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A New Perspective: a social marketing approach to improve mental health service users' implicit and explicit attitudes towards mental health workers

Dissertation submitted in partial fulfilment of the requirements for

M.Sc Behavioural Science

Department of Psychological and Behavioural Sciences

The London School of Economics and Political Science

Submitted to Dr Laura M. Giurge

31 August 2023

Abstract

Amid concerns over power imbalances in mental health settings, this study developed a social marketing intervention to enhance mental health service users' attitudes towards mental health workers. Synthesising elements from 'identity safety cueing', 'similarity-attraction bias', and 'self-disclosure' literature, the intervention involved posters featuring anonymous quotes highlighting workers' own mental health experiences to convey allyship and understanding. Employing a mixed-methods design, the study involved an online, between-subjects, randomised control experiment with 176 mental health service users. Implicit Association Test and 4-Point Ordinal Alliance Self-Report results showed that the intervention significantly improved implicit attitudes towards workers—shifting them from weak to moderate positive biases—but had no effect on explicit attitudes, which were moderately positive across both groups. Robustness checks confirmed the consistency of these findings. Thematic analysis of qualitative data illustrated largely positive sentiments towards workers. Whilst some participants held negative sentiments towards workers, the majority attributed poor therapeutic outcomes to wider systemic issues. Qualitative feedback for the intervention was predominantly positive, with participants reporting that it broke down barriers and humanised workers. Whilst providing cautious support for the intervention's effectiveness, the study provided extensive qualitative data alongside further recommendations for researchers and policy-makers wanting to improve therapeutic engagement and outcomes in the future.

Keywords: mental health, mental health workers, implicit attitudes, explicit attitudes, social marketing, identity safety cueing, similarity-attraction bias, self-disclosure, intervention.

Acknowledgements

As I wrote this paper, I felt a sense of déjà vu wash over me several times. As someone who has worked in the mental health profession—dealing with punches to the nose, managing staff shortages, and feeling burnt out—I found it oddly reassuring to realise that I am part of a bigger statistic that is ready for positive change. As I reminisced, I felt that a 'thank you' was owed to those harsh complexities that encouraged me to dig deeper into what made me feel truly fulfilled. Having opened up my arms to what was previously a mere hobby, behavioural science, I am now ecstatic to be in a place where I can pivot from asking "why is everything on fire?" to exploring "how can we invent a better fire extinguisher?"

To my family, thank you for supporting all of my decisions with unwavering belief and absurd levels of pride. You have provided the stability that I needed to build this new foundation to my life. To my partner, the willing audience to each of my assignments and steadfast companion through my all-nighters, thank you for encouraging me to push the boundaries of my personal growth and academic rigour. To my friends—new and old—thank you for humouring me during my periods of academia-induced absenteeism. Your patience and ruthless quips have made this journey far less lonely. To everyone at LSE—friends and faculty—you have inspired me, humbled me, and even scared me, with your brilliance. You have truly intimidated me into becoming the best I can be, and for that, I am eternally grateful.

Here's to fewer sleepless nights, more lightbulb moments, and a future where our behavioural insights are as carefully applied as they are cited.

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List of Abbreviations

MH	Mental Health
MHSU	Mental Health Service User
TR	Therapeutic Relationship
EPA	European Psychiatric Association
ISC	Identity Safety Cue
SAB	Similarity-Attraction Bias
SM	Social Marketing
IAT	Implicit Association Test
4-POASR	4-Point Ordinal Alliance Self-Report

A New Perspective: a social marketing approach to improve mental health service users' implicit and explicit attitudes towards mental health workers

1. Introduction

In a reality where 90% of mental health (MH) sufferers experience prejudice, discrimination, and self-stigma, their relationships, professional opportunities, and hopes of recovery are severely jeopardised (Hipes et al., 2016; Mental Health Foundation, 2021; Verhaeghe & Bracke, 2011). Records indicate that one in six adults in the United Kingdom (UK) experience MH concerns; yet only 25% of these individuals obtain the necessary treatments, with high dropout rates further undermining treatment efficacy (Baker, 2023; Mental Health Foundation, n.d.). Literature has partially considered the inhibitive role of psychosocial factors, such as perceived power imbalances and discrimination in everyday life, which can evoke distrust in MH providers and deter therapeutic engagement (Thornicroft et al., 2008). However, there has been limited investigation into practical, feasible interventions to mitigate these barriers. In this research, I aimed to investigate a poster-based social marketing intervention towards improving MH service users' (MHSUs) implicit and explicit attitudes towards MH workers - a crucial step that may lay the groundwork for improving treatment engagement and outcomes in the future.

1.1. Causes and Consequences of Poor Perceptions

Individuals experiencing MH concerns often perceive a power-imbalanced, 'us-versus-them' dichotomy with MH workers (Majumder et al., 2014; Priebe et al., 2005; Verhaeghe & Bracke, 2011). This arises due to several reasons, including: *i)* previous experiences of MH-related discrimination which heighten fears of encountering further prejudices in the MH system; *ii)* viewing MH workers as authority

figures; or *iii)* preempting MH workers' lack of understanding (Burgess et al., 2008; Clement et al., 2015; Stewart et al., 2014). These adverse perceptions can engender a negative feedback loop, which affects not only the well-being of MHSUs but also MH workers and their respective organisations.

Negative perceptions of MH workers can trigger adverse behaviours in MHSUs, such as reluctance to disclose essential information, medication non-compliance, and aggression towards workers (Clement et al., 2015; Morken et al., 2008; Najafi et al., 2017; Yang et al., 2018). Consequently, MH workers may feel compelled to employ restrictive measures such as increasing medication, physical restraints, or escalating care to secure hospitals; however, these actions can re-traumatise MHSUs and further diminish trust and engagement (Duxbury, 2002; Khatib et al., 2018; Rugkåsa et al., 2014). Untreated—or inadequately treated—MH issues may persist, become chronic, and sustain the cycle of stigmatisation and continued disengagement (Kessler et al., 1995; Priebe et al., 2005). Vulnerable subsets, including ethnic minorities and individuals with severe symptoms, are particularly susceptible to this cycle, despite their critical need for support (Burgess et al., 2008; Memon et al., 2016; Verhaeghe & Bracke, 2011).

As for the MH workers, the persistence of negative interactions with MHSUs can engender burnout and heightened intentions to leave the profession (Paris & Hoge, 2009; Yang et al., 2018). At the organisational level, this cascade can lead to declining care quality, high resource costs due to repeated MHSU relapses, and staff turnover (D'Ettorre & Pellicani, 2017; Morken et al., 2008).

1.2. Call for a New Perspective

Following recommendations from several academic publications, the European Psychiatric Association (EPA) has advocated for targeted interventions to improve attitudes towards workers by enhancing 'therapeutic relationships' in MH settings. This can equalise the distribution of power between MHSUs and workers, subsequently improving treatment outcomes (Gaebel et al., 2014).

The concept of 'therapeutic relationships' (TRs), also known in the literature as 'therapeutic alliance', gained prominence following Edward Bordin's (1979) 'Theory of Therapeutic Alliance'. Bordin described that TRs comprise: *i)* bonds defined by trust, respect, and care; *ii)* MHSU's perceptions of workers' abilities to engage in helpful, collaborative tasks; and *iii)* goals representing shared therapeutic objectives (Johnson & Wright, 2002). Notably, he emphasised that TRs are "one of the key, if not *the* key, to the change process" (1979, p. 252, parentheses added, italics in original text). In subsequent research, positive TRs have consistently been associated with improved therapeutic outcomes at multiple stages of the recovery process. Independent studies and systematic reviews both show that positive perceptions of workers not only prompt MHSUs to engage in help-seeking behaviours, but also bolster cooperation with long-term treatment plans and facilitate perseverance even when some treatments falter (Brown et al., 2009; Farrelly & Lester, 2014; Green et al., 2008; Have et al., 2009; Kantor & Knefel, 2017). Moreover, MH professionals who are viewed as trustworthy are better able to meet MHSUs' needs and preemptively assess risk, reducing the need for restrictive measures (Brown et al., 2009). Collectively, these factors improve MHSUs' service satisfaction and medication compliance, increase treatment efficacy, and consequently inhibit the damaging cycle of stigma and disengagement (Gaebel et al., 2014; Misdrahi et al., 2011).

Given that strong TRs are contingent upon MHSUs' attitudes towards workers, any ensuing benefits may diminish when MHSUs expect workers to be unempathetic or discriminate against them due to the reasons outlined in Section 1.1 (Bordin, 1979; Hopkins et al., 2009). Despite these risks, and recommendations from the EPA, existing research highlights an enduring lack of viable real-world interventions (Gaebel et al., 2014; Hartley et al., 2020). Although literature has proposed a handful of strategies to improve therapeutic outcomes, I argue that they: *i)* lack cost-effectiveness; *ii)* lack scalability and suitability across different MH services; and most crucially, *iii)* fail to address the psychosocial barriers underlying negative attitudes. For instance, proposals to employ violence prevention checklists and

conflict-management training emphasise risk-minimisation over progressively fostering TRs (Brown et al., 2009; Farrelly & Lester, 2014; Patterson et al., 2013). Alternatively, suggestions to incorporate TR training into psychotherapy qualifications can be costly whilst neglecting a broad group of care personnel who frequently engage with MHSUs without receiving therapy qualifications (e.g. support workers and volunteers) (D'Ettorre & Pellicani, 2017; Hartley et al., 2020; Summers & Barber, 2003). To conclude, I contend that the current state of research and practical approaches de-emphasises the pivotal role of wider organisations in alleviating MHSUs' concerns, and instead, places an onus on individual workers to rectify societal and organisational-level issues.

In the next section, I outline relevant literature, aims, and hypotheses. To proceed, I detail the methods of investigation in Section 3, and present findings in Section 4. I discuss the interpretations and implications in Section 5 and conclude with final takeaways in Section 6.

2. Literature Review

This literature review comprises three segments, each shaping my proposed intervention, and ultimately striving to bridge the gaps outlined in Section 1.2. Firstly, I discuss literature relevant to addressing power imbalances and distrust towards MH workers. Secondly, I propose methods for implementing the insights in a scalable manner. Finally, I highlight further gaps in the literature that my research targeted, concluding with the study's aims and hypotheses.

2.1. Challenging an 'Us versus Them' Dichotomy

2.1.1. Identity Safety Cues

'Identity safety cues' (ISCs) are contextual stimuli assuring stigmatised groups of their safety in environments that they may perceive as threatening. Existing literature suggests that mere representations of allyship and the presence of some relatable members in threatening environments can bolster positive perceptions of the organisation and its members as a whole (Cipollina & Sanchez, 2019). Historically, such cues have been heavily employed in the corporate sector to encourage women towards STEM careers by showcasing female leadership, and to create a sense of belonging for ethnic minorities by highlighting a diverse workforce (Murphy et al., 2007; Purdie-Vaughns et al., 2008). In a more recent study regarding general healthcare settings, Derricks et al. (2022) demonstrated that black American patients felt a heightened sense of trust and alliance when hypothetical white doctors employed ISCs by recognising racial injustice. Further, Cipollina and Sanchez (2019) highlighted that when general healthcare workers belonged to stigmatised groups themselves, they acted as non-typical role models, enhancing patient trust.

As demonstrated, the literature largely considers the role of ICSs in addressing apprehensions amongst race and gender-based demographics. Per my review of literature, the present research has yet to consider the role of using ISCs within MH settings. However, given that MHSUs are a stigmatised group who often fear discrimination within MH settings, I propose that ISCs, which highlight MH workers' allyship and understanding of stigma, may enhance positive attitudes towards professionals.

