

The feasibility of a new self-help intervention supporting mental health professionals with lived experience in reaching disclosure decisions.

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Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Table of Contents

Overview.....	5
Impact Statement.....	6
Acknowledgements.....	8
Part One: Literature Review.....	9
Abstract.....	10
Introduction.....	11
Method.....	16
Results.....	21
Discussion.....	47
References.....	52
Part Two: Empirical Paper.....	59
Abstract.....	60
Introduction.....	61
Method.....	67
Results.....	79
Discussion.....	102
References.....	113
Part Three: Critical Appraisal.....	118
Overview.....	119
Conclusions.....	130
References.....	132
Appendices.....	135
Appendix 1: Literature Review Quality Appraisal.....	136
Appendix 2: Confirmation of Ethical Approval.....	140
Appendix 3: Stakeholder Recruitment.....	142
Appendix 4: Email Invitation to Course Directors.....	148
Appendix 5: Information Sheet.....	150
Appendix 6: Consent Form and Screening Measure.....	155
Appendix 7: HOP-MHP - Baseline Survey.....	158
Appendix 8: HOP-MHP Self-Help Guide.....	159
Appendix 9: Peer Forum Instructions.....	166
Appendix 10: Participant Flow Through Study.....	169
Appendix 11: SAT Questionnaire.....	172
Appendix 12: Qualitative Interview Schedule.....	178
Appendix 13: Trainee Contribution to Project.....	181
Appendix 14: Statistical Analysis.....	183
Appendix 15: Qualitative Interview Extract.....	187

List of Tables

Part One:

Table 1.....	19
Table 2.....	23
Table 3.....	26
Table 4.....	36
Table 5.....	42

Part Two:

Table 1.....	76
Table 2.....	82
Table 3.....	99
Table 4.....	101

List of Figures

Part One:

Figure 1.....	20
---------------	----

Part Two:

Figure 1.....	85
Figure 2.....	87

Overview

This thesis set out to adapt and assess the feasibility of a new self-help intervention for mental health professionals with lived experience of having their own past or current mental health experiences, to help them reach their own decisions about disclosure. Part one is a literature review of research published over the past decade looking at self-help interventions for self-stigma, drawing on research in the field of acceptance and commitment therapy and personal stigma. Part two is an empirical paper based on a pilot RCT of the new Honest Open Proud-Mental Health Professionals (HOP-MHP) self-help intervention for mental health professionals with lived experience, a joint project carried out by two trainee clinical psychologists. The paper outlines the development of the intervention and assesses the feasibility and preliminary outcomes of HOP-MHP with regards to stigma stress, self-stigma and mental wellbeing. Part three is a critical appraisal of the empirical paper, presenting reflections on the research process. It also expands on the discussion of the empirical paper, further considering the limitations and future directions of the research.

Impact Statement

This study has addressed a number of gaps in the literature and research. The literature review identified a lack of literature relating to self-help interventions for reducing self-stigma. Whilst the majority of currently available interventions are group or peer interventions (Mittal, Sullivan, Chekuri, Allee & Corrigan, 2012; Yanos, Lucksted, Drapalski, Roe & Lysaker, 2015) it is important to acknowledge the implicit disclosure involved in such interventions (Herman, 1993). The literature review highlights the potential impact of further research into this area, including the development of self-help interventions for reducing self-stigma. This would enable individuals who are reluctant to disclose (Corrigan, Watson & Bar, 2006), and those who otherwise would avoid or reject individual or group interventions to access help without the fear of further discrimination or embarrassment (Lewis et al., 2002). This would also have potential economic benefits as self-help interventions allow wider reach and the ability for participants to access materials freely at a time that suits them. There is evidence that self-help interventions produce significantly greater outcomes when compared to no treatment and also enable better use of professionals' time (Lewis et al., 2002).

The empirical paper is of clinical value in addressing a gap in provision of support for mental health professionals with their own lived experience of mental health difficulties. The newly adapted HOP-MHP self-help intervention and research protocol was found to be feasible, indicating that further research to assess the effectiveness of the intervention is warranted. Preliminary outcome data indicated a small negative effect on anxiety, but no effect on the other outcomes under consideration (stigma stress appraisal, self-stigma and depression). However, analysis of data from a larger sample is needed to allow a more thorough assessment

of the efficacy of the intervention. The empirical paper makes recommendations, which may be important to take into consideration in future research to improve the feasibility and acceptability of the HOP-MHP intervention and research protocol.

If proven effective, it is recommended to assess the economic value of the HOP-MHP intervention. As a self-help intervention, it may enable better use of professionals' time who would otherwise be facilitating a face-to-face intervention and would also be available at lower costs (Lewis et al., 2002). Its potential economic value in improving wellbeing in mental health professionals and potentially encouraging earlier access to support and treatment, due to reduced stigma and fear of discrimination or embarrassment when compared to more formal interventions (Lewis et al., 2002), and the associated benefits to the workforce should be considered in further evaluations.

If effective, HOP-MHP may be easily implemented in the NHS and may be appropriate for a broad range of mental health professions and could potentially be extended to other health professionals. Not only could this help support individuals reach their own personal decisions about disclosure and help reduce stigma stress, but it also has the potential to make a valuable contribution to reducing mental health stigma within the (mental) health professions and more widely.

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Part 1: Literature Review

Self-help interventions to reduce self-stigma in people with mental health problems: A systematic literature review

Abstract

Aims: People with mental health problems often experience self-stigma, whereby they internalise stereotypic or stigmatising views of others. Self-stigma is known to have negative effects on self-esteem and self-efficacy and a continuing impact on psychological wellbeing. However, we have only seen limited self-help interventions designed to reduce self-stigma. This review aimed to provide a critical review and give an overview of the literature in this area.

Method: A systematic review of five electronic databases (PsycINFO, MEDLINE, CINAHL Plus, Scopus and EMBASE) was carried out to identify articles on self-help interventions for self-stigma related to mental health problems, published between January 2007 and July 2017.

Results: Seven articles were identified and evaluated using a combination of quality appraisal and narrative synthesis.

Keywords: self-stigma, internalised-stigma, self-help, mental health, interventions

Introduction

The term stigma is often used to describe the process of discrimination, or unfair treatment of others and is sometimes termed “external” or “enacted” stigma (Gray, 2002). Self-stigma, also referred to as “felt” or “internalised” stigma, is used to refer to the internalisation of these discriminating beliefs, and associated feelings of shame.

Self-stigma has been presented as a three-level model: stereotype agreement, self-concurrence, and self-esteem decrement (Corrigan et al., 2006). Stereotype agreement is when an individual endorses the stereotypes that are perceived to be commonly accepted by the public. Self-concurrence makes the process of stereotype agreement harmful as this is when the individual believes that these stereotypes apply to themselves. This then results in self-esteem decrement, due to their concurrence with the negative internalised belief. For example, an individual may have stereotype agreement and agree with the public that all people with mental health problems are weak and then have self-concurrence by believing “Yes, and as I have mental health problems I am weak”, which then leads to reduced self-esteem.

Self-stigma is described by Luoma and colleagues (Luoma, Kohlenberg, Hayes & Fletcher, 2012) as a cluster of shame, negative thoughts and fear experiences by individuals who self-identify with a stigmatised group, which negates their ability to achieve valued life goals. Self-stigma has also been described as a type of identity transformation that can lead to the loss of previously held (positive) beliefs about the self, which results in negative consequences for the person such as diminished self-esteem and self-efficacy (Corrigan & Watson, 2002). The negative effects of self-stigma on self-esteem and self-efficacy, which can endure even after

successful treatment of psychological symptoms, continue to negatively affect wellbeing (Link, Struening, Rahav & Phelan, 1997).

Personal stigma is described by Gerlinger et al. (2013) as consisting of three factors: self-stigma, perceived stigma and experienced stigma. Self-stigma is a term used to describe the process of internalisation and adoption of stereotypic or stigmatising views by the individual being stigmatised (Yanos, Roe, Markus & Lysaker, 2008). Perceived stigma refers to the individual's beliefs about the attitudes of the general population towards their condition and towards themselves as members of a potentially stigmatised group (LeBel, 2008). Finally, experienced stigma is described as the discrimination or restrictions actually experienced by the individual (Gerlinger et al., 2013).

The "Why try" effect, outlined by Corrigan, Larson and Rüsç (2009), describes self-esteem and self-efficacy as mediators of self-stigma, which impacts on goal-related behaviour. People with mental health problems living in cultures or societies where negative stereotypes about mental health problems prevail are likely to anticipate and internalize attitudes reflecting devaluation and discrimination. The "Why try" effect describes how individuals agreeing with and applying stigma to themselves may feel unworthy and may feel unable to pursue their life goals. The impact on goal attainment is likely also to impact on treatment engagement and outcomes, with individual's applying the "Why try" to services and treatment options. Empowerment is inversely correlated with self-esteem decrement due to self-stigma and social withdrawal, and is linked to recovery from mental health problems (Corrigan et al., 2009). Therefore, increased levels of self-stigma will also reduce an individual's chances of recovery.

The UK Government's Mental Health Strategy for the period 2011-2015 identified one of its six key objectives as ensuring that fewer people experience stigma and discrimination due to their mental health problems (DoH, 2011). The World Health Organisation's Mental Health Action Plan 2013–2020 dictates that individuals affected by mental health problems should be able to live their lives fully, free from stigmatisation and discrimination both in the workplace and within society (WHO, 2013).

A narrative synthesis was conducted by Gronholm, Henderson, Deb & Thornicroft (2017) of systematic reviews on interventions targeting public discrimination and stigma, published since 2012. None of the interventions identified targeted self-stigma. An earlier meta-analysis into the effectiveness of interventions targeting stigma was conducted by Griffiths, Carron-Arthur, Parsons and Reid (2014). They identified three studies targeting self- or internalised-stigma, all of which involved group interventions. All three trials compared the effect of an intervention with a control condition. Two of the trials included participants with a range of mental health problems (Luoma et al., 2012; Yanos, Roe, West, Smith & Lysaker, 2012), while the third focused on schizophrenia (Fung, Tsang & Cheung, 2011). They all incorporated elements of a psychotherapy intervention (cognitive behaviour therapy, cognitive restructuring, or acceptance and commitment therapy). The pooled mean effect size across these studies was not statistically significant (0.16; 95% CI: -0.41 to 0.73, $p=0.57$) indicating a need to develop more effective interventions in this area.

A review of self-stigma reduction strategies conducted by Mittal and colleagues (2012) identified fourteen relevant articles, with eight reporting a significant improvement in self-stigma outcomes. Of the interventions reported,

eleven were group interventions and three were individual interventions. The authors state that two prominent approaches emerged for reducing self-stigma: interventions aiming to change stigmatising beliefs and attitudes; and interventions aimed at enhancing coping skills, through improved self-esteem, empowerment and help-seeking behaviour.

A more recent review of interventions specifically targeting self-stigma was conducted by Yanos and colleagues (2015) and identified 6 interventions, all of which were group based, with one combining group sessions with individual sessions. These groups were either led by a professional or a peer, with five of the interventions using psychoeducation as the primary mechanism and one using discussion of the pros and cons of disclosure. All of the interventions had a significant impact.

As highlighted by the reviews outlined above, there are a number of interventions available that address self-stigma. However, the majority are group interventions that rely on peer support and mutual aid, which may not be appealing or appropriate to everyone, not least as attending a group involves disclosing one's stigmatised identity. Furthermore, there is evidence that disclosure can result in discrimination and at times concealment can serve a protective function (Ragins et al., 2007). Individualised self-help interventions to address self-stigma may provide an accessible intervention for those unable or disinclined to attend group interventions.

There is evidence that peer support and services applying the peer and helper principle are successful interventions for empowering individuals to pursue their life goals and engage in services (Corrigan et al., 2006). However, disclosing one's

mental health problems is presumed when engaging in these services (Herman, 1993).

In an attempt to avoid self-stigma, many individuals with mental health problems will choose to keep their experiences, including treatment, secret, and therefore avoid disclosure (Corrigan et al, 2006). Individuals need to consider the costs, benefits and implications of disclosing given their own personal goals. Disclosure decisions can be broken down into four levels, requiring an individual to balance their desire to avoid self-stigma versus perceived benefits of “coming out”: social avoidance, selective disclosure, indiscriminant disclosure and broadcasting (Herman, 1993).

A review conducted in 2003 concluded that self-help interventions result in effect sizes considered to be roughly equivalent to those achieved by psychotherapy studies (McKendree-Smith, Floyd & Scogin, 2003). The development of more self-help interventions has been recommended several times (Hollon et al., 2002). A more recent review (Lewis, Pearce & Bisson, 2012) found a significant effect size in favour of self-help versus waiting list conditions (Cohen’s $d= 0.84$). However, when compared with therapist-administered interventions they found a significant difference in favour of therapist guided treatment with a small to moderate effect size (Cohen’s $d= 0.34$).

Benefits of self-help interventions include economic benefits of enabling a better use of a professional’s time and being available at lower cost. They are also considered more acceptable to many due to reduced stigma or embarrassment when compared to meeting for formal therapy, enabling people to access help they would otherwise reject (Lewis et al., 2002). Self-help materials also enable individuals to take responsibility for self-management, working through the resources at a time and

place more convenient for them and fitting it in more easily around work and other commitments. This in turn can empower the individual, addressing the power imbalance between service users and professionals, and lead to increased sense of control over one's difficulties. Research evaluating computer-based treatments of OCD and anxiety conditions reported that the most important reasons for valuing self-help over therapist-aided treatment was reduced stigma and increased confidentiality (Shaw et al, 1999). Benefits of web-based interventions also include 24/7 availability, the ability to access the materials anonymously, being cost effective (Gerhards et al., 2010; Mihalopoulos et al., 2005) and being able to be distributed more widely (Napolitano & Marcus, 2002; Muñoz, 2010).

Aims and Objectives

The purpose of this review is to give an overview of psychological self-help interventions that have been developed and evaluated for self-stigma related to mental health problems. Given the identified gap in the literature of self-help interventions for self-stigma, despite increased evidence for self-help interventions in general (Lewis et al., 2002), a systematic review and narrative synthesis will help to identify the format, outcomes and impact of current interventions to help inform future research. The review seeks to address the following question: What evidence is there for self-help interventions addressing self-stigma associated with mental health problems?

Methods

Search Strategy

A systematic literature search was conducted using PsycINFO, MEDLINE, CINAHL Plus, Scopus and EMBASE. To ensure the findings were relevant to the state of current research, the search was restricted to only include articles published

in the previous 10 years: articles published in English between January 2007 and July 2017 were included in the search.

Searches were conducted focusing on three key areas: mental health, self-help interventions, and self-stigma (See Table 1). These terms and their synonyms were combined using the Boolean terms “OR” and “AND” to search for articles with keywords that included both self-help-related terms and self-stigma-related terms and mental-health-related terms. The terms “self-stigma” and “internalised stigma” are the most common terms used to describe self-stigma. However, some authors use the term “personal stigma”, of which self-stigma is one component (Gerlinger et al., 2013) and so this term was also included. The terms “schizophrenia”, “depression” and “anxiety” were included in the mental-health-related search terms as these are commonly found in the mental health disclosure literature..

The database searches identified 73 articles. Article titles were read to determine which met inclusion criteria. For cases in which this was ambiguous, abstracts and where necessary, entire articles were read. Title and abstract screening reduced the number of studies to 15. Initial readings further reduced the number of studies to eight. Full copies of these articles were retrieved for rating.

Articles were second rated by an independent researcher to assess whether the final selection met the inclusion and exclusion criteria. If there was disagreement between the two researchers then the article was rated by a third researcher (Dr Katrina Scior), who acted as an arbiter to help reach a final agreement. Of the 8 articles, only three met the inclusion criteria.

Searching the reference lists of excluded meta-analyses and systematic reviews identified four further articles. As this was a high proportion of the total articles, the keywords and titles of these articles were reviewed to identify search

terms that may have been overlooked. No additional common term was identified. One article used the keyword “depression-related stigma” and so scoping searches were conducted to identify whether this would be a helpful search term to add to this review. However, this identified no further articles. A flowchart illustrating the process of article selection is presented in Figure 1. The results have been presented as a narrative synthesis to identify and assess the implantation and effects of the interventions in the identified articles (Popay et al., 2006).

Inclusion and Exclusion Criteria

Articles were included if they:

- related to self-help interventions for self-stigma related to mental health problems;
- were empirically based, using either quantitative or qualitative methodologies;
- were written in English; and
- were published within the last 10 years.

Articles were excluded if they:

- focused primarily on external stigma rather than self-stigma;
- involved therapeutic contact with a mental health professional (face-to-face, telephone or email contact);
- relied on mutual aid (e.g. peer support group);
- focused on attitudes towards help seeking (rather than self-stigma);
- were meta-analyses or systematic reviews;
- reported the protocol or study design rather than outcomes of an intervention.

Table 1

Literature Review Search Terms

Mental Health	Self-help Intervention	Self-Stigma
mental health	self-help intervention	self-stigma*
mental illness	self-help treatment	internal* stigma*
mental health problem	guided self-help	self-discrimination
mental disorder	computerised treatment	personal* stigma*
psych* illness	online therapy	
psych* disorder	online treatment	
psych* diagnosis	online CBT	
psych* problem	self-help guide	
distress	self-help manual	
schizophrenia	self-help workbook	
depression		
anxiety		

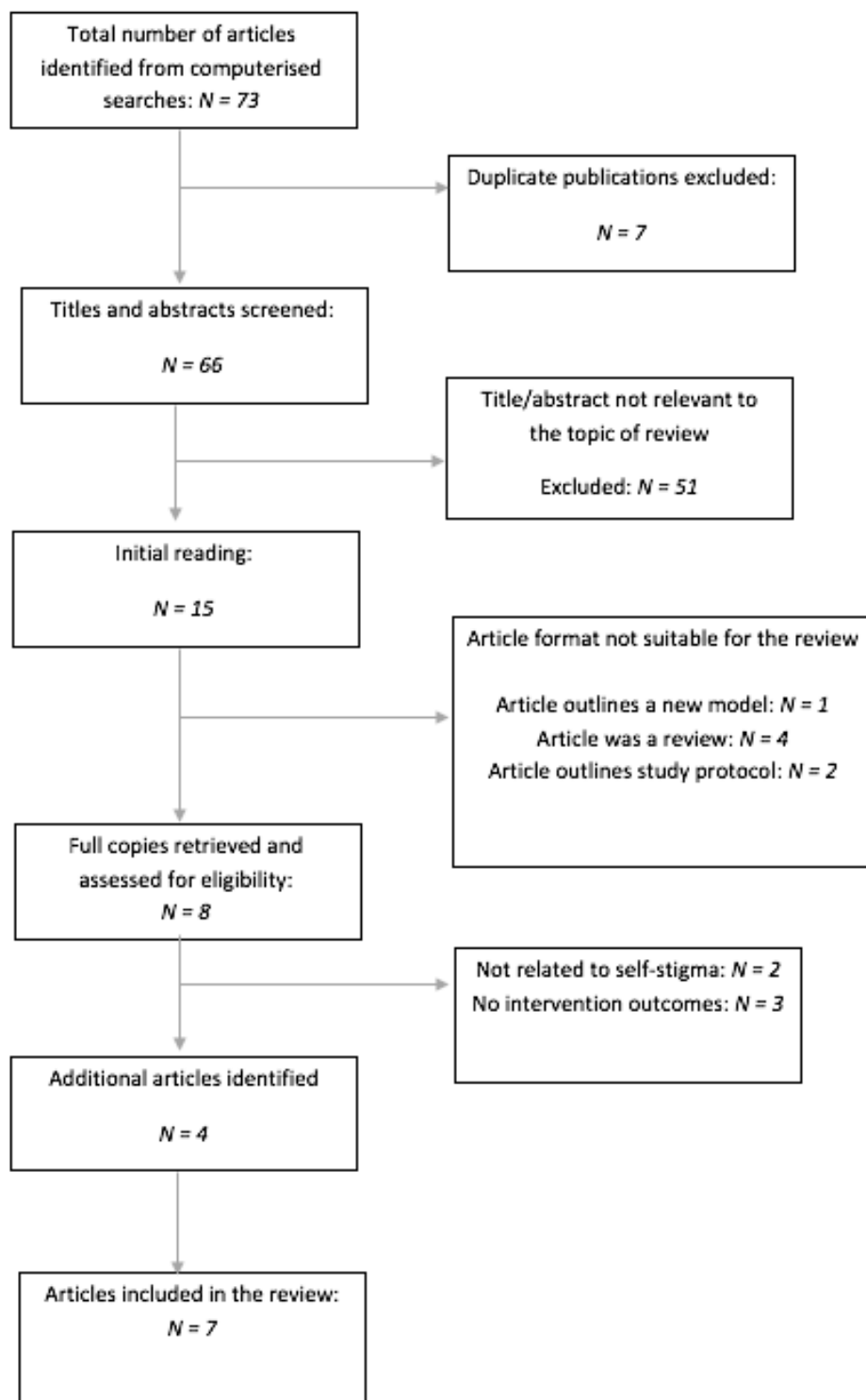


Figure 1. Flowchart illustrating the process of study selection

Quality Assessment

Using the critical appraisal tool developed by Hawker and colleagues (Hawker, Payne, Kerr, Hardey, & Powell, 2002) (Appendix 1), the quality of each article was rated across the specified criteria. This tool enables raters to score articles on a scale of 1 (very poor) to 4 (good) across nine different aspects of the methodology and quality of the article. The tool includes clear guidelines on how to score these different aspects. The sub-scores are summed to give an overall score out of 36: 9 indicates very poor and 36 indicates very good quality, with 18 indicating poor and 27 indicating fair quality. Hawker et al. (2002) reported the tool to have good inter-rater reliability.

Results

No studies were identified that directly answered the research question. This indicates a clear gap in the literature. However, articles were identified which investigated a concept which closely overlaps with self-stigma. All seven publications were quantitative in methodology. These included three articles investigating Acceptance and Commitment Therapy (ACT) in relation to self-acceptance and psychological flexibility and four articles relating to personal stigma, which is a concept that incorporates perceived, experienced and self-stigma (Gerlinger et al., 2013).

ACT is described as a psychological intervention which has been designed to decrease avoidance and increase psychological flexibility in the presence of different private experiences such as self-stigmatising thoughts (Hayes, Strosahl & Wilson, 1999). The articles on ACT self-help interventions were included because on reviewing relevant literature, Luoma and Platt (2015) concluded there is evidence that ACT is effective in reducing self-stigma and shame. They suggest this occurs

through reducing the impact of self-disparaging thoughts, decreasing avoidance, and increasing psychological flexibility. Similarly, Masuda et al. (2012) reviewed the ACT literature relating to self-stigma and prejudice, and concluded that there is preliminary evidence for interventions based on a psychological flexibility model in reducing self-stigma. Therefore, it is appropriate to include the identified studies investigating self-help ACT interventions in this literature review as they can inform our understanding of self-help interventions for self-stigma.

Quality Assessment

The quality appraisal ratings for the studies included in this review are presented in Table 2. A second researcher co-rated all seven articles. Interrater reliability between both raters was high (intraclass correlation = 0.998, $p < 0.01$). Overall, the studies were of good quality. No study scored below 31 of 36 possible points, and no studies were excluded on the basis of methodology.

Scores for item 6 (ethics & bias) showed great variability across the studies (Range 2-4). Very few covered all of the key areas as outlined in the Hawker et al. (2002) quality appraisal tool: addressing ethical issues; necessary ethical approval gained; relationship between researchers and participants adequately considered; confidentiality, sensitivity and consent are addressed; researcher bias addressed. Only two of the seven studies achieved a score of 4 (good): Gulliver et al. (2012) and Kiropoulos, Griffiths, & Blashki (2011) as they covered the majority of these areas in a clear and informative way.

All studies presented a clear summary in the abstract and title, achieving a rating of 4 (good) on item 1. All studies also presented the method and data in a clear and coherent manner, accompanied by tables and graphs and were rated as 4 on item 3. All of the studies except one were Randomised Control Trials (RCTs).

Table 2

Quality Appraisal of Studies Included in Review

Author(s) & date	Methodological items (0-4)									Overall score (9-36)
	Abstract & titles	Intro & aims	Method & data	Sampling	Data analysis	Ethics & bias	Findings & results	Transferability / generalisability	Implications & usefulness	
Farrer et al. (2012)	4	4	4	2	4	3	4	3	3	31
Gulliver et al. (2012)	4	4	4	4	3	4	4	4	4	35
Jeffcoat & Hayes (2012)	4	3	4	3	4	2	4	4	4	32
Kelson et al. (2017)	4	4	4	4	3	3	3	4	4	33
Kiropoulos et al. (2011)	4	3	4	4	4	4	4	4	4	35
Levin et al. (2017)	4	4	4	4	4	3	4	3	4	34
Taylor-Rodgers & Batterham (2014)	4	4	4	4	4	3	4	4	4	35

Outcomes of the interventions

Of the seven studies, all but one used a rigorous, longitudinal design through conducting an RCT, with the remaining study (Kelson, Lam, Keep & Campbell, 2017) planning to use the findings to inform a future RCT. A summary of the outcomes of the interventions for all of the studies is available in Table 3.

All three studies investigating ACT interventions measured psychological flexibility using the Acceptance and Action Questionnaire (AAQ-II: Bond et al, 2011). Outcomes for psychological flexibility were mixed. Only one study (Kelson et al., 2017) found a significant effect on the AAQ-II at follow-up (Cohen's $d= 0.54$). Whereas, Jeffcoat and Hayes (2012) found no effect for treatment condition or time, but they did find a significant and medium effect for the interaction of condition and time (Cohen's $d= 0.69$), and Levin and colleagues (Levin, Haeger, Pierce & Twohig, 2017) found no significant time by condition interactions on the AAQ-II.

