Feasibility and preliminary impact of a guided self-help intervention supporting disclosure decisions regarding lived experience among mental health professionals

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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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Overview

This thesis explores the feasibility and preliminary outcomes of a guided self-help intervention designed to support disclosure decisions regarding lived experience among mental health professionals.

Part one is a conceptual introduction, examining the concepts of stigma and disclosure before considering mental health stigma interventions. It then focuses on decision making around disclosure of a mental health difficulty including important factors in disclosure such as shame, self-stigma and concealment. It considers research into interventions developed to aid those with mental health difficulties in reaching disclosure decisions, and introduces the *Honest, Open, Proud* (HOP) programme.

Part two presents an empirical study which employed a pilot randomised controlled trial to investigate the feasibility and preliminary outcomes of the *Honest, Open, Proud for Mental Health Professionals* (HOP-MHP) guided self-help intervention. Utilising mixed methods HOP-MHP was deemed feasible but requiring improvements and adaptations to promote engagement and support individuals further, given the complexity of making disclosure decisions for this population. Consideration of research into complimentary interventions at structural levels of society and culture are discussed. Data collection for the empirical paper was conducted jointly with a fellow trainee (Smith, 2019).

Part three offers a critical appraisal, reflecting on the process of engaging in the research as a mental health professional with lived experience and the challenges this presented.

Impact Statement

This thesis addresses gaps in the literature and research surrounding supporting disclosure decision making. The conceptual introduction provides a review of areas to consider in designing interventions to support decision making in relation to disclosure of mental health difficulties before presenting the limited number of interventions currently available to support disclosure decision making in this context. It notes that most interventions thus far have focused on mental health difficulties in the general population and disclosure in the workplace. It highlights the sparsity of literature in relation to disclosure decision making both for dual-experienced professionals and in contexts other than the workplace, such as in interpersonal relationships and in other relationships with power discrepancies. Therefore, the conceptual introduction emphasises the importance of further research in these key areas to support individuals with mental health difficulties, including dual-experienced practitioners, in making disclosure decisions across contexts.

The empirical paper is of value in addressing the gap in provision of disclosure decision making support for dual-experienced practitioners. It presents findings regarding the feasibility and preliminary outcomes of HOP-MHP. It addresses gaps in evaluations of the HOP programme conducted to date by utilising qualitative interviews and assessing outcomes at follow-up. The HOP-MHP intervention was found to be feasible but in need of revision in some areas which require further consideration and adaptation. It was found to have moderate, but not significant, effects on perceived helpfulness of the reaction of those disclosed to, and small effects on disclosure related distress in keeping difficulties secret, secrecy and likelihood of disclosure of present mental health difficulties. However, given the complexity of the benefits of disclosure vs non-disclosure in this context, the fuller impact of these

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changes on individuals, such as quality of life and relationships, should be explored further. The empirical paper makes recommendations for adaptions to the intervention and consideration of relevant outcome measures to further evaluate the effectiveness of HOP-MHP. It also notes the importance of considering the HOP-MHP intervention alongside other interventions designed to reduce stigma, and support disclosure decision making more widely in terms of structural and cultural interventions and policy. The research trial itself is likely to have begun to challenge the stigma surrounding dual-experienced practitioners, by emphasising their existence and the need for interventions to support them, both in general and specifically in relation to disclosure.

If proven effective with the suggested adaptations, it is recommended to assess the effectiveness across a wider range of professional disciplines to ensure relevant adaptations are made to each context where required. The potential economic value of HOP-MHP in improving dual-experienced practitioners' wellbeing, supporting them to access appropriate support where required, and service level costs should also be considered. In the current format, HOP-MHP could be easily provided via the NHS to a broad range of dual-experienced practitioners. This could enable dual-experienced practitioners to reach decisions about disclosure, which would enable them to seek support, reduce stigma related stress and contribute to reducing stigma more widely within mental health contexts.

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Part One: Conceptual Introduction

Interventions Supporting Disclosure Decision Making

Overview

Stigma needs challenging at multiple levels. Supporting those directly affected by stigma to challenge this by talking openly about their experiences is one route that has been proposed by Corrigan, Kosyluk and Rüsch (2013). Before considering initiatives focused on the individual and disclosure, this conceptual introduction provides a broader overview of stigma, disclosure, and anti-mental health stigma interventions. It then considers decision making around disclosure of a mental health difficulty before considering some specific factors related to disclosure such as shame, self-stigma and concealment. It then explores experiences of being a dual-experienced practitioner, that is having lived experience of a mental health difficulty and being a mental health professional. It summarises research of interventions developed to aid those with mental health difficulties in reaching disclosure decisions, before focusing on research involving development and application of the intervention on which the present work is based: The Honest, Open, Proud (HOP) programme.

Introduction

Psychological distress is recognised as a universal phenomenon that is on the rise (McManus, Bebbington, Jenkins & Brugha, 2016; Vos et al., 2015; Whiteford et al., 2013). In 2016, more than 40% of adults in the UK reported having experienced a diagnosable mental health difficulty at some point in their life (Mental Health Foundation, 2016). A study across 1993-2007 found that 17.5% of men and 28.6% of women met criteria for a common mental health difficulty according to clinical interview (Spiers et al., 2011) although in 2007 less than a third of people with common mental health difficulties were receiving any form of treatment (Spiers et al., 2016). Figures from Australia suggest that 12% of the general adult population made use of mental health services over a 12-month period, with only 35% of people who met criteria for a mental health difficulty accessing services (Burgess et al., 2009).

As mental health difficulties in the general population lead to costs to society, healthcare, employers, and the economy (LaMontagne et al., 2014), researchers, charities and governments have sought to develop strategies for supporting those with mental health difficulties. These strategies are across a range of forms including education about mental health difficulties, promotion of mental well-being and campaigns to reduce stigma and discrimination, in order to promote help-seeking and engagement with services. However, supporting people with mental health difficulties continues to be an area that requires thought and innovation to address the complex issues that remain (Gopalkrishnan & Babacan, 2015; LaMontagne et al., 2014).

Stigma and Disclosure

Stigma is defined by the Oxford English Dictionary as a mark of disgrace associated with a particular circumstance, quality or person. However, stigma is often an active process and to stigmatize someone is to regard them as deserving of disgrace or great disapproval. Those who experience mental health difficulties often face stigma and discrimination (Berzins, Petch & Atkinson, 2003; NHS Information Centre, 2011; Time to Change, 2014) which in turn impacts on their mental health, help seeking behaviour, engagement with mental health services, and recovery (Corrigan, 2004; Corrigan, Druss & Perlick, 2014; Menke & Flynn, 2009; Rüsch, Angermeyer & Corrigan, 2005; Shrivastava, Johnston & Bureau, 2012; Sickel, Seacat & Nabors, 2016). Stigma associated with mental health difficulties is often greater than that of physical illness (Arboleda-Florez & Stuart, 2012) and has been shown to be as high as the stigma of engaging in criminal activity (Roeloffs et al., 2003).

Various studies suggest that structural stigma still persists at the macro levels of society, institutions and culture (Corrigan, Markowitz & Watson, 2004; Holder, Peterson, Stephens & Crandall, 2018; Huggett et al., 2018), popular media (Corrigan, Powell & Michaels, 2013; Goodwin, 2014; Robinson, Turk, Jilka & Cella, 2018) and even through legislation and policy (Bates & Stickley, 2013; Corrigan et al., 2005; Heginbotham, 1998; Sercu & Bracke, 2016).

Public stigma, stigma experiences, and even the fear of experiencing stigma and discrimination have been demonstrated to impact on individuals' employment, friendships (Roeloffs et al., 2003), family relationships (Reavley & Jorm, 2015), engagement in leisure activities, visits to their GPs (Wright, Henderson, Thornicroft, Sharac & McCrone, 2015), likelihood of contact with the criminal justice system

(Kreek, 2011), general access to healthcare (Thornicroft, 2008) and even suicide rates (Schomerus, Evans-Lacko, Rüsch, Mojtabai, Angermeyer & Thornicroft, 2014).

Stigma has been shown to impact the actions of others in seeking help for close friends or family who may be experiencing mental health difficulties (Yap & Jorm, 2011), on the desire for social distance from those with mental health difficulties (Feeg, Prager, Moylan, Smith & Cullinan, 2014; Lawson, 2016; Schnyder et al., 2018; Svensson & Hansson, 2016; Ye et al., 2016) and on decisions about allocating funds to mental health programmes (DeLuca, Clement & Yanos, 2017).

It is common for those with mental health difficulties to fear judgement (e.g. about their level of dangerousness or the controllability of their symptoms) by those they disclose to (Corrigan, Markowitz, Watson, Rowan & Kubiak, 2003; Link, Phelan, Bresnahan, Stueve & Pescosolido, 1999) or discrimination either personally, professionally or medically (Struch et al., 2008; Stull, McGrew, Salyers & Ashburn-Nardo, 2013).

There is evidence that those with mental health difficulties experience the most stigma in the workplace and appear least likely to disclose at work or to supervisors (Barney, Griffiths, Christensen & Jorm, 2009; Reavley, Morgan & Jorm, 2018; Stromwall, Holley & Bashor, 2011). However, direct experience of discrimination is not required to impact on people's lives (Quinn, Williams & Weisz, 2015). Henderson, Evans-Lacko and Thornicroft (2013) found that even anticipated discrimination was a prominent barrier to seeking help.

Interventions to reduce mental health stigma

Stigma requires challenging at multiple levels. Various interventions and approaches to stigma reduction and mediation have been proposed and trialled,

including campaigns aimed at increasing public awareness (CSCBHSN, BBCSS, DBASE, & NAS, 2016; Henderson et al., 2012b; Palpant, Steimnitz, Bornemann & Hawkins, 2006; Sims, 1993). Mental health education has been delivered across contexts including schools, universities and workplaces (Maranzan, 2016; Perry et al., 2014). Promoting a recovery focus in healthcare settings has been seen to reduce stigma in both those with mental health difficulties and those who treat them, and therefore has been included as a key message in awareness campaigns (Berge, & Ranney, 2005; Clement, Jarrett, Henderson & Thornicroft, 2010; Stacy & Rosenheck, 2017). Increased group identification in and with people with mental health difficulties appears to reduce perceived and reported stigma (Kearns, Muldoon, Msetfi & Surgenor, 2018; McSween, 2002). Therefore, increasing contact with people with mental health difficulties has been another intervention aimed at reducing stigma towards these individuals (Fokuo et al., 2017; Koike et al., 2018; Yap, Reavley, Mackinnon & Jorm, 2013). Many efforts to tackle stigma have focused on the workplace given the impact stigma and discrimination can have in this context (Department for Work and Pensions and Department of Health and Social Care, 2017).

However, many researchers have called for renewed efforts and interventions to continue to address stigma (Smith, 2013; Stuart, 2008), highlighting the need to do so in a multi-faceted and collaborative way (Corrigan, Roe & Tsang, 2011; Harrison & Gill, 2010; Henderson & Gronholm, 2018; Pescosolido, 2013). Interventions need to address different types of stigma including public stigma, self-stigma and label avoidance (Corrigan, 2007; Corrigan & Wassel, 2008). This can be done across a range of strategies including protest, education and increasing contact with those with mental health difficulties (Corrigan et al., 2017; DeBate, Gatto & Rafal, 2018; London & Evans-Lacko, 2010).

Interventions should also target multiple levels where stigma is identified, such as the individual, societal and economic levels (Ahmedani, 2011; Cook, Purdie-Vaughns, Meyer & Busch, 2014; Holder, Peterson, Stephens & Crandall, 2018). They should also be carefully adapted to consider cultural differences in how stigma develops and is maintained (Beldie et al., 2012; Carpenter-Song et al., 2010; Evans-Lacko et al., 2014) including the contribution of family beliefs and concepts such as honour (Brown, Imura & Mayeux, 2014; Mascayano et al., 2016; Shefer et al., 2012)

To effectively combat stigma, the practical limits and barriers in developing interventions have been considered, including reaching large audiences and hidden populations (Ungar, Knaak & Szeto, 2016). Therefore, research has begun to focus on harnessing new technology to overcome these, such as social media (Betton, et al., 2015; Woo, Lam & Kung, 2018; Yap, Zubcevic-Basic, Johnson & Lodewyckx, 2017).

There is evidence that interventions to reduce stigma can be effective. Awareness and anti-stigma campaigns have sought to increase knowledge and familiarity with mental health (Kaminski & Harty, 1999; Rubio-Valera et al., 2016; Thornicroft, Wyllie, Thornicroft & Mehta, 2014), citing improved mental health literacy and reduced discrimination (Hansson, Stjernsward & Svensson, 2016; Henderson et al., 2012b; Henderson et al., 2016). Outcomes also suggest benefits in the context of employment (Henderson, Robinson, Evans-Lacko & Thornicroft, 2017; Henderson, Williams, Little & Thornicroft, 2013).

Programmes that seek to reduce stigma by educating the general public (Morgan, Ross & Reavley, 2018; Pinfold, Thornicroft, Huxley & Farmer, 2005) and those in roles most likely to come into contact with individuals with mental health difficulties (e.g. pharmacists, nurses and medical students) have also been found to be beneficial in reducing stigmatising attitudes (Bamgbade, Ford, & Barner, 2016;

Carroll, 2018; Hankir, Zaman & Evans-Lacko, 2014; Pinto-Foltz & Logsdon, 2009). Multi media campaigns (Ashwood et al., 2016; Bayar, Poyraz, Aksoy-Poyraz & Arikan, 2009) and creative arts have also been utilised as ways of tackling stigma (Koh & Shrimpton 2014; Quinn, Shulman, Knifton & Byrne, 2011; Twardzicki, 2008). Interventions for managers and employers have demonstrated positive results in improving knowledge and reducing stigma in the workplace (Hamann, Mendel, Reichhart, Rummel-Kluge & Kissling, 2016; Hanisch et al., 2016; Hanisch, Birner, Oberhauser, Nowak & Sabariego, 2017).

Facilitating increased contact with people with mental health difficulties is one intervention that has been more widely researched, demonstrating positive impacts on mental health literacy and stigma beliefs (Moxham et al., 2016; Pinto-Foltz, Logsdon & Myers, 2011), internalised stigma (Conner, McKinnon, Ward, Reynolds & Brown, 2015) and future behavioural intentions related to stigma and mental health (Evans-Lacko et al., 2012; O'Reilly, Bell & Chen, 2012; Sontag-Padilla et al., 2018). Positive changes have even been demonstrated when this contact is merely imagined rather than real (Stathi, Tsantila & Crisp, 2012). Simply 're-framing' the concept of mental 'illness' has also been considered (Vyncke & van Gorp, 2018), as well as incorporating therapeutic principles such as acceptance and commitment (Masuda et al., 2007) and enhancing recognition of mental health difficulties as on a continuum of mental health (Schomerus et al., 2016). However, many of these interventions have demonstrated only small to moderate effects in the short term (Dalky, 2012; Gronholm, Henderson, Deb & Thornicroft, 2017; Morgan, Reavley, Ross, Too & Jorm, 2018; Quinn et al., 2013; Xu et al., 2018).

There is a further issue of stigma and discrimination in specific contexts, such as mental health settings, with some studies demonstrating that established

intervention approaches may be ineffective or even counter-productive in some populations unless messages are specifically targeted to them (Ashton, Gordon & Reeves, 2018; Corrigan, 2016a; Corrigan & Fong, 2014). Also, power and hierarchy are essential issues in many settings which have yet to be fully explored (Ashton, Gordon & Reeves, 2018; Corrigan, 2004).

Stigma and discrimination may be just as prevalent among mental health care providers and services where one might expect understanding and acceptance of mental health difficulties to be highest (Flanagan, Miller & Davidson, 2009; Harangozo et al., 2014; Henderson et al., 2014; Scholz, Bocking & Happell, 2018). This includes stigmatisation by nurses and doctors, and in emergency or primary care settings where most individuals are likely to first disclose in order to seek help (Clarke et al., 2014; Morgan, Reavley, Jorm & Beatson, 2016; Vistorte et al., 2018). Stigma may also take the form of associative stigma experienced by mental health professionals merely from working in the field of mental health (Ebsworth & Foster, 2017; Gaebel et al., 2015; Gouthro, 2009; Verhaeghe & Bracke, 2012).

Interventions to reduce stigma and discrimination towards people with mental health difficulties among mental health professionals have also been proposed (Arboleda-Florez & Stuart, 2012; Knaak & Patten, 2016; Pilgrim & Rogers, 2005) and evaluated, including increasing personification and agency of people with mental health difficulties (Lebowitz & Ahn, 2016), and involving people with lived experienced in delivering stigma reduction education (Michaels et al., 2014), again with small to moderate success.

Decision making and disclosure of mental health difficulties

Disclosure of mental health difficulties has been proposed to help combat self-stigma and stigma more widely (Corrigan, Kosyluk & Rüsch, 2013). However, given the evidence for enduring discrimination towards people with mental health difficulties, disclosing personal experiences of these difficulties remains a complex and daunting prospect (Isaksson et al., 2018). Research has aimed to explore the motivators, predictors and impact of disclosure both at an individual and societal level (Bos, Kanner, Muris, Janssen & Mayer, 2009; Grice, Alcock & Scior, 2018b; Rüsch, Brohan, Gabbidon, Thornicroft & Clement, 2014; Rüsch, Evans-Lacko, Henderson, Flach & Thornicroft, 2011) and in contexts such as the workplace (Mendel, Kissling, Reichhart, Buhner & Hamann, 2015; Brohan et al., 2012). Disclosure can be fuelled by various agendas, such as maintaining individual self-worth, promoting people's rights and promoting treatment engagement (Corrigan & Al-Khouja, 2018).

In terms of individual factors, male, single, less educated and socioeconomically disadvantaged individuals often report having the poorest attitudes towards mental health, mental health services and seeking help (Coppens et al., 2013; Holman, 2015; Khlat, Legleye & Sermet, 2014) whilst also being more likely to experience distress. Those with less stigmatised diagnoses and satisfactory social support may be more willing to disclose, whereas those with a lower sense of empowerment may refrain (Nagai & Kajita, 2018).

Disclosure decision making interventions are starting to be developed to support people in considering disclosure. Elwyn, Frosch, Volandes, Edwards and Montori (2010) provide a framework and definition for decision support interventions. Although largely in the context of medical treatment decision making, they emphasise

the importance of patient choice based on individual values and consideration of the benefits and harms of a particular decision. They outline that decision aids have the core elements of tailored information provision, exercises that support 'values clarification' and guidance in how to arrive at decisions. They emphasise the importance of considering how the decision aid or intervention is delivered (e.g. in person or via mediums such as books or websites) and in what settings. The review highlights the value and role of peer support and discussions in making decisions. They explore important aspects of decision making interventions such as facilitating a meaningful choice and accurate forecasting of the outcomes and how the individual might feel about living with the range of outcomes they may experience as a result of their decision. They propose a succinct definition of decision support interventions: "*Decision support interventions help people think about choices they face; they describe where and why choice exists; they provide information about options, including, where reasonable, the option of taking no action. These interventions help people to deliberate, independently or in collaboration with others, about options, by considering relevant attributes; they support people to forecast how they might feel about short, intermediate and long-term outcomes which have relevant consequences, in ways which help the process of constructing preferences and eventual decision making, appropriate to their individual situation.*" (pg. 705). Finally, they consider the development and application of quality standards in creating and implementing decision support interventions.

A Cochrane review by Stacey et al. (2017) reported that decision aids in general increased knowledge, accuracy of risk perceptions and congruency between informed values and care choices. They also reported that decision aids decreased indecision about personal values and the proportion of people who were passive or

undecided in decision making. The review did not report any adverse events associated with the use of decision aids. Although this review was in the context of health care decisions, these areas may be relevant and therefore important considerations in disclosure decision making for mental health difficulties, particularly in how they relate to help seeking for such difficulties.

Carpenter and Greene (2013) propose an intervention called the Disclosure Decision-Making Model (DD-MM) based on principles of communication theory, as a way of combatting stigma. They demonstrate that DD-MM has been applied to various physical health conditions and consider its adaptation to mental health difficulties. They detail a Brief Disclosure Intervention (BDI) based on the DD-MM, again previously trialled with physical health conditions, based on brief motivational interviewing and therefore requiring the input of a trained interviewer. They propose that the BDI-Mental Illness (BDI-MI) could be utilised by individuals who are undergoing treatment to increase social support and maintain treatment adherence, with the aim of enabling individuals to anticipate outcomes and decrease stigmatizing responses to their treatment. Therefore, this intervention is specific to those already diagnosed and receiving treatment for their difficulties.

To support individuals in making decisions regarding disclosure of mental health difficulties in the workplace, Henderson (2010) developed a resource called 'Conceal or Reveal' or CORAL. This has been trialled in those who are being supported to return to employment and noted for its ability to also support and develop employers' understanding of mental health difficulties (Peterson & Collings, 2014).

Honest, Open, Proud (HOP) is another disclosure decision making intervention, developed specifically for those experiencing mental health difficulties to consider disclosure in a range of contexts (Corrigan et al., 2016; Corrigan, Rüsch

and Scior, 2018). The efficacy and effectiveness of HOP continues to be explored in different formats and contexts (Mulfinger et al., 2018; Rüsch et al., 2014; Setti et al., 2019).

Factors related to disclosure

A wide range of factors can be considered in exploring disclosure decision making. For the context of this study self-stigma, shame, stigma stress and concealment are briefly discussed. Self-stigma, the internalisation of public stigma (Corrigan & Watson, 2002; Drapalski et al., 2013; Vogel, Bitman, Hammer & Wade, 2013), is associated with reduced self-esteem, mastery and empowerment (Boyd-Ritcher & Phelan, 2004; Brohan, Gauci, Sartorius & Thornicroft, 2011; Corrigan, Watson & Barr, 2006; Marcussen, Ritter & Munetz, 2010; Oliveira, Carvalho & Esteves, 2016). It can also impact negatively on confidence, (Mackay, Bradstreet, McArthur & Dunion, 2015). Self-stigma has been found to be particularly strong when individuals are experiencing higher symptomatology of their mental health difficulty (Busby-Grant, Bruce & Batterham, 2016).

Self-stigma has been demonstrated to influence help seeking behaviour (Evans-Lacko, Brohan, Mojtabai & Thornicroft, 2012; Ingram, Lichtenberg & Clarke, 2016; Jennings et al., 2015; Jennings et al., 2017; Lannin, Vogel, Brenner, Abraham & Heath, 2016). Once in treatment it can impact on adherence, working alliance and treatment satisfaction (Carrara & Ventura, 2018; Kendra, Mohr & Pollard, 2014; Verhaeghe & Bracke, 2011). Further it may lead to less shared decision making in treatment (Hamann, Buhner & Rüsch, 2017) and a higher risk of hospitalisation (Rüsch et al., 2009b). Self-stigma appears to have a greater impact on certain groups such as men (Latalova, Kamaradova & Prasko, 2014). Therefore, it is an important

area of consideration in designing interventions to promote treatment adherence and help seeking (Boyd-Ritsher, Otilingam & Grajales, 2003; Brohan, Elgie, Sartorius & Thornicroft, 2010; Kao, Lien, Chang, Wang, Tzeng & Loh, 2016).

Interventions to reduce self-stigma continue to be evaluated with various forms demonstrating some positive impact on reducing self-stigma and the associated effects on self-esteem and empowerment (Lucksted et al., 2011; MacInnes & Lewis, 2008; Martinez-Hidalgo, Lorenzo-Sanchez, Garcia & Regadera, 2018; Yanos, Lucksted, Drapalski, Roe & Lysaker, 2015).

Experiences of stigma and self-stigma can lead to increased experiences of stress and shame (Rüsch et al., 2009a; 2009b). Shame is often the primary emotion associated with self-stigma and has been found to impede social engagement, promote interpersonal disconnection and interfere with interpersonal problem solving (Covert, Tangney, Maddux & Heleno, 2003). Stigma stress has been conceptualised as the stress an individual feels in relation to the potential threat or harm of stigma experiences they may encounter (Rüsch et al., 2009a; Rüsch et al., 2009b; Schibalski et al., 2017). Therefore, shame and stigma stress are relevant factors in considering the short- and long-term potential benefits and costs of disclosure, as disclosure may reduce the negative impact of these factors on an individual.

Mental health difficulties can frequently be concealed. This means making decisions about disclosure can be complex as the impact of attempting to continue to conceal mental health difficulties to avoid stigma, needs to be weighed against the benefits of disclosing in order to seek help (Ahmedani, 2011; Barney, Griffiths, Christensen & Jorm, 2009; Corrigan & Watson, 2002). There are also possible positive impacts on levels of self-stigma, self-esteem and empowerment, and of having to address non-concealable stigmatised conditions (Mak, Poon, Pun & Cheung, 2007;

Corrigan & Watson, 2002). Secrecy and concealment are possible coping strategies for managing the fear and distress related to disclosure (whether planned or unwitting) of a stigmatised condition (Link, Cullen, Struening, Shrout & Dohrenwend, 1989; Rüsch et al., 2014). There is evidence that secrecy can have adverse effects including increased shame, helplessness, distress, hypervigilance and fear of discovery (Corrigan, Kosyluk & Rüsch, 2013; Link, Mirotznik & Cullen, 1991; Pachankis, 2007). Further prevailing cultural and societal perceptions around controllability and therefore responsibility for mental health difficulties may add to perceived pressure to conceal mental health difficulties (Barney, Griffiths, Christensen & Jorm, 2009; Corrigan & Watson, 2002; Corrigan, Markowitz, Watson, Rowan & Kubiak, 2003).

Dual-experienced Practitioners

Whilst there is growing evidence and recognition of the prevalence of mental health professionals with their own lived experiences of mental health difficulties (Department of Health, 2009; Perry, Lamont, Brunero, Gallagher & Duffield, 2015; Rao et al., 2016; Tay, Alcock & Scior, 2018), the lack of a coherent and acceptable term for these individuals partly reflects the sparsity of detailed and organised discussion of and research into their experiences. These individuals have been referred to in the literature using a variety of terms including prosumers, wounded healers and mental health professional-consumers (Hankir, Zaman & Evans-Lacko, 2014; Jackson, 2001).

Recent research has indicated that the prevalence of mental health difficulties may be higher among those working in the health and mental health professions compared to general population (Meltzer, Griffiths, Brock, Rooney & Jenkins, 2008). The British Psychological Society (BPS) and New Savoy staff well-being survey

conducted in 2015 reported a high incidence of feelings of depression (46%) and experiences of stress (70%) among psychological practitioners (Rao et al., 2016) although it did not report incidence of depression itself. Research also suggests high levels of burnout (Department of Health, 2009), even among mental health professionals who are at the start of their careers (Lamont et al., 2017; O'Connor, Muller Neff, & Pitman, 2018; Pakenham & Stafford-Brown, 2012; Volpe et al., 2014). A range of issues that contribute to experiences of stress and reduced job satisfaction has been identified including lack of support from colleagues and lack of control (Cushway & Tyler, 1994; Sciberras & Pilkington, 2018).