2.1.2. Similarity-Attraction Bias (SAB)

Similar to ISCs, the concept of 'similarity-attraction bias' (SAB) posits that individuals possess greater liking for those with whom they share important attributes such as ethnic background or political

views (Grant, 1993; Montoya & Horton, 2012). In general medical settings, Street et al. (2008) found that patient-physician relationships and trust were strengthened when similarities in core values and beliefs were made salient. In educational contexts, Gehlbach, Brinkworth, and Harris (2011) similarly reported that highlighting commonalities between students and teachers significantly improved students' perceptions of their working relationships with teachers. The studies indicate that SAB remains effective in promoting enhanced perceptions, even within settings characterised by varying power dynamics.

Notably, when coping with stress and seeking emotional support, the similarity of experiences often trumps the similarity of basic shared attributes such as race or gender. This effect particularly intensifies when groups recognise that they have experienced similar stigmas and unpleasant experiences (Suitor et al., 1995). This realisation can foster a sense of empathy, understanding, and solidarity - crucial elements for nurturing strong TRs (Barnett et al., 1986; Cortland et al., 2017). Much like ISCs, the concept of SAB has not been leveraged in MH settings; yet there is reasonable evidence to suggest that highlighting similarities between MHSUs and workers may improve attitudes because the relationship is contingent upon emotional support.

2.1.3. Self-Disclosure

Whilst ISCs and SAB have not been used in formal MH interventions, MH workers may already be harnessing the therapeutic benefits of shared experiences with MHSUs in an ad-hoc manner. According to Henretty and Levitt (2010), approximately 90% of therapists report using open self-disclosure with their clients, whereby they reveal relevant aspects of their personal life or previous struggles. Literature has emphasised the importance of using self-disclosure ethically within the parameters of professional conduct; however, when used appropriately, it can relieve MHSUs' anxieties and elicit greater liking towards workers (Henretty & Levitt, 2010; Peterson, 2002). Particularly when MHSUs receive self-disclosure, which is

perceived to be similar to their own experiences, positive attitudes towards the discloser are heightened further, thus suggesting that elements of ISC and SAB may intrinsically be at play (Sprecher et al., 2012).

Audet and Everall's (2010) qualitative study offered further insight into this dynamic. They reported that "participants openly appreciated the coexistence of 'imperfect human' and 'professional with expertise'" (2010, p. 339, parentheses added). This balance served to demystify the role of the therapist and decreased perceived power differentials whilst still maintaining professional boundaries. Notably, even participants who initially held reservations about therapists' self-disclosures later reported benefiting from the experience. As such, this created an environment conducive to mutually respectful TRs.

As the benefits of self-disclosure further corroborated the mechanisms underlying ISC and SAB, the three avenues presented findings that may attenuate the dichotomy between MHSUs and workers. Whilst formal use of these concepts in broad-spectrum MH interventions remains scant, their successful applications in other contexts—such as general healthcare and one-to-one therapy—indicate their potential to improve MHSUs' attitudes towards MH workers as collective.

2.2. Social Marketing

Kotler and Zaltman (1971) described social marketing (SM) as the "design, implementation, and control of programs calculated to influence the acceptability of social ideas" (1971, p. 5, parentheses added). Unlike traditional marketing, it does not target profit generation. Instead, it leverages marketing skills to effect social change in a manner that is purposefully designed, and communicated at mass. Independent studies and systematic reviews have evidenced that poster-based SM approaches can improve both long-term behaviours (e.g. regular exercise) and deep-seated attitudes (e.g. prejudice towards marginalised groups) in a low-cost yet highly scalable manner (Almestahiri et al., 2017; Barik et al., 2019; Sampogna et al., 2017; Truong, 2014).

Thornicroft et al. (2008) studied MH-related stigma and discrimination, and stated that some of the strongest evidence for "active ingredients" to reduce stigma points towards SM interventions at the national level (Thornicroft et al., 2008, p. 5, parentheses added). Further, ISC literature has corroborated that posters, brochures, or websites are effective mediums for conveying safety cues (Cipollina & Sanchez, 2019). Montoya and Horton (2012) highlighted that especially if the cues are assessed prior to the similarity evaluation—i.e., MHSUs view posters before interacting with MH workers—positive perceptions are likely to be heightened.

I have noted limited usage of SM approaches towards improving MHSUs' attitudes within the current literature. However, given that the psychosocial roots of MHSUs' apprehensions operate on a societal level, SM offers a pertinent solution that would likely maintain cost-effectiveness and scalability during real-world applications. As such, to leverage ISC, SAB, and self-disclosure on a broader scale, I used a poster-based SM approach to which highlighted MH workers' own previous MH struggles, thus conveying allyship and encouraging attitude improvement.

2.3. Further Gaps in Literature

In addition to the lack of viable interventions to improve MHSUs' attitudes towards workers, I propose further shortcomings in research that warrant attention. Addressing these gaps would not only enhance the existing knowledge base, but also provide more nuanced insights into the efficacy of my proposed intervention.

Firstly, the majority of studies investigating MHSUs' attitudes are qualitative. They largely lack quantitative or mixed-methods approaches, and notably omit implicit attitude measures altogether. Whilst these have provided valuable insights, they remain open to subjectivity and response biases, and lack generalisability due to interviews with small and niche samples (Berzins et al., 2020; Stewart et al., 2014).

Explicit attitudes are conscious, deliberative evaluations that can be intentionally reported and discussed, whereas implicit attitudes are subconscious evaluations that occur without conscious control and must be measured through indirect methods (Greenwald & Banaji; 1995). Therefore, given that poor attitudes towards MH workers may often stem from subconscious apprehensions of discrimination and power imbalances, it is crucial to understand MHSUs' implicit attitudes. Interestingly, Brener et al. (2013) found that whilst MH workers' explicit attitudes towards MHSUs were somewhat positive, their implicit attitudes were somewhat negative, with only the latter predicting helping intentions. In turn, current research falls short in investigating any such contrasts in MHSUs' attitudes towards workers.

Secondly, I noted that studies investigating MHSUs' attitudes towards MH workers largely contained homogeneous samples. They primarily focused on hospitalised individuals with psychosis, or individuals receiving private, one-to-one therapy (Farrelly & Lester, 2014; Verhaeghe & Bracke, 2011). Resultantly, current literature is not generalisable towards the broader array of disorders and service types that are commonly documented in the UK (NHS Digital, 2016).

To understand MHSUs' attitudes and test the intervention's effectiveness in a holistic manner, I devised a mixed-methods study that employed implicit and explicit quantitative and qualitative measures. Further, I strived to recruit individuals with a diverse range of MH-related diagnoses and histories. As such, data collection and analyses were guided by the following research questions:

- RQ1: How will the poster-based SM intervention impact MHSUs' implicit attitudes towards MH workers as a collective?
- RQ2: How will the poster-based SM intervention impact MHSUs' explicit attitudes towards MH workers as a collective?

- RQ3: How will MHSUs' demographic characteristics and MH histories impact the efficacy of the poster-based SM intervention?
- RQ4: Which notable themes will emerge regarding qualitative opinions of MH workers and services among a diverse sample of MHSUs?
- RQ5: How will the qualitative data regarding MHSUs' attitudes differ between the Intervention and Control Groups?

My two primary hypotheses were as follows:

- H1: Exposure to a poster-based SM intervention highlighting MH workers' own MH struggles will yield more positive implicit attitudes towards workers, compared to no exposure.
- H2: Exposure to a poster-based SM intervention highlighting MH workers' own MH struggles will yield more positive explicit attitude scores towards workers, compared to no exposure.

I chose to omit hypotheses relating to the qualitative data to streamline analysis and facilitate an exploratory, data-driven approach. Instead, I aimed to address RQs 4 and 5 within my qualitative analysis.

In sum, this research responded to the call to action by previous scholars and the EPA for targeted interventions to improve MHSUs' attitudes towards MH workers (Gaebel et al., 2014; Patterson et al., 2013). By addressing this gap in research, I hoped to disrupt the cycle of stigma and disengagement, which may lead to improved outcomes for MHSUs, workers, and organisations collectively.

3. Method

3.1. Participants

I conducted an a priori power analysis via G*Power V. 3.1 software, yielding an optimal sample size of 170 participants for a multiple linear regression detecting an R^2 increase; assuming a small-to-medium effect size (d = .29), 95% power, and α = .05 (Cohen, 1988; Faul et al., 2007). I specified 47 total predictors, and 41 tested predictors to limit multicollinearity through reference category coding. The selected effect size reflected findings from systematic reviews of SM interventions (Almestahiri et al., 2017).

Data collection occurred between June 3rd-26th, 2023. I initially recruited participants through volunteer sampling via social media, MH charities, and unpaid recruitment websites (www.callforparticipants.com, www.surveyswap.io, www.surveycircle.com). To incentivise participation, respondents could win one of five £10 Amazon vouchers. I later supplemented the sample through the paid recruitment platform 'Prolific' (www.prolific.co) to minimise the risk of an underpowered study. Prolific participants received £1.62—the equivalent of £6.50 per hour—as compensation for their involvement.

Participants were screened according to six eligibility criteria. Participants should:

i) be above the age of 18 to minimise ethical issues and confounds resulting from being a young person in the MH system;

ii) be fluent in English to understand the questionnaire;

iii) have used MH services in the past five years to ensure recent, first-hand interaction with MH workers;

iv) have used UK-based MH services to minimise confounding effects of largely varying services and cultural stigmas;

v) not have worked in the MH field professionally to minimise biases; and

vi) be able to participate in the study using a laptop or desktop to complete the IAT.

Participation was voluntary, and all participants provided informed consent for procedures approved by the London School of Economics and Political Science's Research Ethics Committee. To minimise response biases, minor deception was used. Participants were told that the study aimed to understand—rather than improve—attitudes. The true aim was clarified during the debrief, and no participants raised concerns. I utilised non-identifiable participant codes and anonymity settings on the online survey platform 'Qualtrics' (www.qualtrics.com) to ensure that no personally identifiable data was collected.

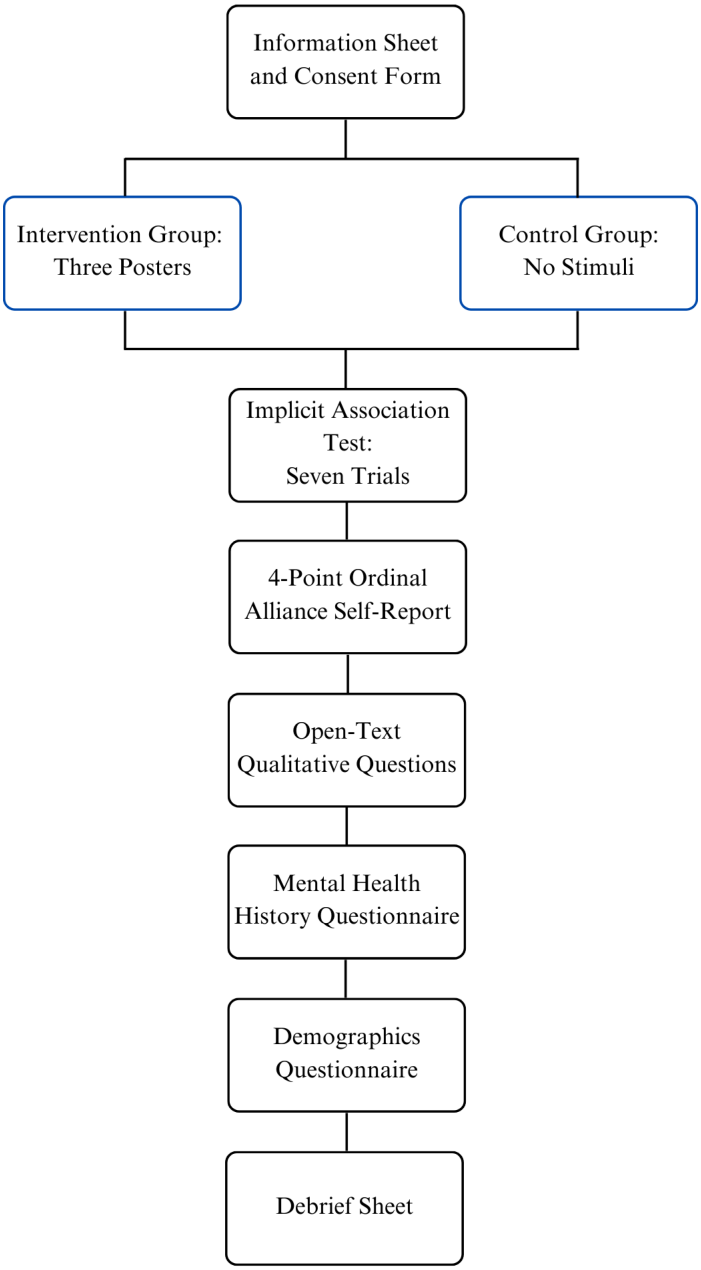
I recruited 179 participants and excluded three due to incomplete responses. The final sample of 176 participants included 120 females (68.18%) and four individuals identifying as 'other' (2.27%). Ages ranged between 19 to 80 years old (M[SD] = 36.15[13.92]), with a skew towards younger participants as 46.6% were 20-30 years old. 157 (89.2%) participants belonged to a White ethnic group. Appendix A contains an overview of sample characteristics. A sensitivity analysis suggested that the final sample would allow detection of the intended minimum effect size, $d = .29$, for a multiple linear regression with 95% power.

