualifications. As the study was presented in English, a level of fluency in English to comprehend and respond to the survey information and provide consent to participate, was also required.

2.6. Materials

The questionnaires used in the present study were reviewed by the research team. Consideration was paid to their psychometric properties, content, length, face validity implementation in previous research and transferability to mobile devices. Permission to use questionnaires which were not freely available was gained.

2.6.1. Participant Demographics

Participants completed a demographic questionnaire which invited them to provide their age, gender, ethnicity, religion, education level, mental health professional training route, current workplace setting, workplace urban/rural classification, and time worked in mental health (Appendix I). A drop-down menu was used to capture this information, using pre-specified categories. Ethnicity, religion and education level categories were based on those used in the 2021 Census (ONS, 2021). Gender categories were based on recommendations by CAMP Rehoboth (see Rattay, 2019) and categories for mental health training routes were drawn from various sources (including: NHS England, n.d.; nidirect, n.d.; HEE, n.d.). A text-box was included if participants wished to report a demographic/ professional characteristic which better described their identity. Of note, whilst the present research is predominantly concerned with the construct of race, participants were asked for their self-identified ethnicity, as this concept is understood to be at least partially determined through choice and a sense of social belonging (Fernando, 2010).

2.6.2. Vignettes

Vignettes were created to assess participants agreement/ disagreement with various mental health clinical decisions, all of which broadly encompassed a moral dilemma. The vignette development process is outlined below.

2.6.2.1. Vignette development

A flow diagram outlining the vignette development process is presented in Appendix J (Figure 5). Literature outlining the process of developing clinical vignettes informed the process (included in Appendix J). Initially, a literature review on existing racial disparities within mental healthcare, as well as NICE guidelines relating to the treatment of relevant mental health presentations, was undertaken. Based on this review, the following constructs of interest were generated: access, assessment and treatment (see sections 1.6.2.2. – 1.6.2.4. for a brief overview of the literature review findings on racial disparities).

Next, a review of a casebook of previous clinical ethics committee discussions held at a large NHS mental health Trust was completed. The casebook included over 100 ethical dilemmas presented to the NHS Trust's Clinical Ethics Committee. Permission to use the casebook was sought from the Trust's Research and Development and Information Governance department. The researcher was advised that neither Research Ethics Committee or Health Research Authority approval was required for this review and use within the current research. A Data Protection Impact Assessment was completed (Appendix K) and approval to use the casebook was granted. Each dilemma was screened against an inclusion/ exclusion criterion based on the above constructs of interest.

Eleven vignettes were developed, based on a triangulation of data gathered through the literature review on racial disparities, the casebook of ethical dilemmas and NICE/ NHS guidelines. A consultation process was subsequently undertaken; vignettes were reviewed by multiple individuals working within mental health settings. This included seven MHPs from the researcher's network; four individuals working/training in clinical psychology (various adult settings), one in a forensic psychology setting, one individual working within the Quality Network for a large mental health professional body and one General Practitioner. During this process, it was important to consider the appropriateness, relevance and cultural sensitivity of the vignettes as well as the potential distress they may elicit. A number of questions were designed to facilitate this process (Appendix L). Several stages of refinement were undertaken and the most appropriate seven vignettes were selected for inclusion in the study. Three versions of each vignette were created, in which only the race of the client depicted was altered (Black, South-Asian, white).

2.6.2.2. Clinically-based vignettes

The study vignettes are presented in Appendix M. Vignettes were designed to depict a scenario in which a MHP/ team is making a clinical decision which may be morally challenging and which could feasibly occur within a mental healthcare setting. Participants were asked to read the vignette and rate the extent to which they agree – disagree with the decision being made, using a Likert scale (0 – 100). Optional open-ended comment boxes were also included should participants wish to provide any additional comments relating to the vignette or their decision-making process.

2.6.3. Moral Values

Moral values were measured using the Morality-as-Cooperation Questionnaire (MAC-Q; Curry et al., 2019a; Appendix N). The questionnaire is based on the Morality-as-Cooperation theory (Curry, 2016) which proposes seven types of cooperation, mapping onto distinct moral domains. These are: family values, group loyalty, reciprocity, heroism, defence, fairness and property rights. The MAC-Q includes 42 items and is split into two sections: moral relevance and moral judgement. For both sections, participants provide a rating for each question on a Likert scale between 0 (not at all relevant/ strongly disagree) and 100 (extremely relevant/ strongly agree). Scores are calculated per category (relevance/ judgement) and an average score for each moral domain is produced. The questionnaire has been validated to assess the seven moral domains and has been found to have acceptable validity and at least sufficient consistency (Cronbach's alpha = 0.53 – 0.83) for all subscales (Curry et al., 2019a).

2.6.4. Moral Distress

The Measure of Moral Distress for Healthcare Professionals (MMD-HP; Epstein et al., 2019) was used to assess moral distress. The measure consists of 27-items pertaining to causes of moral distress within healthcare. For each item, participants indicate the frequency they have experienced the scenario described for each item, as well as the intensity of distress it causes on a 5-point Likert scale, ranging from 0 (never/ none) to 4 (very frequently/ very distressing). A composite score for each item is generated by multiplying the frequency and distress scores. Item scores are then summed to calculate a total score (ranging from 0 – 432); higher scores are suggestive of greater levels of moral distress. Two additional questions, regarding current and past intentions to leave the profession are included in the MMD-HP. The scale has been credited with good concurrent validity (correlated with intentions to leave the profession) and internal consistency (Cronbach's alpha = 0.93) across a range of HCPs (Epstein et al., 2019).

2.6.5. Racial Attitudes Scale

The Colour-Blind Racial Attitudes Scale (CoBRAS; Neville et al., 2000) was used to measure racial attitudes. The scale was designed to measure colour-blind racial attitudes, pertaining to three key factors: unawareness of racial privilege, institutional racism and blatant racial issues. It consists of 20-items; participants rate each item on a Likert scale from 1 (strongly disagree) to 6 (strongly agree). Factor and total scores are then calculated by summing the relevant items. Higher scores are suggestive of greater levels of colour-blind racial attitudes and less awareness of the influence of race on social issues. The scale has been credited with good reliability (Cronbach's alpha =

0.93) and good concurrent validity with other measures of racial bias (Neville et al., 2000). It has been validated in a number of studies (e.g. Neville et al., 2000; Neville et al., 2006; Offermann et al., 2014; Su & Behar-Horenstein, 2017) and has been found to control for social desirability (Neville et al., 2000; Neville et al., 2006). The scale was adapted to suit a UK population in the present study, by replacing references to 'U.S.' with 'U.K'.

2.7. Procedure

The study was accessed by participants through an anonymous electronic link, via Qualtrics. Participants were initially asked to confirm that the eligibility criteria were met. Once confirmed, the PIS and electronic consent form were presented; it was not possible to access the study without providing consent to participate.

The survey took approximately 20 minutes to complete and participants were able to discontinue at any point. Within Qualtrics, a randomiser was used to present participants with one of the three versions (client described as Black, South-Asian, or white) of each of the seven vignettes. The remainder of the test battery was consistent for all participants (Section 2.7.1.). At the end of the survey, participants were presented with the debrief form. Participants were invited to provide their email address if they wanted to receive a summary of the results. Data were downloaded from the Qualtrics server onto Excel and R/ RStudio for analyses.

2.7.1. Order of Measures

The order of the questionnaires was as follows: three eligibility questions (required to access the study), demographic questionnaire, seven vignettes (randomised order), MAC-Q, MMD-HP, and CoBRAS. A decision to place the demographic questionnaire at the beginning of the survey was made as this has been shown to increase the response rate for demographic items without affecting latter responses for online studies (Teclaw et al., 2012). This also allowed a comparison of the characteristics of those who completed the survey compared to those who dropped out to be conducted in order to assess the generalisability of the findings. The vignettes were presented next to prevent responses to other measures from influencing participants responses. Similarly, the MMD-HP and CoBRAS were presented at the end of the survey in an attempt to avoid inadvertently exposing the full aims of the study and therefore to avoid socially desirable responding within the previous questionnaires.

2.8. Analytic Strategy

Analyses were conducted using R statistical software R (RStudio) and Excel. Due to the nature of the study and research questions, various analytic procedures were utilised. To explore the range in participants MAC-Q moral value scores, descriptive statistics were calculated. T-test/ ANOVAs and correlations were then used to consider differences and associations, respectively, in the endorsement of these values by sociodemographic and professional factors. To examine the characteristics of moral distress and factors predicting moral distress, descriptive statistics and multiple linear regression analyses were utilised. In relation to CDM, descriptive statistics and ANOVAs were used to explore differences in CDM by the hypothetical clients race and correlations examined relationships between participants racial attitudes and CDM. Subsequently, multiple linear regression analyses were employed to explore predictive relationships between racial attitudes/ bias, sociodemographic, professional and moral factors. Two structural equation models (SEM) were then developed on the basis of the above findings and previous literature. These aimed to explore the mediating effect of racial attitudes on the relationships between moral values and CDM. Finally, a content analysis of participants qualitative vignette answers was conducted. Qualitative data exploring participants agreement/ disagreement with the clinical decision were reviewed, coded and counted per conceptual category.

2.8.1. Sample Size and Power Calculation

Power calculations for the statistical analyses requiring the greatest power (multiple linear regression and ANOVA) were conducted using G*Power 3 software. The largest number of predictors included was seven for the ANOVA analyses and 37 for the regression (10 predictor variables; 37 when accounting for dummy coded variables created). Using a one-tailed test, with a power of 0.80 and an alpha of 0.05, an estimated 231 participants were required to detect a medium effect size (0.25; Cohen, 1988) for ANOVA analyses, and 284 participants were required to detect a medium effect size (0.15; Cohen, 1988) for regression analyses. These requirements were met by the current sample, inferring adequate power to detect at least medium effects.

The required sample size for SEM analyses has been widely debated (Garson, 2015). Some have suggested that a sample size of 100 – 200 cases is sufficient for analyses (Hoyle, 1995; Loehlin, 1992), while others have proposed that the sample should be greater than 20 times the number of variables in the model (Kline, 2015; Mitchell, 1993). The current sample met these requirements; a sample of 340 (17 variables, including items within latent variables) would be required to satisfy the latter criterion.

2.9. Reflexivity

Reflexivity involves examining the way in which the researcher’s own experiences, personal position, values and assumptions have shaped the research (Willig, 2013). Within quantitative research, these contexts influence the methodology chosen, the selection of information presented and the interpretation of the results (Huntington-Klein, 2021). First-person is used for this section to present a brief reflective account.

I identify as being from a white, Western background, I have been educated in the UK using predominantly Western, Eurocentric ideas and concepts. Over many years, educators, peers, authors, clients, colleges and others have and continue to influence my understanding and views on whiteness and racism. I understand these concepts to be heavily linked to socio-political contexts and processes of socialisation. Reflecting on my own socialisation for example, the whiteness in the UK has created various spaces in which white people, including myself, have not necessarily had to view themselves in racial terms. Consequently, there are instances in which the influence of race at all levels (including systemic and individual levels), have been, and continue to be, precluded. Within the present research, it should be acknowledged that I therefore hold many blind-spots, for instance, the nuances, lived and felt experiences of racial discrimination. I hoped to approach this research with humility, and in an effort to remain aware of my own contexts and the influence of my racial identity, a reflective journal was used (extract included in Appendix O) and relevant material was discussed in supervision. This included personal reflections on my own white, Western, Eurocentric lens, my biases, as well as the influence this had on the process of the research, the methodology chosen, and subsequently, how this may influence the various ways in which results would later be interpreted. Racism is pervasive; therefore, this research is by no means questioning the presence of racism and marginalisation, rather, it aims to explore the operations of racialisation within CDM processes using predominantly quantitative methods.

3. RESULTS

3.1. Chapter Overview

This chapter initially presents a description of the sample of participants, as well as details of the missing data and data management. The research questions are then addressed in turn. This includes results from various analytic procedures, exploring participants moral values, moral distress and subsequently factors associated with CDM, particularly focusing on racial bias/ attitudes within CDM processes.

3.2. Sample Characteristics

3.2.1. Initial Sample

Confirming the eligibility criteria was required to access the survey; this was accessed by 712 participants. Following this, 708 (99.44%) participants completed the consent form and 453 (63.62%) completed the survey until the end. This resulted in a 36.38% drop-out rate. Data from non-completers were deleted; this was taken as a sign of withdrawal. In addition, data from one participant who provided responses suggestive of inauthenticity (consistently rating items 50), and data from two participants, which showed that they did not work in mental health, were deleted. A total of 450 participants were included in the final sample (63.34% of those who accessed the survey).

3.2.2. Completers and Non-Completers

Over half of the non-completers dropped out between zero and ten minutes into the survey (n=135), while the completers most commonly took between 15 and 25 minutes (n=145) to finish the survey. Of those who dropped out (n=259), 198 continued up until the vignettes, 110 until the MAC-Q, and 254 until the MMD-HP; the majority dropped out at this point. A further five participants dropped out at the CoBRAS. There were no sociodemographic/ professional-factor differences found between participants who completed the survey (*n*=450) compared to those who did not (*n*=254; Appendix P).

3.2.3. Sociodemographic Information and Professional Factors

Sociodemographic data are presented in Table 1; data regarding participants professional factors are presented in Table 2. The majority of the participants identified as female (86%), white (84%), and non-religious (66%) and were educated to post-graduate or equivalent level (72%). Participants most commonly had a training background in clinical psychology (39%), followed by mental health nursing (21%) and psychotherapy (10%). Participants workplace settings were fairly broad; 31% worked in adult community settings, 14% in CYP and 11% in primary care/ IAPT services. Over half of the sample worked in an urban area (54%) and the average time working in mental health across the sample was 9.73 years. Some categories were merged for the purposes of analyses; a full list of (text-entry) genders, ethnicities, religions and education levels provided by participants is presented in Appendix Q.

Table 1: Participant Characteristics: Sociodemographic Factors

Total	450
Age (years)	
Mean (SD)	36.15 (11.50)
Range	18 – 76
Prefer not to say (*N*, %)	10 (2)
Gender *N* (%)	
Female	387 (86)
Male	59 (13)
Non-Binary/ third gender/ agender	3 (0.67)
Prefer not to say	1 (0.22)
Ethnicity *N* (%)	
White (incl. any white background)	376 (84)
Black, African, Caribbean or Black British (incl. any Black background)	20 (4)
Asian (incl. any Asian background)	26 (6)
Mixed or multiple ethnic groups (incl. any mixed backgrounds)	27 (6)
Prefer not to say	1 (0.22)
Religion *N* (%)	
No religion	298 (66)
Buddhist	4 (0.89)
Christian	106 (23)
Hindu	7 (2)
Jewish	3 (0.67)
Muslim	12 (3)
Sikh	2 (0.44)
Not listed here/ other – text entry	10 (2)
Prefer not to say	8 (2)

Table 2: Participant Characteristics: Professional Factors

Total	450
Highest Education Level *N* (%)	
No formal qualifications	1 (0.22)
GCSE or equivalent	5 (1)
A-Level or equivalent	12 (3)
Undergraduate or equivalent	104 (23)
Post-graduate	326 (72)
‘Other’ – text entry	2 (0.44)
Professional Training Route *N* (%)	
CBT/ IAPT	26 (6)
Clinical psychology	175 (39)
Counselling psychology	24 (5)
Medically Trained (psychiatrists and General Practitioners)	22 (5)
Mental Health Nursing/ other nursing background	95 (21)
Occupational Therapy	5 (1)
Psychotherapy	45 (10)
Social Work	10 (2)
Support Work	24 (5)
‘Other’ – text entry	17 (4)
Prefer not to say	7 (2)
Current Workplace Setting *N* (%)	
Adult community (various)	140 (31)
Charity/ third sector	9 (2)
Children and young people (various)	65 (14)
Forensic	27 (6)
Health	27 (6)
Inpatient	40 (9)
Learning disabilities	20 (4)
Older adults	27 (6)
Primary care/ IAPT	50 (11)
Private	11 (2)
‘Other’	14 (3)
Prefer not to say	20 (4)
Urbanicity of Workplace *N* (%)	
Urban	242 (54)
Suburban	124 (28)
Rural	19 (4)
Remote	56 (12)
Prefer not to say	9 (2)
Time Working in Mental Health (years)	
Mean (SD)	9.73 (9.37)
Range	0.2 – 50
Prefer not to say (*N*, %)	17 (4)

3.3. Missing Data

Missing data were low and were present only in the demographic and MMD-HP scales. Missing data were present in 1.8% of the demographic section, the highest rates were for time working in mental health and workplace setting (4%). There did not appear to be a distinct pattern to the missing demographic data and there was no data missing at the scale-level. Missing data from this section was therefore excluded from the analysis using pairwise deletion in order to preserve the remainder of the scale (Shrive et al., 2006; Tabachnick & Fidell, 2007). Regarding the MMD-HP questionnaire, missing data were a result of a decision not to use the Qualtrics Software ‘forced response’ due to the questionnaire being more complex/ multifaceted when presented online. This decision was therefore an effort to reduce participant dropout at this point. Overall, 0.04% of the data were missing from the MMD-HP, the majority of which was again, at the item-level (only 3% of all MMD-HP data was missing at the scale-level). Mean imputation was used as a method of managing the missing data, to impute missing item scores where less than 30% of the scale was missing (threshold based on Graham, 2009). This method is appropriate when the overall level of missing data is less than five percent (Tabachnick & Fidel, 2007), as met by the current data, and has been shown to preform comparably to alternative, more advanced methods, such as multiple imputation (Shrive et al., 2006; Sullivan et al., 2018).

3.4. Data Distribution

Significance testing for large samples (over 200) are often sufficiently powered to detect very minor deviations from normality; these tests are therefore not generally recommended for large samples (Field, 2009). As the current sample was relatively large (n=450) data was instead, assessed for normality using skewness and kurtosis statistics and inspection of Q-Q plots. Data are considered to be normally distributed if skewness falls between -2 and +2, and kurtosis falls between -7 and +7 (Curran et al., 1996; George & Mallery, 2010). All subscales fell within these ranges (Appendix R), however, visual inspection of Q-Q plots suggested potential non-normality in a number of subscales (including: MMD-HP, R-family, R-group, R-deference, J-reciprocity, J-fairness and all vignette total scores). All subscales were therefore additionally examined by converting skewness and kurtosis into z-scores. This allowed for further assessment of the normality assumption by comparing skewness and kurtosis scores to known values of normal distribution (Field, 2009). Z-scores can also be adjusted to account for large sample sizes (Field, 2009).

Z-scores for all the MACQ-R subscales fell below the upper threshold of 3.29 for normal distribution for skewness and kurtosis (Field, 2009; Appendix R), with the exception of the family and group loyalty subscale. In addition, MMD-HP and CoBRAS total scores and four of the MACQ-J subscales fell outside of this range. In such instances, data transformations are frequently used, and have been recommended as a method of improving the normality of a distribution (Osborne, 2008; Wilcox, 2010; Zimmerman, 1998). Log and square root transformations were therefore performed on the skewed variables. This improved the skewness for: all MAC-relevance subscales, and the MMD-HP and CoBRAS total scales (Z-scores fell within the acceptable range; Appendix R, Table 14). Four of the MAC-judgement subscales did not meet this cut-off. For subsequent analyses, MAC-judgement subscales were therefore analysed using non-parametric tests.

Although all seven of the vignette total scores fell slightly outside of the acceptable z-score threshold (Appendix R), transformations made little difference to the distribution scores or to visual inspection of corresponding graphs; histograms for V4, V5 and V6 showed broadly normal distribution, whilst V1 and V7 appeared slightly negatively skewed, and V3 and V2 slightly positively skewed (Appendix S). Nonetheless, it has been suggested that for large samples (over 250), parametric statistical tests are robust even to severely skewed data (Elliot & Woodward, 2007; Fagerland, 2012; Kwak & Kim; Pallant, 2020); and according to the central limit theorem, parametric tests have greater statistical power to detect effects than non-parametric tests (Kwak & Kim, 2017). Consequently, a decision to use parametric tests within the present study was made.

3.4.1. Internal Consistency

The internal consistencies of the questionnaires used were calculated using Cronbach's alpha (α). These are presented in Table 3. All of the MAC-Q relevance and CoBRAS subscales fell within the fair to good range (0.70 – 0.89), and the MMD-HP and CoBRAS total scales were in the excellent range (0.90 – 0.99). However, a number of the MAC-Q judgement subscales fell within the questionable range and two subscales were in the unacceptable range.

Table 3: Internal Consistency of Scales

Scale/ subscale	Cronbach's α
MAC-Q Relevance	
R-family	0.87
R-group	0.89
R-reciprocity	0.82
R-heroism	0.82
R-deference	0.79
R-fairness	0.76
R-property	0.81
MAC-Q Judgements	
J-family	0.85
J-group	0.74
J-reciprocity	0.69
J-heroism	0.61
J-deference	0.67
J-fairness	0.22
J-property	0.42
MMD-HP	0.92
CoBRAS Total	0.91
CoBRAS Factor 1	0.86
CoBRAS Factor 2	0.78
CoBRAS Factor 3	0.78

3.5. RQ1: Moral Values

3.5.1. RQ 1a) What is the Range in Participants MAC-Q Moral Value Scores?

Descriptive statistics for the results of the MAC-Q relevance and judgement subscales are presented in Table 3. Scores for all moral values ranged from 0 – 100, with the exception of fairness (judgement scale). Mean scores are included for reference. There are currently no validated cut-off values to constitute high/ low endorsement of these values (Curry et al., 2019a).

Table 3: Descriptive Statistics for MAC-Scales

Subscale	Mean (SD)	Range
MACQ-R		
R-family	56.04 (24.99)	0 – 100
R-group	56.61 (24.56)	0 – 100
R-reciprocity	56.82 (23.87)	0 – 100
R-heroism	46.30 (24.15)	0 – 100
R-deference	34.57 (22.26)	0 – 100
R-fairness	48.28 (24.54)	0 – 100
R-property	51.81 (24.79	0 – 100
MACQ-J		
J-family	37.92 (24.22)	0 – 100
J-group	60.61 (20.16)	0 – 100
J-reciprocity	60.66 (19.87)	0 – 100
J-heroism	46.41 (21.28)	0 – 100
J-deference	30.86 (19.68)	0 – 100
J-fairness	78.39 (15.29)	23 – 100
J-property	65.33 (16.23)	0 – 100

3.5.2. RQ 1bi) Are there Significant Differences in the Endorsement of the MAC Moral Values by Sociodemographic and Professional Factors? ii) Are there Significant Associations in the Endorsement of the MAC Moral Values by Sociodemographic and Professional Factors?

The relevance scale was used for the following analyses. Firstly, as this scale was found to have greater internal consistency. Secondly, as parametric assumptions were met for these, but not the judgement, subscales. Thus, parametric tests, which are known to have greater power to detect effects (Kwak & Kim, 2017), could be performed. Descriptive statistics and associated non-parametric analyses for the judgement scale are presented in Appendix T.

To address RQ 1bi) t-tests were used to examine differences between moral values and the independent categorical variables analysed using two groups and ANOVAs were used to test differences between moral values and the variables containing more than two groups. For significant ANOVA tests, post-hoc tests were employed to examine differences between specific groups. Here, the Games-Howell post-hoc test was used as this test has been recommended for instances in which there are unequal group sample sizes (as with groupings within ethnicity, training route and workplace setting in the current sample; Field, 2009). To address RQ 1bii) Pearson's correlations were employed to examine relationships between moral values and the independent variables consisting of continuous data (age, years in mental health, CoBRAS).

3.5.2.1. Assumptions

In addition to the assumption of normality discussed above, the assumptions of homogeneity of variance should be satisfied in order for both the t-statistic and the F-statistic to be reliable (Field, 2009). Homogeneity of variance tests were conducted using Bartlett's and equal variance tests. All variables met this assumption (Bartlett's and equal variance tests were non-significant) with the exception of the grouping of family and professional training route. The more conservative, Brown–Forsythe test was therefore used for this grouping.

3.5.2.2. Significance testing

Results of the significance tests are presented in Tables 4 and 5. Full details of the results and subsequent post-hoc tests are reported in Appendix U, and described briefly below.

Family: Participants educated to at least post-graduate level, compared to all other qualifications, had significantly higher moral valence scores. There was a significant negative correlation between racial attitudes (CoBRAS scores) and family.

Group loyalty: Men had significantly higher group loyalty scores compared to women, and participants educated to at least post-graduate level had significantly lower scores than those educated to all other levels.

Reciprocity: Men had significantly higher reciprocity scores compared to women, as did participants identifying as non-religious (compared to religious). There was a significant positive correlation between racial attitude scores and reciprocity.

Heroism: Participants educated to at least post-graduate level had significantly lower heroism scores than those educated to all other levels, as did participants identifying as non-religious, compared to religious. Participants identifying as being from a Black ethnic background had significantly higher scores compared to those identifying as being from a white or Asian background. There was a significant positive correlation between racial attitude scores and heroism.

Deference: Participants educated to at least post-graduate level had significantly higher deference scores, as did participants identifying as non-religious. Participants identifying as being from a Black ethnic background had significantly higher scores compared to those identifying as being from a white or mixed ethnic background. There was a significant positive correlation between racial attitude scores and deference.

Fairness: Men had significantly higher fairness scores compared to women, as did participants identifying as religious, compared to non-religious.

Property: Participants identifying as religious had significantly higher property scores. Participants identifying as being from a Black ethnic background had significantly higher scores compared to those identifying as being from a white background. There was a significant positive correlation between racial attitude scores and property.

Table 4: Sociodemographic Factors by MAC-Q Moral Values

	Family	**Group**	**Reciprocity**	**Heroism**	**Deference**	**Fairness**	**Property**
Age (*r*)	0.04	0.05	-0.02	0.01	-0.03	-0.03	0.01
Gender (*T*)	0.79	3.30***	-3.28***	-0.22	-0.76	-2.02*	-0.28
Female (*M, SD*)	55.71	55.04	55.27	46.20	34.37	47.40	51.71
	(24.87)	(24.59)	(23.72)	(23.63)	(21.89)	(24.27)	(24.70)
Male *(M, SD)*	59.07	67.29	66.68	47.73	37.07	55.24	53.57
	(25.25)	(20.69)	(23.17)	(27.40)	(24.68)	(25.50)	(25.38)
Ethnicity (*F*)	2.58	2.55	1.18	3.20*	4.65**	3.23*	2.72*
White *(M, SD)*	55.67	56.24	56.70	45.80	33.21	47.76	51.00
	(24.99)	(24.59)	(24.10)	(24.13)	(22.01)	(24.55)	(24.79)
Black *(M, SD)*	69.35	69.62	65.71	61.53	52.75	63.70	63.50
	(18.51)	(20.38)	(21.35)	(22.38)	(21.44)	(19.50)	(17.53)
Mixed ethnicity *(M, SD)*	58.64	57.04	52.23	47.74	33.78	44.19	48.60
	(26.98)	(27.16)	(21.87)	(26.13)	(21.68)	(22.54)	(23.79)
Asian *(M, SD)*	57.67	56.24	57.32	42.05	41.68	50.12	59.86
	(23.41)	(20.10)	(23.82)	(19.05)	(20.94)	(25.61)	(26.47)
Religion (*T*)	1.79	-0.11	-2.94**	-2.90**	-5.59***	-3.18**	-2.99**
Religious *(M, SD)*	58.88	56.66	54.78	51.18	30.75	53.64	57.08
	(24.99)	(24.66)	(23.87)	(24.94)	(23.64)	(24.76)	(24.58)
Non-religious *(M, SD)*	54.95	57.03	61.84	44.12	42.91	45.85	49.68
	(24.91)	(24.24)	(23.53)	(23.43)	(20.30)	(23.79)	(24.31)

**p<0.05, **p<0.01, ***p<0.001*

Table 5: Professional Factors by MAC-Q Moral Values

	Family	Group	Reciprocity	Heroism	Deference	Fairness	Property
Educ. level (*T*)	-2.78*	-2.46*	1.75	3.73***	2.40*	0.09	0.96
Postgrad *(M, SD)*	60.80	55.00	55.60	43.71	38.63	48.21	53.63
	(24.97)	(24.26)	(23.88)	(23.77)	(21.99)	(25.18)	(24.93)
Any other qual. *(M, SD)*	54.22	60.64	60.02	53.10	33.02	48.46	51.12
	(24.51)	(24.25)	(23.63)	(23.93)	(22.56)	(22.86)	(24.45)
Training route (*F)*	1.45	1.29	0.79	1.27	1.93	1.46	0.57
Psychology *(M, SD)*	55.73	57.98	55.60	44.42	31.32	47.99	49.67
	(24.49)	(21.60)	(22.51)	(22.71)	(20.60)	(23.58)	(24.27)
CBT/ IAPT *(M, SD)*	53.45	54.09	53.69	41.35	40.24	56.04	55.35
	(21.59)	(23.81)	(23.66)	(21.83)	(18.29)	(24.48)	(22.96)
Psychotherapy *(M, SD)*	51.47	49.47	56.25	43.01	31.87	47.44	52.78
	(27.15)	(29.31)	(26.43)	(24.68)	(24.58)	(28.32)	(28.60)
Nursing *(M, SD)*	55.15	53.87	57.56	49.60	36.49	43.61	51.75
	(27.17)	(26.93)	(25.68)	(26.85)	(23.06)	(24.15)	(26.15)
Medical *(M, SD)*	55.24	62.51	55.33	47.63	35.11	51.67	56.08
	(21.66)	(27.10)	(29.03)	(22.96)	(22.61)	(26.02)	(25.40)
Any other AHP*(M, SD)*	62.79	58.75	62.42	50.32	39.12	51.23	53.27
	(24.18)	(25.35)	(20.24)	(25.31)	(23.25)	(23.17(	(21.59)
Work-setting (*F)*	0.35	0.94	1.90	0.07	2.40	0.64	0.58
Adult *(M, SD)*	54.91	55.69	55.45	46.11	34.40	48.20	51.77
	(25.09)	(24.96)	(24.08)	(22.86)	(21.44)	(24.34)	(24.45)
Inpatient *(M, SD)*	56.80	56.23	53.36	46.08	35.89	44.21	50.82
	(23.73)	(23.91)	(24.22)	(27.78)	(22.72)	(23.81)	(25.07)
CYP *(M, SD)*	58.53	59.39	61.43	45.14	28.84	49.66	50.25
	(23.41)	(23.01)	(22.61)	(22.74)	(19.87)	(26.00)	(26.55)
Other *(M, SD)*	52.80	50.57	61.12	44.41	40.45	48.54	56.76
	(27.02)	(24.93)	(24.97)	(28.00)	(25.12)	(23.49)	(23.08)
Urbanicity (*F)*	0.42	1.10	2.27	0.93	0.32	0.83	0.17
Urban *(M, SD)*	56.54	58.91	58.98	47.98	34.26	48.83	52.09
	(24.35)	(22.57)	(23.72)	(24.03)	(22.06)	(24.39)	(25.59)
Suburban *(M, SD)*	55.42	55.40	52.71	43.86	33.52	45.53	50.62
	(25.21)	(26.79)	(23.08)	(22.91)	(21.91)	(23.85)	(22.61)
Rural *(M, SD)*	57.27	52.50	56.61	46.67	36.04	50.53	52.14
	(26.41)	(24.77)	(25.03)	(25.75)	(24.66)	(23.56)	(24.35)
Remote *(M, SD)*	50.02	51.68	50.91	43.04	37.79	50.40	51.17
	(27.38)	(28.49)	(27.02)	(24.53)	(23.22)	(29.92)	(26.18)
Years in MH (*r*)	0.03	0.04	-0.03	0.05	-0.03	0.04	-0.02
CoBRAS (*r*)	-0.10*	0.07	0.13**	0.16***	0.31***	0.05	0.12*

**p<0.05, **p<0.01, ***p<0.001*

3.6. RQ2: Moral Distress

3.6.1. RQ 2a) What are the Characteristics of Moral Distress Among MHPs?

The mean moral distress (MMD-HP) composite score was 98.82 (*SD*=66.69). There are currently no validated cut-off scores to constitute high vs. low moral distress (Epstein et al., 2019).

Overall, 131 participants (29%) reported that they had considered leaving their clinical position due to moral distress at some stage in their career, 138 (31%) had left a position and 181 (40%) had never considered leaving due to moral distress (Figure 1). Sixty-seven participants (15%) reported considering leaving their current position due to moral distress. The most commonly cited reasons for moral distress (items with the highest frequency ratings) were item 4: 'being unable to provide optimal care due to pressures from administrators or insurers to reduce costs'; item 9: 'watching patient care suffer because of a lack of provider continuity'; item 14: 'witnessing low quality of patient care due to poor team communication'; and item 17: 'experiencing compromised patient care due to lack of resources/equipment/bed capacity'. In addition to the pre-specified reasons, participants identified the following as considerable sources of moral distress. Gatekeeping of services (limited sessions, sole use of online service delivery, overuse of data to measure performance); lack of resources (long waiting lists, understaffing); oppressive practices (use of restraint, seclusion, universally applied/ unsuitable standard guidelines); tensions within staff relationships (bullying, witnessing discrimination); unmet social care needs and socioeconomic injustice.

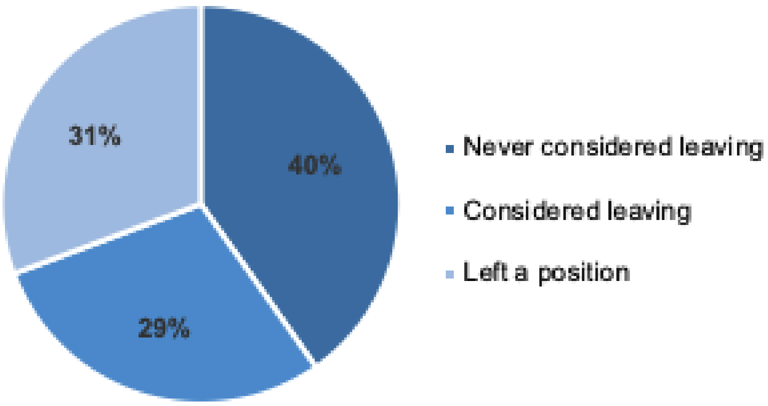


Figure 1: Participants who have considered leaving a position due to moral distress.

3.6.2. RQ 2b) Do Sociodemographic and Professional Factors Predict Moral Distress?

A multiple regression model, including all sociodemographic, professional and moral values described above as predictor variables and MMD-HP scores (moral distress) as the outcome variable, was generated. No prior assumptions about the order in which variables should be entered were made, therefore a forced entry method was used.

3.6.2.1. Assumptions

3.6.2.1.1. Ratio of Cases to Predictors

The rule of thumb of fifteen cases of data per predictor was met (Stevens, 1996). For testing the effects of individual predictors, a sample size of 104+ (n of predictors) has additionally been recommended (Green, 1991). The current test therefore required a sample of 138 (10 variables entered; 34 variables when accounting for dummy coded variables created), which was satisfied.

3.6.2.1.2. Homoscedasticity, linearity and multicollinearity

A data plot of standardised residuals and predicted values showed a random distribution, therefore meeting the assumption of homoscedasticity (Appendix V). This was confirmed by the Breusch Pagan test which was non-significant. The assumption of linearity was also confirmed using R’s Rainbow test (non-significant). All VIF and tolerance statistics were found to be below 10 and above 0.2, respectively, therefore meeting the assumptions of multicollinearity (cut-offs based on Menard, 1995; Myers, 1990).

3.6.2.1.3. Independence and normality of residuals

The independence of residuals assumption was tested using the Durbin Watson statistic (1971), this score was close to the ideal of two (2.05), meeting this assumption. However, inspection of the histogram and Q-Q plots suggested non-normality of residuals. Three outliers were identified using R’s outlier test. These were consequently removed, resolving this issue (histograms and Q-Q plots appeared to display broadly normal distribution; Appendix V).

3.6.2.2. Regression model

The regression model including all sociodemographic, professional and moral values described above explained 19% of the variance in moral distress scores (F(27, 348) = 4.32, $p<0.01$). Age, training background, time working in mental health and the moral values of family and deference were found to be individual predictors of moral distress. Younger participants were more likely to have higher moral distress scores ($\beta=-0.29$, $p<0.01$). Additionally, compared to participants with a training background in psychology, those who trained in psychotherapy ($\beta=-0.44$, $p=0.01$) were more likely to have lower moral distress scores, while those who trained in nursing ($\beta=0.60$, $p<0.01$) medicine ($\beta=0.61$, $p=0.01$) or ‘other’ AHP ($\beta=0.60$, $p<0.01$) were more likely to report greater levels of moral distress. Those who had worked in mental health for longer were likely to report higher levels of moral distress ($\beta=0.19$, $p<0.01$), as were those with higher moral value scores for family ($\beta=0.14$, $p=0.03$) and deference ($\beta=0.22$, $p<0.01$). All standardised regression coefficients (β), significance values and SEs are presented in Appendix W.

3.7. RQ3: Clinical Decision-Making

3.7.1. RQ 3a) Are there Significant Differences in CDM Scores by the Hypothetical Client's Race?

Mean CDM scores by the race of the hypothetical client per vignette are presented in Table 6. Scores ranged from 0–100 for all subscales with the exception of V3-SA which ranged from 0–97, and V6-B, which ranged from 0–93. There were no significant differences in CDM scores by the hypothetical client's race; one-way ANOVAs by race were non-significant.

Table 6: Mean Vignette Scores

Subscale	Mean (*SD*)	Subscale	Mean (*SD*)
V1 total	59.20 (26.02)	**V5 Total**	47.30 (25.55)
W	59.96 (26.16)	W	49.45 (23.33)
B	58.64 (26.07)	B	45.05 (26.65)
SA	59.01 (25.99)	SA	47.39 (26.44)
V2 total	44.80 (28.80)	**V6 Total**	47.25 (26.00)
W	48.07 (26.16)	W	44.51 (27.96)
B	42.28 (26.06)	B	48.48 (24.58)
SA	43.81 (25.99)	SA	48.94 (25.23)
V3 total	43.65 (24.81)	**V7 Total**	58.88 (25.28)
W	44.75 (24.11)	W	60.66 (24.76)
B	44.19 (24.91)	B	56.82 (25.47)
SA	42.06 (25.49)	SA	59.07 (25.64)
V4 total	51.97 (25.22)		
W	52.50 (24.83)		
B	49.62 (25.15)		
SA	54.71 (24.49)		

3.7.2. RQ 3b) Are Racial Attitudes Significantly Associated with CDM?

Racial attitudes were measured using the CoBRAS. Higher scores on the CoBRAS indicate greater unawareness of the influence of racial attitudes on social justice and greater racial prejudice (Neville et al., 2000). The mean total CoBRAS score was 43.31. Mean subscale scores were 17.89 for Factor 1 (unawareness of racial privilege), 14.91 for Factor 2 (institutional discrimination) and 10.51 for Factor 3 (blatant racial issues). Pearson's correlation coefficients exploring the relationship between CDM scores and CoBRAS scores are presented in Table 7. Significant positive associations between CoBRAS total scores and CDM scores were found for all vignettes (Table 7).

Table 7: Correlation Coefficients Between CoBRAS Scores and Vignette Scores

Vignette	1	2	3	4	5	6	7
r	0.18***	0.28***	0.10*	0.26***	0.12*	0.22***	0.30***

**p<0.05, **p<0.01, ***p<0.001*

3.7.3. RQ 3c) Which Factors (racial attitudes/ bias, sociodemographic/ professional factors and moral values) Predict CDM?

Hierarchical linear regression models were used to explore predictive relationships between sociodemographic, professional and moral factors and CDM scores. Given that the vignettes were designed to depict situations in which known racial disparities occur, client race and racial attitudes (CoBRAS) scores were entered at Step 1; sociodemographic factors were added at Step 2; and professional and moral factors were included in Step 3. Separate regression models were produced for each of the seven vignettes.

3.7.3.1. Assumptions

3.7.3.1.1. Ratio of cases to predictors

For all regression models, the sample size recommendations of fifteen cases of data per predictor (Stevens, 1996), and of 104 + (n of predictors; Green, 1991) were met. Based on the above, a sample of 141 (10 variables entered; 37 variables when accounting for dummy coded variables created) was required and satisfied by the current sample.

3.7.3.1.2. Homoscedasticity, linearity and multicollinearity

For all vignette models, a data plot of standardised residuals and predicted values was produced. All plots showed a random distribution (Appendix X), therefore meeting the assumption of homoscedasticity. This was confirmed using the Rainbow test in R (non-significant). All VIF and tolerance statistics were found to be below 10 and above 0.2, respectively, meeting the assumptions of multicollinearity (cut-offs based on: Menard, 1995; Myers, 1990).

3.7.3.1.3. Independence and normality of residuals

The independence of residuals assumption was tested using the Durbin Watson statistic (1971). This score was close to the ideal of two for all vignette models, therefore meeting this assumption. Histograms and Q-Q plots of standardised residuals were inspected in order to confirm the normality of residuals assumption (Appendix X).

3.7.3.2. Regression models

A summary of the significant findings is presented below. Standardised regression coefficients (β), significance values and SEs for these models are presented in Appendix Y.

3.7.3.2.1. V1: Diagnosing psychosis (assessment decision)

The models explained 3, 3 and 9% of the variance in CDM scores (Adjusted R^2), respectively (*Model 3:* F(29, 366) = 2.31, $p<0.01$). Racial attitude scores were significantly associated with CDM in Models 1 ($\beta=0.19$, $p<0.01$) and Model 2 ($\beta=0.24$, $p<0.01$) but not in Model 3. In Model 3, those who trained in medicine ($\beta=0.64$, $p<0.01$), nursing ($\beta=0.54$, $p<0.01$), psychotherapy ($\beta=0.54$, $p<0.01$) and 'other AHP' ($\beta=0.38$, $p<0.05$) were more likely to agree with the clinical decision compared to those who trained in psychology. Participants with higher deference scores were also significantly more likely to agree with the clinical decision ($\beta=0.18$, $p<0.01$).

3.7.3.2.2. V2: Low mood presentation (access decision)

The models explained 8, 8 and 9% of the variance in CDM scores, respectively (*Model 3:* F(29, 366) = 2.36, $p<0.01$). Racial attitudes significantly predicted decision-making scores in all models (*Model 1*: $\beta=0.28$; *Model 2*: $\beta=0.27$; *Model 3*: $\beta=0.22$, all *p's* <0.01). No other individual predictors were significant.

3.7.3.2.3. V3: Perinatal visit (access decision)

None of the regression models for V3 were significant.

3.7.3.2.4. V4: Hospital admission (treatment decision)

The models explained 7, 11 and 12% of the variance in CDM scores, respectively (*Model 3:* $F(29, 366) = 2.86$, $p<0.01$). Again, higher racial attitude scores predicted greater agreement with the decision for all models (*Model 1*: $\beta=0.26$; *Model 2*: $\beta=0.28$; *Model 3*: $\beta=0.15$, all p*'s* <0.05). In Models 2 and 3, being from an Asian (*Model 2*: $\beta=0.46$, $p<0.05$; *Model 3*: $\beta=0.58$, $p<0.01$) or Black ethnic background (*Model 2*: $\beta=0.65$, $p<0.01$; *Model 3*: $\beta=0.64$, $p<0.05$), compared to being from a white background predicted higher CDM scores. In Model 3, a training background in medicine ($\beta=0.53$, $p<0.05$), nursing ($\beta=0.42$, $p<0.01$) and 'other' AHP ($\beta=0.46$, $p<0.05$), compared to in psychology, and working in inpatient settings ($\beta=0.35$, $p<0.01$), compared to other adult settings predicted higher CDM scores.

3.7.3.2.5. V5: Physical vs. mental health query (assessment decision)

Model 1 was significant, although explained only 1% of the variance in CDM; racial attitudes were the sole significant predictor ($\beta=0.10$, $p<0.05$). No other models were significant.

3.7.3.2.6. V6: Antipsychotic medication (treatment decision)

All models were significant and explained 5, 7 and 10% of the variance in CDM scores (*Model 3:* $F(29, 366) = 2.47$, $p<0.01$). Racial attitudes were significant predictors of CDM Models 1 and 2 (*Model 1*: $\beta=0.22$; Model 2: $\beta=0.24$; p*'s* <0.01). Being male (compared to female) significantly predicted CDM in Model 2 but not 3 ($\beta=0.39$, $p<0.01$), and training in medicine, compared to psychology, predicted higher CDM scores ($\beta=0.57$, $p<0.05$), as did working in 'other' workplace settings, compared to adult settings ($\beta=0.41$, $p<0.05$).

3.7.3.2.7. V7: MHA (treatment decision)

All models were significant and explained 9, 9 and 11% of the variance in CDM scores (*Model 3:* $F(29, 366) = 2.71$, $p<0.01$). Racial attitudes were significantly positively associated with CDM scores for all models (*Model 1*: $\beta=0.30$; *Model 2*: $\beta=0.30$; *Model 3*: $\beta=0.19$, all p*'s* <0.01). A training background in nursing ($\beta=0.33$, $p<0.05$) and medicine

(β=0.76, p<0.01), compared to in psychology, significantly predicted CDM in Model 3, as did the endorsement of the value of family (β=0.14, p<0.05).

3.7.4. RQ 3d) Do Racial Attitudes Mediate the Relationship Between Moral Values and CDM?

Bivariate correlations found that racial attitudes (CoBRAS scores) were significantly associated with CDM in all seven of the vignettes. Similarly, multiple regression results found that when controlling for sociodemographic and professional factors, racial attitudes significantly predicted CDM scores in three of the vignette regression models. Furthermore, the MAC moral values of deference, group and family were shown to predict CDM scores in the regression models for V1, V5 and V7, respectively. Equally, previous research has firstly, supported the notion that and MHPs values influence CDM in a range of settings (Chih, 2001; McCabe et al., 1992; Moyo et al., 2019; Schwartz et al., 1975). Secondly, has shown that many decisions within mental healthcare are morally challenging and therefore are likely to involve moral reasoning; thus, the appraisal and endorsement of various moral values may feasibly influence CDM (Campbell, 2007; Grace et al., 2003; Garrigan et al., 2018). Both the aforementioned findings and previous literature therefore informed the construction of structural equation models, which were used to explore relationships between racial attitudes, moral values and CDM.