Those working in mental health professions often take the role of the 'helper' which comes with an implicit expectation that one must be 'mentally healthy' to be able to effectively help others (Aina, 2015; Thoreson, Nathan, Skorina & Kilburg, 1983). This creates an 'us and them' dichotomy which is well-established as a general social psychological phenomenon that promotes bias and discrimination (Link & Phelan; 2001; Perdue, Dovidio, Gurtman & Tyler, 1990). This is likely exacerbated in mental health professionals by mental health environments and staff continuing to hold stigmatising attitudes towards people with mental health difficulties (Foster, 2018; Peris, Teachman & Nosek, 2008; Tei-Tominaga, Asakura & Asakura, 2014). This is in spite of working closely with people with mental health difficulties and many such people joining workplaces as peer employees (Byrne, Roper, Happell & Reid-Searl, 2016; Salzer, Schwenk & Brusilovzkiy, 2010; Corrigan, 2016b). This creates a difficult working environment for those who may be 'dual-experienced professionals', i.e. experienced both as a mental health professional and a person with lived experiences of mental health difficulties (Aina, 2015; Department of Health, 2009).

Historically, research and attempts at supporting professionals in this area have focused on well-being and the stress or emotional demands of working as a mental health professional (Department of Health, 2009; Cushway & Tyler, 1996; Moore & Cooper, 1996), including structural and organisational factors such as workload and team structure (Department of Health, 2009; West, Dyrbye, Enwin & Shanafelt, 2016). Interventions have mainly considered ways of managing stress such as increasing exercise and self-care (Myers et al., 2012; Parry, Oeppen, Amin & Brennan, 2018; West, Dyrbye, Enwin & Shanafelt, 2016). However, this largely overlooks the more nuanced experiences of being a dual-experienced practitioner (Oates, Drey & Jones, 2018; Tsai, 2002).

Literature has sought to explain the phenomenon of dual-experienced practitioners by reflecting on motivations for becoming a mental health professional, suggesting that mental health professions may attract those who have lived experience, whether directly or indirectly (e.g. by caring for others with mental health difficulties), due to the wish to better understand and manage their own difficulties (Huynh & Rhodes, 2011; Murphy & Halgin, 1995; Nikcevic, Kramolisova-Advani & Spada, 2007; Tillett, 2003). Indeed Malan (1979) proposed a 'helping profession syndrome' whereby mental health professionals tend to put the needs of others before their own, explaining why mental health professionals may choose this career, but also then experience mental health difficulties themselves. Personality factors have also been explored to understand risk and vulnerability factors that may be more present in health professionals, including perfectionism, self-criticism and being more obsessional (Department of Health, 2009; D'Souza, Egan & Rees, 2011; Grice, Alcock & Scior, 2018a).

One area that has been more extensively researched, is the increased levels of suicide in medical professionals, which has led to exploration of the experiences of these professionals including their own mental health difficulties (Brooks, Gerada & Chalder, 2011; Gerada, 2017; Meltzer, Griffiths, Brock, Rooney & Jenkins, 2008). Stigma and discrimination remain essential components as to why medical professionals do not seek help for mental health difficulties but other distinct factors, such as pressure to perform, discomfort in seeking help, and fears about the impact on their professional status, have also been identified (Gold, Andrew, Goldman & Schwenk, 2016; Hankir, Northall & Zaman, 2014; Hassan, Ahmed, White & Galbraith, 2009).

Consideration is now being given into how to support mental health professionals to seek help for their mental health difficulties (Brooks, Gerada & Chalder, 2011; Garelick, 2012; Kim, Suetani, Forbes & Nguyen, 2018). The association of having a mental health difficulty with being unable to function sufficiently can leave dual-experienced practitioners in fear of being judged as incapable of performing their role and disclosure of their difficulties impacting on their employment (Byrne, Roper, Happell & Reid-Searl, 2016; Foster, 2018; Tavormina et al., 2016). Alongside past experiences of stigma (Grice, Alcock & Scior, 2018a) and fears around others maintaining confidentiality (Dearing Maddux & Tangney, 2005), this leaves many dual-experienced practitioners feeling unable to disclose (Anonymous, 1993; Zerubravel & Wright 2012) and seek help, irrespective of the cost to them personally and emotionally.

However, rather than exploring the unique experiences of dual-experienced practitioners and addressing stigma and discrimination in this context to promote help-seeking, research has often focused on implementing safeguards to reduce risks to

protect the public, often to the detriment of the practitioner (Brooks, Gerada & Chalder, 2011; Gärtner, Nieuwenhuijsen, Van Dijk & Sluiter, 2012). Furthermore, very little literature has focused on the benefits and unique contributions dual-experienced practitioners can bring to their professional roles, such as increased empathy, understanding and advocacy (Huet & Holttum, 2016; Tavormina et al., 2016).

Given the factors outlined above, disclosure in the work setting remains a complicated issue for professionals who may wish to disclose to colleagues and supervisors whose judgements may directly impact on their employment and professional development (Brohan et al., 2012; Brohan & Thornicroft, 2010; Kirsh, Krupa & Luong, 2018). The fear of disclosure impacting on a professional's employment is unfortunately well founded, with those with mental health difficulties and disabilities facing attitudinal and structural barriers that often lead to actual discrimination (Brohan & Thornicroft, 2010; Stuart, 2004; Stuart, 2006).

One opportunity for addressing barriers to disclosure and help-seeking has been identified in the training programmes of health and mental health professionals (Huet & Holttum, 2016; Thomas, Caputi & Wilson, 2014; Vally, 2018), with many recognising this as a potential time to reduce stigma and promote the value of disclosure in helping professionals manage their needs and experiences of mental health difficulties. However, complexities remain even in this context, with cultural factors (Digiuni, Jones & Camic, 2013) and issues of power (Davidson & Patel, 2009) being important to consider in promoting disclosure and help seeking in trainees.

Interventions for Disclosure Decision Making

In the pursuit of combatting stigma and reducing distress, disclosure has been identified as important as it can potentially provide protection (Equality Act, 2010), increase social support (Davidson et al., 1999), and reduce stigma (Corrigan & Rao, 2012; CSCBHSN, BBCSS, DBASE, & NAS, 2016) both individually and within society. However, as disclosure is a complex and personal issue, and may lead to negative outcomes, interventions have been developed to support individuals in considering disclosure decisions carefully (Rüsch et al., 2014; Gronholm, Henderson, Deb & Thornicroft, 2017).

Literature Search

In order to obtain relevant publications and literature surrounding interventions developed to aid those with mental health difficulties in reaching disclosure decisions, a search was conducted on PubMed. The search was conducted on 29/11/18 using the full terms 'disclosure decision making mental health professionals', 'Disclosure decision making mental health' and 'disclosure decision* mental health' in the title and/or abstract. This yielded a total of 634 references, see Table 1. These results were hand searched to identify articles relevant to the wider study aims, leading to 41 articles (Table 1). The reference lists of these articles were hand searched to identify further relevant articles, leading to a further 93 results. These were then reviewed for relevance to interventions focused on disclosure decisions, leading to a final 12 results to be included in this part of the review. These results were reviewed with other researchers in the area to determine any relevant publications that may have been missed, generating a further three articles to be included (Corrigan et al., 2016; Mulfinger et al., 2018; Rüsch et al., 2014).

Table 1: Numbers of relevant references identified using PubMed.

Terms	Number of Results	Number of Relevant Results (excluding duplicates)
Disclosure decision making mental health professionals	21	1
Disclosure decision making mental health	236	19
Disclosure decision* mental health	377	21
Articles identified from reference lists	-	93
Total	**634**	**134**

1. Identified Literature

A systematic search found 12 publications in relation to interventions for disclosure decision making, with a further three relevant publications identified by consulting experts in the field. Of these, seven articles detailed the Honest Open Proud (HOP) intervention (previously called Coming Out Proud); five articles were related to the 'Conceal or Reveal' intervention (CORAL), two articles explored the 'Plan to Manage Personal Information' intervention (PMPI), and one related to the 'Like Minds Employment Advocacy Project' (LEAP). Table 2 lists general publications relating to disclosure decision making. Table 3 details the articles that report findings of trials of the above interventions and the populations in which they were conducted.

Table 2: Journal articles and publications considering interventions supporting disclosure decision making.

Authors & Date	Title
Corrigan et al., (2010).	Self-stigma and coming out about one's mental illness.
Corrigan et al., (2016).	Mental illness stigma and disclosure in college students.
Corrigan, Kosyluk and Rüsch, (2013).	Reducing self-stigma by coming out proud.
Corrigan and Rao, (2012).	On the self-stigma of mental illness: Stages, disclosure, and strategies for change.
Henderson, (2010).	Conceal or reveal: A guide to telling employers about a mental health condition.
Hielscher and Waghorn, (2015).	Managing disclosure of personal information: An opportunity to enhance supported employment.
Like Minds Employment Advocacy Group (2005).	Taking the first step: A guidebook for jobseekers with experience of mental health issues.
Peterson and Collings, (2014).	To disclose or not: Does a decision tool help?

Table 3: Studies reporting findings of interventions supporting disclosure decision making.

Authors & Date	Population	Intervention
Brohan, Henderson, Slade & Thornicroft (2014)	Adult mental health service users seeking paid or voluntary employment	CORAL
Corrigan et al. (2015)	Adults with mental health difficulties (self-identified as having mental health challenges or mental illness and experiencing shame)	HOP
Henderson et al. (2013)	Adults with mental health difficulties on the caseload of a specialist employment advisor and seeking paid or voluntary employment	CORAL
Lassman et al. (2015)	Adults with mental health difficulties receiving vocational support from a mental health trust	CORAL
McGahey, Waghorn, Lloyd, Morrissey & Williams (2016)	Young unemployed mental health service users, also attending employment services	PMPI
Mulfinger et al. (2018)	Adolescents (13-18 years) with mental health difficulties	HOP
Rüsch et al. (2014)	Adults with mental health difficulties and a moderate level of self-reported disclosure related distress	HOP

The decision aids themselves consist of three interventions for disclosure of mental health difficulties in the workplace (CORAL, PMPI and LEAP), and one for disclosure across contexts, which has been piloted in adults and adjusted for adolescents (HOP).

Overview of interventions

1.1 COP/HOP

The act of 'coming out' about one's mental health difficulties as an approach for reduction of self-stigma was first considered by Corrigan et al (2010) who examined the use of the Coming Out with Mental Illness Scale (COMIS) for assessing the benefits of disclosing and reasons for non-disclosure. The results suggested that disclosure of mental health difficulties may help diminish self-stigma and its impact on quality of life, but the authors asserted that strategies are required to assist individuals in weighing up the costs and benefits of disclosure.

The concepts of stigma and self-stigma in relation to the advantages and disadvantages of disclosure of mental health difficulties are considered by Corrigan and Rao (2012). They discuss the 'why try' effect (or modified labelling theory) of diminished self-esteem and self-efficacy as a result of self-stigma and the impact this has on life goals. They describe this effect as a sense of being less worthy of opportunities which undermines efforts at independence and goal achievement such as trying to obtain a competitive job. They suggest disclosure as an important step in reducing self-stigma, as it leads to reduced secrecy, increased support and personal control. However,

they also highlight disadvantages of disclosure particularly in relation to certain cultures (e.g. due to intersectionality with religious beliefs about mental health difficulties) and contexts, and the need for strategies to support such decisions, such as peer support and exploring different levels of disclosure (e.g. selective vs indiscriminate).

Self-stigma and its relation to identity and disclosure of mental health difficulties is discussed by Corrigan, Kosyluk and Rüsch (2013) in proposing HOP as an intervention to reduce self-stigma. The article reviewed previous research of disclosure in LGBTQ populations and based on such models proposed COP as a three-part programme for considering 1) the costs and benefits of coming out, 2) the range of strategic approaches to disclosure, and 3) the augmenting effects of peer support. The original format of HOP consists of three core sessions and a follow-up session delivered by professionals in a peer group setting.

The findings of a pilot randomised controlled trial (RCT) of COP in a sample of 100 Swiss adults with a self-reported diagnosis of an Axis I or Axis II disorder according to DSM-IV, are presented by Rüsch et al (2014). An intention-to-treat analysis found no effect of COP on measures of self-stigma or empowerment. However, there were positive effects on stigma stress, disclosure-related distress, secrecy and perceived benefits of disclosure. At the 3-week follow-up, some of these effects diminished and the authors called for future research to examine the impact of COP.

The results of another RCT of COP in a sample of 126 individuals in the US are presented by Corrigan et al (2015). They report that those who completed COP showed significant improvement at post-test and one-month follow-up in aspects of self-stigma and stigma stress appraisals. They also report that women who completed COP showed significant reductions in depression post-test and one-month follow-up.

Using structured equation modelling, Corrigan et al (2016) report findings of disclosure in college students using interviews and scales of secrecy, disclosure, desire to join a disclosure programme and attributions of public stigma. The authors suggest that mental health identity and public stigma were significant variables in predicting disclosure. They also reported differences in gender and ethnicity, with men and those of a Caucasian ethnicity being more likely to want to disclose a mental health difficulty or join a programme aiding disclosure.

The results of a pilot RCT of Honest, Open, Proud (previously COP) with 98 German adolescents with mental health difficulties are presented by Mulfinger et al (2018). Here those who completed HOP showed significantly reduced stigma stress post intervention and increased quality of life at 3-week follow-up. They also reported a positive impact of HOP on self-stigma, disclosure-related distress, secrecy, help seeking intentions, attitudes to disclosure, recovery and depressive symptoms. The authors suggested that HOP was

economically cost-efficient in relation to gains in quality of life demonstrated.

1.2 CORAL

A decision aid entitled 'Conceal or Reveal: A guide to telling employers about a mental health condition' (CORAL), developed to support individuals in reaching disclosure decisions in relation to the workplace is described by Henderson (2010). It contains sections in relation to the pros and cons of disclosure, disclosure needs, disclosure values, when to disclose, whom to disclose to, and making a decision, with exercises and questions designed to support exploration of these areas. The aid can be used independently or as an adjunct to a clinical encounter (e.g. with an employment advisor) and is presented as a booklet consisting of 12 pages in six sections.

The findings of an RCT of 71 participants, with intention-to-treat analyses were reported by Henderson et al (2013), showing significantly greater reduction in decisional conflict in the CORAL group compared to a control of usual care. They also report that more of the intervention group were in full time employment at follow-up, than controls.

The development and evaluation of CORAL is discussed by Brohan, Henderson, Slade and Thornicroft (2014), reporting that the majority of participants, who were mental health service users, found CORAL quick and relevant and said they would recommend it. They reported that qualitative analysis suggested demand for more information on the legal implications of disclosure to be included. They

also reported that the mean level of decisional conflict and stage of decision making scores reduced. They concluded that CORAL is feasible, relevant and valuable for those making decisions about disclosing a mental health difficulty to an employer.

The above paper was reviewed by Peterson and Collings (2014) who reflect that the tool may also help enhance the understanding of employers and managers. They also highlight limitations such as the on-going nature of decisions rather than this being a one-off event, and the lack of exploration of the benefits of the tool with those already in employment. They also note that other outcomes such as subsequent experiences of discrimination and reflection on the impact of disclosing may be useful to explore.

Qualitative data collected as part of an RCT of CORAL are presented by Lassman et al (2015) and identified five main themes which suggested that the CORAL aid acts on several dimensions of decisional conflict, including clarifying pros and cons, clarifying needs for disclosure and values, increasing knowledge and structuring the decision making process. The authors suggest that the intervention may be most effective if delivered by a professional with knowledge of employment and mental health issues.

1.3 PMPI

An overview of studies that explore mental health disclosure in the workplace was presented by Hielscher and Waghorn (2015). They reported few examples of structured guidance to support individuals in managing their personal information in these contexts. They reported

preliminary evidence for the utility of Managing Personal Information (MPI) in a supported employment programme for young people and recommend further exploration of this tool, particularly in comparison with CORAL. The Plan to Manage Personal Information (PMPI) is a structured tool for employment specialists and job seekers to discuss and identify disclosure strategies covering six main areas including vocational goals, strengths, sensitive information that could be disclosed, work restrictions or limitations, agreed language and workplace accommodations required. It can also be used more informally and is not intended to be shared with an employer.

The results of a brief trial of the PMPI are presented by McGahey, Waghorn, Lloyd, Morrissey and Williams (2016), whereby those who declared a preference to share information were assisted in completing a PMPI. In a sample of 40 unemployed young people with mental health difficulties, those who completed a PMPI had 4.9 times greater odds of securing employment at 6-week follow-up than those who preferred not to disclose any personal information and therefore did not complete a PMPI. However the authors note that further research is required to explore how these findings relate to those who were reluctant to disclose, and therefore did not complete a PMPI, and the subsequent difference in securing a job, as other factors (such as employment preferences) may play a role in the observed differences between groups.

1.4 LEAP

The Like Minds Employment Advocacy Group Project (LEAP) is an employment rights initiative based in New Zealand. In 2005 they produced a guidebook for job seekers with mental health issues entitled 'Taking the first step' (Like Minds Employment Advocacy Project, 2005). This workbook considers practical areas of returning to work including choosing a type of job (e.g. voluntary work, paid work, apprenticeships or self-employment), how to search for a job, employment support services and discrimination and rights, alongside a specific section dedicated to whether to disclose a mental health difficulty to an employer. This section discusses the pros and cons of disclosure, how and when to disclose and when/if disclosure is mandatory. It also provides a large amount of information about other sources of support and organisations available in New Zealand. It is designed for independent use and was freely available to request via the Like Minds, Like Mine website. No pilot study or findings on its use were identified in literature searching.

2. Discussion & Implications

The identified literature suggests that decision aid tools for disclosure of mental health difficulties are gradually being developed and evaluated. However, it also demonstrates that research on disclosure decision aids is in its infancy. Therefore, further research into disclosure decision aids currently available and their feasibility and

acceptability for use with different populations is required to build a body of evidence as to whether disclosure decision aids are helpful to those with mental health difficulties.

3. Limitations

The literature thus far is limited mainly to the use of disclosure decision aids in an employment context, with the exception of COP/HOP. There appears to be little evaluation of qualitative feedback with regards to the feasibility, acceptability and impact of these disclosure decision aids, and there is limited information about the longer-term impact of disclosure decision aids, except for short follow-up periods.

4. Conclusions

Although some preliminary research into the use of disclosure decision aids for people with mental health difficulties has been conducted, particularly in relation to employment settings, there remains a paucity of information regarding their feasibility, acceptability and impact more widely in supporting people with mental health difficulties in considering disclosure.

Honest, Open, Proud (previously Coming Out Proud)

Honest, Open, Proud (HOP), as detailed above, is the most widely explored disclosure decision intervention thus far (Corrigan, Kosyluk & Rüsch, 2013; Corrigan et al., 2015, 2016; Mulfinger et al., 2018; Rüsch et al., 2014; Setti et al., 2019). This brief peer group intervention, consisting of three core sessions and a follow-up session, co-delivered by a peer support worker, aims to reduce decisional conflict and the stress associated with disclosure and self-stigma. Corrigan et al., (2013, 2015, 2016) suggested that although concealment may have benefits, it may increase the risk of internalising stigma associated with mental health difficulties and therefore viewing oneself as flawed or less valuable. In turn, disclosure, as the opposite of concealment, may provide benefits in tackling internalised self-stigma and the associated distress. However, the HOP programme recognises disclosure must be an individual choice and therefore aims to empower individuals to make personal choices about disclosure that are in line with their preferences (Corrigan, Kosyluk & Rüsch, 2013).

The disclosure process model (DPM: Chaudoir & Fisher, 2010) explores when and why interpersonal disclosure may provide benefits including examining the process and outcome of disclosure events. The model considers a range of contextual factors that may influence the process and outcome of disclosure (e.g. goals of disclosure, communication style, coping with outcomes of disclosure and the recipient's reaction), recognising that these play an important role in the utility of disclosure. HOP incorporates these factors to increase the likelihood of positive disclosure experiences (Corrigan, Kosyluk & Rüsch, 2013; Corrigan et al., 2015, 2016). As noted, HOP has been piloted in the US and Europe with evidence of a positive impact on stigma stress, self-stigma, disclosure-related distress, secrecy and

the perceived benefits of disclosure in mental health service users (Corrigan et al., 2015; Rüsch et al., 2014).

The Present Study

The first phase of this study examined the utility and impact of an adapted version of HOP, Honest, Open, Proud for Mental Health Professionals (HOP-MHP) in the UK. As part of the adaptation, the programme was changed from a peer group intervention to a guided self-help intervention, as stigma surrounding lived experience of mental health difficulties in mental health professionals would likely prohibit participants from engaging with the intervention in a group format. As peer support has been found to reduce isolation, enhance feelings of empowerment and self-esteem (Corrigan, 2016b; Dennis, 2003; Pistrang, Barker & Humphreys, 2008; Resnick & Rosenheck, 2008), the peer support aspects of the original HOP intervention were deemed essential and partly maintained by introducing an anonymous online peer forum. It was hoped this would overcome anxieties about unwittingly disclosing, whilst still providing the opportunity for peer support in a flexible and accessible form.

The HOP-MHP intervention combines a self-help guide with access to the anonymous online peer support forum. It has been adapted and designed specifically for mental health professionals with substantial input of a stakeholder group. It closely follows the original HOP format and content including exercises and learning points, designed to aid a process of decision making about disclosure, across three core sessions and a follow-up. For those who decide to disclose, the intervention explores strategies for disclosing most effectively and successfully. For those who decide against disclosure at the present time, the intervention explores the costs and benefits of this decision, and how to still utilise support and resources.

Phase two, on which the current thesis focuses, examined the longer-term impact of HOP-MHP, through a mixed methods design of outcome measures and semi-structured qualitative interviews at the three-month follow-up point.

Aims and Research Questions

Research Question

What longer-term impact does HOP-MHP have on disclosure, stigma related stress, disclosure related distress, secrecy and symptoms of depression and anxiety?

Aims

This study aimed to explore the feasibility and preliminary outcomes of HOP for Mental Health Professionals (HOP-MHP). Following on from earlier studies into the feasibility and short-term impact of HOP-MHP, the present study had the following aims:

1. To explore the longer-term impact of the HOP-MHP intervention on a range of outcomes previously assessed in relation to HOP:

   a. stigma stress

   b. disclosure related distress

   c. likelihood of disclosure of lived experience

   d. benefits of disclosure and reasons for concealment

   e. secrecy

and on measures of symptomatology, distress and behaviour not previously assessed in research on HOP:

   f. depressive symptoms (PHQ-9)

g. symptoms of anxiety (GAD-7)

h. helpfulness of the process of disclosure and reaction of those disclosed to

2. To use qualitative methods to further understand experiences of disclosure decision making, including exploring how the intervention affected decisions about disclosure behaviour and the impact of subsequent disclosure or non-disclosure on the individual.

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Part Two: Empirical Paper

Feasibility and preliminary impact of a guided self-help intervention

supporting disclosure decisions regarding lived experience among mental health

professionals

Joint project with Vivienne Smith

Abstract

Aims

This study aimed to explore the feasibility and preliminary outcomes of Honest, Open, Proud for Mental Health Professionals (HOP-MHP) including at follow-up. HOP-MHP was adapted to support mental health professionals with lived experience of mental health difficulties in reaching disclosure decisions.

Methods

A mixed methods design was used, with measures at baseline, post core intervention (T1) and post follow-up session (T2) to assess stigma stress, disclosure related distress, likelihood of disclosure, benefits of disclosure and reasons for concealment, secrecy, symptoms of anxiety and depression, and the helpfulness of the process of disclosure and reaction of those disclosed to. Qualitative interviews were conducted on the feasibility of the intervention and its impact on disclosure.

Results

The intervention was found to have moderate, but not significant, effects on perceived helpfulness of the reaction of those disclosed to, and small effects on disclosure related distress in keeping difficulties secret, secrecy and likelihood of disclosure of present mental health difficulties. Qualitative analysis indicated that the intervention provided participants with a framework to consider disclosure decisions.

Conclusion

The intervention was found to be feasible but limited in some areas which require further consideration and adaptation. Qualitative analysis attested to the complexity of studying disclosure decision making for dual-experienced practitioners. Consideration of complimentary research and interventions at structural levels is discussed.

Introduction

People with mental health problems often face stigma and discrimination (Berzins, Petch & Atkinson, 2003; Department of Health, 2008; NHS Information Centre, 2011). Link and Phelan (2001) define stigma as consisting of elements of labelling, stereotyping, separation, status loss and discrimination, occurring together in a situation of power that allows them. This stigma is evident in the workplace, in social interactions and in wider society, including in legislation and structural barriers (Corrigan, Markowitz & Watson, 2004; Roeloffs et al., 2003; Stromwall, Holley & Bashor, 2011). Stigma has been found to contribute to low self-esteem, reduced self-efficacy and increased self-stigma (Rüsch, Angermeyer & Corrigan, 2005; Shrivastava, Johnston & Bureau, 2012; Sickel, Seacat & Nabors, 2016). These in turn can affect the functioning and wellbeing of individuals with mental health problems, particularly due to the impact of stigma on help seeking and engagement in treatment (Corrigan, 2004; Corrigan, Druss & Perlick, 2014).

Mental health professionals may also experience mental health problems and therefore can be considered 'dual-experienced practitioners' (Rao et al., 2016; Tay, Alcock & Scior, 2018). They may face a doubling of stigma both from working in mental health services where stigma has been observed to be inherent and due to their personal experiences of mental health difficulties (Henderson et al., 2014; Scholz, Bocking & Happell, 2018). People often conceal their mental health problems due to stigma or the fear of encountering this (Link, Cullen, Struening, Shrout & Dohrenwend, 1989; Thornicroft, 2008). Mental health professionals may conceal their difficulties due to fear about the impact on their professional status and being seen as unable to competently fulfil their role (Byrne, Roper, Happell & Reid-Searl, 2016; Gold, Andrew, Goldman & Schwenk, 2016; Hassan, Ahmed, White & Galbraith,

2009). However, concealment can lead to negative consequences on the individual, including reduced access to help, increased shame, increased self-stigma, reduced confidence, and reduced social support (Corrigan, Bink, Schmidt, Jones & Rüsch, 2016; Corrigan, Kosyluk & Rüsch, 2013; Pachankis, 2007).

Disclosure, that is sharing information about one's experiences of mental health problems and their impact with selected others, may be a way of combating the negative consequences of stigma, concealment and secrecy, including increased access to social support and protection from discrimination (Corrigan, Kosyluk & Rüsch, 2013; Davidson et al., 1999; Equality Act, 2010). However, this depends on the unique context of the individual, the type of disclosure, and the response of those to whom they disclose. Therefore, disclosure decision aids may be useful in assisting people to decide whether to disclose and how best to do so for optimum benefit (Rüsch et al., 2014a; Gronholm, Henderson, Deb & Thornicroft, 2017).

Disclosure decision aids designed to help a person weigh up the benefits and costs of disclosure, have been developed in physical health contexts but remain under explored for mental health difficulties (Carpenter & Greene, 2013; Elwyn, Frosch, Volandes, Edwards & Montori, 2010; Stacey et al., 2017). Aids developed for disclosing mental health difficulties thus far mostly relate to disclosure in the workplace. These include the CORAL, PMPI and LEAP aids, which support individuals with mental health problems in deliberating how or if to disclose in an employment context (Henderson, et al., 2013; Like Minds Employment Advocacy Project, 2005; McGahey, Waghorn, Lloyd, Morrissey & Williams, 2016).