3.2. Procedure

I conducted an online two-group, between-subjects, randomised control experiment on Qualtrics, wherein block randomisation ensured a roughly equal number of participants across both groups. The Control Group ($n = 84$) completed implicit and explicit attitude measures with no prior stimuli, whilst the Intervention Group ($n = 92$) completed the attitude measures after evaluating a series of SM posters. Participants took approximately 15 minutes to complete the experiment, depicted in Figure 1 (see Appendix B for full survey content).

Figure 1

Overview of the Experimental Design



3.3. Materials

3.3.1. Intervention Posters

Almestahiri et al. (2017) and Andreasen (2002) proposed seven key components of SM (see Table 1). Kubacki et al. (2017) demonstrated that interventions are more successful when using a larger number of these components simultaneously. However, I decided to omit 'segmentation' given monetary constraints and aims to test the intervention with a diverse array of MHSUs. Therefore, I used six out of seven components to inform the intervention's development (see Table 3).

Table 1

Key SM Components Informing the Development of a Poster-Based Intervention to Improve MHSUs' Attitudes Towards MH Workers

Components of SM*	Meaning	Use within the Current Intervention
1. Theory	The intervention design is guided by established behavioural theories and frameworks.	The intervention used quotes from MH workers who had experienced MH struggles, leveraging theories of ISC, SAB, and self-disclosure to evoke trust.
2. Behaviour Change	The intervention is guided by a clear, achievable, and measurable behavioural goal.	The intervention aimed to improve MHSU's attitudes (rather than behaviours) towards MH workers. Attitudes, such as perceptions of TRs, are highly predictive of therapeutic engagement and are measurable via implicit and explicit self-report measures.
3. Audience	The intervention takes a customer-centric approach whereby the audience's needs, attitudes, and beliefs have been understood.	The intervention was tailored to target MHSUs' well-documented need to feel understood and empathised with by MH workers.
4. Competition	Barriers to adopting the target behaviour have been understood and addressed.	By conveying shared experiences, the intervention challenged barriers such as fear of discrimination and distrust towards staff.
5. Exchange	The intervention offers target	The quotes aimed to offer reassurance,

Components of SM*	Meaning	Use within the Current Intervention
	audiences tangible or intangible benefits in return for their behaviour change.	understanding, and empathy; these are valuable exchanges for improved attitudes towards workers.
6. Marketing Matrix (Products, Price, Place, Promotion)	*Product*: The desired behaviour and social benefit. *Price*: Costs to the audience are minimised wherever possible. *Place*: The exchange is convenient and easy. *Promotion*: The intervention is communicated through a medium that is relevant to, and preferred by the target audience.	*Product*: Improved attitudes towards MH workers, leading to better therapeutic engagement and outcomes. *Price:* Minimal costs to MHSUs, requiring little time or resources. *Place:* The poster-based intervention is easy to process, and can be easily incorporated into public posters, websites, and MH establishments. *Promotion:* Posters with quotes may be relatable and eye-catching for MHSUs.
7. Segmentation	Dividing the target audience into groups to facilitate different modes of intervention delivery.	Segmentation was not used due to monetary constraints, and to pilot the intervention with a diverse range of MHSUs.

Note. *Andreasen, 2002; Almestahiri et al., 2017.

I developed three intervention posters based upon the SM components, and informed by ISC, SAB, and self-disclosure literature (See Appendix E). Each featured shortened, adapted quotes based upon real-life experiences of MH workers, which were sourced from a video by Jami, a MH charity, and NHS England articles (NHS England, 2020; Oxford Health NHS, 2023):

i) "Ten years ago, I had severe depression. Now I'm passing on the same support that I received." - Sam P., MH Nurse

ii) "I know first hand that the path to recovery can feel lonely. Let's make the journey less lonely together." - Alex W., Peer Support Worker

iii) "I'm a psychologist. I'm a trauma survivor. I'm an ally. I'm just me, listening to you." - Kay V., Clinical Psychologist

Guided by literature regarding the ethical use of self-disclosure, I ensured that the quotes were not of a graphic nature, and were credited to gender-neutral pseudonyms for privacy and bias-reduction whilst maintaining a personable aspect (Peterson, 2002). Further, all posters shared a common design. Images were featured to capture the audience's attention and depict a meaningful exchange; moreover, best efforts were made to limit biases by featuring images of race- and gender-ambiguous 'comforting hands'.

Each poster was accompanied by the prompt "In a few words, please describe your initial thoughts upon seeing this poster" to encourage sufficient engagement, and gather feedback for the intervention posters.

3.3.2. Implicit Attitudes

I measured participants' implicit attitudes towards MH workers using a reaction-time test known as the 'Implicit Association Test' (IAT). The IAT assesses subconscious associations via the speed—or relative ease—at which stimuli words (e.g. rose, beetle, happy, angry) are correctly assigned to target categories (e.g. flowers versus insects) or attribute categories (e.g. positive versus negative) when these categories are paired together in alternating orders. These assignments are made using two response keys on the keyboard (e.g. 'E' and 'I'). The underlying assumption is that if a target and attribute category are mentally congruent for the participant, they should be able to answer quicker using a shared response key, versus a separate response key (Greenwald et al., 1998).

Whilst the IAT was not a direct measure of TRs, it indicated general subconscious perceptions which may be valuable in holistically understanding participants' attitudes towards MH workers. I specifically chose to use the IAT because, amongst other implicit measures, it showed the greatest evidence of construct validity, predictive validity, internal consistency (usually $\alpha = .80$), and rest-retest values (usually $r = .60$) (Greenwald et al., 1998; Perugini, 2005). The IAT produced the first outcome variable, 'D-Score', which was calculated as the difference in mean latencies of two test blocks, divided by the standard deviation of block

latencies. D-Score can range between +2 (bias towards target category A, e.g., flowers) to -2 (bias towards target category B, e.g., insects), with 0 indicating no significant bias (Nosek et al., 2014).

I used 'IATgen' software to develop IAT code, and embedded it into Qualtrics (Carpenter et al., 2019). The IAT featured seven trial blocks involving two target categories - 'MH Workers' and 'Office Workers', and two attribute categories - 'Positive' and 'Negative' (see Table 2).

Table 2

Example IAT Block Structure

Block	Number of Trials	Function	Items Assigned to Left-Key (E) Response	Items Assigned to Right-Key (I) Response
1	20	Practice	MH Workers	Office Workers
2	20	Practice	Positive	Negative
3	20	Practice	MH Workers + Positive	Office Workers + Negative
4	40	Test	MH Workers + Positive	Office Workers + Negative
5	20	Practice	Office Workers	MH Workers
6	20	Practice	Office Workers + Positive	MH Workers + Negative
7	40	Test	Office Workers + Positive	MH Workers + Negative

Note. The positioning of the 'MH Worker' category on the right or left of the screen and its pairing with 'Positive' or 'Negative' words were randomised and counterbalanced among the participants to reduce order effects. This table displays one of four possible block structures:

i) Compatible first - 'Mental Health Workers' on right initially paired with 'Positive';

ii) Incompatible first - 'Mental Health Workers' on right initially paired with 'Negative';

iii) Compatible first - 'Mental Health Workers' on left initially paired with 'Positive'; and

iv) Incompatible first - 'Mental Health Workers' on left initially paired with 'Negative'.

I selected 'Office Workers' as a comparison for 'MH Workers' based on Warriner et al.'s (2013) database of 41,745 lexical ratings, cross-referenced with Scott et al.'s (2018) database to ensure internal reliability. The databases showed that valence ratings for words such as 'receptionist', 'accountant', and

'administrator' were neutral and comparable to words such as 'psychologist', 'counsellor', and 'psychoanalyst'. As the average valence rating for all occupation-related words was 5.2 (on a scale of one as 'extremely negative' to nine as 'extremely positive'), all chosen words were within one point of this average - theoretically ensuring minimal inherent biases towards either category. Due to insufficient MH worker-related words, I added "psychotherapist" and "support worker". I selected attribute category words from Bradley and Lang's (1999) database of lexical ratings for 1,040 words. Following the authors' guidelines, I selected words with valence scores above seven for the 'Positive' category and words with scores below three for the 'Negative' category. All word-selection procedures complied with recommendations from Axt et al.'s (2021) review of appropriate words for IATs (see Appendix C for stimuli words and corresponding valence ratings).

3.3.3. Explicit Attitudes

3.3.3.1. 4-Point Ordinal Alliance Self-Report

I quantitatively assessed participants' explicit attitudes towards MH workers using the 4-Point Ordinal Alliance Self-Report (4-POASR), a scale designed for understanding MHSUs' perceptions of TRs with their doctors (Misdhari et al., 2009). The 4-POASR was originally tested with MHSUs to ensure its relevance and clarity, even with individuals with moderate-to-high symptomatology. The scale showed high internal consistency ($\alpha = .91$), and high concurrent validity when correlated with the Medication Adherence Rating Scale (MARS), suggesting that it may be indicative of tangible therapeutic outcomes (Misdhari et al., 2009).

For this study, I adapted the scale's items to focus on attitudes towards "mental health workers" rather than "my doctor" to capture broader sentiments towards MH professionals as a collective (see Appendix D). The 11-item questionnaire used a 4-point Likert scale, ranging from 1 (strongly disagree) to 4 (strongly

agree), to capture attitudes. I summed the item responses to produce the second outcome variable, '4-POASR Score,' which could range from 11 to 44, with higher scores indicating better-perceived TRs. I used Qualtrics' randomiser function to minimise order effects, maintaining internal validity.

3.3.3.2. Open-Text Questions

The questionnaire featured two open-text questions: *i)* "Please describe your overall opinion of mental health *workers* in 200 words or fewer"; and *ii)* "Please describe your overall opinion of mental health *services* in 200 words or fewer". To answer RQs 4 and 5, I maintained simple content and wording, ensuring broad applicability to different types of MHSUs and minimising response biases. I counterbalanced the question orders to maintain internal validity.

3.3.4. Additional Measures

I collected data regarding eleven covariates to increase the precision of regression model estimates, adjust for confounders, and explore potential interactions (see Table 3).

Table 3

List of Covariates and Reasons for their Inclusion

Covariate	Reasoning
Age	Different age groups may have varying experiences, outcomes, and perceptions in MH contexts (Fiske et al., 2009).
Gender	Gender-specific barriers to service utilisation and differing therapeutic experiences may impact perceptions of workers and services (Barn, 2008).
Ethnicity	May affect perceptions of trust and power imbalances, particularly amongst minority groups (Burgess et al., 2008; Memon et al., 2016).