3.7.4.1. Assumptions

SEM shares the same assumptions of homoscedasticity, linearity, multicollinearity, independent errors and normality as regression tests (Hatcher & O'Rourke, 2013; Kline, 2015), which have been discussed above (Section 3.7.3.1). In addition, SEM is particularly sensitive to missing data (Tabachnick & Fidell, 2007); there were no missing data in the variables used to construct the following models.

3.7.4.2. Constructing the model

SEM utilises both confirmatory factor analysis (CFA), to measure latent variables, and path analysis, to examine relationships between variables (Fan et al., 2016; Hoyle, 1995; Kline, 2010). In the present models, CFA was initially used to assess the validity of the latent variables used in the SEM. Here, factor loadings for each observed variable included in the latent constructs were calculated. It has been proposed that the factor loadings should be greater than 0.5, as this indicates acceptable convergent validity (Garson, 2015; Hair et al., 2013). Factor loadings less than 0.5 were therefore excluded from the models. For each model, three fit indices (CFI, RMSEA & SRMR) were examined in order to ascertain whether the models provided an adequate fit for the data (Holtzman & Vezzu, 2011). These fit-indices were chosen as they as less sensitive to large sample sizes (>400) than other commonly used indices, such as Chi-Square, and have been widely used to assess model fit amongst the literature (Chen et al. 2008; Fan et al., 2016; Kenny, 2020). As such, recommended cut-off values can be employed to determine acceptable model fit. Cut off-values used were as follows: CFI above 0.9; RMSEA below 0.08; SRMR below 0.08 (Hu & Bentler 1999; Kline 2010).

Two latent variables were constructed for use in the present models: CDM and moral values. The CDM construct was made up of total vignette scores for V1 – V7. However, scores from V2, V3 and V5 were removed from the construct due to having insufficient factor loadings (<0.5). The moral values construct was made up of the seven individual MAC-Q factors. Again, family and heroism were removed due to having insufficient factor loadings.

3.7.4.2.1. Model 1 construction

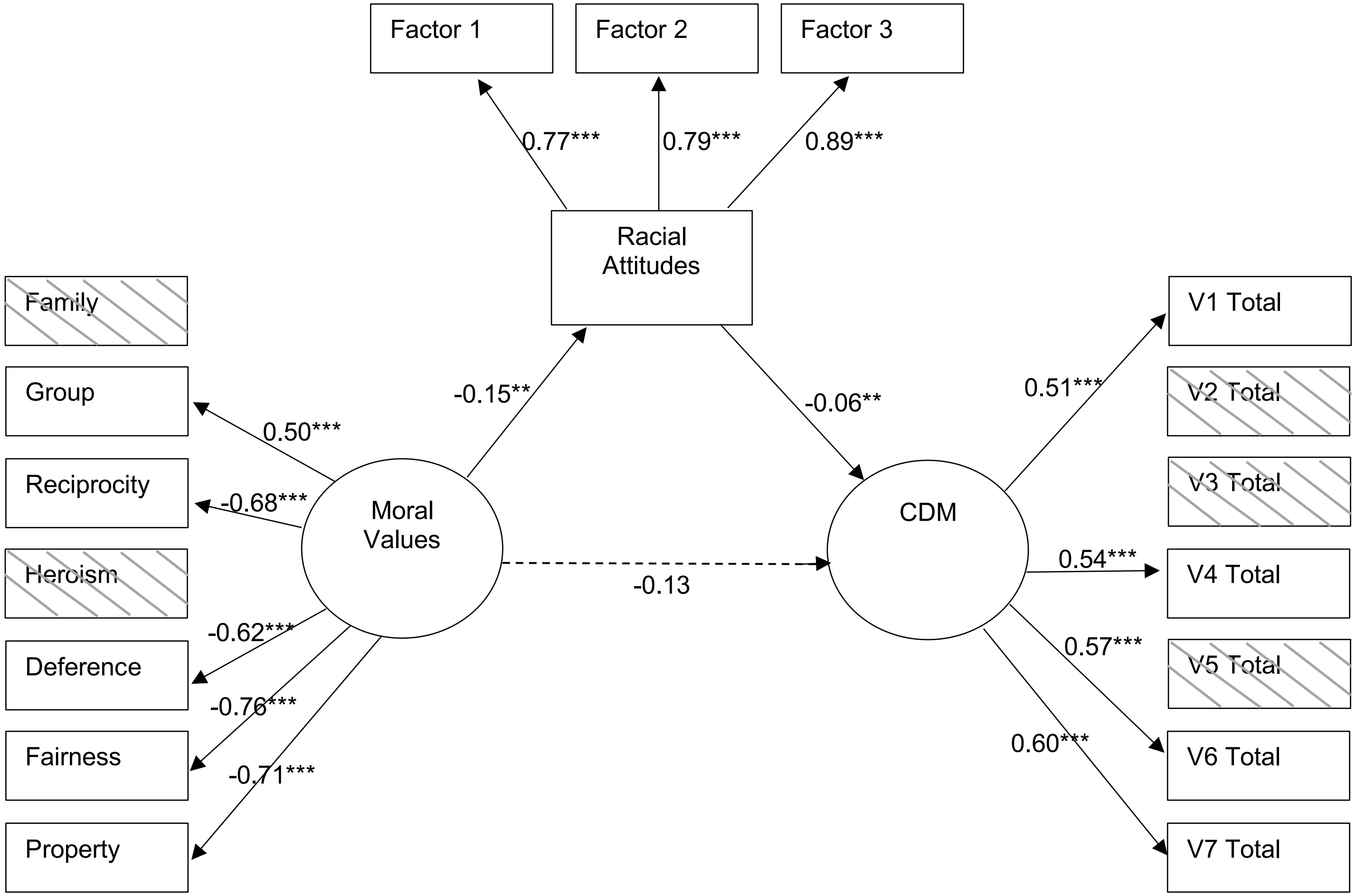
A first SEM model was constructed in order to explore the relationships between racial attitudes, moral values (latent variable) and CDM. The moral values construct was entered as an exogenous variable, and CDM scores as the endogenous variable. Racial attitudes (CoBRAS - made up of three observed variables, Factor 1, Factor 2 and Factor 3) were entered as a mediating exogenous factor. The model was found to be a good fit to the data; CFI, RMSEA and SRMR values were within the acceptable levels (Appendix Z, Table 25).

3.7.4.2.2. Model 2 construction

In the second SEM model, the moral values found to be significantly associated with CDM scores in at least one vignette were entered as separate constructs. The second model was employed due to the fact that the MAC proposes that the seven facets of morality are distinct (Curry et al., 2019a), and therefore it may be hypothesised that they will have differing individual and combined effects on CDM. Here, the moral values of family, deference and group loyalty were entered as exogenous variables, and CDM scores were used as the endogenous variable; racial attitude scores were entered as a mediating exogenous factor. The model was found to be a good fit to the data; CFI, RMSEA and SRMR values were within the acceptable levels (Appendix Z, Table 25).

3.7.4.3. Model 1 findings

The path diagram, displaying direct and indirect effects, is presented in Figure 2. There was a significant direct association between moral values and racial attitudes (β=-0.15, p<0.01), and between racial attitudes and CDM (β=0.42, p<0.01). Moral values did not directly influence CDM (p=0.053), however there was a significant mediation effect of racial attitudes on the relationship between moral values and CDM. Therefore, the relationship between moral values and CDM was mediated by racial attitudes.

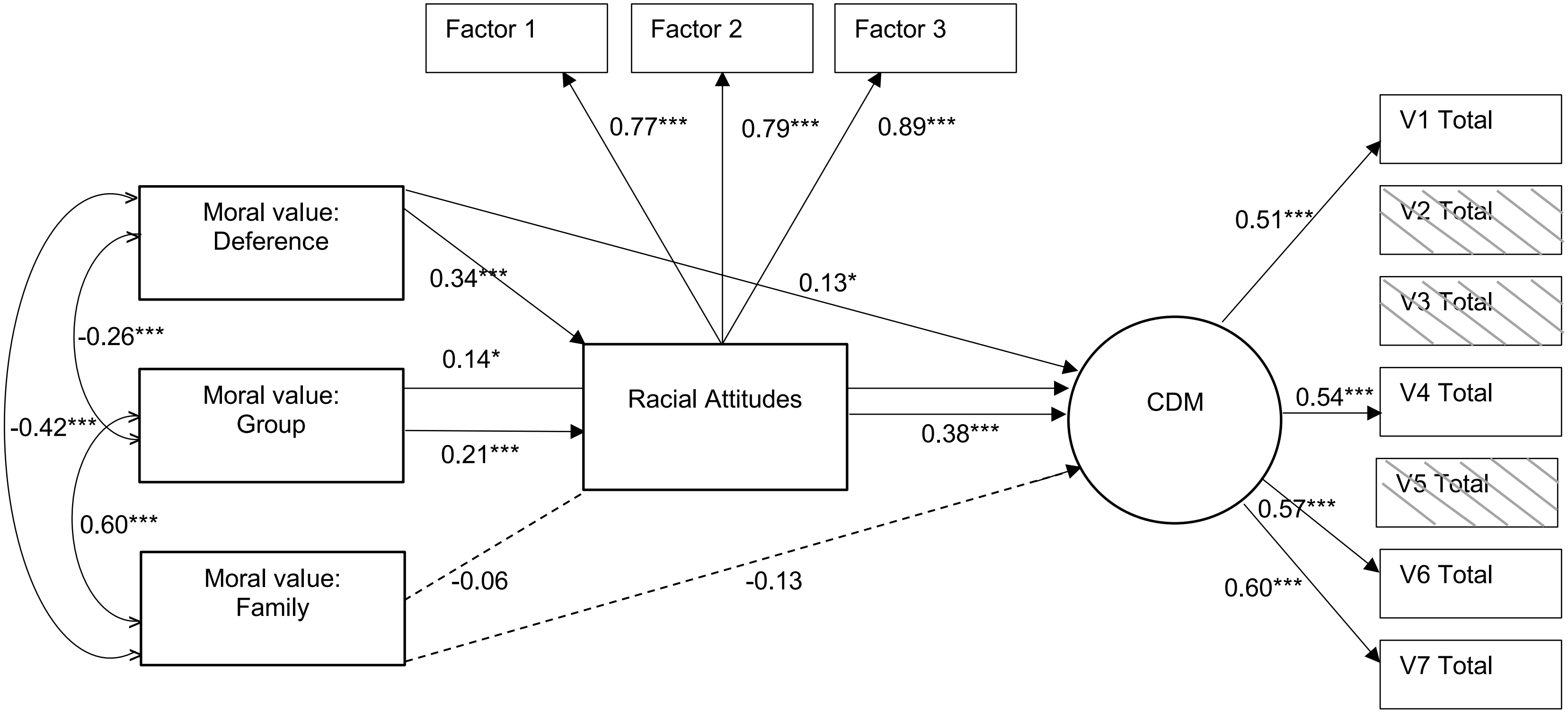


$p<0.05$, $^{**}p<0.01$, $^{***}p<0.001$

Figure 2: Path estimates displaying direct and indirect effects of moral values and racial attitudes on CDM. All coefficients are standardised coefficients. Solid lines represent significant pathways; dashed lines represent non-significant pathways; rectangles indicate observed variables, ovals represent latent variables.

3.7.4.4. Model 2 findings

The path diagram for the SEM model 2 is displayed in Figure 3. The direct effects, presented within this figure, showed a significant direct effect of deference and group loyalty on both racial attitudes and CDM, but a non-significant effect of family. The indirect effects (mediating effects; not displayed in Figure) found a significant indirect effect of racial attitudes on the relationship between deference and CDM scores ($\beta=0.13$, $p<0.001$), as well as between group and CDM scores ($\beta=0.08$, $p<0.01$). The positive association suggests that greater endorsement of the moral values of deference and group loyalty increased the influence of racial attitudes on CDM. The indirect effect of family, as mediated by racial attitudes, was non-significant. Path analyses data for both models are presented in full in Appendix Z (Tables 26 & 27).



**p<0.05, **p<0.01, ***p<0.001*

Figure 3: Path estimates displaying direct effects. Standardised coefficients are presented; regression coefficients are reported on the linear pathway lines and co-variances on the curved lines. Solid lines represent significant pathways; dashed lines represent non-significant pathways; rectangles indicate observed variables, ovals represent latent variables. Indirect effects are presented in-text.

3.8. RQ4: Factors Influencing CDM Processes: Content Analysis

3.8.1. RQ 4ai) Which Factors Influence Participants Agreement/ Disagreement with CDM Processes? ii) Are Participants Judgements of these Factors Influenced by the Race of the Hypothetical Client?

A content analysis was used to explore participants qualitative responses to vignette items. An inductive approach was used, whereby data was initially reviewed and coded; themes were then identified and categorised into broad categories with similar meaning based on the research question (Elo & Kyngäs, 2008). Participants comments often pertained to numerous categories, which were counted as individual entities. It was not possible to capture the full extent of the factors influencing participants CDM due to the wide variety of reasons presented. Nonetheless, a selection of frequently occurring constructs are described below; frequencies per vignette are presented in Table 8.

It is difficult to draw direct comparisons by the race of the client due to their being slightly different numbers of participants in each group. Tentatively, it may be suggested that there were slightly more comments relating to risk, contextual factors and alternative supports when the hypothetical client was Black or South-Asian, compared to when the client was white.

3.8.1.1. Content analysis categories

Thirteen categories relating to common factors influencing participants CDM processes were identified and included in the content analysis (see Table 8). These are described in detail in Appendix AA and briefly outlined below.

The following factors influenced/ guided CDM processes:

1. Risk, risk management and safeguarding.
2. Psychiatric diagnosis.
3. Assessing capacity and obtaining consent.
4. The use of standardised guidelines (NICE), evidence-based interventions, and the law (Acts, treatment orders or legal frameworks).
5. Least restrictive practices or best interest decisions.

6. The need for further assessment/ monitoring.
7. Alcohol and drug use.
8. Collaborative CDM/ centring client’s views.
9. Signposting/ alternative supports.
10. Resource scarcity.
11. Contextual, social and cultural factors.
12. Trauma-informed practice.
13. References to issues of race, culture and racism. Including: highlighting racial disparities and stereotypes within mental health systems, the historical mistreatment of Black and racialised clients in healthcare, professional bias and questioning the cross-cultural validity of specific assessment tools.

Table 8: Content Analysis Categories

	V1			V2			V3			V4			V5			V6			V7			Total			
	W	**B**	**SA**	**W**	**B**	**SA**	**W**	**B**	**SA**	**W**	**B**	**SA**	**W**	**B**	**SA**	**W**	**B**	**SA**	**W**	**B**	**SA**	**W**	**B**	**SA**	**Total**
1. Risk	4	7	10	*na*	*na*	*na*	7	4	6	13	27	25	1	1	0	3	7	6	9	12	14	37	58	61	156
2. Diagnosis	2	1	1	*na*	*na*	*na*	1	1	1	3	1	0	7	4	10	1	0	0	*na*	*na*	*na*	14	7	12	32
3. Consent/ capacity	*na*	*na*	*na*	*na*	*na*	*na*	8	5	9	4	5	5	*na*	*na*	*na*	14	15	10	0	0	1	26	25	25	76
4. Guidelines/ law	2	1	1	2	6	4	*na*	*na*	*na*	1	1	1	2	1	0	3	5	2	1	0	0	11	14	8	33
5. Best interests	*na*	*na*	*na*	0	1	1	*na*	*na*	*na*	2	8	4	*na*	*na*	*na*	5	4	5	3	2	1	10	15	11	36
6. Further ax./ monitoring	11	13	9	8	6	5	23	26	15	2	2	4	11	11	17	5	3	0	6	4	4	66	65	54	185
7. Alcohol & drugs	1	1	5	0	3	1	*na*	*na*	*na*	*na*	*na*	*na*	*na*	*na*	*na*	*na*	*na*	*na*	7	6	3	8	10	9	27
8. Client views/ collaboration	1	0	0	11	8	11	13	8	10	4	6	7	9	10	12	17	19	19	5	4	2	60	55	61	176
9. Alternative supports	0	2	4	16	20	21	8	5	9	12	22	13	6	8	15	13	15	9	7	7	6	62	79	77	218
10. Resource scarcity	0	0	2	2	3	4	1	0	0	6	3	1	*na*	*na*	*na*	1	0	0	*na*	*na*	*na*	10	6	7	23
11. Contextual factors	6	9	9	6	4	7	6	7	8	4	7	6	10	15	12	8	7	12	13	19	12	53	68	66	187
12. Trauma-informed	*na*	*na*	*na*	*na*	*na*	*na*	*na*	*na*	*na*	6	6	3	*na*	*na*	*na*	0	2	0	3	4	3	9	12	6	27
12. Reference to racism in MH	0	1	3	0	0	0	0	4	3	0	2	0	0	0	2	0	2	2	0	2	0	0	11	10	21

3.8.2. RQ 4b) Is the Number of Qualitative Comments Participants Make Influenced by the Race of the Hypothetical Client?

Table 9 details the number and percentage of comments made per vignette, stratified by the race of the hypothetical client. On average, a greater percentage of comments were made when the client in the vignette was described as Black, followed by South Asian, then white.

Table 9: Additional Comments Made per Vignette (V)

	V1	V2	V3	V4	V5	V6	V7	Total
White, % (n)	24.66 (36)	30.05 (50)	34.41 (53)	29.93 (44)	30.82 (45)	35.48 (55)	28.10 (43)	30.84 (326)
Black, % (n)	30.82 (45)	40.84 (58)	40.00 (58)	37.58 (56)	36.30 (53)	33.54 (53)	40.41 (59)	37.02 (382)
South-Asian, % (n)	27.85 (44)	37.50 (57)	39.73 (60)	35.06 (54)	38.60 (61)	30.66 (42)	23.84 (36)	33.36 (354)
Total	125	165	171	154	159	150	138	1062

4. DISCUSSION

4.1. Overview

A broad summary of the study aims and results are initially provided. This is followed by an exploration of the participant characteristics, in order to examine the generalisability of the findings. Subsequently, a more detailed summary and contextualisation of the results pertaining to individual research questions and attending to existing literature is presented. Finally, the strengths, weaknesses and implications of the study findings are considered and an overall conclusion is offered.

4.2. Study Aims and Results Summary

The study aimed to explore associations between various sociodemographic and professional factors and moral values, moral distress and CDM in mental healthcare. Particular attention was paid to the influence of racial attitudes and racial bias in CDM. There was a wide range in MHPs endorsement of each of the MAC moral values and for all seven of the moral values measured, significant associations were found between the moral value and at least one sociodemographic and/ or professional factor. The level of moral distress reported by the current sample was relatively high; 60% of participants had either considered leaving or left their clinical position due to moral distress. Age, training background, time working in mental health and the moral values of deference and family were found to be individual predictors of moral distress; of these, training background was the strongest predictor of moral distress.

With regards to factors predicting CDM, professional training background, workplace setting, time working in mental health, gender, ethnicity and moral values were found to predict CDM scores. Whilst there was at least one significant association between these professional/ sociodemographic factors and CDM scores in all seven of the vignettes, these associations were not consistent across vignettes. Racial attitudes were found to relate most consistently with CDM processes; significant correlations were identified in all seven of the vignettes and when controlling for sociodemographic and professional factors, racial attitudes significantly predicted CDM scores in three of the vignette regression models. Therefore, those with higher colour-blind racial attitude scores were consistently more likely to agree with the hypothetical clinical decision; of note, vignettes were designed such that higher scores indicate greater endorsement of an assessment/ treatment outcome which disproportionately affects racialised clients. Further analyses found that racial attitudes mediated the relationship between moral values and CDM, and that colour-blind racial attitudes influence CDM indirectly; greater endorsement of the moral values deference and group loyalty increased the influence of racial attitudes on CDM. Finally, analysis of participants qualitative comments found that a wide range of factors influenced participants CDM. A greater percentage of comments were made when the client in the vignette was described as Black, followed by South-Asian, then white and more of these comments related to risk, contextual factors and alternative supports when the hypothetical client was from a racialised background.

These findings indicate significant variation in both MHPs moral values and in mental health CDM; decisions are influenced by a range of factors and are often morally challenging. Findings therefore suggest that clinical decisions do not simply arise from rational and neutral processes alone. Rather, socio-political attitudes, namely, racial attitudes, influence CDM and thus, whiteness prevalent in society is reflected within various aspects of CDM. Findings are explored in more detail below.

4.3. Study Sample Considerations

In order to consider the generalisability of the study, the characteristics of the study sample are examined. Within the study sample, the majority of participants identified as female, white, and non-religious and were educated to post-graduate or equivalent level. The most common professional background was clinical psychology.

There were no sociodemographic differences between those who completed the survey and those who did not (Appendix P). Drawing direct comparisons between the sample of MHPs and the general population is somewhat limited as the demographics of the mental health workforce tends to slightly differ from those of the general population (e.g. CHPCCP, 2020; DHSC, 2020). Given that the nationally available demographic data for the mental health workforce is predominantly stratified by professional group, comparisons with the present study were again, fairly limited. In comparison to a synthesis of data on the mental health workforce in the UK (Läng, 2020), a slightly higher percentage of participants in the present study were female (86% vs. 75%), and identified as being from a white ethnic background (84% vs. 73%); a similar percentage identified as being from a Black ethnic background (4% vs. 6%) and slightly fewer participants identified as being from an Asian background (6% vs. 11%). Läng's (2020) report further highlighted differences in the ethnic group participants identified with by profession. For instance, there was a greater representation of individuals from Black ethnic backgrounds in mental health nursing (16%), compared to in psychological professions (2%). This may have influenced the demographics of the current sample which was predominantly made up of psychological professionals. Indeed, the demographic data of the present sample was relatively similar to a Psychological Professions Network workforce report (Self et al., 2021). In this report, 84% of the psychological workforce identified as female; 89% identified as white, while only 1% identified as being from a Black ethic background and 2% from an Asian background. Similar to the present study, the largest age grouping was between 30 – 39. While qualification-level data were not available in either of the above reports, the present sample held a considerably high percentage of participants who had obtained at least postgraduate qualifications (72%); this is far higher than that of the general population (27%; ONS, 2011).

4.4. Summary and Contextualisation of Findings

A summary of the results pertaining to each research question is presented, followed by a respective, broad contextualisation of these findings.

4.4.1. RQ1: Moral Values

It is increasingly recognised that MHPs draw on a wide range of values, attitudes and worldviews to make decisions (King et al., 2009; Stampley, 2008). The study sought to explore moral values specifically, using the MAC-Q. The range in participants endorsement of the MAC moral values, as well as associations between these values and a number of sociodemographic and professional factors were initially investigated.

4.4.1.1. What is the range in participants MAC-Q moral value scores?

Considerable variation in the scores across both scales were found; all bar one of the subscale scores ranged from 0 (minimum score) to 100 (maximum score). This variation overall, may suggest that conceivable or ideal solutions to problems of cooperation (moral frameworks) will differ between MHPs. Hence, this largely challenges the prospect of consistent and systematic healthcare decision-making, as outlined in the NHS Constitution (NHS Constitution for England, 2021).

Participants showed the greatest endorsement for the fairness subscale. This is thought to involve conflict resolution in light of the division of resources, for instance through division on basis of relative power (Skyrms, 1996) or through heuristics (Brams & Taylor, 1996; Henrich et al., 2005). Direct comparisons with other studies employing the MAC-Q are limited as no other study has directly explored the endorsement of the MAC values among MHPs. Nonetheless, these findings are fairly similar to those identified in a large systematic literature review exploring the endorsement of personal and professional values among HCPs (Moyo et al., 2016). Here, the most prominently identified values were altruism, equality and capability, which arguably encompass similar motivational goals to those of the moral value, fairness (Schwartz, 1992).

4.4.1.2. Are there significant differences in the endorsement of the MAC moral values by sociodemographic and professional factors?

The current study sought to explore potential associations between moral values and professional and sociodemographic factors. No differences between participants endorsement of the moral values by professional training route, workplace setting, or workplace rural – urban classification were found. In line with previous literature, this may suggest that personal and professional values are indeed, considerably difficult to distinguish (Dose, 1997; Du Toit, 1995; Moyo et al., 2016). Despite ideas that professional ethics codes and socialisation can considerably influence MHPs values (Borgstrom et al. 2010; Buckland, 2016; Coulehan & Williams 2003), present findings suggest that professional factors alone cannot account for the range in the endorsement of particular moral values.

There were however, differences in the endorsement of each of the moral values by education level, a number of sociodemographic factors (gender, religion, ethnicity), and by racial attitudes scores. Amongst the literature, a number of these findings can be broadly aligned. For instance, the higher endorsement of fairness in those belonging to a religious group (Mobayed, 2019), and the lower endorsement of group loyalty in those educated to at least post-graduate level (Parihar et al., 2018). Though, unlike the current study, some research has found no differences by ethnicity (Kivikangas et al., 2021) or gender (Parihar et al., 2018). Interpretations of these findings may be more usefully understood through the sociocultural contexts in which they exist. For instance, by considering the endorsement of various moral values as a potential response, strategy or adaptation to differing societal and cultural incentives (Curry, 2016; Yamagishi et al., 2008). The following interpretations are offered tentatively. It might be considered that all groups found to have significantly higher fairness scores in the current study (those identifying as being male, Black and religious, respectively) tend to be underrepresented within the mental health workforce (CHPCCP, 2020; DHSC, 2020). Therefore, within the professional context, it could be hypothesised that these individuals may be more likely to perceive acts of discrimination, and consequently place greater emphasis on the value of fairness (Dierckx, 2021; Everett et al., 2016). With regards to the differences by ethnicity, we might consider that the pervasiveness of whiteness in the UK can result in the preclusion of the stark racial inequities present across all levels of society (Baima & Sude, 2020). Therefore, in line with the present findings, those who benefit from whiteness may at times, be less likely to value fairness, as much of this inequity is obscured (e.g. through media, policy and the centralisation of the white experience, DiAngelo, 2012; Guess, 2006). Similarly, given socio-political backdrop of both historical and contemporary racial discrimination, the social incentives/ consequences of valuing heroism and deference are arguably, greater for racialised individuals than they are for white individuals. For instance, the value of heroism may encompass acts of resistance and empowerment (Gopal, 2019; Howarth, 2004), while deference may become an adaptive, default strategy in light of the disparate social incentives/ consequences created by the UK's socio-political context (Joshi & Knight, 2015; Yamagishi et al., 2008). Relationships between racial attitudes and moral values are explored below.

4.4.2. RQ2: Moral Distress

In addition to the range of values MHPs may draw upon during CDM processes and the factors affecting these values, the growing complexity and subjective nature of these processes means that many aspects of CDM are inherently morally challenging. The study subsequently aimed to explore both the prevalence, and factors associated with moral distress among MHPs, using the MMD-HP to measure moral distress.

4.4.2.1. What are the characteristics of moral distress among MHPs?

The mean moral distress score was 98.82. While there are currently no studies which have utilised this measure specifically among MHPs, comparisons with other healthcare settings can be drawn. This score is comparatively lower to those found in studies of HCPs (predominantly nurses) working in intensive care (Boulton et al., 2021; Epstein et al., 2019; Petrisor et al., 2021; Malliarou et al., 2021). Yet, it is relatively similar, or higher, than scores identified in samples of physicians working in paediatric and various other medical settings (Beck et al., 2020; Dias et al., 2022; Rodriguez-Ruiz et al., 2022).

The present study also found that 60% of the sample had either considered leaving or had previously left a position due to moral distress and 15% of participants were considering leaving their current position. Again, these scores are similar to previous studies employing the MMD-HP (Beck et al., 2020; Boulton et al., 2021; Dias et al., 2022), although notably, only one of these studies was conducted in the UK and none were specific to MHPs.

The most commonly cited reasons for moral distress were related to a lack of provider continuity, limited resources and poor team communication (items 4, 9, 14 & 17). In addition, participants self-identified gatekeeping of services, oppressive practices, tensions within staff relationships and unmet social care needs as considerable sources of moral distress. Similar themes have been noted throughout the literature on moral distress among MHPs, largely through the use of qualitative methods (Austin et al., 2003; 2008; Deady & McCarthy, 2010). Within the UK specifically, and in far greater depth than the current study, Sprigings (2021) equally, highlighted the morally distressing effects of limited or inaccessible resources, dehumanising services and social inequalities common in mental health services.

4.4.2.2. Do sociodemographic and professional factors predict moral distress?

In total, sociodemographic, professional and moral factors accounted for 18% of the variance in moral distress scores. Higher moral distress scores were found in participants who were younger and in those who had worked in mental health for longer. Participants who trained in clinical psychology reported higher moral distress than those who trained in CBT/ IAPT and psychotherapy, but lower moral distress than those whose training background was in nursing, medicine or ‘other’ AHP. Participants who endorsed the moral values of family and deference to a greater extent were likely to have higher moral distress scores. No effects of gender, ethnicity, religion, education level, workplace setting or workplace urban – rural classification were found.

Associations between moral distress and age, gender and years of experience are relatively varied amongst the literature. While some have found associations in corresponding directions (Dias et al., 2022; Malliarou et al., 2021; Rodriguez-Ruiz et al., 2022), others have found either null or reverse associations (Boulton et al., 2021; Hamaideh, 2014; Shehadeh et al., 2022). There tends to be more consistency in relation to the association between moral distress and profession/ training route, although previous associations are largely limited to differences between nurses, physicians and varying groupings of AHPs (Boulton et al., 2021; Delgrate et al., 2018; Malliarou et al., 2021). Given the variability in the literature, and in light of the current findings, it may be proposed that rather than individual or standalone factors, moral distress is predominantly influenced by contextual and relational factors as a whole. For instance, as highlighted by participants self-identified sources of moral distress and by prior research, factors such as the organisational environment, ethical climate, power relations/ hierarchies, resource availability and the implicit team culture considerably influence moral distress (Epstein et al., 2019; Lamiani et al., 2017; Sprigings, 2021). Subsequently, the way in which MHPs experience and relate to these factors, and are valued by teams, is likely to be influenced by various features of MHPs personal and professional identity (in the present study this is suggested to be by age, profession, time working in mental health and moral values). Therefore, given that the aforementioned contextual and relational norms tend to vary between services and teams, logically and as evidenced, there will be varying associations between moral distress and sociodemographic/ professional factors amongst the literature.

4.4.3. RQ3: Clinical Decision-Making

While moral distress is one consequence of the subjective, broad and ideologically complex nature of many mental health decisions, another, is that this largely enables these decisions to be shaped by dominant discourses, attitudes and worldviews. Through the use of vignettes, the study sought to explore whether racial attitudes/ bias, sociodemographic, professional and/ or moral factors were associated with, or could predict CDM.

Overall, there was a vast range in participants responses (agreement/ disagreement with the clinical decision presented in the vignette). Across the seven vignettes, all CDM total scores ranged from 0 (minimum) to 100 (maximum); on average, participants displayed relatively neutral responding, with mean scores ranging from 43.65 (V3) to 59.20 (V1).

4.4.3.1. Race and racial attitudes

Regarding racial bias, the current study did not find direct associations between the race of the hypothetical client and CDM scores and thus, the vignette study design was not able to reflect the racial bias present within the UK's mental health systems. Results of previous vignette studies assessing racial bias are fairly varied. While some have found significant effects (Mikton & Grounds, 2007; Minnis et al., 2001; Jones & Williams, 2020), others have also found null effects (Connolly & Taylor, 2016; Currin et al., 2007; Lewis et al., 1990). Nonetheless, considering both the null effects of the present study, as well as the consistently evidenced racial disparities across the mental health system (Bignall et al., 2019), it may be proposed that studying race as a discrete construct which correlates neatly with outcomes of interest is inherently limited. Instead, race operates as a complex set of historical, socio-political and contemporary processes which together, shape particular disparate experiences, interactions and outcomes across various levels of the mental health system (Bhui et al., 2018).

In terms of racial attitudes, significant positive associations between racial attitudes and CDM scores were found for all seven vignettes. Higher racial attitude scores, indicating greater racial prejudice and endorsement of colour-blind ideologies, were associated with higher CDM scores (agreement with clinical decision). This is particularly pertinent given that the vignettes in the present study were designed to depict instances in which racial disparities are known to occur (greater agreement with the decision indicated greater endorsement of an assessment/ treatment outcome which disproportionately affects racialised clients). There may be various reasons for the significant effect of racial attitudes, yet the null effect of race. For instance, the CoBRAS has been found to better control for social desirability (Neville et al., 2000; Neville et al., 2006) and is likely to encompass at least some of the influence of contextual and socio-political attitudes on participants thinking.

Current findings therefore suggest that MHPs racial attitudes significantly impact CDM across various mental health contexts. These findings are broadly in line with previous research which has found colour-blind ideologies to be associated with lower levels of racial sensitivity, lower multicultural awareness and with MHPs perceptions of the client’s presenting difficulties (Burkard & Knox, 2004; Chao et al., 2011; Gushue, 2004). Niemonen (2007) further suggested that therapists who were aware of and attempted to avoid colour-blindness were less likely to perpetuate racist discourses. A number of reasons for this have been highlighted, including that being aware of and contextualising CDM in light of various forms of contemporary racism is crucial for evaluating one’s own biases, prejudices and associated appraisals of normativity (Gushue & Constantine, 2007; Sue et al., 2019).

4.4.3.2. Do racial attitudes, sociodemographic, professional and moral factors predict CDM?

In order to further explore the influence of racial attitudes, as well as various sociodemographic, professional and moral factors on CDM, regression modelling was employed. Together, these variables significantly predicted CDM scores in the majority of the vignettes. Racial attitudes were consistently related to CDM, significant associations were found in all but one of the vignette scenarios. Individual significant predictors are presented in Table 10.

Table 10: Individual Significant Predictors of CDM

	Vignette(s)	Direction of effect
Racial attitudes	1[a], 2, 4, 5[b], 6[a], 7	Higher racial attitude scores significantly predicted greater agreement with the clinical decision.
Training background	1, 3[b], 4, 6, 7	Compared to those training in psychology, participants who trained in nursing (V1, V4, V7), medicine (V1, V4, V6, V7), psychotherapy (V1) and 'other' (V1, V4) training backgrounds were more likely to agree with the clinical decision.
Workplace setting	4, 5[b], 6	Compared to participants working in adult MH settings, those working inpatient (V4, V5) and other MH (V6) settings were more likely to agree with the decision.
Gender	3[b]	Men were more likely to agree with the clinical decision compared to women.
Ethnicity	4	Participants identifying as being from a Black or Asian ethnic background, compared to a white ethnic background, were more likely to agree with the decision.
Moral values: family, deference & group	1, 5[b], 7	Participants who endorsed the values of family (V7), deference (V1) and group loyalty (V5) were more likely to agree with the clinical decision.

[a]Significant in Models 1 & 2 but not in Model 3.
[b]Overall regression model not significant.

Comparable associations between CDM and participants professional training (Littleford, 2007; Luciano et al., 2020; Nakajima et al., 2021), years of experience (Jackson et al., 2019; Tarvydas, 2001), workplace setting (Buckloh & Roberts, 2001) and/ or moral values (Schwartz et al., 1975) have been evidenced. These associations however, are not consistent amongst the literature (Littleford, 2007; Zheng et al., 2014), and as highlighted in the present study, are not necessarily consistent across clinical scenarios, even within the same sample.

Together, these factors only accounted for around 10% of the variance in CDM. While it may be suggested that additional factors not measured here, are implicated in CDM, the vast range and relatively neutral average responding (described above) should also be considered. Although there were no ‘correct’ answers to the vignettes, this perhaps supports the notion that CDM in mental health is a relatively abstract and ideologically complex process – in the absence of underlying pathology and objective signs, these decisions will naturally lack consistency and struggle to fit within logical-empiricist frameworks (Moncrieff, 2010; Thakker & Ward, 1998). They will instead, be shaped by our human interpretation and the imposition of societal attitudes and discourses (Sadler, 2005).

Indeed, the most consistent finding was between racial attitudes and CDM. Given that the measure of racial attitudes arguably, taps into to participants socio-political attitudes (Neville et al., 2000; Neville et al., 2006), this too, largely supports the notion that CDM in mental health is inherently value-laden, influenced by MHPs attitudes and worldviews (Buckland, 2016; Okasha, 2000; Okah et al., 2021). More specifically, it suggests that the normative assumptions and dominant discourses of the wider society, which are embedded within structures of whiteness, are reflected within CDM.

While the nature of whiteness means that it is often difficult to measure quantitatively, the influence of colour-blind racial attitudes in mental health CDM has similarly, been highlighted in previous research (Burkard & Knox, 2004; Chao et al., 2011; Okah et al., 2021; Stampley, 2008). This may for instance, play out through preventing the acknowledgement of racist narratives within CDM processes (Mensah et al., 2021), through the reliance on Western and white-British conceptualisations of distress (Buckland, 2016; Chih, 2001), or through the distancing (referring clients onwards) of clients whose presenting difficulties do not fit with the MHPs own conceptualisations of distress and treatment (Stampley, 2008). As highlighted by the present findings, the inequity resulting from colour-blind racial attitudes is often subtle; whilst all participants had comparatively low colour-blind racial attitude scores (in comparison to the initial validation study; Neville et al., 2000), these attitudes were still, consistently implicated in CDM processes.

4.4.3.3. Do racial attitudes mediate the relationship between moral values and CDM?

The study sought to further explore relationships between CDM, racial attitudes and moral values using SEM. This exploration was informed both by the above findings, in which racial attitudes were found to consistently predict CDM, and previous research which has highlighted the considerable role MHPs values play in CDM (Fulford, 2004; Littleford, 2007; Schwartz, 1975). A significant direct association between moral values and racial attitudes was found; greater endorsement of the moral values predicted lower colour-blind racial attitude scores. Moral values overall did not directly influence CDM, however, there was a small but significant indirect/ mediation effect of racial attitudes on the relationship between moral values and CDM.

Again, these findings are largely in line with those suggesting that various contextual and relational factors, societal attitudes, beliefs and worldviews, influence the endorsement and expression of moral values and subsequently CDM (Berg et al., 2021; Grace et al., 2020; Knapp & VandeCreek, 2007). Authors have for example, suggested that socio-political attitudes shape the way in which we understand the optimal or ideal ways of understanding and arranging our lives (our moral standards; Sadler, 2002). Thus, these attitudes interact with our normative- and value-judgements, and consequently influence the way in which we appraise behaviour/ clinical scenarios (Sadler, 2002). Given the pervasiveness of whiteness across various levels of the UK's society, including but not limited to: whiteness in politics, policy, guidelines and our conceptualisations of distress (Faulkner, 2014; Guess, 2006), it follows that racial attitudes considerably influence CDM. This is both directly, and indirectly, through their effect on moral values.

In a second SEM model, the relationships between the individual moral values found to be significantly associated with CDM in the previous regression analyses (family, deference and group), racial attitudes and CDM were explored. Significant direct effects of deference and group loyalty on both racial attitudes and CDM were found; those who endorsed the values of deference and group loyalty to a greater extent were more likely to have higher colour-blind racial attitude scores and higher CDM scores. A significant mediating effect of racial attitudes on the relationship between

CDM and both deference and group loyalty was also identified. Namely, greater endorsement of the values of deference and group increased the influence of racial attitudes on CDM. Neither the direct or mediating effects of family were significant.

With regards to the value of deference, the MAC proposes that this encompasses the resolution of conflict through displays of submission, such as respect, humility and obedience (Curry, 2007, MacIntyre, 1981). Similarly, regarding group loyalty, traits such as solidarity, conformity and unity are valued because they help to solve the cooperation problem of coordination (situations in which individuals are unsure of how to act in order to achieve mutual benefit; Lewis, 1969). It therefore follows that those who endorse the values of deference and group loyalty to a greater extent will be more likely to adopt/ conform to dominant and normative attitudes, beliefs and ideas of particular groups and/ or society. Consequently, in line with the present findings, in a society and mental health system which is largely dominated by Western norms and ideals and in which whiteness permeates, those who adopt values of deference and group are, broadly generalising, more likely to assume these dominant norms and attitudes. Arguably therefore, neutrality maintains contemporary racism as the various forms of cultural imperialism present within our mental health systems remain largely unchallenged.

Of note, the associations found when considering moral values as a whole (negative relationship between moral values and racial attitudes/ CDM), compared to those identified when exploring the values of deference and group individually (positive relationships) appear somewhat contradictory. This supports the notion that MAC values are indeed, distinct and therefore different facets of morality will have differing effects on MHPs attitudes and worldviews, and subsequently on CDM.

4.4.4. RQ4: Factors influencing CDM processes: Content analysis

A content analysis was used to explore participants qualitative answers to the vignettes presented. Thirteen broad themes were identified. These were: risk, diagnoses, consent/ capacity, guidelines/ the law, Best Interests decisions, the need for further assessment/ monitoring, alcohol and drug use, client views/ collaborative decisions, referrals to alternative supports, the influence of resource scarcity, contextual factors, the use of trauma-informed approaches, and acknowledging racism in mental healthcare. Whilst a strength of the content analyses is that it offered various additional insights into the factors influencing CDM, it should also be noted that CDM is a highly complex process; the categorisation and interpretation of the data will be influenced by the researcher's perspective and experiences (Elo & Kyngäs, 2008). The following interpretations are therefore offered tentatively.

The themes most commonly cited as relevant to participants thinking in the present study were alternative supports (including tailoring support/ seeking support from third sector organisations, social/ peer support networks or alternative services) and centring client views/ collaborative practice. This is largely in line with previous research which suggests that MHPs consider clients views, person-centred and collaborative practice to be fundamental to their CDM (Armstrong et al., 2000; Buckloh & Roberts, 2001; Meeson, 1998; Slade, 2017). Similarly, previous research has supported the potential influence of a number of the additional identified themes on CDM. This includes the way in which scarce resources limit decision/ care options available (Liberati et al., 2021; Quirk, 2003), the impact of mental health diagnoses on MHPs responses (Jackson et al., 2019), and the influence of risk factors (Nathan et al., 2021) on CDM. In accordance with the present findings, the influence of standardised guidelines and policy tends to be fairly inconsistent (Murphy, 2014; Peay, 2003; Rouf et al., 2011). Moreover, while there are evidenced common factors influencing CDM (most prominently clients views/ collaborative practice and the consideration of appropriate/ alternative support), a very broad range of potential factors influencing CDM were identified (themes included in Appendix AA). It should further be noted that decision-making is an extremely complex process; identifying factors influencing in this process will always be limited to the methods and analyses used to do so, and content analyses specifically, may be influenced by the researcher's subjective judgements (Elo & Kyngäs, 2008). Therefore, it is likely that a far greater number of factors and processes than those identified in the present study are involved in mental health CDM.

A potentially unexpected finding was that for the majority of vignettes, a greater percentage of comments were made when the hypothetical client was described as Black, followed by South-Asian, then white. It was further, tentatively suggested that there were more comments relating to risk, contextual factors and alternative supports when the hypothetical client was Black or South-Asian, compared to when the client was white. In relation to the differences in the number of comments overall, previous research by Adams et al. (2014) also found that MHPs tended to make a greater number of inferences for racialised compared to white clients, and suggested that this may be due to greater levels of clinical uncertainty. Here, we may consider the ideological power within our mental health systems, which largely centers white, Eurocentricity and operates within our conceptualisations of distress, diagnostic categories, research and treatment models (Eagleton, 2007; Kline, 2014; Szasz, 1974). As, one of the numerous consequences of these operations of power may be the evidenced uncertainty within MHPs judgements when working with racialised clients, created by the systemic underrepresentation of racialised groups and associated forms of cultural imperialism (Christopher & Hickinbottom, 2008; Stam et al., 2015; Summerfield, 2013).

Various studies have also noted disparities in relation to the particular factors MHPs attend to by race. For instance, Black and racialised clients have been shown to be disproportionally judged as violent or as requiring criminal justice proceedings (Ho & Intravia, 2019; Lewis et al., 1990). Others, have equally suggested that racialised clients are more likely to be referred away from services (alternative supports), whilst white clients are more likely to be offered direct or more intensive mental health support (Chaudary, 2017; Currin et al., 2007; Jones & Williams, 2020). Such findings may suggest that mental health practices continue to replicate the stereotypes, biases and political disadvantages ensuing from various historical and socio-political contexts. This includes both the way in which the mental health system has historically viewed and harmed racialised people. Also, to the UK's current socio-political context which continues to systemically disadvantage and underrepresent racialised people, including in research, treatment practices and the professional workforce (Kline, 2014; Patel & Keval, 2018).

4.5. Clinical Implications

4.5.1. Moral Values and Moral Distress

The findings evidenced considerable variation in both the endorsement of the seven moral values offered by the MAC, and in participants agreement/ disagreement with all of the clinical decisions presented. Therefore, conceivable solutions to problems of cooperation, including solutions to various healthcare dilemmas, may differ between MHPs. Nonetheless, mental health practice in the NHS is largely guided by standardised guidelines, codes of practice and diagnostic criterion (e.g. APA, 2013; Hyman, 2010; NICE, 2012). Such generalist or principlst approaches to CDM largely overlook the importance and presence of differing values amongst individuals working in or accessing the mental health system. Furthermore, as highlighted by participants self-described sources of moral distress, situations in which conflicts in values are discounted or suppressed and/ or where there appears to be no feasible methods of solving the clinical decision (problems of cooperation) frequently elicit moral distress. This is particularly pertinent given the high levels of moral distress evidenced in the current sample of MHPs.

An alternative way of working with the range and inevitable conflict in values may be by drawing upon ideas from the values-based approach (Fulford, 2004; Woodbridge & Fulford, 2004). This approach posits that building an awareness of the diversity of values is key to improving communication and therefore to working collaboratively, inclusively and sensitively both amongst MHPs and with clients. Making these differences more transparent may also shed light on the power imbalances and the privileged and subjugated voices within particular CDM situations. While this approach does not attempt to resolve all value conflicts, it may create a space in which the inevitable value conflicts can be acknowledged and discussed, therefore potentially encouraging opportunities to address this source of moral distress.