Honest, Open, Proud (HOP) was developed to support those with mental health difficulties in making disclosure decisions across contexts. It has been adapted to different populations including students and adolescents and tested in a number of

randomised controlled trials (RCTs) (Corrigan et al., 2016; Mulfinger et al., 2018; Rüsch et al., 2014a; Setti et al., 2019). In the current study, HOP was adapted as an intervention designed to support mental health professionals in disclosure decision making. The input of a stakeholder group was central to this process given the unique context of disclosing mental health difficulties whilst being a mental health professional and the implications this may have for practice.

Aims

This study aimed to explore the feasibility and preliminary outcomes of HOP for Mental Health Professionals (HOP-MHP). Following on from earlier studies into the feasibility and short-term impact of HOP-MHP, the present study had the following aims:

1. To explore the longer-term impact of the HOP-MHP intervention on a range of outcomes previously assessed in relation to HOP:

    a. stigma stress

    b. disclosure related distress

    c. likelihood of disclosure of lived experience

    d. benefits of disclosure and reasons for concealment

    e. secrecy

and on measures of symptomatology, distress and behaviour not previously assessed in research on HOP:

    f. depressive symptoms (PHQ-9)

    g. symptoms of anxiety (GAD-7)

    h. helpfulness of the process of disclosure and reaction of those disclosed to

2. To use qualitative methods to further understand experiences of disclosure decision making, including exploring how the intervention affected decisions about disclosure behaviour and the impact of subsequent disclosure or non-disclosure on the individual.

Method

Participants

The pilot RCT of HOP-MHP which is the focus of this paper was open to any UK based mental health professional, whether qualified or in training, of working age. Participants were required to self-define as currently experiencing psychological, emotional and/or behavioural difficulties that 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, nor were those who had retired from their role as a mental health service provider.

Recruitment. Participants were recruited via various routes, whereby information about the study was provided alongside a web link to the study website. These routes included via professional training courses, practitioner networks, social media, and mental health profession publications and conferences (see Appendix A). Those interested in participating were encouraged to contact the researchers via email if they had questions about taking part in the study. Recruitment via the Division of Clinical Psychology mailing list held by the British Psychological Society was agreed but, in the event, not possible due to internal procedural difficulties.

Demographics. Demographics for all participants and those included in the completer only analysis are presented in Table 4. Most participants were female, heterosexual, aged 25-34, and White British or White Other in ethnicity. Participants were most likely to be clinical psychologists, whether qualified or in training. Other professions included psychiatry, psychotherapy, mental health social work and mental health religious representative. More trainees than qualified professionals took part in

the study; qualified participants were fairly evenly distributed in time since qualification. Most participants were not currently experiencing a mental health difficulty and were in recovery. Almost all participants had experienced a mental health difficulty in the past and there was an even split of participants who felt they were recovered, at risk of a new episode, or continuing to struggle. Two participants had not experienced a mental health difficulty in the past but were currently. More participants had a formal mental health diagnosis than not.

Table 4: Demographics for participants in total sample and completer analysis.

Demographics		Total sample		Completer analysis	
		n	**%**	**n**	**%**
Gender					
	Female	51	85	27	90
	Male	9	15	3	10
Sexuality					
	Heterosexual	43	71.7	22	73.3
	Bisexual	12	20	6	20
	Homosexual	4	6.7	1	3.3
	Other	1	1.7	1	3.3
Age					
	18-24	5	8.3	3	10
	25-34	36	60	15	50
	35-44	12	20	7	23.3
	45-54	4	6.7	4	13.3
	55-64	2	3.3	1	3.3
	65+	1	1.7	0	0
Ethnicity					
	White British or White Other	57	95	29	96.7
	Other	2	3.3	1	3.3
	Asian or British Asian	1	1.7	0	0
Profession					
	Clinical Psychologist (incl in Training)	41	68.3	20	66.7
	Other Mental Health Professional	7	11.7	3	10
	IAPT Low Intensity Therapist	5	8.3	3	10
	Mental Health Nurse	5	8.3	4	13.3
	IAPT High Intensity Therapist	2	3.3	0	0
Qualification Status					
	Trainee	32	53.3	14	46.7
	Qualified	28	46.7	16	53.3
For qualified, time since qualified					
	Less than 2 years	7	25.9	3	18.8
	2 – 5 years	3	11.1	1	6.3
	5 – 10 years	7	25.9	6	37.5
	10 – 20 years	5	18.5	3	18.8
	More than 20 years	5	18.5	3	18.8
	Missing	1	3.6	0	0
Currently experiencing mental health difficulties					
	No	43	71.7	22	73.3
	Yes	17	28.3	8	26.7
If currently experiencing mental health difficulties					
	In recovery	10	58.8	5	16.7
	On the cusp of a potential crisis	7	41.2	3	10
Past mental health difficulties					
	Yes	58	96.7	29	96.7
	No	2	3.3	1	3.3

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Table 4: Continued.

Demographics		Total sample	Completer analysis	Demographics	
		n	%	n	%
Status of past mental health difficulties					
	Recovered	22	37.9	11	36.7
	Continuing to struggle	20	34.5	10	33.3
	At risk of new episode	16	27.6	8	26.7
Formal Mental Health Diagnosis					
	Yes	36	60	17	56.7
	No	24	40	13	43.3

Procedure

Potential participants expressed interest in taking part in the study via email and completed a brief screening questionnaire to assess eligibility for the study, alongside a consent form. The screening questionnaire confirmed that the participant was a mental health professional who was currently or had previously experienced a mental health difficulty and confirmed that they had not fully disclosed this. It also screened for current suicidal or self-harm ideation in order to ensure participants who were at risk of a mental health crisis were appropriately signposted to support. Those who were eligible completed baseline questionnaire measures and demographic information via Qualtrics (Appendix B). The self-help guide and worksheets were provided electronically (Appendix C). Participants in the intervention arm were asked if they were willing to be contacted at the end of the study to engage in semi-structured interviews about their experiences. Those who consented completed these via telephone and/or Skype with the researcher (Appendix D).

Randomisation and blinding. Participants were assigned a unique identifier (UI) in sequential order. Using the 'Sort' function, the random numbers (with associated UIs locked) were randomly sorted. The randomly ordered UIs were allocated to the Intervention or Control condition such as to ensure that the researchers were blind to the next group assignment in the sequence.

The researchers were not blinded to group allocation as they needed to use participant emails to send engagement and reminder emails (Appendix E). A research assistant (LP) and the project's joint trainee (VS) assigned participant numbers and UIs to participants who signed up for the study (Appendix F). They were also responsible for storing and maintaining the list of UIs and matching participant emails in a secure file in the UCL data safe haven. The researcher (JE) and two previous

researchers (HM and AH), who sent weekly engagement emails to participants in both the intervention and control arm, had access to participants' email addresses (alias or otherwise) but not to their survey responses. The researcher (JE) conducted follow-up qualitative interviews with participants from the intervention arm who consented to do so. As all quantitative 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.

The HOP-MHP website. The HOP-MHP website (https://www.ucl.ac.uk/pals/hop-mhp-project) was developed to provide information about the study and intervention, and access to the information sheet, consent form and brief screening measure. The website provided additional information and signposting about other sources of support; information about self-care; information about Fitness to Practice; and signposting to legal and employment support services.

The HOP-MHP peer forum. Participants in the intervention arm were invited to utilise an online, closed peer-group forum whilst completing the HOP-MHP guide. Registration for the forum was not mandatory, although it was hoped this would be utilised by participants alongside engaging with the HOP-MHP guide. The forum was hosted within the Slack platform, and a brief user guide was sent to all intervention group participants along with an invitation to register to the forum. Forum activity was moderated by the study leads (KS and HC) who took responsibility for responding to potential risk issues or concerns. Control participants were invited to join the forum once they had completed the research study. Of the intervention arm (n=30), ten (33.3%) participants in the total sample (n=30) used the forum, and seven (70%) of those included in the completers analysis (n=10).

Design

The study assessed the longer-term impact of the HOP-MHP intervention on a range of outcomes using a mixed method design to explore the impact of the intervention on disclosure and associated distress. Quantitative analysis focused on comparison of outcomes between the intervention and control groups across all three time points to assess change. At T2 participants in the intervention group were invited to engage in semi-structured interviews to further explore their experiences of the intervention and its impact on subsequent disclosure and associated distress.

Data analysis. Quantitative data were analysed using 2 x 3 between group, repeated measures ANOVAs to assess change across outcome measures between the intervention and control groups, across the three time points. Where possible, Intention-to-Treat analyses were conducted using last observation carried forward (LOCF) to account for drop out whilst maintaining sample size.

Qualitative interviews were analysed using thematic analysis based on procedures detailed by Braun and Clarke (2006). Interviews were conducted with five participants, a subsample of the 13 participants who had completed the guide. All interviews were conducted by the researcher. Recordings were transcribed using artificial intelligence technology, before being checked in detail by the researcher with inaccuracies corrected. Data were analysed using NVivo (NVivo qualitative data analysis software, 2018) for developing initial codes (Appendix G). These were then reviewed and developed into more general themes, which in turn were reviewed for coherence and quality, and sub-themes created where necessary. Credibility checks were conducted via consensus checks with an independent researcher. Known demographics of the participants are summarised in Table 5. An example transcript

excerpt has not been included in the appendix due to the sensitive nature of the interviews and to ensure confidentiality.

Table 5: Interview participant demographics.

	Gender	Profession (if disclosed)
P1	F	Clinical Psychologist
P2	F	Trainee Clinical Psychologist
P3	M	Not Disclosed
P4	F	Not Disclosed
P5	F	Clinical Psychologist

Outcome Measures

Participants completed a battery of measures at all three time points: baseline (T0) before randomisation, post HOP-MHP core sessions (T1; approximately six weeks after baseline) and post follow-up HOP-MHP session (T2; approximately three months after baseline). Measures were chosen to allow comparison of the results with outcomes of the original HOP intervention (Rüsch et al., 2014a) (with the exception of the PHQ-9 and GAD-7 measures). However, as many of these measures adopt a medical tone including the term "mental illness", the language was reviewed by stakeholders and adaptations were made where appropriate to improve acceptability of the measures for a population of diverse mental health professionals. Permission for adapting and reproducing measures was sought from the original authors where required.

Stigma Stress Scale (adapted from Rüsch et al., 2009a, 2009b) measures appraisals of 'mental illness' stigma using 12 items rated using a 7-point Likert scale (1=strongly disagree to 7=strongly agree) which assesses percived harmfulness of 'mental illness' stigma and perceived resources to cope with it. A single stress appraisal score was calculated by subtracting perceived resources from perceived

harmfulness, with higher scores indicating more stigma stress. The original measure is reported to have good internal consistency (Harm items: Cronbach's alpha=.88; Resources items: Cronbach's alpha=.78). The measure was adapted to include two items related to career and professional reputation in the harmfulness subscale (Cronbach's alpha=.92), and two items related to dual-experienced practitioners in the resources subscale (Cronbach's alpha=.81) (Appendix B).

Disclosure Related Distress (adapted from Rüsch et al., 2014a) assesses a person's level of distress and worry in relation to keeping their mental health difficulties secret or with people 'finding out' about their mental health difficulties, using 11 items rated using an 8-point Likert scale (1=not at all, 8=already disclosed). Prorated total scores were calculated for the 'keeping secret' and 'finding out' subscales in order to account for variability across participants in the number of type of groups of people disclosed to. Reliability cannot be measured across this scale as participants are expected to differ in their scores. This measure was adapted from the original one-item screening measure, to include groups of people relevant to dual-experienced practitioners such as supervisors, clients and, for those still in training, members of course staff (Appendix B).

Disclosure of Lived Experience (adapted from Rüsch et al., 2014a) assesses the likelihood of disclosure of both past and present mental health difficulties, using an 8-point Likert scale (1=under no circumstances to 8=I've already disclosed to them) across 11 categories of people. Prorated total scores were calculated for the two subscales of 'likelihood of disclosure' for past and current mental health difficulties, in order to account for variability across participants in the number of categories of people disclosed to. Reliability cannot be measured across this scale as participants are expected to differ in their scores. This measure was adapted from the original two-

item disclosure measure, to include groups of people relevant to dual-experienced practitioners and to differentiate between past and current mental health difficulties (Appendix B). In assessing change using this measure it is important to note that, as HOP-MHP helps individuals think about the pros and cons of disclosure versus concealment in different contexts and to identify the strategy most beneficial to them, a 'successful' outcome will vary between individuals and depend on what seems right for them. Some may decide that not disclosing is best, at least in some settings, some may disclose to selected (supportive) others, and some may choose to actively share their experiences, perhaps to feel more empowered and combat stigma.

Disclosure Experience Process and Reaction items were created for the current study to assess the helpfulness of the process of disclosing in the past, and the helpfulness of the reaction of the person disclosed to in the past, using a 7-point Likert scale (1=very unhelpful to 7=very helpful) across 11 categories of people. Prorated total scores were calculated for the helpfulness of the process of disclosure and reaction to disclosure subscales in order to account for variability across participants in the number of groups of people disclosed to. Reliability again cannot be measured across this scale as participants are expected to differ in their scores.

Coming Out with Mental Illness Scale (adapted from COMIS; Corrigan et al., 2010) asks whether or not an individual has 'come out' about their mental health difficulties, and then asks them to rate 54 further items on a 7-point Likert scale regarding perceived 'benefits of being out' (BBO: for those who have selectively disclosed in the past, or potential disclosure in future), and 'reasons for staying in' (RSI: for those who have not disclosed, or potential concealment in future). The original measure is reported to have acceptable internal consistency (those who had selectively disclosed: BBO, Cronach's alpha =.87; RSI, Cronbach's alpha =.94; those

who had not disclosed: BBO, Cronbach's alpha =.90; RSI, Cronbach's alpha =.94). The measure was adapted by adding four items to the BBO scale, and adding two items to the RSI scale relevant to dual-experienced practitioners (those who had selectively disclosed: BBO, Cronach's alpha =.83; RSI, Cronbach's alpha =.89; those who had not disclosed: BBO, Cronbach's alpha =.87; RSI, Cronbach's alpha =.88) (Appendix B). Total scores for the two factors were calculated.

Secrecy Scale (adapted from Link, Cullen, Struening, Shrout & Dohrenwend, 1989) measures an individual's tendency to keep their own mental health difficulties a secret as a way of avoiding discrimination using nine items rated on a 4-point Likert scale (1=strongly disagree to 4=strongly agree), with higher mean scores indicating higher secrecy. This measure is reported to have acceptable internal consistency (Cronbach's alpha =.67). The measure was adapted by changing stigmatising terminology used in some questions after consultation with the stakeholder group (Cronbach's alpha=.80) (Appendix B).

Patient Health Questionnaire (PHQ-9: Kroenke, Spitzer & Williams, 2001) measures symptoms of depression using nine items, with higher total scores indicating more severe depressive symptoms. The measure is widely used and has good levels of sensitivity and specificity for depression (the original authors reported that a PHQ-9 score ≥10 had a sensitivity of 88% and a specificity of 88% for major depression; Cronbach's alpha=.89).

Generalised Anxiety Disorder scale (GAD-7: Spitzer, Kroenke, Williams & Löwe, 2006) measures symptoms of anxiety on seven items, with higher total scores indicating more severe symptoms of anxiety. The measure is widely used and has good reliability and validity (Cronbach's alpha=.92). A GAD-7 score ≥10 had a sensitivity of 89% and a specificity of 82% for generalised anxiety.

Ethical considerations

The study had ethical approval from the UCL Research Ethics Committee (Project ID No:9297/002) (Appendix H). The pilot RCT was registered with a clinical trial register (ISRCTN reference No: 18418155). Participation in the study was voluntary and all participants were provided with an information sheet outlining the study (Appendix I) and asked to complete a comprehensive consent form (Appendix J). Participants were informed that they were free to withdraw from the study at any point.

Potential risks and burden to participants. It was hoped that participants would benefit from the intervention, as an opportunity to consider the benefits and costs of disclosure. However, it was recognised that this process had the risk of causing increased experiences of distress in relation to reflecting on their current and/or past experiences of mental health difficulties and disclosure. In order to provide participants with support, a number of steps were taken including: access to a peer forum for support (during the intervention, or post participation for the control group), access to the HOP-MHP website with information on avenues for information and support, and reminders of the website and signposting in engagement emails. Participants were also encouraged to contact the HOP-MHP leads for a confidential conversation if they experienced increased distress (although no participants contacted the leads for such support).

Confidentiality. All personal identifiable data were stored securely using the UCL Data Safe Haven. No identifiable data were entered or stored on Qualtrics. To maintain confidentiality, participants were encouraged to create an alias email address for the purpose of engaging in the study, including submitting the informed consent form. Sociodemographic data were kept to a minimum to ensure anonymity,

particularly in the analysis and reporting of qualitative interviews. The peer forum was a closed site, available only by invitation to those taking part in the trial. Participants were again encouraged to use an alias email account and advised to limit the use of identifiable information in the forum to ensure anonymity, confidentiality and user safety.

Results

Flow of Participants

Figure 1 demonstrates the flow of participants through the study from enrolment to follow-up.
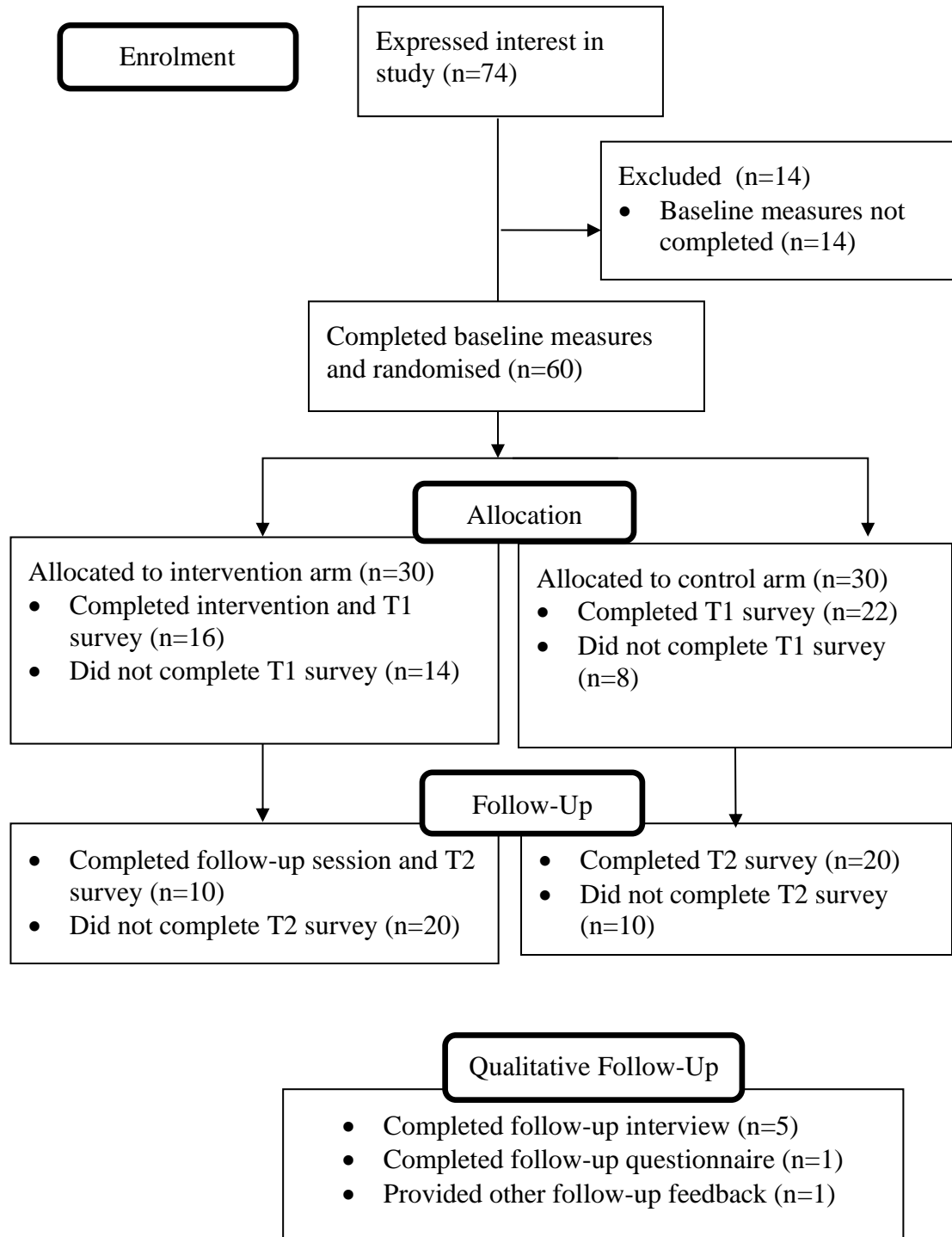
Figure 1: CONSORT diagram of flow of participants throughout study.

Power analysis

Power analyses were conducted using G*Power v 3.1.2 (Faul, Erdfelder, Lang & Buchner, 2007) on the significant results found in completer and ITT analyses (see Table 6).

Table 6: Power analysis calculations.

Analysis	Measure	Observed effect size, r	Total sample size	Number of groups	Number of measurements	Power achieved
Completer	SSS	0.25	30	2	6	0.41
Completer	PHQ-9	0.46	30	2	6	0.89
Completer	COMIS – RSI	0.24	28	2	6	0.36
ITT	SS	0.22	60	2	6	0.59

SSS – Stigma Stress Scale; PHQ-9 – Patient Health Questionnaire; COMIS-RSI – Coming Out with Mental Illness Scale, Reasons for Staying In; SS – Secrecy Scale.

Quantitative Results

Before presenting findings in relation to the study's aims, key information regarding behavior of participants including help seeking and disclosure behaviour is presented. Table 7 summarises help-seeking behaviour of participants included in the total sample and completer analyses at baseline. Table 8 summarises disclosure behaviour of participants in both groups across time points.

In the total sample (n=60), of those who were still taking part in the study at the respective time points and had selectively disclosed at baseline (n=13), three did not disclose between baseline and T1, and four did not disclose between T1 and T2. Of those who were still taking part in the study at the respective time points and had not disclosed at baseline (n=20), five had disclosed by T1, and one further participant by T2.

In the intervention group (n=30), of those who were still taking part in the study at the respective time points and had not disclosed at baseline (n=20), two had disclosed by T1 and no additional participants had disclosed by T2. In the control group (n=30), of those who were still taking part in the study at the respective time points and had not disclosed at baseline (n=17), three had disclosed by T1, and one further participant by T2.

Table 7: Help seeking of participants in total sample and completer analysis at baseline.

Help Seeking		Total sample		Completer analysis	
		Number	**%**	**Number**	**%**
Sought help					
	Yes	57	95	30	100
	No	3	5	0	0
GP					
	Yes	27	49.1	17	56.7
	No	28	50.9	12	40
NHS Clinical Psychologist					
	Yes	9	16.4	2	6.7
	No	46	83.6	27	93.1
NHS Psychiatrist					
	Yes	10	18.2	5	16.7
	No	45	81.8	24	80
NHS Therapist or Counsellor					
	Yes	8	14.5	3	10
	No	47	85.5	26	86.7
Private Clinical Psychologist					
	Yes	7	12.7	4	13.3
	No	48	87.3	25	83.3
Private Psychiatrist					
	Yes	3	5.5	1	3.3
	No	52	94.5	28	93.3
Private Therapist or Counsellor					
	Yes	28	50.9	14	46.7
	No	27	49.1	15	50
Other					
	Yes	5	9.1	4	13.3
	No	50	90.9	25	83.3

Table 8: Type of person disclosed to in intervention and control groups across time points.

Type of person disclosed to	Baseline			T1			T2		
	Intervention	Control	Total	Intervention	Control	Total	Intervention	Control	Total
Family member	10	13	23	8	10	18	4	9	13
Close friend	10	13	23	8	10	18	4	9	13
Acquaintance	7	9	16	6	8	14	3	6	9
Member of course staff (if still in training)	7	9	16	4	5	9	1	5	6
Clinical supervisor	7	9	16	6	6	12	3	6	9
Line manager	5	8	13	6	7	13	2	9	11
A colleague	4	10	14	7	7	14	4	7	11
A fellow trainee (if still in training)	7	8	15	5	5	10	2	5	7
Health professional	10	12	22	8	10	18	3	9	12

Table 8: Continued.

Type of person disclosed to	Baseline			T1			T2		
	Intervention	Control	Total	Intervention	Control	Total	Intervention	Control	Total
Client I am seeing	2	2	4	2	2	4	1	4	5
Service user groups (not my clients)	2	3	5	4	4	8	2	3	5

Descriptive statistics for the data were reviewed for distribution of sociodemographic characteristics between the groups, and for assumptions of normality and homogeneity of the data. In accordance with Field (2013), outliers were identified by calculating z-scores. Only one outlier was identified; this was Winsorised by replacing it with the next highest score that was not an outlier. The skewness and kurtosis of the data were assessed and found to be fairly normally distributed with some elevated skewness and kurtosis on the COMIS measures that did not warrant transformations. Mauchly's Test of Sphericity was applied in all mixed ANOVAs, with all measures meeting assumptions of sphericity except in the completer analysis GAD-7, and COMIS RSI scores, and in the ITT analysis Stigma Stress Scale and GAD-7 scores, where the Greenhouse-Geisser correction was used to adjust for this.

At baseline, there was a significant difference between the two groups on the demographic variable of having been given a diagnosis, $\chi 2$ (1, $N = 60$) = 4.444, p = .035, with the intervention group more likely to have been given a formal mental health diagnosis. There was no significant difference between groups on whether participants had selectively disclosed or not disclosed at baseline. Although not significant at baseline, mean scores on the GAD-7 and PHQ-9 were higher in the control group than in the intervention group.

To assess change over time, mixed 2x3 ANOVAs were carried out for each of the measures to compare the intervention and control groups across baseline, T1 and T2. ANOVAs were conducted on completed cases and also with an Intention-to-Treat (ITT) analysis, using LOCF for participants who dropped out of the study. Effect sizes were calculated by hand using guidance by Field (2013). Means, standard deviations and sample sizes are reported for the completer analysis in Table 9 and for the ITT analysis in Table 10.

In the case of the DOLE and DRD measures, analysis across the three time points was not possible due to the large amount of missing data at T2, which was too large to consider techniques such as multiple imputation. Therefore, only the analyses comparing baseline and T1 are presented for the completer and ITT analyses.

On the DEPR measure, completer analyses are reported for scores between baseline and T1, and T1 and T2 separately as a full ITT could not be conducted due to changes in participants' disclosure or non-disclosure behaviours during the course of the study.

The ITT analyses data are presented below as although they give a more conservative analysis, their results are likely to give a more accurate picture of the outcomes for everyone included in the trial, whether or not they completed the intervention (see Table 10). Due to difficulties with recruitment and slower than anticipated progression through the study, the completer analyses were mostly underpowered and should be interpreted with caution.