Covariate	Reasoning
Education	Correlates with health literacy and stigma perceptions may influence views and interactions in MH contexts (Yan et al., 2022).
Recruitment Source*	Varying characteristics and heterogeneity amongst participants from different platforms may influence regression estimates.
Types of MH Services Used	May shape attitudes towards MH staff. Studies have described poor attitudes amongst hospital in-patients, whilst limited literature regards community-based MHSUs (Rose et al., 2013; Stewart et al., 2014).
Types of MH Concerns Experienced	Certain MHSU groups with psychosis or personality disorders may be more vulnerable to cycles of stigmatisation, distrust, and disengagement (Henderson et al., 2014; Verhaeghe & Bracke, 2011).
Ongoing Support Status*	May differentiate attitudes based on current versus past support.
Helpfulness Ratings for MH Services	Varying experiences with MH services may impact present attitudes towards MH workers (Hopkins et al., 2009).
Prior Disputes	Disputes with MH professionals can exacerbate feelings of powerlessness and distrust (Bhui et al., 2006).
Dispute Severity*	As above, greater severity of disputes may further damage TRs.

Note. *Exploratory covariates.

3.4. Data Moderation

I applied exclusion criteria to both IAT and 4-POASR data to bolster internal validity and reliability. For the IAT, trials exceeding 1000 milliseconds were removed to filter out explicit attitudes, and participants with over 10% of trials under 300 milliseconds were excluded to minimise random responses. For the 4-POASR, I employed an attention check, and failing this resulted in exclusion from the analysis.

3.5. Pilot Study

I conducted a pilot study with 14 participants to evaluate the questionnaire's duration, ease of use, clarity, and display issues. While feedback was largely positive, three participants found the survey length

excessive. Consequently, I removed redundant prompts (e.g. signposts to the next tasks) and introduced a progress bar to facilitate better survey flow and time estimation.

4. Results

4.1. Descriptive Statistics

All participants had used between one to seven different types of MH services (M[SD = 2.16[1.35]), and reported experiencing one to six different types of MH concerns (M[SD = 2.26[1.09]). Of them, 70 (39.8%) were receiving ongoing MH support. Service helpfulness ratings varied between 1 to 100 (M[SD] = 63.02[22.20]). 40 participants (22.7%) reported previous involvement in disputes, with severity ranging from 1 to 81 (M[SD] = 36.92[25.93]). Balance tests showed no significant differences between Control and Intervention Group demographics at the 95% confidence level, except in gender, use of counselling services, and the average number of MH services used (see Tables A1 and A2 in Appendix A for an overview of all demographics and balance checks). These variations were ascribed to random assignment and constraints inherent in volunteer sampling, with some further exacerbated by the limited size of certain demographic subgroups.

Three participants were omitted from the IAT analysis, and two from the 4-POASR, per exclusion criteria in Section 3.4. The 4-POASR scale showed high internal consistency (Cronbach's $\alpha = .94$). For D-Score, 20.2% displayed a negative bias, and 79.8% displayed a positive bias. However, of the latter, 73.2% ($n = 101$) held weak-to-moderate biases, whilst only 26.8% ($n = 37$) held highly positive biases (D-Score $\geq .65$). For 4-POASR Score, 80.1% of participants scored above the halfway value of 27.5 out of 11 to 44. Thus, participants largely showed positive implicit and explicit attitudes towards MH workers. Further descriptive statistics for D-Score and 4-POASR Score are in Table 4, whilst Figures 2 and 3 depict their

respective bar charts. Further means, standard deviations, and correlations amongst the outcome variables and covariates are detailed in Table A3 in Appendix A.

Table 4

Descriptive Statistics for D-Score and 4-POASR Score

Variable	Condition	n / N	Min.	Max.	Mean	SD
D-Score	Control Group	83	-.91	1.26	.22	.46
	Intervention Group	90	-.82	1.39	.43	.37
	Overall	173	-.91	1.39	.33	.43
4-POASR Score	Control Group	82	14	44	33.84	6.92
	Intervention Group	92	14	44	33.20	7.0
	Overall	174	14	44	33.50	6.95

Note. Three participants excluded from the D-Score analysis, and two participants excluded from the 4-POASR Score analysis.

Figure 2

Bar Chart of Means of D-Score in the Control and Intervention Group

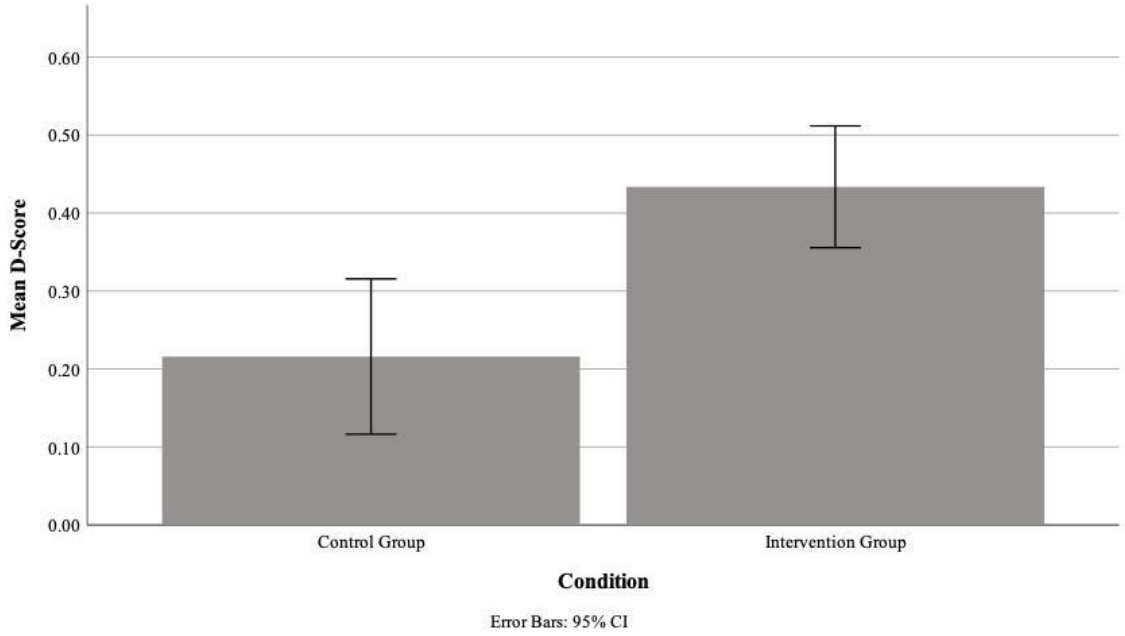
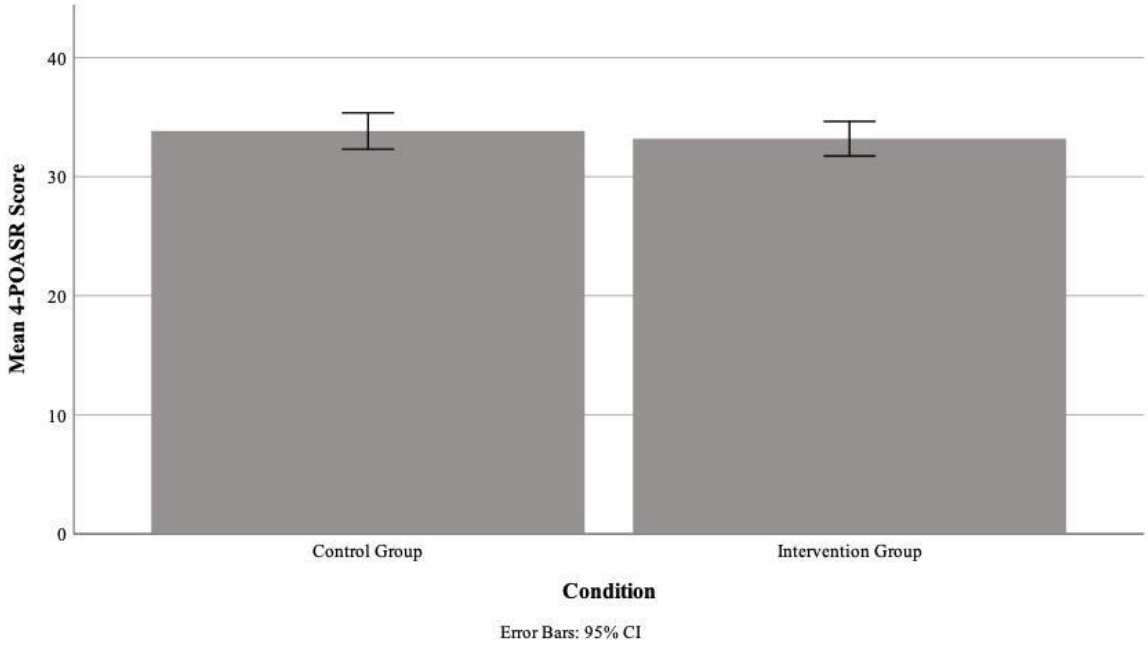


Figure 3

Bar Chart of Means of 4-POASR Score in the Control and Intervention Group



4.2. H1 Hypothesis Testing: Can the poster intervention improve implicit attitudes towards MH workers?

4.2.1. Simple Linear Regression

I conducted an Ordinary Least Squares (OLS) linear regression (R1) to investigate whether assignment to the Intervention Group significantly influenced D-Score, and to assess the directionality and extent of the predicted relationship. The data met all key assumptions of independence, normality, homoscedasticity, and linearity (see Appendix F). I observed no outliers, as no observations deviated more than 3.29 SDs away from the grand mean (M[SD] = .33[.43]) (Min. = -3.02, Max. = 2.51) (Tabachnick et al., 2013; Verkoeijen et al., 2018).

The R1 results were significant, $F(1,171) = 11.89$, $p < .001$, $R^2 = .07$, indicating that approximately 7% of the variation in D-Score could be attributed to Condition assignment. Intervention Group assignment significantly predicted D-Score, $B = 0.22$, $t(171) = 3.45$, $p < .001$, increasing it by an average of 0.22 units and thereby providing initial support for H1 (see Table 5).

Table 5

R1: Regression Analysis Results of Intervention Group's Impact on D-Score

Variable	*B*	*SE*	95% CI	β	*t*	*p*
(Intercept)	0.22	0.05	[0.13, 0.31]	0.00	4.74	< .001**
Condition - Intervention	0.22	0.06	[0.09, 0.34]	0.25	3.45	< .001**

Note. Results: $F(1,171) = 11.89$, $p < .001$, $R^2 = .07$

Unstandardized Regression Equation: DScore = 0.22 + 0.22*ConditionIntervention

* $p < .05$, ** $p < .01$

4.2.2. Multiple Linear Regressions

I conducted an OLS multiple linear regression (R2) to examine whether Intervention Group assignment continued to predict a significant increase in D-Score when controlling for all other covariates. I re-coded all categorical variables into dummy variables to allow for appropriate analysis, and combined ethnicity groups into broader ethnicities (White, Asian, Black, Mixed Race, Other) to prevent excessively small sub-groups. The data met all key assumptions except for normality; however, this was not required for the validity of the OLS regression (see Appendix G) (Schmidt & Finan, 2018). I observed no outliers, as no observations deviated more than 3.29 SDs away from the grand mean (M[SD] = .33[.43]) (Min. = -2.64, Max. = 2.53) (Tabachnick et al., 2013; Verkoeijen et al., 2018).

The R2 model was non-significant overall; although this can be attributed to the presence of multiple non-significant predictors, $F(43,129) = 1.13$, $p = .300$, $R^2 = .27$. However, Intervention Group assignment continued to predict a significant increase in D-Score, $B = 0.21$, $t(129) = 2.80$, $p = .006$. Additionally, involvement in previous disputes also predicted a significant increase in D-Score, $B = 0.32$, $t(129) = 2.04$, $p = .04$ (see Table G2 in Appendix G).