Going further than this, would be to suggest that the frameworks under which our mental health systems operate are ill equipped to solve issues of value conflict in practice (Kirkengen & Thornquist, 2012; Kirkengen et al., 2016; Tjeltveit, 2004). For instance, many modern philosophical frameworks are based upon evidence-based practice, where evidence acts as a neutral arbiter between potentially competing views. However, this largely obscures the distinction between fact and value and ultimately privileges Western, normative ideas and frameworks (Eagleton, 2007; Szasz, 1974). In addition to the moral distress caused by attempts to fit evaluatively complex decisions into standardised guidelines and frameworks, this can also contribute to inequitable and disparate mental healthcare. It may therefore be suggested that a more serious revision of the philosophical frameworks which uphold our mental health systems is required in order to better understand our mental health practice and foster genuine collaborative, equitable and meaningful CDM.

4.5.2. Racism and Whiteness in the Mental Health System

As well as recognising differences in values, the contexts within which the UK's mental health system operates must be acknowledged. As discussed above, this includes recognising the historical and socio-political contexts which influence societal attitudes, dominant discourses and subsequently mental health ideologies (Bhui et al., 2018; Fernando, 2010). For instance, findings showed that racial attitudes influenced both moral values and CDM, as well as mediating the relationship between moral values and CDM. Therefore, in order to truly recognise the influence of values and value conflicts on CDM, we also need to explicitly explore the influence of whiteness within our mental health system; whiteness is not only operating directly within CDM, but also indirectly, through its influence on values and value judgements.

While an awareness of and conversations around various forms of racism in the UK have arguably, considerably amplified over the last two years following the 2020 Black Lives Matter (BLM) movement, various civil rights and anti-racism resistance movements have been made throughout history. Yet, substantial change in the racial disparities present in mental health has not yet been seen. One reason for this may be that services and organisations tend to respond by implementing training and policies targeted at the individual level, such as cultural competency training, or those which are largely based upon diversity and inclusion initiatives. Whilst increasing representation is unquestionably necessary, these approaches neglect the pervasive and often invisible operations of whiteness, institutional racism and the influence of dominant cultural norms present across the mental health system (Patel, 2021). They assume simply that increasing representation will help solve issues of racism and inequity, whilst also implicitly relying on racialised individuals to create change in a system which continues to systematically disadvantage them. Supported by the finding that colour-blind racial attitudes consistently influenced CDM in the present study, there appears a need to instead, centre whiteness and institutional racism, recognising the unpicking of whiteness as a mutual objective within any attempts to genuinely address issues of racialisation and inequity. This includes within policy, professional training and in organisation cultures. At the individual/ team level, this may include through reflective practice in which normative assumptions, operations of whiteness and one's own racial position, biases and attitudes are inspected (Dawber, 2013; Sue, 2015). At the institutional level, the power whiteness holds within the evidence and knowledge base should also be addressed. This includes raising awareness of institutional racism and its effects within mental health education, aiding individuals to gain a critical awareness of their knowledge and practice (Lazaridou & Fernando, 2022; Ramrathan, 2016).

Findings also showed that a greater endorsement of the values of deference and group loyalty increased the influence of colour-blind racial attitudes on CDM. In essence, the whiteness and racial attitudes present within society have a greater influence in those who value deference and group loyalty as these encompass ideas of conformity, submission, obedience and unity (Curry, 2007; Lewis, 1969; MacIntyre, 1981). In practice, this highlights the importance of distinguishing between the position of being against racism and the position of anti-racism across all levels of the system, including organisational and policy levels. The former will allow racism to persist as it signifies neutrality with dominant discourses and the norm culture, while the latter seeks to actively challenge the status quo (Kendi, 2019; Patel, 2021). At the organisational level, one approach to antiracism practice is through organisational consultation (Patel, 2021). Here, organisations are supported through the process of re-centring and de-centring whiteness across the organisation – its structures, processes, practices and within CDM. The Eurocentricity of our concepts, models and assumptions which maintain and legitimise whiteness are inspected, framing whiteness as the problem, rather than probelmatising race itself. All MHPs are encouraged to together, examine the self, the social conditions and evaluate the effects of structural level racism in mental healthcare, formulating the sustainable practice of anti-racism work within the organisation. Though crucially, the lived experiences of racism take precedence within any approach to change (Lazaridou & Fernando, 2022; Patel, 2021).

4.6. Theoretical implications

Broadly, the vast range in participants CDM scores, as well as the influence of racial attitudes, suggested that CDM in mental health is substantially inconsistent. In the absence of objective or observable signs, achieving widespread consensus in CDM is arguably, not conceptually possible (Phillips et al., 2012). Clinical psychology and many mental health fields however, continue to favour research, outcomes and treatment models which are predicated in medical frameworks. The ideologically and evaluatively complex nature of mental health CDM arguably, means that research, theory and practice will inevitably lack the precision, validity and reliability required to fit within medical frameworks. That is not to say that research and mental health concepts and outcomes cannot be extremely meaningful, but it is to suggest that attempts to fit them into a largely incompatible framework means that they will always fall short of their medical counterparts. In order to truly make efforts to achieve parity of esteem, it may be necessary to look beyond this model, to explore ways in which research and theory can better fit with the epistemological and ontological nature of mental health concepts. This may, for instance, involve placing greater value on qualitative research, or exploring longer-term health outcomes in general as opposed to short-term treatment-specific outcomes or Key Performance Indicators (e.g. NICE, 2012; Shepherd et al., 2009).

Furthermore, the current study found a null association between CDM and the hypothetical client's race, yet consistently significant associations between CDM and racial attitudes. It may therefore be suggested that studying race as a discrete construct and drawing finite conclusions based upon particular findings risks obscuring the pervasive and insidious effects of racism. Doing so largely ignores the intersectional nature of racism and the historical, social and political nature of race which allows racism to exist and persist. This therefore, also risks problematising race, implying that race in itself is an outcome or determinant of healthcare disparities (Patel, 2021). Theory and research exploring issues of racialisation and racial bias may therefore wish to shift the focus towards racial attitudes, as opposed to solely considering race as a distinct, standalone construct. This may help to attend to the operations of whiteness and the social and political powers responsible for much of the inequality within our society, potentially encouraging alternative avenues for change.

4.7. Strengths and Limitations

4.7.1. Data Collection and Study Design

The study made use of online data collection methods. This method extends a vast geographical reach and allows for a large number of participants to be recruited in a relatively short time-frame (Casler et al., 2013; Follmer et al., 2017). However, some have suggested that samples collected through online methods tend to be skewed towards particular demographic groups (Follmer et al., 2017). Indeed, in the present study, there was a noticeable lack of representation of various groups; 86% of the sample identified as female, 84% as white and 72% were educated to at least post-graduate level. Therefore, in addition to the implications for generalisability, this led to a number of categories being aggregated during the data analysis process. Including religion (dichotomised into religious/ non-religious) and ethnicity (grouped into Black, white, Asian, Mixed ethnic group). Significant limitations of doing so must be emphasised. For example, this largely obscures the nuances, distinct experiences and perspectives of particular groups/ individuals and omits the intersectional nature of social identity (Crenshaw, 1989). Simultaneously, this makes broad assumptions of homogeneity amongst those who are grouped together (Aspinall, 2021).

Furthermore, the online data collection method allowed participants responses to remain anonymous. A benefit of this is that it may have encouraged participants to feel more comfortable in sharing potentially difficult experiences or processes relating to CDM, or to provide answers which more accurately reflect their decision-making, moral preferences or racial attitudes (Lefever et al., 2006). On the other hand, partaking in the study was wholly optional and recruitment took place via social media, within which individuals are exposed to a wealth of information and advertisements (Adshead et al., 2019). Therefore, it is possible that those who clicked on or completed the survey already had an interest in the study topic, for instance, due to personal experiences or factors which may influence the overall findings (Cheung et al., 2017).

A vignette study-design was used. These studies are often designed such that participants do not require in-depth knowledge of particular topics (Hughes & Huby, 2002), thereby allowing a broad range of participants to be recruited, representing MHPs working across various settings. The vignette design further allowed an extremely complex process (CDM) to be assessed quantitatively, meaning that various factors potentially associated with CDM could be evaluated. Indeed, to the author's knowledge, this was the first UK-study to consider relationships between CDM, moral values and racial attitudes using quantitative methods.

4.7.2. Measuring Moral Values and Moral Distress

Moral values were assessed using the MAC-Q which is based upon the MAC theory (Curry, 2016). The seven moral values offered by the MAC have been found to be applicable across cultures and to correlate well with other measures of morality (Curry et al., 2019a; Curry et al., 2019b). However, in both the initial validation study and in the present study, the judgement subscale was found to have low internal consistency. Therefore, although results from the judgement scale may have been more applicable to the present study, analyses were conducted using the relevance subscale. A limitation of this scale is that it may assess second-order views, rather than directly assessing how one makes moral judgements (Curry et al., 2019a). In addition, authors noted that a wider range of cooperative behaviours/ moral values than those presented are likely implicated in morality (Curry et al., 2019a). In relation to mental health practice specifically, the range of values implicated in CDM is potentially limitless (Fulford et al., 2005; Sadler, 2005; Tjeltveit, 2016). Therefore, inferences about the construct of morality as a whole and its influence on CDM are considerably limited.

MMD-HP was used as a measure of moral distress. This is a validated measure proposed to capture root causes of moral distress at various levels of the system – including the individual, team and system level (Epstein et al., 2019). Nonetheless, while the experience of moral distress applies to all HCPs (Hamric, 2014), the scale was predominantly designed and tested with HCPs working in physical healthcare settings (Epstein et al., 2019). It is possible that additional aspects of moral distress not captured by the items in the MMD-HP are experienced by MHPs. In addition, given that the current study was cross-sectional, it remains unknown whether moral distress changes over time. It is for instance, possible that moral distress is a reactive process, influenced by particular situations, interactions or events (Jameton, 1993).

4.7.3. Measuring Racial Bias/ Attitudes

A predominant challenge of using experimental studies to measure racial bias is that reducing race to a single, discrete entity largely obscures the socio-political nature of race and racism itself. Therefore, studies will never be an assessment of bias in themselves, rather they will present an assessment of the appropriateness of the methodology for detecting racial differences which are inextricably linked to the broader context. Nonetheless, the vignette method has been credited as a way of obtaining insights into the judgements and decision-making processes of individuals working within the healthcare system (Sheringham et al., 2021). Therefore, whilst the method may not directly measure the presence of racial bias, it offered a way of standardising and operationalising complex scenarios in order to consider how various distinct variables, including racial attitudes, influenced CDM. It therefore offered unique insights into potential drivers of variation in mental healthcare CDM.

Furthermore, a strength of the current study was that including a measure of racial attitudes, the CoBRAS, may have allowed for at least some of the influence of socio-political and historical contexts on participants thinking to be captured. This is due to the fact that the measure aims to explore the influence of colour-blind racial attitudes and institutional racism, in addition to blatant racial issues (Neville et al., 2000). Thus, including both a measure of racial bias and a measure of racial attitudes allowed the research to consider the potential for quantitative methods to capture some of the subtleties of racial bias – while the vignette study design was not sensitive enough to evidence racial bias, racial attitudes had a considerable and consistent impact on CDM. Therefore, highlighting the importance of considering institutional racism and whiteness within research, as opposed to solely considering individual variables and race as a standalone factor.

4.7.4. Service-User Involvement

A considerable limitation of the present research is the lack of service-user involvement. Both research and policy has continued to evidence the importance of involving service users in all aspects of research and service delivery (DHSC, 1999; DHSC, 2012; Omeni et al., 2014). For instance, it can provide a starting point for empowerment, as well as improving the relevance and accountability of the research (Ocloo & Matthews, 2016). Nonetheless, it should be noted that service-users are a large and diverse group with unique experiences. Various attitudinal, funding and political barriers to meaningful service-user involvement have been noted (e.g. Beresford, 2013; Faulker & Thomas, 2002). This includes findings that Black and racialised groups tend to be underrepresented within service-user representatives/ user-led research (Beresford, 2013; Boote et al., 2005). Therefore, with particular consideration of the present research, attempts to foster meaningful service-user involvement should recognise the systemic nature of health inequities and the various ways in which different groups can be excluded or underrepresented at various levels of both research and practice. This may include recognising the individual needs of and barriers facing underrepresented groups in research involvement; fostering mutual and reciprocal relations; engaging with a range of networks; and addressing power and professional differentials (Alakeson et al., 2013; Slay & Robinson, 2011).

4.8. Future Research

There are a number of potential intersections between the concepts explored which may elicit various ideas for future research. Much of the research base around both moral distress and CDM focuses on individual factors and discrete constructs, rather than exploring the influence of various contextual factors on these constructs. With regards to moral distress, further research may wish explore the ways in which contextual factors (e.g. the work environment, resource scarcity, professional culture) intersect with various individual factors evidenced to influence moral distress (e.g. age, profession, time working in mental health) and to utilise qualitative studies to explore MHPs experiences of these intersections. Studies exploring moral distress within the UK context are extremely limited and further research is needed to consider potential determinants of moral distress within mental health settings.

The study highlighted that when presented with vignette scenarios, participants colour-blind racial attitudes were consistently implicated in CDM processes. Yet, research exploring the influence of racial attitudes on CDM processes in the UK is again, particularly limited. Further research may wish to firstly, quantitatively explore the influence of racial attitudes in larger samples of additional professional groups, such as psychiatry and nursing professionals (given that the current sample was predominantly made up of psychologists). Secondly, the study demonstrated the value in assessing participants racial attitudes in addition to racial bias; quantitative studies exploring issues of race may therefore wish to further highlight the influence of racial attitudes and institutional processes, as opposed to solely exploring race as a standalone construct. Thirdly, qualitative studies may allow a more in-depth understanding of the processes underpinning the relationship between racial attitudes and CDM to be gained. For instance, it would be interesting to consider MHPs views on the influence of both individual bias/ attitudes and socio-political/ cultural attitudes on CDM, and also to gain a more extensive understanding of the relationship between deference/ group loyalty, racial attitudes and CDM.

Moreover, any efforts to address and understand whiteness and racism should foreground the voices and experiences of those who have been racialised; whilst research exploring CDM processes should also concern the lived experiences of those accessing mental health services. Further research should therefore include service user voices; seeking to sensitively explore the lived experiences of CDM in mental health.

4.9. Summary and Conclusions

The present study aimed to explore associations between various sociodemographic and professional factors and moral values, moral distress and CDM in mental healthcare. Particular attention was paid to the influence of racial attitudes and racial bias in CDM. Findings highlighted significant variation in participants endorsement of each of the moral values, moral distress and in CDM scores. A number of sociodemographic and professional factors were associated with CDM, however associations were not consistent across the clinical scenarios depicted in the vignettes. Racial attitudes however, were found to consistently relate to CDM scores; higher colour-blind racial attitude scores significantly predicted greater agreement with the clinical decision. In addition, Racial attitudes influence CDM indirectly, through their mediating effect on the relationship between CDM and the moral values of deference and group loyalty.

It is therefore proposed that CDM in mental healthcare is ideologically and evaluatively complex. The normative assumptions and dominant discourses of the wider society, which are embedded within structures of whiteness and intersect with various social, political and historical power, are reflected within CDM. Attempts to fit mental health ideologies and decision-making processes into neutral, rational and systematic frameworks and guidelines are therefore, considerably limited. In addition to the moral distress this may elicit, this contributes to the maintenance of the whiteness and Eurocentricity which permeates the structures, processes, practices and CDM within our mental health systems.

It is hoped that further research may continue to find ways of acknowledging both the broad range of values present amongst individuals working in or accessing the mental health system, and the dominant discourses and ideologies of our services, systems and wider society. Ultimately, acknowledging the considerable impact these processes have on the way in which mental health concepts and care are appraised. It is further proposed that future research may wish to shift the focus away from viewing race and racism as a discrete outcome or determinant of healthcare disparities which can be addressed at the individual level, towards the influence of racial attitudes and institutional processes. Therefore, exploring not only the effects of whiteness and racism (disparities/ inequity), but the processes involved in maintaining, perpetuating and dismantling whiteness within CDM.

Finally, it should be highlighted that studies exploring racialisation and racial bias can never fully capture or outweigh individuals lived and real experiences of racism and marginalisation. As King et al. (2009) put it, many crucial issues will be masked by “the theatre of theoretical indulgence” (p. 40).

5. REFERENCES

Abramowitz, S. I., & Herrera, H. R. (1981). On controlling for patient psychopathology in naturalistic studies of sex bias: a methodological demonstration. *Journal of Consulting and Clinical Psychology, 49*(4), 597–603. https://doi.org/10.1037//0022-006x.49.4.597.

Adams, A., Vail, L., Buckingham, C. D., Kidd, J., Weich, S., & Roter, D. (2014). Investigating the influence of African American and African Caribbean race on primary care doctors' decision making about depression. *Social Science & Medicine, 116*, 161–168. https://doi.org/10.1016/j.socscimed.2014.07.004.

Adshead, S., Forsyth, G., Wood, S., & Wilkinson, L. (2019). *Online advertising in the UK*. Plum Consulting. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/777996/Plum_DCMS_Online_Advertising_in_the_UK.pdf.

Afuape, T. (2016). Beyond awareness of ‘difference’ and towards social action: ‘Solidarity practice’ alongside young people. *Clinical Child Psychology and Psychiatry, 21*(3), 402-415.

Aguinis, H., & Bradley, K. J. (2014). Best practice recommendations for designing and implementing experimental vignette methodology studies. *Organizational Research Methods, 17*(4), 351–371. https://doi.org/10.1177/1094428114547952.

Alakeson, V., Bunnin, A., & Miller, C. (2013). *Coproduction of health and wellbeing outcomes: The new paradigm for effective health and social care*. OPM. https://hic.org.au/wp-content/uploads/2019/10/HIC-Coproduction-health-wellbeing-outcomes.pdf.

Allwood, L., & Bell, A. (2021). *Covid-19: Understanding inequalities in mental health during the pandemic.* Centre for Mental Health. https://www.centreformentalhealth.org.uk/sites/default/files/2020-07/CentreforMentalHealth_CovidInequalities_0.pdf.

Altman, D. G., & Royston, P. (2006). The cost of dichotomising continuous variables. *BMJ (Clinical research ed.), 332*(7549), 1080. https://doi.org/10.1136/bmj.332.7549.1080.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596.

Apfelbaum, E. P., Norton, M. I., & Sommers, S. R. (2012). Racial color blindness: Emergence, practice, and implications. *Current Directions in Psychological Science, 21*(3), 205–209. https://doi.org/10.1177/0963721411434980.

Armstrong, A. E., Parsons, S., & Barker, P. J. (2000). An inquiry into moral virtues, especially compassion, in psychiatric nurses: findings from a Delphi study. *Journal of Psychiatric and Mental Health Nursing, 7*(4), 297–305.

Arnett, J. (2008). The neglected 95%: Why American psychology needs to become less American. *American Psychologist, 63*(7), 602–614. https://doi.org/10.1037/14805-008.

Arnold, D. G. (2001). Coercion and moral responsibility. *American Philosophical Quarterly, 38*(1), 53-67.

Aspinall, P. J. (2021). BAME (black, Asian and minority ethnic): The “new normal” in collective terminology. *Journal of Epidemiol Community Health, 75*(2). https://doi.org/10.1136/jech-2020-215504.

Assari S. (2018). Unequal gain of equal resources across racial groups. *International Journal of Health Policy and Management, 7*(1), 1–9. https://doi.org/10.15171/ijhpm.2017.90.

Austin, W., Bergum, V., & Goldberg, L. (2003). Unable to answer the call of our patients: Mental health nurses’ experience of moral distress. *Nursing Inquiry, 10*(3), 177–183. https://doi.org/10.1046/j.1440-1800.2003.00181.x.

Austin, W. J., Kagan, L., Rankel, M., & Bergum, V. (2008). The balancing act: Psychiatrists’ experience of moral distress. *Medicine, Health Care and Philosophy, 11*(1), 89–97. https://doi.org/10.1007/s11019-007-9083-1.

Bachmann, L. M., Mühleisen, A., Bock, A., ter Riet, G., Held, U., & Kessels, A. G. (2008). Vignette studies of medical choice and judgement to study caregivers' medical decision behaviour: systematic review. *BMC Medical Research Methodology, 8*(1), 1-8. https://doi.org/10.1186/1471-2288-8-50.

Bailey, Z. D., Krieger, N., Agénor, M., Graves, J., Linos, N., & Bassett, M. T. (2017). Structural racism and health inequities in the USA: Evidence and interventions. *Lancet, 389*(10077), 1453–1463. https://doi.org/10.1016/S0140-6736(17)30569-X.

Baima, T., & Sude, M. E., (2020). What White Mental Health Professionals need to Understand about Whiteness: a Delphi Study. *Journal of Marital and Family Therapy 46*(1): 62–80. https://doi.org/10.1111/jmft.12385.

Barker, P. (2010). *Mental Health Ethics: The Human Context* (Ed.). Routledge.

Barter, C., & Renold, E. (1999). Social research update 25: The use of vignettes in qualitative research. *Social Research Update, 25*. https://sru.soc.surrey.ac.uk/SRU25.html.

Beauchamp, T. L., & Childress, J. F. (2001). *Principles of biomedical ethics*. Oxford University Press.

Beck, J., Randall, C. L., Bassett, H. K., O'Hara, K. L., Falco, C. N., Sullivan, E. M., & Opel, D. J. (2020). Moral distress in pediatric residents and pediatric hospitalists: sources and association with burnout. *Academic Pediatrics, 20*(8), 1198-1205. https://doi.org/10.1016/j.acap.2020.05.017.

Beresford, P. (2013). *Beyond the usual suspects.* Shaping Our Lives. https://shapingourlives.org.uk/report/beyond-the-usual-suspects-research-report/.

Berg, M. K., Kitayama, S., & Kross, E. (2021). How relationships bias moral reasoning: Neural and self-report evidence. *Journal of Experimental Social Psychology, 95*, 104156. https://doi.org/10.1016/j.jesp.2021.104156.

Berman, G., & Paradies, Y. (2010). Racism, disadvantage and multiculturalism: Towards effective anti-racist praxis. *Ethnic and Racial Studies, 33*(2), 214–232. https://doi.org/10.1080/01419870802302272.

Bhaskar, R. (1998). Philosophy and scientific realism. in M. Archer, R. Bhaskar, A. Collier, T. Lawson, & A. Norrie, *Critical realism: Essential readings* (pp. 16-47). Routledge.

Bhaskar, R. (2008). *A realist theory of science.* Routledge.

Bhopal, R. (2004). Glossary of terms relating to ethnicity and race: for reflection and debate. *Journal of Epidemiology & Community Health, 58*(6), 441-445.

Bhui, K., Stansfeld, S., Hull, S., Priebe, S., Mole, F., & Feder, G. (2003). Ethnic variations in pathways to and use of specialist mental health services in the UK. Systematic review. *The British Journal of Psychiatry, 182*, 105–116. https://doi.org/10.1192/bjp.182.2.105.

Bhui, K. (2016). Discrimination, poor mental health, and mental illness. *International Review of Psychiatry, 28*(4), 411-414. https://doi.org/10.1080/09540261.2016.1210578.

Bhui, K., Halvorsrud, K., & Nazroo, J. (2018). Making a difference: Ethnic inequality and severe mental illness. *The British Journal of Psychiatry, 213*(4), 574-578. https://doi.org/10.1192/bjp.2018.148.

Bignall, T., Jeraj, S., Helsby, E., & Butt, J. (2019). *Racial disparities in mental health: Literature and evidence review.* Race Equality Foundation. https://raceequalityfoundation.org.uk/wp-content/uploads/2020/03/mental-health-report-v5-2.pdf.

Bonilla-Silva, E. (2006). *Racism without racists: Color-blind racism and the persistence of racial inequality in the United States.* Rowman & Littlefield Publishers.

Boote, J., Wong, R., & Booth, A. (2015). 'Talking the talk or walking the walk?' A bibliometric review of the literature on public involvement in health research published between 1995 and 2009. *Health expectations: An International Journal of Public Participation in Healthcare and Health Policy, 18*(1), 44–57. https://doi.org/10.1111/hex.12007.

Borgstrom, E., Cohn, S., & Barclay, S. (2010). Medical professionalism: Conflicting values for tomorrow's doctors. *Journal of General Internal Medicine, 25*(12), 1330-1336. https://doi.org/10.1007/s10459-015-9626-9.

Bornstein, M. H., Jager, J., & Putnick, D. L. (2013). Sampling in developmental science: Situations, shortcomings, solutions, and standards. *Developmental review, 33*(4), 357–370. https://doi.org/10.1016/j.dr.2013.08.003.

Bostyn, D. H., Sevenhant, S., & Roets, A. (2018). Of mice, men, and trolleys: Hypothetical judgment versus real-life behavior in trolley-style moral dilemmas. *Psychological Science, 29*(7), 1084–1093. https://doi.org/10.1177/0956797617752640.

Boulton, A. J., Yeung, J., Slowther, A. M., & Bassford, C. (2021). *A multi-centre quantitative assessment of moral distress amongst intensive care unit professions in the UK*. Research Square. https://doi.org/10.21203/rs.3.rs-764235/v1.

Boyle, M., & Johnstone, L. (2014). Alternatives to psychiatric diagnosis. *The Lancet Psychiatry, 1*(6), 409-411. https://doi.org/10.1016/S2215-0366(14)70359-1.

Brams, S. J., Brams, S. J., & Taylor, A. D. (1996). *Fair Division: From cake-cutting to dispute resolution*. Cambridge University Press.

British Psychological Society. (2012). *e-Professionalism: Guidance on the use of Social Media by Clinical Psychologists*. British Psychological Society. https://www.ucl.ac.uk/clinical-psychology-doctorate/sites/clinical-psychology-doctorate/files/appendix5b.pdf.

British Psychological Society. (2018). *Code of Ethics and Conduct*. Ethics Committee of the British Psychological Society. https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Ethics%20and%20Conduct.pdf.

British Psychological Society. (2021). *Ethics Guidelines for Internet Mediated Research*. British Psychological Society. https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Ethics%20Guidelines%20for%20Internet-mediated%20Research.pdf.

Bruce, C. R., Miller, S. M., & Zimmerman, J. L. (2015). A qualitative study exploring moral distress in the ICU team: the importance of unit functionality and intrateam dynamics. *Critical Care Medicine, 43*(4), 823-831. https://doi.org/10.1097/CCM.0000000000000822.

Bryman, A. (2008). *Social research methods*. Oxford University Press.

Buchanan, A. (2009). Health-care delivery and resource allocation. In A. Buchanan (Ed.), *Justice and healthcare: Selected essays* (pp. 37–76). Oxford University Press.

Buckland, R. (2016). The decision by Approved Mental Health Professionals to use compulsory powers under the Mental Health Act 1983: A Foucauldian discourse analysis. *The British Journal of Social Work, 46*(1), 46–62. https://doi.org/10.1093/bjsw/bcu114.

Buckloh, L. M., & Roberts, M. C. (2001). Managed mental health care: Attitudes and ethical beliefs of child and pediatric psychologists. *Journal of Pediatric Psychology, 26*(4), 193-202. https://doi.org/10.1093/jpepsy/26.4.193.

Burkard, A. W., & Knox, S. (2004). Effect of therapist color-blindness on empathy and attributions in cross-cultural counseling. *Journal of Counseling Psychology, 51*(4), 387–397. https://doi.org/10.1037/0022-0167.51.4.387.

Burr, V. (2003). *Social constructionism*. Routledge.

Campbell, R. (2007). What is moral judgment?. *The Journal of Philosophy, 104*(7), 321-349. https://doi.org/10.5840/jphil2007104716.

Care Quality Commission. (2019). Mental Health Act Code of Practice 2015: An evaluation of how the code is being used. https://www.cqc.org.uk/sites/default/files/20190625_mhacop-report.pdf.

Casler, K., Bickel, L., & Hackett, E. (2013). Separate but equal? A comparison of participants and data gathered via Amazon’s MTurk, social media, and face-to-face behavioral testing. *Computers in Human Behavior, 29*(6), 2156-2160. https://doi.org/10.1016/j.chb.2013.05.009.

Chae, D. H., Yip, T., Martz, C. D., Chung, K., Richeson, J. A., Hajat, A., ... & LaVeist, T. A. (2021). Vicarious racism and vigilance during the COVID-19 pandemic:

mental health implications among Asian and Black Americans. *Public Health Reports, 136*(4), 508-517. https://doi.org/10.1177/00333549211018675.

Chao, R. C., Wei, M., Good, G. E., & Flores, L. Y. (2011). Race/ethnicity, color-blind racial attitudes, and multicultural counseling competence: The moderating effects of multicultural counseling training. *Journal of Counseling Psychology, 58*(1), 72–82. https://doi.org/10.1037/a0022091.

Chaudary, A. R. (2017). *Mental health practitioners' recognition of disordered eating in white and South Asian patients.* [Doctoral dissertation, University of Leeds]. Ethesis. https://etheses.whiterose.ac.uk/18016/.

Chen, F., Curran, P. J., Bollen, K. A., Kirby, J., & Paxton, P. (2008). An empirical evaluation of the use of fixed cutoff points in RMSEA test statistic in structural equation models. *Sociological Methods & Research, 36*(4), 462-494. https://doi.org/10.1177/0049124108314720.

Cheung, J.H., Burns, D.K., Sinclair, R.R., & Sliter, M. (2017). Amazon Mechanical Turk in organizational psychology: An evaluation and practical recommendations. *Journal of Business and Psychology, 32*, 347– 361. https://doi.org/10.1007/s10869-016-9458-5.

Chih, D. W. (2001). *Effects of individualism and collectivism on multicultural counseling and clinical judgment.* [Doctoral dissertation, Indiana University]. ProQuest.

Christopher, J. C., & Hickinbottom, S. (2008). Positive psychology, ethnocentrism, and the disguised ideology of individualism. *Theory & Psychology, 18*(5), 563–589. https://doi.org/10.1177/0959354308093396.

Clearing House for Postgraduate Courses in Clinical Psychology. (2020). *Equal opportunities data*. https://www.leeds.ac.uk/chpccp/equalopps2020.pdf.

Clouser, K. D., & Gert, B. (1990). A critique of principlism. *The Journal of medicine and philosophy, 15*(2), 219-236. https://doi.org/10.1093/jmp/15.2.219.

Coggon, J., & Kong, C. (2021). From best interests to better interests? Values, unwisdom and objectivity in mental capacity law. *The Cambridge Law Journal, 80*(2), 245-273. https://doi.org/10.1017/S0008197321000283.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Lawrence Erlbaum Associates.

Cohen, S. (2004). *The nature of moral reasoning*. Oxford University Press.

Colombo, A., Bendelow, G., Fulford, B., & Williams, S. (2003). Evaluating the influence of implicit models of mental disorder on processes of shared decision making within community-based multi-disciplinary teams. *Social Science & Medicine, 56*(7), 1557-1570. https://doi.org/10.1016/s0277-9536(02)00156-9.

Combs, D. R., Penn, D. L., Cassisi, J., Michael, C., Wood, T., Wanner, J., & Adams, S. (2006). Perceived racism as a predictor of paranoia among African Americans. *Journal of Black Psychology, 32*(1), 87-104. https://doi.org/10.1177/0095798405283175.

Commission on Race And Ethnic Disparities. (2021). *Commission on race and ethnic disparities: The report.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attac hment_data/file/974507/20210331_-_CRED_Report_-_FINAL_-_Web_Accessible.pdf.

Connolly, A., & Taylor, D. (2016). Does race affect prescribing for acute psychosis? Evaluation by a case vignette. *Therapeutic Advances in Psychopharmacology, 6*(3), 172–177. https://doi.org/10.1177/2045125316638051.

Coulehan, J., & Williams, P. C. (2003). Conflicting professional values in medical education. *Cambridge Quarterly of Healthcare Ethics, 12*(1), 7-20. https://doi.org/10.1017/S0963180103121032.

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black Feminist critique of antidiscrimination doctrine, Feminist theory and antiracist politics. *University of Chicago Legal Forum*, 139–167.

Cromby, J., Harper, D., & Reavey, P. (2013). *Psychology, mental health and distress.* Macmillan International Higher Education.

Curran, P. J., West, S. G., & Finch, J. F. (1996). The robustness of test statistics to nonnormality and specification error in confirmatory factor analysis. *Psychological Methods, 1*(1), 16-29. https://doi.org/10.1037/1082-989X.1.1.16.

Currin, L., Schmidt, U., & Waller, G. (2007). Variables that influence diagnosis and treatment of the eating disorders within primary care settings: a vignette study. *The International Journal of Eating Disorders, 40*(3), 257–262. https://doi.org/10.1002/eat.20355.

Curry, O. S. (2005). *Morality as natural history: An adaptationist account of ethics.* [Doctoral dissertation, London School of Economics]. Ethesis. http://etheses.lse.ac.uk/2/1/Curry_Morality_as_Natural_History.pdf.

Curry, O. (2007). The Conflict-Resolution Theory of Virtue. In W. P. Sinnott-Armstrong (Ed.). *Moral Psychology: The Evolution of Morality: Adaptations and Innateness,* (pp 251-261). MIT Press.

Curry, O. S. (2016). Morality as cooperation: A problem-centred approach. In T. Shackelford & R. Hansen (Eds.). *The evolution of morality* (pp. 27-51). Springer. https://doi.org/10.1007/978-3-319-19671-8_2.

Curry, O. S., Jones Chesters, M., & Van Lissa, C. J. (2019a). Mapping morality with a compass: Testing the theory of 'morality-as-cooperation' with a new questionnaire. *Journal of Research in Personality, 78*, 106–124. https://doi.org/10.1016/j.jrp.2018.10.008.

Curry, O. S., Mullins, D. A., & Whitehouse, H. (2019b). Is it good to cooperate? Testing the theory of morality-as-cooperation in 60 societies. Current Anthropology, 60(1), 47-69. https://doi.org/10.1086/701478.

Das-Munshi, J., Bhugra, D., & Crawford, M. J. (2018). Ethnic minority inequalities in access to treatments for schizophrenia and schizoaffective disorders: findings from a nationally representative cross-sectional study. *BMC Medicine, 16*(1), 55. https://doi.org/10.1186/s12916-018-1035-5.

David, D., Cristea, I., & Hofmann, S. G. (2018). Why cognitive behavioral therapy is the current gold standard of psychotherapy. *Frontiers in Psychiatry*, 4. https://doi.org/10.3389/fpsyt.2018.00004.

Day, P., Lawson, J., Mantri, S., Jain, A., Rabago, D., & Lennon, R. (2021). Physician moral injury in the context of moral, ethical and legal codes. *Journal of Medical Ethics,* medethics-2021-107225. https://doi.org/10.1136/medethics-2021-107225.

Dawber, C. (2013). Reflective practice groups for nurses: A consultation liaison psychiatry nursing initiative: Part 1 - the model. *International Journal of Mental Health Nursing, 22*(2), 135–144. https://doi.org/10.1111/j.1447-0349.2012.00839.x.

Deady, R., & McCarthy, J. (2010). A study of the situations, features, and coping mechanisms experienced by Irish psychiatric nurses experiencing moral distress. *Perspectives in Psychiatric Care, 46*(3), 209–220. https://doi.org/10.1111/j.1744-6163.2010.00260.x.

Delfrate, F., Ferrara, P., Spotti, D., Terzoni, S., Lamiani, G., Canciani, E., & Bonetti, L. (2018). Moral distress (MD) and burnout in mental health nurses: A multicenter survey. *La Medicina del lavoro, 109*(2), 97–109. https://doi.org/10.23749/mdl.v109i2.6876.

Delgado, R. & Stefancic, J (Eds.). (2000). *Critical race theory: The cutting edge* (2nd Ed.). Temple University Press.

Department of Health. (2008). *Mental Health Act 1983: Code of Practice*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF.

Department of Health and Social Care. (1999). *National Service Framework: Mental Health*. https://www.gov.uk/government/publications/quality-standards-for-mental-health-services.

Department of Health and Social Care. (2012). *Health and Social Care Act 2012*. https://www.legislation.gov.uk/ukpga/2012/7/contents/enacted.

Department of Health and Social Care. (2020). *The NHS nursing workforce*. National Audit Office. https://www.nao.org.uk/wp-content/uploads/2020/03/The-NHS-nursing-workforce.pdf.

Devonport, T. J., Ward, G., Morrissey, H., Burt, C., Harris, J., Burt, S., ... & Nicholls, W. (2022). A systematic review of inequalities in the mental health experiences of Black African, Black Caribbean and Black-mixed UK populations: Implications for action. *Journal of Racial and Ethnic Health Disparities*, 1-13. https://doi.org/10.1007/s40615-022-01352-0.

DiAngelo, R. (2012). *What does it mean to be white?: Developing white racial literacy.* Peter Lang Incorporated, International Academic Publishers.

Dias, M., Teixeira, C., & Antunes, B. (2022). Translation and cultural adaptation to European Portuguese of the “Measure of Moral Distress–Healthcare Professionals” scale: A cross-sectional multicenter study. *Acta Médica Portuguesa, 35*(13).

Dierckx, K., Valcke, B., & Van Hiel, A. (2021). The trickle-down effect of procedural fairness on perceptions of daily discrimination: How societal actors can build social trust among minority members. *European Journal of Social Psychology, 51*(2), 343-359. https://doi.org/10.1002/ejsp.2742.

Dose, J. J. (1997). Work values: An integrative framework and illustrative application to organizational socialization. *Journal of Occupational and Organizational Psychology, 70*(3), 219-240. https://doi.org/10.1111/j.2044-8325.1997.tb00645.x.

Du Toit, D. (1995). The allied health professions in Australia: Physio, occupational and speech therapy professions. In G. M. Lupton, & J. M. Najman, *Sociology of health and illness: Australian readings,* (pp. 276 – 300). Macmillan Education AU.

Durbin, J., & Watson, G. (1971). Testing for serial correlation in least squares regression. III. *Biometrika, 58*(1), 1-19. https://doi.org/10.2307/2334313.

Eagleton, T. (2007). *Ideology: An introduction*. Verso.

Edbrooke-Childs, J., & Patalay, P. (2019). Ethnic differences in referral routes to youth mental health services. *Journal of the American Academy of Child & Adolescent Psychiatry, 58*(3), 368-375. https://doi.org/10.1016/j.jaac.2018.07.906.

Ellemers, N. (2018). Morality and social identity. In M. Van Zomeren & J. Dovidio (Eds.), *The Oxford handbook of the human essence* (pp. 147-158). Oxford University Press.

Elliott, A. C., & Woodward, W. A. (2007). *Statistical analysis quick reference guidebook with SPSS examples*. Sage.

Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of advanced nursing, 62*(1), 107-115. https://doi.org/10.1111/j.1365-2648.2007.04569.x.

Epstein, E. G., Whitehead, P. B., Prompahakul, C., Thacker, L. R., & Hamric, A. B. (2019). Enhancing understanding of moral distress: The measure of moral distress for health care professionals. *AJOB Empirical Bioethics, 10*(2), 113–124. https://doi.org/10.1080/23294515.2019.1586008.

Evans, S. C., Roberts, M. C., Keeley, J. W., Blossom, J. B., Amaro, C. M., Garcia, A. M., Stough, C. O., Canter, K. S., Robles, R., & Reed, G. M. (2015). Vignette methodologies for studying clinicians' decision-making: Validity, utility, and application in ICD-11 field studies. *International Journal of Clinical and Health Psychology, 15*(2), 160–170. https://doi.org/10.1016/j.ijchp.2014.12.001.

Everett, B. G., Onge, J. S., & Mollborn, S. (2016). Effects of Minority Status and Perceived Discrimination on Mental Health. *Population Research and Policy Review, 35*(4), 445–469. https://doi.org/10.1007/s11113-016-9391-3.

Fagerland, M. W. (2012). T-tests, non-parametric tests, and large studies—a paradox of statistical practice?. *BMC Medical Research Methodology, 12*, 78. https://doi.org/10.1186/1471-2288-12-78.

Fan, Y., Chen, J., Shirkey, G., John, R., Wu, S. R., Park, H., & Shao, C. (2016). Applications of structural equation modeling (SEM) in ecological studies: An updated review. *Ecological Processes, 5*(1), 1-12. https://doi.org/10.1186/s13717-016-0063-3.

Fantus, S., Greenberg, R. A., Muskat, B., & Katz, D. (2017). Exploring moral distress for hospital social workers. *The British Journal of Social Work, 47*(8), 2273–2290. https://doi.org/10.1093/bjsw/bcw113.

Faulkner, A. (2014). *Ethnic inequalities in mental health: Promoting lasting positive change: A consultation with black and minority ethnic mental health service users.*

National Service User Network. https://www.nsun.org.uk/wp-content/uploads/2021/05/Ethnic_Inequalities_in_Mental_Health_Report_February_2014.pdf.

Fearon, P., Kirkbride, J. B., Morgan, C., Dazzan, P., Morgan, K., Lloyd, T., Hutchinson, G., Tarrant, J., Fung, W. L., Holloway, J., Mallett, R., Harrison, G., Leff, J., Jones, P. B., Murray, R. M., & AESOP Study Group. (2006). Incidence of schizophrenia and other psychoses in ethnic minority groups: results from the MRC AESOP Study. *Psychological Medicine, 36*(11), 1541–1550. https://doi.org/10.1017/S0033291706008774.

Feng, C., Wang, H., Lu, N., Chen, T., He, H., Lu, Y., & Tu, X. M. (2014). Log-transformation and its implications for data analysis. *Shanghai Archives of Psychiatry, 26*(2), 105-109. https://doi.org/10.3969/j.issn.1002-0829.2014.02.009.

Ferencz-Kaddari, M., Shifman, A., & Koslowsky, M. (2016). Modeling Psychologists' Ethical Intention: Application of an Expanded Theory of Planned Behavior. *Psychological Reports, 118(3), 691–709. https://doi.org/10.1177/0033294116647691.*

Fernando, S. (2010). *Mental health, race and culture*. Palgrave Macmillan.

Fernando, S. (2014). *Mental health worldwide: Culture, globalization and development*. Springer.

Fernando, S. (2017). *Institutional racism in psychiatry and clinical psychology.* Palgrave Macmillan. https://doi.org/10.1007/978-3-319-62728-1.

Field, A. (2009). *Discovering Statistics using SPSS* (3rd ed.). Sage.

Finch, J. (1987). The vignette technique in survey research. *Sociology, 21*(1), 105-114. https://doi.org/10.1177/0038038587021001008.

FitzGerald, C., & Hurst, S. (2017). Implicit bias in healthcare professionals: a systematic review. *BMC Medical Ethics, 18*(1), 1-18. https://doi.org/10.1186/s12910-017-0179-8.

Flacks, S. (2018). The stop and search of minors: A 'vital police tool'?. *Criminology & Criminal Justice, 18*(3), 364-384. https://doi.org/10.1177/1748895817720485.

Follmer, D.J., Sperling, R.A., & Suen, H.K. (2017) The role of MTurk in education research: Advantages, issues, and future directions. *Educational Researcher, 46*(6), 329–334. https://doi.org/10.3102/0013189X17725519.

Fricker, M. (2007). *Epistemic Injustice: Power and the Ethics of Knowing*. Oxford University Press.

Fulford, K. W. M. (2004). Ten Principles of Values-Based Medicine. In J. Radden (Eds.). *The Philosophy of Psychiatry: A Companion* (pp. 205 – 234). Oxford University Press.

Gallagher. C. A. (2003). Playing the white ethnic card: Using ethnic identity to deny contemporary racism. In A. Doane and E. Bonilla-Silva, *Whiteout: The continuing significance of racism* (pp. 145 – 158). Routledge.

Garb H. N. (2005). Clinical judgment and decision making. *Annual Review of Clinical Psychology, 1,* 67–89. https://10.1146/annurev.clinpsy.1.102803.143810.

Garner, S. (2017) *Racisms: An introduction*. Sage.

Garrigan, B., Adlam, A. L., & Langdon, P. E. (2018). Moral decision-making and moral development: Toward an integrative framework. *Developmental Review, 49*, 80 – 100. https://doi.org/10.1016/j.dr.2018.06.001.

Garson, G. D. (2015). *Structural equation modelling.* Statistical Associates Publishing. http://www.statisticalassociates.com/sem.htm.

George, D., & Mallery, M. (2010). SPSS for Windows Step by Step: A Simple Guide and Reference (10th ed.). Pearson.

Golash-Boza, T. (2016). A critical and comprehensive sociological theory of race and racism. *Sociology of Race and Ethnicity, 2*(2), 129-141. https://doi.org/10.1177/2332649216632242.

Gonyea, J. L., Wright, D. W., & Earl-Kulkosky, T. (2014). Navigating dual relationships in rural communities. *Journal of Marital and Family Therapy, 40*(1), 125-136. https://doi.org/10.1111/j.1752-0606.2012.00335.x.

Gopal, P. (2019). *Insurgent empire: Anticolonial resistance and British dissent.* Verso Books.

Gould, D. (1996). Using vignettes to collect data for nursing research studies: how valid are the findings?. *Journal of Clinical Nursing, 5*(4), 207-212. https://doi.org/10.1111/j.1365-2702.1996.tb00253.x.

Grace, P. J., Fry, S. T., & Schultz, G. S. (2003). Ethics and human rights issues experienced by psychiatric-mental health and substance abuse registered nurses. *Journal of the American Psychiatric Nurses Association, 9*(1), 17–23.

Grace, B., Wainwright, T., Solomons, W., Camden, J., & Ellis-Caird, H. (2020). How do clinical psychologists make ethical decisions? A systematic review of empirical research. *Clinical Ethics, 15*(4), 213-224. https://doi.org/10.1177/1477750920927165.