All four studies investigating personal stigma measured depression stigma using the Depression Stigma Scale (DSS: Griffiths, Christensen, Jorm, Evans & Groves, 2004). For two of the studies (Farrer, Christensen, Griffiths & Mackinnon, 2012; Kiropoulos et al., 2011) this was the only measure of personal stigma. Two studies (Gulliver et al., 2012; Taylor-Rodgers and Batterham, 2014) also included a measure of anxiety related personal stigma, using the Generalised Anxiety Stigma Scale (GASS) (Griffiths, Batterham, Barney & Parsons, 2011), with the latter also measuring suicide personal stigma using the Stigma of Suicide Scale (SOSS) (Batterham, Calear & Christensen, 2013).

All four studies found an improvement in personal stigma for depression. One study (Farrer et al., 2012) found a large effect size for post-intervention in the web-only condition when compared with the control condition (Cohen's $d= 0.94$)

and when compared with the tracking only condition (Cohen's $d=0.96$). However, no significant effect size was found for the web with tracking condition when compared with either control or tracking only conditions (Cohen's $d= 0.17$; Cohen's $d= 0.24$). One other study (Kiropoulos et al., 2011) also found a large effect size for the DSS in the intervention condition (Cohen's $d= 0.83$) and no effect for the control condition. One study (Taylor-Rodgers & Batterham, 2014) found moderate effect from pre- to post-test, with decreased depression stigma (Cohen's $d= 0.53$) for the experimental group. However, they found no significant reduction in either anxiety or suicide related personal stigma. In contrast, Gulliver et al. (2012), only found a significant small effect size (Hedge's $g = 0.25$) for the Mental health literacy and destigmatisation condition versus control at post-intervention. However, this was not maintained at 3-month follow-up. For anxiety related personal stigma they found a significant moderate effect size ($g= 0.50$, 95% CI 0.41 - 1.41) at 3-month follow-up only.

Table 3

Summary of Articles Included in Review

Authors	Sample & Method	Population	Relevant Concept and it's measurement	Overall appraisal (/36)	Reported Outcomes
Farrer et al. (2012) Australia	N= 155 Recruited from counselling centres across Australia, via Lifeline (24-hour telephone counselling service) RCT, Longitudinal Web based CBT for depression With and without telephone tracking	Callers to Lifeline (age not reported)	Personal stigma (Depression) <i>Primary Outcome</i> Depression Stigma Scale (DSS)	31	The interaction of condition and occasion was non-significant for stigma ($F_{8,96.5} = 1.73, P= 0.10$) At 6 months stigma was significantly reduced in Web-only condition (contrast estimate = -3.29, 95% CI -5.97 to -0.61, $P= 0.02$), and Web with tracking condition (contrast estimate = -2.88, 95% CI -5.71 to -0.05, $P= 0.046$) relative to control condition. At post-intervention, effect sizes were 0.94 (95% CI 0.38–1.50) for the Web-only condition and 0.17(95% CI -0.42 to 0.77) for the Web with tracking condition, compared with the control condition. Compared with tracking only, effect sizes were 0.96 (95% CI 0.41–1.50) for the Web-only condition and 0.24 (95% CI -0.34 to 0.82) for the Web with tracking condition. At 12 months stigma was positively correlated with depression symptoms ($r= 0.29, P= 0.03$)

Table 3 (continued)

Authors	Sample & Method	Population	Relevant Concept and it's measurement	Overall appraisal (/36)	Reported Outcomes
Gulliver et al. (2012) Australia	N= 59 Emails distributed via AIS (Australian Institute of Sport) and direct recruitment with elite sporting clubs RCT, Longitudinal Mental health literacy / Destigmatisation webpages	Elite athletes (18-48 years-old)	Personal Stigma (Depression and Anxiety) <i>Secondary Outcomes</i> DSS Generalized Anxiety Stigma Scale (GASS)	35	Overall interaction between condition and occasion for depression personal stigma and anxiety personal stigma was significant ($F_{6,62.22}=3.20, P=0.008$; $F_{6,65.37}=2.27, P=0.047$). Depression Stigma: Depression stigma – statistically significant interaction between condition and time point. Pre- to post-intervention health literacy / destigmatisation showed greatest decrease Between group effect sizes at post-intervention relative to control: (1) ($g=0.25, 95\% CI -0.57$ to 1.06); (2) ($g=-0.15, 95\% CI -0.94$ to 0.65); (3) ($g=0.26, 95\% CI -0.51$ to 1.04) Between group effect sizes at 3-month follow-up relative to control: (1) ($g=0.10, 95\% CI -0.80$ to 0.99); (2) ($g=-0.09, 95\% CI -0.99$ to 0.81); (3) ($g=-0.32, 95\% CI -1.15$ to 0.51)

Depression Stigma:

Effect of condition (1) resulting in greater decrease in depression stigma in comparison with all other interventions was evident at post-intervention but lost at 3-month follow-up

Anxiety:

Between group effect sizes (Hedges' g) at post-intervention relative to control:

(1) ($g = 0.04$, 95% CI -0.77 to 0.85); (2) ($g = -0.54$, 95% CI -1.35 to 0.26); (3) ($g = -0.10$, 95% CI -0.87 to 0.67)

Between group effect sizes at 3-month follow-up relative to control:

(1) ($g = 0.50$, 95% CI -0.41 to 1.41); (2) ($g = 0.12$, 95% CI -1.02 to 0.78); (3) ($g = 0.04$, 95% CI -0.78 to 0.87)

Anxiety Stigma:

Anxiety stigma- statistically significant interaction between condition and measurement occasion. At 3-month follow-up, reduction in health literacy / destigmatisation condition was significant compared with all conditions

Table 3 (continued)

Authors	Sample & Method	Population	Relevant Concept and it's measurement	Overall appraisal (/36)	Reported Outcomes
Jeffcoat & Hayes (2012) USA	N= 236 (91% female) Invitational emails and flyers by WCSD Wellness Office, followed by emails from the research team. RCT, Longitudinal ACT self-help workbook	K-12 school personnel, 30-60 years-old	Psychological flexibility and acceptance. <i>Process Measure</i> Acceptance and Action Questionnaire (AAQ-II)	32	There was no effect for treatment condition or time, but a significant and medium effect for the interaction of condition and time ($F_{1,197.33} = 23.22, p < .001$, effect size = .69). There was a significant and large improvement for participants who were given the workbook (slope estimate = 3.49, SE = .47, $t(201.59) = 7.42, p < .001$, effect size = 1.27) At follow up general mental health, depression, and anxiety outcomes were related to the manner in which participants used the workbook and to post levels of psychological flexibility. Mental health outcomes were related to psychological flexibility at post intervention. Higher reported use of the workbook related to better outcomes.

Table 3 (continued)

Authors	Sample & Method	Population	Relevant Concept and it's measurement	Overall appraisal (/36)	Reported Outcomes
Kelson et al. (2017) Australia	N= 28 Advertising on university bulletin boards and ReachOut.com Professionals e-newsletter Brief, uncontrolled research design. Single group, repeated measures. Online ACT "Fearless"	Australian adults, 18-25 years-old	Psychological flexibility and acceptance. <i>Primary Outcome</i> (AAQ-II)	33	Significant main effect on all psychological measures including AAQ-II. AAQ-II ($F(2, 78) = 6.17, p < .05$). Small within-group effect size on AAQ-II at follow up (Cohen's $d = 0.54$) Pairwise comparisons with Bonferroni adjustments revealed significant improvement by the 2-week follow-up (GAD-7, DASS-A, DASS-D, and AAQ-II) when compared with pre-test (all $p < .05$). However, no significant comparisons were found for stress (DASS-S). From pre-test, moderate within-group Cohen's d effect sizes were found on the GAD-7 at both post-test and follow-up, whereas small within-group effect sizes were found on the DASS-A, DASS-D, and AAQ-II at follow-up. Significant improvements were found on all mental health measures from pre-test to follow-up, except for stress. GAD-7 ($F(2, 78) = 11.04, p < .001$); DASS-21 depression subscale (DASS-D; $F(2, 78) = 4.59, p <$

.05); DASS-21 anxiety subscale (DASS-A; $F(2, 78) = 4.21, p < .05$); DASS-21 stress subscale (DASS-S; $F(2, 78) = 3.65, p < .05$);

Table 3 (continued)

Authors	Sample & Method	Population	Relevant Concept and it's measurement	Overall appraisal (/36)	Reported Outcomes
Kiropoulos et al. (2011) Australia	N= 202 Advertisements RCT, Longitudinal Website for Depression	Greek-born and Italian-born immigrants, Mean age 65.4 yeas	Personal stigma (Depression) <i>Primary Outcome</i> DSS	35	Intervention was associated with lower post-intervention ($F = 38.75, P < .001$) and follow-up ($F = 11.08, P = .001$) personal stigma scores than the control group. However, a further ANCOVA of the follow-up personal stigma measures controlling for post-intervention personal stigma levels indicated that there was a trend toward a small reduction in the effect at follow-up ($F = 3.65, P < .06$). The corresponding effect sizes for personal stigma were 0.83 for the intervention and 0.06 for control.

Table 3 (continued)

Authors	Sample & Method	Population	Relevant Concept and it's measurement	Overall appraisal (/36)	Reported Outcomes
Levin et al. (2017) USA	N= 79 (66% female) Recruited via online research posting on the Sona research platform, brief in-class presentations and flyers on campus RCT, Longitudinal ACT self-help website	College students, aged 18 years and older.	Psychological flexibility. <i>Primary Outcome</i> AAQ-II	34	There were no significant Time x Condition interactions on the AAQ-II ($p > .10$). Relative to waitlist, participants receiving ACT improved on overall distress, general anxiety, social anxiety, depression, academic concerns, and positive mental health. No statistically significant difference in scores on AAQ-II. Psychological flexibility as potential mediating factor.

Table 3 (continued)

Authors	Sample & Method	Population	Relevant Concept and it's measurement	Overall appraisal (/36)	Reported Outcomes
Taylor-Rodgers & Batterham (2014) Australia	N= 67 Recruited via posters on campus and posts on social networking site Facebook relevant to the university RCT, Longitudinal Brief online psychoeducation	Young adults aged 18-25 years	Depression (DSS), anxiety (GASS) and suicide stigma (SOSS)	35	Significant between-group differences were found pre- to post-test: decreased depression stigma ($d= 0.53$) for the experimental group. Differences between-groups were non-significant for anxiety and suicide stigma. Significant between-group differences were also found for the pre- to post-test, with increased anxiety literacy (Cohen's $d= 0.65$), increased help seeking attitudes ($d= 0.58$) and intentions ($d= 0.53$) for the experimental group

Types of intervention

Of the seven studies, six involved web-based interventions (Farrer et al., 2012; Gulliver et al., 2012; Kiropoulos et al., 2011; Kelson et al., 2017; Levin et al., 2017; Taylor-Rodgers & Batterham, 2014). The one non-web-based intervention was investigating an ACT self-help workbook, with hardcopies delivered to participants' workplaces (Jeffcoat & Hayes, 2012). Although the intervention was not delivered online, participants were encouraged to complete exercises and quizzes on the content of the workbook online, with feedback provided by the research team via email.

Although the majority of interventions were web-based, there was a large amount of variability in the format of these interventions. Two of the web-based studies investigated interventions based on ACT, both of which had modules covering key domains of ACT including Avoidance, Defusion, Mindfulness, Acceptance, Values, and Action. However, one included nine of these web-based modules, tested over a two-week period (Kelson et al., 2017), while the other included six web-based modules, with approximately 24 days to complete as participants were encouraged to wait four days before moving onto the next module, allowing time to complete the downloadable between module homework assignments (Levin et al., 2017).

The remaining four studies all focused on psychoeducation based interventions. Two of these studies focused on depression, with one incorporating this with case studies (Kiropoulos et al., 2011), and one incorporating this with CBT for depression and providing a printed manual with week by week instructions over a 6-week period (Farrer et al., 2012). In contrast, Taylor-Rodgers & Batterham (2014), provided psychoeducation on three different topics (depression, anxiety and suicide)

over a 3-week period. One study (Gulliver et al., 2012) compared a psychoeducation condition completed over 2 weeks, focused on mental health literacy and destigmatisation with two other interventions as well as a control condition: a “feedback” condition where participants completed interactive quizzes to receive feedback about their symptoms; and a “Minimal content” condition which was a website providing a list of help-seeking resources.

The hourly input required to complete the intervention was only clearly stated in one of these six studies, with Kelson et al. (2017) clearly stating that the maximum completion time would be 4.5 hours (270 minutes). The other five did not provide data on estimated completion time, but Levin et al. (2017) reported in the results that the average completion time was 73.58 minutes.

In contrast to 5 of the 6 web-based studies above, Kiropoulos et al. (2011) gave participants an hour to explore the MIDonline webpages freely, after receiving a ten-minute introduction given by an interviewer to explain the purpose of the website and how to navigate the pages. Table 4 outlines the different interventions used across the seven studies.

Table 4

Interventions tested in the studies

Authors (Date) Country	Intervention	Format / Structure	Content	Other materials
Farrer et al. (2012) Australia	Web-based CBT for depression (with and without telephone tracking)	Web-based psychoeducation combined with web-based CBT. Week 1 = psychoeducation provided by <i>BluePages</i> , Week 2-6 = Web-based CBT provided by <i>MoodGYM</i> Hours needed for completion not given.	<i>BluePages</i> and <i>MoodGYM</i> (Christensen, Griffiths & Jorm, 2004)	Printed manual with week-by-week instructions for accessing the web programs
Gulliver et al. (2012) Australia	Mental health literacy / Destigmatisation condition; Feedback condition; Minimal content condition (list of help-seeking resources)	34 brief sequential webpages (Week 1 = 19 pages week 2 = 15 pages); Interactive quizzes (2 interactive quizzes, providing tailored feedback); Resources web pages (Week 1 = 3 pages, week 2 = 3 pages) Content was spaced evenly across the two weeks. Hours needed for completion not given.	Psychoeducation: week 1 = depression, week 2 = anxiety; Week 1 = depression, week 2 = anxiety; Week 1 = depression, week 2 = anxiety	n/a

Table 4 (continued)

Authors (Date) Country	Intervention	Format / Structure	Content	Other materials
Jeffcoat & Hayes (2012) USA	ACT self-help workbook	Workbook (hardcopies delivered to their workplaces, Participants were given 8 weeks to read the workbook) Hours needed for completion not given.	<i>Get out of your mind & into your life</i> (Hayes & Smith, 2005)	Exercises and quizzes on the content of the workbook completed online, with email feedback
Kelson et al. (2017) Australia	Web-based ACT "Fearless" (The program was written so that modules are undertaken in a progressive linear sequence)	Web-based eMental Health tool 9 modules (Measure, Create, Recruit, Ground, Defuse, Scan, Discover, Move, Share). Maximum completion time of 4.5 hours (5 to 30 minutes per module) Completed at participants' own pace over a 2- week period	Anxiety mental health information and ACT-based exercises	n/a

Table 4 (continued)

Authors (Date) Country	Intervention	Format / Structure	Content	Other materials
Kiropoulos et al. (2011) Australia	Web-based psychoeducation for Depression <i>MIDonline</i> (Information was available in Greek, Italian or English. Sat together with interviewer.)	Website (10-minute introduction to the site and then 1 hour to explore the read the online material)	Psychoeducation and case studies about depression	Introduction given by interviewer to explain purpose of website and how to navigate the website
Levin et al. (2017) USA	ACT self-help website, transdiagnostic intervention (The program was hosted through Qualtrics) Multimedia (text, images, audio, videos) and interactive (worksheets, assessments, pop up features)	Website (Exercises, metaphors and techniques. 6 sessions in specific sequence (Avoidance, Defusion, Mindfulness, Acceptance, Values, Action). Completed over a period of 4 weeks, with participants encouraged to wait 4 days before moving on the next session.	Adapted from empirically validated ACT and self-help protocols	Brief therapeutic homework assignments to complete after each session. Download links for multimedia or worksheets provided via email.

Table 4 (continued)

Authors (Date) Country	Intervention	Format / Structure	Content	Other materials
Taylor- Rodgers & Batterham (2014) Australia	Brief online psychoeducation Websites for synthesis included <i>BluePages</i> , <i>Youth Beyondblue</i> and the Black Dog Institute.	Online (3 weeks - depression, anxiety, suicide). Vignette, description & symptoms, challenging stigma, treatment & help options. Hours needed for completion not given.	Information synthesised from a range of mental health related websites	Optional multiple- choice questions

Acceptability and Usability

Most of the studies addressed issues of acceptability and usability of their chosen intervention(s). Acceptability refers to how likely individuals are to use an intervention in their everyday life, whereas usability refers to the ease of use of an intervention. However, the procedures used to measure these areas varied greatly across the studies. Table 5 summarises the reported data in this area. A number of studies used data on attrition and recruitment to assess acceptability. A 41.9% acceptance rate was reported by Farrer et al. (2012) as only 155 of the 370 eligible participants consented to take part in their study. One study (Gulliver et al., 2012) recruited participants from a pool of individuals who had completed a previous study, and found that only 7.7% (59/770) of those who had completed the previous study submitted pre- or post-intervention responses.

Two studies (Kelson et al., 2017; Levin et al., 2017) used the 10-item System Usability Scale (SUS), (Brooke, 1996) which measures ease of use, acceptability and satisfaction. The SUS provides a score out of 100, with higher scores indicating greater overall usability. One study (Kelson et al., 2017) reported a mean usability rating of 71.75, which represents an average score, whereas another study (Levin et al., 2017) reported a mean rating of 71.13, and provided further details of how the scores were distributed: 90% agreed slightly or strongly to being satisfied with the quality of the programme; 60% reported that the intervention was too long and/or too repetitive; and 3% reported not liking the web-based, self-help format.

Another study (Taylor-Rodgers & Batterham, 2014) asked participants to rate their satisfaction on a 5-point scale. 88.5% reported that they were satisfied with the intervention. They also found that 58% of the intervention participants rated the intervention as appealing. One study (Kiroopoulos et al., 2011) did not report on

acceptability and usability of their intervention, but the fact that 100% (n = 202) of their participants completed the trial according to their flow diagram, suggests that participants found the intervention acceptable. This is likely due to this being a much shorter intervention in comparison to the others: participants were required to explore the web materials freely for only one hour, completing pre- and post-intervention measures on the day and follow-up measures one week later.

A number of the studies also looked at adherence either through participant self-reporting or through automatic monitoring through the web platform used to host the intervention. One study electronically monitored web-usage (Gulliver et al., 2012) and found that 95% visited their website once, 81% visited the website both during week 1 and 2, of the intervention, with the intervention condition having no significant effect. In contrast, Levin et al. (2017) found that 55% of participants completed all sessions. Two studies relied on participants' self-reported usage, with Jeffcoat and Hayes (2012) finding that 64% of their participants reported reading the entire workbook and completing all of the online exercises and Taylor-Rodgers and Batterham (2014) finding that 65.4% of intervention condition participants reported viewing all four web-pages.

Table 5
Acceptability and Usability of the reviewed studies

Authors & date	Acceptability	Usability	Attrition
Farrer et al. (2012)	41.9% acceptance rate reported as 155/370 eligible participants consented.	No data reported	Of the 155 participants in the study, 69% completed post-intervention and 59% completed 6-month follow-up Telephone tracking was associated with significantly greater dropout in the Web with tracking condition
Gulliver et al. (2012)	Agreeing to participate was significantly related to gender, with men less likely than women; age, with older participants more likely; prior counselling experience, with those who had not had previous counselling more likely; and psychological distress, with those scoring higher more likely to agree.	Intervention Adherence: 95% visited website during 1 st week, 81% visited both week 1 & 2, 5% visited neither. Intervention condition had no effect on the number of programs visited.	Only 7.7% (59/770) of those that completed the stage one survey submitted pre- or post-intervention survey from previous stage 1 survey. 59/120 completed a survey

Table 5 (continued)

Authors & date	Acceptability	Usability	Attrition
Jeffcoat & Hayes (2012)	Of the entire district workforce approached only 236 consented, which equates to 3.6%.	64% reported reading the entire book and completing all of the exercises. Higher reported use of the workbook related to better outcomes.	79% (186/236) had complete data. 24.8% (30/121) drop out in the intervention arm
Kelson et al. (2017)	Participants rated how helpful they found each module on a scale of 0-4, with total scoring ranging 0-36. Article includes table presenting this data for each module.	System usability scale, 10-item (SUS) measured ease of use, acceptability and satisfaction creating a score out of 100, with higher scores indicating greater overall usability Mean usability rating was 71.75, which represents an average score	26% (14/57) attrition within intervention arm, compared to 41% in the whole study (28/68). Between post intervention and follow-up 40% (16/40) returned to use the programme.

Table 5 (continued)

Authors & date	Acceptability	Usability	Attrition
Kiroopoulos et al. (2011)	No data reported	No data reported	100% of participants completed the trial (not reported but taken from flow of participants through trial). No attrition reported.
Levin et al. (2017)	<p>Adequate satisfaction reported on SUS (90% rated “slightly agree” or higher on the Item: “Overall, I was satisfied with the quality of the program”)</p> <p>60% reported that the intervention was too long and/or too repetitive.</p> <p>3% reported not liking the web-based and self-help format for receiving services.</p> <p>86% reported participating for university credit</p>	<p>System usability scale, 10-item (SUS) (see above) scored in the adequate range (71.13).</p> <p>Qualtrics automatically collected data on usage: 55% completed all sessions. Participants spent 73.58 minutes on average in the program.</p>	80% (32/40) within intervention arm completed post assessment. 78% attrition rate in study

Table 5 (continued)

Authors & date	Acceptability	Usability	Attrition
Taylor-Rodgers & Batterham (2014)	88.5% satisfied with intervention and 58% rated the intervention as appealing in the intervention condition.	Adherence - 65.4% of experimental condition reported viewing all three webpages	85% (28/33) completed the post-test survey in the intervention arm.

Heterogeneity of the Articles

As outlined above, the articles identified varied in a number of different ways: focus of intervention (psychological flexibility vs personal stigma); structure and format of intervention (e.g. duration ranging from 1 hour to 8 weeks); methods used to assess outcomes (e.g. acceptability and usability). It is of note that the studies also varied greatly in terms of study populations. Five of the seven studies took place in Australia (Farrer et al., 2012; Gulliver et al., 2012; Kelson et al., 2017; Kiropoulos et al., 2011; Taylor-Rodgers & Batterham, 2014) whereas the other two took place in the USA (Jeffcoat & Hayes, 2012; Levin et al., 2017). The age of participants varied across studies. Three of the seven studies recruited young adults, with two studies recruiting young adults aged 18-25 years (Kelson et al., 2017; Taylor-Rodgers & Batterham, 2014), and one study recruiting college students aged 18 years and older (Levin et al., 2017). One study did not report the age of the participants (Farrer et al., 2012) and the remaining studies recruited adults (Gulliver et al., 2012; Jeffcoat & Hayes, 2012; Kiropoulos et al., 2011). Four of the seven studies reported recruiting from specific populations which included elite athletes (Gulliver et al., 2012), callers to Lifeline (Farrer et al., 2012), school personnel (Jeffcoat & Hayes, 2012) and Greek-born and Italian-born immigrants (Kiropoulos et al., 2011).

Discussion

This review aimed to provide an overview of self-help interventions for self-stigma related to mental health problems published in peer reviewed literature. The systematic review identified seven articles, which considered concepts related to self-stigma: three of the studies identified related to self-help intervention addressing psychological flexibility through ACT approaches, while the remaining four studies related to psychoeducation self-help interventions addressing personal stigma.

All of the studies were rated as good quality, achieving total scores of 31 to 35 on the Hawker et al. (2002) appraisal tool. A common weakness was the way in which the studies addressed ethics and bias.

The majority of the studies made their interventions available through online web platforms, with one study (Jeffcoat & Hayes, 2012) providing its participants with hard copies of the intervention workbook instead. However, this study supplemented the workbook with online exercises. There was variability in how the websites were presented and what additional materials were made available. However, the majority of the interventions required participants to work through sessions in a sequential order over a period of a number of weeks. The length of the interventions ranged from 1 hour to 8 weeks. However, it was unclear how the interventions compared on hourly input required to complete the intervention as this information was only given for one of the studies (Kelson et al., 2017).

All articles except one reported on the acceptability and usability of the interventions. How this was assessed varied across the studies, with two studies using a standardised questionnaire measure (SUS; Brooke, 1996), some creating their own questions to address this and some using attrition rates to explore this.

Adherence to the interventions where reported varied greatly across the studies, ranging from 55%-85%.

Implications

Reviews of interventions aiming to reduce self-stigma identified that the majority of such interventions are group or peer interventions, with a small number being therapist guided individualised interventions (Mittal et al., 2012; Yanos et al., 2015). It is important to be mindful of the presumed disclosure in such interventions (Herman, 1993), and how many individuals would prefer to avoid disclosure (Corrigan et al., 2006). The lack of literature relating to self-help interventions prevents these issues from being addressed.

There are clear benefits of self-help interventions including wider reach and the ability for participants to access materials freely at a time that suits them. Developing self-help interventions to address self-stigma enables individuals who otherwise would avoid or reject individual or group interventions to access help, without the fear of further discrimination or embarrassment (Lewis et al., 2002).