I conducted further robustness checks to corroborate the findings. Firstly, R3 and R4 examined the effects of covariate interaction terms. Both showed no significant effects of any predictors on D-Score, except for Intervention Group assignment, after removing highly correlated predictors to reduce multicollinearity (see Tables G3 and G4 in Appendix G). Secondly, R5 examined the effects of a better-fitting model having removed highly non-significant predictors ($p > .5$); this reaffirmed Intervention Group assignment's significant impact on D-Score, $B = 0.22$, $t(158) = 3.39$, $p < .001$. R5 additionally highlighted that using crisis intervention services, $B = -0.25$, $t(158) = -2.29$, $p = .023$, and being involved in previous disputes, $B = 0.26$, $t(158) = 2.17$, $p = .032$, could also predict significant changes in D-Score (see Table G5 in Appendix G).

Table 6 summarises the coefficients and *p*-values for Intervention Group assignment across R1-R5, and shows that small-to-medium effect sizes could be detected as a minimum. Given that Intervention Group assignment reliably predicted a significant increase in D-Score by 0.2 to 0.25 units across all regression models, I rejected the null hypothesis in support of H1.

Table 6

Intervention Group Assignment Coefficients, P-Values, and Sensitivity Analyses for All Regressions of D-Score

Regression Model	*B* for Condition - Intervention	*p* for Condition - Intervention	Tested Predictors	Total Predictors	Minimum Detectable Effect Size (*d*)
R1: Simple linear regression	.22	< .001**	1	47	.076
R2: Multiple linear regression, all covariates	.21	.006**	43	47	.29
R3: Multiple linear regression, including demographic interactions	.20	.034*	17	47	.19
R4: Multiple linear regression, including MH-related demographic interactions	.25	.003**	9	47	.15
R5: Multiple linear regression, highly non-significant predictors removed	.22	< .001**	14	47	.17

Note. All sensitivity analyses were conducted with input parameters specified as $\alpha = 0.05$, 95% power, and 173 participants for a linear regression detecting an R^2 increase.

* $p < .05$, ** $p < .01$

4.3. H2 Hypothesis Testing: Can the poster intervention improve explicit attitudes towards MH workers?

4.3.1. Simple Linear Regression

I conducted an OLS linear regression (R6) to investigate whether Intervention Group assignment significantly influenced the 4-POASR Score, and to assess the directionality and extent of the predicted relationship. The data met all key assumptions except for normality (see Appendix H). I observed no outliers, as no observations deviated more than 3.29 SDs away from the grand mean (M[SD] = 33.50[6.95]) (Min. = -2.85, Max. = 1.55) (Tabachnick et al., 2013; Verkoeijen et al., 2018).

The R6 results were non-significant, $F(1,172) = 0.37$, $p < .542$, $R^2 = .002$, indicating that Intervention Group assignment did not explain a significant proportion of variation in 4-POASR Score and thus provided no initial support for H2 (See Table 7).

Table 7

R6: Regression Analysis Results of Intervention Group's Impact on 4-POASR Score

Variable	*B*	*SE*	95% CI	β	*t*	*p*
(Intercept)	33.84	0.77	[0.13, 0.31]	0.00	43.99	< .001
Condition - Intervention	-0.65	1.06	[0.09, 0.34]	-0.05	-0.61	0.54

Note. Results: $F(1,172) = 0.37$, $p < .542$, $R^2 = .002$

Unstandardized Regression Equation: 4-POASR = 33.84 - 0.65*ConditionIntervention

4.3.2. Multiple Linear Regressions

I conducted an OLS multiple linear regression (R7) to examine whether Intervention Group assignment could increase the 4-POASR score when controlling for all other covariates. The data met all key assumptions except for normality (see Appendix I). I observed no outliers, as no observations fell more than

3.29 SDs away from the grand mean (M[SD] = 33.50[6.95]) (Min. = -2.56, Max. = 2.57) (Tabachnick et al., 2013; Verkoeijen et al., 2018).

Although the R7 model was significant overall, $F(43,130) = 7.82$, $p < .001$, $R^2 = .72$, accounting for 72% of the variance in 4-POASR score, Intervention Group assignment continued to remain a non-significant predictor, $B = .02$, $t(130) = .03$, $p = .978$. Instead, significant increases were predicted by using residential care services, $B = 6.04$, $t(130) = 2.01$, $p = .047$; having bipolar disorder, $B = 3.87$, $t(130) = 2.05$, $p = .042$; and helpfulness ratings, $B = 0.25$, $t(130) = 15.19$, $p < .001$. Additionally, significant decreases were predicted by using hospital in-patient services, $B = -3.52$, $t(130) = -2.21$, $p = .029$ (see Table I2 in Appendix I). Similarly, further robustness checks involving covariate interaction terms (R8 and R9), and a better-fitting model having removed highly non-significant predictors (R10), reaffirmed that Intervention Group assignment remained a non-significant predictor of changes in 4-POASR Score (see tables I3, I4, and I5 in Appendix I).

Table 8 summarises the coefficients and *p*-values for Intervention Group assignment across R6-R10, and shows that small-to-medium effect sizes could be detected as a minimum. Given that Intervention Group assignment did not predict significant increases in 4-POASR score within any regression model, I rejected H2 and accepted the null hypothesis.

Table 8

Intervention Group Assignment Coefficients, P-Values, and Sensitivity Analyses for All Regressions for 4-POASR Score

Regression Model	*B* for Condition - Intervention	*p* for Condition - Intervention	Tested Predictors	Total Predictors	Minimum Detectable Effect Size (*d*)
R6: Simple linear regression	-.65	.54	1	47	.076
R7: Multiple linear regression, all covariates	.02	.98	43	47	.29
R8: Multiple linear regression, including demographic interactions	-1.66	.43	27	47	.23
R9: Multiple linear regression, including MH-related demographic interactions	.1	.95	17	47	.19
R10: Multiple linear regression, highly non-significant predictors removed	-.04	.95	16	47	.18

Note. All sensitivity analyses were conducted with input parameters specified as $\alpha = 0.05$, 95% power, and 174 participants for a linear regression detecting an R^2 increase.

4.4. Qualitative Analysis

I employed a data-driven, thematic analysis approach to further understand MHSUs' explicit attitudes towards MH workers and services, addressing RQs 4 and 5. I followed Braun and Clarke's (2006) six stages of thematic analysis: *i)* data familiarisation; *ii)* semantic coding; *iii)* broader theme identification; *iv)* theme review; *v)* theme naming and definition; and *vi)* narrative construction. I used NVivo V. 14 software to log codes and themes.

Scholars in qualitative research advise against checking for reliability and validity as it may produce inappropriate and misleading results (Stenbacka, 2001). Instead, to maintain methodological rigour, I focused on the 'trustworthiness' of the data, which comprised:

i) *Credibility,* achieved by triangulating recruitment sources to obtain data from participants with diverse MH backgrounds, thus reducing bias;
ii) *Dependability,* ensured by providing a detailed description of analysis methods;
iii) *Transferability,* increased by using an identical questionnaire for all participants and providing a detailed list of demographics; and,
iv) *Confirmability,* ensured by maintaining awareness of personal biases, such as confirmatory bias, by analysing the data as a whole rather than according to Conditions or a given hypothesis (Golafshani, 2003; Morse, 2015; Thomas & Magilvy, 2011).

4.4.1. Qualitative Attitudes Towards MH Workers and Services

I analysed 352 text pieces resulting from the open-text questions regarding participants' opinions of MH workers and services (per Section 3.3.2.2). These comprised 7,573 words in the 'worker' category and 7,659 in the 'services' category. This yielded 1,026 coded excerpts, classified into 79 codes, 22 sub-themes, and eight overarching themes (see Figure 4). The Control Group contributed 504 excerpts, whilst the Intervention Group contributed 522.

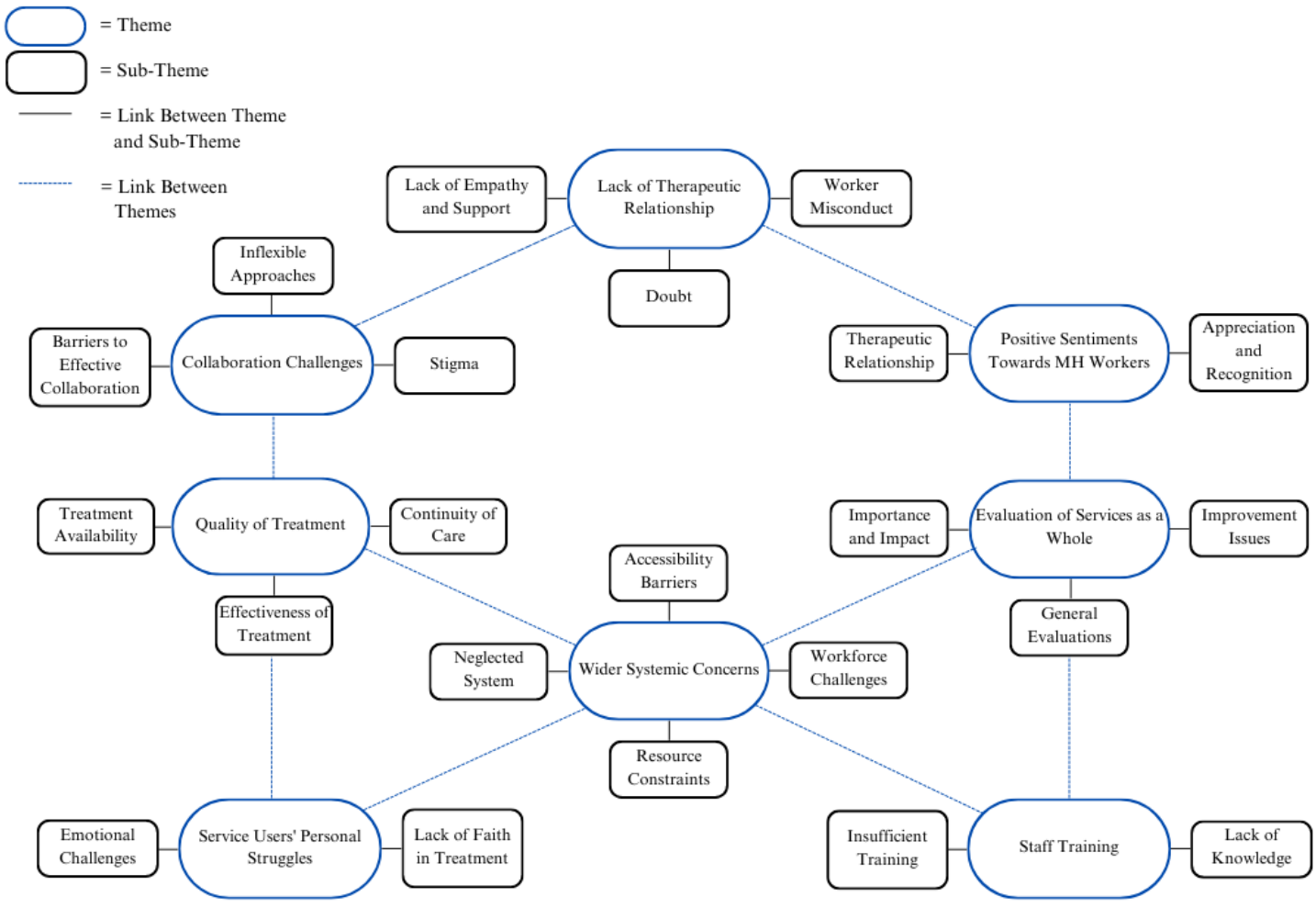
In response to RQ5, both groups showed similar attitudes, with themes generally featuring equal distributions of excerpts from each group. For positively connotated codes, the Control Group had a higher number of excerpts in 11 codes, whilst the Intervention Group had more in 10. Conversely, for negatively

connotated codes, the Control Group had more excerpts in 25 codes, and the Intervention Group had more in 23. Within 10 codes, the number of excerpts from both groups was equal.

I detail each theme in Sections 4.4.1.1-4.4.1.8, whilst a full overview of codes and example excerpts can be found in Appendix J.