Graham, J. W. (2009). Missing data analysis: Making it work in the real world. *Annual Review of Psychology, 60*, 549-576. https://doi.org/10.1146/annurev.psych.58.110405.085530.

Graham, J., Meindl, P., Beall, E., Johnson, K. M., & Zhang, L. (2016). Cultural differences in moral judgment and behavior, across and within societies. *Current Opinion in Psychology, 8,* 125-130. https://doi.org/10.1016/j.copsyc.2015.09.007.

Graham, J., Nosek, B. A., Haidt, J., Iyer, R., Koleva, S., & Ditto, P. H. (2011). Mapping the moral domain. *Journal of Personality and Social Psychology, 101*(2), 366–385. https://doi.org/10.1037/a0021847.

Green, S. B. (1991). How many subjects does it take to do a regression analysis? *Multivariate Behavioral Research, 26*(3), 499-510. https://doi.org/10.1207/s15327906mbr2603_7.

Greene, J. D. (2015). The rise of moral cognition. *Cognition, 135*, 39-42. https://doi.org/10.1016/j.cognition.2014.11.018.

Greenwald, A. G., McGhee, D. E., & Schwartz, J. L. (1998). Measuring individual differences in implicit cognition: the implicit association test. *Journal of Personality and Social Psychology, 74*(6), 1464. https://doi.org/10.1037/0022-3514.74.6.1464.

Guess, T. J. (2006). The social construction of whiteness: Racism by intent, racism by consequence. *Critical Sociology, 32*(4), 649-673. https://doi.org/10.1163/156916306779155199.

Gushue, G. V. (2004). Race, color-blind racial attitudes, and judgments about mental health: A shifting standards perspective. *Journal of Counseling Psychology, 51*, 398 – 407. https://doi.org/10.1037/0022-0167.51.4.398.

Gushue, G. V., & Constantine, M. G. (2007). Color-blind racial attitudes and white racial identity attitudes in psychology trainees. *Professional Psychology: Research and Practice, 38*(3), 321. https://doi.org/10.1037/0735-7028.38.3.321.

Gyani, A., Shafran, R., Myles, P., & Rose, S. (2014). The gap between science and practice: how therapists make their clinical decisions. *Behavior Therapy, 45*(2), 199–211. https://doi.org/10.1016/j.beth.2013.10.004.

Haas, L. J., Malouf, J. L., & Mayerson, N. H. (1988). Personal and professional characteristics as factors in psychologists' ethical decision making. *Professional Psychology: Research and Practice, 19*(1), 35. https://doi.org/10.1037/0735-7028.19.1.35.

Haidt, J., & Graham, J. (2007). When morality opposes justice: Conservatives have moral intuitions that liberals may not recognize. *Social Justice Research, 20*(1), 98-116. https://doi.org/10.1007/s11211-007-0034-z.

Haidt, J., & Kesebir, S. (2010). Morality. In S. T. Fiske, D. T. Gilbert, & G. Lindzey (Eds.), *Handbook of Social Psychology*, (pp. 797–832). John Wiley & Sons, Inc. https://doi.org/10.1002/9780470561119.socpsy002022.

Hair Jr, J. F., Hult, G. T. M., Ringle, C. M., & Sarstedt, M. (2013). *A primer on partial least squares structural equation modeling* (PLS-SEM). Sage publications.

Hamaideh S. H. (2014). Moral distress and its correlates among mental health nurses in Jordan. *International Journal of Mental Health Nursing, 23*(1), 33–41. https://doi.org/10.1111/inm.12000.

Hamric, A. B., Borchers, C. T., & Epstein, E. G. (2012). Development and testing of an instrument to measure moral distress in healthcare Professionals. *AJOB Primary Research, 3*(2), 1–9. https://doi.org/10.1080/21507716.2011.652337.

Harper, D. (2011). Choosing a qualitative research method. in D. Harper, & A. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners,* (pp. 83-97). Wiley Blackwell.

Hatcher, L., & O'Rourke, N. (2013). *A step-by-step approach to using SAS for factor analysis and structural equation modeling*. Sas Institute.

Health & Care Professionals Council. (2018). Standards of conduct, performance and ethics. https://www.hcpc-uk.org/standards/standards-of-conduct-performance-and-ethics/.

Health Education England. (n.d.). *Allied Health Professionals in mental health*. https://www.hee.nhs.uk/our-work/mental-health/new-roles-mental-health/allied-health-professionals.

Helkama, K., Uutela, A., Pohjanheimo, E., Salminen, S., Koponen, A., & Rantanen-VA¨ NTSI, L. (2003). Moral reasoning and values in medical school: A longitudinal study in Finland. *Scandinavian Journal of Educational Research, 47*(4), 399-411. https://doi.org/10.1080/00313830308589.

Helms, J. E. (1995). An update of Helm's White and people of color racial identity models. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counselling* (pp. 181–198). Sage Publications, Inc.

Helms, J. E. (2017). The challenge of making Whiteness visible: Reactions to four Whiteness articles. *The Counseling Psychologist, 45*(5), 717-726. https://doi.org/10.1177/0011000017718943.

Henrich, J., Boyd, R., Bowles, S., Camerer, C., Fehr, E., Gintis, H., ... & Tracer, D. (2005). “Economic man” in cross-cultural perspective: Behavioral experiments in 15 small-scale societies. *Behavioral and brain sciences, 28*(6), 795-815. https://doi.org/10.1017/S0140525X05000142.

Henrich, J., Heine, S., & Norenzayan, A. (2010). The weirdest people in the world? *Behavioral and Brain Sciences, 33,* 61–83. https://doi.org/10.1017/S0140525X0999152X.

Heverly, M. A., Fitt, D. X., & Newman, F. L. (1984). Constructing case vignettes for evaluating clinical judgment: an empirical model. *Evaluation and Program Planning, 7*(1), 45-55. https://doi.org/10.1016/0149-7189(84)90024-7.

Hill, M. (1997). Participatory research with children. *Child & Family Social Work, 2*(3), 171-183. https://doi.org/10.1046/j.1365-2206.1997.00056.x.

Hinkeldey, N. S., & Spokane, A. R. (1985). Effects of pressure and legal guideline clarity on counselor decision making in legal and ethical conflict situations. *Journal of Counseling & Development, 64*(4), 240-245. https://doi.org/10.1002/j.1556-6676.1985.tb01093.x.

HM Government. (2022). *Inclusive Britain: Government response to the commission on race and ethnic disparities.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1061421/Inclusive-Britain-government-response-to-the-Commission-on-Race-and-Ethnic-Disparities.pdf.

Ho, T., & Intravia, J. (2019). Racial disparities and similarities in risk assessment among adjudicated juveniles. *Justice Policy Journal, 16*(1), 1-19.

Hoyle, R. H. (1995). *Structural equation modelling: Concepts, issues, and applications.* Sage Publications.

Holtzman, S., & Vezzu, S. (2011). Confirmatory factor analysis and structural equation modeling of noncognitive assessments using PROC CALIS. *NorthEast SAS Users Group (NESUG), 2011 proceedings*, 11-14.

Howarth, Caroline (2004) Re-presentation and resistance in the context of school exclusion: reasons to be critical. *Journal of Community & Applied Social Psychology, 14*(5), 356-377. https://doi.org/10.1002/casp.798.

Hu, L. t., & Bentler, P. M. (1999). Cut-off criteria for fit indexes in covariance structure analysis: Conventional criteria versus new alternatives. *Structural Equation Modeling: A Multidisciplinary Journal, 6*(1), 1-55. https://doi:10.1080/10705519909540118.

Hughes, R. (1998). Considering the vignette technique and its application to a study of drug injecting and HIV risk and safer behaviour. *Sociology of Health & Illness, 20*(3), 381-400. https://doi.org/10.1111/1467-9566.00107.

Hughes, R., & Huby, M. (2002). The application of vignettes in social and nursing research. *Journal of Advanced Nursing, 37*(4), 382–386. https://doi.org/10.1046/j.1365-2648.2002.02100.x.

Hume, D. (1978). A treatise of human nature. In L. A, Selby-Bigge, & P. H. Nidditch (Eds.), *A treatise of human nature* (2nd Ed.). Oxford University Press.

Huntington-Klein, N., Arenas, A., Beam, E., Bertoni, M., Bloem, J. R., Burli, P., ... & Stopnitzky, Y. (2021). The influence of hidden researcher decisions in applied microeconomics. *Economic Inquiry, 59*(3), 944-960. https://doi.org/10.1111/ecin.12992.

Hyman S. E. (2010). The diagnosis of mental disorders: the problem of reification. *Annual Review of Clinical Psychology, 6*, 155–179. https://doi.org/10.1146/annurev.clinpsy.3.022806.091532.

Inguaggiato, G., Metselaar, S., Molewijk, B., & Widdershoven, G. (2019). How moral case deliberation supports good clinical decision making. *AMA Journal of Ethics, 21*(10), 913-919. https://doi.org/10.1001/amajethics.2019.913.

Islam, S., Joseph, O., Chaudry, A., Forde, D., Keane, A., Wilson, C., Begum, N., Parsons, S., Grey, T., Holmes, L., & Starling, B. (2021). "We are not hard to reach, but we may find it hard to trust" …. Involving and engaging 'seldom listened to' community voices in clinical translational health research: *A social innovation approach. Research involvement and engagement, 7*(1), 46. https://doi.org/10.1186/s40900-021-00292-z.

Jackson, H., Baker, J., & Berzins, K. (2019). Factors influencing decisions of mental health professionals to release service users from seclusion: A qualitative study. *Journal of Advanced Nursing, 75*(10), 2178–2188. https://doi.org/10.1111/jan.14086.

Jameton, A. (1984). *Nursing practice: The ethical issues.* Prentice Hall.

Jameton, A. (1993). Dilemmas of moral distress: moral responsibility and nursing practice. *AWHONN's Clinical Issues in Perinatal and Women's Health Nursing, 4*(4), 542–551.

Jansen, T. L., Hem, M. H., Dambolt, L. J., & Hanssen, I. (2019). Moral distress in acute psychiatric nursing: Multifaceted dilemmas and demands. *Nursing Ethics, 27*(5), 1315-1326. https://doi.org/10.1177/0969733019877526.

Jinkerson, J. D. (2016). Defining and assessing moral injury: A syndrome perspective. *Traumatology, 22*(2), 122–130. https://doi.org/10.1037/trm0000069.

Joinson, A. (1999). Social desirability, anonymity, and Internet-based questionnaires. *Behavior Research Methods, Instruments, & Computers, 31*(3), 433-438. https://doi.org/10.3758/BF03200723.

Jones, B., & de C Williams, A. C. (2020). Psychological therapists' judgments of pain and treatment decisions: The impact of 'medically unexplained symptoms'. *Journal of Psychosomatic Research, 131,* 109937. https://doi.org/10.1016/j.jpsychores.2020.109937.

Joseph-Salisbury, R., Connelly, L. and Wangari-Jones, P. (2021). “The UK is not innocent”: Black Lives Matter, policing and abolition in the UK. *Equality, Diversity and Inclusion: An International Journal, 40*(1), 21-28.

Joshi, A., & Knight, A. P. (2015). Who defers to whom and why? Dual pathways linking demographic differences and dyadic deference to team effectiveness. *Academy of Management Journal, 58*(1), 59-84. https://doi.org/10.5465/amj.2013.0718.

Kahneman, D. (2002). Maps of bounded rationality: A perspective on intuitive judgment and choice. *Nobel prize lecture, 8*(1), 351-401.

Kapadia, D., Brooks, H. L., Nazroo, J., & Tranmer, M. (2017). Pakistani women's use of mental health services and the role of social networks: a systematic review of quantitative and qualitative research. *Health & Social Care in the Community, 25*(4), 1304–1317. https://doi.org/10.1111/hsc.12305.

Karlsen, S. (2007). Better Health Briefing 3. Ethnic inequalities in health: The impact of racism. *Ethnicity and Inequalities in Health and Social Care, 58*.

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

Kenny, D. A. (2020, June 5). *Measuring Model Fit*. DavidKenny. http://www.davidakenny.net/cm/fit.htm.

Kerridge, I. (2010). Ethics and EBM: acknowledging bias, accepting difference and embracing politics. *Journal of Evaluation in Clinical Practice, 16*(2), 365-373. https://doi.org/10.1111/j.1365-2753.2010.01412.x.

Khatri, K. K. (2020). Research paradigm: A philosophy of educational research. *International Journal of English Literature and Social Sciences, 5*(5), 1435-1440.

Kim, K. R., Kang, J. -S., & Yun, S. (2012). Moral intuitions and political orientation: Similarities and differences between South Korea and the United States. *Psychological Reports, 111*, 173-185. https://doi.org/10.2466/17.09.21.PR0.111.4.173-185.

King, C., Fulford, B., Williamson, T., Dhillon, K., Vasiliou-Theadore, C., Cornah, D., Fleming, B., Greaves, J., MacNaughton, A., & Ryrie, I. (2009). *Model Values? Race, values and models in mental health.* Mental Health Foundation. https://www.mentalhealth.org.uk/sites/default/files/model_values.pdf.

Kirkengen, A. L., & Thornquist, E. (2012). The lived body as a medical topic: an argument for an ethically informed epistemology. *Journal of Evaluation in Clinical Practice, 18*(5), 1095–1101. https://doi.org/10.1111/j.1365-2753.2012.01925.x.

Kirkengen, A. L., Ekeland, T. J., Getz, L., Hetlevik, I., Schei, E., Ulvestad, E., & Vetlesen, A. J. (2016). Medicine's perception of reality - a split picture: Critical reflections on apparent anomalies within the biomedical theory of science. *Journal of Evaluation in Clinical Practice, 22*(4), 496–501. https://doi.org/10.1111/jep.12369.

Kivikangas, J. M., Fernández-Castilla, B., Järvelä, S., Ravaja, N., & Lönnqvist, J. E. (2021). Moral foundations and political orientation: Systematic review and meta-analysis. *Psychological Bulletin, 147*(1), 55. https://doi.org/10.1037/bul0000308.

Kline, R. B. (2010). Promise and pitfalls of structural equation modeling in gifted research. In B. Thompson & R. F. Subotnik (Eds.), *Methodologies for conducting* *research on giftedness* (pp. 147–169). American Psychological Association. https://doi.org/10.1037/12079-007.

Kline, R. B. (2015). *Principles and practice of structural equation modelling* (4th Ed.). Guilford Press.

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. https://doi.org/10.22023/mdx.12640421.v1.

Knapp, S., & VandeCreek, L. (2007). When values of different cultures conflict: Ethical decision making in a multicultural context. *Professional Psychology: Research and Practice, 38,* 660–666. https://doi.org/10.1037/0735-7028.38.6.660.

Kohlberg, L. (1969). Stage and sequence: The cognitive–developmental approach to socialization. In D. A. Goslin (Ed.). *Handbook of socialization theory and research* (pp. 347–480). Rand McNally.

Kohlberg, L. (1984). *The psychology of moral development: Essays on moral development.* Harper & Row.

Kohlberg, L. (1981). *The philosophy of moral development: Moral stages and the idea of justice*. Harpercollins.

Konttila, J., Holopainen, A., Kyngäs, H., & Pesonen, H. M. (2021). Background characteristics and exposure to violence predict well-being at work among psychiatric outpatient nurses. *Archives of Psychiatric Nursing, 35*(2), 223-231. https://doi.org/10.1016/j.apnu.2020.06.006.

Kuyken, W. (2006). Evidence-based case formulation: Is the emperor clothed?. In N. Tarrier, & J. Johnson, *Case formulation in cognitive behaviour therapy* (pp. 28-51). Routledge.

Kwak, S. G., & Kim, J. H. (2017). Central limit theorem: the cornerstone of modern statistics. *Korean Journal of Anesthesiology, 70*(2), 144–156. https://doi.org/10.4097/kjae.2017.70.2.144.

Lamiani, G., Borghi, L., & Argentero, P. (2017). When healthcare professionals cannot do the right thing: A systematic review of moral distress and its correlates. *Journal of Health Psychology, 22*(1), 51–67. https://doi.org/10.1177/1359105315595120.

Läng, J. (2020). *Analysis and recommendations on diversity of the mental health workforce*. The Tavistock and Portman NHS Foundation Trust. https://trustsrv-io-tavistock-tenant-mediabucket-jxlat5oi107p.s3.amazonaws.com/media/documents/Analysis_and_recommendations_on_diversity_of_the_mental_health_workforce.pdf?X-Amz-Algorithm=AWS4-HMAC-SHA256&X-Amz-Credential=AKIASPFGSFA5MV75PZDY%2F20220612%2Feu-west-2%2Fs3%2Faws4_request&X-Amz-Date=20220612T201206Z&X-Amz-Expires=3600&X-Amz-SignedHeaders=host&X-Amz-Signature=4e9744989d9b6ef09d3bc3fd31058b42113e4735b42b76ea26a4db58414697d9.

Lawrence V., McCombie C., Nikolakopoulos G., & Morgan C. (2021). Ethnicity and power in the mental health system: experiences of white British and black

Caribbean people with psychosis. *Epidemiology and Psychiatric Sciences, 30*(12),1–7. https://doi.org/10.1017/S2045796020001043.

Lazaridou, F., & Fernando, S. (2022). Deconstructing institutional racism and the social construction of whiteness: A strategy for professional competence training in culture and migration mental health. *Transcultural Psychiatry, 59*(2), 175–187. https://doi.org/10.1177/13634615221087101.

Lerman, H. (1994). The practice of ethics within feminist therapy. *Women & Therapy, 15*(1), 85-92. https://doi.org/10.1300/J015v15n01_08.

Lefever, S., Dal, M., & Matthíasdóttir, Á. (2007). Online data collection in academic research: advantages and limitations. *British Journal of Educational Technology, 38*(4), 574-582. https://doi.org/10.1111/j.1467-8535.2006.00638.x.

Lewis, D. K. (1969*). Convention. A philosophical study*. Harvard University Press.

Lewis, G., Croft-Jeffreys, C., & David, A. (1990). Are British psychiatrists racist?. *The British journal of psychiatry: The Journal of Mental Science, 157,* 410–415. https://doi.org/10.1192/bjp.157.3.410.

Li, F., & Vermillion, L. J. (2006). Asian collectivism and ethical decision making. Allied Academies International Conference. *Academy for Studies in International Business.Proceedings, 6*(1), 11-15.

Liberati, E., Richards, N., Willars, J., Scott, D., Boydell, N., Parker, J., Pinfold, V., Martin, G., Dixon-Woods, M., & Jones, P. B. (2021). A qualitative study of experiences of NHS mental healthcare workers during the Covid-19 pandemic. *BMC Psychiatry, 21*(1), 250. https://doi.org/10.1186/s12888-021-03261-8.

Lightbody, R. (2017). *"Hard to reach'or 'easy to ignore'? Promoting equality in community engagement*. What Works Scotland.

Littleford, L. N. (2007). How psychotherapists address hypothetical multiple relationships dilemmas with Asian American clients: A national survey. *Ethics & Behavior, 17*(2), 137-162. https://doi.org/10.1080/10508420701378081.

Littlewood, R. (1992). Psychiatric diagnosis and racial bias: empirical and interpretative approaches. *Social Science & Medicine, 34*(2), 141–149. https://doi.org/10.1016/0277-9536(92)90091-4.

Litz, B. T., Stein, N., Delaney, E., Lebowitz, L., Nash, W. P., Silva, C., & Maguen, S. (2009). Moral injury and moral repair in war veterans: A preliminary model and intervention strategy. *Clinical Psychology Review, 29*(8), 695-706. https://doi.org/10.1016/j.cpr.2009.07.003.

Loehlin, J. C. (1992). Latent variable models: *An introduction to factor, path, and structural analysis* (2nd Eds.). Lawrence Erlbaum.

Lomis, K. D., Carpenter, R. O., & Miller, B. M. (2009). Moral distress in the third year of medical school; a descriptive review of student case reflections. *American Journal of Surgery, 197*(1), 107–112. https://doi.org/10.1016/j.amjsurg.2008.07.048.

Louviere, J. J., Eagle, T. C., & Cohen, S. H. (2005). Conjoint analysis: Methods, myths and much more. *Documento de trabajo del Censoc, 5*, 31-31.

Luciano, M., Sampogna, G., Del Vecchio, V., Loos, S., Slade, M., Clarke, E., Nagy, M., Kovacs, A., Munk-Jørgensen, P., Krogsgaard Bording, M., Kawohl, W., Rössler, W., Puschner, B., Fiorillo, A., & CEDAR Study Group (2020). When does shared decision making is adopted in psychiatric clinical practice? Results from a European multicentric study. *European Archives of Psychiatry and Clinical Neuroscience, 270*(6), 645–653. https://doi.org/10.1007/s00406-019-01031-y.

Luke, M., Gilbride, D., & Goodrich, K. M. (2017). School counselors' approach to ethical decision making. *Journal of Counselor Leadership and Advocacy, 4*(1), 1-15. https://doi.org/10.1080/2326716X.2016.1223569.

Lützen, K., Blom, T., Ewalds-Kvist, B., & Winch, S. (2010). Moral stress, moral climate and moral sensitivity among psychiatric professionals. *Nursing Ethics, 17*(2), 213-224. https://doi.org/10.1177/0969733009351951.

MacIntyre, A. (1981). The nature of the virtues. *Hastings Center Report*, 27-34. https://doi.org/10.2307/3561072.

Malliarou, M., Nikolentzos, A., Papadopoulos, D., Bekiari, T., & Sarafis, P. (2021). ICU Nurse's Moral Distress as an Occupational Hazard Threatening Professional Quality of Life in the Time of Pandemic COVID 19. *Materia Socio-Medica, 33*(2), 88–93. https://doi.org/10.5455/msm.2021.33.88-93.

Mandal, J., Ponnambath, D. K., & Parija, S. C. (2016). Utilitarian and deontological ethics in medicine. *Tropical Parasitology, 6*(1), 5–7. https://doi.org/10.4103/2229-5070.175024.

Marmot, M., Allen, J., Boyce, T., Goldblatt, P., & Morrison, J. (2020). *Health equity in England: The Marmot review 10 years on.* https://www.health.org.uk/publications/reports/the-marmot-review-10-yearson.

McCabe, D. L., Dukerich, J. M., & Dutton, J. E. (1992). Values and ethical decision-making among professional school students: A study of dental and medical students. *Professional Ethics, A Multidisciplinary Journal,* 1(3/4), 117-136. https://doi.org/10.5840/profethics199213/414.

McCarthy, J., & Gastmans, C. (2015). Moral distress: A review of the argument based nursing ethics literature. *Nursing Ethics, 22*(1), 131–152. https://doi.org/10.1177/0969733014557139.

McEvoy, P., & Richards, D. (2006). A critical realist rationale for using a combination of quantitative and qualitative methods. *Journal of Research in Nursing, 11*(1), 66–78. https://doi.org/10.1177/1744987106060192.

McGuire, J., Nieri, D., Abbott, D., Sheridan, K., & Fisher, R. (1995). Do Tarasoff principles apply in AIDS-related psychotherapy? Ethical decision making and the role of therapist homophobia and perceived client dangerousness. *Professional Psychology: Research and Practice, 26*(6), 608. https://doi.org/10.1037/0735-7028.26.6.608.

Meeson, B. (1998). Occupational therapy in community mental health, part 2: factors influencing intervention choice. *British Journal of Occupational Therapy, 61*(2), 57-62. https://doi.org/10.1177/030802269806100203.

Menard, S. (1995). *Applied logistic regression analysis* (Vol. 106). Sage.

Mensah, M., Ogbu-Nwobodo, L., & Shim, R. S. (2021). Racism and mental health equity: History repeating itself. *Psychiatric Services, 72*(9), 1091–1094. https://doi.org/10.1176/appi.ps.202000755.

Mental Health Foundation. (2016). *Fundamental facts about mental health 2016*. Mental Health Foundation. https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-about-mental-health-2016.pdf.

Mikton, C., & Grounds, A. (2007). Cross-cultural clinical judgment bias in personality disorder diagnosis by forensic psychiatrists in the UK: a case-vignette study. *Journal of Personality Disorders, 21*(4), 400–417. https://doi.org/10.1521/pedi.2007.21.4.400.

Mills, C. & Fernando, S. (2014). Globalising mental health or pathologising the Global South? Mapping the ethics, theory and practice of global mental health. *Disability and the Global South, 1*(2), 188 – 202.

Minnis, H., McMillan, A., Gillies, M., & Smith, S. (2001). Racial stereotyping: survey of psychiatrists in the United Kingdom*. BMJ, 323*(7318), 905–906. https://doi.org/10.1136/bmj.323.7318.905.

Mitchell, R. J. (1993). Path analysis: Pollination. In S. M. Schneider, & J. Gurevitch, (Eds.), *Design and analysis of ecological experiments* (pp. 211-231). Chapman & Hall.

Mobayed, T. (2019). Religious differences across moral foundations. *LSE.* https://blogs.lse.ac.uk/religionglobalsociety/2019/12/religious-differences-across-moral-foundations/.

Mohan, R., McCrone, P., Szmukler, G., Micali, N., Afuwape, S., & Thornicroft, G. (2006). Ethnic differences in mental health service use among patients with psychotic disorders. *Social Psychiatry and Psychiatric Epidemiology, 41*(10), 771-776. https://doi.org/10.1007/s00127-006-0094-7.

Moncrieff, J. Psychiatric diagnosis as a political device. *Social Theory & Health, 8*, 370–382 (2010). https://doi.org/10.1057/sth.2009.11.

Morgan, A., Felton, A., Fulford, B., Kalathil, J., & Stacey, G. (2015). *Values and ethics in mental health: an exploration for practice*. Macmillan International Higher Education.

Morgan, H. C. M., Randall, J., Lyons, A. J., Oliver, S., Saffer, J., Scott, J. M., & Nolte, L. (2019). Pebbles in palms: Counter-practices against despair. *Psychotherapy and Politics International, 17*(1), 1–10. https://doi.org/10.1002/ppi.1481.

Moyo, M., Goodyear-Smith, F. A., Weller, J., Robb, G., & Shulruf, B. (2016). Healthcare practitioners' personal and professional values. *Advances in Health Sciences Education, 21*(2), 257 – 286. https://doi.org/10.1007/s10459-015-9626-9.

Moyo, M., Shulruf, B., Weller, J., & Goodyear-Smith, F. (2019). Effect of medical students' values on their clinical decision-making. *Journal of Primary Health Care, 11*(1), 64-74. https://doi.org/10.1071/HC18055.

Murphy N. (2004). An investigation into how community mental health nurses assess the risk of violence from their clients. *Journal of Psychiatric and Mental Health Nursing, 11*(4), 407–413. https://doi.org/10.1111/j.1365-2850.2004.00727.x.

Myers, R. H. (1990). *Classical and modern regression with applications* (2nd ed.). PWS-KENT Publishing.

Nakajima, M., Dykiert, D., Wilkinson, P., & Midgley, N. (2021). How do therapists assess suitability? A qualitative study exploring therapists' judgements of treatment suitability for depressed adolescents. *Counselling and Psychotherapy Research, 22*(2), 503-513. https://doi.org/10.1002/capr.12452.

Nathan, R., Gabbay, M., Boyle, S., Elliott, P., Giebel, C., O'Loughlin, C., Wilson, P., & Saini, P. (2021). Use of acute psychiatric hospitalisation: A study of the factors influencing decisions to arrange acute admission to inpatient mental health facilities. *Frontiers in Psychiatry, 12,* 696478. https://doi.org/10.3389/fpsyt.2021.696478.

National Health Service. (2019). *The NHS Long Term Plan.* https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan-june-2019.pdf.

National Institute for Health and Care Excellence. (2021). *NICE strategy 2021 to 2026: Dynamic, collaborative, excellent.* https://static.nice.org.uk/NICE%20strategy%202021%20to%202026%20-%20Dynamic,%20Collaborative,%20Excellent.pdf.

Neely, B., & Samura, M. (2011). Social geographies of race: Connecting race and space. *Ethnic and Racial Studies, 34*(11), 1933-1952. https://doi.org/10.1080/01419870.2011.559262.

Neville, H. A., Lilly, R. L., Duran, G., Lee, R. M., & Browne, L. (2000). Construction and initial validation of the Color-Blind Racial Attitudes Scale (CoBRAS). *Journal of Counseling Psychology, 47*(1), 59–70. https://doi.org/10.1037/0022-0167.47.1.59.

Neville, H., Spanierman, L., & Doan, B. T. (2006). Exploring the association between color-blind racial ideology and multicultural counseling competencies. *Cultural Diversity and Ethnic Minority Psychology, 12*(2), 275. https://doi.org/10.1037/1099-9809.12.2.275.

NHS Confederation (2012). *Race equality in mental health.* http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/Race_equality_in_mental_health_final_for_website_8_May.pdf.

NHS Digital. (2021). *Mental Health Act Statistics, Annual Figures - 2020-21*. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2020-21-annual-figures.

NHS England. (n.d.). *Working for the NHS in mental health*. https://www.england.nhs.uk/mental-health/working-in-mental-health/.

NHS. (2013). *Commissioning Policy: Ethical framework for priority setting and resource allocation*. https://www.england.nhs.uk/wp-content/uploads/2013/04/cp-01.pdf.

NHS. (2021). *The NHS constitution for England, Department of Health & Social Care.* https://www.gov.uk/government/publications/the-nhs-constitution-forengland/the-nhs-constitution-for-england.

nidirect. (n.d.). *Mental health care professionals.* https://www.nidirect.gov.uk/articles/mental-health-care-professionals.

Niemonen, J. (2007). Antiracist education in theory and practice: A critical assessment. *The American Sociologist, 38*(2), 159-177. https://doi.org/10.1007/s12108-007-9006-x.

Nilsson, A., & Erlandsson, A. (2015). The moral foundations taxonomy: Structural validity and relation to political ideology in Sweden. *Personality and Individual Differences, 76*, 28-32. https://doi.org/10.1016/j.paid.2014.11.049.

Nimmagadda, S., Caton, C., Anunobi, K., Crossley, K., Glynn, J., & Buchan, C. (2017). Why is Principlism limited in its' Utility in Psychiatric Settings?. *Global Bioethics Enquiry, 4*(1), 4-9.

Norman I, Ryrie I (2018). *The art and science of mental health nursing: Principles and practice.* Open University Press.

Nussbaum, J. (2019). *The Social Metrics Commission 2019 Report.* SMC.

Ocloo, J., & Matthews, R. (2016). From tokenism to empowerment: progressing patient and public involvement in healthcare improvement. *BMJ Quality & Safety, 25*(8), 626-632. http://dx.doi.org/10.1136/bmjqs-2015-004839.

Offermann, L. R., Basford, T. E., Graebner, R., Jaffer, S., De Graaf, S. B., & Kaminsky, S. E. (2014). See no evil: Color blindness and perceptions of subtle racial discrimination in the workplace. *Cultural Diversity and Ethnic Minority Psychology, 20*(4), 499. https://doi.org/10.1037/a0037237.

Office for National Statistics. (2011). *2011 Census: Key Statistics for England and Wales, March 2011.* https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/2011censuskeystatisticsforenglandandwales/2012-12-11.

Ohnishi, K., Kitaoka, K., Nakahara, J., Välimäki, M., Kontio, R., & Anttila, M. (2019). Impact of moral sensitivity on moral distress among psychiatric nurses. *Nursing Ethics, 26*(5), 1473 – 1483. https://doi.org/10.1177/0969733017751264.

Okah, E., Thomas, J., Westby, A., & Cunningham, B. (2021). Colorblind racial ideology and physician use of race in medical decision-making. *Journal of Racial and Ethnic Health Disparities*, 1-8. https://doi.org/10.1007/s40615-021-01141-1.

Okasha, A. (2000). Ethics of psychiatry practice: consent, compulsion, and confidentiality. *Current Opinion in Psychiatry, 13*(6), 693-698.

Omeni, E., Barnes, M., MacDonald, D., Crawford, M., & Rose, D. (2014). Service user involvement: impact and participation: A survey of service user and staff perspectives. *BMC Health Services Research, 14*(1), 1-13. https://doi.org/10.1186/s12913-014-0491-7.

Omi, M., & Winant, H. (2014). *Racial formation in the United States.* Routledge.

Office for National Statistics. (2021). Question development: How we researched and tested the questions for the questionnaire. https://www.ons.gov.uk/census/planningforcensus2021/questiondevelopment.

Osborne, J. W. (2008). Best practices in data transformation: *The overlooked effect of minimum values.* Sage Publishing.

O'Shea, N. (2021). *Now Or Never: A systemic investment review of mental health care in England.* Centre for Mental Health.

https://www.centreformentalhealth.org.uk/sites/default/files/publication/download/CentreforMH_NowOrNever_PDF.pdf.

Pallant, J. (2020). *SPSS survival manual: A step by step guide to data analysis using IBM SPSS*. Routledge.

Paradies, Y., Truong, M., & Priest, N. (2014). A systematic review of the extent and measurement of healthcare provider racism. *Journal of General Internal Medicine, 29*(2), 364–387. https://doi.org/10.1007/s11606-013-2583-1.

Parihar, P., Tiwari, G. K., Pandey, R., & Rai, P. K. (2018). Assessing the relative impacts of gender and educational levels on the moral foundations of the students. *International Journal of Indian Psychology, 6*(4), 11-25. https://doi.org/10.25215/0604.082.

Patel, N., Bennett, E., Dennis, M., Dosanjh, N., Mahtani, A., Miller, A. C., & Nadirshaw, Z (Eds). (2000). *Clinical psychology, 'race' and culture: A training manual.* Blackwell.

Patel, N. & Keval, H. (2018) Fifty ways to leave … your racism. *Journal of Critical Clinical Psychology Counselling and Psychotherapy, 18*(2), 61– 79.

Patel, N. (2021). Dismantling the scaffolding of institutional racism and institutionalising anti-racism. *Journal of Family Therapy, 44*(1), 91-108. https://doi.org/10.1111/1467-6427.12367.

Peabody, J. W., Luck, J., Glassman, P., Jain, S., Hansen, J., Spell, M., & Lee, M. (2004). Measuring the quality of physician practice by using clinical vignettes: a prospective validation study. *Annals of Internal Medicine, 141*(10), 771–780. https://doi.org/10.7326/0003-4819-141-10-200411160-00008.

Peay, J. (2003*). Decisions and dilemmas: Working with mental health law*. Bloomsbury Publishing.

Peters, M. D. J., Godfrey, C., McInerney, P., Munn, Z., Tricco, A. C., & Khalil, H. (2020). Chapter 11: Scoping Reviews (2020 version). In E. Aromataris & Z. Munn (Eds). *JBI Manual for Evidence Synthesis*, JBI. https://doi.org/10.46658/JBIMES-20-12.

Petrișor, C., Breazu, C., Doroftei, M., Mărieș, I., & Popescu, C. (2021, October). Association of Moral Distress with Anxiety, Depression, and an Intention to Leave among Nurses Working in Intensive Care Units during the COVID-19 Pandemic. *Healthcare, 9(*10), 1366. https://doi.org/10.3390/healthcare9101377.

Phillips, J., Frances, A., Cerullo, M. A., Chardavoyne, J., Decker, H. S., First, M. B., ... & Zachar, P. (2012). The six most essential questions in psychiatric diagnosis: a pluralogue part 1: conceptual and definitional issues in psychiatric diagnosis. *Philosophy, Ethics, and Humanities in Medicine, 7*(1), 1 – 29. https://doi.org/10.1186/1747-5341-7-8.

Piaget, J. (1932). *The moral judgement of the child.* Routledge & Kegan Paul.

Pilgrim, D. (2015). *Understanding mental health: A critical realist exploration*. Routledge.

Pilgrim, D. (2019). *Critical realism for psychologists*. Routledge.

Pilgrim, D., & Patel, N. (2015). The emergence of clinical psychology in the British post-war context. In J. Hall, D. Pilgrim & G. Turpin (Eds.), *Clinical Psychology in Britain*, (pp.52-64). British Psychological Society.

Ponterotto, J. G., Gretchen, D., Utsey, S. O., Rieger, B. P., & Austin, R. (2002). A revision of the Multicultural Counseling Awareness Scale. Journal of Multicultural Counseling and Development, 30(3), 153–180. https://doi.org/10.1002/j.2161-1912.2002.tb00489.x.

Popescu, B. A. (2015). Moral dilemmas and existential issues encountered both in psychotherapy and philosophical counseling practices. *Europe's Journal of Psychology, 11*(3), 509. https://doi.org/10.5964/ejop.v11i3.1010.

Porter, R. (2002). *Madness: A brief history*. Oxford University Press.

Proctor, R. N. (1991). *Value-free science? Purity and power in modern knowledge*. Harvard University Press.

Quirk, A., Lelliott, P., Audini, B., & Buston, K. (2003). Non-clinical and extra-legal influences on decisions about compulsory admission to psychiatric hospital. *Journal of Mental Health, 12*(2), 119-130. https://doi.org/10.1080/0963823031000103434.

Ramrathan, L. (2016). Beyond counting the numbers: Shifting higher education transformation into curriculum spaces. *Transformation in Higher Education, 1*(1), 1-8. https://doi.org/10.4102/the.v1i1.6.

Raphael, D. D. (1981). *Moral philosophy*. Oxford University Press.

Rattay K. T. (2019). Improved data collection for our LGBTQ population is needed to improve health care and reduce health disparities. *Delaware Journal of Public Health, 5*(3), 24–26. https://doi.org/10.32481/djph.2019.06.007.

Rawlins, M. D., & Culyer, A. J. (2004). National Institute for Clinical Excellence and its value judgments. *BMJ, 329*(7459), 224-227. https://doi.org/10.1136/bmj.329.7459.224.

Read, J. (2004). Poverty, ethnicity and gender. In J. Read, L. Mosher, & R. Bentall (Eds.), *Models of madness: Psychological, social and biological approaches to schizophrenia*, (pp. 161-195). Routledge.

Read, J. Mosher, L. Bentall, R. (2004). *Models of madness: Psychological, social and biological approaches to schizophrenia*. Routledge.

Redshaw, M., & Henderson, J. (2016). Who is actually asked about their mental health in pregnancy and the postnatal period? Findings from a national survey. *BMC Psychiatry, 16*(1), 322. https://doi.org/10.1186/s12888-016-1029-9.

Rees, R., Stokes, G., Stansfield, C., Oliver, E., Kneale, D., & Thomas, J. (2016). *Prevalence of mental health disorders in adult minority ethnic populations in England.* EPPI-Centre. https://eppi.ioe.ac.uk/cms/Portals/0/PDF%20reviews%20and%20summaries/BME%20Mental%20Health%202016%20Rees%20report.pdf?ver=2016-01-07-110035-067.

Regier, D. A., Narrow, W. E., Kuhl, E. A., Kupfer, D. J., & American Psychopathological Association. (2011). *The conceptual evolution of DSM-5.* American Psychiatric Publishing.

Rethink. (2004). *Behind closed doors, the current state and future vision of acute mental health care in the UK.* Rethink.

Rodriguez-Ruiz, E., Campelo-Izquierdo, M., Boga Veiras, P., Mansilla Rodríguez, M., Estany-Gestal, A., Blanco Hortas, A., Rodríguez-Calvo, M. S., & Rodríguez-Núñez, A. (2022). Impact of the coronavirus disease 2019 pandemic on moral distress among nurses and physicians in Spanish ICUs. *Critical Care Medicine, 50*(5), e487–e497. https://doi.org/10.1097/CCM.0000000000005434

Ross, K. (2017). Making empowering choices: How methodology matters for empowering research participants. *Forum Qualitative Social Research, 18*(3), 17. https://doi.org/10.17169/fqs-18.3.2791.

Ross, S., Jabbal, J., Chauhan, K., Maguire, D., Randhawa, M., & Dahir, S. (2020). *Workforce race inequalities and inclusion in NHS providers*. The King's Fund. https://www.kingsfund.org.uk/sites/default/files/2020-07/workforce-race-inequalities-inclusion-nhs-providers-july2020.pdf.

Rouf, K., Larkin, M., & Lowe, G. (2012). Making decisions about parental mental health: An exploratory study of community mental health team staff. *Child Abuse Review, 21*(3), 173-189. https://doi.org/10.1002/car.1172.

Roy, W. (2001). Making societies: *The historical construction of our world.* Pine Forge Press.

Ryde, J. (2019). *White Privilege Unmasked: How To Be Part Of The Solution.* Jessica Kingsley Publishers.

Rydell, R. J., & McConnell, A. R. (2006). Understanding implicit and explicit attitude change: a systems of reasoning analysis. *Journal of Personality and Social Psychology, 91*(6), 995–1008. https://doi.org/10.1037/0022-3514.91.6.995.

Sabshin, M., Diesenhaus, H., & Wilkerson, R. (1970). Dimensions of institutional racism in psychiatry. *American Journal of Psychiatry, 127*(6), 787-793. https://doi.org/10.1176/ajp.127.6.787.

Sadler J. Z. (1997). Recognizing values: a descriptive-causal method for medical/scientific discourses. *The Journal of Medicine and Philosophy, 22*(6), 541–565. https://doi.org/10.1093/jmp/22.6.541.

Sadler, J. Z. (2002). *Descriptions and prescriptions: Values, mental disorders, and the DSMs*. Johns Hopkins University Press.

Sadler, J. Z. (2005). *Values and psychiatric diagnosis.* Oxford University Press.

Saini, A. (2019). *Superior: The return of race science*. Fourth Estate.

Schulberg, H. C., & McClelland, M. (1981). Ethical dilemmas in administering mental health services. *Administration in Mental Health, 9*(1), 20-34.

Schwartz, J. M., & Abramowitz, S. I. (1975). Value-related effects on psychiatric judgment. *Archives of General Psychiatry, 32*(12), 1525–1529. https://doi.org/10.1001/archpsyc.1975.01760300063004.

Schwartz, S. H. (1992). Universals in the content and structure of values: Theory and empirical tests in 20 countries. *Advances in Experimental Social Psychology, 25*, 1-65. https://doi.org/10.1016/S0065-2601(08)60281-6.

Scott, J., Weatherhead, S., Daker-White, G., Manthorpe, J., & Mawson, M. (2020). Practitioners' experiences of the mental capacity act: a systematic review. *The Journal of Adult Protection*. https://doi.org/10.1108/jap-02-2020-0005.

Self, P. J., Gallop, C. A., Cavanna, A. R., Laidlaw, K., & Partridge, S. *The Psychological Professions in the South West: Workforce Report March 2021.* Psychological Professions Network. https://www.ppn.nhs.uk/all-ppn-resources/42-ppn-south-west-workforce-report-final/file.

Shah, R., Edgar, D. F., & Evans, B. J. (2010). A comparison of standardised patients, record abstraction and clinical vignettes for the purpose of measuring clinical practice. *Ophthalmic and Physiological Optics, 30*(3), 209-224. https://doi.org/10.1111/j.1475-1313.2010.00713.x.

Sharma, G. (2017). Pros and cons of different sampling techniques. *International Journal of Applied Research, 3*(7), 749-752.

Shehadeh, J., Almaraira, O., & Hamdan-Mansour, A. (2022). Determinants of moral distress among mental health professionals. *Open Nursing Journal, 16*, e187443462203030. https://doi.org/10.2174/18744346-v16-e2203030.

Shepherd, G., Lockett, H., Bacon, J., & Grove, B. (2009). *Measuring what matters; Key indicators for the development of evidence-based employment services.* Sainsbury Centre for Mental Health. https://www.centreformentalhealth.org.uk/sites/default/files/measuring_what_matters.pdf.

Sheringham, J., Kuhn, I., & Burt, J. (2021). The use of experimental vignette studies to identify drivers of variations in the delivery of health care: a scoping review. *BMC Medical Research Methodology, 21*(1), 1-17. https://doi.org/10.1186/s12874-021-01247-4.

Shrive, F. M., Stuart, H., Quan, H., & Ghali, W. A. (2006). Dealing with missing data in a multi-question depression scale: a comparison of imputation methods. *BMC Medical Research Methodology, 6*, 57. https://doi.org/10.1186/1471-2288-6-57.

Singh, S. P., Burns, T., Tyrer, P., Islam, Z., Parsons, H., & Crawford, M. J. (2014). Ethnicity as a predictor of detention under the Mental Health Act. *Psychological Medicine, 44*(5), 997–1004. https://doi.org/10.1017/S003329171300086X.

Skyrms, B. (1996). *Evolution of the social contract*. Cambridge University Press.

Slade, M. (2017). Implementing shared decision making in routine mental health care. *World Psychiatry: Official Journal of the World Psychiatric Association, 16*(2), 146–153. https://doi.org/10.1002/wps.20412.

Slay J., & Robinson B. (2011). *In this together: Building knowledge about co-production.* New Economics Foundation. https://neweconomics.org/uploads/files/b3d00daf74d4c4411b_k1m6ibw57.pdf.

Smedley, A., & Smedley, B. (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. https://doi.org/10.1037/0003-066X.60.1.16.

Spandler, H., & Anderson, J. (Eds.). (2015). *Madness, distress and the politics of disablement.* Policy Press.

Spivak, G. C. (1998). Can the subaltern speak? In C. Nelson, & L. Grossberg (Eds.), *Marxism and the interpretation of culture* (pp. 66 – 111). University of Illinois Press.

Sprigings, K. (2021). *Clinical psychology and moral distress*. [Doctoral dissertation, University of East London]. Repository. https://repository.uel.ac.uk/download/874fd05c361a118c01c0d46d29d097b532ad03f1e42dce0a6568a2e5821247cc/2219037/2021_ClinPsychD_Sprigings.pdf.

Stam, M. T., Ford-Gilboe, M., & Regan, S. (2015). Primary health care service use among women who have recently left an abusive partner: Income and racialization, unmet need, fits of services, and health. *Health Care for Women International, 36*(2), 161-187. https://doi.org/10.1080/07399332.2014.909431.

Stampley, C. D. (2008). Social workers' culture-based countertransferences. *Journal of Ethnic & Cultural Diversity in Social Work, 17*(1), 37-59. https://doi.org/10.1080/15313200801906401.