In order to account for risk of type I error, only significant results at the 1% level of significance ($p < 0.01$) will be considered. Effect sizes are reported to account for the risk of type II error due to the small sample size obtained

Table 9: Means (M), standard deviations (SD) and sample sizes (n) for each measure in completers analyses.

Measure		Intervention						Control					
		Baseline		T1		T2		Baseline		T1		T2	
		M (SD)	n	M (SD)	n	M (SD)	n	M (SD)	n	M (SD)	n	M (SD)	n
SSS		5.80 (9.07)	10	9.20 (9.21)	10	12.60 (14.68)	10	2.75 (10.79)	20	5.75 (10.49)	20	5.15 (11.54)	20
DRD	Keeping Secret	0.51 (0.24)	15	0.51 (0.25)	15	-	-	0.59 (0.15)	19	0.46 (0.18)	19	-	-
	Finding Out	0.55 (0.24)	15	0.49 (0.27)	15	-	-	0.61 (0.16)	19	0.55 (0.24)	19	-	-

Table 9: Continued.

Measure			Intervention						Control					
			Baseline		T1		T2		Baseline		T1		T2	
			M (SD)	n	M (SD)	n	M (SD)	n	M (SD)	n	M (SD)	n	M (SD)	n
DOLE	Past		0.50 (0.18)	15	0.51 (0.18)	15	-	-	0.57 (0.14)	19	0.53 (0.14)	19	-	-
	Present		0.50 (0.16)	14	0.51 (0.18)	14	-	-	0.59 (0.15)	19	0.56 (0.16)	19	-	-
DEPR	Process	(Baseline – T1)	0.70 (0.17)	6	0.70 (0.14)	6	-	-	0.69 (0.15)	7	0.69 (0.12)	7	-	-
		(Baseline – T2)	0.83 (0.00)	2	-	-	0.80 (0.12)	2	0.74 (0.10)	5	-	-	0.73 (0.10)	5

Table 9: Continued.

Measure			Intervention						Control					
			Baseline		T1		T2		Baseline		T1		T2	
			M (SD)	n	M (SD)	n	M (SD)	n	M (SD)	n	M (SD)	n	M (SD)	n
DEPR	Reaction	(Baseline – T1)	0.71 (0.18)	6	0.69 (0.18)	6	-	-	0.70 (0.14)	7	0.66 (0.10)	6	-	-
		(Baseline – T2)	0.81 (0.10)	2	-	-	0.80 (0.10)	2	0.76 (0.08)	5	-	-	0.71 (0.12)	5
COMIS	BBO		44.50 (12.67)	10	45.50 (15.15)	10	45.90 (12.57)	10	52.79 (9.10)	19	50.53 (7.34)	19	48.42 (10.50)	19
	RSI		82.60 (13.70)	10	75.70 (18.96)	10	78.40 (20.97)	10	86.72 (11.33)	18	82.00 (13.53)	18	83.33 (12.04)	18

Table 9: Continued.

Measure	Intervention						Control					
	Baseline		**T1**		**T2**		**Baseline**		**T1**		**T2**	
	M (SD)	**n**	**M (SD)**	**n**	**M (SD)**	**n**	**M (SD)**	**n**	**M (SD)**	**n**	**M (SD)**	**n**
SS (overall mean score)	2.29 (.572)	10	2.04 (.545)	10	2.04 (.663)	10	2.14 (.489)	20	2.18 (.529)	20	2.11 (.629)	20
PHQ-9	3.60 (3.31)	10	3.70 (2.06)	10	4.00 (3.46)	10	6.90 (3.82)	20	6.50 (3.29)	20	7.50 (4.50)	20
GAD-7	4.90 (3.57)	10	5.40 (2.99)	10	5.50 (3.69)	10	6.70 (3.40)	20	5.80 (2.80)	20	6.50 (3.10)	20

SSS – Stigma Stress Scale; DRD – Disclosure Related Distress; DOLE – Disclosure of Lived Experience; DEPR – Disclosure Experiences Process and Reaction; COMIS – Coming Out with Mental Illness Scale, BBO – Benefits of Being Out, RSI – Reasons for Staying In; SS – Secrecy Scale; PHQ-9 – Patient Health Questionnaire; GAD-7 – Generalised Anxiety Disorder.

Table 10: Means (M), standard deviations (SD) and sample sizes (n) for each measure in ITT analyses.

Measure		Intervention						Control					
		Baseline		T1		T2		Baseline		T1		T2	
		M (SD)	n	M (SD)	n	M (SD)	n	M (SD)	n	M (SD)	n	M (SD)	n
SSS		6.27 (9.49)	30	7.17 (11.28)	30	8.30 (13.24)	30	3.80 (10.29)	30	5.57 (9.78)	30	5.33 (10.39)	30
DRD	Keeping Secret	0.47 (0.22)	27	0.47 (0.23)	27	-	-	0.54 (0.21)	27	0.44 (0.21)	27	-	-
	Finding Out	0.54 (0.21)	27	0.51 (0.23)	27	-	-	0.59 (0.20)	27	0.55 (0.19)	27	-	-

Table 10: Continued.

Measure		Intervention						Control					
		Baseline		T1		T2		Baseline		T1		T2	
		M (SD)	n	M (SD)	n	M (SD)	n	M (SD)	n	M (SD)	n	M (SD)	n
DOLE	Past	0.49 (0.17)	27	0.50 (0.17)	27	-	-	0.55 (0.14)	26	0.52 (0.14)	26	-	-
	Present	0.51 (0.15)	26	0.52 (0.16)	26	-	-	0.56 (0.15)	25	0.53 (0.15)	25	-	-
SS (overall mean score)		2.17 (0.49)	30	1.99 (0.54)	30	1.98 (0.62)	30	2.18 (0.44)	30	2.15 (0.47)	30	2.10 (0.52)	30

Table 10: Continued.

Measure	Intervention						Control					
	Baseline		T1		T2		Baseline		T1		T2	
	M (SD)	n	M (SD)	n	M (SD)	n	M (SD)	n	M (SD)	n	M (SD)	n
PHQ-9	5.60 (5.10)	30	5.87 (5.23)	30	5.97 (5.42)	30	7.40 (4.88)	30	7.23 (4.61)	30	7.83 (5.26)	30
GAD-7	5.63 (4.39)	30	6.00 (4.78)	30	6.03 (4.92)	30	7.27 (4.76)	30	6.53 (4.23)	30	7.07 (4.22)	30

SSS – Stigma Stress Scale; DRD – Disclosure Related Distress; DOLE – Disclosure of Lived Experience; SS – Secrecy Scale; PHQ-9 – Patient Health Questionnaire; GAD-7 – Generalised Anxiety Disorder.

Completer Analyses. These analyses yielded three findings approaching significance, see Table 11. For stigma stress, there was main effect for time that approached significance, $F(2,56) = 3.743$, $p = .030$. Contrasts revealed that stigma stress scores were higher at T2 than at baseline, $F(1,28) = 5.864$, $p = .022$.

For 'reasons for staying in' (COMIS), there was no main effect for time ($F(2,52) = 3.193$, $p = .064$) however pairwise comparisons revealed that RSI scores were approaching significance, with scores being lower at T1 than at baseline ($p = .018$).

On the PHQ-9, there was a significant main effect of group, $F(1,28) = 7.409$, $p = .011$, with those in the control group having significantly higher total scores on the PHQ-9 than the intervention group. It should be noted that the increases in PHQ-9 and GAD-7 scores summarised in Tables 8 and 9 were neither clinically significant nor found to be a serious adverse event when reviewed by the prinicipal investigator and HOP-MHP team.

Table 11: ANOVA results for completer analyses.

Measure				*F*	*p*	*r*
SSS						
			Time	3.743	.030	0.250
			Time*Cond	0.996	.376	0.132
			Cond	1.503	.230	0.226
DRD	Keeping Secret	Baseline – T1				
			Time	2.751	.107	0.281
			Time*Cond	2.870	.100	0.287
			Cond	0.050	.825	0.039
	Finding Out	Baseline – T1				
			Time	1.969	.170	0.241
			Time*Cond	0.006	.939	0.014
			Cond	1.089	.305	0.181
DOLE	Past	Baseline – T1				
			Time	0.489	.489	0.123
			Time*Cond	0.934	.341	0.168
			Cond	0.832	.369	0.159
	Present	Baseline – T1				
			Time	0.550	.464	0.132
			Time*Cond	1.349	.254	0.204
			Cond	1.646	.209	0.225
DEPR	Process	Baseline – T1				
			Time	0.024	.881	0.047
			Time*Cond	0.005	.944	0.021
			Cond	0.016	.900	0.038
		Baseline – T2				
			Time	0.158	.707	0.175
			Time*Cond	0.024	.883	0.069
			Cond	1.783	.239	0.513
	Reaction	Baseline – T1				
			Time	0.548	.475	0.218
			Time*Cond	0.030	.865	0.052
			Cond	0.095	.764	0.093
DEPR		Baseline – T2				
			Time	2.656	.164	0.589
			Time*Cond	1.235	.317	0.445
			Cond	0.818	.407	0.375

Table 11: Continued.

Measure				F	p	r
COMIS	BBO	All timepoints				
			Time	0.486	.649	0.094
			Time*Cond	1.643	.203	0.172
			Cond	1.952	.174	0.260
COMIS	RSI	All timepoints				
			Time	3.193	.064	0.241
			Time*Cond	0.111	.841	0.046
			Cond	1.011	.324	0.193
SS		All timepoints				
			Time	2.396	.100	0.203
			Time*Cond	2.612	.082	0.211
			Cond	0.007	.936	0.016
PHQ-9		All timepoints				
			Time	0.511	.603	0.095
			Time*Cond	0.143	.867	0.050
			Cond	7.409	.011*	0.457
GAD-7		All timepoints				
			Time	0.161	.813	0.054
			Time*Cond	0.496	.578	0.094
			Cond	1.276	.268	0.209

$* p < .01$

SSS – Stigma Stress Scale; DRD – Disclosure Related Distress; DOLE – Disclosure of Lived Experience; DEPR – Disclosure Experiences Process and Reaction; COMIS – Coming Out with Mental Illness Scale, BBO – Benefits of Being Out, RSI – Reasons for Staying In; SS – Secrecy Scale; PHQ-9 – Patient Health Questionnaire; GAD-7 – Generalised Anxiety Disorder.

Intention to Treat Analyses. Intention to treat analyses were completed for measures as listed in Table 12. ITT analysis could not be conducted for the COMIS, as it is unknown whether participants who dropped out may have changed from not disclosing to disclosing or vice versa. ITT analysis could not be conducted for the DEPR measures as some participants may not have completed the measure at baseline or T1 as they had not yet disclosed, but later did complete the measure if they had selectively disclosed by T1 or T2.

The ITT analyses yielded one significant finding (see Table 12). On secrecy scale mean scores, there was a significant main effect for time, $F(2,116) = 5.828$, $p = .004$. Pairwise comparisons revealed that mean secrecy scale scores were significantly higher at baseline than at T1 (p = .018) and than at T2 (p = .005).

Table 12: ANOVA results for ITT analyses.

Measure				*F*	*p*	*r*
SSS						
			Time	1.758	.182	0.122
			Time*Cond	0.244	.747	0.046
			Cond	0.846	.362	0.120
DRD	Keeping Secret	Baseline – T1				
			Time	3.381	.072	0.247
			Time*Cond	3.497	.067	0.251
			Cond	0.144	.706	0.053
	Finding Out	Baseline – T1				
			Time	1.972	.166	0.191
			Time*Cond	0.008	.930	0.012
			Cond	0.585	.448	0.105
DOLE	Past	Baseline – T1				
			Time	0.710	.403	0.117
			Time*Cond	1.159	.287	0.149
			Cond	0.945	.336	0.135
	Present	Baseline – T1				
			Time	0.914	.344	0.135
			Time*Cond	1.717	.196	0.184
			Cond	0.487	.489	0.099
SS						
			Time	5.828	.004*	0.219
			Time*Cond	1.527	.221	0.114
			Cond	0.588	.446	0.100
PHQ-9						
			Time	0.810	.447	0.083
			Time*Cond	0.314	.731	0.052
			Cond	1.792	.186	0.173
GAD-7						
			Time	0.309	.677	0.052
			Time*Cond	1.135	.314	0.098
			Cond	0.942	.336	0.126

* $p < .01$

SSS – Stigma Stress Scale; DRD – Disclosure Related Distress; DOLE – Disclosure of Lived Experience; SS – Secrecy Scale; PHQ-9 – Patient Health Questionnaire; GAD-7 – Generalised Anxiety Disorder.

Qualitative Results

This section explores the five interviewees' experiences of disclosure decision making including the impact of the intervention on disclosure decision making and disclosure behaviour, and subsequent disclosure or non-disclosure. Deductive coding was used to code and collate themes relating to the HOP-MHP manual and peer forum, in line with questions asked in the semi-structured interviews. Inductive coding was used throughout the rest of the analysis to generate codes and themes relating to disclosure and disclosure experiences more widely. Tentative themes and sub-themes are presented given the limited number of participants. The main themes and sub-themes are presented in Table 13. Endorsement of each sub-theme is presented in Table 14.

Table 13: Main themes and sub-themes.

Main Theme	Sub-themes
1. Lots to think about in considering disclosure	1.1 Concealment and the pressure to disclose
	1.2 Considering consequences of disclosure
	1.3 Past experiences of disclosure
	1.4 Power – professionals as stigmatisers
	1.5 Responsibility for normalising, advocating and social justice
	1.6 Sense of self – feeling disingenuous or dissonant
2. What it means to be a dual-experienced practitioner	2.1 Lived experience as motivation to work in mental health
	2.2 Lived experience as a skill
	2.3 Defiance
3. Fears about consequences of disclosing	3.1 Avoiding vulnerability
	3.2 Feeling unsafe, anxious or paranoid
	3.3 Uncertainty about the consequences of disclosure
	3.4 Feelings of shame and embarrassment
	3.5 The stigma of being judged or defined by mental health difficulties
4. Effects of disclosure	4.1 Interpersonal relationships
	4.2 Disclosure at work
	4.3 Confidence
	4.4 Mental health symptoms
5. Context to disclosure	5.1 Personal disclosure
	5.2 Disclosure in own personal therapy
	5.3 Disclosure in relation to client work
	5.4 Professional disclosure and the unique impact of supervision
	5.5 Levels of disclosure – from unwitting, to selective, to broadcast

1. **Lots to think about in considering disclosure.** The intervention allowed participants to consider disclosure decisions in depth. These decisions about disclosure were mediated by a number of factors for all the participants.

Concealment was recognised by all participants as an option in relation to disclosure. Some spoke about feeling a pressure to stop concealing while others recognised that concealment represented the best option for them, and others, at different times or in different contexts.

> *"I thought 'Oh God, no, never.'" HOP5*

> *"There was kind of… a little bit of a sense of then feeling a bit pushed to do that, which I was then thinking, 'I'm not sure I'm ready for this' and whether this is what I want to do." HOP4*

However, there were differences in whether concealment felt like a conscious decision in protecting oneself from the consequences of disclosure, or an automatic, assumed default position that was likely to be more beneficial.

All participants reflected on the consequences they perceived of disclosing their lived experience. The decision whether to disclose or not appeared not to be a simple one and would take time and reflection.

> *"I wanted to see where it took me and just use it I guess as an opportunity to reflect on my own experience and then what that might mean in a work context rather than then making a decision from the beginning 'Yes, I want to do this!'" HOP4*

> *"I was interested to think about how I haven't disclosed, and what that's about… I think I was… interested to sit back and think about why am I keeping things so separate? What is this about?" HOP5*

Taking part in the study and working through the manual appeared to provide the participants with a space and framework for considering their past disclosure or non-disclosure and how changing their disclosure in future might affect them in a variety of ways.

Past experiences of disclosure, whether negative or positive, were also a prominent factor in considering disclosure.

> *"I'd had some bad experiences and my employer isn't necessarily great at dealing with staff with mental illness… some of them felt outright punished… no accommodations being made, having to fight for reasonable adjustments and those being incredibly hard to win through because… the difficulties that were having an effect on those members of staff's work was mental as opposed to physical." HOP1*

> *"There were a couple of times that he made some comments about it that didn't feel very nice…I mean that was really difficult actually and I didn't feel supported at all. I felt quite…stigmatised actually for having been so honest about my experiences." HOP5*

These negative experiences were across contexts including in personal and professional disclosure situations. However, in many cases there were also positive experiences of disclosing.

> *"I definitely think there were positive experiences… sharing with… a tutor specifically about someone close to me with mental health difficulties and how that might impact on my mental health…that was, yeah I think useful." HOP4*

> *"I picked something quite personal…so I talked to my supervisors about that quite a bit and I found that really helpful and really positive." HOP5*

However, these did not always compensate for negative experiences and power appeared to be influential in how disclosure was experienced.

> *"The colleagues that I spoke about are all less senior, so in a sense they feel more vulnerable. Or I can understand why they feel more vulnerable." HOP1*

> *"Obviously as a kind of lowly trainee psychologist it's going to have much less of an impact… I always thought it would be easier to disclose the higher up you get, but actually well I'm quite high up now and it hasn't proved to be." HOP2*

Participants also recognised that many of their negative experiences came from professionals themselves, particularly in terms of professionals expressing or maintaining stigmatising beliefs.

> *"I do feel that there is a stigma, and even for people that work in mental health and in terms of 'this is us and this is them'… for some clinicians in the team some groups of patients feel like really mystifying… you know people have asked me questions before like 'can anyone ever recover?'…there's a bit of me that wants to say 'yeah, people bloody can'." HOP5*

> *"My experience of that was not strictly positive… I do have evidence… of a huge amount of stigma towards people with mental health difficulties within the workforce … I've seen that first hand… I felt quite persecuted… I just think the levels of stigma are very high and I suppose there is unfortunately research backing that up…that the mental health workforce is definitely not immune to it… even the most apparently empathic, caring, lovely clinicians still view it in those kind of 'us and them' terms." HOP2*

These experiences of stigma within and by the mental health workforce seemed to contribute to the participants' consideration of disclosure as a means to normalise mental health difficulties, to advocate for clients and colleagues, and to contribute to social justice and macro level changes in how mental health is viewed.

"I think probably helpful in the sense of role… modelling…normalising that this is a really common experience…I think it does have a positive normalising effect…from a social justice point of view…I saw it in quite a… macro level… for the greater good…I didn't see it as beneficial to me...we wish to be a good citizen." HOP 3

"I think it's quite important to think about that and… open up the conversation around all that kind of stuff… I find that inspiring because… I would like to be in a place where I can contribute to the conversation…almost leaning toward the activist." HOP3

Although participants spoke about disclosure in relation to helping others, they also expressed that disclosure may help them in feeling less disingenuous or dissonant in relation to their own sense of self.

"In terms of feeling disingenuous…as a professional who has experience of mental illness." HOP1

"I suppose that's something that I have kind of reflected on and thought about in terms of feeling a bit dissonant, maybe almost hypocritical at times, in terms of...preaching the anti-stigma message, but not necessarily feeling able to disclose in order to help, potentially help, lessen that stigma… if I'd been able to overcome that and be a bit more integrated and feel that actually I was presenting my whole self to the world rather than just a part of it." HOP2

2. **What it means to be a dual-experienced practitioner.** In using the intervention to consider disclosure decisions, some participants reflected on their experiences of being a dual-experienced practitioner including how they viewed this status and what skills it had enabled them to develop. Some participants noted that their lived experience was in part a motivator to work in the mental health field.

> *"I'm somebody who had a mental health difficulty as an adolescent, and I think it really was why I then decided to train as a clinical psychologist."* HOP1

Others reflected on the skills and insight being a dual-experienced practitioner provided them with.

> *"I think I'm a better clinician because I've had these experiences and I've had more therapy than many other clinicians because I've had these experiences which in itself has also been a good idea."* HOP1

> *"I've had days where I've thought actually this really adds to me as a professional. I think this gives me a different insight or a deeper insight into something."* HOP5

Being a dual-experienced practitioner also seemed to have led some participants to a place of defiance or wilfulness in relation to disclosing their lived experience or utilising it in positive ways.

> *"I'm at the moment I'm sort of looking forward to it, in a well, I wouldn't say belligerent, but in a kind of 'Well yeah, what are you gonna do about it?" kind of way... if this does go dreadfully wrong, then sod them."* HOP1

> *"I think I didn't regret it afterwards actually. Afterwards I thought 'like why not?".* HOP5

3. **Fear about consequences of disclosing.** The intervention provided an opportunity to consider the pros and cons of disclosure. In spite of reflections that lived experience is a skill and that disclosure can be a defiant way of combating stigma, all participants expressed fears about the consequences of disclosing. This included avoiding a sense of vulnerability that comes with disclosure.

> *"I think also I don't really like to come across as weak or vulnerable and really struggle with that."* HOP5

> *"What if I'd disclosed to this person? I would have been so vulnerable and I think probably not wanting to be that vulnerable is a significant factor in kind of where I'm at with it all now."* HOP2

Building upon vulnerability, participants spoke about feeling unsafe, anxious or paranoid in relation to disclosure.

> *"I think I just felt so anxious…there's another sort of bit of me that quietly panics about doing that [disclosing]…to go and tell somebody that…has a direct professional link, feels quite scary."* HOP5

> *"I think it made me quite paranoid in terms of how that had been interpreted…I came away with this sort of sense of, I guess paranoia might be a strong way of putting it… I didn't feel safe interpersonally in those situations…it wasn't a safe place to think about those things."* HOP2

This was in terms of worries about how disclosure would affect them in various contexts but also about dealing with the uncertainty around whether disclosure actually had influenced or might influence people's views and behaviour in relation to them.

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"I think that was the kind of learning I unfortunately took from it, that when you do disclose unless someone's overtly kind of discriminatory… it is kind of impossible to know if it is having a negative impact." HOP2

"Just the idea that someone might change their mind whether it's in a 'bad way' in quotes, you know like avoid me, or in a good way." HOP3

Participants also spoke about feelings of shame and embarrassment in relation to disclosure experiences.

"I think it probably reinforced my fears that were kind of there and probably had prevented me telling anyone previously…I think there is a lot of shame, and that's probably one of my kind of core difficulties." HOP2

"I think I just felt really awful about it. I felt really ashamed and really embarrassed." HOP5

Others also spoke about fears of being judged or defined by their mental health difficulties.

"That it would be judged negatively…somehow not being seen as, as competent as a professional, or as good as somebody without a mental illness." HOP1

"Then I sort of felt like 'Oh shit I feel like people won't think that I can do my job very well.'" HOP5

4. **Experiences of disclosure.** Participants reflected on their experiences of disclosure pre and post engagement in the HOP-MHP guide, and how these have affected them in a variety of ways. In interpersonal relationships these participants noted positive results.

> *"I told them things about myself and actually, actually sort of felt quite nice. I feel like it sort of deepened our friendship." HOP5*

> *"In retrospect I suppose it's a good thing. I think it's brought us closer." HOP3*

Whereas the impact of disclosure in work settings was much more mixed, with more negative experiences.

> *"It certainly put me on the back foot with the manager and the supervisor in my first job, and made things, quite, walking on eggshells like, and um uncomfortable for the first three or four months or so until we knew each other." HOP1*

> *"I think it probably reinforced my fears that were kind of there and probably had prevented me telling anyone previously." HOP2*

Participants also reflected on the impact disclosure did, or could have, on their confidence, including considering disclosure as part of the HOP-MHP guide.

> *"I don't know if it's to do with the study or just to do with things being a bit different a few years later, [I] feel like I would have a bit more confidence to manage it a bit differently." HOP1*

> *"I think…feeling a bit more confident around that because I generally do feel confident, but when I think about it I wonder whether there is something about confidence." HOP3*

Participants also considered the impact of disclosure and engaging in the HOP-MHP guide on their symptoms, with mixed experiences.

> *"I think it's helped with my anxiety." HOP4*

> *"I wouldn't say kind of 'symptoms' but…I think I wouldn't say it changed that kind of stuff." HOP2*

5. **Context to disclosure.** In exploring different experiences of disclosure using the HOP-MHP guide, a number of different contexts in which to disclose were identified with diverse benefits, challenges and areas for consideration.

> *"I didn't feel unsafe interpersonally in those situations [personal] and I suppose I did very much in the professional one. So that would be a key difference." HOP2*

Participants reflected on to whom they had disclosed and in what contexts they had chosen to conceal. These varied across participants.

> *"In the context of the rest of my life, I have to be honest I've disclosed to almost nobody. My now husband kind of guessed… so in a way I didn't even disclose to him…the other time was with another very close friend, but it was in a very kind of ambiguous and generalised terms, so it didn't really feel like a disclosure." HOP2*

> *"Rationally you sort of say, well if it's a good friend then it shouldn't change too much because they know you…rationally I kind of know that. It's just emotionally I'm not there yet." HOP3*

Some participants reflected on disclosing in personal therapy including the impact this has had on their thoughts about potentially disclosing elsewhere.

"I have had some experience in disclosing especially over the last couple of years. I've also more recently gotten back into my own therapy. So, I think in some ways…I was just thinking a little bit differently about myself and my own experiences." HOP5

"I trusted her [therapist] with that stuff. I could actually tolerate it myself." HOP2

Participants related disclosure in their own personal therapy and in work settings to their work with clients, seeing both the benefits and challenges of this.

"If I'm honest the value I see is in really being able to think clearly about the possible impact on your work and avoiding your own stuff, you know, invading that, is really important." HOP2

"I usually think I'm quite open with my feelings with clients to some extent. I'm not gonna say 'Well yeah I did X Y and Z'. But if someone tells me 'Well I'm really weird. I do this,' and that's actually quite normal I do that too, so I'm quite comfortable with doing that. And I think that's really important… I think obviously there's that balance between making it your own therapy… but… I think it's important to not sort of say 'no your feelings don't have a place in the room' because actually they do." HOP3

However, disclosure in professional contexts appeared most complex for the participants to consider with the HOP-MHP guide, especially in relation to the responses of supervisors to disclosure.

"I think it has made me think more about whether I want to disclose certain things to supervisors and at what time that would be best. Or what sort of conditions might need to be present for me to feel able to do that." HOP4

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"I have had quite sort of difficult, supervisory experiences… and it felt incredibly unsafe and to have added disclosure into the mix, I think might have just been, I mean could have destroyed me… I mean my current supervisor again, as lovely as she is, I think is quite pathologising. I think she would pathologise me if she had any inkling of actually what has happened in the past." HOP2

The relationship with a supervisor and their personal stance in relation to mental health difficulties and disclosure of these in a professional context appear to present a complex set of challenges to consider and overcome before disclosure can be fully considered in such contexts.

Given the potential for a range of responses and consequences to disclosure, it is understandable that the participants expressed having disclosed across different levels in different contexts, varying from selective to broadcast.

"What I conceptualise as disclosure… that means something quite in detail, well elaborated and might involve saying certain diagnoses which I don't necessarily have medically speaking but I've definitely talked to different people about my experiences of anxiety and depression." HOP4

"I didn't make a conscious decision to go and disclose, it was just in the context of the conversation. And they asked me some questions, and I thought rather than just sort of moving it over or giving… a very short answer, that I would tell them a bit more." HOP5

Interestingly participants also spoke about unwitting disclosure, where their mental health difficulties were disclosed without their choice due to circumstances surrounding their difficulties or visible aspects of their difficulties.