Further research is required to address this gap in the literature, especially given the evidence that self-help interventions produce significantly greater outcomes when compared to no treatment (Lewis et al., 2012). Further research is also required to assess whether such self-help interventions can positively impact self-stigma more broadly than depression personal stigma, as the results were mixed for other areas of personal stigma such as anxiety or suicide (Gulliver et al., 2012; Taylor-Rodgers & Batterham, 2014).

Limitations

A key limitation of this systematic review is the lack of literature identified that directly addressed the research question. It is possible that the decision to limit

selection criteria to mental health may have impacted on the number of studies identified. When defining the mental-health-related search terms scoping searches identified that the terms “schizophrenia”, “depression” and “anxiety” are commonly found in mental health disclosure and stigma literature. It is acknowledged that it is possible that some eligible articles may have been overlooked, by not including additional mental health diagnoses such as bipolar or personality disorder. Future reviews may wish to review self-help interventions for self-stigma more broadly, combining research across mental health, sexuality, substance dependency, HIV/AIDS and other stigmatised identities. A meta-analysis of interventions for reducing stigma relating to substance use (Livingston, Milne, Fang, & Amari, 2012) identified three studies targeting self-stigma and concluded that the evidence indicated that self-stigma can be reduced through ACT group interventions. There is also evidence that ACT interventions have positive outcomes in self-stigma relating to weight (Berman, Morton, & Hegel, 2016).

It is of note that the four articles relating to personal stigma were identified from reference lists and meta-analyses and were not identified from the database searches. It is possible that this is due to personal stigma not being a widely used term to refer to self-stigma. It is possible that other overlapping constructs, similar to psychological flexibility, self-acceptance and personal stigma, may have been missed and so it may be helpful to consider factors influencing or contributing to self-stigma more broadly in order to inform future reviews of the literature available. It may be helpful to explore interventions for shame and self-criticism, such as Compassion Focused Therapy (Gilbert & Procter, 2006). Internal shame may be of particular relevance to the field of self-stigma, as it involves the self-focused evaluations of the self as inadequate (Lewis, 2003). reference.

It is of note that the articles identified were disparate in many ways, which included variation in intervention format and structure and also high levels of heterogeneity across the target populations for participants. This poses questions regarding the generalisability of these studies, and therefore any comparison between studies should be made with caution (Popay et al., 2006). However, this clearly emphasises the need for more research in the field of self-help interventions for self-stigma relating to mental health problems.

While it is important to acknowledge the limitations of this review, it should be stressed that the identification of common strengths and weaknesses of the articles included can inform further critical analyses of the literature in the field of self-help interventions for self-stigma.

Conclusion

Self-stigma related to mental health problems affects self-esteem and self-efficacy and chances of recovery and has continuing impact on psychological wellbeing. While there has been an increase in research in this area and a growing wealth of interventions including peer support, there is a clear gap in the literature regarding self-help interventions to target mental health self-stigma. As peer or group interventions presume disclosure (Herman, 1993), it is important to address this gap, especially as the act of disclosure essential to other interventions may contribute to negative experiences such as discrimination (Ragins, Singh & Cornwell, 2007). Self-stigma impacts large numbers of people and impacts outcomes (Link et al., 1997; Corrigan & Watson, 2002). It is important to address potential barriers to accessing help, by providing interventions in a range of formats, including self-help, as this is often more acceptable and more easily accessible (Lewis et al., 2002).

It is recommended that future reviews into the literature consider exploring the concept of self-stigma more broadly in order to incorporate the literature from other overlapping areas, similar to psychological flexibility and personal stigma.

This systematic review and narrative synthesis suggests that increased investment into the development and evaluation of self-help interventions in the field of self-stigma may be helpful, as this review has shown they have potential to produce positive outcomes. Researchers may find it helpful to consider incorporating psychoeducation targeting stigma (Farrer et al., 2012; Gulliver et al., 2012; Kiropoulos et al., 2011; Taylor-Rodgers & Batterham, 2014), whilst also drawing on components of ACT for increasing psychological flexibility (Kelson et al., 2017). Web-based interventions have been found to be acceptable and usable formats for such self-help interventions (Kelson et al., 2017; Levin et al., 2017; Lewis et al., 2012).

Studies of new self-help interventions should carefully assess their acceptability and usability in order to develop interventions that will be successful at reducing the clinical impact of self-stigma.

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Part 2: Empirical Paper

The feasibility of a new self-help intervention supporting mental health professionals with lived experience in reaching disclosure decisions.

Abstract

Aims: To assess the feasibility of the newly developed Honest Open Proud- Mental Health Professionals (HOP-MHP) self-help guide, for supporting mental health professionals in reaching disclosure decisions. This includes the feasibility of recruiting mental health professionals to a randomised controlled trial (RCT) of HOP-MHP delivered as a self-help guide, in combination with access to web-based peer support and to assess the feasibility of delivering the outcome measures in the format, volume and at the time points intended.

Method: This is a mixed methods design, combining feasibility data, qualitative data and preliminary outcomes. A new guided self-help intervention was adapted with input from stakeholders who include mental health professionals with lived experience and a mini pilot to inform the finalised version of the HOP-MHP self-help guide. A pilot RCT was conducted to assess the feasibility of the intervention and to analyse the preliminary outcome data in relation to stigma related stress, self-stigma, and symptoms of depression and anxiety.

Results: Overall the intervention and research protocol were found to be feasible.

Recommendations are made for considerations for improving feasibility in the future.

Preliminary outcome data indicate a small negative effect on anxiety, but no effect on the other outcomes under consideration (stigma stress appraisal, self-stigma and depression).

Conclusions: While the intervention and research protocol have been found to be feasible, further research is required to confirm the effectiveness of the HOP-MHP self-help intervention.

Introduction

Mental health professionals who have lived experience of mental health problems themselves are faced with the challenge of whether or not to disclose their experiences. They often are faced with negative perceptions, which include a dominant discourse about “impaired healers” and “a lack of resilience”: fear of stigma and discrimination can cause people to feel reluctant to share or speak out about their personal experiences (Adame, 2011). Recent research shows that more mental health professionals are now choosing to disclose their own mental health difficulties and to speak out about their own lived experiences (Ahmed, 2007; Fox, 2002). However, many still chose to remain silent, preferring to keep their personal and professional identities separate, or due to fears of the potential negative consequences of disclosure. There is evidence that there can be difficulties in how an individual constructs their identity due to discrepancies between their personal identity as a service user and their professional identity as a mental health worker. For some individuals these identities become integrated, whereas for others they remain separate (Richards, Holtum & Springham, 2016). Those with more integrated service user - professional identities have been found to be better able to draw on the benefits of having lived experience, through use of concepts such as ‘personal recovery’ and ‘wounded healer’ (Adame, 2014).

The mental wellbeing of mental health practitioners has recently attracted increased attention following the publication of figures from the British Psychological Society and New Savoy Partnership (Rao, Bhutani, Clarke, Dosanjh & Parhar, 2015)

staff wellbeing survey, which noted that 46% of psychological professionals who completed the survey reported experiencing symptoms of depression. The report also showed that 49.5% reported at times feeling a failure and that 70% found their job stressful. Following this report, the BPS launched a Charter for Psychological Staff Wellbeing and Resilience, in collaboration with the New Savoy Partnership and with support from Public Health England. The Charter aims to improve support for staff-wellbeing and to create workplaces that are both compassionate and sustainable (Rao et al., 2015).

Two recent UCL student research projects (Grice, 2016; Tay, 2016) surveyed trainee and qualified clinical psychologists about their current and past experiences of mental health problems. Of the 425 qualified participants who reported lived experience of mental health problems (62% of the whole sample), 11% (n=46) had not disclosed this to anyone, whether in their social or work circle or a health professional. This figure is likely an inflated estimate due to self-selection bias to this survey which was disseminated by the DCP. But in any case, the findings suggest lived experience is common rather than the exception. Reluctance to disclose, influenced by the stigma attached to mental health problems is a real concern for many. This is due to concerns about being judged negatively, a potential negative effect on their career, but also shame and embarrassment. This fear and reluctance to disclose their own experiences pose risks to their own wellbeing but also to their fitness to practice, potentially affecting their clients' wellbeing as well. Therefore, it is important to find ways to support clinical psychologists (and other mental health professionals who are likely to struggle with very similar issues) in carefully reaching decisions about disclosing mental health problems they are experiencing and in the actual disclosure process.

Staff wellbeing has also been identified as affecting service outcomes and patient wellbeing. The Francis Report (2013) identified a lack of compassionate care within the NHS, and reported that business targets were at times prioritised over the needs of patients. The report made recommendations that compassion be made central to the NHS again. Poor staff wellbeing will negatively impact on economics and productivity. 15.7 million days were lost due to sickness in 2013-14 (HSCIC, 2015, cited in Rao et al., 2015), and there are higher rates of absences in mental health services compared to the rest of the NHS (Quality Watch, 2015, cited in Rao et al., 2015). It has been estimated that improving staff wellbeing can add value, with every £1 invested in staff wellbeing, reaping £9.20 in benefits (PwC, 2008, cited in Rao et al., 2015).

Disclosure can result in discrimination and at times concealment may be a necessary and adaptive response to an environment that may be unsupportive or hostile to disclosure (Ragins et al., 2007). However, self-disclosure can have positive outcomes and lead to reduced feelings of depression, reduced stigma stress and general improvements in well-being, including improved self-esteem and empowerment (Corrigan et al., 2010, 2015; Mulfinger et al., 2018; Rüsçh et al., 2014). On a wider level, where mental health professionals are apprehensive of the stigma associated with mental health problems and the risk of unsympathetic and discriminatory responses they are in a compromised position in challenging mental health stigma within health services and wider society. Therefore, it is important to find ways to empower mental health professionals in reaching carefully considered disclosure decisions, and to draw attention to both the potential benefits and risks of disclosure.

Honest, Open, Proud

The 'Honest, Open, Proud' (HOP) programme (Corrigan, Kosyluk, & Rüsçh, 2013) was developed to support careful decision making regarding disclosure of mental health problems and in the actual disclosure process (if disclosure is the course of action chosen by the individual). It is a three-session programme addressing the costs and benefits of disclosure, different approaches to disclosure and providing peer support.

As outlined above, disclosure decisions depend on the individual and the context. Therefore, HOP does not aim to push participants towards disclosure, but to empower them to make their own informed decisions. HOP discusses different levels of disclosure (social avoidance, keeping it private, selective disclosure, indiscriminate disclosure, actively sharing). It begins by exploring attitudes about having mental health problems. It then explores the pros and cons of disclosure and how to decide to whom to disclose, and practise telling their story. Finally, the role of peer support and additional support is considered in order to think about “what next?”.

In three recent pilot RCTs, HOP was shown to reduce symptoms of depression, stigma related stress, disclosure related distress, and a perceived need for secrecy (Corrigan et al., 2015; Mulfinger et al., 2018; Rüsçh et al., 2014). An investigation of the use of HOP in a sample of participants with at least one Axis I or Axis II disorder according to DSM-IV (Frances, 1994) by Rüsçh et al. (2014) found the programme to be feasible, retaining 87% of the sample recruited at follow up. Feedback indicated that participants found the programme content clear and relevant, with many reporting that the most helpful part was comparing the pros and cons of disclosure versus secrecy in specific settings, rather than thinking more globally. The study also found positive effects in a number of areas including stigma stress, disclosure-related distress, perceived need for

secrecy, and perceived benefits of disclosure. Although some effects reduced at follow-up, the positive effect on stigma stress remained significant with a medium effect size at follow up. HOP was originally designed as a peer led group intervention, but as mental health professionals may be concerned about the potential negative effects of disclosure on their career and professional reputation in this project HOP was adapted as a manualised self-help intervention instead.

The Medical Research Council's (MRC) guidelines for complex interventions (Craig et al., 2008) emphasises the importance of assessing feasibility as part of piloting interventions, prior to large-scale evaluation studies. They acknowledge that this is often missed, resulting in evaluations being undermined by issues of acceptability, compliance, intervention delivery, and recruitment and retention. They advise that a combination of quantitative and qualitative methods be used to assess these issues in order to more fully understand barriers. The MRC guidance for process evaluation (Moore et al., 2014), indicates that while RCTs represent the most internally valid means of establishing effectiveness, feasibility and piloting enables key issues to be identified and addressed prior to subsequent evaluations of effectiveness. The guidelines state that process evaluations require the examination of key aspects: implementation and delivery of the intervention; mechanisms of impact, including intervention and how participants interact with them; and context, such as how external factors impact the intervention.

The Present Study

The aim of this project was to develop an adapted version of HOP that is suitable as a self-help intervention to support mental health professionals with lived experience of mental health problems in carefully reaching decisions about whether or not to disclose these experiences, and how to go about disclosing. It was hypothesised that this would

reduce stress associated with a perceived need for secrecy and reluctance to seek support and help, and ultimately increase professionals' wellbeing and patient safety. In the longer term, through supporting increased disclosure of mental health problems among mental health professionals, we hope to contribute to challenging the 'us and them' (professional versus service user divide) and to reduce mental health stigma. To achieve this, we adapted the HOP manual into a self-help guide for mental health professionals (HOP-MHP) (Appendix 8).

The project aimed to identify whether the adapted HOP intervention reduces stress associated with a stigmatised concealed identity via the stigma stress measure, and whether the intervention results in reduced levels of internalised stigma, and improved wellbeing in relation to depression and anxiety symptom severity. It was predicted that the process of exploring the pros and cons of disclosure and how to go about telling their story in a personally meaningful way would encourage disclosure, and reduce the negative impact of maintaining a concealed identity. Those with concealed identities often experience anxiety related to others finding out and the perceptions of others, withdraw socially and thus miss out on support, and experience guilt related to keeping secrets from those around them (Corrigan et al., 2013). While it is clear that for some the right decision may be to maintain concealment, in these cases it was predicted that the process of actively thinking through their options would still result in reduced levels of stigma stress as it will help move away from global statements such as seeing disclosure as "good" or "bad" to exploring their own personal views across different settings (Rüsch et al., 2014).

Aims

The key objectives were:

1. to develop HOP-MHP with input from stakeholders who include mental health professionals with lived experience.
2. to assess the feasibility of recruiting mental health professionals to a randomised controlled trial (RCT) of HOP-MHP, its delivery as a self-help guide, and the study procedures and administration of outcome measures.
3. to assess the preliminary outcomes of HOP-MHP for stigma stress, self-stigma, and mental health status (anxiety and depression).

Method

This study involved three main stages:

1. Development of the HOP-MHP self-help guide and research protocol with stakeholder guidance
2. Small pilot study as an initial test of feasibility
3. Pilot Randomised Control Trial (RCT) – mixed methods design to assess feasibility and preliminary outcomes

Development Stage and Stakeholder Involvement

The initial stage of this project involved recruiting members to the HOP-MHP Stakeholder Group, consisting of trainees and qualified mental health professionals with lived experience (Appendix 3). Stakeholders played an essential role in adapting and developing the intervention and the research protocol. This included providing guidance on how to adapt the original HOP group intervention to be suitable for mental health

professionals with lived experience, based in the UK. The three-session structure and key activities for each session outlined above were retained but the language, case stories, tables and work sheets were adapted, such as changing the language, terminology, structure and content to make it more acceptable. This process was informed by the Nominal Group Technique (NGT: Sample, 1984), whereby a structured small-group discussion is used to first gather information and then reach a consensus by prioritising the ideas and suggestions of group members. The NGT method was used as it is a time efficient way of reaching a consensus, encouraging participation from all group members, while preventing the discussion from being dominated by certain individuals.

Stakeholders also provided detailed feedback on the selected outcome measures, which was used to ensure that the measures were feasible and acceptable to the target population, taking into consideration the use of language and completion time. Stakeholders also informed decisions about how to manage anonymity and confidentiality during the study and how to link with peer support and other available support options, by making this information available on the HOP-MHP webpage.

A small sub group of six stakeholders reviewed the adapted HOP-MHP self-help guide and provided in-depth feedback in order to finalise the intervention before a mini pilot with five participants was conducted, leading to some more revisions in line with their feedback.

Participants and Data Collection

The project was open to any UK based mental health professional, whether qualified or currently in training, of working age. Participants were required to self-define as currently experiencing psychological, emotional and/or behavioural difficulties

that have diminished their capacity for coping with the ordinary demands of life, or to have experienced such difficulties in the past. They were required to either not have disclosed their experiences of mental health problems, or to have done so only in some settings. Potential participants who were publicly 'out' about their current or past difficulties were not eligible for the study. Participants needed to be willing to complete the battery of standardised measures in order to take part in the research study. Those participants expressing an interest in taking part but who did not have personal experience of a significant mental health problem or who had retired from their post as a mental health service provider were excluded from the study at the screening point, before randomisation. Participants who were currently on extended leave due to sickness or maternity, and who had not disclosed their current or past mental health problems in their work setting were eligible to participate in the study. Potential participants completed a brief screening questionnaire alongside the consent form to assess eligibility for the study.

Recruitment

Potential participants were recruited for the pilot RCT via several routes. Each route provided information about the study and contained a web link to the study webpage. Those interested in participating were encouraged to contact the researchers via the study email if they had any questions about the study. Recruitment via the Division of Clinical Psychology mailing list held by the British Psychological Society was not successful due to internal procedural difficulties. A short newsletter item was circulated to the North-West England Psychological Practitioner Network. Course directors and academics across all 30 UK based clinical psychology training courses were asked to disseminate information about the study to their trainees

(Appendix 4). Invitations were sent to 27 IAPT courses. Social media, including Facebook and Twitter were used to advertise the study. Short blogs were written to provide information about the study and to advertise recruitment (BPS; UCL Unit of Stigma research, UCLUS: <https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/ucl-unit-stigma-research-uclus>). A short article was published in The Psychologist magazine outlining the study and flyers were developed to advertise the study which were shared with colleagues, posted at UCL, and shared at conferences.

Randomisation and Blinding

A simple randomisation procedure was used to allocate participants to either the intervention or control group. Using Excel, a randomisation file with three separate sheets was set up. Participants who signed up to the study by email, provided a signed consent form, and met all the inclusion criteria upon screening, were sent a personalised link to the baseline survey (Appendix 7). All participants who completed the baseline survey were allocated a study unique identifier (UI) in sequential order. The UIs for the first 52 participants were assigned a random number between 0 and 1 using the ‘Random’ function in Excel. Using the ‘Sort’ function, the random numbers (with associated UIs locked) were randomly sorted. In the third step, the randomly ordered UIs were allocated to the Intervention (n=25) or Control (n=25) condition such as to ensure that the researchers were in ignorance of the next assignment in the sequence (Egan et al., 2014).

The researchers were not blinded to group allocation as they needed to use participant emails to send engagement and reminder emails (Appendix 10). However, as all data were collected through web surveys, and email communication used standardised

templates for each point of contact, the failure to blind is not expected to have influenced engagement with the study or analysis of the data. A research assistant (LP) assigned participant numbers and UIDs to participants who signed up for the study. She was also responsible for storing and maintaining the list of UIDs and matching participant emails in a secure file in the UCL data safe haven. The two researchers (AH and HM) who sent weekly engagement emails to participants in both the intervention and control arm and who subsequently completed qualitative interviews with a subsample of these participants had access to participants' email addresses (alias or otherwise) but not to their survey responses. The study leads (KS and HC) had access to participants' UIDs and survey responses but not their emails, unless they were prompted to respond to specific queries or concerns.

The HOP-MHP Peer Forum

Participants in the intervention arm were invited to register on a closed peer-group forum at the same time as being provided with the HOP-MHP guide. They were provided with a brief user guide for the forum (Appendix 9) which was hosted using the Slack forum platform. It was anticipated that the peer-forum would be used alongside the self-help guide but neither registration for the peer forum nor regular use of it was mandatory. Forum entries were moderated by the study leads (KS and HC) who took responsibility for responding to any concerns and potential risk issues. Control participants were given access to the peer forum once they completed the research study.

The HOP-MHP Website

The HOP-MHP website (<https://www.ucl.ac.uk/pals/hop-mhp-project>) provided information about the intervention and participation in the pilot study, including the information sheet and a consent form and brief screening measure. The website also provided additional information and signposting including the following: information about other sources of support; information about self-care; information about Fitness to Practice; signposting for legal and employment support services.

Procedure

Participants in the experimental arm received weekly email reminders to work through the self-help guide and visit the peer forum if they wished. Control participants were also emailed regularly in order to maintain contact and to remind them of the resources available via the study webpage. At week 4 participants from both study arms were prompted to complete the Time 1 measures. Intervention participants were given three weeks to complete the HOP-MHP self-help guide, in line with previous HOP interventions of completing one session per week. Intervention participants were required to indicate that they had finished the core modules of the intervention prior to being sent the survey link. Non-responders were prompted by email reminders five days later, reminding them to complete the survey as the link expires after seven days. Two weeks later a follow-up email was sent to check if they still intended to complete the survey, and informing them that if nothing was heard within two weeks they would be marked as dropping out of the study. Approximately four weeks later (10-12 weeks after baseline), participants were sent the Time 2 survey link. Intervention participants were required to indicate that they had finished the Follow-Up component of the guide prior

to being sent the survey link. Upon completion of the Time 2 measures, all participants were sent a thank you email and those from the experimental arm were invited to take part in a semi-structured telephone interview. Participants from the control arm were given access to the HOP-MHP self-help guide and access to the peer forum at this point. The pilot RCT was registered with a clinical trials register and has the International Standard Randomised Control Trial Number (ISRCTN) reference number 18418155.

Ethical Considerations

The study was approved by the UCL Research Ethics Committee (Project ID No.: 9297/002) (Appendix 2). Participation was voluntary and all potential participants were provided with an information sheet and consent form outlining the study (Appendices 5 and 6). Participants were informed that they were able to withdraw their data from the study at any point up until the follow-up.

Confidentiality

All personal identifiable data were held securely and confidentially using the UCL Data Safe Haven. No identifiable data were entered or stored on Qualtrics. To help protect confidentiality, participants were given the option to set up an alias email address for the purpose of the study. As participants might well be concerned about the potential negative effects of disclosure on their career and professional reputation, sociodemographic data collected were kept to a minimum to ensure their anonymity.

Another potential risk was a breach of privacy while using the peer forum. This was addressed by ensuring the peer forum site was a closed forum, available only to participants taking part in the trial. Furthermore, participants were given the option to use

an alias email account, and discouraged from using identifiable information in the peer forum to ensure anonymity, user safety and confidentiality.

Informed consent was gained by providing participants with details about the study and access to the HOP-MHP webpage which provides further background information about the intervention and pilot RCT. Participants who wanted to take part in the study after consideration of this information were required to submit a signed consent form by email and encouraged to set up an anonymised email account for the purpose of the study to avoid disclosing their identity.

Potential risks and burden to participants

While it was hoped that participants would benefit from the opportunity to consider potential disclosure of their experiences of mental health problems in depth, we were aware that some might experience increased distress upon reflecting on their own mental health problems and reasons for and against disclosing, or as a consequence of reporting on a negative disclosure experience. Several steps were taken to provide participants with support: those in the intervention arm of the pilot RCT were able to discuss their experiences with others enrolled in the study on the HOP-MHP web based peer forum. All participants, regardless of group allocation, had access to information about sources of support via the HOP-MHP webpage. Any participant who experienced increased distress during the study was encouraged to contact the HOP-MHP leads for a confidential conversation (in the event no participants contacted the project leads or raised any ethical concerns).

Feasibility

The assessment of feasibility of HOP-MHP was informed by the indicators of feasibility as outlined by Sidani and Braden (2011), which include feasibility of the intervention (material resources, context), feasibility of the implementation (clarity, comprehensiveness, ease of use) and feasibility of research methods (recruitment, screening, randomisation, retention and data collection). My colleague looked at the acceptability of the study and intervention. While we had separate research questions, it is likely that there will be some overlap as these two concepts are related. Table 1 outlines the feasibility questions this study aimed to address.

Table 1
Feasibility Questions

Feasibility of the research trial and procedure:	<ul style="list-style-type: none"> - Can we recruit qualified and trainee mental health professionals to an RCT of this self-help intervention? - Can we retain participants across both arms of the study? - Do the procedures work as set out in the study proposal in terms of screening, random allocation to study arms and using the online survey software?
Feasibility of the intervention: (Can the intervention be delivered as intended?)	<ul style="list-style-type: none"> - Are participants able to access and make use of the self-help guide? - Are participants able to complete the intervention in the proposed timeframe? - Are participants able to complete the guide as a self-help intervention (without guidance from facilitators and outside a group setting)? - Can a peer web forum be run alongside the intervention without added risks?

Outcome Measures

The measures were based on or adapted from those used by Rüsçh et al. (2014) to allow comparison of HOP outcomes between studies. Participants completed measures at three time points (baseline- T0; 4-6 weeks later- T1; and 10-12 weeks after T0- T2), designed to assess general distress, stigma related stress, disclosure related distress, internalised stigma, secrecy, and perceived benefits of disclosure. The battery of measures was estimated to take approximately 15 to 20 minutes to complete. The baseline survey also included sociodemographic questions (gender, ethnicity, age group, qualification status and years since qualifying/years in training) and questions relating to current and past mental health status. Due to HOP-MHP being a self-help intervention, there was some variation in time taken to complete the core and booster sessions, and therefore those requiring longer also completed the outcome measures over a longer timeframe.

The outcome measures specific to this study are outlined below. As this is a joint project (Appendix 13), additional measures were completed and analysed as part of a separate project. All outcome measures across both studies are presented in full in the appendix.