Stevens, J. (1996). *Applied multivariate statistics for the social sciences* (3rd ed.). Lawrence Erlbaum.

Stone, K. (2019). Approved mental health professionals and detention: An exploration of professional differences and simularities. *Practice, 31*(2), 83-96. https://doi.org/10.1080/09503153.2018.1445709.

Su, Y., & Behar-Horenstein, L. S. (2017). Color-Blind Racial Beliefs Among Dental Students and Faculty. *Journal of Dental Education, 81*(9), 1098–1107. https://doi.org/10.21815/JDE.017.064.

Sue, D W., (2015). *Race talk and the Conspiracy of silence: Understanding and facilitating difficult dialogues on Race.* Wiley.

Sue, D. W., Sue, D., Neville, H. A., & Smith, L. (2019). *Counseling the culturally diverse: Theory and practice.* John Wiley & Sons.

Sullivan, T. R., White, I. R., Salter, A. B., Ryan, P., & Lee, K. J. (2018). Should multiple imputation be the method of choice for handling missing data in randomized trials?. *Statistical Methods in Medical Research, 27*(9), 2610–2626. https://doi.org/10.1177/0962280216683570.

Summerfield, D. (2013). “Global mental health” is an oxymoron and medical imperialism. *BMJ, 346*. https://doi.org/10.1136/bmj.f3509.

Szasz, T. (1974). *The myth of mental illness: Foundations of a theory of personal conduct.* Harper & Row.

Tabachnick, B. G., & Fidell, L. S. (2007). *Using Multivariate Statistics* (5th ed.). Pearson.

Tao, X., & Fisher, C. B. (2022). Exposure to social media racial discrimination and mental health among adolescents of color. *Journal of Youth and Adolescence, 51*(1), 30–44. https://doi.org/10.1007/s10964-021-01514-z.

Tarvydas, V. M., Leahy, M. J., Saunders, J. L., & Fong, C. (2001). Beliefs about the ethics of practice among CRC: A national survey. *Journal of Applied Rehabilitation Counseling, 32(*2), 9.

Teclaw, R., Price, M. C., & Osatuke, K. (2012). Demographic question placement: Effect on item response rates and means of a veterans health administration survey. *Journal of Business and Psychology, 27*(3), 281-290. https://doi.org/10.1007/s10869-011-9249-y.

Thakker, J., & Ward, T. (1998). Culture and classification: The cross-cultural application of the DSM-IV. *Clinical Psychology Review, 18*(5), 501–529. https://doi.org/10.1016/s0272-7358(97)00107-4.

Tjeltveit, A. C. (2004). The good, the bad, the obligatory, and the virtuous: The ethical contexts of psychotherapy. *Journal of Psychotherapy Integration, 14*(2), 149–167. https://doi.org/10.1037/1053-0479.14.2.149.

Tjeltveit, A. C. (2016). Value Conversion and Moral (and Spiritual?) Transformations: Addressing Some Complexities of the Ethical Dimensions of Psychotherapy. *Journal of Psychology & Christianity, 35*(4), 330 – 343.

Toleikyte, L., & Salway, S. (2018). L*ocal action on health inequalities: Understanding and reducing ethnic inequalities in health.* Public Health England. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/730917/local_action_on_health_inequalities.pdf.

van den Berghe, P. L. (1967). *Race and racism: A comparative perspective*. John Wiley & Sons.

Varcoe, C., Rodney, P., & McCormick, J. (2003). Health care relationships in context: An analysis of three ethnographies. *Qualitative Health Research, 13*(7), 957–973. https://doi.org/10.1177/1049732303253483.

Varcoe, C., Pauly, B., Webster, G., & Storch, J. (2012). Moral distress: Tensions as springboards for action. *HEC Forum, 24*(1), 51–62. https://doi.org/10.1007/s10730-012-9180-2.

Vaughn, L. (2008). *Doing ethics: Moral reasoning and contemporary issues*. Norton.

Veloski, J., Tai, S., Evans, A. S., & Nash, D. B. (2005). Clinical vignette-based surveys: A tool for assessing physician practice variation. *American Journal of Medical Quality, 20*(3), 151–157. https://doi.org/10.1177/1062860605274520.

Von Wright, G. H. (1963). *The varieties of goodness.* Routledge & Kegan Paul.

Weidman, A. C., Sowden, W. J., Berg, M. K., & Kross, E. (2020). Punish or protect? How close relationships shape responses to moral violations. *Personality and Social Psychology Bulletin, 46*(5), 693 – 708. https://doi.org/10.1177/0146167219873485.

Wilcox, R. R. (2010). *Fundamentals of modern statistical methods: Substantially improving power and accuracy*. Springer.

Williams, D. R., Lawrence, J. A., & Davis, B. A. (2019). Racism and Health: Evidence and Needed Research. *Annual review of public health, 40*, 105–125. https://doi.org/10.1146/annurev-publhealth-040218-043750.

Willig, C., & Rogers, W. S. (Eds.). (2008). *The Sage Handbook of Qualitative Research in Psychology.* Sage.

Willig, C. (2013). *Introducing qualitative research in psychology* (3rd ed.).

Open University Press.

Woodbridge, K., & Fulford, K. W. M. (2004). *Whose values. A workbook for values-based practice in mental health care.* Sainsbury Centre for Mental Health.

World Health Organization (WHO). (1993). *The ICD-10 classification of mental and behavioural disorders.* World Health Organization.

Wu, H., & Leung, S. O. (2017). Can Likert scales be treated as interval scales? – A simulation study. *Journal of Social Service Research, 43*(4), 527-532. https://doi.org/10.1080/01488376.2017.1329775.

Yamagishi, T., Hashimoto, H., & Schug, J. (2008). Preferences versus strategies as explanations for culture-specific behavior. *Psychological Science, 19*(6), 579-584. https://doi.org/10.1111/j.1467-9280.2008.02126.x.

Yasmin-Qureshi, S., & Ledwith, S. (2020). Beyond the barriers: South Asian women's experience of accessing and receiving psychological therapy in primary care. *Journal of Public Mental Health*. https://doi.org/10.1108/JPMH-06-2020-0058.

Zheng, P., Gray, M. J., Zhu, W.-Z., & Jiang, G.-R. (2014). Influence of culture on ethical decision making in psychology. *Ethics & Behavior, 24*(6), 510–522. https://doi.org/10.1080/10508422.2014.891075.

Zimmerman, D. W. (1998). Invalidation of parametric and nonparamteric statistical tests by concurrent violation of two assumptions. *Journal of Experimental Education, 67*(1), 55-68. https://doi.org/10.1080/00220979809598344.

6. APPENDICES

Appendix A: Literature Review Search Strategy

Guiding question: What is the current understanding of the relationship between values, clinical decision-making and/ or moral distress, and race/ culture/ racism in mental healthcare

Search terms:

The following search terms were searched using the Boolean operators ‘AND’ and ‘OR’. Keywords truncation searches were used where possible.

- *Values/ moral values:* Values OR moral*.
- *Clinical Decision Making:* Clinical decision making OR ethical decision making OR judgement OR moral distress.
- *Race/ Racism*: Race OR ethnicity OR culture OR ethnic groups OR ethnic identity OR minority groups OR racism OR racial bias.
- *Mental Health Professional:* Mental health professional OR mental health services OR therapists OR counsellors OR psychologists OR social workers OR mental health practiti* OR psychiatrist OR psychiatry OR mental health nurse OR psychiatric nursing.

Key words searches were used where possible. The above search terms and limiters were used in the following databases: EBSCO (including Academic Search Ultimate, CINAHL, PsycArticles and PsycInfo), Scopus and PubMed. Limiters included: English language; adults; human; and keyword and abstract only. Google scholar and reference lists were also utilised. Qualitative and quantitative studies were included. Studies were then considered against the following inclusion and exclusion criteria.

Inclusion criteria:

- Studies including references to values and/ or moral/ ethical factors affecting CDM.
- Factors related to CDM at the individual (MHP) level.
- Studies referencing issues of race/ culture/ racism within CDM.

- Participants include MHPs.

Exclusion criteria:

- Studies which did not relate specifically to values or moral/ ethical factors affecting MHPs CDM.
- Studies not related to CDM at the individual level (MHP).
- Study not relevant to mental healthcare.
- Study did not consider issues of race/ culture/ racism.
- Review, commentary or case-study.

Together, the searches identified 558 papers which were reviewed for relevance. After abstract reading, 27 papers were considered to have potential relevance and were read in full. These were further filtered based on the guiding question, resulting in five relevant papers. One additional paper was identified through manual searching, resulting in six papers included in the final literature review.

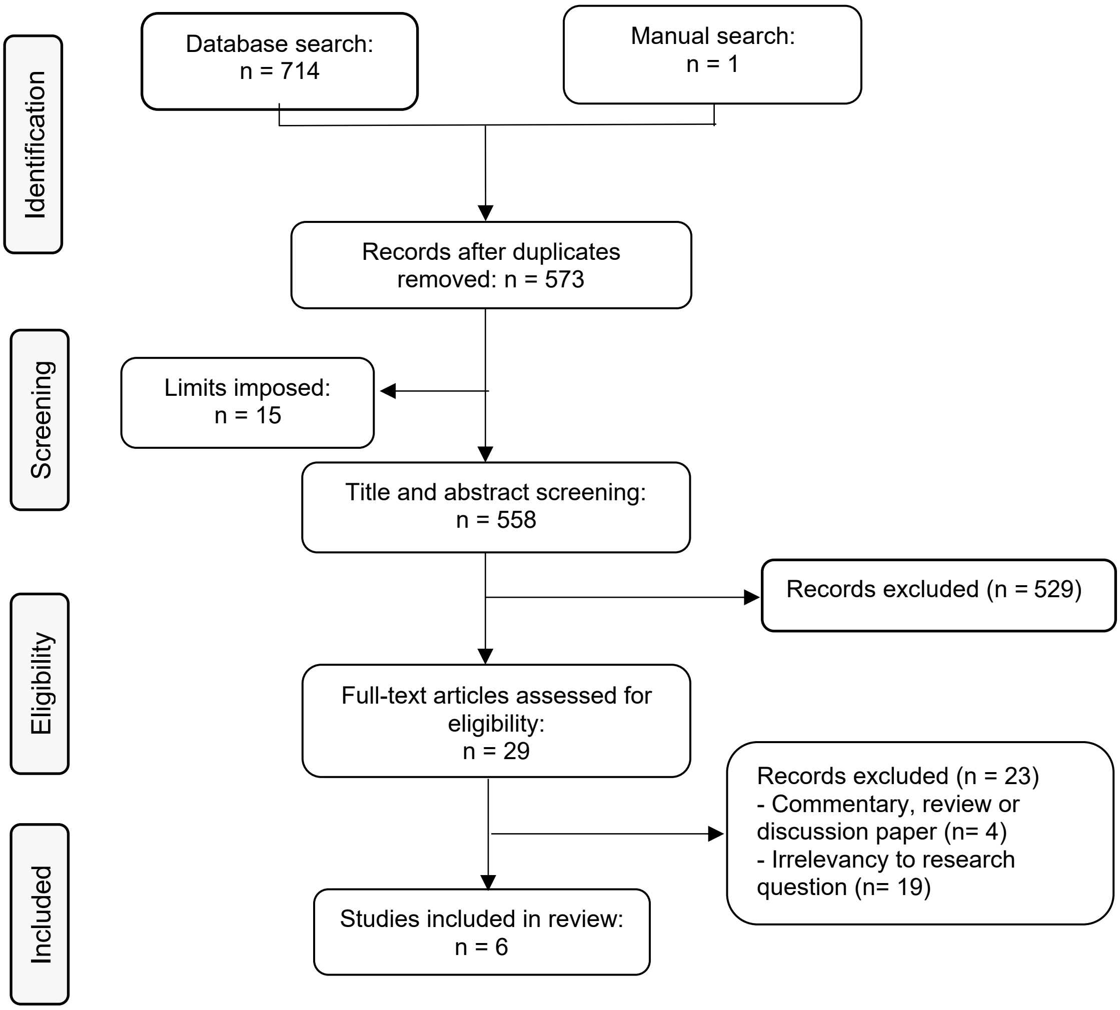


Figure 4: Flow diagram of study selection method

Appendix B: Ethics Application and Approval

UNIVERSITY OF EAST LONDON
School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL
FOR RESEARCH INVOLVING HUMAN PARTICIPANTS
(Updated October 2019)

FOR BSc RESEARCH
FOR MSc/MA RESEARCH
FOR PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

1. Completing the application

1.1 Before completing this application please familiarise yourself with the British Psychological Society's Code of Ethics and Conduct (2018) and the UEL Code of Practice for Research Ethics (2015-16). Please tick to confirm that you have read and understood these co ☑

1.2 Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will then look over your application.

1.3 When your application demonstrates sound ethical protocol, your supervisor will submit it for review. By submitting the application, the supervisor is confirming that they have reviewed all parts of this application, and consider it of sufficient quality for submission to the SREC committee for review. It is the responsibility of students to check that the supervisor has checked the application and sent it for review.

1.4 Your supervisor will let you know the outcome of your application. Recruitment and data collection must NOT commence until your ethics application has been approved, along with other research ethics approvals that may be necessary (see section 8).

1.5 Please tick to confirm that the following appendices have been completed. Note: templates for these are included at the end of the form.

- The participant invitation letter ☑
- The participant consent form ☑
- The participant debrief letter ☑

1.6 The following attachments should be included if appropriate. In each case, please tick to either confirm that you have included the relevant attachment, or confirm that it is not required for this application.

- A participant advert, i.e., any text (e.g., email) or document (e.g., poster) designed to recruit potential participants.
  Included ☑ or

  Not required (because no participation adverts will be used) ☐

- A general risk assessment form for research conducted off campus (see section 6).
  Included ☐ or

  Not required (because the research takes place solely on campus or online ☑

- A country-specific risk assessment form for research conducted abroad (see section 6).
  Included ☐ or

  Not required (because the researcher will be based solely in the UK) ☑

- A Disclosure and Barring Service (DBS) certificate (see section 7).
  Included ☐ or

  Not required (because the research does not involve children aged 16 or under or vulnerable adults) ☑

- Ethical clearance or permission from an external organisation (see section 8).
  Included ☐ or

  Not required (because no external organisations are involved in the research) ☑

- Original and/or pre-existing questionnaire(s) and test(s) you intend to use.
  Included ☑ or

  Not required (because you are not using pre-existing questionnaires or tests ☐

- Interview questions for qualitative studies.
  Included ☐ or

  Not required (because you are not conducting qualitative interviews) ☑

- Visual material(s) you intend showing participants.
  Included ☑ or

  Not required (because you are not using any visual materials) ☐

2. Your details

2.1 Your name: Emily Mortimer

2.2 Your supervisor’s name: Dr Trishna Patel (Director of Studies), Dr Kenneth Gannon (Second Supervisor)

2.3 Title of your programme: Professional Doctorate in Clinical Psychology

2.4 UEL assignment submission date (stating both the initial date and the resit date): May 2022

3. Your research

Please give as much detail as necessary for a reviewer to be able to fully understand the nature and details of your proposed research.

3.1 The title of your study:

Race and Clinically-Based Moral Judgements Among Mental Healthcare Professionals

3.2 Your research question:

Background information:
Those accessing services within the National Health Service (NHS) should expect decisions about their care to be made rationally, with care provided equally across patient groups and in light of competing demands (NHS, 2013). Decision making within the NHS is however, becoming ever more complex and is compounded by a growing demand for services and competing needs (NHS, 2019). Decisions are often ethically complex and intersect with social and emotional factors and narrative reasoning (Nussbaum, 2001; Russel & Greenhalgh, 2013). Thus, professionals often rely on their moral appraisals to make sense of the situation and to determine the course of action (Hunter, 1996; Dickerson, 2010).

Moral judgements can be defined as a cognitive process of reasoning, guided by principles of what is right and wrong (Rest, 1994). Recent theories of morality have highlighted the role of culture, norms and values in predicting moral judgements (Curry, 2016; Haidt & Joseph, 2004) and suggest that both biological and cultural mechanisms drive social, cooperative and altruistic behaviour. Implicating social intuition and cultural factors within moral judgements questions whether ethical decisions within healthcare can ever be wholly rational.

While research on the dynamics of moral judgements in healthcare is somewhat limited, moral judgements have been shown to be influenced by variations in client and clinician characteristics. This includes age, gender, education level, race and culture, as well as emotions such as disgust (Graham et al., 2016; Hill, 2010; Rosen et al., 2016; Schnall et al., 2008). Moral distress can also influence the quality of clinical decision making (Deady & McCarthy, 2010). We might therefore question whether variations in moral judgements play a role in healthcare relationships, in providing patient-centred and evidence-based care and ultimately in outcome disparities (Hill, 2010).

The precise combinations of client, clinician and environmental factors which prompt negative moral judgements, and thus risk poorer patient outcomes, are largely unknown.

Exploring relationships between moral judgements and existing healthcare disparities may help us to better understand the potential impact of these judgements. For example, racial disparities are particularly pertinent in mental healthcare. Black-Caribbean and Black African groups are more likely to be diagnosed with psychotic disorders, to be admitted to hospital, to be sectioned under the mental health act and to be prescribed a depot injection, compared to White groups. Indirect evidence suggests that race may play a role in healthcare professionals' moral judgements. For example, studies have highlighted differences in healthcare professional's judgements of clinical situations, depending on the race of the client (Heins et al., 2006; Wisniewski & Walker, 2020). Racial attitudes, including colour-blind racial ideology, have also been shown to influence screening and treatment decisions in healthcare. For example, Okah et al. (2021) found that physicians who endorsed more colour-blind racial ideology were more likely to use race in medical decision making, as were older, rural practitioners and those who worked in less diverse areas. Additionally, colour-blind ideologies have been associated with lower multicultural awareness and lower levels of racial sensitivity among primarily white counsellors and therapists (Burkard & Knox, 2004; Chao, Wei, Good, & Flores, 2011).

Relevance:
Exploring relationships between moral judgements and existing healthcare disparities, namely racial disparities, may help us to understand the potential impact these judgements have in creating and maintaining these disparities. There is some research exploring relationships between moral judgements, moral distress, racial attitudes and client/ clinician demographics with patient outcomes. However, very little focuses on mental healthcare professionals specifically and direct associations between racial disparities and moral judgements in mental healthcare has not yet been explored.

Aim:
To explore relationships between clinically-based moral judgements and: race, moral values, racial attitudes, moral distress, clinician sociodemographic factors and mental health profession (training route).

Research Questions:
Are the following variables associated with, and do they predict, clinically-based moral judgements among mental healthcare professionals?

a. Moral values
b. Racial attitudes
c. Moral distress
d. Clinician sociodemographic factors
e. Client race
f. Mental health profession (training route).

3.3 Design of the research:

A critical-realist epistemological approach will be taken to allow associations and possible predictive relationships between the above variables to be explored quantitatively. A cross-sectional, factorial design will be employed. Measures of morality, racial attitudes and demographic factors will be assessed through quantitative measures and vignettes. Data will be collected online, via Qualtrics.

3.4 Participants:

Participants will be recruited online – for example, through online forums, relevant email circulations, online newsletters and social media websites. This may include Twitter, Linkedin, Facebook and online forums such as Psychology Forum, ClinPsy, Psychiatry and Ethics Forum etc. The study may also be advertised through posters (Appendix M) in relevant institutions, such as clinical psychology departments within universities. Permission will be gained before advertising if necessary.

Inclusion criteria:

- aged 18+;
- working as a mental healthcare professional in the UK;
- able to read and write in English as materials will be presented in English.

3.5 Recruitment:

Participants will be recruited online, through online forums, relevant email circulations, online newsletters and social media websites. This may include Twitter, Linkedin, Facebook and online forums such as Psychology Forum, ClinPsy, Psychiatry and Ethics Forum etc. The study may also be advertised through posters (Appendix M) in relevant institutions, such as clinical psychology departments within universities. Permission will be gained before advertising if necessary. None of the researcher's personal accounts will be used to recruit through such forums; separate accounts will be set up if necessary, containing only the researcher's UEL contact details.

Here, participants will be invited to complete a survey online, via Qualtrics. A power calculation using G-Power suggested a sample of approximately 400 would be sufficient for the proposed analyses. If a sufficient sample cannot be obtained within the timeframe, the inclusion criteria will be extended to include all healthcare professionals.

3.6 Measures, materials or equipment:

Materials/ equipment:

- Access to Qualtrics
- Access to UEL secure data storage.
- Access to SPSS
- Study advert, information sheet, consent form, debrief form.

Measures:

Vignettes

Vignettes will be used to assess participants' moral judgements of clinical situations. The development of the vignettes was informed by: a literature review of racial disparities within mental healthcare and NICE guidelines relating to relevant topics; a content analysis of a casebook of previous clinical ethics committee discussions held at a London NHS Foundation Trust; and consultations with individuals working in relevant mental healthcare settings. Based on the literature search of racial disparities, the following themes for the vignette content were proposed: diagnoses (most notably in relation to psychosis), access to services (including service use, admissions to hospital), assessment of distress (including uncertainty in assessment and physical vs. mental health concerns) and treatment (including medication, referrals for treatment, detention and sectioning). Eleven vignettes were originally created, however this was reduced to seven following the consultation phase (appendix F).

Participants will be asked to read situations in which a mental health professional is making a moral judgement and rate how much they agree – disagree with the decision (0 – 100 Likert scale). Optional open-ended comment boxes will be included.

Client Race

Within the vignettes, a number of client demographics will be presented, of which only race will be manipulated. For the purposes of this study, race groupings will include Black, White and South-Asian. Groupings were chosen as they are most prominent in disparity research (e.g. Bignall et al., 2019); it must be acknowledged that categorising heterogeneous racial groups is inherently limited as it fails to capture individual identities and experiences.

Moral Values

The Morality-as-Cooperation Questionnaire (MAC-Q; Curry et al., 2019) will be used to measure moral attitudes. The questionnaire is based on the Morality-as-Cooperation (Curry, 2016) theory. This proposes that there are seven types of cooperation, all of which map onto a distinct moral domain (family values, group loyalty, reciprocity, heroism, deference, fairness and property rights). The questionnaire includes 42 items and is split into two sections – moral relevance (participants are asked to rate the moral relevance of particular statements) and moral judgement (participants are asked to judge whether they agree/ disagree with various moral judgements presented). For both sections, participants rate questions on a scale between 0 to 100. Scores are calculated either as a total in each category (relevance/ judgement) or as a composite score for each moral domain (average of the 6 items relating to each moral domain). The questionnaire has been validated to assess seven moral domains and has been found to have good test-retest reliability (Curry et al., 2019).

The questionnaire is presented within an open access publication (appendix G).

Moral Distress

The Measure of Moral Distress for Healthcare Professionals (MMD-HP; Epstein et al., 2019) will be used to assess moral distress. This consists of 27-items pertaining to causes of moral distress within healthcare. Participants are asked to score the frequency of experiencing the identified cause and the intensity of the moral distress on a 5-point Likert scale. The measure is scored by generating composite scores for each item (multiplying frequency and distress scores), and subsequently generating a composite score of moral distress by summing the item scores (resultant scores range from 0 – 432). The scale has been credited with good reliability and acceptable validity and aims to capture moral distress across a range of healthcare professionals (Epstein et al., 2019).

Permission to use the scale has been sought (appendix K). The measure is included in appendix H.

Racial Attitudes
The Colour-Blind Racial Attitudes Scale (CoBRAS; Neville, 2000) will be used to measure racial attitudes. The scale was designed to measure colour-blind racial attitudes, pertaining to three key dimensions: unawareness of racial privilege, institutional racism and blatant racial issues. The scale consists of 20-items; participants ae asked to rate each item on a Likert scale from 1 (strongly agree) to 6 (strongly agree). Higher scores on the CoBRAS indicate higher levels of colour-blind racial attitudes and less awareness of the influence of race on social issues. The scale has been validated in a number of studies (e.g. Neville et al., 2000; Neville et al., 2006; Offermann et al., 2014; Su & Behar-Horenstein, 2017). The scale has acceptable reliability and good concurrent validity with other measures of racial prejudice (Neville, 2000) and has been found to control for social desirability (Neville, 2006). It has been used to explore mental health professionals' attitudes in a number of US studies (Burkard & Knox, 2004; Chao et al., 2011; Neville et al., 2006). The scale was developed and has been predominantly used in America, although some studies have adapted it for UK and European samples (e.g. Osmar, 2020; West et al., 2021). The scale will be adapted to suit a UK population in the present study, by replacing references to 'U.S.' with 'U.K.'.

The measure is included in appendix I. Permission to use and adapt the scale has been sought and is included in appendix L.

Clinician Demographics
A demographic questionnaire will be designed, inviting participants to provide their age, gender, race, religion, education level, job title, workplace setting and time working in mental healthcare (appendix J).

3.7 Data collection:

Data collection will be conducted online; the study will be advertised through online platforms, including relevant social media sites and forums designed for mental healthcare professionals. A link to the survey will be included in the advert. Participants will be invited to complete the questionnaires and measures stated above. It is estimated the study will take around 30 minutes to complete. It will be possible for participants to close the survey and come back to it at a later time, provided the survey is opened on the same device it was started on.

Participants will be provided with an information sheet, given the opportunity to contact the researcher prior to consenting to take part in the study, and provided with a debrief form at the end of the survey. They will be assured that they can withdraw from the study at any point without providing a reason. Support and signposting information will be provided in the debrief sheet, as well in the participant information sheet, for those who close the survey before the end.

3.8 Data analysis:

Statistical analysis will be conducted using SPSS. Associations between the above measures will be explored using descriptive statistics and chi-square/ independent samples t-tests/ Person correlations for categorical/ continuous variables, respectively. Non-parametric equivalent tests will be used if parametric assumptions are not met. General linear modelling will subsequently be used to examine predictive relationships between moral judgements and the above measures. Content analysis will be used to assess open-ended vignette answers.

4. Confidentiality and security

It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the UEL guidance on data protection, and also the UK government guide to data protection regulations.

4.1 Will participants data be gathered anonymously?
Yes

4.2 If not (e.g., in qualitative interviews), what steps will you take to ensure their anonymity in the subsequent steps (e.g., data analysis and dissemination)?
N/a

4.3 How will you ensure participants details will be kept confidential?

The majority of data generated in this study will be quantitative, collected using online questionnaires. This will include a demographic questionnaire (age, gender, ethnicity etc.) – this will not collect specific enough information to identify individuals. Participants will be asked to create a unique code which will act as their participant number, which can also be used to withdraw data following submission of survey responses. Participants will not be asked to enter their name, date of birth or address; IP addresses and location data will not be linkable to participant data.

The study will be conducted online via Qualtrics (licenced by UEL School of Psychology). Within Qualtrics, the ‘anonymise responses’ setting will be enabled to ensure data are gathered using anonymous links. This will remove participants IP addresses and location data from the results.

If participants wish to receive further information about the study, they will be asked to provide their email addresses. These will be stored on a separate password-protected document to the data which only the researcher will have access to. This information will be deleted upon completion of the thesis.

4.4 How will the data be securely stored?

Data from online surveys (using Qualtrics) will be transferred onto password-protected spreadsheets and stored on the researcher’s UEL OneDrive spreadsheet. This data will not contain identifying information. Those wishing to receive additional information about the study will have the option to enter their email address. This will be stored on a separate password protected document which only the researcher will have access to. Research data will not be linkable to the details on this spreadsheet.

Survey data will be backed up onto the researcher’s UEL H: Drive, which will be accessed through the Virtual Private Network and the UEL Remote App.

Once sufficient data has been collected, the Qualtrics survey will be closed. All data will be downloaded from Qualtrics onto Excel files and stored as above. All data will be deleted from the Qualtrics server at the end of the study. The thesis will be backed up to the researcher’s UEL storage.

4.5 Who will have access to the data?

Only the researcher, supervisors and examiners will have access to anonymised data. Data sharing between the research team, and for examination purposes will be done via OneDrive for Business.

Participants contact details provided to receive a summary of the study findings will be stored on a password-protected document on the researcher’s UEL OneDrive, which only the researcher will have access to. This will be stored on a separate document, in a separate folder, to the research data. This document will be deleted once these participants have been provided with a summary of the findings.

No one outside the research team will have access to personal or research data.
Any data sharing will be done with the research supervisor via UEL email. All shared data will be anonymised and any sensitive data will be removed.

Qualtrics will be accessed through https://uelpsych.eu.qualtrics.com (licenced account via UEL school of psychology). Access will be granted for the duration of the thesis. Only the researcher will have access to this account using the researcher’s UEL username and specified password. Examiners will only have access to anonymised data.

4.6 How long will data be retained for?

All data on the researcher’s UEL servers (OneDrive) will be deleted once the thesis has been examined and passed. All data will be erased from the researcher’s OneDrive and H: Drive once the thesis has been examined and passed. The anonymised database will be retained by the research supervisor and stored on their UEL OneDrive for a maximum of three years for dissemination purposes.

Anonymised raw data may be stored on the research supervisor’s secure UEL server for up to three years for dissemination purposes. Participants will be made aware of these data storage intentions in the consent and debrief forms.

5. Informing participants

Please confirm that your information letter includes the following details:

5.1 Your research title:

Brief version: ‘clinically-based moral judgements among mental healthcare professionals.’ ☑

5.2 Your research question: ☐

The precise research question will not be included in the information sheets as it may influence the way participants respond, e.g. through social desirability bias. A broad description of the study will be included in the information sheet and detailed information about the nature of the study will be included in the debrief sheet.

5.3 The purpose of the research: ☑

5.4 The exact nature of their participation. This includes location, duration, and the tasks etc. involved: ☑

5.5 That participation is strictly voluntary: ☑

5.6 What are the potential risks to taking part: ☑

5.7 What are the potential advantages to taking part: ☑

5.8 Their right to withdraw participation (i.e., to withdraw involvement at any point, no questions asked): ☑

5.9 Their right to withdraw data (usually within a three-week window from the time of their participation): ☑

5.10 How long their data will be retained for: ☑

5.11 How their information will be kept confidential: ☑

5.12 How their data will be securely stored: ☑

5.13 What will happen to the results/analysis: ☑

5.14 Your UEL contact details: ☑

5.15 The UEL contact details of your supervisor: ☑

Please also confirm whether:

5.16 Are you engaging in deception? If so, what will participants be told about the nature of the research, and how will you inform them about its real nature.

Participants will not be directly deceived about the nature of the study. However, the extent of the information provided will be more limited in the information sheet. This will inform participants that the study is exploring clinically based moral judgements among mental healthcare professionals; it will not state that the research is looking for relationships between race and moral judgements specifically. This is an effort to avoid biases such as social desirability bias within the questionnaires. Participants will be fully informed of the nature and aims of the study in the debrief form.

5.17 Will the data be gathered anonymously? If NO what steps will be taken to ensure confidentiality and protect the identity of participants?
Yes

5.18 Will participants be paid or reimbursed? If so, this must be in the form of redeemable vouchers, not cash. If yes, why is it necessary and how much will it be worth?
No

6. Risk Assessment

Please note: If you have serious concerns about the safety of a participant, or others, during the course of your research please see your supervisor as soon as possible. If there is any unexpected occurrence while you are collecting your data (e.g. a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.

6.1 Are there any potential physical or psychological risks to participants related to taking part? If so, what are these, and how can they be minimised?

While research will be conducted online, and participants will not be asked about their own personal experiences, a number of the topics and scenarios depicted in the vignettes may be distressing. For example, given the prominence of systemic racism in the UK, vignettes containing depictions of minority ethnic clients being treated negatively within mental health systems may be particularly distressing. Additionally, vignettes have been designed to represent morally challenging healthcare scenarios which may be distressing for those working in the field. Signposting information for supporting agencies will be provided in the debrief form, as well as in the Participant Information Sheet for those who end the survey prior to completion.

6.2 Are there any potential physical or psychological risks to you as a researcher? If so, what are these, and how can they be minimised?

No; data collection will be completed online and the researchers personal contact details will not be used for the study. Only institutional (UEL) email addresses will be used.

6.3 Have appropriate support services been identified in the debrief letter? If so, what are these, and why are they relevant?

Signposting to services relating to issues raised in the vignettes will be provided. These include:

- The Samaritans: 116 123. A free 24/7 helpline for anybody experiencing distress.
- Support line for NHS staff: 0800 06 96 222 (7am to 11pm, 7 days a week).
- Shout Text service: NHS and other health and social care staff can text ‘frontline’ to 85258 for support

- Project5: provides NHS staff free access to support sessions via an online booking system: www.project5.org.
- Black Minds Matter UK – a charity supporting Black people to access mental health services. www.blackmindsmatteruk.com.
- The Black, African and Asian Therapy Network – a network offering resources and information relating to mental health and wellbeing. www.baatn.org.uk.
- Mental health and wellbeing apps such as Headspace, Unmind and Sleepio and Daylight for free.
- General Practitioner (GP).

Of note, all of the above signposting services will be presented to participants in the debrief form, however Black Minds Matter UK and the The Black, African and Asian Therapy Network will be omitted from the signposting information provided at the end of the information sheet. Here, participants will also be advised that they can contact me or my supervisor for more specific signposting information relating to issues raised in the study. This is an effort to avoid biases such as social desirability bias within the questionnaires by inadvertently informing participants of the full nature of the study. Participants will be fully informed of the nature and aims of the study in the debrief form and the full list of signposting services will be provided.

6.4 Does the research take place outside the UEL campus? If so, where?

No, the study will be conducted online. Risk assessment form completed in consideration of sensitive topics/ potential distress to participants.

If so, a 'general risk assessment form' must be completed. This is included below as appendix D. Note: if the research is on campus, or is online only (e.g., a Qualtrix survey), then a risk assessment form is not needed, and this appendix can be deleted. If a general risk assessment form is required for this research, please tick to confirm that this has been completed: ☑

N.b. The research will be conducted online, however due to the sensitive nature of the topic area, a risk assessment has been completed and attached for review (appendix E).

6.5 Does the research take place outside the UK? If so, where?
No

If so, in addition to the 'general risk assessment form', a 'country-specific risk assessment form' must be also completed (available in the Ethics folder in the Psychology Noticeboard), and included as an appendix. [Please note: a country-specific risk assessment form is not needed if the research is online only (e.g., a Qualtrix survey), regardless of the location of the researcher or the participants.] If a 'country-specific risk assessment form' *is* needed, please tick to confirm that this has been included: ☐

However, please also note:

- For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on ‘sign in’ and then ‘register here’ using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance.
- For *on campus* students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be signed by the Head of School (who may escalate it up to the Vice Chancellor).
- For *distance learning* students conducting research abroad in the country where they currently reside, a risk assessment must be also carried out. To minimise risk, it is recommended that such students only conduct data collection on-line. If the project is deemed low risk, then it is not necessary for the risk assessments to be signed by the Head of School. However, if not deemed low risk, it must be signed by the Head of School (or potentially the Vice Chancellor).
- Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree.

7. Disclosure and Barring Service (DBS) certificates

7.1 Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)?
No

7.2 If so, you will need a current DBS certificate (i.e., not older than six months), and to include this as an appendix. Please tick to confirm that you have included this: ☐

Alternatively, if necessary for reasons of confidentiality, you may email a copy directly to the Chair of the School Research Ethics Committee. Please tick if you have done this instead: ☐

Also alternatively, if you have an Enhanced DBS clearance (one you pay a monthly fee to maintain) then the number of your Enhanced DBS clearance will suffice. Please tick if you have included this instead: ☐

7.3 If participants are under 16, you need 2 separate information letters, consent form, and debrief form (one for the participant, and one for their parent/guardian). Please tick to confirm that you have included these: ☐

7.4 If participants are under 16, their information letters consent form, and debrief form need to be written in age-appropriate language. Please tick to confirm that you have done this ☐

* You are required to have DBS clearance if your participant group involves (1) children and young people who are 16 years of age or under, and (2) ‘vulnerable’ people aged 16 and

over with psychiatric illnesses, people who receive domestic care, elderly people (particularly those in nursing homes), people in palliative care, and people living in institutions and sheltered accommodation, and people who have been involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak to your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible. For more information about ethical research involving children click here.

8. Other permissions

8.1. Is HRA approval (through IRAS) for research involving the NHS required? Note: HRA/IRAS approval is required for research that involves patients or Service Users of the NHS, their relatives or carers as well as those in receipt of services provided under contract to the NHS.
No

If yes, please note:

- You DO NOT need to apply to the School of Psychology for ethical clearance if ethical approval is sought via HRA/IRAS (please see further details here).
- However, the school *strongly discourages* BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process.
- If you work for an NHS Trust and plan to recruit colleagues from the Trust, permission from an appropriate manager at the Trust must be sought, and HRA approval will probably be needed (and hence is likewise strongly discouraged). If the manager happens to not require HRA approval, their written letter of approval must be included as an appendix.
- IRAS approval is not required for NHS staff even if they are recruited via the NHS (UEL ethical approval is acceptable). However, an application will still need to be submitted to the HRA in order to obtain R&D approval. This is in addition to a separate approval via the R&D department of the NHS Trust involved in the research.
- IRAS approval is not required for research involving NHS employees when data collection will take place off NHS premises, and when NHS employees are not recruited directly through NHS lines of communication. This means that NHS staff can participate in research without HRA approval when a student recruits via their own social or professional networks or through a professional body like the BPS, for example.

8.2. Will the research involve NHS employees who will not be directly recruited through the NHS, and where data from NHS employees will not be collected on NHS premises?
Yes

8.3. If you work for an NHS Trust and plan to recruit colleagues from the Trust, will permission from an appropriate member of staff at the Trust be sought, and will HRA be sought, and a copy of this permission (e.g., an email from the Trust) attached to this application?
N/a

8.4. Does the research involve other organisations (e.g. a school, charity, workplace, local authority, care home etc.)? If so, please give their details here.
No

Furthermore, written permission is needed from such organisations if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation. If that is the case, please tick here to confirm that you have included this written permission as an appendix: ☐

In addition, before the research commences, once your ethics application has been approved, please ensure that you provide the organisation with a copy of the final, approved ethics application. Please then prepare a version of the consent form for the organisation themselves to sign. You can adapt it by replacing words such as 'my' or 'I' with 'our organisation,' or with the title of the organisation. This organisational consent form must be signed before the research can commence.

Finally, please note that even if the organisation has their own ethics committee and review process, a School of Psychology SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s as may be necessary.

9. Declarations

Declaration by student: I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor.

Student's name (typed name acts as a signature): Emily Mortimer

Student's number: 1945541 Date: 28/06/2021

As a supervisor, by submitting this application, I confirm that I have reviewed all parts of this application, and I consider it of sufficient quality for submission to the SREC committee.

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Jolanta Golan

SUPERVISOR: Trishna Patel

STUDENT: Emily Mortimer

Course: Prof Doc Clinical Psychology

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY
(Please indicate the decision according to one of the 3 options above)

APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES

Minor amendments required *(for reviewer)*:

It is not clear how the qualitative data will be analysed – content analysis may be considered from either quantitative or qualitative perspective. If qualitative approach is taken, then it is a mixed, not quantitative design.
Supervisor's electronic signature and confirmation missing

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):* Emily Mortimer
Student number: 1945541

Date: 14/07/2021

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES / NO

Please request resubmission with an adequate risk assessment

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐ HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☐ MEDIUM (Please approve but with appropriate recommendations)

☒ LOW

Reviewer comments in relation to researcher risk (if any).

Reviewer *(Typed name to act as signature)*: Jolanta Golan

Date: 9th July 2021

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

RESEARCHER PLEASE NOTE:

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard

Appendix C: Amendment Requests

Amendment request 1: Change of measure

School of Psychology Ethics Committee

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology

Note that approval must be given for significant change to research procedure that impact on ethical protocol. If you are not sure as to whether your proposed amendment warrants approval, consult your supervisor or contact Dr Trishna Patel (Chair of the School Research Ethics Committee).

7. How to complete and submit the request

1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	When submitting this request form, ensure that all necessary documents are attached (see below).
4	Using your UEL email address, email the completed request form along with associated documents to Dr Trishna Patel: t.patel@uel.ac.uk
5	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.
6	Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

Required documents

A copy of your previously approved ethics application with proposed amendment(s) added with track changes.	**YES** ☒
Copies of updated documents that may relate to your proposed amendment(s). For example, an updated recruitment notice, updated participant information sheet, updated consent form, etc.	**YES** ☒
A copy of the approval of your initial ethics application.	**YES**

	☒

Details	
Name of applicant:	**Emily Mortimer**
Programme of study:	**Professional Doctorate in Clinical Psychology**
Title of research:	**Race and Clinically-Based Moral Judgements Among Mental Healthcare Professionals**
Name of supervisor:	**Dr Trishna Patel (Director of Studies), Dr Kenneth Gannon (Second Supervisor)**

Proposed amendment(s)

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	**Rationale**
Removal of Implicit Association Test (IAT; Greenwald et al., 1998) from online questionnaire/ study.	One of the study aims is to explore associations between moral judgements and race. While the IAT can be used to explore attitudes relating to race, the questionnaire must be completed on a computer is not compatible with mobile devices. This would limit the potential number of responses gained. Additionally, the IAT has been criticised for its ability to predict real-world behaviour and racial discrimination (e.g. Oswald et al., 2015) and the test has been found to have modest test-restest reliability (Phills & Galdi, 2017). Given that the present study is aimed at healthcare professionals, it is likely they will have completed the IAT before and will be aware of the aim and nature of the IAT.
Addition of the Colour-Blind Racial Attitudes Scale (CoBRAS; Neville, 2000) in place of IAT.	The CoBRAS can also be used to explore issues/ attitudes relating to race. It can be completed online both on a computer and mobile devices. The CoBRAS may be more appropriate for measuring racial attitudes among healthcare professionals for this study. The measure has acceptable reliability and good concurrent validity with other measures of racial prejudice (Neville, 2000) and has been found to control for social desirability (Neville, 2006). The scale has been used to explore mental health professionals' attitudes in a number of US studies (Burkard & Knox, 2004; Chao et al., 2011; Neville et al., 2006).
Proposed amendment	Rationale for proposed amendment

Proposed amendment	Rationale for proposed amendment

Confirmation

Is your supervisor aware of your proposed amendment(s) and have they agreed to these changes?	**YES** ☒	**NO** ☐

Student's signature

Student: (Typed name to act as signature)	**Emily Mortimer**
Date:	**19/11/2021**

Reviewer's decision

Amendment(s) approved:	**YES** ☒	**NO** ☐
Comments:	Please enter any further comments here	
Reviewer: (Typed name to act as signature)	**Trishna Patel**	
Date:	**19/11/2021**	

Amendment request 2: Recruitment methods

School of Psychology Ethics Committee

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology

Note that approval must be given for significant change to research procedure that impact on ethical protocol. If you are not sure as to whether your proposed amendment warrants approval, consult your supervisor or contact Dr Trishna Patel (Chair of the School Research Ethics Committee).

8. How to complete and submit the request

1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	When submitting this request form, ensure that all necessary documents are attached (see below).
4	Using your UEL email address, email the completed request form along with associated documents to Dr Trishna Patel: t.patel@uel.ac.uk
5	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.
6	Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

Required documents

A copy of your previously approved ethics application with proposed amendment(s) added with track changes.	**YES** ☒
Copies of updated documents that may relate to your proposed amendment(s). For example, an updated recruitment notice, updated participant information sheet, updated consent form, etc.	**YES** ☒
A copy of the approval of your initial ethics application.	**YES** ☒

Details

Name of applicant:	**Emily Mortimer**
Programme of study:	**Professional Doctorate in Clinical Psychology**
Title of research:	**Race and Clinically-Based Moral Judgements Among Mental Healthcare Professionals**
Name of supervisor:	**Dr Trishna Patel (Director of Studies), Dr Kenneth Gannon (Second Supervisor)**

Proposed amendment(s)

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	**Rationale**
Expansion of ways to recruit participants to include online newsletters and physical posters.	Currently ethics only permits participants to be recruited online, e.g. via social media. This may limit the number of participants who see and therefore take part in the study. Expanding the recruitment methods may increase the chances of reaching the desired number of participants needed to complete the proposed analysis (power calculation suggests a sample of 400 would be sufficient).
Proposed amendment	Rationale for proposed amendment
Proposed amendment	Rationale for proposed amendment
Proposed amendment	Rationale for proposed amendment

Confirmation

Is your supervisor aware of your proposed amendment(s) and have they agreed to these changes?	**YES** ☒	**NO** ☐

Student's signature

Student: (Typed name to act as signature)	**Emily Mortimer**
Date:	**03/12/2021**

Reviewer's decision		
Amendment(s) approved:	**YES** ☒	**NO** ☐
Comments:	Please enter any further comments here	
Reviewer: (Typed name to act as signature)	**Trishna Patel**	
Date:	**03/12/2021**	

Amendment request: Change of title

School of Psychology Ethics Committee

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for a proposed title change to an ethics application that has been approved by the School of Psychology

By applying for a change of title request, you confirm that in doing so, the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed, then you are required to complete an 'Ethics Application Amendment Form'.

9. How to complete and submit the request

1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	Using your UEL email address, email the completed request form along with associated documents to Dr Jérémy Lemoine (School Ethics Committee Member): j.lemoine@uel.ac.uk
4	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.

Required documents

A copy of the approval of your initial ethics application.	**YES** ☒

Details

Name of applicant:	**Emily Mortimer**
Programme of study:	**DClinPsy**
Title of research:	**Race and Clinically-Based Moral Judgements Among Mental Healthcare Professionals**

Name of supervisor:	**Dr Trishna Patel**

Proposed title change

Briefly outline the nature of your proposed title change in the boxes below

Old title:	**Race and Clinically-Based Moral Judgements Among Mental Healthcare Professionals**
New title:	Race, Morality, Moral Distress and Clinical Decision Making Among Mental Health Professionals
Rationale:	The current title does not capture the full aims of the study and research question. For example, the study will explore associations between participants clinical decision making and: race, moral values and moral distress.