Figure 4

Thematic Map of Participants' Opinions of MH Workers and Services



4.4.1.1. Wider Systemic Concerns

Comprising almost a third of all coded excerpts (327), 'Wider Systemic Concerns' was a central theme within the data, interlinked with several others. It chiefly highlighted difficulties in accessing services, whereby participants reported struggling with lengthy processes and long waitlists, forcing some to seek faster, albeit pricier, private care.

> *"I myself had to wait about 6 months before I could get the help I needed from the NHS. I have since got private treatment but this isn't an option that's affordable to everyone." — P43*

Within the 'Resource Constraints' sub-theme, participants criticised the UK MH system as being poorly structured, underfunded, and subsequently overburdened.

> *"There is not enough services nor funding to keep up with demand which can lead to a breakdown in services - meaning they are not providing an expected level of care that would have been promised" — P7*

The 'Workforce Challenges' sub-theme, with 72 excerpts, acknowledged that the workforce may face several pressures such as underpayment, overwork, and staff shortages - ultimately resulting in poor standards of care.

> *"Over-working the mental health workers as a result of short-staffing results in worse services." — P147*

4.4.1.2. Positive Sentiments Towards MH Workers

The second-most populated theme, with 285 excerpts, encapsulated participants' acknowledgement of MH workers' crucial roles, and recognition of their emotional challenges.

> *"They have a significant impact on their clients' lives, (...) However, they also face considerable challenges, such as high levels of stress and burnout due to the emotionally demanding nature of their work." — P41*

The 'Therapeutic Relationship' sub-theme comprised 188 excerpts referring to MH workers' positive qualities and ability to understand MHSUs.

> *"I feel that they have provided a listening ear whilst also challenging me at times. They have understood where I am coming from and enabled me to understand my own experiences better." — P159*

4.4.1.3. Collaboration Challenges

Several participants acknowledged that workers may struggle to understand MHSUs' viewpoints due to lack of lived experience and MHSUs' difficulties in conveying such hardships.

> *"It is often very clear when working with them that they can't truly understand what it feels like inside the mind of someone who has these issues, despite their desire to help. I felt this can make it difficult to connect." — P144*

Participants also reported instances of MH workers exhibiting rigid thinking, and relying on generic or impersonal strategies without making an effort to consider MHSUs' perspectives.

> *"I feel they sometimes rely on 'textbook' definitions or theories and can dismiss the patient's view if it*

doesn't match them." — P58

Within the 'Stigma' sub-theme, a small number of participants (n = 11) recounted instances of MH-related discrimination within services and daily life, criticising the lack of effort to diminish this stigma.

"In my experience, if you're wellish (i.e. not psychotic) people treat you much better. If you're actually severely ill though, way more workers act shitty, as if you won't even remember it or you're not even human. Or they treat you like a child. And the problem is, there is no recourse to complain because we all know how that will work out. The power differential is not in my favour." — P121

4.4.1.4. Quality of Treatment

Across several codes in this theme, participants voiced dissatisfaction with current treatment and support options. They attributed poor care to various factors, including a lack of diverse treatment options, poor continuity of care, and ineffective therapeutic techniques. Notably, only two participants reported satisfactory continuity of care.

"Access to quality care varies greatly depending on geographic location, socio-economic status, and cultural background. Additionally, stigma around mental health often discourages individuals from seeking help. I have a friend that died after being let down by mental health services. After many cries for help they let it go until it was too late." — P41

4.4.1.5. Evaluation of Services as a Whole

39 excerpts conveyed positive, general evaluations of MH services, and acknowledged their importance.

"I have had a fairly good experience with services in general. They've helped me get to the better and more stable point I am today, and although there is a lot that could be better, they've still helped

and deserve points for that." — P34

Conversely, 11 participants conveyed negative sentiments, with six explicitly mentioning a need for improvement. Only two participants felt that services are currently improving.

"I have found the services generally to be very poor. The care has been non-existent" — P99

4.4.1.6. Lack of Therapeutic Relationships

The third-smallest theme, with 57 excerpts, spotlighted MH workers' negative behaviours, such as indifference and patronisation.

"I try very hard to remember that mental health workers are good people, who have worked incredibly hard to get where they are today. However, the reality is that I have been treated poorly by almost every single one I've come into contact with." — P38

Eight participants shared instances of worker misconduct.

"Totally intolerant, shout, disregard issues and make you think that you are wasting their time. This is especially so in hospital." — P111

4.4.1.7. MHSUs' Personal Struggles

This theme was closely connected to 'Wider Systemic Concerns' and 'Quality of Treatment' as participants' struggles with frustration and disillusionment were often induced by the shortcomings of the MH system, services, and workers.

"I spent years finding a counsellor that was right for me, after 35 years I found one, my GP misdiagnosed me which did not help my confidence and caused a lot of frustration. I felt I wasn't

important and it was just a day job to them." — P151

Reports of loneliness and feeling burdensome often stemmed from personal beliefs and past mistreatment within MH services.

"I always feel like the problem lies with me, that I am not 'mentally ill' but instead doing something wrong and creating a burden that the service must deal with." — P38

4.4.1.8. Staff Training

The smallest theme, with 29 excerpts, included reports of workers lacking adequate training and experience.

"Often times (beyond having a listening ear and some availability) largely unknowledgeble and for the most part under-qualified or unqualified (most certification certificates are not worth their value in paper)." — P33

In summary, the thematic analysis revealed that participants perceived numerous shortcomings in their care, largely due to systemic issues that individual MH workers cannot control. The majority of participants sympathised with workers' hardships, appreciated their positive qualities, and believed that they try their best within a strained and unsupportive system. Albeit, codes relating to MH workers' negative traits, rigidity of thinking, and lack of understanding accounted for some blame attribution towards workers.

4.4.2. Qualitative Poster Feedback

I analysed 282 text pieces, comprising 2,063 words for Poster 1 (Nurse), 1,876 words for Poster 2 (Support Worker), and 2,184 words for Poster 3 (Psychologist). This yielded 305 coded excerpts classified

into 19 codes and three broad themes. I detail each theme further in Sections 4.4.2.1-4.4.2.3, whilst a full overview of codes and example excerpts can be found in Appendix K.

4.4.2.1. Positive Sentiments

Positive sentiments constituted 63.3% (193) of the coded excerpts, with many referencing feelings of hope, comfort, support, positivity, and collaboration.

> *"It IS lonely and very difficult to connect with people during recovery so this makes me feel less alone just reading it!" — P176*

In 49 excerpts, participants appreciated the concept of MH workers sharing similar experiences and being able to relate. Reportedly, this led to feelings of power imbalances being equalised; it humanised workers, and made participants feel more comfortable with the idea of approaching services and opening up to workers.

> *"I like it - it's removing the power imbalance of doctor and patient, making the psychologist seem 'human' and experienced in life and not just academia." — P154*

Poster 1 was associated with the highest number of excerpts for inspiring hope (21), Poster 2 with feeling supported (22), and Poster 3 with the notion of MH workers understanding MHSUs (22).

4.4.2.2. Constructive Feedback

Constructive feedback constituted 19.3% (59) of the coded excerpts. 11.8% (36) of excerpts referred to aspects requiring improvement, such as using different images or changing the formatting.

> *"I find it a little bit basic and would like more information." — P99*

Alternatively, 7.5% (23) of excerpts provided positive feedback, such as the posters being eye-catching with comforting imagery.

"Good layout. The information stands out well and is quite hard hitting." — P98

4.4.2.3. Negative Sentiments

Negative sentiments constituted 16.1% (49) of coded excerpts, with participants reporting that the posters contained too much information about MH workers, thus making them too personal, intimidating, or patronising.

"Not professional, even though [the MH worker] is clearly trying to come across as empathetic and Compassionate." — P108

Some participants reported being sceptical and feeling disconnected to the quotes in the posters.

"I guess I never felt lonely in recovery while some people definitely might. Feels disconnected to the issues I experienced though." — P86

In summary, the posters received largely positive feedback, indicating considerable emotional resonance with the participants. They also received some constructive and negative feedback, which may offer insights for future iterations. I discuss the collective results' interpretations and implications further in Section 5.

5. Discussion

Despite repeated calls from the EPA and MH scholars for interventions to improve MHSUs' attitudes towards MH workers, real-world and research uptake remains scarce (Brown et al., 2009; Gaebel et al.,

2014; Hartley et al., 2020). To address these gaps, I aimed to explore the effectiveness of an SM intervention in improving MHSUs' implicit and explicit attitudes towards workers.

The study was high-powered, providing robust results with a reduced risk of false-negative errors. H1 was strongly supported, as Intervention Group assignment was a highly significant predictor of improved implicit attitudes across all regression models (R1-R5). Through exposure to the posters, weak positive biases were elevated to moderate positive biases. Conversely, H2 was rejected as Intervention Group assignment did not predict explicit attitudes across any regression models (R6-R10). Average 4-POASR scores in both groups remained moderately high, indicating perceptions of strong TRs with MH workers. I did not specify hypotheses for the qualitative data, albeit I noted no prominent between-group differences in the open-text answers. Whilst some participants discussed issues such as worker misconduct and communication challenges, several participants reported positive sentiments towards workers. The majority attributed shortcomings to broader systemic issues. Only a few participants mentioned topics including discrimination, stigma, and distrust, which literature has commonly linked to negative attitudes (Majumder et al., 2014; Priebe et al., 2005; Verhaeghe & Bracke, 2011).

As part of the poster feedback, participants communicated that the posters helped to break down barriers, humanise workers, and evoke feelings of support and understanding. The feedback suggests that the principles of ISC, SAB, and self-disclosure were leveraged appropriately, with participants interpreting the posters in the intended manner. Despite these conscious and positive evaluations, the posters only evoked improvements in implicit attitudes and not explicit attitudes.

The results contradict the majority of attitude-formation literature, which has historically asserted that implicit attitudes typically change at a gradual pace due to slow-learning and associative reasoning, whilst explicit attitudes can change rapidly through fast-learning (Rydell & McConnell, 2006). However, a study by Xiao and Van Bavel (2019) suggests that implicit attitudes can shift suddenly when preceded by 'social

identity cues' that indicate changes in intergroup context. As the posters made similarities between MHSUs and MH workers salient, participants may have rapidly viewed workers as a part of the favourable ingroup, thus improving D-Scores. Alternatively, Karpinski and Hilton (2001) would argue that rapid changes in implicit attitudes can simply arise due to priming through environmental cues, regardless of whether these views are genuinely supported by the individuals. Additionally, explicit attitudes may have remained consistent due to self-presentational or social desirability motives, whereby participants maintained favourable responses for the study (Dodou & De Winter, 2014; Steenkamp et al., 2010). A deeper understanding of the mechanisms underlying this intervention remains open to debate and warrants additional research, as suggested in Section 5.1.

5.1. Implications for Future Research

Through this study, I offered three major contributions to the existing literature. Firstly, I confirmed that highlighting similarities between MHSUs and anonymous workers can positively influence subconscious perceptions towards MH workers as a collective. To the best of my knowledge, this marked the first validation of ISC and SAB frameworks in MH settings, and advocated for broader applications of self-disclosure through SM techniques (Cipollina & Sanchez, 2019; Grant, 1993; Henretty & Levitt, 2010). Secondly, the mixed-methods approach and diverse participant pool augmented existing research, which has previously been constrained by homogeneous samples and limited methods of attitude measurement (i.e., lack of implicit measures). Finally, the results suggested that overall perceptions towards MH workers may not be as negative as previous literature has suggested; both quantitative and qualitative outcomes were positively skewed. D-Score and 4-POASR score were also weakly correlated, indicating that participants who held more positive implicit attitudes also held more positive explicit attitudes. However, given that the

Control Group's explicit attitudes were more positive than their implicit attitudes, the results provided the first evidence of a slight divide between MHSUs' conscious and subconscious perceptions.