"The colleagues who've known me for a long time, six years ago I had to take time off because of stress and depression and anxiety, and that happened in a team where we were all quite stressed, so we did talk about these things." HOP1

"Although I didn't technically disclose, because I was off school for a year… everybody kind of knew without anyone saying what had happened." HOP2

Table 14: Endorsement of sub-themes by participants.

Main Theme	Lots to think about in considering disclosure						What it means to be a dual-experienced practitioner			Fears about consequences of disclosing					Experiences of disclosure				Context to disclosure				
Sub-theme	*1.1*	*1.2*	*1.3*	*1.4*	*1.5*	*1.6*	*2.1*	*2.2*	*2.3*	*3.1*	*3.2*	*3.3*	*3.4*	*3.5*	*4.1*	*4.2*	*4.3*	*4.4*	*5.1*	*5.2*	*5.3*	*5.4*	*5.5*
HOP1	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓				✓	✓	✓
HOP2	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
HOP3	✓	✓	✓	✓	✓	✓			✓		✓	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓
HOP4	✓	✓	✓	✓	✓	✓															✓	✓	✓
HOP5	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓

Thoughts about HOP-MHP. In reviewing the impact of the HOP-MHP guide, participants reflected on both helpful and challenging aspects of the guide and study.

Helpful aspects included:

- Weighing up benefits and costs of disclosure (HOP4, HOP1)

- Being able to complete the manual in different forms (e.g. paper vs on a computer) (HOP4)

- Developing a narrative for disclosure (HOP4, HOP3)

- Providing a step-by-step framework for considering disclosure (HOP4, HOP1)

- Prompting from the study team to complete the guide (HOP1)

- Normalisation from reading the guide (HOP5)

- The guide being balanced and objective with a range of experiences and professional backgrounds (HOP2)

- Being interviewed about their experiences, offering an opportunity for further reflection and consolidation (HOP3)

Challenges of the guide included:

- Time needed to complete the guide and reflect on the process (HOP4, HOP1)

- Not being able to open the guide on a phone or tablet (HOP1)

- Not being in the 'right place' at the time of reading particular aspects of the guide (HOP3)

Interestingly almost all participants reflected that they felt they required more time and space to reflect on disclosure than they expected, both during the process of the study and since.

"I think because it's some time since taking part now. There's been time for me to consider things and not be, I haven't been pushed into it." HOP4

"Completing doesn't take that long… but the preparation in terms of sitting down and freeing up the time and working through before… anything is filled in or read… I didn't feel it frustrating… I don't think there was anything else you could have done. I think it was part of a necessary consolidation process." HOP1

Participants also reflected on the peer forum, with both benefits and costs being identified.

"I found it useful reading other people's experiences... but at the same time they made me feel a bit uncomfortable. I think because some people were so much more open about their experiences than I was or am, about talking about it at work that it just felt too different for me. But at the same time, it was good to see that difference, and to read about how other people do manage it, and what's that like for them. I posted and then…nobody had really responded. So, I felt... rejected is too strong, but it's something, that's the word that's in my head." HOP4

"I've used the forum…which is badly underused… and reading what other people were thinking and saying also had a big part in that. Maybe that's even the most helpful bit." HOP1

"I really liked it… I read more than I contributed… It was still helpful to even, just reading their experiences if that makes sense… I found it quite easy to use, very interactive and it's certainly made a difference with how I interacted with the guide." HOP3

Participants generated various ideas for possible adaptations to the guide and peer forum. These included:

- Choice in how questionnaires are completed (e.g. on paper vs online) (HOP4).

- Choice in how participants were prompted to complete the guide (e.g. via email or telephone) (HOP4).

- More material, space and focus in the guide about developing a narrative (HOP4).

- Reducing the length of the example stories (HOP4).

- Less focus on considering how people may respond to disclosure (HOP1).

- Increasing use of the peer forum, including making this more accessible by restructuring into a 'discussion' rather than separate threads (HOP1, HOP3).

- Reducing technical problems with completing online questionnaires (HOP1).

- Making the guide and peer forum accessible on mobile devices, including possibly developing an e-book format or an app (HOP1).

- Promoting the study more widely, including at conferences (HOP1).

- Making the guide and worksheets less onerous (HOP5).

- Making it clearer on signing up to the peer forum whether your sign-up name will be visible or not (HOP2).

Discussion

This study aimed to explore the longer-term impact of HOP-MHP using a mixed methods design, and across a range of outcomes. Quantitative analyses found no significant interaction effects. However, given the small sample size this is unsurprising. The largest interaction effect size observed in the completer analysis was for the helpfulness of the reaction of those disclosed to between baseline and T2 ($r=.445$) with helpfulness decreasing from baseline to T2 more so for the control group than the intervention group. There was a small effect size for the interaction in completer analysis for disclosure related distress related to keeping difficulties secret between baseline and T1 ($r=.287$) with the control group's distress scores decreasing from baseline to T1 whilst the intervention group remained similar. This effect was also observed in the ITT analysis ($r=.251$). There was also a small effect size for the interaction in completer analysis for the secrecy scale across all timepoints ($r=.211$) where the intervention group scores decreased over time, whilst the control group remained more stable. However, it should be noted that the standard deviations observed on this measure were very large. Finally, there was a small interaction effect size observed for the disclosure of present mental health difficulties between baseline and T1 ($r=.204$) with the control group scores for likelihood of disclosing decreasing and the intervention group scores increasing between these time points.

Across both groups, secrecy and endorsement of reasons for staying in decreased over time. This may be an incidental change due to time. However, given that both groups made a conscious decision to participate in the HOP-MHP study, it may be that starting to consider disclosure, if only by signing up to the study, may have affected participants' subsequent experiences and behaviour in relation to considering secrecy and concealment of their lived experience. The decrease in

secrecy scores was also maintained in the ITT analysis, despite this being a more conservative analysis. Conversely, there was a significant increase in stigma stress across time, regardless of condition. Again, this may reflect that choosing to engage in HOP-MHP may have led to increased awareness of experiences of stigma stress rather than an actual increase in the amount of stigma stress.

A significant difference between groups, with a large effect size, was found on PHQ-9 scores, which reflects differences in the groups at randomisation. Therefore, consideration of randomisation criteria to prevent significant differences between groups at the outset of the study should be made when planning further research.

These findings differ from previous research into the HOP programme in other populations which reported positive effects on stigma stress, disclosure related distress and benefits of disclosure and depression, not confirmed here (Corrigan et al., 2016; Mulfinger et al., 2018; Rüsch et al., 2014a). However, they do support the finding of positive effects on levels of secrecy (Mulfinger et al., 2018; Rüsch et al., 2014a), although this may not be due to HOP itself but rather to the process of taking part in a study related to considering disclosure. The current findings support those of Setti et al. (2019) who found that stigma stress increased over the course of group HOP delivered to individuals with Schizophrenia, although in this case independent of group.

It is important to note that this study is the first assessing the impact of HOP-MHP in a population of mental health professionals and therefore it would be reasonable for the results to differ for this population, not least given their knowledge and experience of working in mental health settings. It may also be that the outcome measures used did not fully capture the concepts more likely to change as a result of HOP-MHP, given the unique context of the participants. It would therefore be

beneficial to consider other outcomes that may be pertinent to this population, including (professional) quality of life or wellbeing, and impact on areas such as work life and interpersonal relationships (e.g. using the ProQOL; Heritage, Rees & Hegney, 2018).

The qualitative findings suggest that the HOP-MHP intervention provided participants with a framework to consider disclosure decisions, providing important scaffolding to support this, including structure, prompting and opportunity for reflection. The themes identified also attest to the complexity of studying disclosure decision making for dual-experienced practitioners. Although the number of interviews were limited, common themes emerged that suggest issues of power, supervision, context and ongoing discrimination need to be examined when supporting dual-experienced practitioners in their disclosure decision making. Whilst some of the fears of disclosing were common to other populations with lived experience (Barney, Griffiths, Christensen & Jorm, 2009; Rüsch et al., 2014b), dual-experienced practitioners highlighted unique factors that have not been fully explored in previous research. These areas, such as the interplay between disclosure in contexts such as personal therapy, client work and the workplace, should be studied further.

This study builds on previous HOP research by including a follow-up time point to assess continued change post the core sessions of the intervention. However, methodological issues were identified during the study which could be rectified in future research. These included a lack of randomisation criteria to address systematic bias between the two groups at baseline. Randomisation based on levels of symptomatology (e.g. PHQ-9 and GAD-7 scores) should be considered, alongside randomisation for profession, qualification status, age and gender. The survey platform used for collection of data allowed for data to be missed leading to a large

increase in missing data at T2, and this should be more closely monitored in future. Although measures were used to enable comparison to previous research, these could be more specifically tailored to the population or adapted to enable a fuller understanding of the data (e.g. 'selective disclosure' could be more specifically defined). Outcome measures were also not designed with non-disclosure in mind and did not fully assess the impact or benefits of choosing not to disclose for the individual, which should be explored more fully in future studies.

A number of important considerations for exploring disclosure decision making for dual-experienced practitioners arise from this study. Firstly, the levels of symptomatology at baseline were higher than expected. This should be given careful thought with regards to inclusion criteria in order to support participants to seek appropriate support where required and ensure taking part in the study is not contra-indicated given the status of their current mental health difficulties. Retention across the time points was low, particularly in the intervention group, leading to reduced statistical power. Qualitative feedback suggests this may have been due to the demands of engaging in the intervention including time and energy, which was greater than initially expected. Therefore, future studies need to consider how to reduce the demands of the intervention and measurements. Allowing more time between measurements may be one way of addressing these issues, as many participants in the intervention arm took longer than originally anticipated to complete the core sessions of the guide and the follow-up session. Increasing time between measurement points may reduce the burden for participants whilst also allowing more time for participants to engage in disclosure or non-disclosure and reflect on the impact this has had for them. That said, feedback also highlighted that mental health professionals have a number of competing demands on their time and therefore engaging in a study of this

kind may continue to be difficult for the population. Ideas for adaptations presented in the qualitative feedback may help to mediate some of these demands, such as being more flexible in the formats of presentation of the intervention and collection of measures. Stigma stress scores and symptomatology scores increased across time for the intervention group which may also have contributed to retention and drop-out in this group. It is also important to consider the major adaptation of HOP-MHP from a peer group intervention to an individual one. It may be that the peer group aspect of the original HOP programme is essential to the findings presented in earlier research, and that the peer forum used in HOP-MHP and the modest level of moderation within this, did not provide sufficient peer support in considering disclosure.

Recruitment barriers were identified early on and should be carefully examined when designing future research. Despite contacting a wide range of professional groups and networks, the study was unfortunately not shared as widely as hoped due to procedural issues in disseminating to these groups. This likely affected the number and range of professionals recruited which was biased towards clinical psychology. This means that the results are less generalisable to other mental health professionals, particularly those who may work in more stigmatising environments, such as medical settings, and those who traditionally have less power in health services such as nurses and those in training (Gold, Andrew, Goldman & Schwenk, 2016; Hankir, Northall & Zaman, 2014; Kim, Suetani, Forbes & Nguyen, 2018). Recruitment for qualitative interviews was also low. However, this is understandable given the fears around disclosure identified here that may have prevented participants from engaging in individual interviews. Other avenues for collecting qualitative data could be explored including anonymous feedback. It was also noted that two months after the HOP-MHP study began, the In2Gr8 forum was launched which provides a space for dual-

experienced practitioners to converse and support each other. This initiative may have affected recruitment and retention in this study as it provided an alternative space to consider disclosure decision making.

The context of the study, such as its place alongside other interventions and campaigns, is important in considering the impact of HOP-MHP. It was originally conceived following publication of the BPS Psychological Practitioner Wellbeing Charter, and the launch of a Collaborative Learning Network (CLaN) tasked with implementing the Charter. HOP-MHP was chosen as one of the CLaN's pathfinder projects. However, other initiatives designed to complement HOP-MHP as part of the same network were delayed due to various issues including funding, meaning concurrent interventions to help combat stigma at a structural level were not in place whilst HOP-MHP was piloted.

Whilst individual change is important, the literature presented previously shows how structural and cultural stigma are likely to prevent individual change and thus, given the lack of structural changes evident in mental health professional bodies and contexts, it is reasonable to conclude individual change would be more difficult to achieve. The HOP-MHP research team was very mindful of the risk of individual change in the absence of culture change, as evidenced by the website, resources and peer forum being provided as essential aspects of the study. It may be that more attention needs to be paid to tackling stigma at structural, institutional and cultural levels, before individual change can be supported and actualised. Leading on from this study, the research team are giving consideration to opportunities for achieving structural change, such as supporting mental health workplaces, employers and healthcare organisations to become more compassionate as a sensible and rational alternative or supplement to tackling individual disclosure on its own. Working

collaboratively with mental health organisations will be paramount in continuing to address stigma for dual-experienced practitioners, given the evidence provided here, and the continuing sense that disclosure continues to feel dangerous in mental health settings.

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Part Three: Critical Appraisal

<center>**Critical Appraisal**</center>

This critical appraisal is structured in two parts. The first will consider methodological and procedural issues of conducting the research. The second is a personal reflection on the process of conducting this research as a dual-experienced practitioner.

Methodological and procedural issues

Conducting an RCT will always have challenges due to the scale and complexity of designing a trial that adequately compares two groups and controls where possible for extraneous variables. However, conducting this research project has emphasised the importance of taking time and care in the design and set up of such research. Methodological issues that seem insignificant at the design stage or may be felt to be holding up the process, can become far more troublesome by the point of analysis. For example, in this case more thought and time should have been given to considering how best to randomise participants to ensure there was no bias inherent in the groups at baseline, on demographics and measures such as current symptomology. The qualitative feedback emphasised the need for more flexibility in how the intervention was delivered and, again, time and space to consider how participants would like to engage with the intervention may have enabled the research to have developed flexible ways for participants to complete the guide and measures, therefore impacting on the recruitment, retention and ultimately amount of data collected.

Procedural issues, such as creating Qualtrics surveys for completion of measures, may have seemed simple enough at the time. However, the lack of attention to detail at this stage led to a sparsity of data at the follow-up time point and therefore reduced power to observe any present effect. A simple click of a button would have removed this issue. Of course, it is always easier to see these issues in hindsight, but

this hindsight could be used to guide future researchers in ensuring the quality of their research is high and the effort they invest is not in vain.

Recruitment was another important factor in the limitations of this study and whilst this was approached with enthusiasm and dedication by the research team, again careful thought at the outset may have reduced the barriers experienced. NHS ethical approval was not sought for the study, and the implications of this for not being able to advertise the study via NHS contacts, emails and publications were probably large. Although the ethical approval process for NHS research is lengthy and not without its own drawbacks, having access to the NHS workforce may have helped to improve recruitment, widen the study's impact on reducing stigma and broadened the range of mental health professionals who engaged in the study.

In analysing the data, it became clear that the outcome measures used also had their limitations. Whilst they covered the potential benefits of disclosure well and allowed comparison with previous research of HOP, they did not appear to fully capture the more objective negative aspects of disclosure and the benefits of concealment. Given HOP-MHP aimed to be balanced and support the participants to make the right disclosure decision for them, the lack of useful measures for concealment and the impact of this on an individual across contexts may have left important questions unanswered. It is difficult to measure the absence of something, and so measuring the benefits of concealment in terms of preventing stigma and discrimination will not be simple. However, consideration of measures around quality of life, and employment and career progression may be useful to start to unpack the benefits of concealment.

Reflection

Since embarking on this project, my awareness of the experiences of dual-experienced practitioners have obviously grown. It may be just this awareness that has allowed me to notice and acknowledge the level of change there has been in relation to recognising the existence of such individuals. However, I believe there has been a real shift in this regard, one that I have also felt personally.

HOP-MHP first came to my attention as a first-year trainee, eager to please and engage in anything and everything that came my way, to prove that I was the right choice for the course after years of unsuccessful applications. The invitation to attend a focus group on adapting an intervention for professionals with lived experience of mental health difficulties seemed simple enough. However, walking into the first meeting of that group demonstrated to me the complexity of this undertaking almost immediately. I had unwittingly disclosed my lived experience to members of my cohort, to members of staff on my training course, to members of other training courses, and to professionals out working in the field I aimed to join. I was lucky that I felt in a place where I was able to manage this unwitting disclosure. However, I was aware that I could well have not been in that place and started to consider the impact that walking blindly into that space could have had for me, and all the other people in that room. When the opportunity to become involved in the pilot RCT of HOP-MHP as my thesis project presented itself, I hoped I could bring those experiences to the work, in a way that made it more meaningful to those invested in it.

As a dual-experienced practitioner myself, there were obvious reasons for my interest in and passion for supporting mental health professionals with lived experience in making decisions about disclosure that would benefit them, and ideally those around them, including those under their care. However, I was also acutely aware of the

pitfalls and conflicts of interest that being a dual-experienced practitioner might present.

These conflicting feelings drew strong parallels to the dilemmas of the dual-experienced practitioners taking part in the study. Therefore, I felt well placed to create a higher level of understanding and recognition of the multiple facets of understanding and researching the experiences of people in relation to disclosure. I hoped I could keep in mind my own biases, experiences and assumptions so as to not cloud my understanding, analysis and representation of the individuals engaging in HOP-MHP.

I feel I have been able to do this. Partially this is due to having had my own personal therapy before and during training, having disclosed in various contexts (both willingly and unwittingly), and making time to reflect on the impact of these disclosure experiences. Initially I was concerned that my experiences of disclosure (having largely been positive in the past) would assign me to one 'camp' in terms of my beliefs about how HOP-MHP should support people in reaching disclosure decisions. However, a negative experience of disclosure during training allowed me to reflect on and adjust my expectations of disclosure, personally and more broadly, helping me to align myself more fully with the aim of supporting individuals to make the best decisions for their own context and experiences. I continued my battle with considering disclosure throughout the project, with various influences causing me to doubt my thoughts and beliefs about the best disclosure behaviour for me personally. At one point during analysis of the data, it was obviously so present in my mind, that I dreamt about an unwitting disclosure to a new colleague, where I was in the client role. However, experiences such as being asked to talk about HOP-MHP for an article for the Minorities in Clinical Psychology Group, helped me consolidate my motives for disclosure and recognise the impact my actions will hopefully have for others.

I acknowledge that this concern about others, and making a difference at a macro level is something expressed in the qualitative interviews in this study, and whilst I hoped that the participants never felt a pressure from the HOP-MHP study to think beyond their own needs and values in considering disclosure, I can't help but echo their thoughts. Although HOP-MHP is essentially aimed at the intrapersonal level of stigma change (see Figure 2, Cook et al., 2014), I hope I am not naïve in thinking that a project like HOP-MHP can inspire interpersonal and structural changes also.
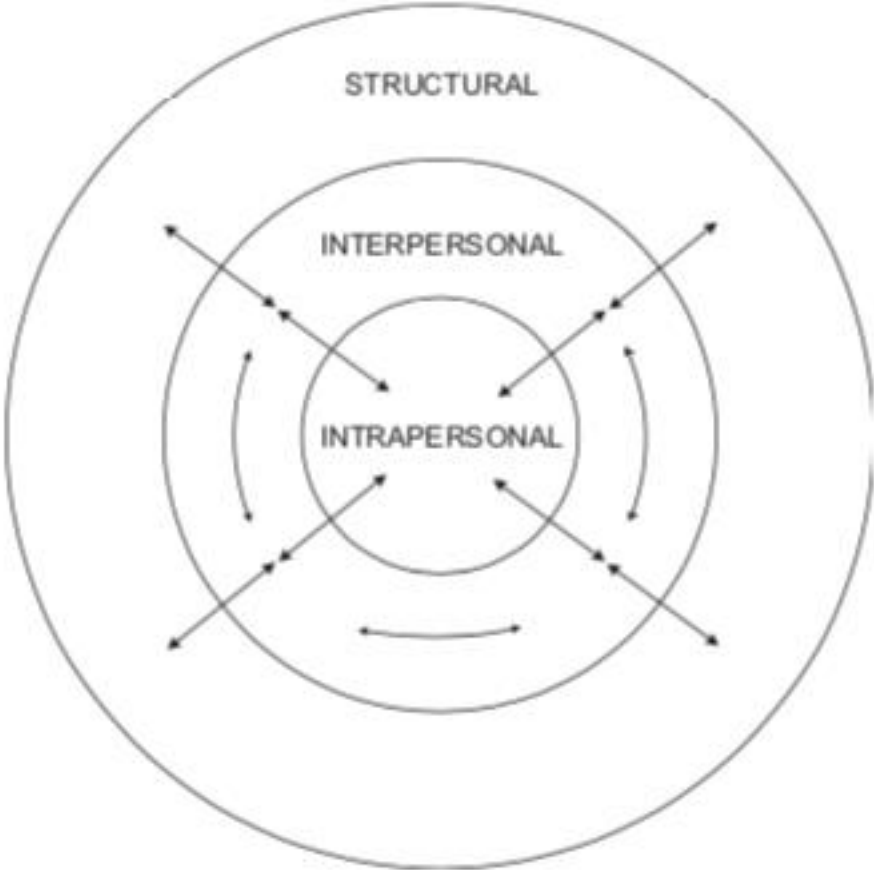
Figure 2: A multilevel system with arrows depicting the possibility for bidirectional influences within and between system levels (Cook et al., 2014).

As demonstrated by Cook et al., (2014) in Figure 3, just the presence of HOP-MHP as a project, shared and spoken about at the interpersonal level, will hopefully

have at least raised awareness, if not changed behaviour, in healthcare providers and legislation makers.

A MULTILEVEL APPROACH TO STIGMA AND PUBLIC HEALTH
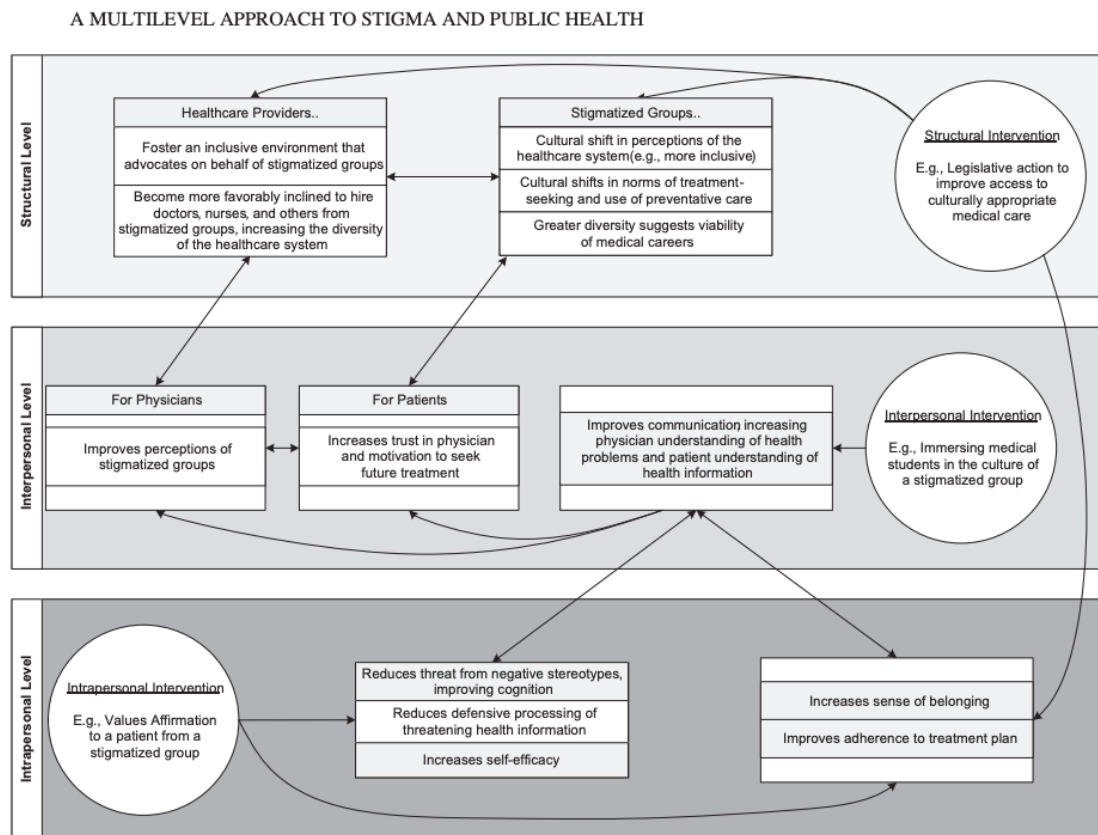
Figure 3: A hypothetical illustration of multilevel intervention effects (Cook et al., 2014).

Possibly inevitably during my training, in line with my thesis, I became more proactive in addressing stigma, highlighting the presence of dual-experienced practitioners and endeavoring to make changes where I could to support dual-experienced practitioners in my workplaces. Although I cannot say every experience was positive, I was pleasantly surprised that mostly these endeavors were greeted with openness, acceptance and a willingness to engage. I am likely privileged, having been in placements with supportive supervisors, with the same training as mine, and much vaster experience of the impact of mental health difficulties on people. If I were in a position of less power or status, or in a role with less space and time for reflection and

supervision, this may well have been a different case. That said, the challenges of being a temporary staff member were evident and I was often left wondering whether what I had started was a drop in the ocean that would never resurface after I had left the service. My hope was that just by opening up the conversation something irreversible had occurred, in that the people present could not un-hear it and that this alone could instigate some change, however small. Luckily there was also evidence of bigger shifts around me. The Secretary of State for Health and Social Care announced the NHS Staff and Learners' Mental Wellbeing Commission (HEE, 2019), which recognised the potential impact of disclosure of mental health difficulties in the workplace for staff. My local NHS trust, within which I had held roles for over seven years prior to training, launched a co-production based 'lived experience in the workforce task group', aiming to create an environment where dual-experienced practitioners' skills and experience are valued and utilised in the trust. Within my institution, the UCL Unit for Stigma Research (UCLUS) was launched with a successful conference on stigma in relation to mental health professionals and trainees from all three cohorts contributed to the discussion of well-being of mental health professionals in another conference held by the course.

In wider society I noticed shifts also. Mental health awareness week in 2019 felt different to many previously, where a number of documentaries and news programmes featured well known people speaking about a range of experiences of mental health difficulties including Nadiya Hussain on her experiences of anxiety, Alastair Campbell on his experiences of depression and David Harewood on his experiences of psychosis. News stories that previously did not seem to hit the headlines were more prominent such as a headline that '305 nurses have died by suicide over the

last 7 years', and people were asking why this had happened, and not been addressed sooner.