Confirmation

Is your supervisor aware of your proposed change of title and in agreement with it?	**YES** ☒	**NO** ☐
Does your change of title impact the process of how you collected your data/conducted your research?	**YES** ☐	**NO** ☒

Student's signature

Student: (Typed name to act as signature)	**Emily Mortimer**
Date:	**23/03/2022**

Reviewer's decision

Title change approved:	**YES** ☒	**NO** ☐
Comments:	**The new title reflects better the research study and will not impact the process of how the data are collected or how the research is conducted**	
Reviewer: (Typed name to act as signature)	**Dr Jérémy Lemoine**	
Date:	**25/03/2022**	

Appendix D: Participant Information Sheet

PARTICIPANT INVITATION LETTER

Clinically-Based Moral Judgements Among Mental Healthcare Professionals

You are being invited to participate in a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

Who am I?

I am a postgraduate student in the School of Psychology at the University of East London and am studying for a Doctorate in Clinical Psychology. As part of my studies I am conducting the research you are being invited to participate in.

What is the purpose of the research?

I am conducting research around moral judgements among mental healthcare professionals in the UK. I am looking at how a number of characteristics might affect our judgements of situations which may be morally challenging within mental healthcare services. It is hoped that the study may help to understand factors which influence these judgements, in order to provide valued, accessible and mindful care to individuals accessing mental health support within these services.

My research has been [will be if study is made available] approved by the School of Psychology Research Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society. All research conducted in the University of East London is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, well-being and dignity.

Why have I been asked to participate?

I am hoping to recruit a range of mental healthcare professionals in the UK. I am looking to involve those who are over the age of 18 and are currently working as a mental healthcare professional (this may include: working in a mental healthcare setting; work requires a mental healthcare qualification).

Participation in the study is entirely voluntary and you can withdraw at any time without providing a reason for doing so or any negative consequences.

What will my participation involve?

If you agree to participate you will be asked to complete an online survey which will last approximately 30 minutes. You can complete this on any device (laptop, phone etc.). Your survey progress will be saved on your device, therefore you are welcome to close the survey and come back to it at a later point should you wish to, provided you open the survey on the same device you started it on.

You will be presented with short vignettes depicting a mental healthcare professional experiencing a moral dilemma within their practice, followed by a question relating to this vignette. You will also be asked to complete a number of questionnaires exploring morality and social issues, as well as some demographic (non-identifiable) questions. You will not be asked to provide your name or any other identifiable information and all your data will remain anonymous and confidential.

Are there any disadvantages or risks to taking part?

The questions are not designed to cause distress. It should be highlighted that they are intended to depict incidences which may be morally challenging, and which are not uncommon to experience when working in mental healthcare settings. If you experience any distress from the survey, you are free to stop at any point without providing a reason for doing so. Support organisations will be provided in the debrief form at the end of the survey. These organisations are also provided at the end of this participant information sheet. You may wish to save these now in the event that you withdraw from the survey before the end.

How will my information be kept safe and confidential?

Your privacy and safety will be respected at all times. You will not be asked to enter any identifiable information (name, date of birth, email or IP address etc.), therefore your data will not be identifiable. The online survey will make use of anonymous links, meaning location data and IP addresses will not be stored or linkable to survey responses.

At the beginning of the survey, you will be asked to generate a unique participant number. You will need to provide this code if you would like to withdraw your data from the study following completion. If you do wish to withdraw, this will need to be requested within three weeks of completing the study; after this date, analysis of the data will begin.

Anonymised data will be stored for a maximum of three years on a password protected database. Within this time, only the research team will have access to the data. Once analysed, data will be used for the write-up of the research and disseminated as appropriate. This will include findings being disseminated to a range of audiences (e.g. academics, clinicians, the public), through journal articles, presentations, talks and other relevant articles, as appropriate. The thesis will also be made publicly available on ROAR (Registry of Open Access Repositories); a database containing publications and theses which can be accessed for free by anyone. Individual data will not be identifiable within any of the disseminated material.

What will happen to the information that I provide?

The survey will be conducted online and you will be asked to generate a unique participant number. All data will therefore be anonymous and your data will not be identifiable. You are free to withdraw your data from the study provided you request to do so within three weeks of completion (data analysis will begin after this time). You will need your unique participant number if you are requesting your data to be withdrawn. At the end of the study, you will be invited to provide an email address if you would like to receive a summary of the research findings. If you provide an email address, it will be stored on a password-protected document, separate to the data and only the researcher will have access to it. This information will be deleted once the requested study findings have been provided.

Data will be stored on a password protected spreadsheet and backed-up on the researcher's UEL secure-drive. All data will be anonymised and analysed at the group level; therefore, your individual responses will not be identifiable. Only the researcher, supervisors and examiners will have access to anonymised data. Anonymised data will be stored on the research supervisor's UEL secure-drive for a maximum of three years.

What if I want to withdraw?

You are free to withdraw from the research study at any time without explanation, disadvantage or consequence. Separately, you may also request to withdraw your data even after you have submitted your responses, provided that this request is made within three weeks of completing the study (after which point the data analysis will begin, and withdrawal will not be possible). Please make sure you note down your unique participant number as you will need to provide this number if you would like to withdraw your data from the study.

Who can I contact if I have questions about the study?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me: u1945514@uel.ac.uk (Emily Mortimer).

If you have any questions or concerns about how the research has been conducted please contact the research supervisor, Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: t.patel@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

You may find the following resources/services helpful in relation to obtaining information and support:

- The Samaritans: 116 123. A free 24/7 helpline for anybody experiencing distress.
- Support line for NHS staff: 0800 06 96 222 (7am to 11pm, 7 days a week).
- Shout Text service: NHS and other health and social care staff can text ‘frontline’ to 85258 for support
- Project5: provides NHS staff free access to support sessions via an online booking system: www.project5.org.
- You can access mental health and wellbeing apps such as Headspace, Unmind and Sleepio and Daylight for free.
- Your General Practitioner (GP) can signpost you to additional services if you experience emotional distress.

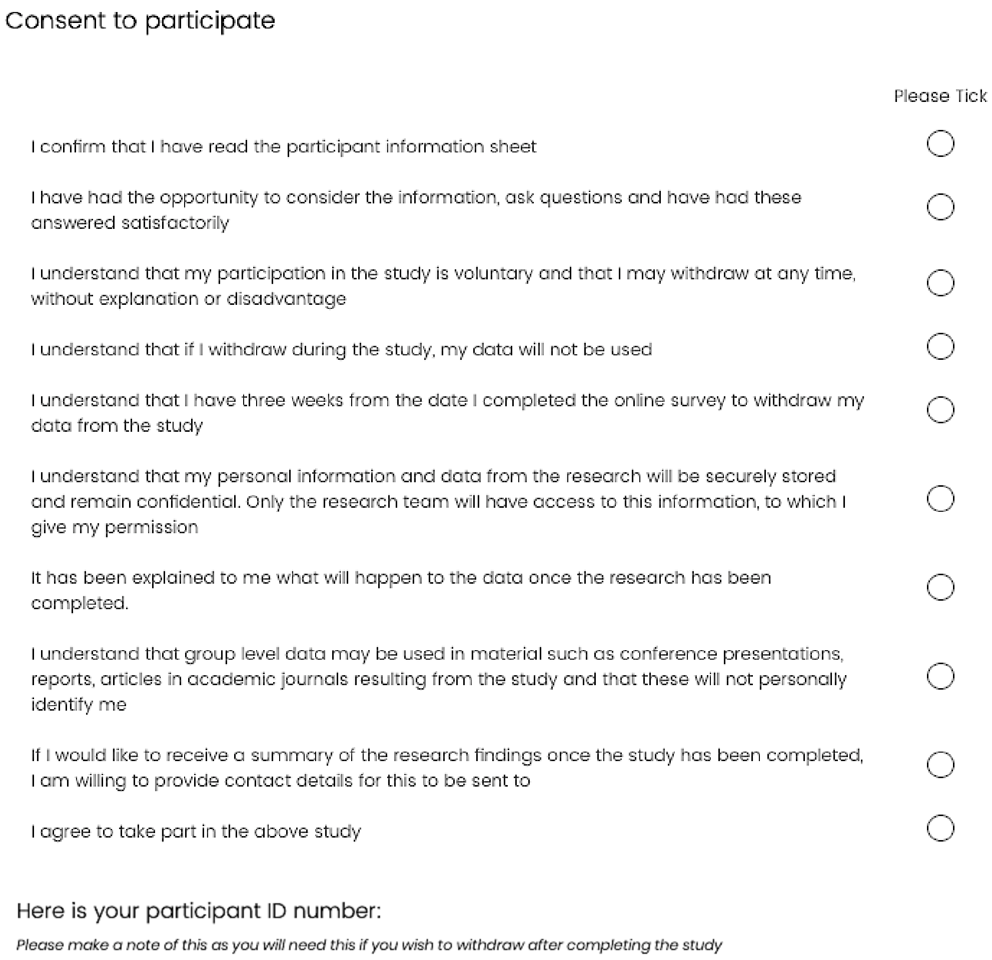
You are also very welcome to contact me or my supervisor if you have specific questions or concerns or would like more specific signposting information relating to issues raised in the study.

Appendix E: Consent Form (extracted from Qualtrics).

Clinically-Based Moral Judgements Among Mental Healthcare Professionals

Contact person: Emily Mortimer

Email: u1945514@uel.ac.uk



Consent to participate

	Please Tick
I confirm that I have read the participant information sheet	○
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily	○
I understand that my participation in the study is voluntary and that I may withdraw at any time, without explanation or disadvantage	○
I understand that if I withdraw during the study, my data will not be used	○
I understand that I have three weeks from the date I completed the online survey to withdraw my data from the study	○
I understand that my personal information and data from the research will be securely stored and remain confidential. Only the research team will have access to this information, to which I give my permission	○
It has been explained to me what will happen to the data once the research has been completed.	○
I understand that group level data may be used in material such as conference presentations, reports, articles in academic journals resulting from the study and that these will not personally identify me	○
If I would like to receive a summary of the research findings once the study has been completed, I am willing to provide contact details for this to be sent to	○
I agree to take part in the above study	○

Here is your participant ID number:

Please make a note of this as you will need this if you wish to withdraw after completing the study

Appendix F: Debrief Form

University of East London

PARTICIPANT DEBRIEF LETTER

Race and Clinically-Based Moral Judgements Among Mental Healthcare Professionals

Thank you for participating in my research study on clinically based moral judgements among mental healthcare professionals. This letter offers information that may be relevant in light of you having now taken part.

The purpose of this study was to explore how a number of characteristics, including: our morals, biases, the race of the client and clinician, demographic factors, might affect our judgements of situations which may be morally challenging within mental healthcare services. It is hoped that the study may help to understand factors which influence these judgements, in order to provide valued, accessible and mindful care to individuals accessing mental health support within these services.

What will happen to the information that you have provided?

The following steps will be taken to ensure the confidentiality and integrity of the data you have provided. You have been asked to generate a unique participant number to ensure your data remains anonymous. You should make a note of this number so that you can provide it to the researcher if you later choose to withdraw from the study. It will be possible for you to withdraw your data up to three weeks after you have completed the survey; after this time analysis of the data will begin.

Once the all data for the study has been collected and the survey is closed, anonymised data will be downloaded. This will subsequently be stored on a password protected spreadsheet; only the researcher, supervisors and examiners will have access to anonymised data. Data will be stored for a maximum of three years; after this time all data will be deleted. Dissemination of the study will only involve group-level data and therefore no individual data will be identifiable.

If you are interested in receiving a summary of the research, please email u1945514@uel.ac.uk. Please do not add any information which may relate to the answers provided in the survey in this email to ensure email addresses cannot be linked to your data and it will remain anonymous. Email addresses of those requesting a research summary will be deleted once the request has been satisfied.

What if you have been adversely affected by taking part?

The research was not designed to cause distress and reasonable steps have been taken to minimise potential harm. Nevertheless, it is still possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. It should be acknowledged that the vignettes created are intended to depict incidences which may be morally challenging, and which are not uncommon to experience when working in mental healthcare settings. It should also be acknowledged that some of the vignettes were designed to link to situations in which racial disparities around assessment/ treatment/ outcomes are known to occur. Both scenarios may evoke a number of reactions and distressing for various reasons. If you have been affected in any of those ways, you may find the following resources/services helpful in relation to obtaining information and support:

- The Samaritans: 116 123. A free 24/7 helpline for anybody experiencing distress.
- Support line for NHS staff: 0800 06 96 222 (7am to 11pm, 7 days a week).
- Shout Text service: NHS and other health and social care staff can text ‘frontline’ to 85258 for support
- Project5: provides NHS staff free access to support sessions via an online booking system: www.project5.org.
- Black Minds Matter UK – a charity supporting Black people to access mental health services. www.blackmindsmatteruk.com.
- The Black, African and Asian Therapy Network – a network offering resources and information relating to mental health and wellbeing. www.baatn.org.uk.
- You can access mental health and wellbeing apps such as Headspace, Unmind and Sleepio and Daylight for free.
- Your General Practitioner (GP) can signpost you to additional services if you experience emotional distress.

You are also very welcome to contact me or my supervisor if you have specific questions or concerns.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me: u1945514@uel.ac.uk (Emily Mortimer).

If you have any questions or concerns about how the research has been conducted please contact the research supervisor, Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: t.patel@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

Appendix G: Risk Assessment

UEL Risk Assessment Form

Name of Assessor:	Emily Mortimer	**Date of Assessment**	16/04/2021
Activity title:	Online research study as part of thesis for DClinPsy. Research title: Race and Clinically-Based Moral Judgements Among Mental Healthcare Professionals	**Location of activity:**	Online study
Signed off by Manager (Print Name)	Dr Trishna Patel	**Date and time (if applicable)**	Online study as part of thesis – thesis research duration: April 2021 – October 2022.

Please describe the activity/event in as much detail as possible (include nature of activity, estimated number of participants, etc)
If the activity to be assessed is part of a fieldtrip or event please add an overview of this below:

Activity: online research study as part of thesis for DClinPsy. Participants will be recruited online and will be asked to complete a series of online questionnaires, lasting approximately 25 minutes.
Estimated number of participants required for study: 400

Overview of FIELD TRIP or EVENT:

While research will be conducted online, and participants will not be asked about their own personal experiences, a number of the topics and scenarios depicted in the vignettes may be distressing. For example, given the prominence of systemic racism in the UK, vignettes containing depictions of minority ethnic clients being treated negatively within mental health systems may be particularly distressing. Additionally, vignettes will be designed to represent morally challenging healthcare scenarios which may be distressing for those working in the field. Signposting information for supporting agencies will be provided in the debrief form.

Guide to risk ratings

a) Likelihood of Risk	b) Hazard Severity	c) Risk Rating (a x b = c)
1 = Low (Unlikely)	1 = Slight (Minor / less than 3 days off work)	1-2 = Minor (No further action required)
2 = Moderate (Quite likely)	2= Serious (Over 3 days off work)	3-4 = Medium (May require further control measures)
3 = High (Very likely or certain)	3 = Major (Over 7 days off work, specified injury or death)	6/9 = High (Further control measures essential)

Hazards attached to the activity

Hazards identified	Who is at risk?	Existing Controls	Likelihood	Severity	Residual Risk Rating (Likelihood x Severity)	Additional control measures required (if any)	Final risk rating
Sensitive topics discussed/ potential psychological distress.	Participants	- Study will be conducted online; participants are free to withdraw at any point and will be informed of this. - Participants will be informed broadly of the study in the information sheet (prior to commencing the study) and will their consent to take part will be sought. - Debrief form providing more information on the study will be provided at the end. - Signposting information for supporting agencies will be provided in the debrief form.	2	1	2	*Signposting to services relating to issues raised in the vignettes will be provided. These include:* - The Samaritans: 116 123. - Support line for NHS staff: 0300 131 7000. - Shout Text service: NHS and other health and social care staff can text 'frontline' to 85258 for support - Project5: provides NHS staff free access to support sessions via an online booking system. - Black Minds Matter UK – a charity supporting Black people to access mental health services. - The Black, African and Asian Therapy Network – a network offering resources and information relating to mental health and wellbeing. - Mental health and wellbeing apps	2

A comprehensive guide to risk assessments and health and safety in general can be found in UEL's Health & Safety handbook at http://www.uel.ac.uk/hrservices/hs/handbook/ and a comprehensive guide to risk assessment is available on the Health & Safety Executive's web site at http://www.hse.gov.uk/risk/casestudies/index.htm.

Appendix H: Study Advertisement

Research Study: Moral Judgements/ Dilemmas in Healthcare

Decision making in mental healthcare is becoming ever more complex. As a result, some decisions can be ethically or morally challenging. I am looking at how a number of characteristics might affect our judgements and decisions.

Who can take part:

I am looking for anyone who works in mental healthcare in the UK and who is over the age of 18 to complete a short (~20 minute) online survey.

Please note: you do not need any specific qualifications in mental health, working in a mental healthcare setting is all that is required.

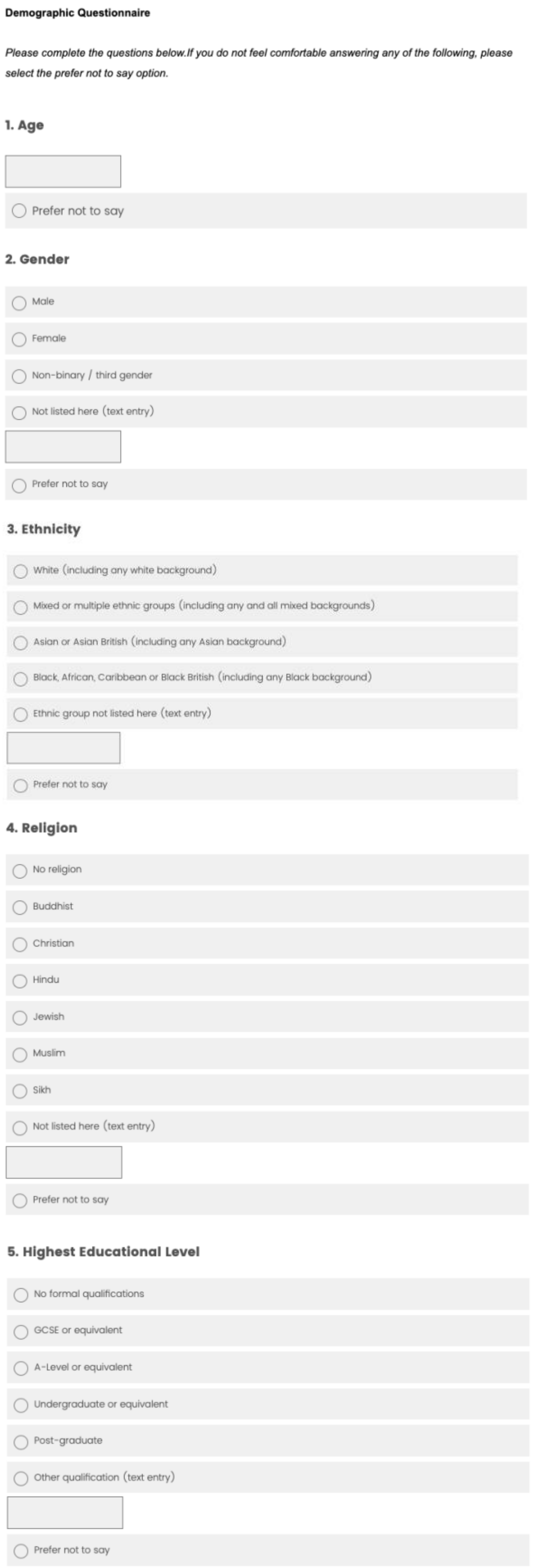
Please click on the link above for more details about the study and to take part. All contributions would be highly valued.

The research forms part of my Doctorate in Clinical Psychology. The study has been approved by the University of East London School of Psychology Ethics Committee.

University of East London

If you would like any further information or have any questions, please contact Emily Mortimer: u1945514@uel.ac.uk

Appendix I: Demographic Questionnaire (extracted from Qualtrics).



Demographic Questionnaire

Please complete the questions below.If you do not feel comfortable answering any of the following, please select the prefer not to say option.

1. Age

○ Prefer not to say

2. Gender

○ Male
○ Female
○ Non-binary / third gender
○ Not listed here (text entry)
○ Prefer not to say

3. Ethnicity

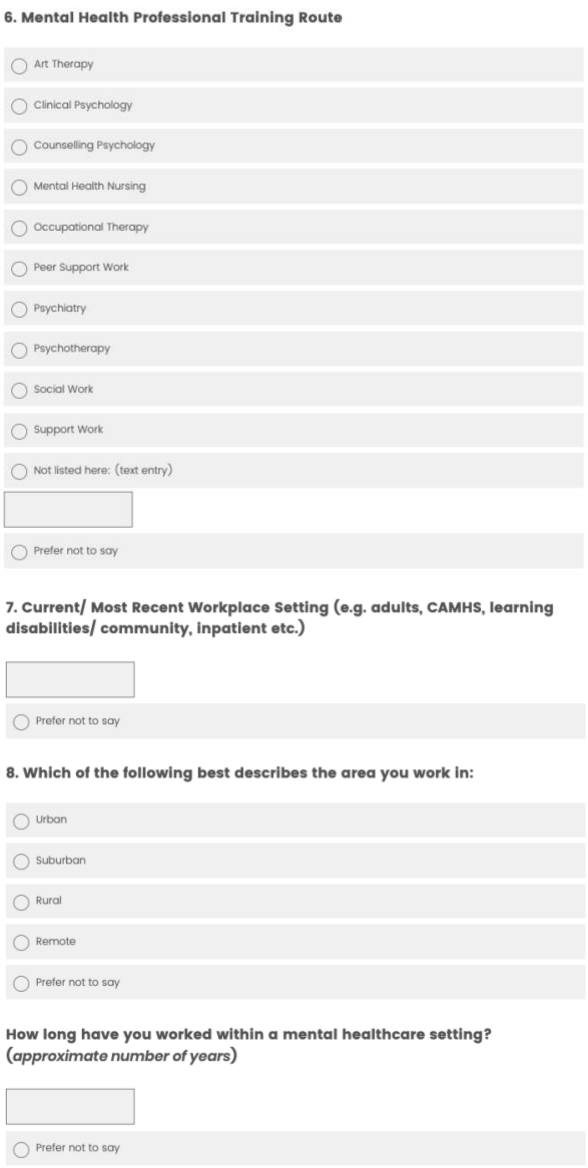
○ White (including any white background)
○ Mixed or multiple ethnic groups (including any and all mixed backgrounds)
○ Asian or Asian British (including any Asian background)
○ Black, African, Caribbean or Black British (including any Black background)
○ Ethnic group not listed here (text entry)
○ Prefer not to say

4. Religion

○ No religion
○ Buddhist
○ Christian
○ Hindu
○ Jewish
○ Muslim
○ Sikh
○ Not listed here (text entry)
○ Prefer not to say

5. Highest Educational Level

○ No formal qualifications
○ GCSE or equivalent
○ A-Level or equivalent
○ Undergraduate or equivalent
○ Post-graduate
○ Other qualification (text entry)
○ Prefer not to say



6. Mental Health Professional Training Route

○ Art Therapy
○ Clinical Psychology
○ Counselling Psychology
○ Mental Health Nursing
○ Occupational Therapy
○ Peer Support Work
○ Psychiatry
○ Psychotherapy
○ Social Work
○ Support Work
○ Not listed here: (text entry)
○ Prefer not to say

7. Current/ Most Recent Workplace Setting (e.g. adults, CAMHS, learning disabilities/ community, inpatient etc.)

○ Prefer not to say

8. Which of the following best describes the area you work in:

○ Urban
○ Suburban
○ Rural
○ Remote
○ Prefer not to say

How long have you worked within a mental healthcare setting? (*approximate number of years*)

○ Prefer not to say

Appendix J: Data Protection Impact Assessment Form

This screening questions is to determine if you need to complete a full DPIA

Data Protection Impact Assessment screening questions

The following questions should be answered when you know your project or procurement involves **personal data** or **sensitive personal data**. It is important that these are answered before any personal data is used.

Send the completed form to xxxx@nhs.net for your answers to be reviewed. We will then contact you with the next steps.

Name: Emily Mortimer
Project name: Content analysis of clinical cases presented in the [NHS Trust] clinical casebook (2003 – 2019)
Department: xxxx.
Email: xxxxx@nhs.net
Date: 05/03/2021

1.**Please provide an overview of the project?**

The proposed project involves a content analysis of the ethical discussions outlined in the [NHS Trust] 'Clinical Ethics Committee 2003 – 2019' casebook (openly available on the Trustnet). From here, I would hope to use the broad themes identified to generate a number of vignettes depicting ethical dilemmas which might occur in a mental health setting. None of the information would be identifiable; it has already been anonymised in the ethics casebook and further steps could be taken to anonymise the Trust etc. if vignettes are subsequently used for research purposes in the future.

The information gathered would not be used as research data. It would just be to inform and generate ideas for vignettes (vignettes would then be used within a university study to collect research data). The final vignettes would not be replicas of the ethical debates from the casebook, but may generate themes and ideas around the kind of discussions and dilemmas to include.

2. **Will you be providing access to, or sharing personal or sensitive data with an external organisation or individual?** If yes, please provide as much detail as possible, including what the personal data is, why we are sharing/providing access (e.g. they are providing a service to us) and whether they are only using data on our behalf.

No

3. **Will you receive or be provided access to personal data from an external organisation or individual?** If yes, please provide details on why we are receiving this personal data from them.

No

4. **Does the project involve the use of sensitive personal data?** If yes, please provide more details on how the sensitive personal data will be used. This data requires extra protection because of the potential harm and distress it may cause if it is used in the wrong way.

No – there is some sensitive personal data within the clinical casebook which will be used but all data has already been anonymised and individuals cannot be identified on the basis of this information.

5. **Does the project involve other information expected to be kept particularly private, such as financial information?** If yes, please provide more details on how the data will be used.

No

6. **Does the project involve using technologies or technology suppliers that are new to the trust, such as a new IT system? Are there any known or immediate technical / IT / Information Security / Cyber Security concerns?** If yes, please provide details on what the new technology will do with personal or sensitive personal data. Please also send this completed DPIA part 1 to xxxxx@nhs.net

No

If you have completed yes to questions 1 to 4 then you will need to complete a full DPIA form

FAQs

What is personal data?

Personal Data is information about a living individual that could identify them, such as their name, address or bank details. This also includes opinions about individuals and images, like photographs and CCTV.

What is sensitive personal data?

Sensitive personal data is personal data about physical and mental health information, trade union memberships, racial or ethnic origin, religious beliefs, sexual life, criminal proceedings (alleged or otherwise) and any commission of an offence (alleged or otherwise).

Appendix K: Vignette Development Process

General structure and purpose:

- Short scenarios (approximately 100 words) in written form presenting a hypothetical ethical dilemma occurring within a mental health setting, intending to elicit responses (perceptions, beliefs, attitudes) to typical clinical scenarios (Hill, 1997).
- These included concrete examples or stories of individuals, situations, structures or opinions in which participants can offer an opinion (Barter & Renold, 1999; Hughes, 1998).
- The vignettes aimed to contain enough context for participants to have a general understanding about the situation described, whilst being vague enough to elicit a range of responses in which participants may draw on various additional factors to make decisions (Finch, 1987).
- All participants were presented with the same vignettes; the hypothetical client’s race (3 factors) was manipulated to allow for between-subject analysis of this variable. One of the three versions of the vignettes (white, Black, South-Asian) was randomly allocated to participants.

Proposed number of vignettes

- Eleven vignettes were initially produced, in line with the number of themes identified by the researcher through a triangulation of information gathered from the literature review on racial disparities in mental health; the casebook of ethical dilemmas and NICE guidelines (see Figure 5).
- While there is no consensus regarding the acceptable number of vignettes (Bachman et al., 2008), previous literature has suggested that the number of vignettes presented should not exceed eight (Louviere et al., 2005) due to the potential for respondent fatigue. Too few vignettes can however, limit the researcher’s ability to explore and manipulate key variables of interest.
- The eleven initial vignettes were subsequently reduced to seven, in line with the above suggestions from previous research as well as the feedback from the vignette consultation phase.

- During the consultation phase, particular attention was given to the clarity and validity regarding the key theme/ construct of interest of the vignettes (Gould, 1996; Veloski et al., 2005).

Scoring

- It is proposed that participants will be asked to rate how much they agree – disagree with the clinical decision/ judgement being made in the vignette, using a Likert scale from 0 – 100. This scale was chosen firstly, to encourage a wide range of potential responses, and secondly, it has been suggested that increasing Likert-scale points (e.g. to >11) results in a closer approximation to normality (Wu & Leung, 2017). Therefore, it was hoped that this scale would allow the construct of CDM processes to be quantified and for this data to be analysed using parametric testing.
- A qualitative text box will also be included if participants want to expand on reasons for their rating or on their thoughts regarding the vignette. This will be optional.

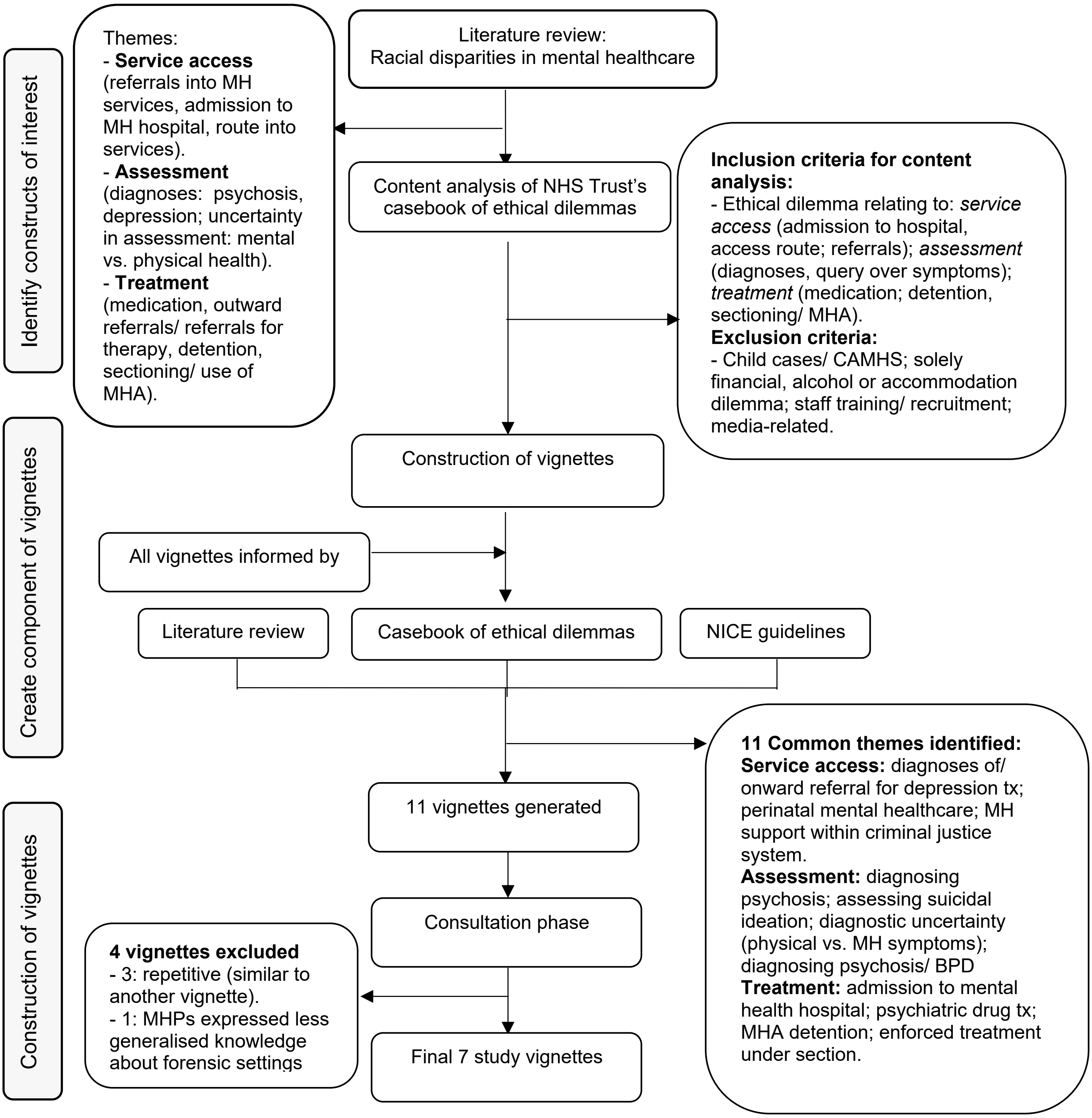


Figure 5: Flow diagram of vignette development process (adapted from Heverly et al., 1984).

Appendix L: Vignette Consultation Questions

Plausibility and content validity

1. Do you think this story could feasibly occur within the setting being described? Does it appear plausible or real to you or resemble real case stories?
2. Do you think it is ambiguous enough to resemble a range of responses from participants? (*too ambiguous, adequate ambiguity, not ambiguous enough*)
3. Is the content suitable for all mental health professionals, including nurses, social workers, psychologists, doctors etc. (*too simplistic/ too complex/ adequate level*).

Simplicity/ clarity

1. Please could you rate the clarity of the vignette content *(limited clarity, moderate clarity, good clarity*).
2. Please could you rate the simplicity of the vignette (too simplistic, too complex, adequate level of simplicity).
3. Please could you rate the word length of the vignette (*too long, adequate, too short*).
4. Do you have any comments about the response question for the vignette? (*too vague, adequate, too specific)*.
   - Or the proposed Likert scale (0 – 100).
   - Do you think there should be one consistent question (how much do you agree with the decision being made) or could this also be followed by additional questions which tap into specific constructs (e.g. how much do you agree with the decision to diagnose x/ refer for x).

Construct

1. In your opinion, what do the decisions being made within the vignette relate to? (diagnosis, assessment, referrals for treatment, service use, sectioning, use of the mental health act, medication criminal justice system etc.)
2. Do you think this vignette would provide a range of responses reflecting ambiguity in whether the client should be [1. Diagnosed with psychosis; 2. Diagnosed with depression; 2.b. questioned further about suicidality; 3. Referred to perinatal MH services; 4. admitted to MH hospital; 5. Treated for his physical rather than mental health; 6. Not referred for a MH assessment; 7. Diagnosed with BPD/ not given medication; 8. Coerced into taking medication; 9. Sectioned under section 3; 10. Admitted to MH hospital.

Sensitivity

1. The study is looking at whether race affects our clinical judgements; please replace the word [race] with white, Black and South-Asian, respectively. In doing so, did you find the vignette distressing or difficult to read? Do you feel it would be distressing or upsetting for others to read?
2. Do you find the language used in the vignette acceptable and appropriate in relation to the content being discussed?

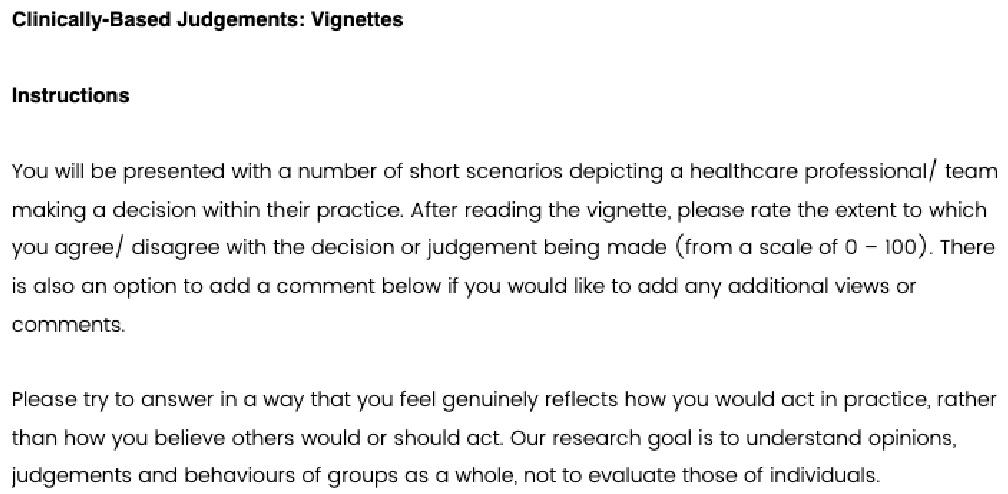
Other factors

1. The study will involve completing a number of other questionnaires, overall it will last around half an hour. If you had 4 questionnaires, each lasting around 3 - 5 minutes, to complete after the vignette section, how many vignettes would you be prepared to read? After how many vignettes do think fatigue would begin to affect your responses?

Any further comments

Appendix M: Study Vignettes (extracted from Qualtrics)

N.b. vignettes were randomised such that participants were presented with one of the three versions of each vignette (Black, white, South-Asian). An example of one version per vignette is presented below (extracted from Qualtrics).



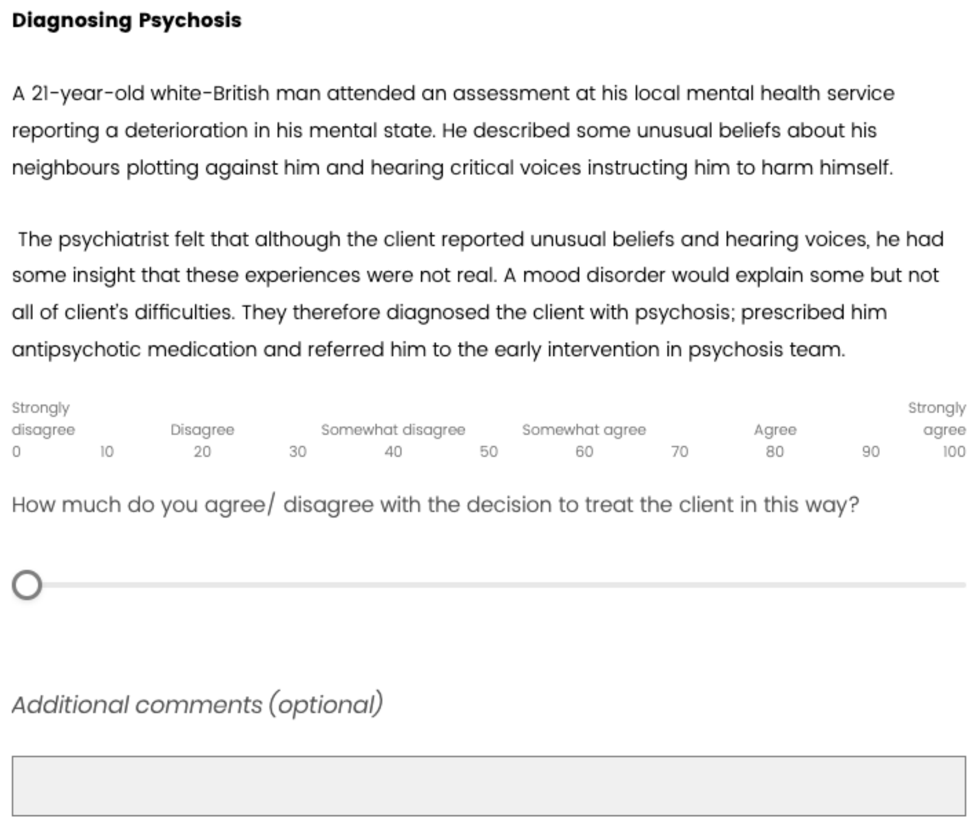
Clinically-Based Judgements: Vignettes

Instructions

You will be presented with a number of short scenarios depicting a healthcare professional/ team making a decision within their practice. After reading the vignette, please rate the extent to which you agree/ disagree with the decision or judgement being made (from a scale of 0 – 100). There is also an option to add a comment below if you would like to add any additional views or comments.

Please try to answer in a way that you feel genuinely reflects how you would act in practice, rather than how you believe others would or should act. Our research goal is to understand opinions, judgements and behaviours of groups as a whole, not to evaluate those of individuals.

Vignette 1:



Diagnosing Psychosis

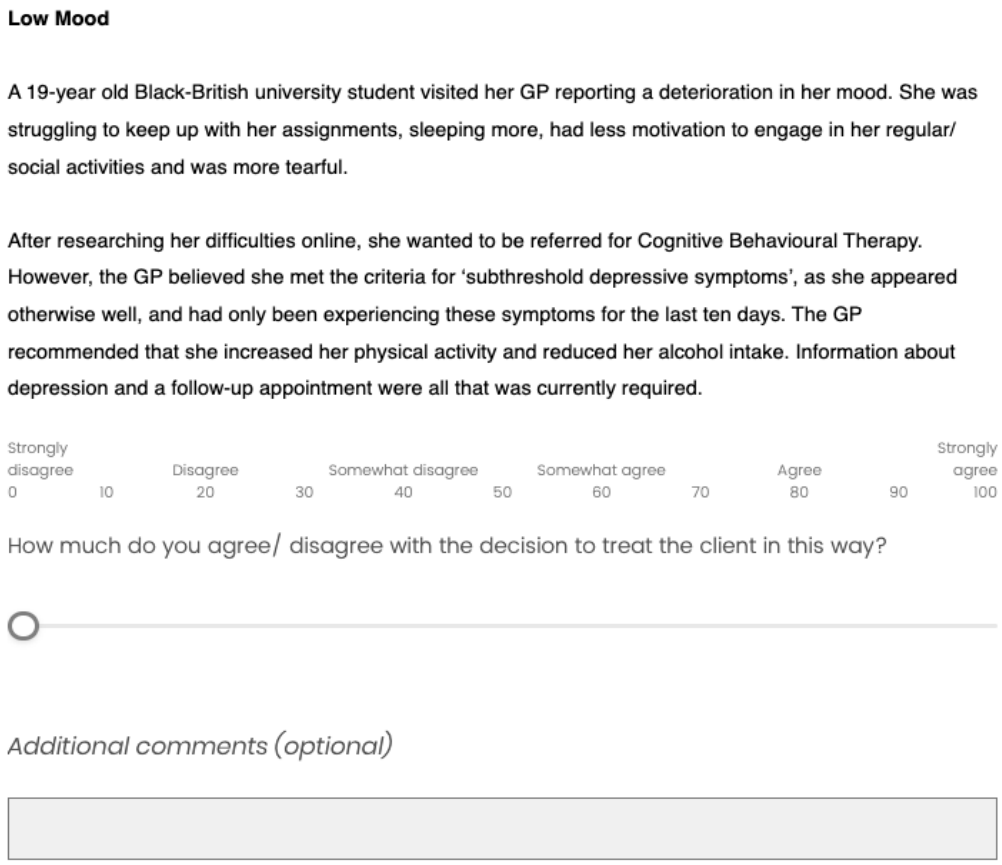
A 21-year-old white-British man attended an assessment at his local mental health service reporting a deterioration in his mental state. He described some unusual beliefs about his neighbours plotting against him and hearing critical voices instructing him to harm himself.

The psychiatrist felt that although the client reported unusual beliefs and hearing voices, he had some insight that these experiences were not real. A mood disorder would explain some but not all of client's difficulties. They therefore diagnosed the client with psychosis; prescribed him antipsychotic medication and referred him to the early intervention in psychosis team.

How much do you agree/ disagree with the decision to treat the client in this way?

Additional comments (optional)

Vignette 2:



Low Mood

A 19-year old Black-British university student visited her GP reporting a deterioration in her mood. She was struggling to keep up with her assignments, sleeping more, had less motivation to engage in her regular/ social activities and was more tearful.

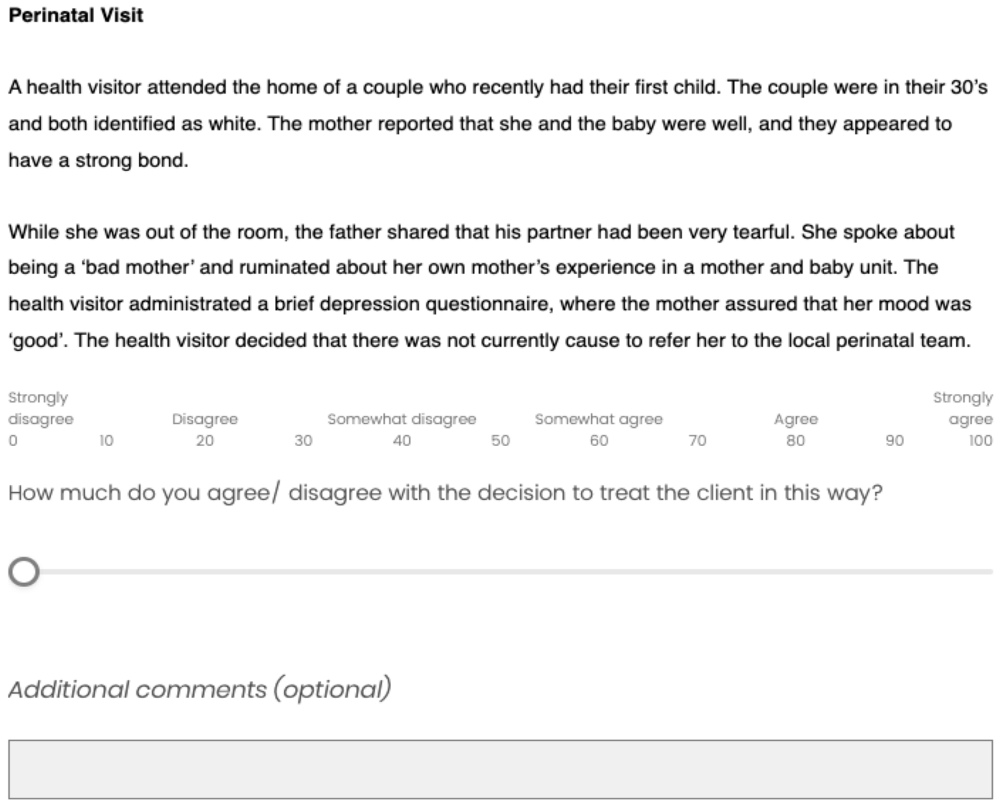
After researching her difficulties online, she wanted to be referred for Cognitive Behavioural Therapy. However, the GP believed she met the criteria for ‘subthreshold depressive symptoms’, as she appeared otherwise well, and had only been experiencing these symptoms for the last ten days. The GP recommended that she increased her physical activity and reduced her alcohol intake. Information about depression and a follow-up appointment were all that was currently required.