Primary Outcome

Appraisal of “mental illness” stigma was assessed with the Stigma Stress Scale adapted from Rüsçh et al. (2009). The scale contains twelve items rated using a 7-point Likert scale (1=strongly disagree to 7=strongly agree) which assess the primary appraisal of perceived harmfulness of “mental illness” stigma and the secondary appraisal of perceived resources to cope with stigma. A single stress appraisal score was computed by subtracting perceived resources from perceived harmfulness, with higher

scores indicating more stigma stress. The original measure has good internal consistency (Harm items: Cronbach's alpha =.88; Resources items: Cronbach's alpha =.78)

Secondary Outcomes

Self-Stigma was measured using an adapted 15 item version of the Self-Stigma of Mental Illness Scale – Short Form (SSMIS-SF, Corrigan et al., 2012). The SSMIS-SF has been found to have good internal consistency. The adapted scale contains five items assessing awareness of negative stereotypes about mental health problems, five items assessing how they apply these stereotypes to themselves, and five items assessing related harm to self-esteem.

Mental health status was measured regarding depression using the Patient Health Questionnaire 9 (PHQ-9, Kroenke & Spitzer, 2002), and anxiety using the Generalised Anxiety Disorder 7 questionnaire (GAD-7, Spitzer, Kroenke, Williams & Löwe, 2006).

Power analysis

The power analysis for the present study utilised a medium effect size based on the stigma stress score from Rüscher et al.'s (2014) study. A G*Power analysis (Faul, Erdfelber, Lang & Buchner, 2007) was conducted for a repeated measures ANOVA, $\beta=0.80$, $\alpha=0.05$, $f=0.3333$, [SS2] correlation of repeated measures = 0.5 and a non-sphericity correction = 0.75. This yielded an overall sample size of $N = 20$. For the present study, the sample size was doubled to take into consideration the potential to overestimate effect sizes due to publication bias, thus producing a desired sample of 40.

Attrition rates in previous RCT's were used to inform the desired sample size calculation for the present study. Christensen, Griffiths, and Jorm (2004) investigated an

internet based treatment for depression and found a 25% dropout, while Rüscher et al. (2014) found a 20% dropout for the COP group intervention. Based on these studies, an expected dropout rate of 25% was taken into consideration. Therefore, whilst the power calculation suggested a sample of N=20 or N=40 once overestimation and publication bias had been taken into account, this pilot RCT aimed to recruit a sample of N=50 to allow for publication bias and drop-out rates.

The power estimation reported in Rüscher et al. (2014) was based on a number of measures with small to medium effect sizes. As the current study is based on the specific primary outcome measure of stigma stress, which showed a medium to large effect in response to HOP in Rüscher et al.'s (2014) study, the effect of the same HOP intervention can be demonstrated on a smaller sample of N= 50.

Results

Qualitative Data Analysis

Participants' satisfaction with the HOP-MHP intervention was assessed using a mixture of Likert scales and open comment boxes, informed by Richards and Timulak's (2013) Satisfaction with Treatment questionnaire (SAT) (Appendix 11). Additional qualitative feedback regarding satisfaction was collected from a subsample via a semi-structured telephone interview (Appendix 12). A content analysis, as recommended by Sidani and Braden (2011), was conducted on the qualitative feedback provided in the SAT questionnaire and during the telephone interviews (Appendix 15). As this was a feasibility study, we combined the feedback from the 14 participants who completed the survey at Time 1 with the feedback from the five participants who completed the survey at Time 2 to allow a richer analysis. A sub sample of three intervention participants completed a qualitative telephone interview at time of analysis. After completion of

data-collection, the semi-structured interviews were transcribed verbatim omitting any personal identifiable information. It was taken into consideration when more than one source of information was available for one participant so as not to unfairly bias the analysis of the qualitative data.

Feasibility of Recruitment

Recruitment for the pilot RCT was slower than anticipated. This was partly due to our initial routes of recruitment, with the DCP not disseminating the information due to internal procedural issues and the route via training courses not being as successful as anticipated. Of the 30 DClinPsy courses contacted, only four confirmed they had circulated the study information to their trainees. Due to low uptake from course directors, an attempt was made to contact trainees on each of the courses in order to share the information, which enabled us to reach an additional four courses. Courses were then contacted via the Group of Trainers in Clinical Psychology (GTiCP) academics list, which enabled us to reach another five courses. The remaining courses did not respond and so it is not certain whether this information was shared. As such, a minimum of 13 courses circulated the study information to their trainees.

As a number of different routes were used for recruitment, a question was added to the Time 2 survey asking participants to report where they heard about the study. However, due to lack of data at this time point it is not yet possible to assess whether one route is favourable over another.

During this initial phase of the study, 62 eligible participants consented to take part in the pilot RCT. Of these, only 51 participants completed the baseline survey and were randomly allocated to either the control (N=25) or intervention (N=26) arm. Baseline demographic characteristics by experimental condition are shown in Table 2.

There were no substantial differences between groups for gender ($p = 0.419$, Fisher's exact test) or current mental health problems ($X^2 (1) = 0.510, p = 0.475$). However, there was a significant small to moderate (Phi = -0.299) difference between groups for whether they had received a diagnosis ($X^2 (1) = 4.561, p = <0.05$), with more participants in the intervention group having received a diagnosis.

Table 2

Demographic Variables

Demographic Variables	Intervention Group (N=26)		Control Group (N=25)	
Profession				
Clinical Psychologist	18	(69%)	18	(72%)
IAPT HI Therapist	1	(4%)	1	(4%)
IAPT LI Therapist	2	(8%)	1	(4%)
Mental Health Nurse	2	(8%)	2	(8%)
Psychotherapist	1	(4%)	0	(0%)
Other	2	(8%)	3	(12%)
Qualification Status				
Qualified	13	(50%)	12	(48%)
Trainee	13	(50%)	13	(52%)
Time Qualified				
< 2 years	4	(33%)	3	(25%)
2-5 years	3	(25%)	0	(0%)
5-10 years	2	(17%)	4	(33%)
10-20 years	1	(8%)	3	(25%)
> 20 years	2	(17%)	2	(17%)
Current MH Problem				
Yes	6	(23%)	8	(32%)
No	20	(77%)	17	(68%)
Past MH Problem				
Yes	26	(100%)	24	(96%)
No	0	(0%)	1	(4%)
Recovered	12	(46%)	6	(25%)
At risk of a new episode	6	(23%)	9	(38%)
Continuing to struggle	8	(31%)	9	(31%)
Received Diagnosis				
Yes	20	(77%)	12	(48%)
No	6	(23%)	13	(52%)

The large majority of participants were female (Full sample: N=44, 86%; Intervention: N=21, 81%; Controls: N=23, 92%). The majority of participants were aged between 25 and 34 years old (N=29, 57%), and reported their ethnicity as White British (Full Sample: N=48, 94%; Intervention: N=24, 92%; Controls: N=24, 96%).

The proportion of trainee versus qualified mental health professionals was evenly distributed (qualified: N=25, trainee: N=26). For those qualified, the number of years qualified was fairly evenly distributed. The majority of participants reported their profession to be clinical psychology (N=36, 71%), of these 56% were trainees and 44% were qualified clinical psychologists. However, this is not unexpected as recruitment originally targeted the profession of clinical psychology and then opened up to mental health professionals more broadly. The final mixed sample included a mixture of different mental health professionals, with 29% (N=15) of the sample from mental health professions other than clinical psychology. The mixture of different professions was evenly distributed across the control and intervention groups (See Table 2). Further analyses showed that the different groups (clinical psychologists and other mental health professionals) did not differ on age, gender, ethnicity and past and current mental health problems. As the groups did not differ on key demographic data it was appropriate to include all participants in the data analysis.

While only 28% (N=14) of participants reported currently experiencing a mental health problem, 98% (N=50) reported having experienced a mental health problem in the past. Of those with current mental health problems, 57% reported being in recovery, and 43% reported being on the cusp of a potential crisis. When incorporating those with past mental health difficulties 35% reported being in recovery, 29% reported being at risk of

a new episode, and 33% reported continuing to struggle with their past mental health problems.

Participants were asked to explain how they understood their difficulties. Rich qualitative data were provided; the type of information varied from descriptions of how participants were currently relating to their difficulties, to more specific descriptions of the types of difficulties they had experienced across their lives.

The majority of participants had been given a diagnosis (N=32, 63%). Figure 1 shows the distribution of diagnoses. The most common diagnoses were depression (N=16, 50%) and anxiety (N=10, 31%), with diagnoses of other specific anxiety disorders being reported by 44% (N=14). Of those with current diagnoses (N=28), the majority had at least two or more comorbid diagnoses (N=16, 57%).

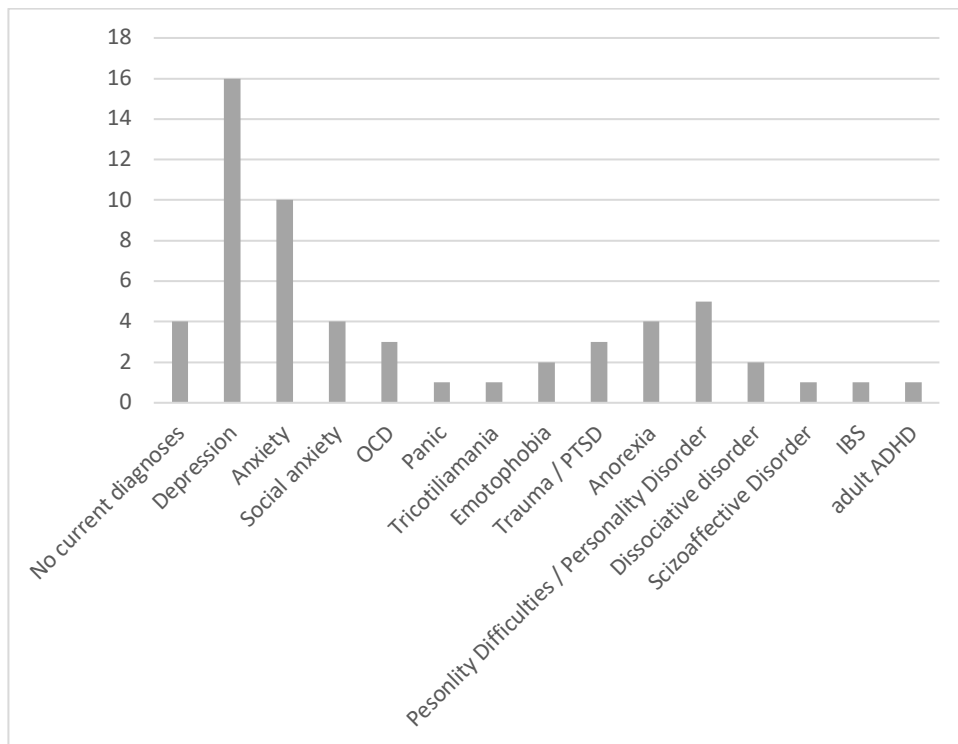


Figure 1: Distribution of Current Diagnoses

Each diagnosis is only counted once (e.g. a diagnosis of panic or social anxiety would not also be counted as a diagnosis of anxiety)

The majority of participants had sought help for their mental health problems (Full Sample N=48, 94%; Intervention: N=24, 92%; Controls: N=24, 96%), with most via their GP (N=10) or private therapist (N=14). This suggests that while the majority had sought help for their mental health problems, that there is still a need to consider disclosure making decisions and the impact of such decisions in the context of being a mental health professional with lived experience.

Feasibility of Trial Procedures

Dropout Rates / Attrition

At time of analysis, 10 participants had dropped out of the study prior to completing the Time 1 survey (control, N=2; intervention, N=8). In addition to these dropouts, two intervention participants had indicated that they still intended to complete the intervention but requested more time. Figure 2 shows the participant flow through the study.

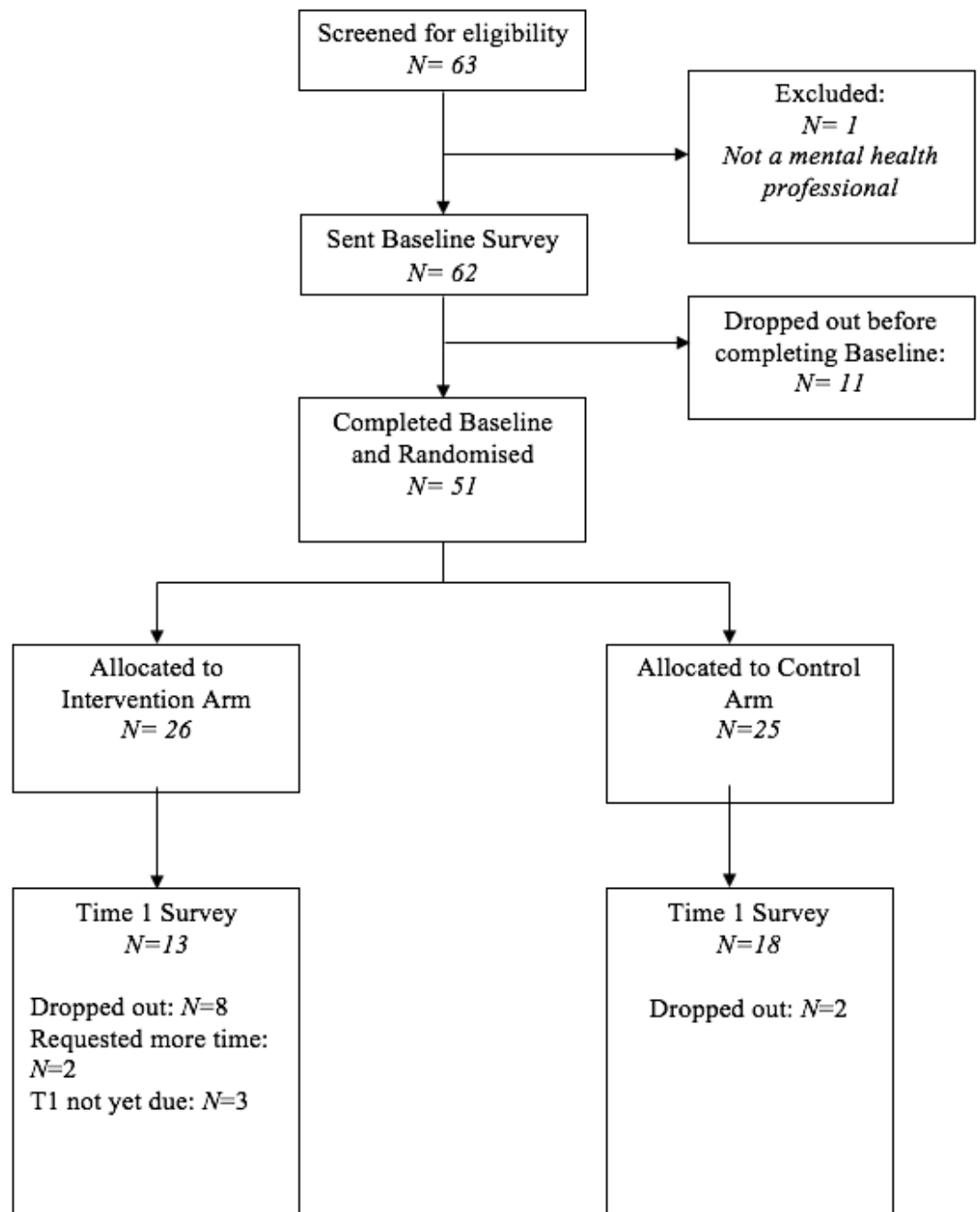


Figure 2: Consort flow chart of the HOP-MHP Pilot RCT design

Feasibility of Screening and Randomisation

The research team found that screening procedures were successful at efficiently identifying those who met eligibility criteria and randomisation procedures were successfully used to allocate participants to either study arm. However, one participant expressed disappointment with being randomly allocated to the control arm and expressed concerns about the ethical issue of such a study design.

Feasibility of the Outcome Measures

The fact that 18% of those who submitted a completed consent form and screening measure failed to complete the baseline survey suggests that the baseline survey may have been a deterrent for people to engage with the study. While it was estimated that it would take between 15 to 20 minutes to complete the baseline survey, in reality this varied greatly (Range 11 minutes to 3 days). At time of analysis, 31 participants had completed the Time 1, post intervention survey (Control: N=18, Intervention: N=13): 61% of those who completed baseline, and only 50% of those who consented to take part in the study. It was originally intended that Time 2 data would also be analysed as part of this project. However, at time of analysis only 14 participants had completed the Time 2 survey (Control: N=9, Intervention: N=5). It is clear that progression and completion of the intervention and surveys took longer than anticipated.

Time taken between baseline survey completion and Time 1 survey completion ranged from 20 to 123 days with the average time taken 43 days. The average time taken for control participants was 35 days (Range 24 to 61 days), which was close to the estimated time frame of 3 to 4 weeks. However, for the intervention participants the average time taken was 55 days (Range 20 to 123 days). This indicates that the 3 week

estimate of time required for participants to complete the self-help intervention was an underestimation, with the majority requiring considerably more than this.

The time to complete the surveys was also much greater than anticipated, with the time from being sent the survey link to survey completion ranging from 0-50 days for the baseline survey, and ranging from 0-41 days for Time 1, with 54% of intervention participants completing within 7 days compared to 77% of controls.

Of the 31 participants who completed the Time 1 SAT questionnaire 75% agreed that they were happy to complete the outcome measures at the three time points and 71% agreed that they were happy with the time taken to complete the measures. 71% of respondents reported that they found the measures easy to complete and 81% reported that the measures were appropriately worded for this intervention. Satisfaction across these areas were fairly even across the control and intervention groups.

Qualitative feedback was gained via the SAT questionnaire about the pros and cons of the outcome measures, and any suggestions for improvements. A content analysis identified three main positive themes, with 48% (N=10) liking the content of the questionnaires, 33% (N=7) reporting finding them easy to complete, and 29% (N=6) liking the wording.

P8- *“Super easy software to use - I could easily complete them on my phone which was a massive benefit”*

P12- *“Clearly worded non double negatives enabled clarity. Was very sensitive.”*

A content analysis identified four main negative aspects of the outcome measures, with 36% (N=8) finding them too long, 27% (N=6) finding some of the

wording confusing, 23% (N=5) not finding the selection of answers suitable, and 23% (N=5) finding them too repetitive.

P18- *“Time taken to do it each time, it felt like a challenge but I signed up for this and understand the importance of measures!”*

P55- *“They felt a bit repetitive”*

A variety of different suggestions were made as to how the outcome measures could be improved (N=19), including making them shorter (N=3), less repetitive (N=2), more context specific (N=3), having space for comments so participants can clarify their responses (N=3), and simplifying the wording (N=2). It was also suggested to have a way of tracking progress such as including a progress bar (N=2).

P35- *“Bit shorter possibly generally... not hugely practical for front line people in very busy secondary care mh services if I am completely honest.”*

Feasibility of the Intervention

Of the 13 intervention participants who completed the Time 1 SAT questionnaire, 12 reported finding it easy to access the intervention, with 12 accessing it via PC and one via their mobile phone. Of these 13 participants, 10 reported finding the intervention easy to complete, and 7 reported being happy to complete the intervention in the given time frame, with 2 responding “neither agree or disagree” and 4 responding “disagree”.

Qualitative feedback was gained via the SAT questionnaire about the pros and cons of the HOP-MHP intervention, whether it had any impact on their disclosure making decisions, and whether they think there are any barriers to people taking part or completing the intervention. Asked what they liked most about the intervention (N=7), 3

reported liking the content of the guide, 2 how the guide enabled them to reflect on their experiences, and 2 liking the flexibility of a self-help intervention. Also, 3 reported finding the peer forum integral to the intervention, with 2 finding the sharing of experiences beneficial.

P35- *“I thought it gave me the means to reflect on my choices in terms of disclosure and how I communicate (or sometimes not) my mental health difficulties to others”*

P6- *“What I liked most was the peer forum. The worksheets are helpful but actually talking about it made a big difference, particularly seeing that others have similar thoughts.”*

Asked what they liked least about the intervention (N=7), 2 reported the content being too repetitive. Other feedback included not finding some of the worksheets applicable, and then factors relating to the study more broadly, such as the research design, and inactivity on the peer forum.

P19- *“Repetitive questions.”*

P48- *“maybe it was a little tedious at parts?”*

Feedback regarding the impact of the intervention on disclosure making decisions (N=6) indicated that participants were able to make use of the intervention. Of these 6 participants, 3 reported that the intervention enabled them to think more about disclosure, with one person commenting on how they now felt they had more options, and two people reporting they can now see more of the benefits of disclosing. One person commented on how the intervention had given them helpful tools to use in the future.

P6- *“Reaffirmed how important it is, and made me think a bit more about when and how I will disclose.”*

P48- *“I suppose I'm now more open to think about the potential benefits of my experiences, rather than how terrible they were.”*

Asked about the barriers to the intervention (N=7), 3 reported that it requires too much time, and 2 reported issues regarding to accessing the intervention. Other barriers included personal issues and issues relating to disclosure.

P5- *“Having the time. Needing to complete the exercises (it's easy to read through it and say you'll do those bits later, but then actually doing them is another thing). I prefer to print out things and it took me ages to find the time to do that (it's a lot of pages!)”*

P19- *“Having to admit to having had MH problems. It was strange to complete this and not talk about it with colleagues as the criteria for completing it was to have experienced MH problems, therefore to discuss was to reveal.”*

Feasibility of the Peer Forum

Of the 13 intervention participants at Time 1, 11 reported having used the peer forum. Five of these reported using it weekly, 2 using it fortnightly, and 2 using it monthly. Nine reported finding the peer forum useful alongside the HOP-MHP guide, ranging from somewhat useful to very useful, with only 2 finding it not useful. Ten reported that they felt the peer forum would be useful as a resource separate to the HOP-MHP guide ranging from somewhat useful to very useful.

Qualitative feedback was gained via the SAT questionnaire about the peer forum (N=10), including ways in which it could be improved and the barriers to using it. Asked how to improve the forum, 2 suggested that regular input from moderators would be

helpful, 2 reported that having separate threads would be useful and 2 commented on issues relating to confidentiality.

P5- *“Active participation of the study team in the Slack group perhaps so there weren't long periods of silence after someone had posted.”*

P18- *“Have different sections to talk about the different aspects of the workbook. It was difficult to follow all the different conversations going on.”*

Only three participants responded to the questions regarding barriers to using the peer forum, each giving a different reason: not being able to access it, time constraints and not wanting to disclose online.

Semi-structured Telephone Interviews

Intervention participants were able to opt in to taking part in a semi-structured telephone interview after completing the intervention. It is worth taking into consideration that due to the slower than anticipated progression through the study this was offered after Time 1. However, it was felt that this was still an appropriate time to give feedback as they had completed the core sessions of HOP-MHP. At time of analysis only three participants had completed the interviews. A content analysis of the qualitative feedback gained from the three participants who consented to the telephone interview was used to further address the feasibility questions relating to the intervention.

- Are participants able to access and make use of the self-help guide?

Similar to the SAT questionnaire feedback, the participants reported finding the content of the guide helpful. There was a sense that the guide addressed things in a sensitive and balanced manner, presented in a suitable way.

P2- *“I think it was most definitely balanced in looking at the upsides and downsides”*

P6- *“I think the guide I found quite helpful particularly because it was broken up into sort of neat segments, and that made it quite easy to work through”*

All three participants commented on sections they found particularly helpful and sections they found less helpful. However, this was different depending on the individual and there was a sense that it was helpful to spend less time on the sections that felt less relevant.

P27- *“I thought that the erm guidance erm in terms of really going into detail about why people might disclose and what people might want to get out of it and responses you might get was really interesting.”*

There was a sense that participants were able to get use out of the intervention, but that perhaps it could be made more suitable for mental health professionals.

P6- *“I think I feel much more confident, especially with the choice to not necessarily disclose, I think it’s just sort of validated that a little bit for me.”*

P2- *“it maybe explains more than it would need to for clinical psychologists but sometimes it’s good to be reminded of the basics”*

When asked about potential negative impact, one individual reflected on their personal experience, which may be a challenge of not having the opportunity to discuss the intervention with a facilitator.

P2- *“They made me feel slightly guilty, even though they are not setting out to do that... I’m feeling a little bit like a coward... Yes, guilt and admiration in equal measures.”*

- Are participants able to complete the intervention in the proposed timeframe?

There was a sense that while all three participants had completed the intervention, more time was needed, and that it should be seen as an ongoing process.

P6- "it's a process and it's quite a long-term thing, so I think maybe it just needs a lot more time than a few weeks. And maybe there's stuff that is an ongoing kind of thing... or I think that's what it feels like for me. So, I think it's helpful to run through it in those few weeks but also with the expectation that actually some of that will need much more time."

There was a common reflection that it is up to individual how long to spend on the different sections of the guide, and which sections to focus on.

P2- "It felt ok. As soon as I'd given myself permission to only complete the bits that felt relevant, it wasn't something I needed to avoid. And I think the advice I would give other people is to do a skim read of the lot when it arrives because that would have certainly reduced my procrastination because it wasn't an onerous as I was expecting it to be."

Overall, there was a sense that the HOP-MHP guide was feasible as a self-help intervention.

P2- "The materials themselves are a good idea just to kick off people like me thinking about these things because taking time to think about these things is a luxury at the moment."

- Are participants able to complete the guide as a self-help intervention (without guidance from facilitators and outside a group setting)?

The qualitative feedback indicates that a potential barrier to a self-help intervention is around motivation and engagement with the resources.

P27- "I found it really difficult to motivate myself to complete the erm [laugh] worksheets" ... "I do think I put off doing the worksheets 'cause the idea of having to sit down, and think about them and go through them felt quite scary"

Two of the three participants reported printing out the guide, with one stating that this in itself was a barrier to completing the guide.