At points, hearing about negative experiences of disclosure from dual-experienced professionals could have left me disheartened and resigned. However, the optimism for change that was still embodied by those who took part made this unlikely. The fact that so many colleagues, against the odds of stigma, had chosen to take part in the project, and continued to support it, even when they had decided disclosure was not for them personally, gave me hope and the impetus to continue. Elif Sharak, who I saw speak towards the end of my training, talked about activism and oppression of women, and used the words 'Can we talk about this? It matters!' in relation to opening up conversations to change the status quo. It feels as if the dialogue about dual-experienced practitioners has started, and people are recognising that it matters. However, she also spoke about the pessimism of the intellect vs the optimism of the heart. Intellectually, the results presented here can leave me partly feeling pessimistic about the state and rate of change in supporting dual-experienced practitioners, whether they disclose or not. Given my predisposition to evidence-based practice, I could be left believing HOP-MHP has not been as successful as hoped and may not be the most useful way forward to combat the stigma experienced by dual-experienced practitioners. However, I have the optimism of the heart, buoyed by the personal stories and dedication shown by the participants, that HOP-MHP is of benefit. This change may be very hard to measure or even conceptualise, may take months or years to be actualised, and may be hard to demonstrate in terms of measurable outcomes, but I have heard about and seen the change it has made, including personally for me.

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Appendices

Appendix A: Recruitment sources

Note: requests were sent to each of the named networks and groups, however it is not confirmed that all of the sources below did share information about the study.

- Psychological practitioner networks:
  - North West Psychological Professions Network
  - North East Psychological Professions Network
  - Northern IAPT Trainers
  - PWP network – North West
  - PWP network – North East
  - PWP network – Yorkshire and Humber
- Doctoral Courses in Counselling Psychology:
  - University of Wolverhampton
  - University of East London
  - London Metropolitan University
  - City University London
  - University of the West of England (Bristol)
  - University of Manchester
  - University of Roehampton
- BABCP mailing list
- All 30 UK based DClinPsy course directors
- 27 UK based IAPT course directors
- IAPT PWP course directors
- National IAPT therapist workforce
- Paediatric Psychologists network
- Counsellors in the NHS network
- UCL Pre-qualification group
- Trainee contacts on training courses via cohort WhatsApp Groups

Information was also shared via social and print media:
- Twitter
  - UCLUS account
  - Association of Clinical Psychologists UK (ACP-UK)
  - DCP Pre-Qual group
- Facebook
  - 'UK based Clinical Psychology' Group
  - 'Trainee Clinical Psychologist Group UK' Group
  - 'ClinPsyLand' Group
  - 'Widening access training scheme' Group
  - 'Minorities in Clinical Psychology' Group

- o 'BPS East Midlands' Group
- o 'BPS East of England' Group
- o 'BPS North East of England' Group
- o 'BPS North West of England' Group
- o 'BPS South West of England' Group
- o 'BPS Wessex Branch' Group
- o 'BPS West Midlands' Group
- Researcher LinkedIn Account
- Newsletter and blog articles via:
    - o UCLUS website and newsletter
    - o In2Gr8 Mental Health
    - o BPS
    - o North-West England Psychological Practitioner Network
- Short article in The Psychologist magazine
- Poster circulated via colleagues, at UCL and at conferences

PHASE 2 Baseline HOP-MHP - PHASE 2

Start of Block: Default Question Block

Welcome to the HOP-MHP evaluation and thank you for signing up to the trial. This survey was designed to assess the impact of the HOP-MHP self-help guide on its users. Thank you in advance for participating - your input is very valuable to us.

You may wish to complete this survey in a private space where you will not be interrupted. The survey consists of a range of questions including information about you and your personal experience with mental health problems, scales asking your views relating to mental health stigma and disclosure of mental health problems, and open comment boxes. The whole survey should take around 15 to 20 minutes to complete. If you find any of the questions distressing, please prioritise your own well-being - if you wish to stop at any time whilst completing the survey, close the tab on your web browser.

You will be asked to complete this survey, or a similar version of it, at three time points. Once you have completed the survey for the first time, you will be informed which study arm you have been randomly allocated to. If you are in the intervention arm, you will be asked to complete the survey again once you have completed the three core sessions of the HOP-MHP guide (around 3 to 4 weeks after signing up) and again when you have completed the follow-up session. If you are in the control arm, you will be asked to complete the survey for the second time approximately three weeks after the initial survey, and then again a month later. Your feedback will be used to help us assess the feasibility, acceptability and impact of the HOP-MHP self-help guide. Unsubmitted responses will be stored for 7 days before being automatically deleted. In the event that you are interrupted, you may return to the survey within 7 days of starting and pick up where you left off (in order to pick up where you stopped you will need to use the same computer or device). If you decide to restart the survey after 7 days you will need to follow the link from your e-mail and complete it from the beginning. Your responses will be entirely anonymous and will be stored securely in line with the Data Protection Act 1998. We do wish to track progress though and hence you have been sent a personalised link. We will track your progress using the e-mail you used to sign up to the study. This survey has received ethical approval from University College London's Research Ethics Committee (ID: 8807/001). Should you wish to contact the research team please email hopproject@ucl.ac.uk. Should you have concerns about the survey please contact the project lead: k.scior@ucl.ac.uk. Click on the arrow button to get started!

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Q1.1   What is your gender?

○ Female (1)

○ Male (4)

○ Other: (3) _____

- -

Q1.2 What is your sexual orientation?

○ Bisexual (1)

○ Heterosexual (2)

○ Homosexual (3)

○ Other: (4) _____

- -

Q1.3   What is your age group?

○ 18 - 24 (1)

○ 25 - 34 (2)

○ 35 - 44 (3)

○ 45 - 54 (4)

○ 55 -64 (5)

○ 65 + (6)

- -

Q1.4 How would you define your ethnicity?   (The categories are intentionally broad to ensure anonymity of responses.)

○ Asian/British Asian (1)

○ Black British/African/Caribbean (2)

○ Middle Eastern (3)

○ White British/White Other (4)

○ Other (5) _____

Q1.5 Your profession (whether qualified or currently in training)

○ Clinical Psychologist (1)

○ Counselling Psychologist (3)

○ Counsellor (5)

○ IAPT High Intensity Therapist (7)

○ IAPT Low Intensity Therapist (8)

○ Mental Health Nurse (11)

○ Psychiatrist (12)

○ Psychotherapist (13)

○ Other Mental Health Professional, please specify: (14)

_____

○ Not a Mental Health Professional (15)

Skip To: End of Survey If Your profession (whether qualified or currently in training) = Not a Mental Health Professional

- -

Q1.6 Qualification status

○ Qualified (1)

○ Trainee (2)

- -

Q1.7 How long have you been qualified as a mental health professional?

○ < 2 years (1)

○ 2 to 5 years (2)

○ 5 to 10 years (3)

○ 10 to 20 years (4)

○ > 20 years (5)

- -

Q1.8 Are you currently experiencing a significant mental health problem?
For the purpose of this survey, 'significant mental health problem' refers to psychological, emotional and/or behavioural difficulties that have diminished your capacity for coping with the ordinary demands of life. This includes but is not limited to mental health problems as defined by DSM or ICD criteria, and is regardless of whether or not you have received a formal diagnosis.

○ Yes (1)

○ No (2)

- -

Q1.9 Where do you see yourself in relation to your current mental health problem/s?

○ In recovery (1)

○ On the cusp of a potential crisis (2)

○ In acute crisis (3)

- -

Q1.10   Have you experienced a significant mental health problem/s <u>in the past</u>?

○ Yes (1)

○ No (2)

Q1.11 Where do you see yourself in relation to your past mental health problem/s?

○ Recovered (1)

○ At risk of new episode (2)

○ Continuing to struggle (3)

Display This Question:

If Are you currently experiencing a significant mental health problem? For the purpose of this surve... != No

Or   Have you experienced a significant mental health problem/s in the past? != No

Q1.12 How do you understand your difficulties?

_____

_____

_____

_____

_____

Q1.13 Have you been given a diagnosis?

○ Yes, I have been given a diagnosis. (1)

○ No, I have not been given a diagnosis. (2)

- -

Q1.14 What diagnosis were you given?

_____

_____

_____

_____

_____

- -

Q1.15 Have you sought professional help for your mental health problem?

○ Yes (1)

○ No (2)

Q1.16 Who have you sought help from?

○ GP (1)

○ NHS Clinical Psychologist (2)

○ NHS Psychiatrist (3)

○ NHS Therapist or Counsellor (4)

○ Private Clinical Psychologist (5)

○ Private Psychiatrist (6)

○ Private Therapist or Counsellor (7)

○ Other: (8) _____

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Q1.17 The following questions ask about how you have been feeling <u>over the last two weeks</u>.
For each item, please select the response which best describes how you have felt.
Please make sure to prioritise your own wellbeing and to seek immediate help if you feel in acute crisis. Information about crisis support is available at this link:
https://www.rethink.org/about-us/our-mental-health-advice/crisis-contacts

Over the <u>last two weeks</u>, how often have you been bothered by any of the following problems

	Not at all (1)	Several days (2)	More than half the days (3)	Nearly every day (4)
Little interest or pleasure in doing things (1)	○	○	○	○
Feeling down, depressed, or hopeless (2)	○	○	○	○
Trouble falling asleep or staying asleep, or sleeping too much (3)	○	○	○	○
Feeling tired or having little energy (4)	○	○	○	○
Poor appetite or overeating (5)	○	○	○	○
Feeling bad about yourself - or that you are a failure or have let yourself or your family down (6)	○	○	○	○
Trouble concentrating on things, such as reading the newspaper or watching television (7)	○	○	○	○
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual (8)	○	○	○	○

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| Thoughts that you would be better off dead or of hurting yourself in some way (9) | ○ | ○ | ○ | ○ |

Q1.18 Over the <u>last two weeks</u>, how often have you been bothered by any of the following problems?

	Not at all (1)	Several days (2)	More than half the days (3)	Nearly every day (4)
Feeling nervous, anxious or on edge (1)	○	○	○	○
Not being able to stop or control worrying (2)	○	○	○	○
Worrying too much about different things (3)	○	○	○	○
Trouble relaxing (4)	○	○	○	○
Being so restless that it is hard to sit still (5)	○	○	○	○
Becoming easily annoyed or irritable (6)	○	○	○	○
Feeling afraid as if something awful might happen (7)	○	○	○	○

End of Block: Default Question Block

Start of Block: Section 2

Start of Block: Section 3

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Q3.1 The questions in the following section ask about your experience of and views relating to disclosure of lived experience of mental health problems.
Have you disclosed your mental health problems? In other words, have you decided to tell most of your family, friends, and acquaintances that you have a mental health problem/s? Have you decided not to hide this?

○ Yes, I have disclosed to most of my family and friends. (1)

○ No, I have not disclosed, or only to a very select number of people. (2)

Skip To: Q3.2 If The questions in the following section ask about your experience of and views relating to disclos... = Yes, I have disclosed to most of my family and friends.

Skip To: Q3.2 If The questions in the following section ask about your experience of and views relating to disclos... = No, I have not disclosed, or only to a very select number of people.

Q3.2 I disclosed my mental health problem/s...

	Strongly disagree (1)	Disagree (2)	Somewhat disagree (3)	Neither agree nor disagree (4)	Somewhat agree (5)	Agree (6)	Strongly agree (7)
to gain acceptance from others. (1)	○	○	○	○	○	○	○
to broaden my network of family, friends, and others. (2)	○	○	○	○	○	○	○
to support a consumer/survivor political movement. (3)	○	○	○	○	○	○	○
because I was comfortable with myself. (4)	○	○	○	○	○	○	○
to be true to myself. (5)	○	○	○	○	○	○	○
to be happier. (6)	○	○	○	○	○	○	○
to help others with the disclosure process. (7)	○	○	○	○	○	○	○
to access support. (8)	○	○	○	○	○	○	○
to increase options for help-seeking. (9)	○	○	○	○	○	○	○
to reduce self-stigma/shame. (10)	○	○	○	○	○	○	○
to educate others. (11)	○	○	○	○	○	○	○

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Q3.3 In the past I concealed my mental health problem/s...

	Strongly disagree (1)	Disagree (2)	Somewhat disagree (3)	Neither agree nor disagree (4)	Somewhat agree (5)	Agree (6)	Strongly agree (7)
to avoid being labelled (as a person experiencing mental health problems). (1)	○	○	○	○	○	○	○
to avoid negative impact on my job. (2)	○	○	○	○	○	○	○
to avoid harming my family. (3)	○	○	○	○	○	○	○
to avoid harming my self-identity. (4)	○	○	○	○	○	○	○
to hide my personal life. (5)	○	○	○	○	○	○	○
to maintain my personal safety. (6)	○	○	○	○	○	○	○
to avoid self-shame. (7)	○	○	○	○	○	○	○
to avoid public shame. (8)	○	○	○	○	○	○	○
to avoid discrimination (e.g. at work). (9)	○	○	○	○	○	○	○

to avoid becoming vulnerable. (10)	○	○	○	○	○	○	○
to avoid stress. (11)	○	○	○	○	○	○	○
because I feared negative reactions from others. (12)	○	○	○	○	○	○	○
to conform with societal demands. (13)	○	○	○	○	○	○	○
to maintain control in my life. (14)	○	○	○	○	○	○	○
to avoid social rejection by colleagues. (15)	○	○	○	○	○	○	○
to avoid a negative impact on my future career. (16)	○	○	○	○	○	○	○

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Q3.4 When I have disclosed in the past, I found the process of disclosing to...

	Very unhelpful (1)	Unhelpful (2)	Somewhat unhelpful (3)	Neither helpful nor unhelpful (4)	Somewhat helpful (5)	Helpful (6)	Very Helpful (7)	Not applicable (9)
Family member (2)	○	○	○	○	○	○	○	○
Close friend (1)	○	○	○	○	○	○	○	○
Acquaintance (13)	○	○	○	○	○	○	○	○
Member of course staff (if still in training) (3)	○	○	○	○	○	○	○	○
Clinical supervisor (4)	○	○	○	○	○	○	○	○
Line manager (21)	○	○	○	○	○	○	○	○
A colleague (5)	○	○	○	○	○	○	○	○
A fellow trainee (if still in training) (9)	○	○	○	○	○	○	○	○
Health professional (e.g. GP) (6)	○	○	○	○	○	○	○	○
Client I am seeing (7)	○	○	○	○	○	○	○	○
Service user groups (not	○	○	○	○	○	○	○	○

my clients)
(8)

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Q3.5 When I have disclosed in the past, I found the reaction of the person I disclosed to...

	Very unhelpful (1)	Unhelpful (2)	Somewhat unhelpful (3)	Neither helpful nor unhelpful (4)	Somewhat helpful (5)	Helpful (6)	Very Helpful (7)	Not applicable (9)
Family member (2)	○	○	○	○	○	○	○	○
Close friend (1)	○	○	○	○	○	○	○	○
Acquaintance (13)	○	○	○	○	○	○	○	○
Member of course staff (if still in training) (3)	○	○	○	○	○	○	○	○
Clinical supervisor (4)	○	○	○	○	○	○	○	○
Line manager (21)	○	○	○	○	○	○	○	○
A colleague (5)	○	○	○	○	○	○	○	○
A fellow trainee (if still in training) (9)	○	○	○	○	○	○	○	○
Health professional (e.g. GP) (6)	○	○	○	○	○	○	○	○
Client I am seeing (7)	○	○	○	○	○	○	○	○

| Service user groups (not my clients) (8) | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

- -

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Q3.2 In the future I will disclose my personal experiences of mental health problem/s...

	Strongly disagree (1)	Disagree (2)	Somewhat disagree (3)	Neither agree nor disagree (4)	Somewhat agree (5)	Agree (6)	Strongly agree (7)
to gain acceptance from others. (1)	○	○	○	○	○	○	○
to broaden my network of family, friends, and others. (2)	○	○	○	○	○	○	○
to support a consumer/survivor political movement. (3)	○	○	○	○	○	○	○
because I will become comfortable with myself. (4)	○	○	○	○	○	○	○
to be true to myself. (5)	○	○	○	○	○	○	○
to be happier. (6)	○	○	○	○	○	○	○
to help others with the disclosure process. (7)	○	○	○	○	○	○	○
to access support. (8)	○	○	○	○	○	○	○
to increase options for help-seeking. (9)	○	○	○	○	○	○	○
to reduce self-stigma/shame. (10)	○	○	○	○	○	○	○

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to educate others. (11)	○	○	○	○	○	○	○

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Q3.3 I conceal my mental health problem/s...

	Strongly disagree (1)	Disagree (2)	Somewhat disagree (3)	Neither agree nor disagree (4)	Somewhat agree (5)	Agree (6)	Strongly agree (7)
to avoid being labelled (as a person experiencing mental health problems). (1)	○	○	○	○	○	○	○
to avoid negative impact on my job. (2)	○	○	○	○	○	○	○
to avoid harming my family. (3)	○	○	○	○	○	○	○
to avoid harming my self-identity. (4)	○	○	○	○	○	○	○
to hide my personal life. (5)	○	○	○	○	○	○	○
to maintain my personal safety. (6)	○	○	○	○	○	○	○
to avoid self-shame. (7)	○	○	○	○	○	○	○
to avoid public shame. (8)	○	○	○	○	○	○	○
to avoid discrimination (e.g., at work). (9)	○	○	○	○	○	○	○

to avoid becoming vulnerable. (10)	○	○	○	○	○	○	○
to avoid stress. (11)	○	○	○	○	○	○	○
because I fear negative reactions. (12)	○	○	○	○	○	○	○
to conform to societal demands. (13)	○	○	○	○	○	○	○
to maintain control in my life. (14)	○	○	○	○	○	○	○
to avoid social rejection by colleagues. (15)	○	○	○	○	○	○	○
to avoid a negative impact on my future career. (16)	○	○	○	○	○	○	○

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Q3.6   The following questions are interested in how you feel about disclosing to different people.

How likely is it that you would talk to the following people about mental health problems that you experienced in the past?

	Under no circumstances (1)	Very unlikely (2)	Somewhat unlikely (3)	Undecided (4)	Somewhat likely (5)	Likely (6)	Very likely (7)	I've already disclosed to them (8)	Not applicable (9)
Family member (2)	○	○	○	○	○	○	○	○	○
Close friend (13)	○	○	○	○	○	○	○	○	○
Acquaintance (1)	○	○	○	○	○	○	○	○	○
Member of course staff (if still in training) (3)	○	○	○	○	○	○	○	○	○
Clinical supervisor (4)	○	○	○	○	○	○	○	○	○
Line manager (22)	○	○	○	○	○	○	○	○	○
A colleague (5)	○	○	○	○	○	○	○	○	○
A fellow trainee (if still in training) (9)	○	○	○	○	○	○	○	○	○
Health professio	○	○	○	○	○	○	○	○	○

nal (e.g. GP) (6)									
Client I am seeing (7)	◯	◯	◯	◯	◯	◯	◯	◯	◯
Service user groups (not my clients) (8)	◯	◯	◯	◯	◯	◯	◯	◯	◯

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Q3.7 How likely is it that you would talk to the following people about mental health problems that you are experiencing at present?

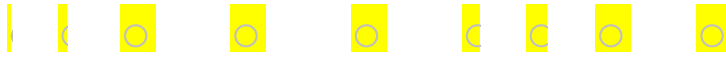|	Under no circumstances (1)	Very unlikely (2)	Somewhat unlikely (3)	Undecided (4)	Somewhat likely (5)	Likely (6)	Very likely (7)	I've already disclosed to them (8)	Not applicable (9)
Family member (2)	○	○	○	○	○	◠	◠	○	○
Close friend (1)	○	○	○	○	○	◠	◠	○	○
Acquaintance (13)	○	○	○	○	○	◠	◠	○	○
Member of course staff (if still in training) (3)	○	○	○	○	○	◠	◠	○	○
Clinical supervisor (4)	○	○	○	○	○	◠	◠	○	○
Line manager (21)	○	○	○	○	○	◠	◠	○	○
A colleague (5)	○	○	○	○	○	◠	◠	○	○
A fellow trainee (if still in training) (9)	○	○	○	○	○	◠	◠	○	○
Health professional (e.g. GP) (6)	○	○	○	○	○	◠	◠	○	○
Client I am seeing (7)	○	○	○	○	○	◠	◠	○	○

Service user groups (not my clients) (8) ○ ○ ○ ○ ○ ○ ○ ○ ○

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Q3.8 How distressed or worried are you about keeping your mental health problem/s secret from the following people?

	Not at all (1)	A little (5)	Somewhat (6)	Moderately (8)	Considerably (9)	A great deal (10)	Very much (11)	I've already disclosed to them (12)	Not applicable (13)
Family member (2)	○	○	○	○	○	○	○	○	○
Close friend (1)	○	○	○	○	○	○	○	○	○
Acquaintance (13)	○	○	○	○	○	○	○	○	○
Member of course staff (if still in training) (3)	○	○	○	○	○	○	○	○	○
Clinical supervisor (4)	○	○	○	○	○	○	○	○	○
Manager (21)	○	○	○	○	○	○	○	○	○
A colleague (5)	○	○	○	○	○	○	○	○	○
A fellow trainee (if still in training) (9)	○	○	○	○	○	○	○	○	○
Health professional (e.g. during a routine GP appointment) (6)	○	○	○	○	○	○	○	○	○
Client I am seeing (7)	○	○	○	○	○	○	○	○	○

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Service user groups (8)

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Q3.9 How distressed or worried are you about the following people finding out about your mental health problem/s?

	Not at all (1)	A little (11)	Somewhat (2)	Moderately (3)	Considerably (6)	A great deal (7)	Very much (8)	I've already disclosed to them (9)	Not applicable (12)
Family member (2)	○	○	○	○	○	○	○	○	○
Close friend (1)	○	○	○	○	○	○	○	○	○
Acquaintance (13)	○	○	○	○	○	○	○	○	○
Member of course staff (if still in training) (3)	○	○	○	○	○	○	○	○	○
Clinical supervisor (4)	○	○	○	○	○	○	○	○	○
Manager (21)	○	○	○	○	○	○	○	○	○
A colleague (5)	○	○	○	○	○	○	○	○	○
A fellow trainee (if still in training) (9)	○	○	○	○	○	○	○	○	○
Health professional (e.g. during a routine GP appointment) (6)	○	○	○	○	○	○	○	○	○

Client I am seeing (7)		○	○	○	○	○	○	○	
Service user groups (8)		○	○	○	○	○	○	○	

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Q3.10 Please rate your agreement with the following items relating to disclosure in general:

	Strongly disagree (1)	Disagree (2)	Agree (3)	Strongly agree (4)
If you had a close relative who had been treated for a mental health problem, you would advise him or her not to tell anyone about it. (1)	○	○	○ `	○
If you were in treatment for a mental health problem you would worry about certain people finding out about your treatment. (2)	○	○	○	○
If you have ever been treated for a mental health problem, the best thing to do is to keep it a secret. (3)	○	○	○	○
There is no reason for a person to hide the fact that he or she used mental health services at one time. (4)	○	○	○	○
In view of society's negative attitudes toward people experiencing mental health problems, you would advise people	○	○	○	○

experiencing mental health problems to keep it a secret. (5)				
In order to get a job, a former user of mental health services will have to hide this fact. (6)	○	○	○	○
You encourage other members of your family to keep your mental health problem a secret. (7)	○	○	○	○
You believe that a person who has recovered from a mental health problem experienced earlier in life should not tell other people about it. (8)	○	○	○	○
When you meet people for the first time, you make a special effort to keep the fact that you have been in receipt of some form of mental health treatment to yourself. (9)	○	○	○	○

Q4.1 The questions in the following section ask about your views relating to mental health stigma, actions to challenge it, and its likely impact on you.
Prejudice against people experiencing mental health problems…

	Strongly disagree (1)	Disagree (2)	Somewhat disagree (3)	Neither agree nor disagree (4)	Somewhat agree (5)	Agree (6)	Strongly agree (7)
Will have a negative impact on my future. (1)	○	○	○	○	○	○	○
Will have harmful or bad consequences for me. (2)	○	○	○	○	○	○	○
Will affect many areas of my life. (3)	○	○	○	○	○	○	○
Will have a severe impact on my life. (4)	○	○	○	○	○	○	○
Will have a negative impact on my career. (5)	○	○	○	○	○	○	○
Will harm my professional reputation. (6)	○	○	○	○	○	○	○

Q4.2

Please rate your agreement with the following items:

	Strongly disagree (1)	Disagree (2)	Somewhat disagree (3)	Neither agree nor disagree (4)	Somewhat agree (5)	Agree (6)	Strongly agree (7)
I am prepared to challenge prejudice against people experiencing mental health problems. (1)	○	○	○	○	○	○	○
I have the resources I need to handle problems posed by prejudice against people experiencing mental health problems. (2)	○	○	○	○	○	○	○
I will do the best I can to challenge prejudice against people experiencing mental health problems. (3)	○	○	○	○	○	○	○
I feel able to challenge prejudice against	○	○	○	○	○	○	○

people experiencing mental health problems. (4)						
Within my profession, I will do the best I can to challenge prejudice against members of my profession who experience mental health problems. (5)	○	○	○	○	○	○	○
Within my profession, I feel able to challenge prejudice against members of my profession who experience mental health problems. (6)	○	○	○	○	○	○	○
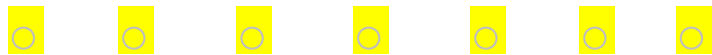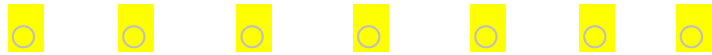
End of Block: Section 4

Appendix C: HOP-MHP guide and worksheets

Removed for final submission

Appendix D: Interview schedules

Interview Schedule (Intervention Group)

Introductions

Tell me about yourself

- ➢ Diagnosis, symptoms, brief chronology of mental illness
- ➢ Work environment

Previous disclosure & outcome of this

- ➢ Positive vs negative
- ➢ Impact on areas: psychological, practical, work, social

What were your thoughts about disclosure/non-disclosure pre HOP-MHP?

- ➢ Where have these come from?
- ➢ Thoughts and considerations

Experiences of using the HOP-MHP Manual

- ➢ How did they use it, as specified or otherwise?

Could you tell me how you found using the HOP-MHP manual?

- ➢ Acceptability & use – briefly
- ➢ Helpfulness

How did using the HOP-MHP manual influence your disclosure?

- ➢ Thoughts and considerations
- ➢ Actual disclosure/non-disclosure

If disclosed, how did this go?

- ➢ Positive vs negative

How did disclosure/non-disclosure impact on you?

- ➢ Psychologically, symptoms, relapse
- ➢ Help seeking, support
- ➢ Work, practically, financially
- ➢ Socially
- ➢ Anything else?

How do you now feel about future disclosure?

- ➢ How much was this impacted by HOP-MHP
- ➢ How much was this influenced by disclosure/non-disclosure after HOP

➢ Any other factors? E.g. therapy

Interview Schedule (Intervention Group – Non-Completers)

<u>BRIEF</u>

Introductions

Tell me about yourself

> - Diagnosis, symptoms, brief chronology of mental illness
> - Work environment

Previous disclosure & outcome of this

> - Positive vs negative
> - Impact on areas: psychological, practical, work, social

What were your thoughts about disclosure/non-disclosure pre HOP-MHP?

> - Where have these come from?
> - Thoughts and considerations

Experiences of using the HOP-MHP Manual

> - How did they use it, as specified or otherwise?
> - Acceptability & use – briefly

Reasons for not completing the study

> - Manual?
> - Time?
> - Prompting?
> - Measures?
> - Lack of support?
> - Peer forum?
> - Adverse consequences?