How much do you agree/ disagree with the decision to treat the client in this way?

○

Additional comments (optional)

Vignette 3:



Perinatal Visit

A health visitor attended the home of a couple who recently had their first child. The couple were in their 30’s and both identified as white. The mother reported that she and the baby were well, and they appeared to have a strong bond.

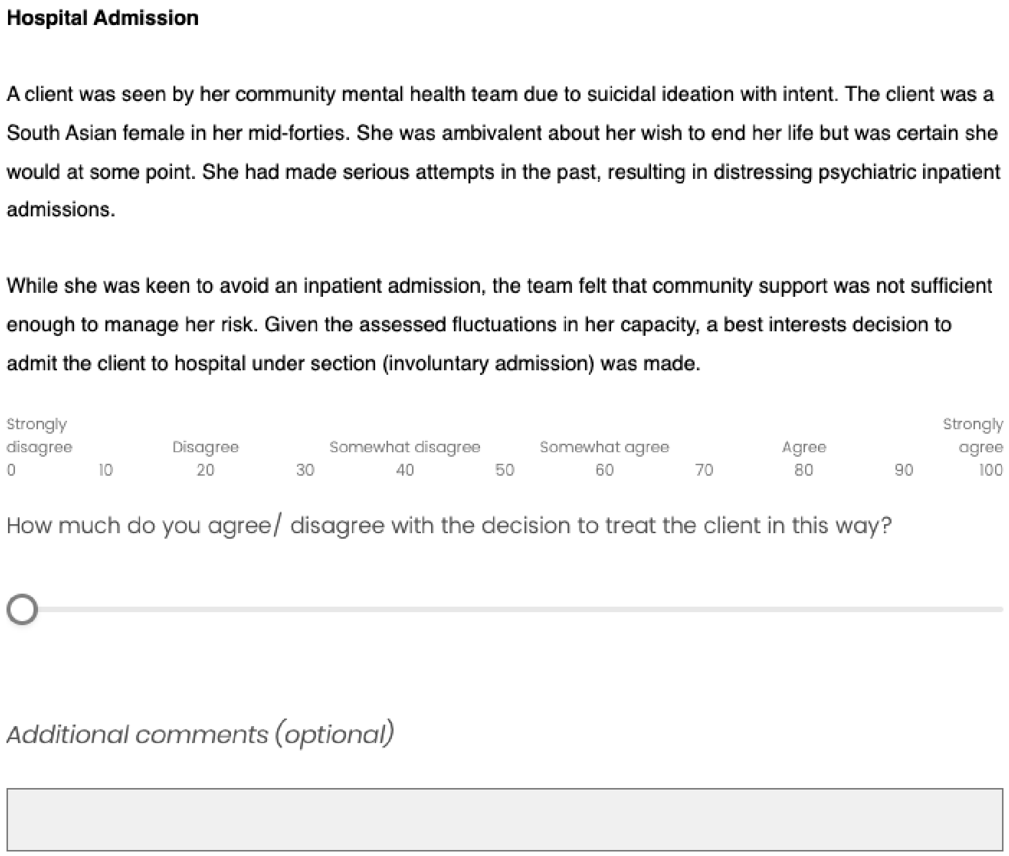
While she was out of the room, the father shared that his partner had been very tearful. She spoke about being a ‘bad mother’ and ruminated about her own mother’s experience in a mother and baby unit. The health visitor administrated a brief depression questionnaire, where the mother assured that her mood was ‘good’. The health visitor decided that there was not currently cause to refer her to the local perinatal team.

How much do you agree/ disagree with the decision to treat the client in this way?

○

Additional comments (optional)

Vignette 4:



Hospital Admission

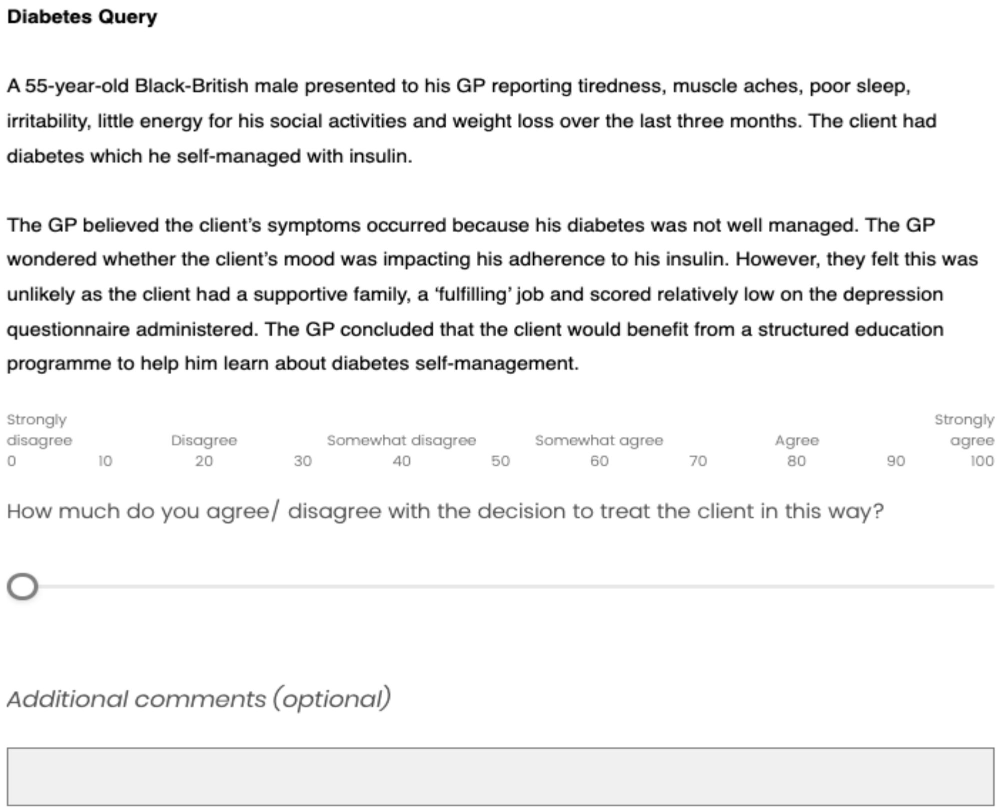
A client was seen by her community mental health team due to suicidal ideation with intent. The client was a South Asian female in her mid-forties. She was ambivalent about her wish to end her life but was certain she would at some point. She had made serious attempts in the past, resulting in distressing psychiatric inpatient admissions.

While she was keen to avoid an inpatient admission, the team felt that community support was not sufficient enough to manage her risk. Given the assessed fluctuations in her capacity, a best interests decision to admit the client to hospital under section (involuntary admission) was made.

How much do you agree/ disagree with the decision to treat the client in this way?

Additional comments (optional)

Vignette 5:



Diabetes Query

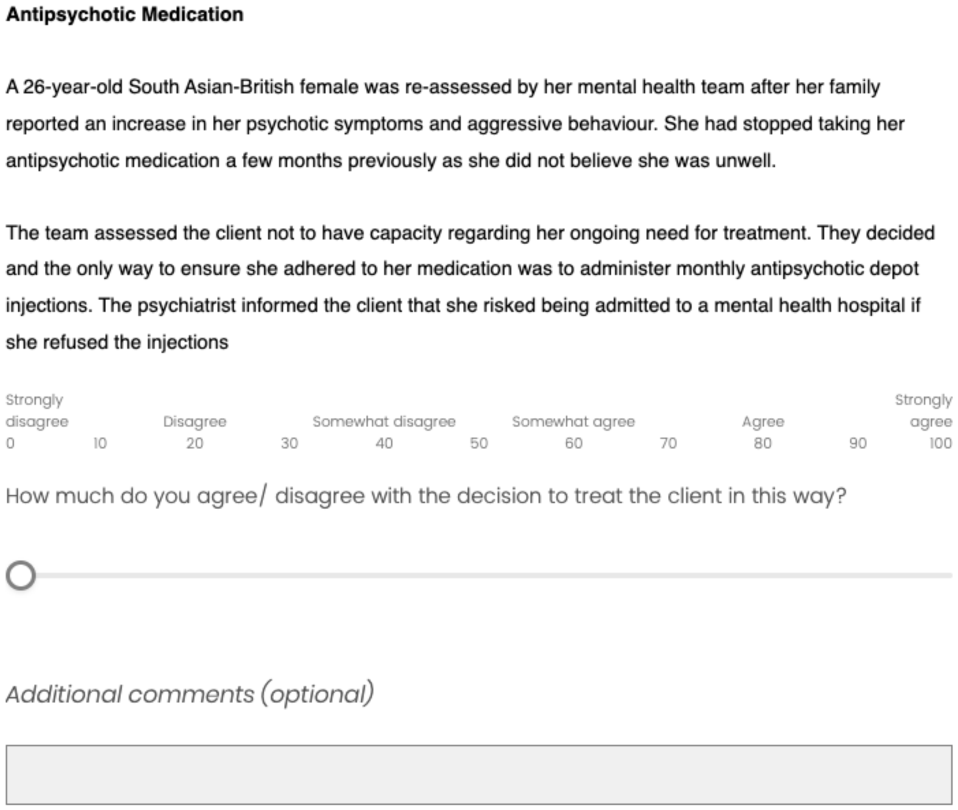
A 55-year-old Black-British male presented to his GP reporting tiredness, muscle aches, poor sleep, irritability, little energy for his social activities and weight loss over the last three months. The client had diabetes which he self-managed with insulin.

The GP believed the client's symptoms occurred because his diabetes was not well managed. The GP wondered whether the client's mood was impacting his adherence to his insulin. However, they felt this was unlikely as the client had a supportive family, a 'fulfilling' job and scored relatively low on the depression questionnaire administered. The GP concluded that the client would benefit from a structured education programme to help him learn about diabetes self-management.

How much do you agree/ disagree with the decision to treat the client in this way?

Additional comments (optional)

Vignette 6:



Antipsychotic Medication

A 26-year-old South Asian-British female was re-assessed by her mental health team after her family reported an increase in her psychotic symptoms and aggressive behaviour. She had stopped taking her antipsychotic medication a few months previously as she did not believe she was unwell.

The team assessed the client not to have capacity regarding her ongoing need for treatment. They decided and the only way to ensure she adhered to her medication was to administer monthly antipsychotic depot injections. The psychiatrist informed the client that she risked being admitted to a mental health hospital if she refused the injections

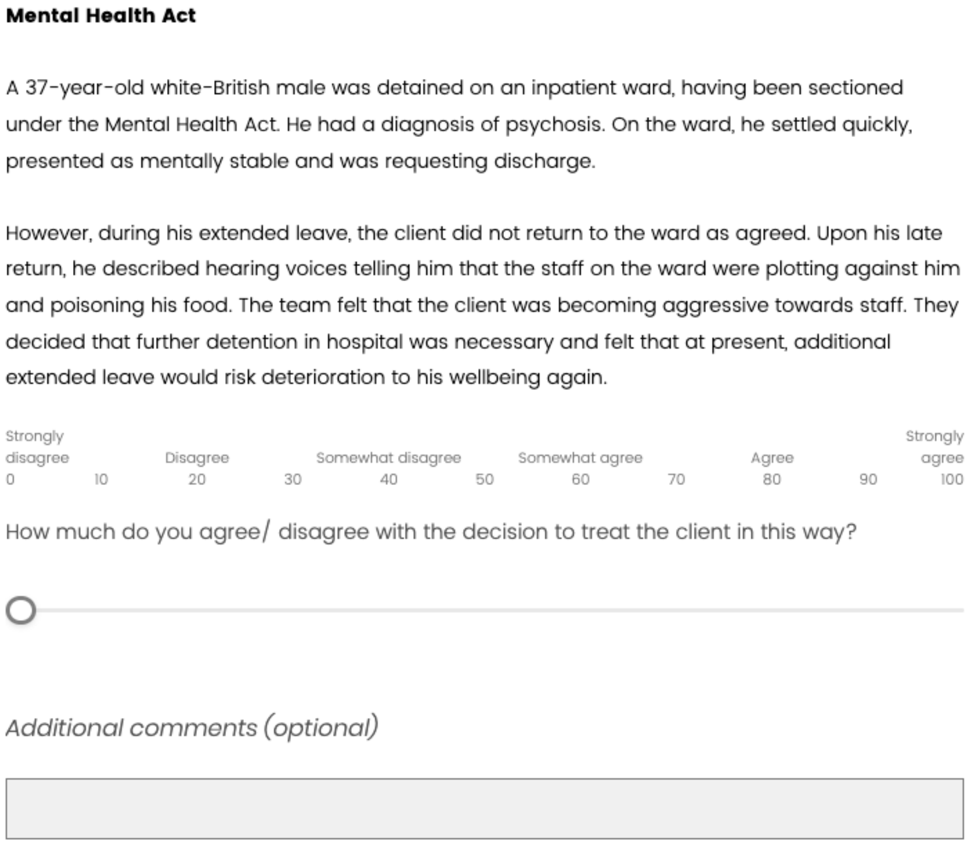
Strongly disagree		Disagree		Somewhat disagree		Somewhat agree		Agree		Strongly agree
0	10	20	30	40	50	60	70	80	90	100

How much do you agree/ disagree with the decision to treat the client in this way?

○

Additional comments (optional)

Vignette 7:



Mental Health Act

A 37-year-old white-British male was detained on an inpatient ward, having been sectioned under the Mental Health Act. He had a diagnosis of psychosis. On the ward, he settled quickly, presented as mentally stable and was requesting discharge.

However, during his extended leave, the client did not return to the ward as agreed. Upon his late return, he described hearing voices telling him that the staff on the ward were plotting against him and poisoning his food. The team felt that the client was becoming aggressive towards staff. They decided that further detention in hospital was necessary and felt that at present, additional extended leave would risk deterioration to his wellbeing again.

Strongly disagree		Disagree		Somewhat disagree		Somewhat agree		Agree		Strongly agree
0	10	20	30	40	50	60	70	80	90	100

How much do you agree/ disagree with the decision to treat the client in this way?

○

Additional comments (optional)

Appendix N: Morality-as-Cooperation Questionnaire (Curry et al., 2019a)

N.b. Items within each scale (relevance/judgement) were randomised using Qualtrics.

MAC-Q: Relevance Items

When you decide whether something is right or wrong, to what extent are the following considerations relevant to your thinking? *(0–100; not at all relevant, not very relevant, slightly relevant, somewhat relevant, very relevant, extremely relevant)*

Family

Whether or not someone acted to protect their family.
Whether or not someone helped a member of their family.
Whether or not someone's action showed love for their family.

Group

Whether or not someone acted in a way that helped their community.
Whether or not someone helped a member of their community.
Whether or not someone worked to unite a community.

Reciprocity

Whether or not someone did what they had agreed to do.
Whether or not someone kept their promise.
Whether or not someone proved that they could be trusted.

Heroism

Whether or not someone acted heroically.
Whether or not someone showed courage in the face of adversity.
Whether or not someone was brave.

Deference

Whether or not someone deferred to those in authority.
Whether or not someone disobeyed orders.
Whether or not someone showed respect for authority.

Fairness

Whether or not someone kept the best part for themselves.
Whether or not someone showed favouritism.
Whether or not someone took more than others.

Property

Whether or not someone vandalised another person's property.
Whether or not someone kept something that didn't belong to them.
Whether or not someone's property was damaged.

MAC-Q: Judgement Items

To what extent do you agree with the following statements?
(0–100; strongly disagree, disagree, neither agree or disagree, agree, strongly agree)

Family

People should be willing to do anything to help a member of their family.
You should always be loyal to your family.
You should always put the interests of your family first.

Group

People have an obligation to help members of their community.
It's important for individuals to play an active role in their communities.
You should try to be a useful member of society.

Reciprocity

You have an obligation to help those who have helped you.
You should always make amends for the things you have done wrong.
You should always return a favour if you can.

Heroism

Courage in the face of adversity is the most admirable trait.
Society should do more to honour its heroes.
To be willing to lay down your life for your country is the height of bravery.

Deference

People should always defer to their superiors.
Society would be better if people were more obedient to authority.
You should respect people who are older than you.

Fairness

Everyone should be treated the same.
Everyone’s rights are equally important.
The current levels of inequality in society are unfair.

Property

It’s acceptable to steal food if you are starving. (R)
It’s ok to keep valuable items that you find, rather than try to locate the rightful owner. (R)
Sometimes you are entitled to take things you need from other people. (R)

Appendix O: Extracts from Reflective Log

Extract 1: Beginning the research

Although I have known about racial inequalities in healthcare and beyond for a long time, before training, I had not spent time reflecting on my own race and what that meant – both personally and professionally. As a child, I remember being asked to reflect on my identity and cultural background at school and even then, chose to focus on all aspects of myself which were not solely white British. Reflecting on this experience has helped me to see how white complacency, silence, and the privilege I have from not having to consider my explicit racial identity is so implicitly entwined in our society and represents more than simply overt inequalities. I am very grateful for the ongoing conversations and the openness of lots of peers, friends and colleagues when having discussions about race and racism, but can also see how even the nature and trajectory of these conversations might be influenced by my own racial identity. I worry that I may not be the right person to do this research because of my white identity and all the blind spots that I have when talking about these topics, the things I might miss and the way I might convey the topic, but also feel strongly that research on racism should not always fall on the shoulders of people who from racialised backgrounds. I should discuss in supervision.

Extract 2: Research process

Doing and thinking about this research has been very challenging. I am aware that the research uses quite a Western research model, using positivist ideas/ the scientist-practitioner model which really doesn’t fit with people’s individual lived experiences of race and racism which is so present at all levels and I’m not sure can be captured using these models. I am really interested to see if these methods can capture some of the racial bias/ attitudes that we know exist, but I worry that the methods will overshadow the reality of the inequity, and also how the results will be interpreted by others if they don’t reflect the realities. There is not any service user/ expert panel involvement in the research so I think it will be really important to find research and books to read about people’s lived experiences of both healthcare and experiences of racialisation, although this will still be interpreted through my lens and in itself is a privilege to be able to read about.

Appendix P: Participant Characteristics: Completers and Non-completers

Table 11: Comparison Between Completers and Non-Completers[a]

	Complete (n=450)[b]	Non-complete (n=254)[b]	t/ X^2	P
Age (*m*)	36.15	36.23	0.08	0.95
Gender			0.00	0.95
Female, % (n)	86.77 (387)	87.19 (211)		
Male, % (n)	13.23 (59)	12.81 (31)		
Ethnicity			1.36	0.85
White (incl. any white background), % (n)	83.74 (376)	85.31 (209)		
Black, African, Caribbean or Black British (incl. any Black background), % (n)	4.45 (20)	4.08 (10)		
Asian (incl. any Asian background), % (n)	5.79 (26)	5.71 (12)		
Mixed or multiple ethnic groups (incl. any mixed backgrounds)	6.01 (27)	5.71 (14)		
Religion			0.81	0.37
Religious, % (n)	32.58 (144)	28.28 (69)		
Non-religious, % (n)	67.42 (298)	71.72 (175)		
Education[c]			3.17	0.08
No formal qual., % (n)	0.22 (1)	0.00 (0)		
GCSE or equivalent, % (n)	1.11 (5)	1.28 (3)		
A-level or equivalent, % (n)	2.68 (12)	3.85 (9)		
Undergraduate or equivalent, % (n)	23.21 (104)	27.78 (65)		
Post-graduate, % (n)	72.77 (326)	67.09 (157)		
Training route			10.09	0.07
Psychology, % (n)	47.27 (208)	35.86 (85)		
CBT/ IAPT, % (n)	5.68 (25)	4.64 (11)		
Psychotherapy, % (n)	10.45 (46)	13.08 (31)		
Nursing, % (n)	21.36 (94)	26.58 (63)		
Medical, % (n)	4.55 (20)	4.64 (11)		
Any other AHP, % (n)	10.61 (47)	15.19 (36)		
Workplace setting			2.48	0.65
Adult, % (n)	65.03 (279)	63.34 (140)		
Inpatient, % (n)	16.08 (69)	19.91 (44)		
CYP, % (n)	16.32 (70)	14.03 (31)		
‘other’ workplace setting	2.56 (11)	2.71 (6)		
Urbanicity			3.58	0.31
Urban, % (n)	52.88 (242)	59.58 (143)		
Suburban, % (n)	28.12 (124)	23.75 (57)		
Rural, % (n)	4.31 (19)	10.42 (25)		
Remote, % (n)	12.70 (56)	6.25 (15)		
Time in MH (*m*)	9.32	9.30	-0.02	0.98

[a] t-test (*t*) performed for continuous variables; Pearson’s chi-squared tests (X^2) performed for categorical variables.

[b] Prefer not to say and some self-identified categories are not included due to small numbers per category, therefore, total *n* per variable does not always equate to the total *n* of completers/ non-completers.

[c] Due to small numbers in some Education subcategories, this variable was merged into postgraduate compared to all other qualifications for the significance (X^2) test.

Appendix Q: Text-Entry Demographic and Professional Categories (duplicates removed)

In addition to the pre-specified categories (see Appendix I), participants reported the following genders, ethnicities, religions, education levels, professional training routes and workplace settings:

Gender
Agender
Sex is female – no gender

Ethnicity
Black/Hispanic
Chinese
Greek Cypriot
Sri Lankan Tamil
Turkish

Religion
Agnostic
Atheist
Catholic
None/ spiritual
Pagan
Quaker
Spiritual

Highest Education Level
Doctorate
DPsychClin
Foundation diploma
Graduate
High school
M Phil, F.r.C.Psych
MSc
Multiple post graduate qualifications as necessary in this field
PhD
RMN
Trainee Clinical Psychologist

Mental Health Professional Training Route

Advanced Lived Experience Practitioner
AHP
And psychotherapy
Assistant Psychologist
BABCP accreditation
CBT
Child & Adolescent Psychotherapist
Children’s psychological well-being practitioner
Counselling (not counselling psych)
Educational Psychology
Facilitator of Peer Group Work
Forensic Psychology
GP
Health Psychology
Health Psychology trainee working in MH setting
Health Psychology, recovery worker
Health visitor maternal mental health
IAPT - CBT therapist
IAPT Psychological Well-being Practitioner
Integrative Counselling
Medical billing and Coding
Mental Health Advisor
Music psychotherapy
Nurse and DBT therapist
Psychiatry
Psychoanalysis
Psychological Wellbeing Practitioner
Psychology
PWP
Quality Improvement
Social worker and CBT therapist
Stage 1 Forensic Psychology
Therapeutic Counselling
Therapy

Trainee nursing associate apprentice (Mental health based)
Trainee Psychological Wellbeing Practitioner Work

Current/ most recent workplace setting

This category did not include a pre-specified text-box due to the broad range of potential workplace settings.

16 and above MH presentations in A&E/paramedic joint-response service.
Acute Mental Health Ward
Addiction psychology
Adult
Adult acute inpatient
Adult acute mental health- crisis team
Adult carers (Dementia)
Adult CMHT
Adult community
Adult Community Learning Disabilities Team
Adult Eating Disorder service
Adult IAPT
Adult inpatient Forensic
Adult memory research
Adult mental health
Adult MH secondary care
Adult neuropsychology
Adult NHS and private practice
Adult Physical Health
Adult PICU
Adult primary care
Adult Prison
Adult psychoanalysis self employed
Adult secondary care community mental health
Adult Specialist Service
adult substance misuse
Adult trauma
Adults and neuro
Adults but recently CAMHS forensic and CAMHs Community
Adults Dual Diagnosis Support Worker and also Medical School Teaching Associate for
Adults outpatients
Adults, psychiatric liaison in general hospital
AMHP Hub
CAMHS
CAMHS & YJS
CAMHS Community Eating Disorders
CAMHS Crisis
CAMHS Inpatient
Care home support team
Charity
Charity. Professional regulator
Child Neuro
Child Psychology
Children, ASD
Children's hospital
Clinical education
Clinical Health Psychology
CMHT
Community
Community 16-21 semi independent Residential
Community drug and alcohol service
Community general Adult and perinatal community older adults
Community perinatal
Community rehabilitation
Community Stroke Service
Counselling private practice and IMCA for Libra Partnership
Counselling services
Criminal justice liaison and diversion service
Crisis Team
bank mental healthcare assistant
Domestic and sexual violence counselling
Early intervention in psychosis
Eating disorder service and Personality disorder pathway in recovery service
Eating Disorders
EI
Forensic - liaison and Diversion
Forensic + IAPT
Forensic community
Forensic inpatient
Forensic LD
Forensic mental health (community and inpatient)
Forensic Psychology
General Adult Psychiatry
General Practice
Health Psychology
Hiv Psychology
IAPT
ICMHT
Independent, CAMHS before that inpatient
Inpatient - brain injury

Inpatient "open" rehab
Inpatient Acute Mental Health
Inpatient acute MHSOP
Inpatient Adult Male Rehab
Inpatient and outpatient hospital
Inpatient eating disorder hospital
Inpatient forensic and community older adult
inpatient forensic LD
Inpatient mother and baby
Inpatient Neuropsychology
Learning Disabilities
Learning disability community forensic
Learning Disability Community Mental Health Team
Liaison and diversion
Liaison psychiatry
Local Mind
Long term health conditions
Low secure forensic mental health and LD service
Medical students
Medium secure MH hospital, private
Mental health liaison
MHST CYP
MIND Sanctuary
Mobility rehab inpatients.
Neuropsychology
NHS Adult Psychological Therapies
Older adult community and inpatient
Older Adult Community Mental Health
Older adult inpatient
Older Adults
Older adults dementia
Older Adults Pain Management
Older people community Home Treatment service.
outpatient
Outpatient physical health setting
Outpatient Psychotherapy Unit
Paediatrics
Paediatric Clinical and Health Psychology
Perinatal
Perinatal psychiatry
Persistent pain management
Personality disorder
Physics health amputee services and surgery
PICU
Police custody
Practice Education
Primary care
Private practice
Private practice and Charity work
Private practice, plus recovery service for adults with mental health diagnosis
Psychological Wellbeing Services
Psychosexual therapies
Public Hospital
Rehabilitation (psychosis)
Relationship Charity and Private Practice
School
Secure forensic setting
Secure Inpatient
Self employed as a private psychotherapist
Sexual Health
social services
Social Work with children and families
Specialist Rehabilitation
Specialist trauma outpatient psychotherapy service
Student Mental Health
Substance misuse
Third Sector
Transport and PP
University Mental Health Team
Voluntary sector
Women’s low secure forensic inpatient
Working Age Crisis

Appendix R: Skewness and Kurtosis Values

Table 12: Skewness and kurtosis for continuous variables

Subscale	Skewness	Kurtosis	Z Skewness	Z Kurtosis
Age	0.93	0.22	7.75	0.95
Time in MH	1.67	2.55	13.92	11.09
MACQ-R				
R-family	-0.49	-0.40	-4.08	-1.74
R-group	-0.54	-0.40	4.5	-1.74
R-reciprocity	-0.39	-0.58	-3.25	-2.52
R-heroism	-0.11	-0.66	-0.92	-2.87
R-deference	0.32	-0.59	2.67	-2.57
R-fairness	-0.22	-0.72	-1.83	-3.13
R-property	-0.26	-0.64	-2.17	-2.78
MACQ-J				
J-family	0.24	-0.82	2.00	-3.57
J-group	-0.44	0.00	-3.67	0.00
J-reciprocity	-0.37	0.02	-3.08	0.09
J-heroism	0.19	-0.27	1.58	-1.17
J-deference	0.60	0.32	5	1.39
J-fairness	-0.50	-0.04	-4.17	-0.17
J-property	-0.36	0.52	-3.00	2.26
MMD-HP total	0.84	0.49	7.00	2.13
CoBRAS total	0.66	-0.03	5.50	-0.13
Factor 1	0.64	-0.12	5.33	-0.52
Factor 2	0.91	0.86	7.50	3.74
Factor 3	1.07	0.55	8.92	2.39

SE skewness = 0.12; SE kurtosis = 0.23 for all subscales.

Table 13: Skewness and Kurtosis for Vignette Subscales

Subscale	Skewness (SE)	Kurtosis (SE)	Z Skewness	Z kurtosis
V1 total	-0.43 (0.12)	-0.74 (0.23)	-3.58	-3.22
W	-0.54 (0.20)	-0.57 (0.40)	-2.70	-1.43
B	-0.47 (0.20)	-0.75 (0.40)	-2.35	-1.88
SA	-0.25 (0.19)	-0.87 (0.38)	-1.32	-2.29
V2 total	0.22 (0.12)	-1.06 (0.23)	1.83	-4.60
W	0.07 (0.20)	-1.01 (0.39)	0.35	-2.59
B	0.33 (0.21)	-1.01 (0.41)	1.57	-2.89
SA	0.30 (0.20)	-1.08 (0.39)	1.50	-2.77
V3 total	0.08 (0.12)	-0.93 (0.23)	0.67	4.04
W	0.15 (0.20)	-1.07 (0.39)	0.75	2.74
B	0.02 (0.20)	-0.89 (0.40)	0.10	2.23
SA	0.09 (0.20)	-0.82 (0.40)	0.45	2.05
V4 total	-0.16 (0.12)	-0.78 (0.23)	-1.33	-3.39
W	-0.00 (0.20)	-0.93 (0.40)	-0.00	-2.33
B	-0.06 (0.20)	-0.87 (0.40)	-0.30	-2.18
SA	-0.35 (0.20)	-0.42 (0.39)	-1.75	-1.08
V5 total	-0.01 (0.12)	-0.79 (0.23)	-0.08	-3.43
W	-0.08 (0.20)	-0.51 (0.40)	-0.40	-1.28
B	0.14 (0.20)	-0.95 (0.40)	0.70	-1.36
SA	-0.04 (0.19)	-0.78 (0.39)	-0.21	-2.00
V6 total	-0.14 (0.12)	-0.98 (0.23)	-1.17	-4.26
W	-0.01 (0.20)	-1.11 (0.39)	-0.05	-2.85
B	-0.18 (0.19)	-0.95 (0.38)	-0.95	-2.50
SA	-0.21 (0.21)	-0.82 (0.41)	-1.00	-2.00
V7 total	-0.48 (0.12)	-0.54 (0.23)	-4.00	-2.34
W	-0.47 (0.20)	-0.51 (0.39)	-2.35	-1.31
B	-0.35 (0.20)	-0.62 (0.40)	-1.75	-1.55
SA	-0.59 (0.20)	-0.45 (0.39)	-2.95	-1.15

Table 14: Skewness and Kurtosis Values for Transformed Data

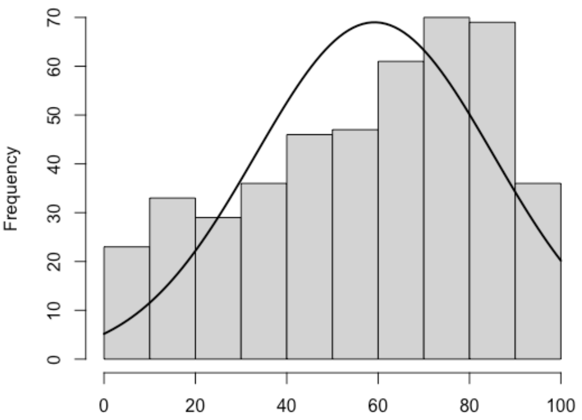
Subscale	Skewness	Kurtosis	Z Skewness	Z Kurtosis
MACQ-R				
R-family[a]	-0.37	0.11	3.08	0.48
R-group[a]	-0.19	-0.18	1.58	0.78
MACQ-J				
J-family[b]	-0.64	-0.17	5.33	0.74
J-group[a]	-0.44	0.43	3.67	1.87
J-deference[b]	-0.54	0.17	4.5	0.74
J-fairness[a]	-0.38	-0.59	3.16	2.57
MMD-HP total[b]	-0.08	-0.29	0.67	1.26
CoBRAS total[c]	0.32	-0.63	2.66	2.74
Factor 1[c]	-0.20	-0.69	1.67	3.00
Factor 2[c]	0.08	-0.64	0.67	2.78
Factor 3[c]	0.42	-0.85	3.5	3.69

SE skewness = 0.12; SE kurtosis = 0.23 for all subscales.

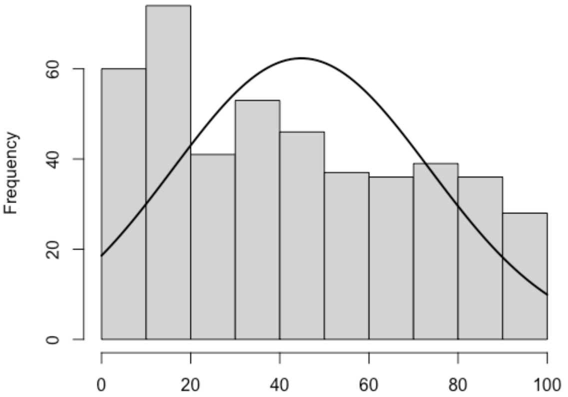
[a] Square root transformation for negative skew
[b] Square root transformation for positive skew
[c] Log transformation for positive skew

Appendix S: Normal Distribution Plots (Histograms) for Vignette Total Scores

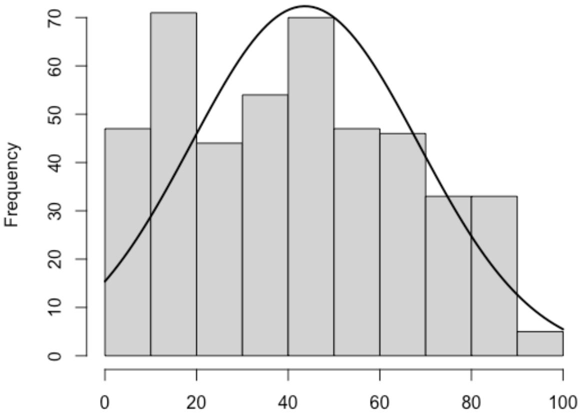
Vignette 1 total:



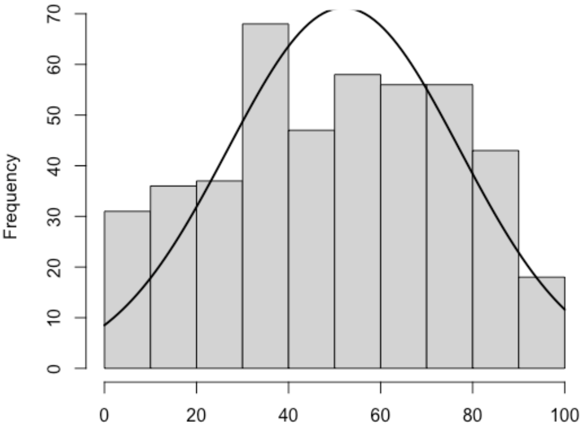
Vignette 2 total:



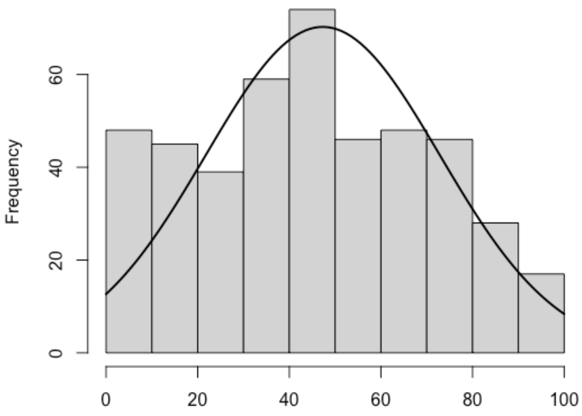
Vignette 3 total:



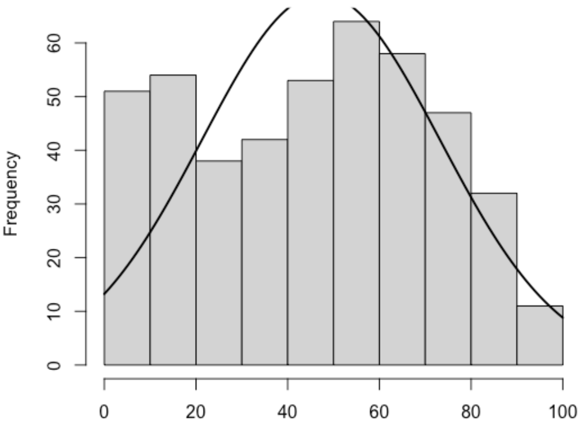
Vignette 4 total:



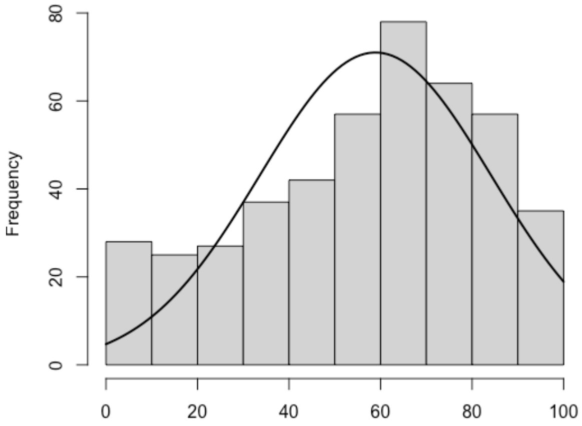
Vignette 5 total:



Vignette 6 total:



Vignette 7 total:



Appendix T: MAC-Q Judgement Scale: Descriptives and Non-Parametric Analyses

Table 15: MAC-Q Judgement Scale Descriptive Statistics and Non-Parametric Analyses: Demographic Factors[a]

	Family	Group	Reciprocity	Heroism	Deference	Fairness	Property
Age (*r*)	-0.01	-0.02	-0.14**	-0.01	-0.06	-0.05	0.03
Gender (*W*)	10108	6930**	10839	10675	11677	12812	12302
Female (*M, SD*)	37.28 (23.54)	58.68 (20.08)	60.20 (19.48)	46.06 (21.28)	30.76 (18.88)	78.77 (15.34)	65.74 (15.78)
Male *(M, SD)*	42.82 (27.65)	71.79 (16.73)	62.99 (19.26)	48.89 (21.70)	32.07 (24.08)	75.90 (15.22)	63.06 (19.15)
Ethnicity (χ^2)	17.45***	5.15	17.97***	8.06*	22.10***	2.31	13.93**
White *(M, SD)*	36.10 (23.97)	60.02 (19.77)	59.52 (19.52)	45.42 (21.18)	29.07 (18.38)	78.62 (15.04)	64.24 (15.92)
Black *(M, SD)*	55.22 (20.66)	70.13 (16.14)	76.12 (11.30)	58.58 (22.92)	50.63 (24.78)	73.72 (15.80)	73.40 (25.00)
Mixed ethnicity *(M, SD)*	43.48 (26.08)	58.83 (25.20)	61.35 (24.40)	51.67 (20.67)	34.19 (25.05)	80.26 (14.02)	67.36 (12.31)
Asian *(M, SD)*	46.59 (20.85)	63.00 (21.87)	65.50 (19.93)	45.82 (19.95)	39.18 (16.93)	77.47 (19.30)	72.71 (12.92)
Religion (*W*)	14334**	17590**	16138**	14660**	13328**	22422	16976**
Religious *(M, SD)*	47.28 (24.01)	65.32 (18.99)	66.34 (17.93)	54.22 (21.36)	39.78 (20.73)	77.38 (15.95)	69.27 (16.59)
Non-religious *(M, SD)*	33.22 (24.01)	58.55 (20.36)	57.93 (20.16)	42.72 (19.95)	26.40 (17.50)	78.90 (14.78)	63.45 (15.86)

$^{*}p<0.05$, $^{**}p<0.01$, $^{***}p<0.001$

[a]Spearman's rho correlations were used to examine relationships between moral values and the independent variables consisting of continuous data (age, years in mental health, CoBRAS); Wilcoxon tests were used to explore differences between moral values and the independent categorical variables being analysed with two groups (gender, religion, education level); Kruskal-Wallis tests were used to test differences between moral values and the categorical variables containing more than two groups (ethnicity, training route, workplace setting, urbanicity).

Table 16: MAC-Q Judgement Scale Descriptive Statistics and Non-Parametric Analyses: Professional Factors[a]

	Family	Group	Reciprocity	Heroism	Deference	Fairness	Property
Educ. level (*W*)	23025**	19868	20924	24192**	21544	20824	20282
Postgrad *(M, SD)*	36.14	60.77	60.11	44.33	29.80	78.13	65.44
	(23.59)	(20.07)	(20.52)	(20.53)	(18.20)	(15.30)	(15.88)
Any other qual. *(M, SD)*	42.61	60.17	62.10	51.88	33.63	79.06	65.04
	(25.30)	(20.07)	(18.06)	(22.29)	(22.98)	(15.31)	(19.41)
Training route (χ^2)	5.02	3.50	4.75	23.32***	2.43	8.17	12.09*
Psychology *(M, SD)*	35.87	61.61	60.09	40.86	29.16	79.38	63.35
	(24.19)	(18.65)	(19.72)	(18.85)	(17.39)	(13.06)	(14.95)
CBT/ IAPT *(M, SD)*	31.90	55.49	62.56	45.64	29.19	79.31	67.28
	(20.86)	(22.95)	(22.41)	(23.99)	(16.29)	(16.22)	(14.67)
Psychotherapy *(M, SD)*	37.19	60.48	58.11	47.32	28.59	73.88	62.91
	(24.58)	(22.09)	(18.51)	(21.40)	(18.91)	(16.22)	(17.61)
Nursing *(M, SD)*	41.75	58.47	58.99	53.03	31.23	78.37	68.66
	(24.44)	(20.26)	(19.61)	(22.15)	(19.46)	(16.08)	(16.93)
Medical *(M, SD)*	37.72	63.55	61.14	47.68	31.24	71.50	64.67
	(13.44)	(20.27)	(21.04)	(16.97)	(20.83)	(16.84)	(12.45)
Any other AHP*(M, SD)*	39.49	60.55	64.80	52.35	33.66	80.03	68.14
	(27.08)	(22.77)	(19.51)	(22.08)	(25.99)	(17.81)	(15.51)
Work-setting (χ^2)	2.94	1.83	3.61	4.58	2.72	2.00	1.48
Adult *(M, SD)*	36.63	59.82	60.16	45.24	29.46	78.67	65.29
	(23.43)	(19.75)	(19.02)	(20.34)	(18.93)	(14.94)	(15.75)
Inpatient *(M, SD)*	41.76	62.17	62.68	51.43	33.42	77.21	65.21
	(24.30)	(20.01)	(21.17)	(23.10)	(19.47)	(14.63)	(15.46)
CYP *(M, SD)*	36.36	61.90	60.90	43.70	29.44	77.81	63.54
	(23.63)	(19.17)	(20.25)	(19.55)	(16.59)	(16.31)	(15.78)
'other' *(M, SD)*	35.91	54.76	54.82	43.36	31.55	80.79	68.00
	(24.75)	(24.06)	(21.85)	(23.65)	(20.16)	(17.67)	(16.03)
Urbanicity (χ^2)	1.68	8.67*	4.27	2.52	1.28	2.47	4.18
Urban *(M, SD)*	38.81	62.98	62.06	46.48	31.90	77.94	64.60
	(24.17)	(19.31)	(20.69)	(20.40)	(20.04)	(15.28)	(16.60)
Suburban *(M, SD)*	35.91	58.08	58.11	45.50	29.47	79.92	65.41
	(23.31)	(19.63)	(20.69)	(20.59)	(18.97)	(13.97)	(14.68)
Rural *(M, SD)*	37.88	58.08	61.17	49.23	29.45	78.50	68.53
	(25.46)	(21.51)	(18.77)	(25.60)	(21.47)	(15.83)	(18.06)
Remote *(M, SD)*	33.63	49.79	53.32	41.44	28.89	73.37	62.49
	(25.49)	(27.40)	(22.84)	(24.36)	(14.45)	(20.22)	(16.48)
Years in MH (*r*)	0.01	0.06	0.06	0.01	0.04	-0.11*	0.03
CoBRAS (*r*)	0.31***	0.03	0.13**	0.36***	0.36***	0.13**	0.28***

*p<0.05, **p<0.01, ***p<0.001

[a] Spearman's rho correlations were used to examine relationships between moral values and the independent variables consisting of continuous data (age, years in mental health, CoBRAS); Wilcoxon tests were used to explore differences between moral values and the independent categorical variables being analysed with two groups (gender, religion, education level); Kruskal-Wallis tests were used to test differences between moral values and the categorical variables containing more than two groups (ethnicity, training route, workplace setting, urbanicity).

Appendix U: Moral Values Significance Testing

Family:

- Participants educated to at least post-graduate level (*m*=60.80, *SD*=24.97), had significantly higher moral valence scores for family, compared to participants educated to all other levels (*m*=54.22.80, *SD*=24.51), (*t*(448)=-2.78, p=0.01).
- There was a significant negative correlation between racial attitude (CoBRAS) scores and family (*r*(448)=-0.10, p<0.05).

Group loyalty:

- Men (*m*=67.29, *SD*=20.69) had significantly higher group loyalty scores compared to women (*m*=55.04, *SD*=24.59), (t(443)=3.58, p<0.01).
- Participants educated to at least post-graduate level (*m*=55.00, *SD*=24.26) had significantly lower group loyalty scores compared to participants educated to all other levels (*m*=60.64, *SD*=24.25), (*t*(448)=-2.46, p=0.01).

Reciprocity:

- Men (*m*=66.68.04, *SD*=23.17) had significantly higher reciprocity scores, compared to women (*m*=55.27, *SD*=23.72), (*t*(443)=3.42, p<0.01).
- Participants identifying as religious (*m*=54.78, *SD*=23.87) had significantly lower scores for reciprocity compared to those identifying as non-religious (*m*=61.84, *SD*=23.53), (*t*(440)=-2.94, p<0.01).
- There was a significant positive correlation between racial attitude (CoBRAS) scores and reciprocity (*r*(448)=0.13, p=0.01).