The differing implicit and explicit attitudes partially reflect findings of previous studies, which have also shown disparities between MH professionals' implicit and explicit attitudes towards MHSUs, with only implicit attitudes predicting helping intentions (Brener et al., 2013). Since no similar studies have been conducted with MHSUs, and I did not collect behavioural measures, it is unclear how changes, or disparities, in these attitudes may impact real-world behaviours such as help-seeking and therapeutic engagement. The scholarly community is divided on this issue; while some argue that both implicit and explicit attitudes can predict behaviours, others contend that only explicit attitudes have significant predictive power, leaving the intervention's direct behavioural effects open for further exploration (Greenwald & Krieger, 2006; Karpinski & Hilton, 2001; Machery, 2021; Rudman, 2004).

As the study offered primary investigations of several theories in MH contexts, it raised further questions for future examination. Since I did not examine long-term viability due to monetary constraints, future investigators should consider using: *i)* follow-up measures to determine the durability of implicit attitude improvements after a time delay; and *ii)* a longitudinal, repeated measures design to examine whether implicit and explicit attitudes become more positive with repeated exposure to poster-based interventions. Alongside this, researchers should examine the intervention's effectiveness in large-scale, naturalistic settings to address concerns related to self-selection bias and behaviour measurement. For example, comparisons could be made between MH websites that display such posters and those that do not in terms of appointment bookings, or between in-patient wards that display such posters and those that do not in relation to serious incidents or medication compliance. Finally, future studies should focus on groups particularly vulnerable to stigma and disengagement cycles; as the current sample was notably limited in

ethnic minorities (10.8%), hospital in-patients (6.82%), and individuals with psychosis (.57%) (Burgess et al., 2008; Memon et al., 2016; Verhaeghe & Bracke, 2011).

5.2. Practical Implications

The results provide promising initial support for real-world applications. Given that the demographic variables displayed no interaction effects with Intervention Group assignment, I infer that the intervention may be equally effective across several general and MH demographics. Moreover, the characteristics of the participant pool largely reflected the wider population of MHSUs in the UK, with most individuals experiencing depression and anxiety (NHS Digital, 2016). This suggests the intervention's suitability towards improving implicit attitudes amongst a large facet of British MHSUs.

If implemented, the MHSUs' poster feedback (see Appendix K) should be used to tailor the intervention more effectively, thereby strengthening key elements of SM such as 'audience,' 'competition,' and 'exchange' (Almestahiri et al., 2017; Andreasen, 2002). Further, previous research has suggested that poster interventions are more effective when used alongside other media, such as videos, and that such similarity evaluations may be more effective in increasing liking when viewed before interacting with the targets - the MH workers (Barik et al., 2019; Montoya & Horton, 2012). Therefore, I recommend an ex-ante mass media approach to tackle perceptions of the 'us-versus-them' dichotomy at a societal level.

Separately, I encourage future researchers and policy-makers to consider the implications of my qualitative analysis of MHSUs' perceptions of services and workers. The data highlights that whilst such interventions may be relevant for improving attitudes towards workers, they cannot act as a proxy for resolving systemic issues such as lack of resources and difficulty accessing treatments. These qualitative insights could be employed to rectify broader issues that may be driving MHSUs to disillusionment, undoubtedly contributing further to the cycle of stigma and disengagement due to untreated MH concerns.

5.3. Limitations

I note that the study had limitations that must be considered to both ensure responsible interpretation of the results and inform future research. Firstly, the poster intervention may have only exerted a significant impact on implicit attitudes due to order effects, as all Intervention Group participants completed the IAT first, immediately after viewing the posters. If the posters only had a short-lived effect, it may have diminished before participants began the 4-POASR. As such, the study would have benefited from counterbalancing the order of attitudinal measures.

Secondly, the study's external validity was compromised by its lack of mundane realism. Participants engaged solely with isolated posters, whereas in real-world settings, environmental distractions could mitigate their level of engagement and response. This could result in more subdued changes in implicit attitudes in naturalistic settings.

Lastly, despite significant changes in the implicit attitudes, Intervention Group assignment only explained 7% of the variation in D-Score, whilst all predictors together explained only 27% of the variance. This could indicate that other, unknown variables may have additionally accounted for changes in implicit attitudes.

The study yielded encouraging findings for enhancing MHSU's implicit attitudes; however, given the above factors, I advise for the results to be interpreted with caution. I advocate for further investigation of the above points to ensure the intervention's efficacy prior to allowing real-world applications and expending resources.

6. Conclusion

Knowledge of the root causes of MHSU disengagement is still limited. However, in this study, I focused on one proposed cause—perceived power imbalances—and aimed to improve attitudes via a

poster-based SM intervention. My results provided support for the hypothesis that the intervention can improve subconscious attitudes towards workers. The poster did not improve explicit attitudes, which were already moderately high at baseline. I advise cautious interpretation of the results due to prominent limitations, including external validity and potential response biases. To conclude, I emphasise the onus on larger organisations to exercise their bureaucratic power to improve the approachability of MH environments, rather than relying on the limited influence of individual workers. Curbing the cycle of stigma and disengagement necessitates a recalibration of both perceived power dynamics and systemic barriers. Through the current study, I have offered results and implications that provide researchers and policy-makers with suggestions that may be valuable in improving MHSUs' engagement and treatment outcomes in the future.

References

Almestahiri, R., Rundle-Thiele, S., Parkinson, J., & Arli, D. (2017). The Use of the Major Components of Social Marketing. *Social Marketing Quarterly*, *23*(3), 232–248. https://doi.org/10.1177/1524500417704813

Andreasen, A. R. (2002). Marketing Social Marketing in the Social Change Marketplace. *Journal of Public Policy & Marketing*, *21*(1), 3–13. https://doi.org/10.1509/jppm.21.1.3.17602

Audet, C., & Everall, R. D. (2010). Therapist self-disclosure and the therapeutic relationship: a phenomenological study from the client perspective. *British Journal of Guidance & Counselling*, *38*(3), 327–342. https://doi.org/10.1080/03069885.2010.482450

Axt, J., Feng, T., & Bar-Anan, Y. (2021). The good and the bad: Are some attribute words better than others in the Implicit Association Test? *Behavior Research Methods*, *53*(6), 2512–2527. https://doi.org/10.3758/s13428-021-01592-8

Baker, C. (2023, July 22). *Mental health statistics: prevalence, services and funding in England - House of Commons Library*. House of Commons Library. https://commonslibrary.parliament.uk/research-briefings/sn06988/

Barik, A. L., Purwaningtyas, R. A., & Astuti, D. (2019). The Effectiveness of Traditional Media (Leaflet and Poster) to Promote Health in a Community Setting in the Digital Era: A Systematic Review. *Jurnal Ners*, *14*(3), 76–80. https://doi.org/10.20473/jn.v14i3.16988

Barn, R. (2008). Ethnicity, Gender and Mental Health: Social Worker Perspectives. *International Journal of Social Psychiatry*, *54*(1), 69–82. https://doi.org/10.1177/0020764007082528

Barnett, M. A., Tetreault, P. A., Esper, J. A., & Bristow, A. (1986). Similarity and empathy: the experience of rape. *Journal of Social Psychology*, *126*(1), 47–49. https://doi.org/10.1080/00224545.1986.9713568

Berzins, K., Baker, J., Louch, G., & Albutt, A. (2020). A qualitative exploration of mental health service user and carer perspectives on safety issues in UK mental health services. *Health Expectations*, *23*(3), 549–561. https://doi.org/10.1111/hex.13025

Bhui, K., Shanahan, L., & Harding, G. (2006). Homelessness and Mental Illness: A Literature Review and a Qualitative Study of Perceptions of the Adequacy of Care. *International Journal of Social Psychiatry*, *52*(2), 152–165. https://doi.org/10.1177/0020764006062096

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, *16*(3), 252. https://doi.org/10.1037/h0085885

Bradley, M. M., & Lang, P. J. (1999). Affective norms for English words (ANEW): Instruction manual and affective ratings, 30(1), 25-36. Technical report C-1, the center for research in psychophysiology, University of Florida.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Brener, L., Rose, G., Von Hippel, C., & Wilson, H. (2013). Implicit Attitudes, Emotions, and Helping Intentions of Mental Health Workers Toward Their Clients. *Journal of Nervous and Mental Disease*, *201*(6), 460–463. https://doi.org/10.1097/nmd.0b013e318294744a

Brown, P. O., Calnan, M. W. ., Scrivener, A., & Szmukler, G. (2009). Trust in Mental Health Services: A neglected concept. *Journal of Mental Health*, *18*(5), 449–458. https://doi.org/10.3109/09638230903111122

Burgess, D. J., Ding, Y., Hargreaves, M., Van Ryn, M., & Phelan, S. (2008). The Association between Perceived Discrimination and Underutilization of Needed Medical and Mental Health Care in a Multi-Ethnic Community Sample. *Journal of Health Care for the Poor and Underserved*, *19*(3), 894–911. https://doi.org/10.1353/hpu.0.0063

Carpenter, T. P., Pogacar, R., Pullig, C., Kouril, M., Aguilar, S. J., LaBouff, J. P., Isenberg, N., & Chakroff, A. (2019). Survey-software implicit association tests: A methodological and empirical analysis. *Behavior Research Methods*, *51*(5), 2194–2208. https://doi.org/10.3758/s13428-019-01293-3

Cipollina, R., & Sanchez, D. T. (2019). Reducing health care disparities through improving trust: An identity safety cues intervention for stigmatized groups. *Translational Issues in Psychological Science*, *5*(4), 315–325. https://doi.org/10.1037/tps0000207

Clement, S., Williams, P., Farrelly, S., Hatch, S., Schauman, O., Jefferey, D., Henderson, C., & Thornicroft, G. (2015). Mental Health–Related Discrimination as a Predictor of Low Engagement With Mental Health Services. *Psychiatric Services*, *66*(2), 171–176. https://doi.org/10.1176/appi.ps.201300448

Cohen, J. (1988). Statistical Power Analysis for the Behavioral Sciences (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum Associates, Publishers

Cortland, C., Craig, M. A., Shapiro, J. R., Richeson, J. A., Neel, R., & Goldstein, N. J. (2017). Solidarity through shared disadvantage: Highlighting shared experiences of discrimination improves relations between stigmatized groups. *Journal of Personality and Social Psychology*, *113*(4), 547–567. https://doi.org/10.1037/pspi0000100

Derricks, V., Johnson, I. R., & Pietri, E. S. (2022). Black (patients') lives matter: Exploring the role of identity-safety cues in healthcare settings among Black Americans. *Journal of Health Psychology*, *28*(1), 30–47. https://doi.org/10.1177/13591053221090850

D'Ettorre, G., & Pellicani, V. (2017). Workplace Violence Toward Mental Healthcare Workers Employed in Psychiatric Wards. *Safety and Health at Work*, *8*(4), 337–342. https://doi.org/10.1016/j.shaw.2017.01.004

Dodou, D., & De Winter, J. (2014). Social desirability is the same in offline, online, and paper surveys: A meta-analysis. Computers in Human Behavior, 36, 487–495. https://doi.org/10.1016/j.chb.2014.04.005

Duxbury, J. (2002). An evaluation of staff and patient views of and strategies employed to manage inpatient aggression and violence on one mental health unit: a pluralistic design. *Journal of Psychiatric and Mental Health Nursing*, *9*(3), 325–337. https://doi.org/10.1046/j.1365-2850.2002.00497.x

Farrelly, S., & Lester, H. (2014). Therapeutic relationships between mental health service users with psychotic disorders and their clinicians: a critical interpretive synthesis. *Health & Social Care in the Community*, *22*(5), 449–460. https://doi.org/10.1111/hsc.12090

Faul, F., Erdfelder, E., Lang, A. G., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods*, *39*(2), 175–191. https://doi.org/10.3758/bf03193146

Fiske, A., Wetherell, J. L., & Gatz, M. (2009). Depression in Older Adults. *Annual Review of Clinical Psychology*, *5*(1), 363–389. https://doi.org/10.1146/annurev.clinpsy.032408.153621

Gaebel, W., Muijen, M., Baumann, A., Bhugra, D., Wasserman, D., Van Der Gaag, R., Heun, R., & Zielasek, J. (2014). EPA guidance on building trust in mental health services. *European Psychiatry*, *29*(2), 83–100. https://doi.org/10.1016/j.eurpsy.2014.01.001

Gehlbach, H., Brinkworth, M. E., & Harris, A. (2011). Changes in teacher-student relationships. *British Journal of Educational Psychology*, *82*(4), 690–704. https://doi.org/10.1111/j.2044-8279.2011.02058.x

Golafshani, N. (2003). Understanding reliability and validity in qualitative research. The qualitative report, 8(4), 597-607.