Concerns about the manual or study?

> - Adverse consequences?
> - Use in this population?

How could the study/manual be improved?

> - Peer support?
> - Less directed?

If relevant – BRIEF:

Did engaging in the study have an influence on your subsequent disclosure?

- ➢ Thoughts and considerations
- ➢ Actual disclosure/non-disclosure

If disclosed, how did this go?

- ➢ Positive vs negative

How did disclosure/non-disclosure impact on you?

- ➢ Psychologically, symptoms, relapse
- ➢ Help seeking, support
- ➢ Work, practically, financially
- ➢ Socially
- ➢ Anything else?

How do you now feel about future disclosure?

- ➢ How much was this impacted by HOP-MHP
- ➢ How much was this influenced by disclosure/non-disclosure after HOP
- ➢ Any other factors? E.g. therapy

Appendix E: Engagement and reminder emails

ALL PARTICIPANTS – BASELINE

Baseline email (after participants have sent in their completed consent & screening)
Dear HOP-MHP participant,
This is an email from the HOP-MHP project team. Thank you for consenting to take part in our research project. Please log in and complete the baseline survey using your personalised link below:

<INSERT BASELINE SURVEY LINK>

Please note that unsubmitted responses will be automatically deleted 7 days after you were last active on the survey.
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.

Best Wishes
HOP-MHP Team

Baseline dropout email (sent 5 days after participant started baseline survey IF they have not submitted their responses)

Dear HOP Participant,
Further to my earlier email, we note that you started the HOP-MHP baseline survey but did not complete it. I am simply writing to check that this is as intended – as stated in the information sheet, you are entirely within your rights to withdraw from the study at any time and without giving a reason. In case you have decided to withdraw from the study we thank you for your interest and wish you all the best for the future. In case you intended to continue the survey at a later point, please note that your unsubmitted responses will be automatically deleted 7 days after you were last active on the survey and take this as a gentle reminder. If you wish to continue after this period you would need to restart the survey.
Best wishes
HOP-MHP Team

DROPOUT EMAILS
Intervention arm drop-out email (to be sent if no response 2 weeks after final reminder email to complete core sessions of guide)

Dear HOP-MHP participant,

I have not heard from you in a while. I am writing to check that this is as intended?

As stated in the information sheet, you are entirely within your rights to withdraw from the study at any time and without giving a reason. In case you have decided to withdraw from the study we thank you for your interest and wish you all the best for the future.

In case you do intend to continue with the study, please get in touch to let me know when you have completed the three sessions of the guide, so I can send you the link to the second survey.

If I don't hear from you in the next two weeks I will take that as an indication that you no longer wish to take part in this study.

A reminder – when you signed up for this study you indicated that you were not feeling suicidal at the time. We recognise that things can change and would like to stress that if at any point you are feeling in acute distress and/or suicidal, we advise you to seek urgent support, either through NHS services or through crisis services. You can find more information on our web page (under the heading 'Information about other sources of support'): https://www.ucl.ac.uk/pals/hop-mhp-project-0

Best Wishes
Julie Evans
HOP-MHP Team

Intervention arm drop-out email WITH dropout survey link

Dear HOP-MHP participant,

I have not heard from you in a while. I am writing to check that this is as intended? As stated in the information sheet, you are entirely within your rights to withdraw from the study at any time and without giving a reason. However, we would be grateful if you were willing to answer these brief questions to help us better understand how we can address any potential barriers to participation. If you do not wish to answer this survey, that is absolutely fine and we wish you all the best for the future.

<INSERT LINK TO DROPOUT SURVEY – E.G. SURVEYMONKEY>

In case you do intend to continue with the study, please get in touch to let me know when you have completed the three sessions of the guide, so I can send you the link to the second survey.

A reminder – when you signed up for this study you indicated that you were not feeling suicidal at the time. We recognise that things can change and would like to stress that if at any point you are feeling in acute distress and/or suicidal, we advise you to seek urgent support, either through NHS services or through crisis services. You can find more information on our web page (under the heading 'Information about other sources of support'): https://www.ucl.ac.uk/pals/hop-mhp-project-0

Best Wishes,
Julie Evans
HOP-MHP Team

Intervention arm drop out email WITH dropout survey link and **drop out info**

Dear HOP-MHP participant,

I have not heard from you in a while. I am writing to check that this is as intended? As stated in the information sheet, you are entirely within your rights to withdraw from the study at any time and without giving a reason. However, we would be grateful if you were willing to answer these brief questions to help us better understand how we can address any potential barriers to participation. If you do not wish to answer this survey, that is absolutely fine and we wish you all the best for the future.

<INSERT LINK TO DROPOUT SURVEY – E.G. SURVEYMONKEY

If I don't hear from you in the next two weeks I will take that as an indication that you no longer wish to take part in this study.

In case you do intend to continue with the study, please get in touch to let me.

A reminder – when you signed up for this study you indicated that you were not feeling suicidal at the time. We recognise that things can change and would like to stress that if at any point you are feeling in acute distress and/or suicidal, we advise you to seek urgent support, either through NHS services or through crisis services. You can find more information on our web page (under the heading 'Information about other sources of support'): https://www.ucl.ac.uk/pals/hop-mhp-project-0

Best Wishes,
Julie Evans
HOP-MHP Team

Control group drop out email (e.g. if no response after all reminder emails and T1 survey sent) - or if they started the T1 survey could send something similar to baseline dropout warning email and adapt it for this time point
Dear HOP-MHP participant,

I have not heard from you in a while. I am writing to check that this is as intended? As stated in the information sheet, you are entirely within your rights to withdraw from the study at any time and without giving a reason. In case you have decided to withdraw from the study, we thank you for your interest and wish you all the best for the future.

Please get in touch if you do wish to continue with the study or if you would like to discuss the project. If I don't hear from you in the next two weeks I will take that as an indication that you no longer wish to take part in this project.

A reminder – when you signed up for this study you indicated that you were not feeling suicidal at the time. We recognise that things can change and would like to stress that if at any point you are feeling in acute distress and/or suicidal, we advise you to seek urgent support, either through NHS services or through crisis services. You can find more information on our web page (under the heading 'Information about other sources of support'): https://www.ucl.ac.uk/pals/hop-mhp-project-0

Best Wishes
Julie Evans
HOP-MHP Team

INTERVENTION GROUP:

HOP-MHP guide email - **attach PDF of guide (sessions 1-3), corresponding worksheets in Word format & peer forum joining instructions** (to be sent after baseline survey completed - **forward to Katrina once sent with subject line: 'Invite to peer forum' and set to high importance**)

Dear HOP-MHP participant,

My name is Julie and I am one of the researchers on the HOP-MHP project team. I will be keeping in touch with you and sending you reminders for the duration of the project.
Thank you for completing the baseline survey. You have been randomly allocated to the intervention arm. Please find attached the HOP-MHP guide containing sessions 1-3 and a separate Word document containing the worksheets for these sessions (these are identical to the worksheets in the guide but we are including them here in Word format in case you want to complete them electronically).

I will be in touch again soon to see how you are getting on. Please get in touch if you have any queries or have completed the guide before you next hear from me. Whilst using the guide you may also find it helpful to access information and resources on our website via the link below:
 https://www.ucl.ac.uk/pals/hop-mhp-project-0

You will be given access to a web peer forum while you are using the guide. You should receive an invitation to join the forum within the next 72 hours. Please check your inbox for an invitation to join a 'Slack team' (Slack is the name of an online forum and downloadable app) and follow the joining instructions attached to this email to sign up. You will see that the joining instructions suggest that you need to enter a participant number to sign up to the forum. This number is no longer essential and you should be able to sign up by entering details of your own choice but if you would like to enter your participant number you can use number '<INSERT THEIR ALLOCATED HOP NUMBER (E.G. '55')>'.

If for any reason, you do not appear to receive an invitation, please get in touch with the HOP-MHP team at hopproject@ucl.ac.uk and ask us to send (or resend) your invite.
If an invitation still doesn't arrive, be sure to check all the tabs, folders, and spam filters in your inbox.

A reminder – when you signed up for this study you indicated that you were not feeling suicidal at the time. We recognise that things can change and would like to stress that if at any point you are feeling in acute distress and/or suicidal, we advise you to seek urgent support, either through NHS services or through crisis services.

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You can find more information on our web page (under the heading 'Information about other sources of support'): https://www.ucl.ac.uk/pals/hop-mhp-project-0

Best Wishes
Julie Evans
HOP-MHP Team

HOP-MHP guide reminder email (to be sent once a week, 3 times)

Dear HOP-MHP participant,

I hope you are getting on well with the HOP-MHP guide and the peer forum.
This is a reminder to please complete the three sessions of the guide, using worksheets from the additional Word document if needed. Please let me know once you have completed the guide and I will send you the link to the second survey.
A reminder – when you signed up for this study you indicated that you were not feeling suicidal at the time. We recognise that things can change and would like to stress that if at any point you are feeling in acute distress and/or suicidal, we advise you to seek urgent support, either through NHS services or through crisis services. You can find more information on our web page (under the heading 'Information about other sources of support'): https://www.ucl.ac.uk/pals/hop-mhp-project-0

Best Wishes
Julie Evans
HOP-MHP Team

Example response to participant queries about time frame for completing sessions 1-3 (if applicable) - adapt to specific participant enquiry.

Dear HOP-MHP participant,

Thanks for getting in touch - that is absolutely fine. We estimate that participants will take around three weeks on average to complete the three sessions but are mindful that many will move at a different pace. We send out regularly reminder emails to check in with participants and to remind them to let us know when they have completed the sessions.

A reminder – when you signed up for this study you indicated that you were not feeling suicidal at the time. We recognise that things can change and would like to stress that if at any point you are feeling in acute distress and/or suicidal, we advise you to seek urgent support, either through NHS services or through crisis services. You can find more information on our web page (under the heading 'Information about other sources of support'): https://www.ucl.ac.uk/pals/hop-mhp-project-0

Best wishes,
Julie Evans
HOP-MHP Team

<u>Time 1 survey email (once participants confirm they have completed HOP-MHP guide core sessions)</u>

Dear HOP-MHP participant,

Thank you for letting me know that you have completed the core sessions of the HOP-MHP guide. Please log on to complete the second survey using your personalised link below:

<INSERT TIME 1 SURVEY LINK>
Please note that the survey link expires 7 days after you last accessed the survey and that unsubmitted responses will be automatically deleted at that point.
You will receive the Follow-Up sessions of the HOP-MHP guide approximately three weeks / one month after you have completed this survey.

A reminder – when you signed up for this study you indicated that you were not feeling suicidal at the time. We recognise that things can change and would like to stress that if at any point you are feeling in acute distress and/or suicidal, we advise you to seek urgent support, either through NHS services or through crisis services. You can find more information on our web page (under the heading 'Information about other sources of support'): https://www.ucl.ac.uk/pals/hop-mhp-project-0

Best wishes,
Julie Evans
HOP-MHP project team

<u>Time 1 survey reminder (5 days after Time 1 survey has been sent if not completed)</u>

Dear HOP-MHP participant,

This is a reminder to please complete the second survey using your personalised link below:
<INSERT TIME 1 SURVEY LINK>

Please note that the survey link expires 7 days after you last accessed the survey and that unsubmitted responses will be automatically deleted at that point. If your link expires, please contact me to request a new link.

A reminder – when you signed up for this study you indicated that you were not feeling suicidal at the time. We recognise that things can change and would like to stress that if at any point you are feeling in acute distress and/or suicidal, we advise you to seek urgent support, either through NHS services or through crisis services. You can find more information on our web page (under the heading 'Information about other sources of support'): https://www.ucl.ac.uk/pals/hop-mhp-project-0

Best Wishes
Julie Evans
HOP-MHP Team

Dear HOP-MHP participant,

Thank you for completing the second survey.

I will send you the Follow-Up and What Next sessions of the HOP-MHP guide in approximately three / four weeks' time.

A reminder – when you signed up for this study you indicated that you were not feeling suicidal at the time. We recognise that things can change and would like to stress that if at any point you are feeling in acute distress and/or suicidal, we advise you to seek urgent support, either through NHS services or through crisis services. You can find more information on our web page (under the heading 'Information about other sources of support'): https://www.ucl.ac.uk/pals/hop-mhp-project-0

Best Wishes
 Julie Evans
 HOP-MHP Team

Follow Up sessions email (to be sent three weeks / 1 month after Time 1 survey has been completed) - **attach Follow-Up and What Next document as both PDF and Word**

Dear HOP-MHP participant,

Thank you again for completing the second survey. Please find attached the Follow-Up and What Next sessions of the HOP-MHP guide. As you can see I have attached two files - they are exactly the same except one is a PDF document and one is in Word format in case you wanted to complete the worksheets electronically.

Please let me know when you have completed these sessions and I will send you the link to the next survey.

A reminder – when you signed up for this study you indicated that you were not feeling suicidal at the time. We recognise that things can change and would like to stress that if at any point you are feeling in acute distress and/or suicidal, we advise you to seek urgent support, either through NHS services or through crisis services. You can find more information on our web page (under the heading 'Information about other sources of support'): https://www.ucl.ac.uk/pals/hop-mhp-project-0

Best Wishes
Julie Evans
HOP-MHP Team

Follow Up email reminder (1 week later)

Dear HOP-MHP participant,

I hope you are getting on well with the Follow-Up and What Next sessions. This is a reminder to please let me know once you have completed these sessions. I will then send you the link to the next survey.

A reminder – when you signed up for this study you indicated that you were not feeling suicidal at the time. We recognise that things can change and would like to stress that if at any point you are feeling in acute distress and/or suicidal, we advise you to seek urgent support, either through NHS services or through crisis services. You can find more information on our web page (under the heading 'Information about other sources of support'): https://www.ucl.ac.uk/pals/hop-mhp-project-0

Best Wishes
Julie Evans
HOP-MHP Team

Follow-Up dropout warning email

Dear HOP-MHP participant,

I have not heard from you in a while and am writing to check whether you still wish to continue with the study? As stated in the information sheet, you are entirely within your rights to withdraw from the study at any time and without giving a reason. In case you have decided to withdraw from the study we thank you for your interest and wish you all the best for the future.

If you would like to continue with the study, please let me know once you have completed the Follow-Up and What Next sessions of the HOP-MHP guide. I will then send you the link to the final survey.

A reminder – when you signed up for this study you indicated that you were not feeling suicidal at the time. We recognise that things can change and would like to stress that if at any point you are feeling in acute distress and/or suicidal, we advise you to seek urgent support, either through NHS services or through crisis services. You can find more information on our web page (under the heading 'Information about other sources of support'): https://www.ucl.ac.uk/pals/hop-mhp-project-0

Best Wishes

Julie Evans
HOP-MHP Team

Time 2 survey email (once participants confirm they have completed Follow Up sessions)

Dear HOP-MHP participant,

Thank you for letting me know that you have completed the Follow-Up and What Next sessions. Please log on to complete the next survey using your personalised link below:
<INSERT TIME 2 SURVEY LINK>

Please note that the survey link expires 7 days after you last accessed the survey and that unsubmitted responses will be automatically deleted at that point.

A reminder – when you signed up for this study you indicated that you were not feeling suicidal at the time. We recognise that things can change and would like to stress that if at any point you are feeling in acute distress and/or suicidal, we advise you to seek urgent support, either through NHS services or through crisis services. You can find more information on our web page (under the heading 'Information about other sources of support'): https://www.ucl.ac.uk/pals/hop-mhp-project-0

Best Wishes
Julie Evans
HOP-MHP Team

Time 2 survey reminder (~5 days after Time 2 survey has been sent)

Dear HOP-MHP participant,

This is a reminder to please complete the third survey using your personalised link below:
<INSERT TIME 2 SURVEY LINK>

Please note that unsubmitted responses will be automatically deleted 7 days after you were last active on the survey.

A reminder – when you signed up for this study you indicated that you were not feeling suicidal at the time. We recognise that things can change and would like to stress that if at any point you are feeling in acute distress and/or suicidal, we advise you to seek urgent support, either through NHS services or through crisis services. You can find more information on our web page (under the heading 'Information about other sources of support'): https://www.ucl.ac.uk/pals/hop-mhp-project-0

Best Wishes
Julie Evans
HOP-MHP Team

Completion - Thank you email (**not** opted into qualitative interview at 3 months):

Dear HOP-MHP participant,

Thank you for completing the final survey and for participating in our research project. We hope you found the HOP-MHP guide helpful.

If you would like to share the guide with friends or colleagues, please can we ask you refrain from doing so, but please do direct them to our website to take part in our research project.

A reminder – when you signed up for this study you indicated that you were not feeling suicidal at the time. We recognise that things can change and would like to stress that if at any point you are feeling in acute distress and/or suicidal, we advise you to seek urgent support, either through NHS services or through crisis services. You can find more information on our web page (under the heading 'Information about other sources of support'): https://www.ucl.ac.uk/pals/hop-mhp-project-0

Best Wishes
Julie Evans
HOP-MHP Team

Completion – Thank you email (opted into follow-up qualitative interview at 3 months):

Dear HOP-MHP participant,

Thank you for completing the final survey and for participating in our research project. We hope you found the HOP-MHP guide helpful.

If you would like to share the guide with friends or colleagues, please can we ask you refrain from doing so, but please do direct them to our website to take part in our research project.

Thank you for expressing an interest in taking part in a follow-up telephone interview. We will be in touch again in around three months' time to arrange this. If you have any questions in the meantime please do not hesitate to contact us.

A reminder – when you signed up for this study you indicated that you were not feeling suicidal at the time. We recognise that things can change and would like to stress that if at any point you are feeling in acute distress and/or suicidal, we advise you to seek urgent support, either through NHS services or through crisis services. You can find more information on our web page (under the heading 'Information about other sources of support'): https://www.ucl.ac.uk/pals/hop-mhp-project-0

Best Wishes
Julie Evans
HOP-MHP Team

Follow-Up Qualitative interview (3 months after T2 completed):

Dear HOP-MHP participant,

We are getting back in touch with you as you kindly took part in our research project and said you would be happy for us to contact you to take part in a telephone interview.

We hope you are still happy to take part. If so, please can you reply to this email with your availability and the best telephone number to reach you on and I will be in touch again to suggest some dates for the interview.

If you no longer wish to take part in an interview, please let us know. If we don't hear back from you within two weeks we will assume that you no longer wish to take part, but wish to thank you again for your time.

A reminder – when you signed up for this study you indicated that you were not feeling suicidal at the time. We recognise that things can change and would like to stress that if at any point you are feeling in acute distress and/or suicidal, we advise you to seek urgent support, either through NHS services or through crisis services. You can find more information on our web page (under the heading 'Information about other sources of support'): https://www.ucl.ac.uk/pals/hop-mhp-project-0

Best Wishes
Julie Evans
HOP-MHP Team

Qualitative reminder email:

Dear HOP-MHP participant,

I am emailing to remind you that I will be calling you on DATE, at TIME to complete the qualitative interview.

If this time is no longer convenient, please reply to this email and a member of the research team will be in touch to rearrange.

A reminder – when you signed up for this study you indicated that you were not feeling suicidal at the time. We recognise that things can change and would like to stress that if at any point you are feeling in acute distress and/or suicidal, we advise you to seek urgent support, either through NHS services or through crisis services. You can find more information on our web page (under the heading 'Information about other sources of support'): https://www.ucl.ac.uk/pals/hop-mhp-project-0

Best Wishes
Julie Evans
HOP-MHP Team

Non-Completers Drop-Out Survey & Interview Email

Subject: HOP-MHP Study - Feedback Request

Dear HOP-MHP participant,

We are getting back in touch with you as you kindly took part in our research project. We are inviting participants to provide feedback on their experience of the project so that we can improve the guide and tackle any difficulties participants may have had with taking part in the study.

We would like to interview participants who started the intervention but did not go on to complete this. We hope you may be interested in taking part in a brief telephone interview with myself to share your experiences of the guide and the

project. This information will be made completely anonymous and will be central to improving the guide and project for future participants.

If you would like to take part in an interview, please can you reply to this email with your availability and I will be in touch again by email to suggest some dates for the interview.

If you do not wish to take part in an interview, we are also hoping to gather information via a brief anonymous survey, which you can complete via this link: https://www.surveymonkey.co.uk/r/TB9X3DM

Thank you again for your time and your support of the project.

Best Wishes
Julie Evans
HOP-MHP Team

CONTROL GROUP:

Control email 1 (after baseline completed)

Dear HOP-MHP participant,

My name is Julie and I am one of the researchers on the HOP-MHP project team. I will be keeping in touch with you and sending you reminders for the duration of the project.

Thank you for completing the baseline survey. You have been randomly allocated to the control arm. Once you have completed all three surveys, I will send you the HOP-MHP guide and information about joining the peer forum.

I will be in touch again soon and will send you the link to the next survey in about six weeks' time.

 Here is a link to our website where you can find information about available resources:
 https://www.ucl.ac.uk/pals/hop-mhp-project-0

A reminder – when you signed up for this study you indicated that you were not feeling suicidal at the time. We recognise that things can change and would like to stress that if at any point you are feeling in acute distress and/or suicidal, we advise you to seek urgent support, either through NHS services or through crisis services. You can find more information on our web page (under the heading 'Information about other sources of support'): https://www.ucl.ac.uk/pals/hop-mhp-project-0

Best Wishes

Julie Evans
HOP-MHP Team

Control email 2 (1 week after baseline allocation email)

Dear HOP-MHP participant,

Thank you again for joining our study. I will send you the link to the next survey in two to three weeks' time and will also be in touch again next week to remind you of this.
In the meantime, our website has plenty of relevant resources you might want to have a look at: https://www.ucl.ac.uk/pals/hop-mhp-project-0

A reminder – when you signed up for this study you indicated that you were not feeling suicidal at the time. We recognise that things can change and would like to stress that if at any point you are feeling in acute distress and/or suicidal, we advise you to seek urgent support, either through NHS services or through crisis services. You can find more information on our web page (under the heading 'Information about other sources of support'): https://www.ucl.ac.uk/pals/hop-mhp-project-0

Best Wishes
Julie Evans
HOP-MHP Team

Control email 3 (1 week after previous email [2 weeks after baseline allocation email])

Dear HOP-MHP participant,

This is a reminder that I will be sending you the link to the next survey in approximately one to two weeks' time.

If you are interested in finding out more about available resources, please follow this link to our website:
https://www.ucl.ac.uk/pals/hop-mhp-project-0

A reminder – when you signed up for this study you indicated that you were not feeling suicidal at the time. We recognise that things can change and would like to stress that if at any point you are feeling in acute distress and/or suicidal, we advise you to seek urgent support, either through NHS services or through crisis services. You can find more information on our web page (under the heading 'Information about other sources of support'): https://www.ucl.ac.uk/pals/hop-mhp-project-0

Best Wishes
Julie Evans
HOP-MHP Team

<u>Time 1 email: (3 to 4 weeks after baseline)</u>

Dear HOP-MHP participant,

I hope you are doing well. It is now time to complete the second survey. Please access this using your personalised link below.

<INSERT TIME 1 SURVEY LINK>

Once you have completed the Time 1 survey, you will be asked to complete the final survey approximately one month later. I will then send you the HOP-MHP guide and information about accessing the peer forum.

A reminder – when you signed up for this study you indicated that you were not feeling suicidal at the time. We recognise that things can change and would like to stress that if at any point you are feeling in acute distress and/or suicidal, we advise you to seek urgent support, either through NHS services or through crisis services. You can find more information on our web page (under the heading 'Information about other sources of support'): https://www.ucl.ac.uk/pals/hop-mhp-project-0

Best Wishes
Julie Evans
HOP-MHP Team

<u>Time 1 survey reminder (5 days after Time 1 survey has been sent if not completed)</u>

Dear HOP-MHP participant,

This is a reminder to please complete the second survey using your personalised link below:
<INSERT TIME 1 SURVEY LINK>

Please note that the survey link expires 7 days after you last accessed the survey and that unsubmitted responses will be automatically deleted at that point. If your link expires, please contact me to request a new link.

A reminder – when you signed up for this study you indicated that you were not feeling suicidal at the time. We recognise that things can change and would like to stress that if at any point you are feeling in acute distress and/or suicidal, we advise you to seek urgent support, either through NHS services or through crisis services. You can find more information on our web page (under the heading 'Information about other sources of support'): https://www.ucl.ac.uk/pals/hop-mhp-project-0

Best Wishes
Julie Evans
HOP-MHP Team

<u>Control email 4 (after T1 completed)</u>

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Dear HOP-MHP participant,

Thank you for completing the second survey. I will be contacting you in approximately one month with the link to the final survey.

I will also send you another email in a couple of weeks to stay in touch during this time. Once you have completed the final survey, I will send you the HOP-MHP guide and information about accessing the peer forum.

Here is a link to our website where you can find information about available resources:
https://www.ucl.ac.uk/pals/hop-mhp-project-0

A reminder – when you signed up for this study you indicated that you were not feeling suicidal at the time. We recognise that things can change and would like to stress that if at any point you are feeling in acute distress and/or suicidal, we advise you to seek urgent support, either through NHS services or through crisis services. You can find more information on our web page (under the heading 'Information about other sources of support'): https://www.ucl.ac.uk/pals/hop-mhp-project-0

Best Wishes
Julie Evans
HOP-MHP Team

Control email 5 (two weeks after Control email 4)

Dear HOP-MHP participant,

I hope you are doing well. This is a reminder that I will be sending you the link to the final survey in approximately two weeks.

Once you have completed the final survey, I will send you the HOP-MHP guide and information about accessing the peer forum.

Please also have a look at our website where you can find information about available resources:
https://www.ucl.ac.uk/pals/hop-mhp-project-0s

A reminder – when you signed up for this study you indicated that you were not feeling suicidal at the time. We recognise that things can change and would like to stress that if at any point you are feeling in acute distress and/or suicidal, we advise you to seek urgent support, either through NHS services or through crisis services. You can find more information on our web page (under the heading 'Information about other sources of support'): https://www.ucl.ac.uk/pals/hop-mhp-project-0

Best Wishes

Julie Evans
HOP-MHP Team

Time 2 email: (1 month after Time 1 completed)

Dear HOP-MHP participant,

It is now time to complete the final survey. Please access this using your personalised link below:

<INSERT TIME 2 SURVEY LINK>

Once you have completed this survey, I will send you the HOP-MHP guide and information about accessing the peer forum.

A reminder – when you signed up for this study you indicated that you were not feeling suicidal at the time. We recognise that things can change and would like to stress that if at any point you are feeling in acute distress and/or suicidal, we advise you to seek urgent support, either through NHS services or through crisis services. You can find more information on our web page (under the heading 'Information about other sources of support'): https://www.ucl.ac.uk/pals/hop-mhp-project-0

Best Wishes
Julie Evans
HOP-MHP Team

Time 2 survey reminder (5 days after Time 2 survey has been sent if not completed)

Dear HOP-MHP participant,

This is a reminder to please complete the final survey using your personalised link below:
<INSERT TIME 2 SURVEY LINK>

Please note that the survey link expires 7 days after you last accessed the survey and that unsubmitted responses will be automatically deleted at that point. If your link expires, please contact me to request a new link.