P27- *“I printed it out at work, and then got incredibly anxious about somebody seeing it in the printer”*

- Can a peer web forum be run alongside the intervention without added risks?

Across participants it was reported that it was challenging accessing the peer forum when first starting the intervention, due to starting a conversation part way through. They also commented on the lack of activity on the forum.

P6- *“I struggled to get into a little in the beginning, because erm, I dunno, it sort of like when I joined there was already a conversation going on so I wasn't... I didn't really know what to say or do”*

Similar to the SAT questionnaire feedback, it was felt that having separate threads would make the peer forum more user friendly.

P6- *“I think it would be helpful in the forum if there were more channels, or there were ways to sort of make threads, because at the moment it is just one massive conversation and I think that's what put me off at the beginning.”*

However, all three reported finding the peer forum helpful and felt that it was useful as a resource in its own right.

P6- *“the forum is quite helpful, because people are talking about different things at different times so if you're not there yet you can revisit that, or if you are there you can join in. Or you can just start your own thing”*

P27- *“really like it to stay open actually, and the idea that it is something that I could dip into, yeah, or that... yeah. It feels like a really nice resource to have.”*

Key benefits of the peer forum included its anonymity and how it reduced isolation through sharing experiences.

P2- *“it’s got the advantage that it’s anonymous and doesn’t require travel so, yeah, massively more feasible.”*

P27- *“so I have come into this profession partly because of my own experiences and then have often felt really ashamed about that. But to hear other people commenting on that in a very similar way, and how they kind of negotiate those bits of themselves felt really validating just to read and hear and think: “Well, of course, like of course we have all experiences like this”. And that’s, I think, been really helpful for me.”*

There was a sense that knowing it was a moderated forum made it feel safer and therefore more feasible.

P2- *“I think the peer forum and having a moderated peer forum where people were gently encouraging was really helpful.”*

P2- *“And I also think that it makes participants feel safer to know that a moderator is there”*

Feedback Relating to the Research Process

All three participants reported finding the regular email contact from the researchers appropriate and helpful.

P6- *“having that sort of regular check in meant that I was actually doing it as intended”*

One participant reflected on their personal experience of signing up to the research study and experiencing this as exposing. However, another participant reflected on the potential benefits of the research study.

P27- *“I found it quite scary to sign up to something that feels quite exposing when you’re not quite sure what it is you’re signing up for.”*

P2- *“Because then we can take it forward in terms of what is relevant for our services and what we can do in terms of staff training etc.”*

Preliminary Outcomes

An initial analysis of descriptive statistics was conducted to assess the distribution of sociodemographic characteristics across the conditions, and the assumptions of normality and the homogeneity of the data. Guided by Field (2013), any outliers were identified by converting the scores into z-scores. Those outliers within the probable or extreme range were Winsorized, replacing them with the next highest score that was not an outlier. The skewness and kurtosis of the data was then assessed and found to be fairly normally distributed. To confirm the normal distribution, the Kolmogorov-Smirnov test was conducted, with all of the measures meeting assumptions of normality, apart from the Time 1 PHQ-9 data ($D(13)=0.312$, $p<0.01$). Descriptive statistics are presented in Table 3.

To assess preliminary outcomes data, ANOVAs were carried out for each of the measures, to compare the intervention group with the control group over two time points (T0 and T1) due to limited data being available at T2. ANOVAs were conducted on the data for completed cases (Appendix 14), and also for an Intention-to-Treat (ITT) analysis, using Last Observation Carried Forward (LOCF) for those participants who had dropped out of the study. Effect sizes were calculated using an ANOVA Cohen's d calculator (Lenhard & Lenhard, 2016). The ITT data has been presented in this paper because it gives a more conservative, but likely more accurate picture of the outcomes for everyone included in the trial, whether or not they completed the intervention. However, the data for the completed cases has been included when this is notably different to the findings from the ITT analyses. Due to difficulties with recruitment and slower than anticipated progression through the study, the preliminary outcomes were greatly underpowered and should be interpreted with caution.

Table 3

ITT Means and Standard Deviations

Outcomes- Means Measures	Intervention (n=21)		Control (n=20)	
	Baseline <i>M (SD)</i>	Time 1 <i>M (SD)</i>	Baseline <i>M (SD)</i>	Time1 <i>M (SD)</i>
SSS- Appraisal	-5.71 (8.47)	-5.90 (8.47)	-2.65 (11.08)	-4.95 (10.63)
SSS- Harm	27.90 (7.61)	27.38 (6.93)	29.30 (8.22)	26.90 (9.32)
SSS- Coping	33.62 (5.51)	33.29 (5.87)	31.95 (5.75)	31.85 (5.43)
SSMIS- Aware	28.52 (4.02)	28.14 (5.11)	29.45 (5.59)	29.95 (6.99)
SSMIS- Apply	12.90 (6.21)	13.57 (6.76)	12.50 (6.23)	12.70 (4.69)
SSMIS- Hurt	15.67 (8.37)	15.48 (8.46)	14.35 (7.85)	14.05 (6.24)
PHQ-9	15.43 (4.48)	16.00 (5.62)	16.65 (5.02)	16.50 (4.50)
GAD-7	13.71 (3.81)	14.29 (4.97)	14.50 (4.88)	13.20 (4.56)

Primary Outcomes

An ITT analysis was conducted, using analysis of variance to test for interactions between time and condition. A small effect was found for overall Stigma Stress Appraisal scale ($d = 0.282$) and Stigma Stress Harm subscale scores ($d = 0.396$), with control group participants showing reduced harm over time, and therefore achieving a better overall appraisal score at Time 1. No effect was detected on the Stigma Stress Coping subscale. See Table 4 for ANOVA results.

Secondary Outcomes

There was no significant effect of the intervention on internalised stigma, as measured on the SSMIS for the ITT analysis across all three subscales (Awareness, Application and Self-harm). However, for the completed cases analyses there was a small effect ($d = 0.378$) for the time x condition interaction on the stigma awareness subscale, with control group participants showing an increase in awareness and intervention participants showing a decrease over time.

Due to the assumptions of normality not being met, it was not possible to interpret the ANOVAs for depression symptoms as measures on the PHQ-9. Mann-Whitney tests were conducted, which found that at baseline, intervention participants ($Mdn = 14$) did not differ significantly from control participants ($Mdn = 16$), $U = 238.000$, $p = .100$. At Time 1 the intervention participants ($Mdn = 15$) and the control participants ($Mdn = 15$) continued to not differ significantly, $U = 177.500$, $p = .394$, indicating that there was no effect of the intervention.

There was a moderate non-significant effect ($d = 0.577$) of the intervention on anxiety symptoms as measured on the GAD-7, with control participants showing a decrease in anxiety scores and intervention participants showing an increase over time.

However, although this interaction was also present for the completed cases analysis ($d = 0.584$), the increase in anxiety scores for intervention participants was not present.

Table 4
ANOVA results for ITT analyses

Measure		F	P	Cohen's d
SSS- Appraisal				
	Time	1.082	.305	0.333
	Time*Cond	0.777	.384	0.282
	Cond	0.506	.481	0.228
SSS- Harm				
	Time	3.704	.062	0.617
	Time*Cond	1.525	.224	0.396
	Cond	0.036	.850	0.061
SSS- Coping				
	Time	0.095	.760	0.099
	Time*Cond	0.028	.869	0.054
	Cond	0.922	.343	0.308
SSMIS- Aware				
	Time	0.004	.952	0.020
	Time*Cond	0.203	.654	0.144
	Cond	0.928	.341	0.309
SSMIS- Apply				
	Time	0.355	.555	0.191
	Time*Cond	0.103	.750	0.103
	Cond	0.134	.716	0.117
SSMIS- Hurt Self				
	Time	0.050	.824	0.072
	Time*Cond	0.002	.960	0.014
	Cond	0.397	.532	0.202
GAD-7				
	Time	0.494	.487	0.225
	Time*Cond	3.244	.079	0.577
	Cond	0.013	.911	0.037

Discussion

The main purpose of this feasibility and pilot study was to evaluate the feasibility of HOP-MHP, a recently developed self-help intervention to support disclosure decisions in mental health professionals who have personally experienced mental health problems.

Recruitment, screening and randomisation procedures were found to be feasible. As recruitment initially focused on the profession of clinical psychology, the majority of participants were either trainee or qualified clinical psychologists. In order to assess HOP-MHP more broadly, alternative recruitment routes will need to be considered to access other professions. Initial data on dropout rates suggest higher rates in the intervention condition, which may be due to issues of time constraints and the current research procedure time frame being unrealistic as the majority of participants required more time to complete the intervention than anticipated. The time required to complete the surveys and the intervention varied greatly, impacting on the feasibility of the research trial in the current format.

Descriptive statistics and qualitative feedback from participants indicated that overall the intervention was feasible. While the study procedures were found to be feasible, with participants finding the survey software easy to use, and finding the email reminders helpful, their feedback highlighted some key areas for improvement. This included the amount of time required for the study. With study completion taking much longer than anticipated, it would be important to adjust expectations placed on participants accordingly so as not to affect engagement. While most participants provided positive feedback about the outcome measures, including that they were thoughtfully selected, clear and user friendly, suggestions for improving the outcome measures included making them shorter and less repetitive.

With regards to the HOP-MHP intervention, overall participants were satisfied with the intervention, placing particular value on the peer forum as a resource alongside the guide. It was originally intended that the peer forum would close after the research project. However, due to requests from current participants it was decided that the peer forum will remain open after the completion of the project as it has been extremely valued by its members and we felt it was unethical to close it. Feedback on the specific content of the HOP-MHP guide was varied, with participants having very individual experiences of what they found helpful versus unhelpful, most choosing to focus more time and effort on the sections that felt most relevant to them. It may be helpful to more explicitly give permission to future users to skim read the whole document first and then decide which sections to invest more time and effort into to meet their individual needs, so as to remove the potential barrier of the whole self-help guide feeling overwhelming. Also, it is important to consider that the time taken to complete the intervention varied greatly, with most taking longer than the three weeks anticipated. While flexibility in completion time is a benefit to self-help interventions, it seems that in its current format there is a risk of participants losing momentum, which in turn may have impacted on the outcomes. It might be helpful to consider more guidance for the self-help intervention with more structured time frames encouraged in order to prevent this.

Due to the variety in views given in this pilot RCT, it is recommended that participant feedback be reviewed as part of ongoing data collection, to see if a clearer consensus is reached with suggestions for improvements, before any significant changes be made to the intervention or research procedures. However, some common themes were clear, and it seems that it would be helpful to review the outcome measures to make them shorter, less repetitive, and possibly more context specific, or include more space for

commenting to allow participants to clarify their responses. It is recommended that any criticisms where 50% or more of participants agree should be addressed prior to full scale research studies proceed (Oremus et al., 2005). While the Stakeholder Group provided helpful feedback on the outcome measures during the development stage of this study, it may be helpful to use semi-structured interviews or a focus group with study participants to inform adaptations prior to future research (Sidani & Braden, 2011).

Preliminary Outcomes

A small effect was found for the primary outcome measure Stigma Stress Appraisal score ($d = 0.282$). This indicated that the control participants improved over time. Outcomes on the secondary outcome measures suggest that in the short term the intervention may have mixed effects on mental wellbeing as measured on the PHQ-9 and GAD-7, as there was no change in depressive symptoms and a small increase in anxiety symptoms in the intervention group. However, it is of note that levels of anxiety remained within the moderately severe range as measured by the GAD-7 for both conditions, indicating that this change was not of clinical significance. It is possible that through the process of focusing on their lived experience of mental health problems, and the pros and cons of disclosure, mental wellbeing may have been negatively affected, at least in the short term. It is also possible that the additional resources available via the website and the knowledge that they would receive access to the HOM-MHP guide and peer forum after completing the study may have led to improvement in control participants.

These findings indicate that potential positive effects of the intervention, identified from the qualitative feedback, may be accompanied by a small increase in anxiety, at least in the short term. These findings should be interpreted with caution. Due to the small sample size, it is advised that data collection continue so that the outcomes can be

confirmed with a larger sample size and greater power, over a longer timeframe as some effects may take time to materialise. It was not possible to look at Time 2 follow up data due to participants' slower than anticipated progression through the study; further analyses should be conducted once sufficient Time 2 data have been collected to allow further exploration of the outcomes.

Both groups remained within the severe range for depression, as measured on the PHQ-9, indicating that the participants had clinically significant symptoms of depression. Future studies should identify whether levels of depression interact with engagement and progression through the HOP-MHP self-help guide and whether this impacts on other outcomes by controlling for depression as a covariate.

Difficulties with recruitment and progression through the study meant that the outcomes were greatly underpowered. Guidance for feasibility studies often recommend preliminary outcomes be assessed in order to estimate the effect sizes and likely outcomes of the intervention (Sidani & Braden, 2011). However, this approach has become more criticised as often feasibility studies are underpowered due to small sample sizes, which can lead to effects being underestimated (Hertzog, 2008). While the inclusion of preliminary outcomes in feasibility studies is contentious, it may be helpful to conduct qualitative process analyses to identify whether certain groups of participants have responded to the intervention differently to others, as recommended by the MRC (Moore et al., 2014).

Strengths of the Study

The intervention was adapted with close guidance from a stakeholder group. This helped ensure that the language, content and structure were adapted in a way that is suitable for the desired audience, mental health professionals working in the UK.

The study design enabled mental health professionals to complete the intervention at a time convenient for them. Participants were encouraged to choose which tasks they complete depending on how relevant they are to their current needs. Alongside the self-help guide, participants also had the option of joining an online peer-forum, and could choose how actively they used this. The benefit of a self-help intervention is the increased flexibility with regards to timeframe, enabling participants to complete the intervention at a time appropriate to their individual needs. However, it will be important to adjust expectations moving forwards as placing unrealistic time constraints on participants may act as a barrier to recruitment and engagement.

A key strength of this study is the careful attention paid to protecting the confidentiality of participants. The research team worked closely with UCL Data Protection department to consider these issues in the study design, balancing confidentiality alongside our ethos of encouraging a more open approach with regards to standing up against mental health stigma. The option for participants to set up an alias email address for the purpose of the study enabled them to be contacted and provided with the HOP guide without the researchers needing to know their true identity. This, combined with the use of unique identifiers throughout data collection protected the participants' confidentiality.

Limitations

One participant raised concerns about the ethical issue of randomly allocating participants to either a control or intervention arm. While the study design was explained in the information sheet it is possible that this needs to be made even clearer if more people express similar concerns. This should be monitored as part of ongoing data collection, as

it is recommended that if 30% or more of the participants in feasibility studies resent randomisation alternative research designs be considered (Sidani and Braden, 2011).

The majority of participants (94%) reported their ethnicity as White British. This is somewhat higher than the proportion of White British in the workforce data, which was reported as 90.5% in 2013 (Smith, 2017). It may be helpful to consider this as part of adapting the intervention and recruitment procedures for future studies. However, this should be interpreted carefully due to the small numbers in our sample.

While the intervention was designed to be easily accessible, feedback from the semi-structured interviews indicated that some participants would have preferred to receive a hard copy of the guide, and that printing it themselves acted as a barrier to engaging with the intervention. It may be helpful to consider having an option whereby participants can request to receive a hard copy to eliminate this potential barrier.

Another issue with the HOP-MHP self-help guide is fidelity of the intervention. A fidelity measure for the original HOP intervention was developed by Rüscher et al. (2014) and adapted in a more recent study (Mulfinger et al., 2018). As a self-help intervention, where participants access the guide in a number of different ways, it is not easy to monitor the fidelity of the HOP-MHP intervention, and assessment in this study has been dependent on participant self-report. From the qualitative feedback gained it seems likely that fidelity would be moderate as each participant seemed to choose which sections felt most relevant to them and to invest time and effort in. Therefore, participants may be missing out core components of the HOP-MHP intervention. An electronic version of HOP-MHP should be considered, whereby the software monitors participant usage, tracking time spent on each section or page. However, this would

likely impact on accessibility as not everyone would be willing or able to access the intervention in this way.

An important consideration is that the adaptation of HOP into a self-help intervention resulted in reduced levels of peer support in comparison to the original peer led group intervention. A self-help intervention was favourable due to mental health professionals' concerns about the potential negative effects of disclosure on their career and professional reputation. All participants had the option to access a closed peer support forum during the study, which was confidential and only accessible by people participating in the study. It was hoped this would provide the peer support integral to the original HOP intervention. While most participants reported finding the peer forum useful, the amount of use varied greatly. Therefore, it is likely that the benefits of peer interactions deemed integral to the original HOP intervention were diminished in HOP-MHP in its current form. If possible, future research should aim to more closely monitor whether engaging with the peer forum contributes to more positive outcomes.

Unfortunately, due to the longer than anticipated time required for participants to progress through the study only a small sample had completed measures at all three time points within the time constraints of this study. Therefore, for the purpose of this feasibility study preliminary data was only analysed for those with both baseline and time 1 data. An ITT analysis was conducted to include those who had dropped out between baseline and Time 1. This means that the power of the analyses was less than expected.

Some stakeholders raised frustrations that this intervention would potentially be placing the emphasis on the individual rather than on system or political change. While the project is positioned within The BPS Wellbeing Charter and Pathfinder Site for Collaborative Learning Network, which aims to improve support for staff-wellbeing and

to create workplaces that are both compassionate and sustainable (Rao et al., 2015; 2016), it was important to ensure this be made clear in the introduction to the intervention. It was also deemed essential that information be made available to both intervention and control participants about how to access support. In response to this a study website was developed alongside the intervention with information about how to access support from the research team if participation in the study causes distress; information about other sources of support; information about self-care; information about Fitness to Practice; and signposting for legal and employment support services.

Implications

This study found that the HOP-MHP intervention and research protocol is feasible, with some small adaptations needed, including making some minor changes to the outcome measures and adapting the time allocated to participants to complete the intervention. It has become clear that balancing participation alongside employment, without the structure of attending group sessions, means that it takes longer than the original HOP intervention. However, the ability to go at a more personal pace makes it likely that more people would be willing and able to access the intervention, and at this time seems more feasible for mental health professionals, due to the implicit need to disclose if attending a face-to-face group.

The preliminary outcome data found a small increase in anxiety in the short term. This will need careful further examination and consideration. However, the increase in anxiety scores for intervention participants was not present for the completed cases analysis. Caution is required in moving forwards as an increase in anxiety scores as measured on the GAD is of potential concern. Based on Rüsç et al. (2014) a larger effect size was assumed than was achieved. Therefore, the evaluation of the preliminary

outcomes was greatly underpowered. For this reason, it was not appropriate to interpret the results according to statistical significance. A larger sample size is required to increase the power. It is possible that in the data at the follow up time point, when participants have had longer to consolidate and process the information covered during the intervention, that the outcomes of the intervention will be clearer.

If proven effective, HOP-MHP could be easily implemented. Although the majority of participants in this pilot RCT were clinical psychologists (trainee and qualified), the intervention was designed to be suitable for mental health professionals from a range of disciplines. Not only could this help support individuals in reaching their own personal decisions about disclosure and reduce stigma stress, but it also has the potential to make a valuable contribution to reducing mental health stigma and challenging the ‘us and them’ professional versus service user divide if more mental health professionals were to speak out about their own lived experience.

Recommendations

As this intervention has been found to be feasible and acceptable it warrants further investigation into whether it produces positive outcomes, and to confirm its economic value as a self-help intervention. Future research should consider the economic value in terms of financial cost and whether as a self-help intervention it enables better use of professionals’ time who would otherwise be facilitating a face-to-face intervention (Lewis et al., 2002). It would also be helpful to consider the economic value in terms of staff burnout and work outcomes (Lewis et al., 2002). However, a number of recommendations have been made, which may be helpful to consider with future research.

Recommendations for improving the research procedure include exploring alternative recruitment routes to access other professions outside of clinical psychology,

and to assess whether the intervention and procedures are feasible for other mental health professions. To ensure that participants are able to access the intervention in their preferred method and to reduce any barriers to access, it would be helpful to provide an option whereby participants can request to receive a hard copy of the HOP-MHP guide. It may be helpful to consider ways of tracking or assessing treatment fidelity with regards to which sections of the guide participants use, as this may affect the outcomes. It is also recommended that feedback be gathered from participants about their usage of the HOP-MHP website, as a potential confounding variable.

It is recommended that the outcome measures be reviewed to consider ways to make the surveys shorter and less repetitive, review the response options, adding qualitative comment boxes where appropriate so that participants can clarify their responses.

For the HOP-MHP intervention it is recommended that expectations be amended with regards to how long it is anticipated it will take participants to complete the intervention. Initial time frames were closely based on the group intervention and this feasibility study has identified that as a self-help intervention more time is required for completion.

Recommendations for the peer forum include more active participation from moderators during periods of inactivity. It is also recommended that the use of more forum sub-channels be explored, with potentially adding the function whereby participants can add their own sub-channels to enable conversations on different topics. To assess the role of peer support and how the peer forum is providing this in comparison to the original HOP group intervention, it is recommended that future research consider ways of more closely monitoring activity on the peer forum and how

this impacts on outcomes. A benefit of online peer support includes increasing numbers of virtual communities where individuals can share their experiences and provide emotional support to each other (Eysenbach, Powell, Englesakis, Rizo & Stern, 2004). It may be helpful for the research team to monitor the use of the peer forum and to quantify participants' use and active engagement with the peer forum. This will enable analysis of how these impact on outcomes by controlling for these factors as covariates. Future studies may want to consider a factorial design, enabling comparisons between the current combined intervention with a peer forum only condition and a HOP-MHP guide only condition, alongside a control group. This would enable evaluation of the impact of the peer forum and help identify which components of the intervention contribute to outcomes. However, factorial design RCTs require much larger sample sizes (Montgomery, Peters & Little, 2003). Longitudinal analysis of quantitative and qualitative data and the different mediators across groups will help identify the key mechanisms of change of the intervention (Kazdin, 2007). As it is hypothesised that peer support may be a key mechanism of change in the current HOP-MHP, it would be helpful to include a clearer measure of peer support or connectedness, such as the Social Connectedness Scale or the Social Assurance Scale (Lee & Robbins, 1995).

Conclusions

This research has provided insight into the feasibility of the HOP-MHP intervention and study procedures, as well as preliminary outcomes. The findings suggest that overall the HOP-MHP intervention and research procedures are feasible. However, some adaptations are recommended to improve the feasibility of the research moving forwards. The intervention's outcomes will need more careful evaluation over time and with larger samples.

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Part 3: Critical Appraisal

Overview

This critical appraisal begins by discussing the development of the project. When writing the empirical paper, it became clear that it would be impossible to cover all aspects of the project in detail, from the adaptation of the workbook and outcome measures with the stakeholders, the small pilot as an initial test of feasibility and then the pilot RCT. The empirical paper focuses on the pilot RCT, and therefore space has been allocated here to cover these areas and considerations in more detail. It then presents some of the challenges that arose during the project and expands on some of the main limitations of the research. Finally, it addresses my personal learning and implications for the future, including dissemination.

Development of the Project

When I first started my journey on this project, I focused on the previous literature around Honest Open Proud, previously Coming Out Proud (Corrigan, Kosyluk & Rüsçh, 2013; Corrigan et al., 2015; Rüsçh et al., 2014) and the benefits of supporting individuals with making decisions about disclosure. The evidence indicated that the intervention has immediate positive effects on disclosure and stigma stress and has the potential to alleviate the negative impact of stigma (Rüsçh et al., 2014).

The recent research conducted by UCL trainees (Grice, 2016; Tay, 2016) highlighted the prevalence of lived experience of mental health problems amongst clinical psychologists. To me it was clear that an adapted HOP intervention, aimed at helping mental health professionals to ultimately disclose their own experiences in a personally meaningful way, had a number of implications for the individual, but also systemically: challenging the 'us and them' divide within the field of mental health and public health. However, on reviewing my research proposal, it became clear that my

focus on the potential benefits of disclosure had hindered my ability to consider the potential negative consequences. It was necessary to take a step back and consider a more balanced perspective, acknowledging that disclosure might not be the right decision for everyone. I realised that it was important to be mindful of this throughout every stage of this research project to ensure that the intervention is unbiased and allows space for those where disclosure may not be helpful. It was important to acknowledge that disclosure is a personal decision and to ensure that the intervention provides support regardless of what an individual's decisions about disclosure are. The balancing and weighing of costs and benefits of disclosure "is a very complex, unique and personal process; as such, this process, and ultimately his or her decision on whether to come out or not, is one that can really only be made by that individual" (Buchholz & Corrigan, p. 3; adapted from Corrigan et al., 2013).

Alongside reviewing published journal articles, it was also of great value to review other media and resources. Reading Corrigan, Larson and Michaels (2015) book "Coming Out Proud to Erase the Stigma of Mental Illness" gave great insight into the experiences of a variety of individuals in reaching their own decisions to "come out proud" about their own experiences. Some give brief summaries, others provide rich and detailed narratives. For some their mental health difficulties are historical, and for others they are very much still part of the ups and downs of day to day life. This highlighted to me how each individual's decisions about disclosure are unique. One stakeholder shared with us their personal experience of disclosing their own mental health difficulties and how "broadcasting" this had brought with it mixed reactions from their peers and colleagues. In a letter to the editor of the journal *Psychosis* (Richardson, 2016a) they speak about their own personal experiences of depression, mania and hypomania. In a

letter to The Psychologist magazine (Richardson, 2016b), they reflected on how many remain silent due to fear of judgement, and upon their own “sense of relief” about now feeling able to write openly about their experiences of being a mental health professional with lived experience of mental health problems.