Heroism:

- Significant differences were found by ethnicity (*t*(448)=3.74, p<0.01). Post-hoc tests showed significant differences in scores between participants identifying as being from a Black ethnic background (*m*=61.53, *SD*=22.38) compared to both those identifying as being from an Asian (*m*=42.05, *SD*=19.05) and a white background (*m*=45.80, *SD*=24.13).

- Those identifying as religious (*m*=51.18, *SD*=24.94) had significantly higher heroism scores compared to those identifying as non-religious (*m*=44.12, *SD*=23.42), (*t*(440)=-2.91, p<0.01).
- Participants educated to at least post-graduate level (*m*=43.71, *SD*=23.77), had significantly lower heroism scores compared to participants educated to all other levels (*m*=53.10, *SD*=23.93), (*t*(448)=-2.46, p=0.01).
- There was a significant positive correlation between racial attitude (CoBRAS) scores and heroism (*t*(448)=3.74, p<0.01).

Deference:

- Significant differences were found by ethnicity (F(3, 445)=6.00, p<0.01). Post-hoc tests showed significant differences in scores between participants identifying as being from a Black ethnic background (*m*=52.75, *SD*=21.44) compared to both those identifying as being from a white (*m*=33.21, *SD*=22.01) and a mixed ethnic background (*m*=33.78, *SD*=21.68).
- Participants identifying as religious (*m*=30.75, *SD*=23.64) had significantly lower deference scores compared to those identifying as non-religious (*m*=42.91, *SD*=20.30), (*t*(440)=-5.59, p<0.01).
- Participants educated to at least post-graduate level (*m*=38.63, *SD*=21.99) had significantly higher deference scores compared to participants educated to all other levels (*m*=33.02, *SD*=22.56), (*t*(448)=2.40, p=0.02).
- There was a significant positive correlation between racial attitudes (CoBRAS) and deference scores (*r*(448)=0.33, p<0.01).

Fairness:

- Men (*m*=55.24, *SD*=25.50) had significantly higher moral valence scores for fairness compared to women (*m*=47.40, *SD*=24.27), (*t*(443)=-2.28, p<0.01).
- Significant differences were found by ethnicity (F(3, 445)=3.04, p=0.03). Post-hoc tests showed significant differences in scores between participants identifying as being from a Black ethnic background (*m*=63.70, *SD*=19.50) compared to both those identifying as being from a white (*m*=47.76, *SD*=24.55) and a mixed ethnic background (*m*=44.19, *SD*=22.54).

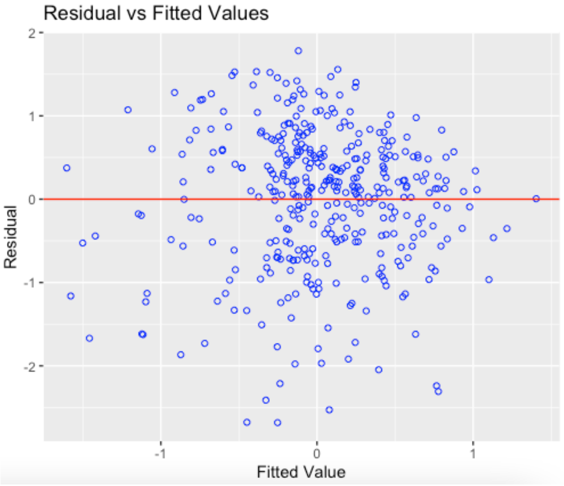
- Participants identifying as religious (*m*=53.64, *SD*=24.76) had significantly higher fairness scores compared to those identifying as non-religious (*m*=45.85, *SD*=23.79), (*t*(440)=-3.18, p<0.01).

Property:

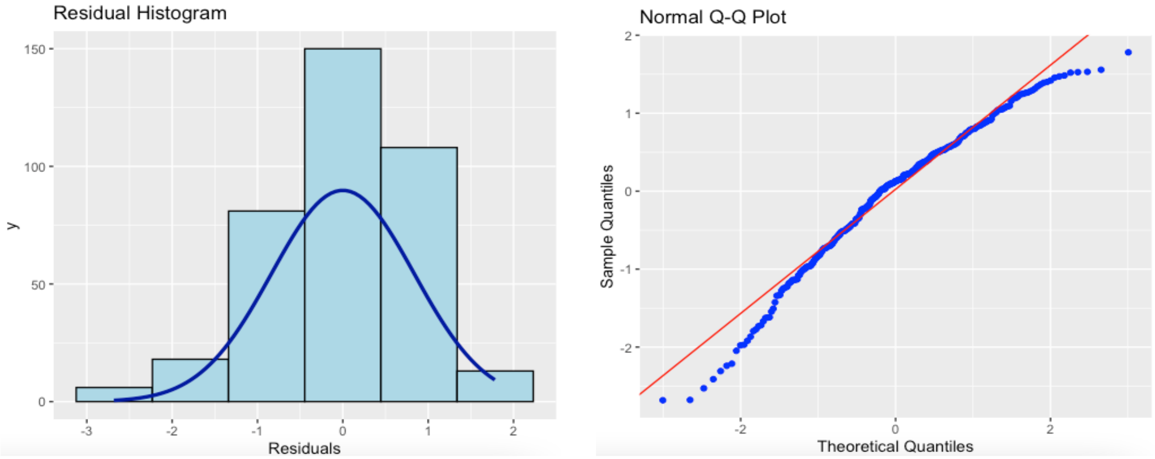
- Participants identifying as religious (*m*=57.08, *SD*=24.58) had significantly higher moral valence scores compared to those identifying as non-religious (*m*=49.68, *SD*=24.31), (*t*(440)=-2.99, p<0.01).
- Significant differences were found by ethnicity (F(3, 445)=2.73, p<0.05). Post-hoc tests showed significant differences in scores between participants identifying as being from a Black ethnic background (*m*=63.50, *SD*=17.53) compared to those identifying as being from a white background (*m*=51.00, *SD*=24.79).
- There was a significant positive correlation between racial attitude (CoBRAS) scores (*r*(448)=0.11, p=0.01) and property scores.

Appendix V: MMD-HP Regression Assumption Plots

Homoscedasticity (Standardised residuals against standardised predicted values)



Normality of Residuals (Histogram and Q-Q plot)



Appendix W: Regression Model: MMD-HP

Table 17: MMD-HP Regression Model

	β	t	*p*	SE
Age	-0.29	-3.56	<0.01	0.08
Gender (ref. female)	-0.09	-0.57	0.15	0.57
Ethnicity (ref. white)				
Asian	0.10	0.47	0.64	0.21
Black	-0.17	-0.60	0.55	0.28
Mixed ethnicity.	-0.05	-0.27	0.79	0.19
Religion (ref. non-religious)	0.02	0.22	0.11	0.83
Education (ref. all other qual.)	0.10	0.84	0.12	0.40
Training Route (ref. psychology)				
CBT/ IAPT	-0.10	-0.54	0.19	0.60
Medical	0.61	2.63	0.23	0.01
Nursing	0.60	4.12	0.15	<0.01
Psychotherapy	-0.44	-2.55	0.17	0.01
Other AHP	0.60	3.53	0.17	<0.01
Workplace setting (ref. adult)				
CYP	0.02	0.18	0.13	0.86
Inpatient	0.14	1.05	0.14	0.30
'Other"	-0.07	-0.33	0.20	0.74
Urbanicity (ref. urban)				
Suburban	-0.15	-1.36	0.17	0.11
Rural	-0.05	-0.33	0.74	0.15
Remote	-0.44	-1.84	0.07	0.24
Time in MH	0.29	3.70	<0.01	0.08
CoBRAS	-0.02	-0.30	0.76	0.06
Moral Values				
Family	0.14	2.18	0.03	0.06
Group	-0.09	-1.40	0.16	0.07
Reciprocity	-0.03	-0.51	0.60	0.06
Heroism	0.02	0.28	0.78	0.07
Deference	0.22	3.54	<0.01	0.06
Fairness	0.07	1.16	0.24	0.06
Property	-0.08	-1.44	0.15	0.06

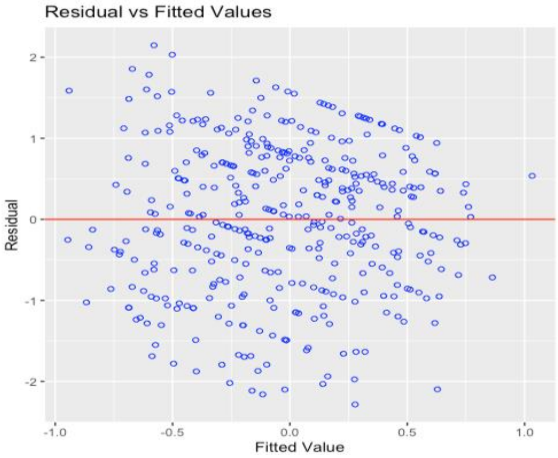
F(27, 348) = 4.32, p <0.01; Adj. R^2 = 19.29

Appendix X: CDM Regression Assumption Plots

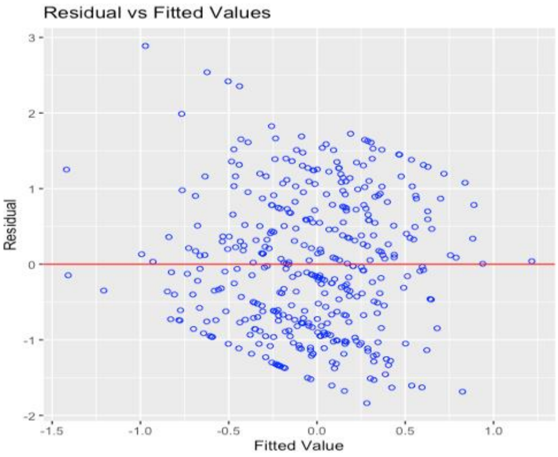
N.b. all of the below (scatterplots, histograms, Q-Q plots) were performed for the final stepwise regression models (Model 3), including all predictor variables.

Homoscedasticity (Standardised residuals against standardised predicted values)

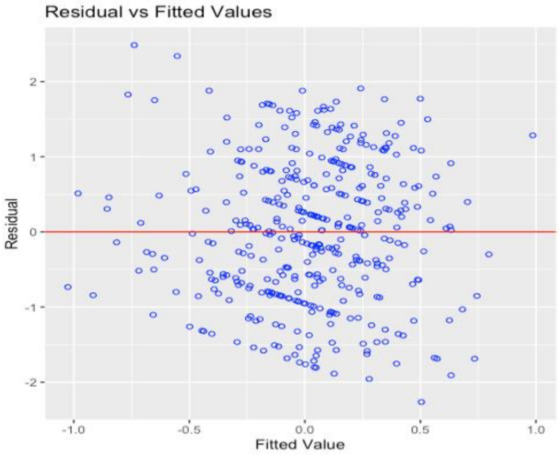
V1



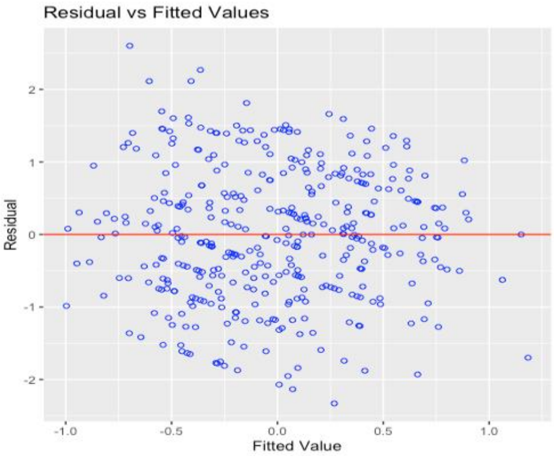
V2



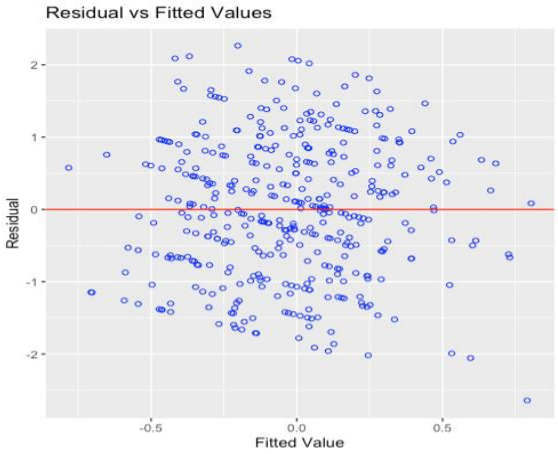
V3



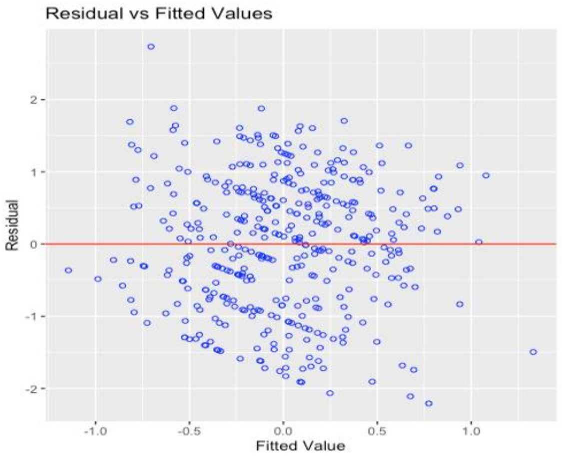
V4



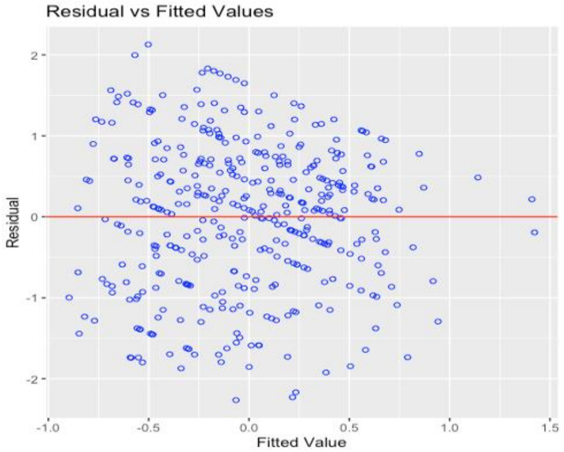
V5



V6

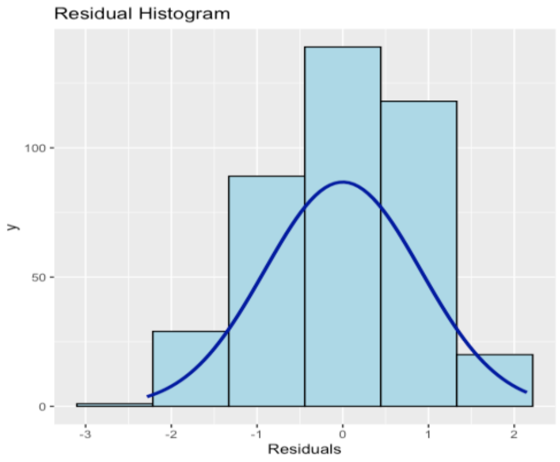


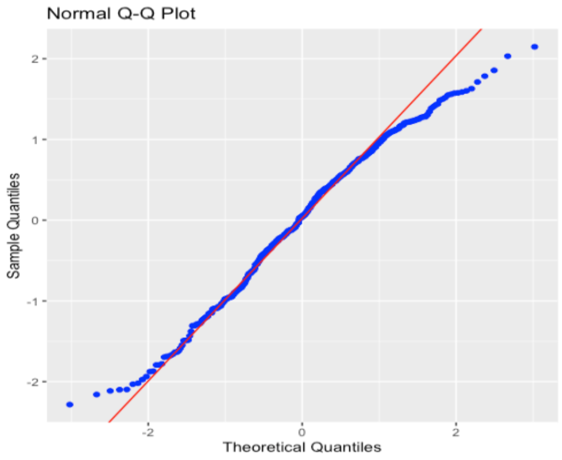
V7



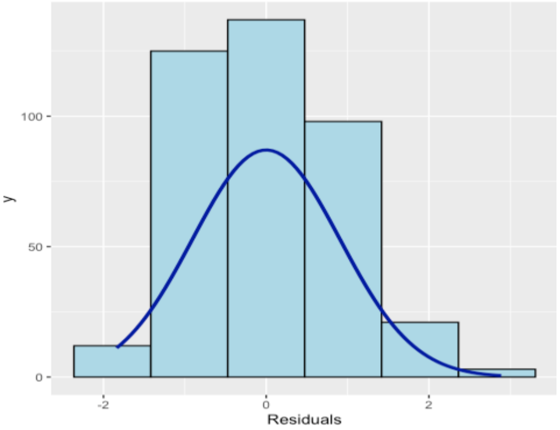
Normality of Residuals (Histograms and Q-Q plots)

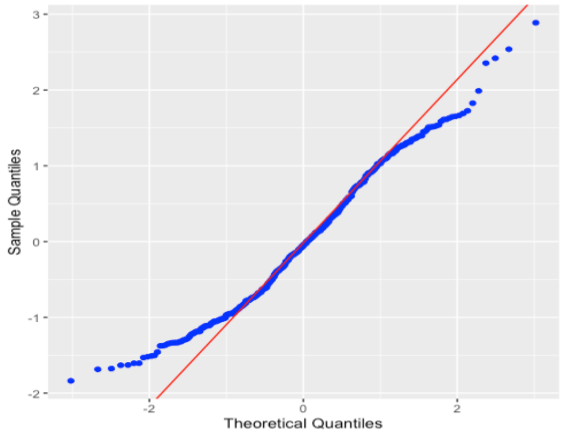
V1



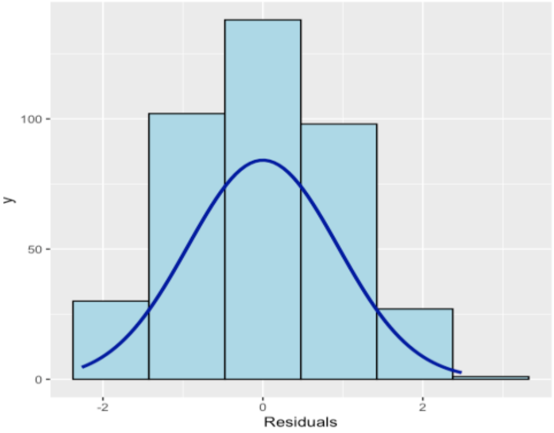


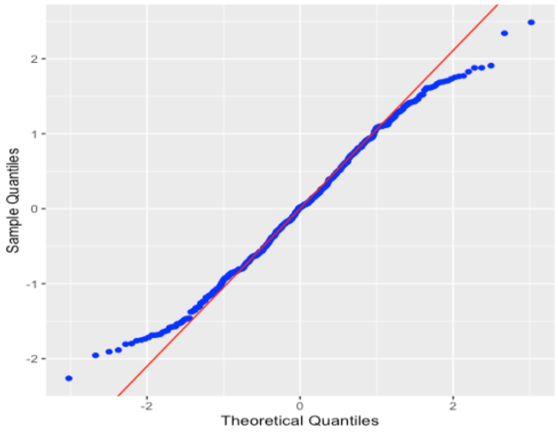
V2


Residual Histogram

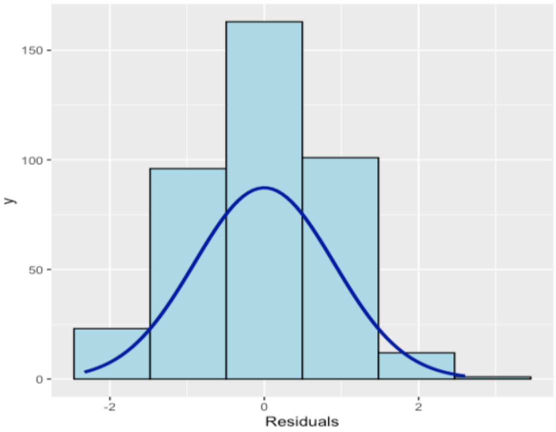

Normal Q-Q Plot

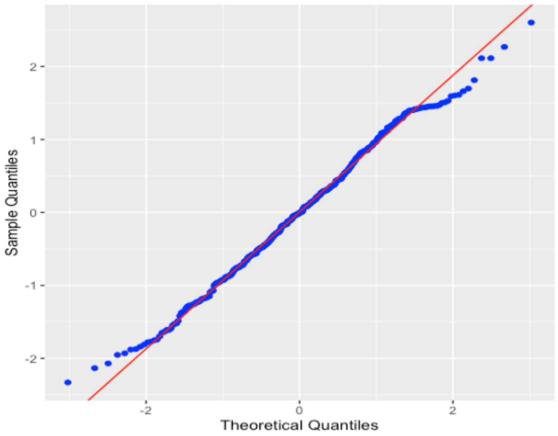
V3


Residual Histogram

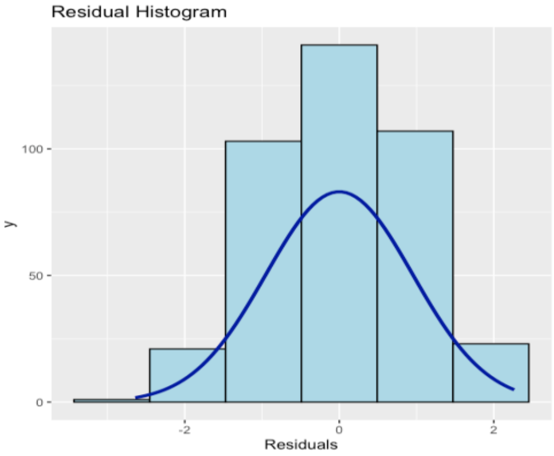

Normal Q-Q Plot

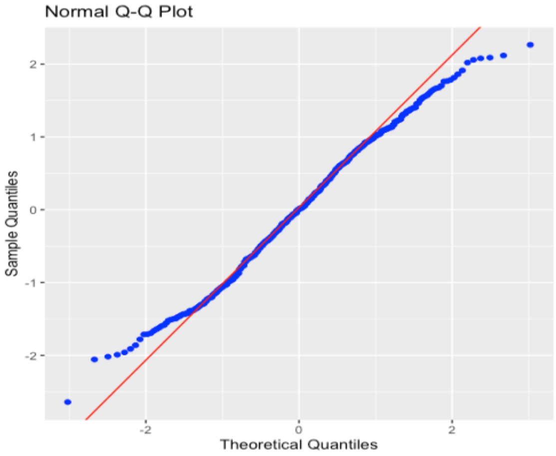
V4


Residual Histogram

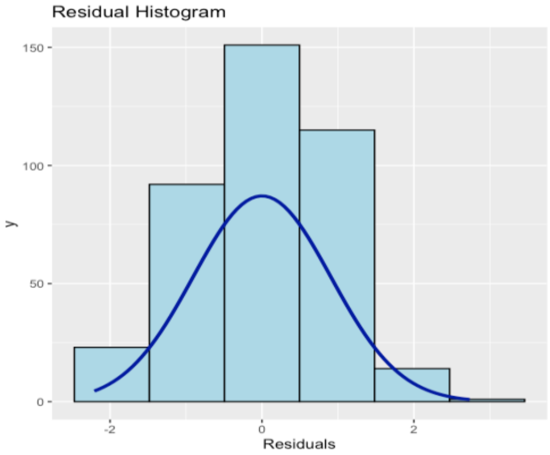

Normal Q-Q Plot

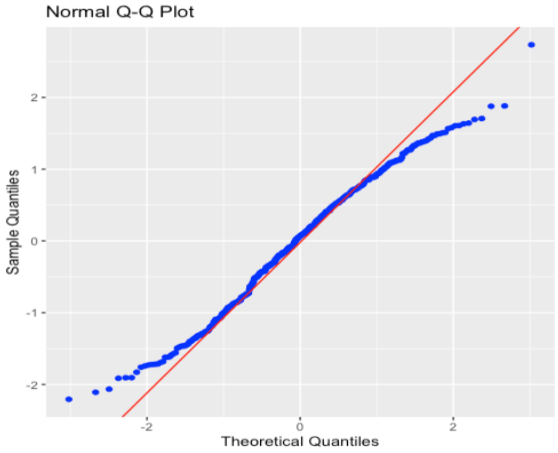
V5


Residual Histogram
y
0
50
100
-2
0
2
Residuals

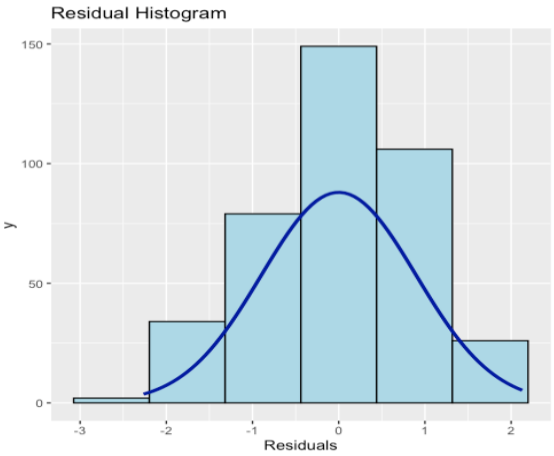

Normal Q-Q Plot
Sample Quantiles
-2
-1
0
1
2
-2
0
2
Theoretical Quantiles

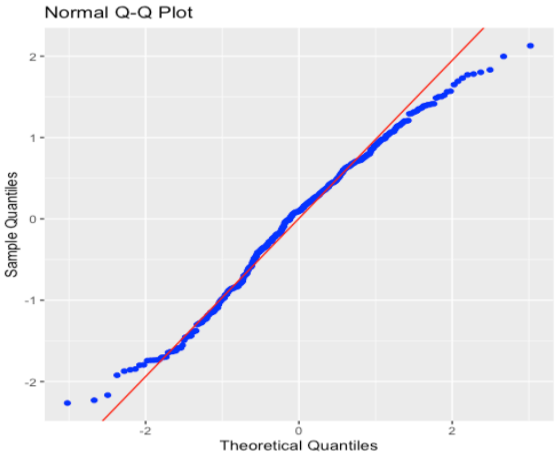
V6


Residual Histogram
y
0
50
100
150
-2
0
2
Residuals


Normal Q-Q Plot
Sample Quantiles
-2
-1
0
1
2
-2
0
2
Theoretical Quantiles

V7


Residual Histogram
y
0
50
100
150
-3
-2
-1
0
1
2
Residuals


Normal Q-Q Plot
Sample Quantiles
-2
-1
0
1
2
-2
0
2
Theoretical Quantiles

Appendix Y: CDM Regression Models

Table 18: Hierarchical Regression Analysis Vignette 1

	Model 1			Model 2			Model 3		
Predictor variables	**β**	***t***	**Adj. R^2**	**β**	***t***	**Adj. R^2**	**β**	***t***	**Adj. R^2**
Client race (ref. white)			0.03			0.03			0.09
Black	-0.05	-0.42		-0.09	-0.73		-0.08	-0.65	
South-Asian	-0.01	-0.05		-0.03	-0.26		-0.07	-0.59	
CoBRAS	0.19***	3.97		0.24***	4.75		0.05	0.80	
Age				-0.05	-0.91		-0.06	-0.67	
Gender: Male: (ref. female)				-0.09	-0.62		-0.06	-0.35	
Ethnicity: (ref. white)									
Asian				-0.06	-0.31		0.03	0.16	
Black				0.01	0.05		-0.09	-0.28	
Mixed ethnicity				0.07	0.34		-0.01	-0.06	
Religion: Religious (ref. non-religious)				-0.06	-0.52		-0.14	-1.14	
Education level: post-grad. (ref. any other qual.)							-0.12	-0.91	
Training route (ref. psychology)									
CBT/ IAPT							0.28	1.32	
Medical							0.64**	2.60	
Nursing							0.54***	3.44	
Psychotherapy							0.54**	2.95	
‘other’ AHP							0.38*	2.13	
Workplace setting: (ref. adults)									
CYP							-0.10	-0.71	
Inpatient							0.13	0.90	
‘Other’							-0.12	-0.60	
Urbanicity: (ref. urban)									
Suburban							0.08	0.74	
Rural							0.29	1.86	
Remote							0.05	0.21	
Time in MH							-0.04	-0.51	
Moral values:									
Family							0.12	1.80	
Group							0.01	0.20	
Reciprocity							0.11	1.58	
Heroism							0.02	0.22	
Deference							0.18**	2.72	
Fairness							-0.09	-1.32	
Property							0.04	0.67	
	F(3, 446) = 5.32, *p* = <0.001			F(9, 419) = 2.61, *p* = <0.001			F(29, 366) = 2.31, *p* <0.001		

**p<0.05, **p<0.01, ***p<0.001*

Table 19: Hierarchical Regression Analysis Vignette 2

	Model 1			**Model 2**			**Model 3**		
Predictor variables	**β**	***t***	**Adj. R^2**	**β**	***t***	**Adj. R^2**	**β**	***t***	**Adj. R^2**
Client race (ref. white)			0.08			0.08			0.09
Black	-0.21	-1.90		-0.22	-1.88		-0.21	-1.78	
South-Asian	-0.11	-0.98		-0.11	-0.93		-0.10	-0.85	
CoBRAS	0.28***	6.16		0.27***	5.23		0.22***	3.71	
Age				-0.04	-0.83		0.01	0.09	
Gender: (ref. female)				-0.05	-0.35		-0.11	-0.71	
Ethnicity: (ref. white)									
Asian				-0.37	-1.78		-0.23	-1.07	
Black				0.03	0.10		-0.29	-0.97	
Mixed ethnicity				-0.33	-1.68		-0.31	-1.49	
Religion: (ref. non-religious)				0.08	0.74		-0.01	-0.07	
Education level: post-grad. (ref. any other qual.)							-0.22	-1.74	
Training route (ref. psychology)									
CBT/ IAPT							-0.34	-1.63	
Medical							0.20	0.81	
Nursing							0.19	1.21	
Psychotherapy							0.07	0.40	
'other' AHP							-0.26	-1.46	
Workplace setting: (ref. adults)									
CYP							0.28	1.91	
Inpatient							0.26	1.81	
'Other'							-0.34	-1.70	
Urbanicity: (ref. urban)									
Suburban							-0.13	-1.14	
Rural							-0.09	1.61	
Remote							-0.27	-1.10	
Time in MH							-0.02	-0.23	
Moral values:									
Family							-0.04	-0.52	
Group							0.01	0.19	
Reciprocity							0.04	0.62	
Heroism							-0.09	-1.26	
Deference							0.01	0.16	
Fairness							0.04	0.60	
Property							-0.01	-0.77	
	F(3, 446) = 13.85, *p* <0.001			F(9, 419) = 4.88, *p* <0.001			F(29, 366) = 2.36 *p* <0.001		

**p<0.05, **p<0.01, ***p<0.001*

Table 20: Hierarchical Regression Analysis Vignette 3

	Model 1			**Model 2**			**Model 3**		
Predictor variables	**β**	***t***	**Adj. R^2**	**β**	***t***	**Adj. R^2**	**β**	***t***	**Adj. R^2**
Client race (ref. white)			0.01			0.01			0.03
Black	-0.04	-0.33		-0.08	-0.69		-0.09	-0.72	
South-Asian	-0.11	-0.97		-0.13	-1.13		-0.10	-0.82	
CoBRAS	0.10*	2.18		0.09	1.82		0.07	1.25	
Age				-0.02	-0.41		-0.14	-1.60	
Gender: (ref. female)				0.31*	2.08		0.45**	2.68	
Ethnicity: (ref. white)									
Asian				0.04	-0.18		0.02	0.10	
Black				-0.20	-0.81		-0.47	-1.50	
Mixed ethnicity				-0.31	-1.59		-0.40*	-1.89	
Religion: (ref. non-religious)				0.08	0.71		0.13	1.03	
Education level: post-grad. (ref. any other qual.)							-0.05	-0.40	
Training route (ref. psychology)									
CBT/ IAPT							-0.17	-0.77	
Medical							-0.56*	-2.27	
Nursing							-0.14	-0.85	
Psychotherapy							0.16	0.85	
‘other’ AHP							-0.05	-0.26	
Workplace setting: (ref. adults)									
CYP							-0.18	-1.19	
Inpatient							0.20	1.31	
‘Other’							0.17	0.85	
Urbanicity: (ref. urban)									
Suburban							0.21	1.62	
Rural							0.45**	2.81	
Remote							0.16	0.77	
Time in MH							0.08	1.03	
Moral values:									
Family							0.10	1.46	
Group							-0.02	-0.29	
Reciprocity							0.05	0.80	
Heroism							0.00	0.06	
Deference							-0.03	-0.45	
Fairness							-0.01	-0.18	
Property							0.01	0.16	
	F(3, 446) = 1.94, *p* = 0.12			F(9, 419) = 1.37, *p* = 0.20			F(29, 366) = 1.40, *p* =0.09		

**p<0.05, **p<0.01, ***p<0.001*

Table 21: Hierarchical Regression Analysis Vignette 4

	Model 1			**Model 2**			**Model 3**		
Predictor variables	**β**	***t***	**Adj. R^2**	**β**	***t***	**Adj. R^2**	**β**	***t***	**Adj. R^2**
Client race (ref. white)			0.07			0.11			0.12
Black	-0.03	-0.24		0.02	0.16		-0.03	-0.23	
South-Asian	0.15	1.37		0.12	1.10		0.06	0.54	
CoBRAS	0.26***	5.63		0.28***	5.70		0.15*	2.55	
Age				-0.09	-1.95		-0.14	-1.71	
Gender: (ref. female)				-0.22	-1.55		-0.17	-1.07	
Ethnicity: (ref. white)									
Asian				0.46*	2.26		0.58**	2.67	
Black				0.65**	2.67		0.64*	2.11	
Mixed ethnicity				0.14	0.74		0.03	0.15	
Religion: (ref. non-religious)				0.02	0.39		-0.05	-0.39	
Education level: post-grad. (ref. any other qual.)							-0.01	-0.08	
Training route (ref. psychology)									
CBT/ IAPT							0.13	0.63	
Medical							0.53*	2.18	
Nursing							0.42**	2.73	
Psychotherapy							0.26	1.46	
‘other’ AHP							0.46*	2.54	
Workplace setting: (ref. adults)									
CYP							0.09	0.61	
Inpatient							0.35*	2.43	
‘Other’							0.11	0.54	
Urbanicity: (ref. urban)									
Suburban							0.19	1.65	
Rural							0.26	1.68	
Remote							0.46	1.85	
Time in MH							0.04	0.46	
Moral values:									
Family							-0.06	-0.84	
Group							0.10	1.38	
Reciprocity							0.01	0.16	
Heroism							0.00	0.04	
Deference							0.09	1.42	
Fairness							0.00	-0.01	
Property							-0.07	-1.06	
	F(3, 446) = 11.68, *p* = <0.001			F(0, 419) = 6.81, *p* <0.001			F(29, 366) = 2.86, *p* <0.001		

**p<0.05, **p<0.01, ***p<0.001*

Table 22: Hierarchical Regression Analysis Vignette 5

	Model 1			**Model 2**			**Model 3**		
Predictor variables	**β**	***t***	**Adj. R^2**	**β**	***t***	**Adj. R^2**	**β**	***t***	**Adj. R^2**
Client race (ref. white)			0.01			0.01			0.01
Black	-0.16	-1.35		-0.14	-1.18		-0.16	-1.22	
South-Asian	-0.10	0.85		0.07	-0.68		-0.12	-0.95	
CoBRAS	0.12*	2.52		0.11*	2.20		0.03	0.41	
Age				0.05	0.91		0.11	1.21	
Gender: (ref. female)				0.06	0.43		0.13	0.77	
Ethnicity: (ref. white)									
Asian				0.02	0.09		0.08	0.33	
Black				-0.01	-0.05		-0.05	-0.15	
Mixed ethnicity				-0.13	-0.63		-0.17	-0.79	
Religion: (ref. non-religious)				-0.00	-0.04		-0.11	-0.91	
Education level: post-grad. (ref. any other qual.)							-0.07	-0.55	
Training route (ref. psychology)									
CBT/ IAPT							-0.22	-1.00	
Medical							0.10	0.39	
Nursing							0.24	1.50	
Psychotherapy							0.14	0.74	
‘other’ AHP							0.10	0.56	
Workplace setting: (ref. adults)									
CYP							0.27	1.80	
Inpatient							0.39*	2.57	
‘Other’							0.02	0.09	
Urbanicity: (ref. urban)									
Suburban							0.04	0.36	
Rural							0.19	1.18	
Remote							-0.11	-0.42	
Time in MH							-0.09	-1.13	
Moral values:									
Family							-0.01	-0.08	
Group							0.14*	1.99	
Reciprocity							-0.02	-0.30	
Heroism							0.06	0.88	
Deference							0.04	0.57	
Fairness							0.01	0.16	
Property							0.01	0.21	
	F(3, 446) = 2.84, *p* = 0.04			F(9, 419) = 1.07, *p* =0.38			F(29, 366) = 1.10, *p* =0.34		

**p<0.05, **p<0.01, ***p<0.001*

Table 23: Hierarchical Regression Analysis Vignette 6

	Block 1			**Block 2**			**Block 3**		
Predictor variables	**β**	***t***	**Adj. R^2**	**β**	***t***	**Adj. R^2**	**β**	***t***	**Adj. R^2**
Client race (ref. white)			0.05			0.07			0.10
Black	0.15	1.32		0.14	1.23		0.16	1.35	
South-Asian	0.18	1.60		0.17	1.45		0.20	1.65	
CoBRAS	0.22***	4.82		0.24***	4.89		0.10	1.78	
Age				-0.07	-1.41		-0.02	-0.21	
Gender: (ref. female)				-0.39**	-2.75		-0.30	-1.89	
Ethnicity: (ref. white)									
Asian				-0.13	-0.62		-0.11	-0.49	
Black				0.12	0.51		-0.00	-0.01	
Mixed ethnicity				-0.03	-0.17		-0.19	-0.90	
Religion: (ref. non-religious)				0.16	1.46		0.10	0.84	
Education level: post-grad. (ref. any other qual.)							-0.05	-0.37	
Training route (ref. psychology)									
CBT/ IAPT							0.23	1.11	
Medical							0.57*	2.32	
Nursing							0.25	1.65	
Psychotherapy							0.13	0.71	
‘other’ AHP							0.32	1.81	
Workplace setting: (ref. adults)									
CYP							0.13	0.87	
Inpatient							0.24	1.66	
‘Other’							0.41*	2.08	
Urbanicity: (ref. urban)									
Suburban							0.06	0.52	
Rural							0.18	1.14	
Remote							-0.31	-1.24	
Time in MH							-0.12	-1.54	
Moral values:									
Family							-0.13	-1.89	
Group							0.08	1.11	
Reciprocity							0.06	0.87	
Heroism							-0.08	-1.13	
Deference							0.10	1.59	
Fairness							-0.02	-0.29	
Property							0.05	0.83	
	F(3, 446) = 8.66, *p* <0.001			F(9, 419) = 4.59, *p* <0.001			F(29, 366) = 2.47, *p* <0.001		

**p<0.05, **p<0.01, ***p<0.001*

Table 24: Hierarchical Regression Analysis Vignette 7

	Model 1			**Model 2**			**Model 3**		
Predictor variables	**β**	***t***	**R^2**	**β**	***t***	**R^2**	**β**	***t***	**R^2**
Client race (ref. white)			0.09			0.09			0.11
Black	-0.13	-1.22		-0.12	-1.07		-0.12	-1.04	
South-Asian	-0.05	-0.49		-0.05	-0.42		-0.04	-0.35	
CoBRAS	0.30***	6.72		0.30***	6.03		0.19**	3.18	
Age				0.01	0.27		-0.03	-0.31	
Gender: (ref. female)				-0.01	-0.10		0.02	0.12	
Ethnicity: (ref. white)									
Asian				-0.03	-0.15		0.10	0.46	
Black				-0.42	-1.71		-0.37	-1.24	
Mixed ethnicity				0.29	1.50		0.20	0.96	
Religion: (ref. non-religious)				0.17	1.56		0.11	0.94	
Education level: post-grad. (ref. any other qual.)							-0.20	-1.56	
Training route (ref. psychology)									
CBT/ IAPT							0.21	1.01	
Medical							0.76**	3.12	
Nursing							0.33*	2.17	
Psychotherapy							0.24	1.31	
‘other’ AHP							0.28	1.56	
Workplace setting: (ref. adults)									
CYP							0.04	0.23	
Inpatient							0.12	0.85	
‘Other’							0.09	0.43	
Urbanicity: (ref. urban)									
Suburban							0.09	0.77	
Rural							-0.03	-0.20	
Remote							0.14	0.55	
Time in MH							0.03	0.40	
Moral values:									
Family							-0.14*	-1.97	
Group							0.10	1.49	
Reciprocity							-0.11	1.72	
Heroism							-0.10	-1.41	
Deference							0.02	0.27	
Fairness							0.04	0.60	
Property							-0.05	-0.76	
	F(3, 446) = 15.70, *p* <0.001			F(9, 419) = 5.99, *p* <0.001			F(29, 366) = 2.71, *p* <0.001		

**p<0.05, **p<0.01, ***p<0.001*

Appendix Z: SEM Model Fit and Path Analyses

Model Fit Indices

Table 25: Model Fit Indices

	CFI	RMSEA	SRMR
SEM Model 1	0.99	0.03	0.03
SEM Model 2	0.98	0.04	0.03

*Chi-Square testing was not used as a fit index due to the suggestion that for large samples (over 400), they almost always result in significance (Kenny, 2020).

SEM Modelling: Direct and Indirect Effects Analyses

Table 26: Model 1, Direct and Indirect Analyses

Path	*β (standardised)*	SE	*p*
Direct effects			
Moral values → CDM	-0.13	0.85	0.053
CoBRAS → CDM	0.42	2.80	<0.001
Moral values → CoBRAS	-0.15	0.02	<0.01
Indirect effects			
Moral values → CoBRAS → CDM	-0.06	0.35	0.02

Table 27: Model 2, Direct and Indirect Analyses

Path	*β (standardised)*	SE	*p*
Direct effects			
Deference → CDM	0.13	0.37	0.05
Group → CDM	0.14	0.46	0.05
Family → CDM	-0.13	0.46	0.07
CoBRAS → CDM	0.38	2.76	<0.001
Deference → CoBRAS	0.34	0.01	<0.001
Family → CoBRAS	-0.06	0.01	0.32
Group → CoBRAS	0.21	0.01	<0.001
Indirect effects			
Deference → CoBRAS → CDM	0.13	0.18	<0.001
Family → CoBRAS → CDM	-0.02	0.15	0.33
Group → CoBRAS → CDM	0.08	0.18	<0.01

Appendix AA: Content Analyses Categories

1. *Risk*

Comments highlighted a focus assessing risk, risk management and safeguarding as a guide for their CDM. This included risks to the client and to others, and/or consideration of protective factors. References were also made to positive approaches to risk management or the need to seek additional risk-related information.

2. *Diagnosis*

Participants expressed a desire to clarify the client’s psychiatric diagnosis in order to guide their CDM. Some comments also suggested particular diagnoses for the client described and associated clinical decisions.

3. *Consent/ capacity*

Participants referenced the need to assess the client’s capacity or obtain consent before making clinical decisions.

4. *Guidelines/ the law*

Comments related to whether the decision was in line with standardised guidelines (NICE) and diagnostic criterion, and referenced the use of evidence-based interventions. Comments regarding the law referred to specific Acts, treatment orders or legal frameworks as a reference for CDM.

5. *Least restrictive/ best interest decisions*

Participant’s considered a guiding principle for CDM to be the use of least restrictive or best interest decisions. At times this included balancing the least restrictive practice with ensuring client safety.

6. *Further assessment, monitoring or follow-up*

Comments referred to a need to obtain more information or monitor the client in order to make a measured clinical decision. Comments included a desire to refer the client to another team or service for further assessment.

7. *Alcohol and drugs*

Participant's considered potential drug or alcohol use and how this would impact their CDM/ recommended treatment pathway.

8. *Client views/ collaboration*

Comments explicitly mentioned the need to centre the client's views in CDM and to provide collaborative, person-centred care. This also encompassed comments describing the importance of trust and the therapeutic relationship. Comments describing the inappropriateness of decisions which omit the client's views or appear coercive were also included.

9. *Alternative supports*

Participants suggested alternative supports, including from third sector organisations, social/ peer support networks, referrals to alternative services (including self-referrals) and alternative medication choices. Generally, participants suggested that the provision or signposting of alternative support would result in more effective CDM.

10. *Resource scarcity*

Comments pertained to the current strain on mental health services and associated resource scarcity. Participants tended to justify the decision being made on the basis of the current resource scarcity. This included references to long waiting lists, limited community support and reduced bed capacity.

11. *Contextual factors*

Comments referred to a need to explore social, cultural and contextual factors when making decisions, including but not limited to: an exploration of the client's history, support network, past trauma and potential organic causes of changes in behaviour. A number of comments also referred to impact of mental health stigma as a barrier to seeking support.

12. *Trauma-informed care*

These comments explicitly referenced the need to consider the distressing, traumatising and re-traumatising effects of MH services when making clinical decisions.

13. *Reference to issues of race/ culture/ racism in mental health*

Participants directly referenced issues of race, culture and racism within mental health systems. This included highlighting racial disparities and stereotypes present in mental health services, the historical mistreatment of Black and racialised clients in healthcare, professional bias and questioning the cross-cultural validity of specific assessment tools.

Three responses additionally suggested that race or ethnicity constituted a mental health ‘risk factor’ or ‘hard to reach community’. These responses were not included in this category (category 13) due to the notion that these discourses tend to problematise underrepresented groups rather than placing onus on or considering the accessibility and appropriateness of our services, models and frameworks (Islam et al., 2021; Lightbody, 2017).