A reminder – when you signed up for this study you indicated that you were not feeling suicidal at the time. We recognise that things can change and would like to stress that if at any point you are feeling in acute distress and/or suicidal, we advise you to seek urgent support, either through NHS services or through crisis services. You can find more information on our web page (under the heading 'Information about other sources of support'): https://www.ucl.ac.uk/pals/hop-mhp-project-0

Best Wishes
Julie Evans
HOP-MHP Team

Completion - HOP-MHP guide email - **attach combined guide (sessions 1-3 & follow-up PDF), combined worksheets Word document & peer forum joining instructions & forward to Katrina once sent with subject line: 'Invite to peer forum' & set to high importance:**

Dear HOP-MHP participant,

Thank you for completing the final survey and for participating in our research project. Please find attached the HOP-MHP guide and a separate Word document containing the worksheets for these sessions (these are identical to the worksheets in the guide but we are including them here in Word format in case you want to complete them electronically).

If you would like to share the guide with friends or colleagues, please can we ask you refrain from doing so, but please do direct them to our website to take part in our research project:

https://www.ucl.ac.uk/pals/hop-mhp-project-0

You will be given access to a web peer forum while you are using the guide. You should receive an invitation to join the forum within the next 72 hours. Please check your inbox for an invitation to join a 'Slack team' (Slack is the name of an online forum and downloadable app) and follow the joining instructions attached to this email to sign up. You will see that the joining instructions suggest that you need to enter a participant number to sign up to the forum. This number is no longer essential and you should be able to sign up by entering details of your own choice but if you would like to enter your participant number you can use number '<INSERT THEIR ALLOCATED HOP NUMBER (E.G. '55')>'.

If for any reason, you do not appear to receive an invitation, please get in touch with the HOP-MHP team at hopproject@ucl.ac.uk and ask us to send (or resend) your invite.

If an invitation still doesn't arrive, be sure to check all the tabs, folders, and spam filters in your inbox.

A reminder – when you signed up for this study you indicated that you were not feeling suicidal at the time. We recognise that things can change and would like to stress that if at any point you are feeling in acute distress and/or suicidal, we advise you to seek urgent support, either through NHS services or through crisis services. You can find more information on our web page (under the heading 'Information about other sources of support'): https://www.ucl.ac.uk/pals/hop-mhp-project-0

Best Wishes

Julie Evans
HOP-MHP Team

Appendix F: Outline of trainee contribution to joint study
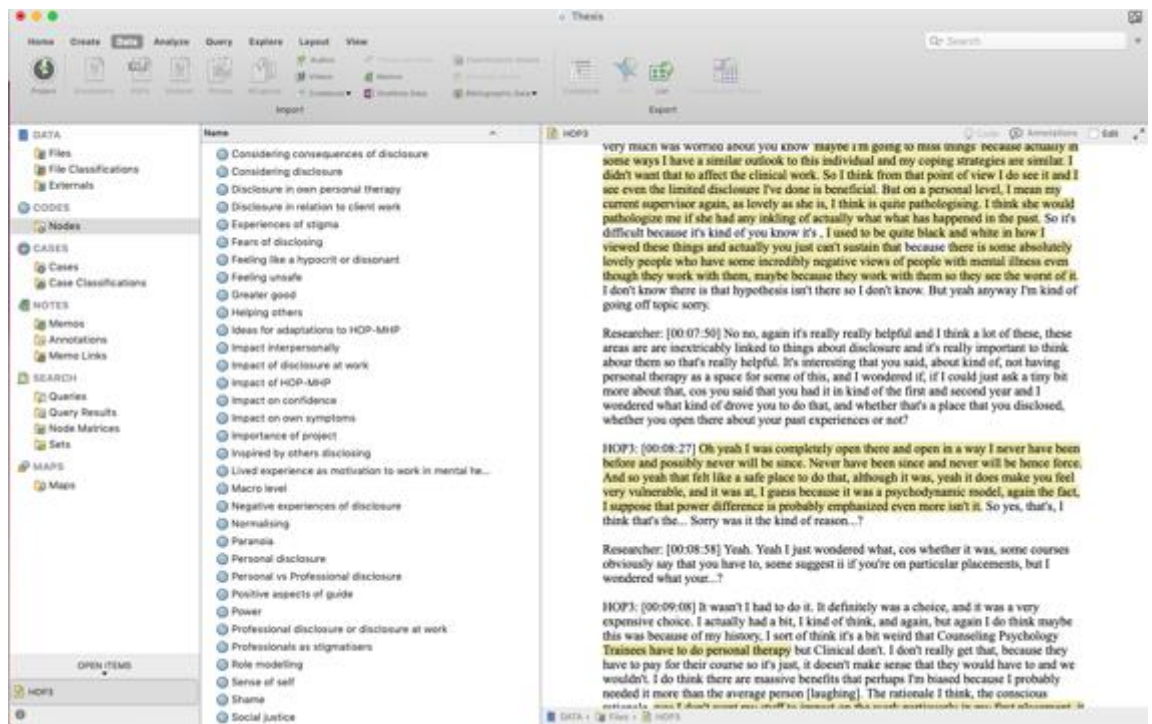
Julie Evans, Trainee
- Recruitment.
- Monitoring of HOP-MHP email account for emails related to recruitment and participant follow-up.
- Participant follow-up via email, including sending of guide and worksheets, T1 and T2 measures and engagement emails.
- Sending of invitations to engage in follow-up interviews and questionnaires.
- Completion of all follow-up qualitative interviews.
- Data cleaning.
- Analysis of data and write up for this thesis.

Vivienne Smith, Trainee
- Recruitment.
- Monitoring of HOP-MHP email account for emails related to recruitment, completed consent forms and baseline measure completion.
- Checking of eligibility criteria.
- Sending and confirming completion of baseline measures.
- Randomisation of participants.
- Storing and maintaining list of unique identifiers and participant emails.
- Access to survey responses.
- Data cleaning.

Appendix G: Qualitative analysis

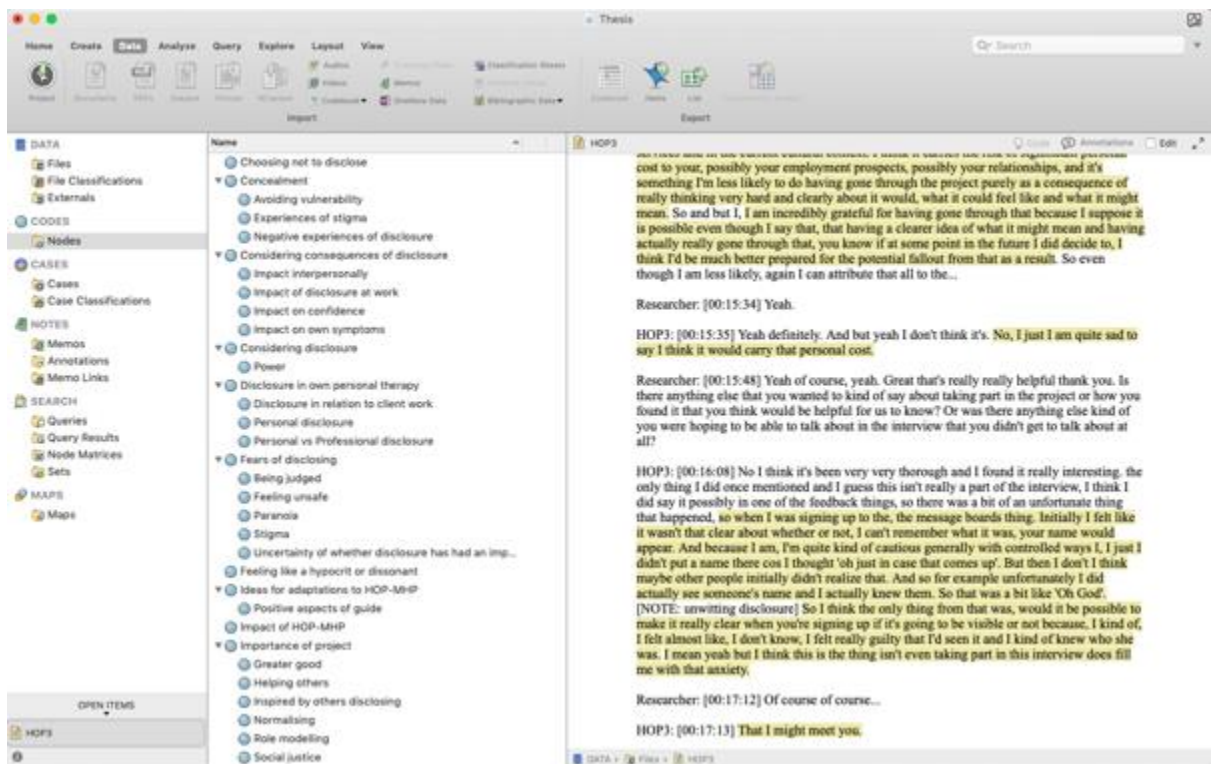1. Initial codes and line by line coding.

2. Initial codes across cases

3. Initial grouping and organisation of codes.

4. Further organisation of codes.
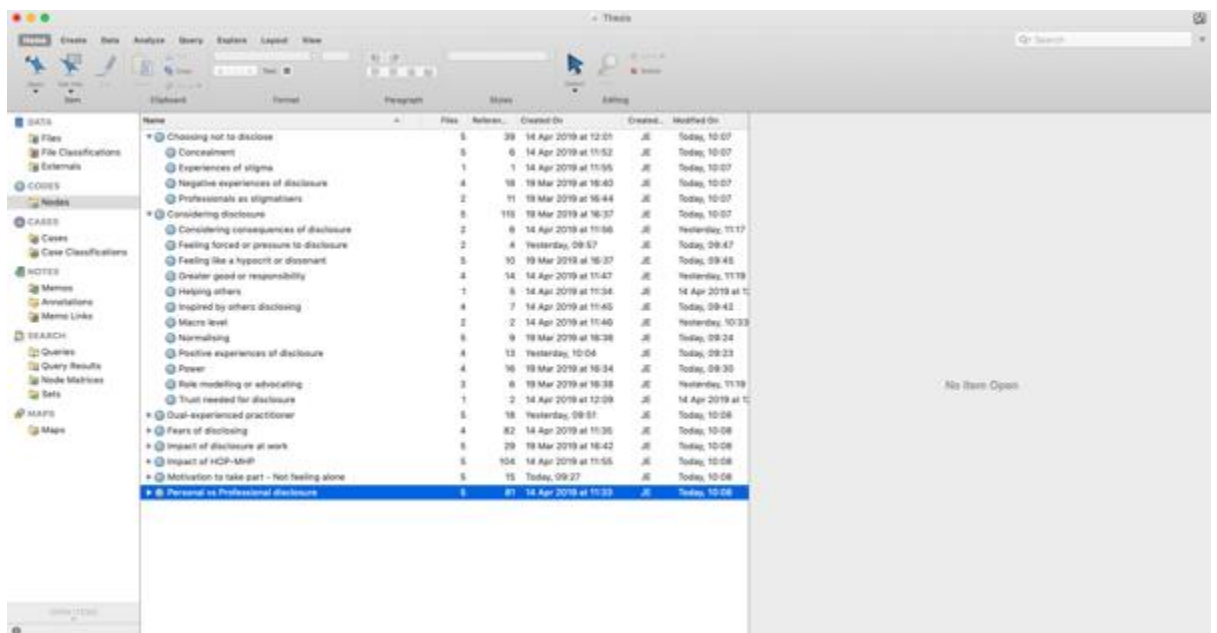
Appendix H: Ethics approval

UCL RESEARCH ETHICS COMMITTEE

Amending an Approved Application

Should you wish to make an amendment to an approved study, you will need to submit an 'amendment request' for the consideration of the Chair of the UCL Research Ethics Committee. Applications can only be amended **after** ethical approval has been granted.

You will need to apply for an amendment approval if you wish to:

1. Add a new participant group;
2. Add a new research method;
3. Ask for additional data from your existing participants;
4. Remove a group of participants or a research method from the project, and have not yet commenced that part of the project;
5. Apply for an extension to your current ethical approval.

If you need to apply for an amendment approval, please complete the Amendment Approval Request Form on the next page.

When completing the form, please ensure you do the following:

- Clearly explain what the amendment you wish to make is, and the justification for making the change.
- Insert details of any ethical issues raised by the proposed amendments.
- Include all relevant information regarding the change so that the Chair can make an informed decision, and submit a copy of the sections of your application that have changed with all changes highlighted/underlined for clarity.
- You do not need to submit your original application in full again. However, if the changes you wish to make alters several sections of your application form, you are advised to submit this.

One signed hard copy of the form (and any amended documents), as well as an electronic copy of these same documents must be submitted to the REC Administrator to the address detailed below:

Administrator of the UCL Research Ethics Committee
Academic Services
1-19 Torrington Place
UCL
London
WC1E 6BT

Email: ethics@ucl.ac.uk

Amendment requests are generally considered within 5-7 days of submission.

Amendment Approval Request Form

1	Project ID Number: 9297/002	Name and Address of Principal Investigator: Dr Katrina Scior, Research Dept of Clinical Educational & Health Psychology, UCL, Gower Street, London WC1E 6BT
2	Project Title: Supporting disclosure related decisions among clinical psychologists experiencing mental health problems: a feasiblity and pilot study	
3	**Type of Amendment/s (tick as appropriate)** Research procedure/protocol (including research instruments) ☒ Participant group ☐ Sponsorship/collaborators ☐ Extension to approval needed (extensions are given for one year) ☒ *To 01/01/2019 ** Information Sheet/s ☒ Consent form/s ☒ Other recruitment documents ☐ Principal researcher/medical supervisor* ☐ Other ☐ *Additions to the research team other than the principal researcher, student supervisor and medical supervisor do not need to be submitted as amendments but a complete list should be available upon request.	
4	**Justification** (give the reasons why the amendment/s are needed) We are looking to extend the research to encompass a follow-up period, three months after completion of the current study. 1. We will ask current participants already engaged with this project whether they would be willing to complete the project outcome measures at one additional time point (T3 -3 months post T2). We will also ask participants in the intervention group whether they would be happy to be contacted about engaging in qualitative one-to-one semi-structured interviews about their experiences and disclosure related actions since engaging in the intervention. Current participants will be given information about these follow-up procedures and asked to consent to be contacted for the additional measures (and interviews for the intervention group) at the end of the T2 measures survey. 2. We are also looking to commence a 'phase two' of the project whereby all participants will be informed of the follow-up as part of the information sheet and consent at the point of signing up to the trial. In phase two, the T2 measures would no longer be administered to reduce the burden on participants. T3 measures and interviews would be conducted as described above. The amended information sheet and consent form are attached.	

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Details of Amendments (provide full details of each amendment requested, state where the changes have been made and attach all amended and new documentation)

1. To add collection of measures at T3 in both intervention and control groups. To add conducting one-to-one interviews with intervention participants at T3. To add the following information to the end of the T2 questionnaire measures to gain informed consent to contact participants at T3:

Intervention Group:

Thank you very much for taking part in the study so far. We greatly appreciate your input and would like to invite you to take part in the follow-up section of the study.

To further assess the effectiveness of the HOP-MHP intervention we would like to follow-up with you in another three months' time. This would involve completing the outcome measures through the web survey one last time, which take around 15-20 minutes to complete.

We would also like to speak to participants about their experiences since using HOP-MHP and whether they have disclosed or not disclosed since. This would be in the form of one-to-one semi-structured interviews which will take place at University College London or by telephone or Skype.

Please indicate below whether you are willing for us to contact you again in three months' time to ask you to complete the surveys, and to invite you to take part in an interview about your experiences.

☐ I am happy to be contacted in three months' time to complete one last set of outcome measures via a web survey.

☐ I am happy to be contacted in three months' time to be invited to take part in an interview about my experiences.

Control Group:

Thank you very much for taking part in the study so far. We greatly appreciate your input and would like to invite you to take part in the follow-up section of the study.

To further assess the effectiveness of the HOP-MHP intervention we would like to follow-up with you in another three months' time. This would involve completing the outcome measures through the web survey one last time, which take around 15-20 minutes to complete.

Please indicate below whether you are willing for us to contact you again in three months' time to ask you to complete the surveys.

☐ I am happy to be contacted in three months' time to complete one last set of outcome measures via a web survey.

2. To drop measures collection at T2. To add collection of measures at T3 instead in both groups. To add conducting one-to-one interviews with intervention group at T3. To amend information sheet and consent form (as attached) to reflect these changes.

Ethical Considerations (insert details of any ethical issues raised by the proposed amendment/s)
Participants will be asked to engage in the study for longer and the control group will have to wait longer to receive the intervention to conduct the T3 follow-up. However participants will be informed of this and all participants will continue to be able to access other sources of support via the project website.

Participants may experience some distress when reflecting on their mental well-being before, during or after measure completion, including T3, and taking part in any qualitative interview. Participants are informed from the outset that they can contact us on a confidential basis if they experience distress and they are also encouraged to access one or more suggested sources of support listed on the research project webpages: www.ucl.ac.uk/pals/research/cehp/stigma-research/documents/hop_docs/hop-mhp and http://www.ucl.ac.uk/pals/research/cehp/stigma-research/documents/hop_docs/hop_additional_resources . The qualitative interviewer will remind each participant about these support procedures and resources both when arranging the interview and when conducting it.

7	**Other Information** (provide any other information which you believe should be taken into account during ethical review of the proposed changes) none

Declaration (to be signed by the Principal Researcher)

- I confirm that the information in this form is accurate to the best of my knowledge and I take full responsibility for it.
- I consider that it would be reasonable for the proposed amendments to be implemented.
- For student projects I confirm that my supervisor has approved my proposed modifications.

Signature: █████████████

Date: 23.11.2017

FOR OFFICE USE ONLY:

Amendments to the proposed protocol have been *approved* by the Research Ethics Committee.

Signature of the REC Chair: ███████████████████

Date: 28/11/2017 ████████████████

Participant Information Sheet for pilot RCT of the HOP-MHP Self-Help Guide
This study has been approved by the UCL Research Ethics Committee [Project ID: 9297/002]

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of Study:

Supporting disclosure related decisions among clinical psychologists experiencing

mental health problems: a feasibility and pilot study.

Department:

Research Department of Clinical, Educational & Health Psychology

Name and Contact Details of the Researcher(s):

Julie Evans and Vivienne Smith, Clinical & Health Psychology, UCL, Gower Street,

London, WC1E 6BT.

hopproject@ucl.ac.uk

Name and Contact Details of the Principal Researcher:

Dr Katrina Scior, Clinical & Health Psychology, UCL, Gower Street, London, WC1E

6BT.

+44 (0)20 7679 1897
k.scior@ucl.ac.uk

1. Introduction

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what participation will involve. Please take time to read the following information carefully and discuss with others if you wish. Please contact us if there is anything that is not clear or if you would like more information.

We are currently recruiting participants to take part in a pilot RCT of the new HOP-MHP self-help guide. 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.

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.

2. What is the project's purpose?

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.

3. Why have I been chosen?

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.

4. Do I have to take part?

Participation is entirely voluntary and choosing not to take part will not disadvantage you in any way. If you do decide to take part please keep a copy of this information sheet. You will be asked to sign a consent form. You can withdraw at any time without giving a reason. If you decide to withdraw you will be asked what you wish to happen to the data you have provided up until that point.

5. What will happen to me if I take part?

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. Three months after receiving the follow-up session, you will be invited to take part in a one-to-one semi-structured interview about your experiences since using the HOP-MHP self-help guide and whether you have disclosed or not disclosed since. These interviews will take place over the telephone or skype. You can choose whether or not to participate in the 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 six weeks after completing the baseline survey and the final survey six weeks after this. 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.

6. Will I be recorded and how will the recorded media be used?

If you agree to take part in an interview as part of the intervention arm of the study, this interview will be audio recorded and transcribed in order to be analysed. These audio recordings will be used only for analysis and will be destroyed once transcribed. Transcribed interviews will be anonymised and you will not be identifiable from them. No other use will be made of the recordings and no one outside the project will be allowed access to the recordings.

7. What are the possible disadvantages and risks of taking part?

It is possible that reflecting on your mental health problems and thinking about disclosure may cause you some distress. If you do experience distress and would like support, then please contact us and we will be happy to speak with you on a confidential basis.

8. What are the possible benefits of taking part?

Whilst there are no explicit benefits for those participating in the project, 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.

9. What if something goes wrong?

If you have any concerns or need support in the first instance you should contact the Principal Researcher. However, should you feel your complaint or concern has not been handled to your satisfaction you can contact the Chair of the UCL Research Ethics Committee by emailing ethics@ucl.ac.uk

10. Will my taking part in this project be kept confidential?

All the information that we collect about you during the course of the research will be kept strictly confidential. You will not be able to be identified in any ensuing reports or publications.

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 <u>not</u> 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. This will not affect your access to or ability to engage with the peer forum in any way.](hopproject@ucl.ac.uk)

11. Limits to confidentiality

Please note that confidentiality will be maintained as far as it is possible – if, on the basis of anything you express in an interview or on the HOP peer forum, we feel that <u>you</u> may be at risk we will signpost you towards relevant avenues of support; If we feel that someone might be in danger of harm, we may have to inform relevant agencies of this.

12. What will happen to the results of the research project?

We intend to publish the results of the research in due course. If you would like to be contacted when the results are published please indicate this on the consent form. Individuals will not be identified in any report or publication. The data collection during the course of the project might be used for additional or subsequent research within the department but will remain anonymous and unidentifiable.

13. Data Protection Privacy Notice

Notice:
The data controller for this project will be University College London (UCL). The UCL Data Protection Office provides oversight of UCL activities involving the processing of personal data, and can be contacted at [data-protection@ucl.ac.uk.](data-protection@ucl.ac.uk) UCL's Data Protection Officer is Lee Shailer and he can also be contacted at data-protection@ucl.ac.uk.

Your personal data will be processed for the purposes outlined in this notice. The legal basis that would be used to process your personal data will be the provision of your consent. You can provide your consent for the use of your personal data in this project by completing the consent form that has been provided to you.

Your personal data will be processed so long as it is required for the research project. If we are able to anonymise or pseudonymise the personal data you provide we will undertake this, and will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, please contact UCL in the first instance at data-protection@ucl.ac.uk. If you remain unsatisfied, you may wish to contact the Information Commissioner's Office (ICO). Contact details, and details of data subject rights, are available on the ICO website at: https://ico.org.uk/for-organisations/data-protection-reform/overview-of-the-gdpr/individuals-rights/

14. Who is organising and funding the research?

This research is sponsored by University College London and supported with funding from the British Psychological Society.

15. Contact for further information

If you require any further information about the study please contact:

Dr Katrina Scior and Dr Henry Clements

Research Department of Clinical & Health Psychology, UCL, Gower Street, London,

WC1E 6BT.

+44 (0)20 7679 1897
k.scior@ucl.ac.uk henry.clements@ucl.ac.uk

Thank you for reading this information sheet and for considering taking part in this research study.

Please retain a copy of this information sheet and the completed consent form for your information.

INFORMED CONSENT FORM FOR PARTICIPANTS IN THE PILOT RCT

OF THE HOP-MHP SELF-HELP GUIDE (PHASE 2)

This consent form is in line with new data protection requirements in place from May 2018 – please forgive the level of detail required under the new regulation.

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

Title of Study:

Supporting disclosure related decisions among clinical psychologists experiencing mental health problems: a feasibility and pilot study.

Department:

Research Department of Clinical, Educational & Health Psychology

Name and Contact Details of the Researcher(s):

Julie Evans, Trainee Clinical Psychologist and Vivienne Smith, Trainee Clinical Psychologist

Research Department of Clinical & Health Psychology, UCL, Gower Street, London, WC1E 6BT.

Name and Contact Details of the Principal Researcher:

Katrina Scior, Research Department of Clinical & Health Psychology, UCL, Gower Street, London, WC1E 6BT.

Name and Contact Details of the UCL Data Protection Officer:

Lee Shailer, data-protection@ucl.ac.uk

This study has been approved by the UCL Research Ethics Committee [Project ID: 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.

I confirm that I understand that by ticking/initialling each box below I am consenting to this element of the study. I understand that it will be assumed that unticked/initialled boxes means that I DO NOT consent to that part of the study. I understand that by not giving consent for any one element that I may be deemed ineligible for the study.

Tick

Box

1. *I confirm that I have read and understood the Information Sheet for the above study. I have had an opportunity to consider the information and what will be

expected of me. I have also had the opportunity to ask questions which have been answered to my satisfaction

[and would like to take part in (please tick one or more of the following)

- *the pilot randomized controlled trial of HOP-MHP*

- *an individual interview at the three month follow-up time point (if randomized to the intervention arm)]*

2. *I understand that I will be able to withdraw my data up to 4 weeks after completing my participation

3. *I consent to the processing of my personal information (i.e. demographic information and questionnaire responses) for the purposes explained to me. I understand that such information will be handled in accordance with all applicable data protection legislation.

4. **Use of the information for this project only**

*I understand that all personal information will remain confidential and that all efforts will be made to ensure I cannot be identified.

I understand that my data gathered in this study will be stored anonymously and securely. It will not be possible to identify me in any publications.

5. *I understand that my information may be subject to review by responsible individuals from the University.

6. *I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason.

I understand that if I decide to withdraw, any personal data I have provided up to that point will be deleted unless I agree otherwise.

7. I understand the potential risks of participating and the support that will be available to me should I become distressed during the course of the research.

8. I understand the direct/indirect benefits of participating.

9. I understand that the data will not be made available to any commercial organisations but is solely the responsibility of the researcher(s) undertaking this study.

10. I understand that I will not benefit financially from this study or from any possible outcome it may result in in the future.

11. I agree that my anonymised research data may be used by others for future research. No one will be able to identify you when this data is shared.

12. I understand that the information I have submitted will be published as a report and I wish to receive a copy of it. Yes/No

13. If participating in interviews:

    I consent to my interview being audio recorded and understand that the recordings will be destroyed immediately following transcription.

14. I hereby confirm that I understand the inclusion criteria as detailed in the Information Sheet and explained to me by the researcher.

15. I hereby confirm that:

    (a) I understand the exclusion criteria as detailed in the Information Sheet and explained to me by the researcher; and

    (b) I do not fall under the exclusion criteria.

16. I have informed the researcher of any other research in which I am currently involved or have been involved in during the past 12 months.

17. I am aware of who I should contact if I wish to lodge a complaint.

18. I voluntarily agree to take part in this study.

19. Use of information for this project and beyond

    I would be happy for the data I provide to be archived at UCL in accordance with data protection laws.

    I understand that other authenticated researchers will have access to my anonymized data.

20. 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.

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

    _____ (please print very clearly)

_____   _____

                                    _____

Name of participant   Date   Signature

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

   ☐ Yes   ☐ No

2. Do you feel that your current life experiences in any way relate to present problems that you

   ☐ Yes   ☐   No

3. Are you fully ready to disclose experiences that there is a little place for

   ☐ Yes   ☐   No

4. Over the last 2 weeks, how often have you bothered by thoughts

   ☐ 0 – Not at all

   ☐ 1 – Several days

   ☐ 2 – More than half the days

   ☐ 3 – Nearly every day

Thank you for your interest in our research study.