More recently I read Adams (2004) “The Myth of the Untroubled Therapist” which summarises qualitative doctoral research into ways in which forty therapists believe their personal lives impact on their professional lives, covering a variety of experiences including diagnosed mental health problems such as anxiety and depression, alongside other mental health related experiences such as bereavement and family or relationship difficulties. Adams notes that “like our clients, every therapist has their own story to tell, and how they deal with difficult personal circumstances is as individual as the narrative surrounding it” (p. 5).

Engaging with Stakeholders

An essential stage of this project was the recruitment and engagement with stakeholders. While the research team already had ideas about how to go about adapting the HOP group intervention for mental health professionals with lived experience, we were aware that we might be making certain assumptions and that it was integral to the development stage that we gained the valuable insights of individuals with direct experience of managing their “dual” identities and the challenges of doing so. At this point in time the focus was on qualified and trainee clinical psychologists, following previous research conducted by UCL trainees (Grice, 2016; Tay, 2016) identifying high levels of mental health problems within these groups. However, the assumption was made that the adaptation would be relevant for other mental health professionals if we broadened recruitment at a later stage. Recruitment of qualified stakeholders began in

July 2016, contacting trainee and qualified clinical psychologists who expressed an interest in being involved in future research following the previous UCL/DCP surveys conducted by the previous trainees (Grice, 2016; Tay, 2016). It was important to consider how joining the stakeholder group involved an element of disclosure, especially for the trainees who were colleagues with the research team.

In November 2016, stakeholders were invited to attend a day long meeting to provide feedback on the current HOP intervention and the proposed procedures for the pilot RCT. We presented an overview of HOP, the proposed methodology, and considered the suitability of adapting HOP into a self-help intervention for clinical psychologists. The HOP intervention was reviewed in small groups and then key themes were fed back to the whole group. Finally, the outcome measures were presented in order to gain stakeholder feedback. Options for peer support and other necessary support were discussed.

To review the HOP intervention, we broke up into small groups of approximately 4-5 people, each focusing on one section of the HOP intervention, to provide ideas and suggestions for changes to be made. This process was informed by the Nominal Group Technique (NGT: Sample, 1984), with group members making suggestions and then ranking them in order of priority, in order to come to a group consensus. Common themes arose out of the discussions including adapting the language and content to be more appropriate for clinical psychologists, particularly the worksheets. The main concern was the use of language, in particular with the term “mental illness” being used throughout the intervention. It was important to adapt the language to make it more acceptable for the target population of mental health professionals in the UK. While I am aware that not all would agree with the term “mental health problems”, this was used as

it was the most agreed upon term from discussions with the stakeholders. Other considerations included making changes to the language as it was originally designed for an American audience, and to also make adaptations to language and examples to make it more relevant to mental health professionals as it was felt certain aspects could be seen to be condescending or patronising.

The outcome measures were also reviewed as part of the Stakeholder day. Again, concerns were raised about the use of the term “mental illness”, used repeatedly through the Stigma Stress Scale (Rüsch et al., 2009). Following the stakeholder feedback the HOP-MHP self-help guide was developed and the battery of measures were adapted. Time was taken to estimate the length of the battery to ensure it was a suitable length. A small number of stakeholders, one per group, reviewed the workbook to ensure that the changes made by the research team reflected the feedback given at the stakeholder day.

Looking back at my reflections in my research journal at this time, it is clear that there was an overwhelming sense that this was a valuable and much needed area of research. Although there were some concerns raised, the majority of stakeholders were supportive and keen to stay involved where possible. I remember being taken aback by how openly people were speaking to the group about their own personal experiences, both negative and positive. They all seemed to value having this opportunity to come together and share their experiences and to contribute to the intervention and emphasised the need for additional support from the organisations and systems that surround them.

In parallel with this research my supervisor Dr Katrina Scior set up the UCL Unit for Stigma Research (UCLUS: <https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/ucl-unit-stigma-research-uclus>), a hub for innovation in research and theory production in the stigma field. It was a privilege to

witness the conception of this and to contribute to its early stages. It was also of great value to have the opportunity to both share our own research experiences, but also to learn from the experiences of colleagues both internal and external to UCL, all working in the field of stigma, but across different stigmatised conditions and disciplines including intellectual and developmental disabilities, mental health problems and dementia. The positioning of this research project within UCLUS has enabled me to remain conscious of the broader political environment of such research. At a more recent UCLUS seminar Graham Scambler, Emeritus Professor of Sociology at UCL, presented on the “weaponising of stigma in neoliberal times”, considering how governments append blame to shame as a political strategy. In his blog (Scambler, 2018) he outlines how this “social abjection” (Tyler, 2013) renders people personally responsible for their problems, whatever they be (disability, mental health problems or homelessness).

Peer Forum

Another key consideration in developing the self-help intervention was the lack of the peer support provided from the original HOP group intervention, which is a key component in reducing stigma and isolation and empowering individuals to pursue their life goals and engage in services (Corrigan, Watson & Bar, 2006). It was felt essential to incorporate some form of peer support in the self-help version and it was decided that an optional online peer forum was the most practical and feasible approach, given it was a self-help intervention. Due to the issue of confidentiality it was decided that the forum would be closed access and due to issues of disclosing one’s professional identity it was decided that participants be encouraged to use an anonymised username or pseudonym for their access to the forum, but that it would ultimately be down to individual preference as some individuals might prefer to be open about their identity. We felt that

this needed to be flexible as to insist a participant hid their identity felt contradictory to the aim of the intervention of being able to make one's own decisions about disclosing.

The research team deliberated over the need for moderators to ensure the space was used safely and appropriately and to respond to any concerns as they arise. It was decided that the principal investigators would moderate the forum as it was felt that it would be inappropriate for a research assistant and that there was a need for the main researchers to remain blind to the forum data as it might impact on data analysis and email contact with participants as they progressed through the study.

Slack was identified as the best program for hosting the forum as it is freely available and easily accessible on multiple platforms including computers and phones.

Challenges and Limitations

Funding:

An ongoing challenge with this project was delayed funding from the DCP. While the DCP provisionally agreed to fund the research, there were issues with reaching a final decision which meant there was a lot of uncertainty about when funds would be made available. The anticipated funding from the DCP had still not arrived by June 2018. This uncertainty meant some of the original plans for the study did not come to fruition, such as having a research assistant dedicated to emailing participants throughout their journey through the study, and for helping with the moderation of the peer forum. Whilst on a practical side this meant that researchers were required to work more flexibly, taking on additional work and changing plans for research roles as and when required, it also highlights some of the barriers to conducting research in this area. The economic barriers to improved mental health practice and policy are discussed by Knapp and colleagues (2006), who identify six key barriers, including an information

barrier and resource insufficiency, distribution, inappropriateness, inflexibility and timing. Stigma needs to be addressed on a macro level through policy change (Ahmedani, 2011), including addressing the lack of resources, when compared to other areas.

Recruitment:

In the initial stages of this project the research team felt quietly optimistic about recruitment. Uptake for the two previous UCL studies in this area (Grice, 2016; Tay, 2016) was promising and the universities and DCP had engaged in the recruitment process and indicated that they would be willing to engage in follow up studies. However, the DCP did not disseminate the study information to their national list of trainee and clinical psychologists due to internal procedural issues and very few of the universities confirmed that they had received and shared the study information. This made it hard to assess exactly how many sites engaged in the recruitment process, but it was certainly much fewer than anticipated. Again, this perhaps sheds some light on the controversial nature of this research area and a certain unwillingness for organisations to be seen to engage with the research. It also meant that as a team we were required to think more creatively about recruitment, within a tighter time scale due to waiting for the original recruitment paths to go ahead.

It is of note that the proportion of the sample reporting their ethnicity as White British (94%) was somewhat higher than the proportion of White British in the workforce data, which was reported as 90.5% in 2013 (Smith, 2017). While this should be interpreted carefully due to the small numbers in our sample, it poses questions about how accessible the intervention is for mental health professionals from Black, Asian and Minority Ethnic (BAME) groups. Future research may find it beneficial to consider intersectionality,

whereby multiple identities and experiences of exclusion and oppression interact (Crenshaw, 1991; Davis, 2008). This would likely impact on the willingness of mental health professionals from BAME groups engaging with HOP-MHP, due to experiencing marginalisation both as a mental health professional with lived experience, and as an individual from a minority ethnic group. Further consideration may be helpful to address how to make the intervention and the research procedure more accessible.

Analysis

When analysing the qualitative data, I was surprised by the level of detail people provided about their personal experiences in their responses in the Satisfaction with Treatment questionnaire (SAT: adapted from Richards & Timulak, 2013). This was also echoed in the detailed responses during the qualitative interviews. The process of analysis was a challenging one as I felt myself being drawn to cover all of the information provided. This could easily have become an unwieldy task, and I needed to ensure I remained focused on the specific questions of feasibility for this study. To remind myself to keep focused on the specific research question I laid out my feasibility questions in front of me whilst reviewing the qualitative data to ensure I remained focused. However, I am aware that the wealth of qualitative data has not been captured in the empirical paper. It may be helpful to complete a more thorough thematic analysis of the data, combined with the information provided via the peer forum to more clearly illustrate the experiences, views and opinions of mental health professionals with lived experience of mental health problems.

Learning

Reflecting on my journey through this research project I am aware that I have shifted perspective, from initially focusing on how stigma and disclosure can be

addressed on a personal, individual level, to now considering the wider impact of HOP-MHP and how psychologists can contribute to change more broadly, focusing on stigma and disclosure as systemic issues that need to be addressed within the mental health profession but also across healthcare and society. As reflected by Adams (2014) “In a field which purports to work towards the psychological health of others, it is essential that we also promote the good health of our own community” (p. 120). While HOP-MHP is a self-help intervention, the process of development and piloting has contributed to broader considerations, it is essential that interventions empower and support individuals, but that this occurs alongside changes at a political level.

Along this journey I have also reflected on my own personal experiences. Through pursuing this research interest and actively promoting the need for change in how the experience of mental health problems within mental health professionals is perceived, there is an innate disclosure, whereby it is assumed that I therefore have my own experiences. As outlined in HOP-MHP I have reflected on the different types of disclosure, and how through conducting this research I am almost broadcasting my own experiences without actively broadcasting what those experiences are. A number of colleagues have commented on this, and how it would be a potential barrier for other trainees interested in researching in this field. I think this is an important consideration for researchers in the field of stigma, and that careful consideration of the pros and cons of disclosing one’s own experiences is needed, to ensure the right decisions are made for each individual.

Implications and Future Directions

What's in a Name?

Throughout this project, from the stakeholder group to the qualitative interview feedback, it has regularly been fed back that the name “Honest, Open, Proud” (HOP) is not ideal, with many believing it is in itself stigmatising as it implies that you should be those things and if you choose to keep your mental health experiences to yourself then you are in some way being dishonest. At one point this attracted attention on Twitter and there was a lively debate considering the impact of such a name. At the time of writing this, it has been confirmed that the name for the intervention can be changed. While some oppose the inclusion of HOP in the title at all, HOP has attracted a lot of attention over the years through conferences and publications, and therefore it is likely that it will still be included in the title. Alternatives currently being considered are “HOP: Deciding About Sharing” and “HOP: To Share or Not Share” with the subtitle of “Erasing Stigma through Empowerment”. While it is unfortunate that the name change was not possible for our pilot study, I feel that this will help improve the acceptability of the intervention and any research trials moving forwards.

Data Analysis:

It was recommended in the empirical paper that further data analysis be conducted once more participants have been recruited and have completed both Time 1 and Time 2 surveys. As part of this analysis it would be valuable to consider covariates and predictor variables, which were not possible to explore at this stage due to small sample sizes. It may be helpful to explore factors impacting on the outcomes, such as sociodemographic factors, the number of years qualified, the amount of peer forum support accessed and the amount of use of the study website. If recruitment is successful

across different mental health professions it may also be helpful to explore if experiences and outcomes differ across different mental health professions.

Dissemination

A brief summary of this initial phase of the study will be shared with those participants who have completed the study, addressing the outcomes with regards to acceptability and feasibility. However, as this is part of an ongoing pilot, preliminary outcome data will not be included and participants will be asked not to share the information with interested peers, but instead to guide them to the study website where they can sign up to participate in the research.

The process of submitting the literature review for journal publication is already underway, in collaboration with colleagues. While the empirical paper is part of an ongoing study, the research team intend to submit the results for publication. In the meantime, we aim to submit for journal publication a joint paper on the acceptability and feasibility of the adapted HOP-MHP intervention, combining the research conducted by the two trainee clinical psychologists. We also intend to present the findings of this study at the UCL DClinPsy Conference on Staff Wellbeing in December 2018 and at a future UCLUS conference.

Conclusions

This research followed the findings of recent UCL student research projects, that clinical psychologists report high levels of mental health difficulties (Grice, 2016; Tay, 2016) and aimed to address this by developing a self-help intervention to support mental health professionals in reaching disclosure decisions. While this study reports on the preliminary outcomes of the HOP-MHP intervention, it is promising that not only is ongoing work being done to complete the pilot RCT, but plans are also underway for a

future trial of HOP-MHP aiming to collaborate with the Royal College of Psychiatrists, the Royal College of Nursing, the BPS and IAPT programmes.

This research has aimed to analyse a combination of quantitative and qualitative feasibility data, whilst also conducting statistical analyses on the preliminary outcomes of stigma stress, self-stigma, anxiety and depression. The limitations identified should provide helpful guidance in the ongoing research of HOP-MHP and more broadly the field of stigma and disclosure within health professionals. The feasibility data outlined in the empirical paper should shed some light on the potential barriers to the intervention and the research procedures, and can inform the direction of future research. It is hoped that this will help to address the “us and them” divide within the field of mental health and more widely.

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Appendices

Appendix 1: Literature Review Quality Appraisal

Appendix 2: Confirmation of Ethical Approval

Appendix 3: Stakeholder Recruitment

Appendix 4: Email Invitation to Course Directors

Appendix 5: Information Sheet

Appendix 6: Consent Form and Screening Measure

Appendix 7: HOP-MHP - Baseline Survey

Appendix 8: HOP-MHP Self-Help Guide

Appendix 9: Peer Forum Instructions

Appendix 10: Participant Flow Through Study

Appendix 11: SAT Questionnaire

Appendix 12: Qualitative Interview Schedule

Appendix 13: Trainee Contribution to Project

Appendix 14: Statistical Analysis

Appendix 15: Qualitative Interview Extract

Appendix 1: Literature Review Quality Appraisal

Quality Appraisal Checklist (Hawker et al., 2002)

1. Abstract and title: Did they provide a clear description of the study?
 - Good (4) Structured abstract with full information and clear title.
 - Fair (3) Abstract with most of the information.
 - Poor (2) Inadequate abstract.
 - Very poor (1) No abstract.

2. Introduction and aims: Was there a good background and clear statement of the aims of the research?
 - Good (4) Full but concise background to discussion/study containing up-to date literature review and highlighting gaps in knowledge. Clear statement of aim AND objectives including research questions.
 - Fair (3) Some background and literature review. Research questions outlined.
 - Poor (2) Some background but no aim/objectives/questions, OR aims/objectives but inadequate background.
 - Very poor (1) No mention of aims/objectives. No background or literature review.

3. Method and data: Is the method appropriate and clearly explained?
 - Good (4) Method is appropriate and described clearly (e.g., questionnaires included). Clear details of the data collection and recording.
 - Fair (3) Method appropriate, description could be better. Data described.
 - Poor (2) Questionable whether method is appropriate. Method described inadequately. Little description of data.
 - Very poor (1) No mention of method, AND/OR method inappropriate, AND/OR no details of data.

4. Sampling: Was the sampling strategy appropriate to address the aims?
 - Good (4) Details (age/gender/race/context) of who was studied and how they were recruited. Why this group was targeted. The sample size was justified for the study. Response rates shown and explained.
 - Fair (3) Sample size justified. Most information given, but some missing.
 - Poor (2) Sampling mentioned but few descriptive details.
 - Very poor (1) No details of sample.

5. Data analysis: Was the description of the data analysis sufficiently rigorous?
- Good (4) Clear description of how analysis was done. Qualitative studies: Description of how themes derived/respondent validation or triangulation. Quantitative studies: Reasons for tests selected hypothesis driven/numbers add up/statistical significance discussed.
- Fair (3) Descriptive discussion of analysis.
- Poor (2) Minimal details about analysis.
- Very poor (1) No discussion of analysis.
6. Ethics and bias: Have ethical issues been addressed, and what has necessary ethical approval gained? Has the relationship between researchers and participants been adequately considered?
- Good (4) Ethics: Where necessary issues of confidentiality, sensitivity, and consent were addressed. Bias: Researcher was reflexive and/or aware of own bias.
- Fair (3) Lip service was paid to above (i.e., these issues were acknowledged).
- Poor (2) Brief mention of issues.
- Very poor (1) No mention of issues.
7. Results: Is there a clear statement of the findings?
- Good (4) Findings explicit, easy to understand, and in logical progression. Tables, if present, are explained in text. Results relate directly to aims. Sufficient data are presented to support findings.
- Fair (3) Findings mentioned but more explanation could be given. Data presented relate directly to results.
- Poor (2) Findings presented haphazardly, not explained, and do not progress logically from results.
- Very poor (1) Findings not mentioned or do not relate to aims.
8. Transferability or generalizability: Are the findings of this study transferable (generalizable) to a wider population?
- Good (4) Context and setting of the study is described sufficiently to allow comparison with other contexts and settings, plus high score in Question 4 (sampling).
- Fair (3) Some context and setting described, but more needed to replicate or compare the study with others, PLUS fair score or higher in Question 4.
- Poor (2) Minimal description of context/setting.
- Very poor (1) No description of context/setting.

9. Implications and usefulness: How important are these findings to policy and practice?
- | | |
|---------------|--|
| Good (4) | Contributes something new and/or different in terms of understanding/insight or perspective.
Suggests ideas for further research. Suggests implications for policy and/or practice. |
| Fair (3) | Two of the above (state what is missing in comments). |
| Poor (2) | Only one of the above. |
| Very poor (1) | None of the above |

Appendix 2: Confirmation of Ethical Approval



27th September 2016

Dr Katrina Scior
Research Department of Clinical, Educational & Health Psychology
UCL

Dear Dr Scior

Notification of Ethical Approval

Re: Ethics Application 9297/002: Supporting disclosure related decisions among clinical psychologists experiencing mental health problems. A feasibility and pilot study

I am pleased to confirm in my capacity as Chair of the UCL Research Ethics Committee (REC) that your pilot and feasibility study has been ethically approved by the UCL REC until **1st January 2018**.

Approval is subject to the following conditions:

1. You must seek Chair's approval for proposed amendments (to include extensions to the duration of the project) to the research for which this approval has been given. Ethical approval is specific to this project and must not be treated as applicable to research of a similar nature. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing the 'Amendment Approval Request Form': <http://ethics.grad.ucl.ac.uk/responsibilities.php>
2. It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator (ethics@ucl.ac.uk) immediately the incident occurs. Where the adverse incident is unexpected and serious, the Chair or Vice-Chair will decide whether the study should be terminated pending the opinion of an independent expert. The adverse event will be considered at the next Committee meeting and a decision will be made on the need to change the information leaflet and/or study protocol.
3. For non-serious adverse events the Chair or Vice-Chair of the Ethics Committee should again be notified via the Ethics Committee Administrator (ethics@ucl.ac.uk) within ten days of an adverse incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Chair or Vice-Chair will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

On completion of the research you must submit a brief report of your findings/concluding comments to the Committee, which includes in particular issues relating to the ethical implications of the research.

Appendix 3: Stakeholder Recruitment

Email to recruit Stakeholders

Dear colleagues,

We are contacting you as you expressed an interest in being kept informed of the results and/or of follow-up actions to a survey UCL undertook jointly with the DCP during 2015. Through the survey we wanted to address a subject that has been largely taboo within the profession and for which there is little available data, namely to what extent members of our profession have personal experience of a range of mental health problems, and what their experiences are of disclosure and help-seeking. Thanks to individuals like you and many others who clearly found this topic the profession should give more thought to, we obtained detailed responses from 678 UK-based clinical psychologists. (In parallel we conducted a similar survey of trainees and obtained detailed responses from 348 trainees.)

In summary, two-thirds of participants reported having experienced a significant mental health problem at some point in their lives, with mild to moderate depression and anxiety the most common, but also many who reported having experienced severe depression and eating disorders. A small but not insignificant number said they'd experienced bipolar disorder, psychosis, and /or addiction. (Of note, the figures for qualified clinical psychologists and trainees were very similar.) We found a high level of perceived stigma and low levels of external stigma among participants (i.e. respondents thought mental health problems are still heavily stigmatised but held very positive views towards those experiencing mental health problems themselves). Overall participants were much more likely to have talked about their experience of mental health problems to family and/or friends than to people in their work settings. Concerningly over 10% of respondents who had experienced significant mental health problems had not disclosed this to anyone. We will be reporting the findings in detail in the near future and will be presenting them as well at the next DCP conference and the next Group of Trainers in Clinical Psychology Conference to encourage discussion.

It is this last finding regarding disclosure that informs a follow-up project we hope you may be interested in. We entirely respect anyone's right to reach a decision that feels right for them regarding whether or not to talk to others about their mental health. However, not surprisingly, our findings suggest that at least some experience a lot of tension, worry and in some cases distress around the decision whether to disclose and to whom, and fear a range of negative consequences both in terms of others' possible responses but also very much in terms of how they view themselves. Thus it would seem that some level of support around disclosure decisions may well be beneficial.

On this note, colleagues in Chicago, led by Pat Corrigan of the US National Consortium on Stigma and Empowerment, have developed the Honest Open Proud Programme (HOP), designed to support individuals who experience mental health problems to carefully reach disclosure related decisions in a supportive and non-judgmental way, with an opportunity to weigh up the pros and cons of disclosure and to carefully plan how to go about disclosing, should they decide to do so. We are now planning to adapt HOP, which is originally a 3-session group based peer led intervention, as a self-help

intervention for clinical psychologists and trainees. Given that psychologists are clearly in many instances concerned about disclosing to members of their profession, we felt as a first step a self-help intervention is much more suitable. We are also very mindful though of the importance of peer support and are looking to ensure that some means of (initially anonymous) peer support is available to anyone undertaking the self-help intervention.

At this point we are looking for clinical psychologists and trainees who are interested in working with us in the initial stage of adapting the HOP manual and workbook to make it suitable as a self-help intervention for mental health professionals. We envisage this will take place during the autumn of this year and will either involve attending an all-day stakeholder meeting in London in the autumn (on a date that is convenient to all or most stakeholders who come forward) or participating in telephone group conferences. We are keen to ensure that the new self-help intervention really reflects the views and needs of members of the profession, and that we've carefully addressed a range of concerns they may have before we move to the next stage of testing the effects of the new intervention in 2017. We would be delighted if you would consider being part of the stakeholder group. If you are, please reply to this email and state whether you'd be interested in attending a stakeholder meeting in London in person or prefer taking part in a series of telephone conferences.

We should make a few things clear to help you decide:

-there will be no expectation that stakeholders talk about personal experiences of mental health problems in the stakeholder meetings. Instead the focus will be on carefully reviewing the manual and our initial thoughts about adapting it. Of course, should attendees choose to talk about their personal experiences, we will ensure that they find themselves in a supportive environment.

-the project has been declared a pathfinder project for the new Collaborative Learning Network set up by the BPS to support action in line with the Charter for Wellbeing and Resilience issued by the BPS jointly with the New Savoy Partnership and supported by numerous bodies including Mind, Rethink and the Royal College of Psychiatrists:

http://www.healthcareconferencesuk.co.uk/news/newsfiles/charter-2016_1314.pdf As such, the project is closely linked in with BPS thinking on how to promote staff wellbeing, and in turn in a position to influence this work.

-finally, the project is supported by Pat Corrigan and the international HOP network, and as such is striving to promote the best practice in challenging mental health stigma at all levels.

So, at this point we are simply soliciting expressions of interest in joining the stakeholder group informing this work. If you are interested, or might be pending having any queries you might have answered, please drop us a line and tell us whether you'd be interested in attending a stakeholder meeting in London in person or prefer taking part in a series of telephone conferences.

Best Wishes

Katrina Scior & Henry Clements

Dr Katrina Scior
Senior Lecturer & Academic Director

Dr Henry Clements
Clinical Tutor

Joint Leads for HOP-CP project

Invitation to stakeholder day

Dear all,

Thank you very much for your interest in joining us to consider how best to support members of our profession around disclosure of mental health problems they are experiencing. From your responses to our recent invitation to contribute to a follow-on project (see email text at bottom of this message in case this did not reach you for some reason), it seems that nearly everyone prefers a meeting in London to telephone conversations. We have identified three possible dates for such a meeting: Monday, 17th October, Tuesday, 1st November, and Friday, 4th November. If you are happy to attend a meeting in London could you kindly complete this Doodle poll to indicate which of these dates you can make:

<http://doodle.com/poll/rw5iaycftm8fifsc>

Timing wise we suggest 10:30 to 16:00 to allow those of you who come from further afield to make it.

The meeting will focus on three aspects:

- (1) Adaptation of the Honest Open Proud (HOP) programme manual and workbook to make the new version suitable as a resource for a self-help intervention for clinical psychologists.
- (2) Discussion of proposed procedures for piloting and evaluation of the new HOP self-help intervention.
- (3) Identification of other resources that should be available alongside the HOP intervention, e.g. as information and support from the BPS/DCP.

Once we've heard from everyone, we'll write to you with a date and will also send you the original HOP workbook to give you a sense prior to our meeting.

If you said you'd prefer a phone conversation, we'll set this up separately to hear your views on conclusions reached at the stakeholder meeting and to see whether we've missed anything, especially re. points (2) and (3) on the agenda.

Best Wishes

Katrina & Henry

Dr Katrina Scior
Senior Lecturer & Academic Director

Dr Henry Clements
Clinical Tutor

Joint Leads for HOP-CP project

Reminder Stakeholder Day

Dear colleagues,

We are writing to you as a reminder of our upcoming stakeholder meeting for the project on supporting disclosure decisions among members of our profession who have personal experiences of mental health problems.

Date: **Friday, 4th November 2016**

Time: **10.30am to 4pm**

Venue: **Room 446, 1-19 Torrington Place, UCL, London, WC1E 7HB**

The nearest underground stations are Goodge Street (Northern line), Warren Street (Victoria line and Northern line) and Euston Square (Circle line, Hammersmith & City line and Metropolitan line). It is also in walking distance to Euston rail and underground station.

Lunch and refreshments will be provided on the day. Travel expenses will also be covered (please ensure you book your travel in advance to access the best rates, and make sure that you keep your receipts for a claim).

The meeting will focus on three aspects:

- (1) Adaptation of the Honest Open Proud (HOP) programme manual and workbook to make the new version suitable as a resource for a self-help intervention for clinical psychologists.
- (2) Discussion of proposed procedures for piloting and evaluation of the new HOP self-help intervention.
- (3) Identification of other resources that should be available alongside the HOP intervention, e.g. as information and support from the BPS/DCP.

Please find attached the HOP manual in preparation for the meeting. We have also attached the HOP workbook for your reference.

Best Wishes

Katrina & Henry

Appendix 4: Email Invitation to Course Directors

Dear Programme Directors,

We are now recruiting mental health professionals and those in training to a study testing the feasibility, acceptability and preliminary outcomes of a new intervention designed to support decision making around disclosure of mental health problems. To this purpose, we would be grateful if you would consider forwarding this invitation to your trainees, alumni and course staff.

Our new HOP-MHP intervention (short for ‘Honest Open Proud for Mental Health Professionals’) aims to reduce depression, stigma stress and disclosure related distress among mental health professionals who have current or past lived experience of mental health problems by supporting them in reaching disclosure related decisions. HOP-MHP is a 3-session (plus booster) guided self-help intervention adapted from the original evidence based HOP group programme. You can read more about the HOP-MHP project on our project website: http://www.ucl.ac.uk/pals/research/cehp/stigma-research/documents/hop_docs/hop-mhp

This project follows on from national surveys of clinical psychologists and trainees which we conducted in collaboration with the DCP and with support from 19 of the 30 UK training courses in 2015. The findings of said surveys indicated that a large proportion of the profession and trainees have lived experience and that many are fearful of talking to others about their experiences, particularly within a work and training context, due to a fear of being seen as less competent, or of becoming the target of discrimination. The HOP-MHP intervention seeks to support colleagues and trainees who find themselves in this position in reaching balanced decisions around potential disclosure of their lived experience in a way that is personally meaningful, safe and empowering. The project is supported by the BPS and the DCP, is a pathfinder project for the BPS/New Savoy Conference Charter on Psychological Wellbeing and Resilience, and has ethical approval from the UCL Research Ethics Committee.

Participants who took part in an initial pilot of the HOP-MHP guide had this to say:

“I found the guide empowering and also very interesting. I think it will help people to feel supported and also more accepted, and the fact it considers the cons as well as the pros of disclosing is helpful and realistic.”

“The guide is very supportive and accepting. It is also interesting to reflect on how many other clinicians have experienced their own difficulties.”

“I would feel more confident and supported about disclosing to my next supervisor following this intervention. I was nervous about disclosing to my current supervisor on placement when I did so at the beginning of the year, but having completed this guide I think I would feel more comfortable, even if my next supervisor isn't as understanding as my current supervisor.”

“The content was sensitive and useful. It encouraged me to think carefully about disclosure in different contexts.”

Anyone interested in taking part can find more information, including the information sheet and consent form, on our project website:

http://www.ucl.ac.uk/pals/research/cehp/stigma-research/documents/hop_docs/hop-mhp

We should be more than happy to respond to any queries you may have. Thanks in advance for supporting this project.

Kind Regards Katrina Scior and Henry Clements, University College London

Appendix 5: Information Sheet

Information Sheet for the HOP-MHP Study

Supporting mental health professionals in considering disclosure of their own mental health problems through a self-help intervention

We are recruiting participants to take part in a pilot RCT of the new HOP-MHP self-help guide. We would like to invite you to consider participating in this research project, which is overseen by us and carried out by a research team at UCL.

Dr Katrina Scior and Dr Henry Clements
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University College London
1-19 Torrington Place
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United Kingdom
+44 (0)20 7679 1897
k.scior@ucl.ac.uk henry.clements@ucl.ac.uk

This study has been approved by the UCL Research Ethics Committee (Project ID No.: 9297/002).

Overview

This study will test the delivery and impact of a new self-help intervention (HOP-MHP, short for *Honest Open Proud for Mental Health Professionals*) designed to support mental health professionals (including those in training) in reaching decisions relating to the disclosure of mental health problems they may be experiencing or may have experienced in the past. If you personally have lived experience of mental health problems and you are not currently completely 'out' about this in both your social and work circles, you may find this intervention helpful.

Using the self-help guide will help you personally consider whether, where and how you may want to disclose your own lived experience. For the duration of the study, you will also have access to an anonymous peer forum where you can discuss your experiences and thoughts regarding disclosure with other mental health professionals with lived experience.

Aim of the HOP-MHP project

The aim of the HOP-MHP project is to test the feasibility, acceptability and effectiveness of a self-help intervention to support mental health professionals (qualified and still in training) in reaching decisions relating to the disclosure of mental health problems they may be experiencing or may have experienced in the past. The aims of the intervention are to reduce stigma stress, disclosure-related distress and empower participants in deciding for themselves if and how they want to talk about their lived experience. Through access to a peer forum we are also looking to provide opportunities for support from colleagues with lived experience. HOP-MHP is based on a manualised group intervention called Honest, Open, Proud (HOP), which was developed by Professor Patrick Corrigan and colleagues at the Illinois Institute of Technology, as part of the US National Consortium on Stigma and Empowerment.

The project follows on from research that shows that significant proportions of mental health professionals have lived experience but that many are reluctant to disclose their experience, particularly in a work and professional context, due to fears about negative consequences and a perceived lack of appropriate support.

Who can participate?

Anyone interested in participating in this project must meet *all* of the following criteria:

- (1) They are a qualified or trainee mental health professional and a UK national or resident;
- (2) They have current or past lived experience of mental health problems;
- (3) They would like an opportunity to consider whether or not they would like to be (more) open about their lived experience in social and/or work settings. The intervention is designed for anyone who up to this point has chosen either to keep their lived experience private in all or some settings and relationships and who would welcome an opportunity to consider in depth whether to disclose their lived experience more widely or in different contexts. As such it is not suitable for anyone who is already entirely open about their lived experience in their social and professional circles.

Participation is voluntary and choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part, it is important for you to read the following information carefully and discuss it with others if you wish. Please contact us if there is anything that is not clear or if you would like more information.

What does participation involve?

If you decide to take part in this pilot RCT, please return the completed consent form and screening questionnaire to the research team. If you meet the project's inclusion criteria you will then be asked to complete a number of outcome measures through a web survey – these relate to mental health stigma, disclosure, past and present mental health problems you may have experienced, and demographics. The survey will take approximately 15 to 20 minutes to complete. Once you have completed the survey and it has been confirmed that you meet the inclusion criteria, you will be informed whether you have been randomly allocated to the intervention or control arm. You will have a 50:50 chance of being allocated to either the intervention or the control/delayed intervention arm.

If you are assigned to the intervention arm, you will be sent the HOP-MHP self-help guide. This consists of three sessions and some follow-up activities. You will be asked to complete the three sessions and follow-up at a time and place of your convenience - each session is expected to take approximately 1 to 1.5 hours to complete. You will be asked to complete the initial three sessions within around 3 weeks, i.e. one session per week. We will send you reminders and will be available throughout to respond to any queries you may have. You will also have access to information relevant to mental health professionals with lived experience including resources providing support and advice.

After completing the three sessions you will be asked to complete the survey again. We will then send you the follow up session of the HOP-MHP guide one month later. After completing the follow-up session, you will be asked to complete the survey one final time and will also be invited to take part in a 30-minute telephone interview about your experience of the self-help guide and the survey. You can choose whether or not to participate in an interview after completing the intervention.

While you are using the HOP-MHP guide you will also have the opportunity to use an anonymous online peer forum for the duration of the study. Our choice of an anonymous web based peer support forum is based as much on our belief in the value of peer support as it is on evidence on the benefits of peer support.

If you are assigned to the control arm, you will have access to information that is relevant to mental health professionals with lived experience including information about resources providing support and advice. You will also be asked to complete the second survey three weeks after completing the baseline survey and the final survey one month later. Once you have completed all three surveys you will be sent the HOP-MHP self-help guide and will also be given access to the anonymised online peer forum at that point.

Anonymity and Confidentiality

The project is carried out by a team at UCL involving, in addition to the two project leads, research staff as well as trainee clinical psychologists. The project will be carried out in a way that strictly protects participant confidentiality by storing any personal identifiable data securely in the UCL Data Safe Haven. All project data will be stored according to the Data Protection Act 1998.

The outcome measures will be completed through a web survey using a programme called Qualtrics. You will not be asked to provide any of the completed worksheets that are part of the HOP-MHP self-help guide. Your contributions to the peer forum are anonymous (as long as you sign up using an alias e-mail address and user name) and may be used as data in future research - you can opt out of your data being used in this way by sending an e-mail to [hopproject@ucl.ac.uk](mailto:hoproject@ucl.ac.uk). This will not affect your access to or ability to engage with the peer forum in any way.

Benefits and risks

We anticipate that participating in the project will be helpful in supporting you to make decisions in relation to disclosure or non-disclosure of lived experience. We also anticipate publishing the outcome of the completed study, and we hope that it will have a positive impact on encouraging greater openness to lived experience and in tackling mental health stigma within the mental health professions and beyond.

It is possible that reflecting on your current or past difficulties and thinking about disclosure while you participate in the study may cause you distress. If that is the case and you would like to discuss this, please contact the project's Clinical Lead, Dr Henry Clements (henry.clements@ucl.ac.uk ; tel. 0207 679 1897). Henry will be happy to speak with you on a confidential basis and to help signpost you to appropriate support. If he is unavailable then please contact the Project Lead, Dr Katrina Scior (k.scior@ucl.ac.uk ; tel. 0207 679 1897). Please do also access one or more of the suggested sources of support listed on the following webpage, especially if you need urgent help: http://www.ucl.ac.uk/pals/research/cehp/stigma-research/documents/hop_docs/hop_additional_resources

How do I participate?

If you would like to participate, then please email a copy of your completed consent form and screening questionnaire to the project team at [hopproject@ucl.ac.uk](mailto:hoproject@ucl.ac.uk)

The consent form and screening questionnaire are available from the HOP-MHP web page: (<http://www.ucl.ac.uk/pals/research/cehp/stigma-research/research>)

v.8

Communications as part of this project will be conducted via email. As such a first step in taking part is to identify an email address you are comfortable to use for this purpose. We recommend participants set up an alias email address, such as a Gmail address. Setting up a new Gmail address for this purpose is fast and easy and will make you non-identifiable to the research team. However, the choice is entirely yours - throughout we are keen to respect participants' choices and to make sure that what we offer feels comfortable and safe.

Importantly, if you do set up a new email address for the purpose of participating in this study, it is vital that you make a record of the address and your password. We would also strongly advise you to set up message forwarding from any new email address you set up to the email address you use most frequently to ensure that all communications from the project team reach you. Instructions on how to do this are available at <https://support.google.com/mail/answer/10957?hl=en>

Your participation in this project is voluntary and you are free to withdraw from the project at any time and without giving any reason.

Thank you very much for considering taking part in this project.

Appendix 6: Consent Form and Screening Measure

Informed Consent Form for Participants in the pilot RCT of the HOP-MHP Self-Help Guide

Supporting mental health professionals in considering disclosure of their own mental health problems through a self-help intervention

Please complete this consent form and the screening questions after you have read the Information Sheet (available to download at <http://www.ucl.ac.uk/pals/research/cehp/stigma-research/research>)

This study has been approved by the UCL Research Ethics Committee (Project ID No.: 9297/002).

Thank you for your interest in taking part in this research study. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you to decide whether to join in. Please retain a copy of this Consent Form to keep and refer to at any time.

Participant's Statement

- I have read the notes written above and the Information Sheet, and understand what the study involves.
- I understand that it is my choice whether to use a personal email address or to set up a new Gmail address for the purpose of the study to help protect my confidentiality.
- I understand that if I decide at any time that I no longer wish to take part in this project, I can notify the researchers involved and withdraw immediately, without having to give any reason.
- I consent to the processing of my personal information for the purposes of this research study.
- I understand that such information will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 1998.
- I agree that the research project named above has been explained to me to my satisfaction and I agree to take part in this study.

I consent to take part in the research project as outlined in the Information Sheet

The email address I would like to be used for the purpose of this research is:

_____ (please print very clearly)

Date: _____

Please ensure you also complete the screening questions on the next page

HOP-MHP Screening Questions

Please answer all four questions below to ensure that you meet the inclusion criteria for the HOP-MHP study. For each item please place a tick under yes or no.

1. Are you a mental health professional (whether qualified or in training)?

Yes No

2. Do you think of yourself as experiencing a mental health problem that has affected your functioning in some way either at present, or have you experienced such problems in the past?

Yes No

3. Are you fully 'out' about your experiences of mental health problems, that is have you widely disclosed these (so that there is little place for thinking about future disclosure)?

Yes No

4. Over the last 2 weeks, how often have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?

Please select one of the following options:

- 0 – Not at all
- 1 – Several days
- 2 – More than half the days
- 3 – Nearly every day

If you have selected 3 ('nearly every day') on item 4, we advise that you should seek urgent support, either through NHS services or through crisis services – you can find more information about accessing support on our web page:

http://www.ucl.ac.uk/pals/research/cehp/stigma-research/documents/hop_docs/hop-mhp At the present time, we think this needs to be a priority and that engaging with this study is not in your best interests.

If you have answered 'no' to items 1 and 2, or 'yes' to item 3, you do not meet the inclusion criteria for this study.

Thank you for your interest in our research study.

Appendix 7: HOP-MHP - Baseline Survey

[Removed due to copyright]

Appendix 8: HOP-MHP Self-Help Guide

HONEST, OPEN, PROUD

To Eliminate the Stigma of Mental Health Problems


A Self-Help Guide for Mental Health Professionals



**Katrina Scior, Henry Clements, Anna Hildebrand,
Harriet Mills, and Patrick W. Corrigan**

**ILLINOIS INSTITUTE
OF TECHNOLOGY**

 **The British
Psychological Society**
Promoting excellence in psychology

 **Division of
Clinical Psychology**

HONEST, OPEN, PROUD – MENTAL HEALTH PROFESSIONALS
SELF-HELP GUIDE

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This guide is to be used in conjunction with the HOP-MHP website:

<https://www.ucl.ac.uk/pals/research/cehp/stigma-research/documents/hop-docs>

For more information about the original Honest, Open, Proud programme visit: www.hopprogram.org

All illustrations by Ashley Boscoe: ashley.boscoe.15@ucl.ac.uk

Acknowledgements

We are indebted to the original authors and other members of the HOP 'community' for their support in developing this self-help guide. In particular, we thank Pat Corrigan for his enthusiastic support in all aspects, and Nicolas Rüsçh for his support with the evaluation. We also thank the many mental health professionals who generously gave up their time to help us in developing this self-help guide. Last but not least, we thank Ashley Boscoe and Siir Saydam for their assistance with this project.

CONTENTS

PREFACE	4
SESSION 1	10
Considering the Pros and Cons of Disclosing	10
SESSION 2	24
There are Different Ways to Disclose	24
SESSION 3	48
Sharing Your Experiences	48
APPENDIX.....	61



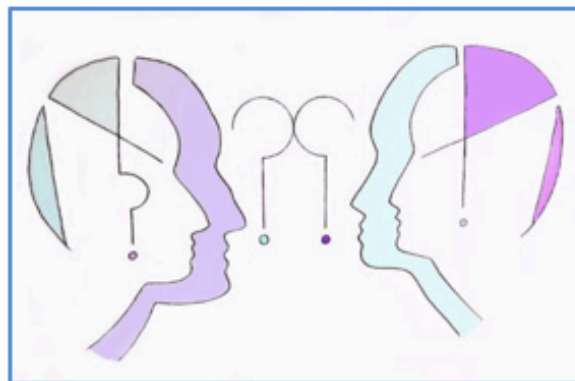
UCL

HONEST, OPEN, PROUD

To Eliminate the Stigma of Mental Health Problems

A Self-Help Guide for Mental Health Professionals

FOLLOW-UP



**Katrina Scior, Henry Clements, Anna Hildebrand,
Harriet Mills, and Patrick W. Corrigan**

ILLINOIS INSTITUTE
OF TECHNOLOGY

 The British
Psychological Society
Promoting excellence in psychology

 Division of
Clinical Psychology

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CONTENTS

INTRODUCTION	71
SECTION 1	71
The Decision to Disclose.....	71
SECTION 2	76
Peer Support	76
SECTION 3	79
What Has Changed?	79
WHAT NEXT?	88

Appendix 9: Peer Forum Instructions

Text on Hop-MHP Slack Forum- Welcome Channel

Welcome to the HOP-MHP peer forum!

This forum is moderated but not on a 24 hour basis. Our policy is to keep intervention to a minimum and to let forum users provide peer-to-peer support and encouragement. With that aim in mind, and since we can all be a bit impulsive at times, we politely ask that everyone use the same courtesy when posting as they would when speaking with someone face to face.

To help keep things running smoothly, we have a few forum rules as follows (we reserve the right to update these rules as needed):

1. No disclosure outside of the forum of what a participant posts within the forum without their express consent to do.
2. No personal attacks.
3. No trolling, misleading or deliberately inflammatory behaviour.
4. No naming of individuals in a way that could damage them personally/professionally, or harm their business.
5. No referring/recommending products &/or services in which you or family members have beneficial interest.
6. No spamming

You can report any of the above to us using the 'report post' function which can be found in the drop down list on the button to the far right of the post, or by sending us an email at hoproject@ucl.ac.uk. Admin will consider these reports and make the final decision whether a post should be deleted. At our discretion, we will also warn, suspend, or, if necessary, ban any forum user who repeatedly violates these rules.

If you are experiencing distress and would like to discuss this, please contact the project's Clinical Lead, Dr Henry Clements (henry.clements@ucl.ac.uk ; tel. 020 76791897). Henry will be happy to speak with you on a confidential basis and to help signpost you to appropriate support. If he is unavailable please contact the Project Lead, Dr Katrina Scior (k.scior@ucl.ac.uk ; tel. 020 76791897). Please do access one or more of the suggested sources of support on our website, especially if you need urgent help:

http://www.ucl.ac.uk/pals/research/cehp/stigma-research/documents/hop_docs/hop_additional_resources

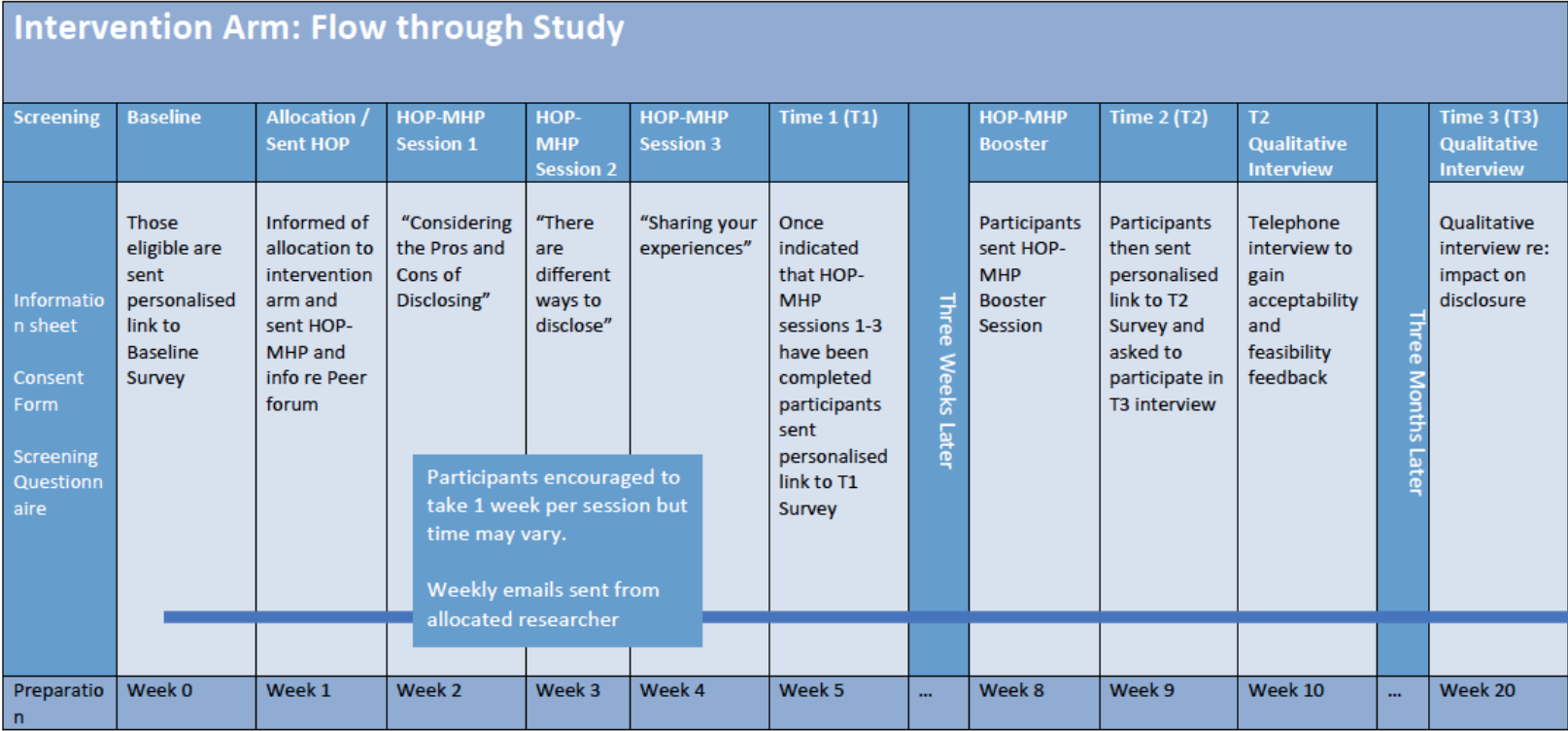
There is also a section on the importance of self-care on our website:

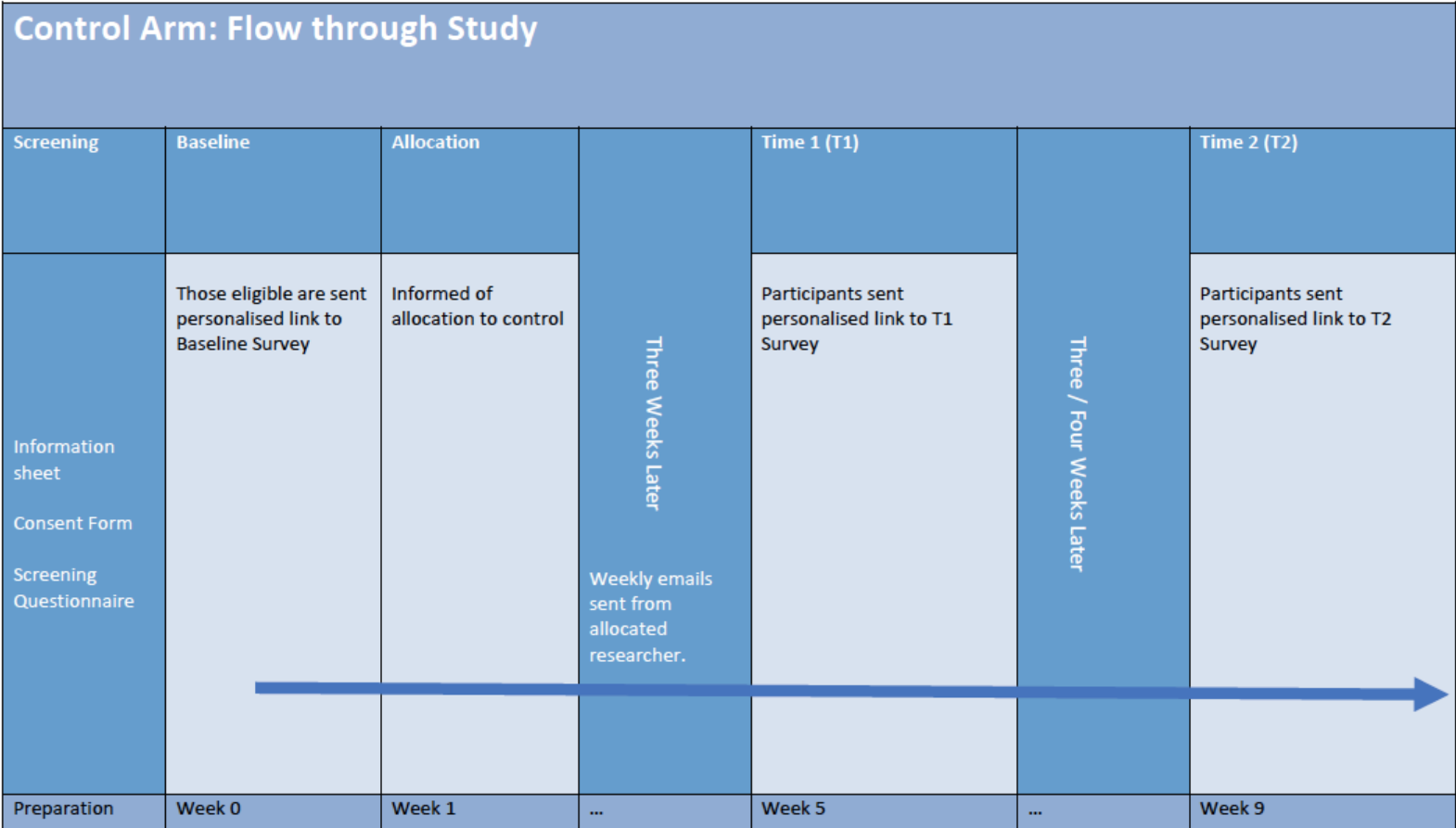
http://www.ucl.ac.uk/pals/research/cehp/stigma-research/documents/hop_docs/hop-mhp

Text on Hop-MHP Slack Forum- HOP-Discussion-space Channel

This forum was set up to provide a space where project participants can exchange thoughts and experiences relating to the HOP-MHP guide and wider issues with others in a safe and comfortable setting. We want this forum to offer a space for conversations and exchange of experiences and views. We suggest you start by introducing yourselves to other forum users when you first join. Above all, we're keen that we should have more opportunities within the mental health professions to talk about personal struggles and times when mental health problems affect our wellbeing. In order to make sure this can happen, the HOP-MHP team feel it is of prime importance that we respect one another (Rogers' unconditional positive regard towards our colleagues seems a good lead), which includes respecting others' experiences in whatever language or terms they choose to use to talk about their experiences. We ask that forum members subscribe to this vision. Finally, it is important that participants are confident about and respect the confidentiality of the forum, so, as noted in the forum rules, we ask that you do not disclose what another participant posts here outside of the forum without their express consent to do so. Let's get talking...

Appendix 10: Participant Flow Through Study





Appendix 11: SAT Questionnaire

Q5.1

The following questions ask about your opinion of the HOP-MHP self-help guide, your experiences of completing this survey and experience of using the web peer forum.

How did you access the HOP self-help workbook?

- PC
- Tablet
- Phone

Q5.2

For the following questions please rate how much you agree with each statement:

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I found it easy to access the intervention.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I found the intervention easy to complete.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I was happy to complete the intervention in the given time-frame.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel the intervention will have a lasting effect.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would recommend the intervention to others.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Q5.3

How helpful did you find the intervention?

- Not at all helpful
- Not really helpful
- Quite helpful

- Very helpful

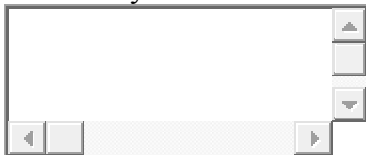
Q5.4

How would you rate your overall satisfaction with the intervention?

- Very dissatisfied
- Dissatisfied
- Neither satisfied nor dissatisfied
- Satisfied
- Very satisfied

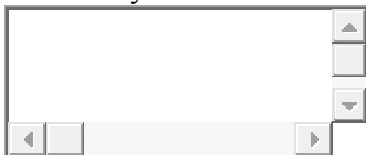
Q5.5

What did you like most about the HOP-MHP intervention (guide and peer forum)?

A text input field with a light gray background and a thin border. It contains no text. On the right side, there are three small square buttons with upward, middle, and downward arrows. On the bottom left, there are two small square buttons with left and right arrows. On the bottom right, there is a small square button with a right arrow.

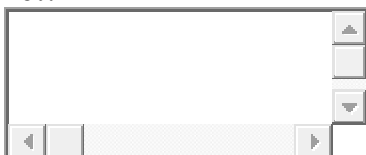
Q5.6

What did you like least about the HOP-MHP intervention?

A text input field with a light gray background and a thin border. It contains no text. On the right side, there are three small square buttons with upward, middle, and downward arrows. On the bottom left, there are two small square buttons with left and right arrows. On the bottom right, there is a small square button with a right arrow.

Q5.7

Did the intervention have an impact on your decision about whether to disclose or not?

A text input field with a light gray background and a thin border. It contains no text. On the right side, there are three small square buttons with upward, middle, and downward arrows. On the bottom left, there are two small square buttons with left and right arrows. On the bottom right, there is a small square button with a right arrow.

Q5.8

What do you think might stop someone from taking part in this intervention or completing it?

Q5.9

For the following questions, please rate how much you agree with each statement:

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I was happy to complete the measures at the three time points.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I was happy with the time taken to complete the measures.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I found the measures easy to complete.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel the measures were appropriately worded for this intervention.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Q5.10

What did you like most about the measures?

Q5.11

What did you dislike most about the measures?

Q5.12

What do you think could be improved?

Q5.13

Did you use the peer support forum?

- Yes
- No

Condition: **No Is Selected**. Skip To: **Was there anything in particular that...** Options

Display This Question: If Did you use the peer support forum? Yes Is Selected

Q5.14

How often did you use the forum?

- Daily
- Almost daily
- Weekly
- Fortnightly
- Monthly
- Other:

Display This Question: If Did you use the peer support forum? Yes Is Selected

Q5.15

Did you find the forum useful in combination with the self-help guide?

- Very useful

- Useful
- Somewhat useful
- Not useful

Display This Question: If Did you use the peer support forum? Yes Is Selected

Q5.17

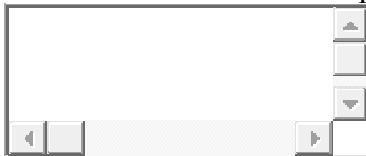
How useful was the forum as a resource separate to the guide?

- Very useful
- Useful
- Somewhat useful
- Not useful

Display This Question: If Did you use the peer support forum? Yes Is Selected

Q5.18

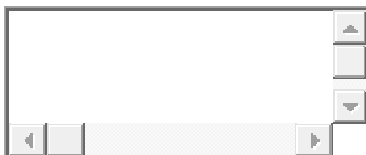
How could the forum be improved?

A text input field with a scroll bar on the right and navigation buttons at the bottom.

Display This Question: If Did you use the peer support forum? No Is Selected

Q5.14

Was there anything in particular that stopped you from using the forum?

A text input field with a scroll bar on the right and navigation buttons at the bottom.

Q41

Finally, where did you hear about the HOP-MHP project?

Appendix 12: Qualitative Interview Schedule

Semi-structured interview schedule for pilot RCT

- Check time available. Switch recorder on!
 - Acknowledge they may already have provided feedback about the intervention at the end of the survey but note that as interviewer we do not know what feedback they gave as the survey data is anonymised. This interview is a chance to explore their experience of using the HOP-MHP guide and peer forum in more detail.
 - Set up interview by sensitively establishing preferred terms (e.g. they may prefer other terms to ‘disclosure’ or ‘dual status professionals’) and try to use their terms.
 - Start with broad question and use prompts flexibly.
1. Overall, how would you describe your experience of the intervention as a whole (the HOP-MHP guide and peer forum)?
 - a. What did you find most helpful / least helpful?
 2. What did you think of the self-help guide??
 - a. Content, tone and structure
 - b. Which parts/sessions of the guide did you find most helpful?
 - c. Which did you find less helpful?
 - d. Is there anything (else) you think should be changed about the guide?
 3. How did you find completing the self-help guide? (e.g. format / length)
 - a. How much of it did you complete? (i.e. how many sessions, how much of each session)
 - b. How long did it take you to complete each session?
 - c. Did you complete all or most of the written worksheets? If not, what would you say was the reason?
 4. Did you use the peer support forum?
 - a. At what point did you access the forum? (in parallel with the guide? After completing parts of the guide? Only later on?)
 - b. What about the forum did you find most helpful?
 - c. Anything about the forum you found less helpful?
 - d. Do you see the forum as an essential or optional component of the HOP-MHP intervention? (ask to explain)
 5. What was the impact of the intervention (self-help guide & forum), if any, for you?

Did it make you think or feel differently about disclosure, dual status professionals, or anything else?

 - a. Did you make a disclosure as a result of taking part? Who did you disclose to (e.g. supervisor, fellow trainee, a close friend)?

- i. Was the intervention of any benefit in the process? Would you re-consider disclosing in the future?
 - b. Do you think the self-help guide or peer forum were harmful in any way?
 - c. Have you noticed any changes in how you feel about being a dual status professional?
- 6. How confident / comfortable do you feel about your disclosure-related decisions now? Has this changed as a result of the intervention?
- 7. Do you think this self-help guide is suitable for use with a range of mental health professionals, e.g. in addition to psychologists and IAPT therapists, MH nurses, psychiatrists? Would you advise colleagues to use it, or a revised version of it?
- 8. Are there any other comments or feedback you would like to add?

Appendix 13: Trainee Contribution to Project

This project was conducted jointly with another Trainee Clinical Psychologist at University College London (UCL). We worked jointly on the development of the adapted HOP-MHP manual, both recruiting stakeholders, collecting, analysing and implementing changes from the feedback gained from Stakeholders.

Tasks were shared between us, with us each taking ownership for different aspects of the study, e.g. focusing efforts on different routes of recruitment. Both researchers were responsible for emailing and monitoring the progress of approximately half of the research participants, both control and intervention arms.

Data for both projects were collected from the same participants. Separate research questions were assigned and analysis of the outcome data allocated accordingly. Analysis and write up was completed independently. However, we attended research meetings together with our supervisors, Dr Katrina Scior and Dr Henry Clements, and contributed to each other's work through discussion in this context.

A research assistant carried out the random allocation of participants and initial email contact prior to participants being allocated Unique Identifiers and being assigned to one of the two researchers. From this point onwards all email contact was carried out by the assigned researcher. All participants who opted to take part in the qualitative telephone interviews were participants allocated to my colleague. Therefore, they conducted and transcribed the interviews. However, all analysis of this data was conducted separately

Appendix 14: Statistical Analysis

Full Sample Means and Standard Deviations

Outcomes-	Intervention		Control	
	Means			
Measures	Baseline (n=26) <i>M (SD)</i>	Time 1 (n=13) <i>M (SD)</i>	Baseline (n=25) <i>M (SD)</i>	Time1 (n=18) <i>M (SD)</i>
SSS- Appraisal	-5.84 (9.25)	-7.30 (9.21)	-4.36 (10.74)	-4.83 (9.21)
SSS- Harm	27.62 (7.63)	27.00 (7.29)	28.36 (7.94)	25.50 (8.70)
SSS- Coping	33.46 (5.52)	34.41 (6.33)	32.72 (5.43)	31.06 (5.02)
SSMIS- Aware	28.38 (4.81)	27.08 (5.72)	29.56 (5.29)	30.41 (4.44)*
SSMIS- Apply	12.50 (6.49)	13.38 (7.19)	12.72 (6.08)	13.00 (4.54)*
SSMIS- Hurt	14.69 (8.37)	15.15 (9.75)	13.72 (7.64)	14.47 (6.37)*
PHQ-9	14.65 (4.44)	14.62 (4.48)	16.84 (5.10)	16.17 (3.85)
GAD-7	12.88 (3.96)	13.69 (4.40)	14.44 (4.67)	12.39 (3.07)

*SSMIS Control N=17

Completed Cases Means and Standard Deviations

Outcomes-	Intervention (n=13)		Control (n=18)	
	Baseline	Time 1	Baseline	Time1
Means	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>
SSS- Appraisal	-7.00 (9.81)	-7.31 (8.99)	-3.00 (11.50)	-4.83 (9.21)
SSS- Harm	27.85 (8.37)	27.00 (7.29)	28.17 (7.82)	25.50 (8.70)
SSS- Coping	34.85 (5.65)	34.31 (6.33)	31.17 (5.43)	31.06 (5.02)
SSMIS- Aware	27.69 (4.17)	27.08 (5.72)	28.82 (5.73)	30.41 (4.44)*
SSMIS- Apply	12.31 (6.24)	13.38 (7.19)	12.76 (6.38)	13.00 (4.54)*
SSMIS- Hurt	15.46 (9.63)	15.15 (9.75)	14.82 (8.20)	14.47 (6.37)*
PHQ-9	14.15 (3.29)	14.62 (4.48)	16.33 (4.52)	16.17 (3.85)
GAD-7	13.15 (3.11)	13.69 (4.40)	14.06 (4.24)	12.39 (3.07)

*SSMIS Control N=17

ANOVA results for all completed cases

Measure		F	P	Cohen's d
SSS- Appraisal				
	Time	0.481	.494	0.261
	Time*Cond	0.244	.625	0.186
	Cond	0.961	.335	0.369
SSS- Harm				
	Time	2.983	.095	0.650
	Time*Cond	0.801	.378	0.337
	Cond	0.045	.833	0.080
SSS- Coping				
	Time	0.117	.735	0.129
	Time*Cond	0.051	.823	0.085
	Cond	3.758	.062	0.730
SSMIS- Aware				
	Time	0.197	.661	0.167
	Time*Cond	1.011	.323	0.378
	Cond	2.173	.152	0.555
SSMIS- Apply				
	Time	0.423	.521	0.245
	Time*Cond	0.174	.680	0.157
	Cond	0.000	.986	0.000
SSMIS- Hurt Self				
	Time	0.047	.830	0.082
	Time*Cond	0.000	.988	0.000
	Cond	0.060	.809	0.092
GAD-7				
	Time	0.631	.433	0.299
	Time*Cond	2.412	.131	0.584
	Cond	0.030	.864	0.065

Appendix 15: Qualitative Interview Extract

Extract from HOP-MHP Telephone Interview with P27

Introductions, double check consent & explanation of interview structure / content etc...

(1:35) Q1. Overall experience of intervention (guide & peer forum)

H: I actually think I found it really interesting. I thought that the erm guidance erm in terms of really going into detail about why people might disclose and what people might want to get out of it and responses you might get was really interesting. I've never really broken things down before in that way or thought about what it was that I might feel anxious about, about it or what it was about, so I thought that was really interesting. Erm I really liked the forum,

A: Did you? Okay-

H: Erm, yeah I found it... I spoke on it quite a bit initially actually, erm and then later not so much, erm but found it really interesting to read other people's feedback. Erm, and something about it being really anonymous and just being able to be really open I found really helpful actually.

A: Okay. That's erm interesting feedback to start off with... **[summarised points about things they liked best]**

(3:16) Q2. Least helpful?

H: Erm, I found it really difficult to motivate myself to complete the erm [laugh] worksheets... Partly I think I was telling myself that this was due to not having printed it out as of yet, so I read it quite a bit on my phone, and I wasn't able to complete the worksheets on my phone just purely from a practical reason. But then I was constantly putting off printing them out... erm [laugh]. Which I think was a sort of unconscious not really wanting to. I found it really difficult, actually, to motivate myself to do it. And I also found that when I did print it out, I printed it out at work, and then got incredibly anxious about somebody seeing it in the printer or the printer sort of stopping in the middle, which does happen-

A: Hm, that makes sense.

H: And what I would do with them, 'cause we had no printer ink at home. So that just became a sort of practical task that went on for ages. But I think that was probably me diverting a bit of anxiety about actually sitting down and doing the worksheets... Erm, so I felt that although I was quite engaged in sort of thinking about the ideas in the worksheets, and also the discussions on the forum, when it actually came down to sitting down to do it I really put it off. And then I sort of only really did it very half-heartedly I think if I'm really honest, erm yeah... so I found that a bit harder.

A: Okay... yeah, I mean, that's interesting for us to think about because making it a self-help guide sort of, I guess tells people they can complete it in the way they prefer, and I wonder actually if you thought that thinking through the worksheets was equally as useful or if that was less useful?

H: Yeah... yeah...

(5:21) Q3. A: Hm. And in the end, did you manage to complete most of the worksheets even if they were, as you say, half-heartedly?

H: [Laugh] Erm... pretty much, erm pretty much. It was quite sort of half-hearted. I think I got an email, possibly from you, sort of chasery, I thought "oh shit, I really need to do this, erm..." [laugh]. Erm, so I think... so I did complete it, but yeah...

A: It is quite a lot of effort and time, I suppose, I mean it takes most people I think at least an hour if not a few hours per session, if they do it properly.

H: Yeah.

A: Yeah, so I think that we have to acknowledge that we are expecting people to invest quite a lot of time.

H: I did the reading, I found that really interesting, so I sort of read through it all, and I read through it all a couple of times actually. But in terms of actually sitting down and doing the worksheets, I very much left that to last and then I did it after... probably about a month after I'd read through everything. So, I was sort of doing it a bit on the backfoot. Erm... yeah.

A: I guess that gives you a bit of time to process the ideas as well.

H: Yeah.

(6:32) Q4: Anything we could do to make it easier to complete the worksheets?

H: I mean, I think if they were able to be filled out on a phone or a device or whatever it is called, actually that would be easier. I probably would have done it sooner, I think, if I could have completed in on my phone just because I was reading it all on my phone anyway, so that possibly might have been easier. Erm... but I also found that some of the steps on it felt like a bit overly onerous. I can't remember which ones specifically but sort of... yeah. But they really got into something, I wasn't really sure how relevant that felt.

A: [Summarise]. By having it on your phone it would have also saved you the anxiety around printing it out at work... yeah that's a good point for us to think about.

(7:41) Q5. Tone, structure and content of the guide?

H: Erm, I mean I think actually the whole project really got me thinking. Erm... because I... you know obviously... have had lived experience of mental health issues, work in mental health, erm... there's always been a bit of a tension there for me. Erm, so I think just this idea that there is a project thinking about what it means... erm... was really interesting. And the sort of tone of it, and what it was pitched at, and I found myself reading through some of it and thinking "Oh yeah, I think that" and "Oh yeah, I think that", and that felt really validating, actually. So, there were bits that didn't feel particularly relevant... and then there were other bits that I read and I thought "Oh, I didn't even realise that that was something that could be relevant or interesting, or maybe I could take things to supervision that I haven't thought about" or erm.. so that actually really got me thinking. I think it made me think more than actually the process of filling it out, if that makes sense.

A: That's so interesting from you to hear that [summarise].

(09:01) Q6: Any parts where you thought the tone was off or which felt harmful / offensive or similar (more than just not relevant)?

H: Erm, I don't think so actually. I don't think so. I think some of the steps felt a little bit unnecessary... there was one, I'm trying to remember now 'cause it was a little while ago, but I think there was one about sort of testing it out with somebody about what their views are on mental health or something. And I didn't do that because that just felt really unnecessary... erm, and yeah and a bit forced in a way, so I didn't do that. And parts of it also felt very kind of cognitive-behavioural which I think probably isn't an approach that fits

particularly well with me so I had a bit of a resistance to... erm [laugh]. But I think that's more to do with me than the actual study.

A: Well that makes sense... [brief summary].

(10:17) Q7: Any other exercises or worksheets that did not feel helpful / didn't want to do?

H: No, I think the sort of weighing up the pros and cons actually was really helpful, and thinking through for me I think what the barriers might be, what my reasons might be, what my motivations might be, how it would be if I got a negative response, that was really useful actually, to think through. Yeah...

A: [Brief summary, normalise in context of how feedback varies i.t.o. which bits participants find helpful].

(11:11) Q8: How much of the guide, or how many sessions would you say you kind of worked through properly?

H: So, basically what I did is I read the whole thing in one go, without doing any of the worksheets [laugh]. Erm, and then I probably read it again all in one go without doing any of the worksheets. And then quite a bit later I thought "Oh shit, I really need to do the worksheets". And then I did, or attempted to do the worksheets all in one go, but found that bit harder going [laugh]. I didn't really do it in a sensible way...

A: [laugh] A bit like creaming.

H: A little bit like cramming, yeah [laugh].

A: And then you attempted most of them in some way or another, I guess?

H: Yeah.

A: But did you, the ones that you thought were unnecessary, did you attempt to do them or did you kind of leave them be?

H: No, I did attempt to do them.

(12:26) Q9: Do you remember how long it approximately took you to read through the sessions? 'Cause you read them all in one go so I guess it would be one longer period of time.

H: Erm, I think about an hour, actually. Erm, yeah... which is why I went back and read it again not that long after. Erm... yeah.

(12:55) Q10: And doing the worksheets, how long do you think that took you all in one go?

H: Erm, not as long as it should have [laugh].

A: That's alright.

H: I don't know how long I sat down with them, maybe like half an hour. I did a bit of a blitz, basically, with the worksheets.

A: That's absolutely fine, it's just good for us to know about it I think.

(13:22) Q11: How was experience of regular email reminders?

H: Erm, so when I got it, I think probably the day that I got the whole lot through I read the whole manual. Because I was really interested in it actually. And then I went back and read it again probably about a week later. So, in terms of the emails, I think they were just... every time I got an email I thought "I really need to print it off, I really need to print it off". That was sort of what came to my mind. And then I would make some attempts to print it all off and get sort of thwarted half way and forget about it. So, they were sort of reminders. Until the last email whenever it was that I got it and I thought "I really need to do this, I'm just putting it off". Yeah, so I thought they were helpful reminders.

A: They kind of prompted you to continue with it.

H: Yeah.

A: You didn't find them irritating or anything like that?

H: No, no, they were fine.

(14:29) Q12: Peer forum. [Summarised what she previously said about using it]. At what point did you access the forum – immediately or after reading the manual for the first time?

H: No, I did it immediately, I was really curious, I think I was really curious about the whole study actually. So yeah, whenever it got emailed to me, I logged in, downloaded it... erm, I sort of sat back for a few days and read through what other people had written and then it did feel quite scary... in terms of writing something. And I initially... erm... you know how you put your name as something or other. And I hadn't really thought about it and I just put my name... erm... and then I wrote something and then I thought "Oh shit, I really need to go and change my name to something that isn't my name". [laugh] And sort of went back and did that... and I mean, I think there is something about it being really anonymous, erm... but also slightly exposing or anxiety-... so I'd sort of write something and then feel really anxious about what other people would say. But then found it really validating and *really* supportive and really interesting, actually. And I sort of still... I haven't written anything for a while but I sort of dip in and out of reading it... Because I do feel that people have sort of really said things that really resonate. So, I found that really interesting. Erm, yeah...

A: Was it validating to sort of see people have similar experiences or just the way people responded to you?

H: I think it was both actually. I think it was really both. I think it was really, erm... So, I'm going to use the word enlightening but it feels like a bit of an extreme word, but to think... so I have come into this profession partly because of my own experiences and then have often felt really ashamed about that. But to hear other people commenting on that in a very similar way, and how they kind of negotiate those bits of themselves felt really validating just to read and hear and think: "Well, of course, like of course we have all experiences like this". And that's, I think, been really helpful for me. Yeah...

A: That's really good to hear 'cause I suppose that was the hope we had for the forum that people would be supportive and find it validating. So, it's good that that part of it worked quite well.

H: Yeah, I mean I really felt that it did, actually. And I... erm... was sort of a little bit surprised by the things that I wrote on the forum. Because I felt that I would sort of write something and then step back and think "Oh my god, I can't believe I've just written that" [laugh] on the forum and then would come back into it and see the responses from other people and actually think that actually it's alright to sort of put that, that that did feel okay.

A: Do you think it was the atmosphere on the forum that kind of led you to write things that you surprised yourself with?

H: I think it was a bit of both, I think the atmosphere was very welcoming and very warm, and I think... potentially, and I don't want to speak for the other people in it but we were all kind of in the same boat, a bit nervous... and anonymous, erm and wanting to support each other and talk about our own experiences. Erm... so I think that helped. But I do, I mean the kind of anonymity [laugh] like just really being able to put things out there without anybody knowing who you are was... yeah...

A: Yeah, I think that was so important.

H: Yeah.

(18:26) Q13: Anything about the forum that was less helpful or that we can improve?

H: I mean, I don't know... I think, erm... I think I quite liked that it was just an open space. I know that some people spoke quite a bit and some people didn't, and I don't know whether that matters, I don't know if people just wanted to be on it to read and maybe that was helpful. I quite liked that there weren't discussion topics and actually that we were just sort of able to dip in and out of it. The only bit of it that sort of worried me a little bit, that I know I contributed to this as well, was that if somebody wrote something that was sort of quite detailed and in depth and insightful and personal, and then nobody commented on it for like a few days or a week. I just thought "Oh gosh, what has this person been left with?" Erm, but I sort of knew that I also didn't necessarily comment immediately. Erm... so that's kind of, but I think, yeah... yeah...

A: So as researchers we can't actually see what people write on the forum, so hearing that makes me think... whether it would be helpful if there was a moderator or someone who dips in and does pick up posts that haven't been responded to and just says something or do you think that would be intrusive?

H: I thought there was a moderator?

A: There is a moderator who welcomes people but I'm not sure if they comment on additional posts.

H: Erm I don't know, actually, 'cause I think the atmosphere was warm, erm, but I just know that I sort of stepped in and out of feeling that I wanted to sort of say quite a lot or comment on other people and this other bit of me that felt a little bit exposed and felt I was saying too much and sort of took a bit of a step back. But then felt that people would say loads of things and wouldn't have a response for weeks, erm... which I might not even notice 'cause I wasn't on it daily, I'd sort of dip in and out of it. Erm...

A: And I guess many people do that, dipping in and out.

H: I think probably a lot of people do that, and there would be sort of spurts of conversation over a couple of days and then nothing for ages. Erm, yea...

A: And I guess that can also be one of the things that happen when it's a smaller study as opposed to a bigger forum with lots of people in it. I'll let my research team know about it and they might have thoughts on what we could do or what could happen in the future.