Grant, P. R. (1993). Reactions to intergroup similarity: Examination of the similarity-differentiation and the similarity-attraction hypotheses. *Canadian Journal of Behavioural Science*, *25*(1), 28–44. https://doi.org/10.1037/h0078789

Green, C. A., Polen, M. R., Janoff, S. L., Castleton, D. K., Wisdom, J. P., Vuckovic, N., Perrin, N., Paulson, R. I., & Oken, S. L. (2008). Understanding how clinician-patient relationships and relational continuity of care affect recovery from serious mental illness: STARS study results. *Psychiatric Rehabilitation Journal*, *32*(1), 9–22. https://doi.org/10.2975/32.1.2008.9.22

Greenwald, A. G., & Banaji, M. R. (1995). Implicit social cognition: Attitudes, self-esteem, and stereotypes. Psychological Review, 102(1), 4–27. https://doi.org/10.1037/0033-295X.102.1.4

Greenwald, A. G., & Krieger, L. H. (2006). Implicit Bias: Scientific Foundations. *California Law Review*, *94*(4), 945. https://doi.org/10.2307/20439056

Greenwald, A. G., McGhee, D. E., & Schwartz, J. L. K. (1998). Measuring individual differences in implicit cognition: The implicit association test. *Journal of Personality and Social Psychology*, *74*(6), 1464–1480. https://doi.org/10.1037/0022-3514.74.6.1464

Hartley, S., Raphael, J., Lovell, K., & Berry, K. (2020). Effective nurse–patient relationships in mental health care: A systematic review of interventions to improve the therapeutic alliance. *International Journal of Nursing Studies*, *102*, 103490. https://doi.org/10.1016/j.ijnurstu.2019.103490

Have, M. T., De Graaf, R., Ormel, J., Vilagut, G., Kovess, V., Alonso, J. A., & Investigators, M. (2009). Are attitudes towards mental health help-seeking associated with service use? Results from the European Study of Epidemiology of Mental Disorders. *Social Psychiatry and Psychiatric Epidemiology*, *45*(2), 153–163. https://doi.org/10.1007/s00127-009-0050-4

Henderson, R. C., Williams, P., Gabbidon, J., Farrelly, S., Schauman, O., Hatch, S. L., Thornicroft, G., Bhugra, D., & Clement, S. (2014). Mistrust of mental health services: ethnicity, hospital admission

and unfair treatment. *Epidemiology and Psychiatric Sciences*, *24*(3), 258–265. https://doi.org/10.1017/s2045796014000158

Henretty, J. R., & Levitt, H. M. (2010). The role of therapist self-disclosure in psychotherapy: A qualitative review. *Clinical Psychology Review*, *30*(1), 63–77. https://doi.org/10.1016/j.cpr.2009.09.004

Hipes, C., Lucas, J. W., Phelan, J. C., & White, R. C. (2016). The stigma of mental illness in the labor market. *Social Science Research*, *56*, 16–25. https://doi.org/10.1016/j.ssresearch.2015.12.001

Hopkins, J., Loeb, S. J., & Fick, D. M. (2009). Beyond satisfaction, what service users expect of inpatient mental health care: a literature review. *Journal of Psychiatric and Mental Health Nursing*, *16*(10), 927–937. https://doi.org/10.1111/j.1365-2850.2009.01501.x

James, G., Witten, D., Hastie, T., & Tibshirani, R. (2021). *An Introduction to Statistical Learning: with Applications in R*. https://link.springer.com/content/pdf/10.1007/978-1-0716-1418-1.pdf

Johnson, L. N., & Wright, D. W. (2002). Revisiting Bordin's theory on the therapeutic alliance: Implications for family therapy. *Contemporary Family Therapy: An International Journal*, *24*(2), 257–269. https://doi.org/10.1023/A:1015395223978

Kantor, V., & Knefel, M. (2017). Perceived barriers and facilitators of mental health service utilization in adult trauma survivors: A systematic review. *Clinical Psychology Review*, *52*, 52–68. https://doi.org/10.1016/j.cpr.2016.12.001

Karpinski, A., & Hilton, J. L. (2001). Attitudes and the implicit association test. *Journal of Personality and Social Psychology*, *81*(5), 774–788. https://doi.org/10.1037/0022-3514.81.5.774

Kessler, R. C., Sonnega, A., Bromet, E. J., Hughes, M., & Nelson, C. P. (1995). Posttraumatic Stress Disorder in the National Comorbidity Survey. *Archives of General Psychiatry*, *52*(12), 1048. https://doi.org/10.1001/archpsyc.1995.03950240066012

Khatib, A., Ibrahim, M., & Roe, D. (2018). Re-building Trust after Physical Restraint During Involuntary Psychiatric Hospitalization. *Archives of Psychiatric Nursing*, *32*(3), 457–461. https://doi.org/10.1016/j.apnu.2018.01.003

Kotler, P., & Zaltman, G. (1971). Social Marketing: an approach to planned social change. *Journal of Marketing*, *35*(3), 3. https://doi.org/10.2307/1249783

Kubacki, K., Ronto, R., Lahtinen, V., Pang, B., & Rundle-Thiele, S. (2017). Social marketing interventions aiming to increase physical activity among adults. *Health Education*, *117*(1), 69–89. https://doi.org/10.1108/he-02-2016-0008

Machery, E. (2021). Anomalies in implicit attitudes research. *Wiley Interdisciplinary Reviews: Cognitive Science*, *13*(1). https://doi.org/10.1002/wcs.1569

Majumder, P., O'Reilly, M., Karim, K., & Vostanis, P. (2014). 'This doctor, I not trust him, I'm not safe': The perceptions of mental health and services by unaccompanied refugee adolescents. *International Journal of Social Psychiatry*, *61*(2), 129–136. https://doi.org/10.1177/0020764014537236

Memon, A., Taylor, K., Mohebati, L., Sundin, J., Cooper, M. D., Scanlon, T., & De Visser, R. O. (2016). Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England. *BMJ Open*, *6*(11), e012337. https://doi.org/10.1136/bmjopen-2016-012337

Mental Health Foundation. (n.d.). *People seeking help for diagnosed mental health problems: statistics*. Retrieved June 2, 2023, from https://www.mentalhealth.org.uk/explore-mental-health/statistics/people-seeking-help-diagnosed-mental-health-problems-statistics

Mental Health Foundation. (2021, October 4). *Stigma and discrimination*. Retrieved June 2, 2023, from https://www.mentalhealth.org.uk/explore-mental-health/a-z-topics/stigma-and-discrimination

Misdrahi, D., Petit, M., Blanc, O., Bayle, F., & Llorca, P. (2011). The influence of therapeutic alliance and insight on medication adherence in schizophrenia. *Nordic Journal of Psychiatry*, *66*(1), 49–54. https://doi.org/10.3109/08039488.2011.598556

Misdrahi, D., Verdoux, H., Lançon, C., & Bayle, F. (2009). The 4-Point ordinal Alliance Self-report: a self-report questionnaire for assessing therapeutic relationships in routine mental health. *Comprehensive Psychiatry*, *50*(2), 181–185. https://doi.org/10.1016/j.comppsych.2008.06.010

Montoya, R. M., & Horton, R. S. (2012). A meta-analytic investigation of the processes underlying the similarity-attraction effect. *Journal of Social and Personal Relationships*, *30*(1), 64–94. https://doi.org/10.1177/0265407512452989

Morken, G., Widen, J. H., & Gråwe, R. W. (2008). Non-adherence to antipsychotic medication, relapse and rehospitalisation in recent-onset schizophrenia. *BMC Psychiatry*, *8*(1). https://doi.org/10.1186/1471-244x-8-32

Morse, J. M. (2015). Critical Analysis of Strategies for Determining Rigor in Qualitative Inquiry. *Qualitative Health Research*, *25*(9), 1212–1222. https://doi.org/10.1177/1049732315588501

Murphy, M. C., Steele, C. M., & Gross, J. J. (2007). Signaling threat. *Psychological Science*, *18*(10), 879–885. https://doi.org/10.1111/j.1467-9280.2007.01995.x

Najafi, F., Fallahi-Khoshknab, M., Ahmadi, F., Dalvandi, A., & Rahgozar, M. (2017). Antecedents and consequences of workplace violence against nurses: A qualitative study. *Journal of Clinical Nursing*, *27*(1–2), e116–e128. https://doi.org/10.1111/jocn.13884

NHS Digital. (2016, September 29). *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014.* Retrieved August 1, 2023, from https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014

NHS England. (2020). *Working for the NHS in mental health*. Retrieved April 3, 2023, from https://www.england.nhs.uk/mental-health/working-in-mental-health/

Nosek, B. A., Bar-Anan, Y., Narayanan, S., Axt, J., & Greenwald, A. G. (2014). Understanding and Using the Brief Implicit Association Test: Recommended Scoring Procedures. *PLOS ONE*, *9*(12), e110938. https://doi.org/10.1371/journal.pone.0110938

Oxford Health NHS. (2023, January 11). *"All that support that I got, I can give to someone else."* Oxford Health NHS Foundation Trust. Retrieved April 3, 2023, from https://www.oxfordhealth.nhs.uk/news/all-that-support-that-i-got-i-can-give-to-someone-else/

Paris, M., & Hoge, M. A. (2009). Burnout in the Mental Health Workforce: A Review. *Journal of Behavioral Health Services & Research*, *37*(4), 519–528. https://doi.org/10.1007/s11414-009-9202-2

Patterson, B., Leadbetter, D., & Miller, G. L. (2013). Beyond Zero Tolerance: a varied approach to workplace violence. *British Journal of Nursing*, *14*(15), 810–815. https://doi.org/10.12968/bjon.2005.14.15.18598

Perugini, M. (2005). Predictive models of implicit and explicit attitudes. *British Journal of Social Psychology*, *44*(1), 29–45. https://doi.org/10.1348/014466604x23491

Peterson, Z. D. (2002). More than a mirror: The ethics of therapist self-disclosure. *Psychotherapy*, *39*(1), 21–31. https://doi.org/10.1037/0033-3204.39.1.21

Priebe, S., Watts, J., Chase, M., & Matanov, A. (2005). Processes of disengagement and engagement in assertive outreach patients: qualitative study. *British Journal of Psychiatry*, *187*(5), 438–443. https://doi.org/10.1192/bjp.187.5.438

Purdie-Vaughns, V., Steele, C. M., Davies, P., Ditlmann, R., & Crosby, J. R. (2008). Social identity contingencies: How diversity cues signal threat or safety for African Americans in mainstream

institutions. *Journal of Personality and Social Psychology*, *94*(4), 615–630. https://doi.org/10.1037/0022-3514.94.4.615

Rose, D., Evans, J., Laker, C., & Wykes, T. (2013). Life in acute mental health settings: experiences and perceptions of service users and nurses. *Epidemiology and Psychiatric Sciences*, *24*(1), 90–96. https://doi.org/10.1017/s2045796013000693

Rudman, L. A. (2004). Sources of Implicit Attitudes. *Current Directions in Psychological Science*, *13*(2), 79–82. https://doi.org/10.1111/j.0963-7214.2004.00279.x

Rugkåsa, J., Canvin, K., Sinclair, J., Sulman, A., & Burns, T. R. (2014). Trust, Deals and Authority: community mental health professionals' experiences of influencing reluctant patients. *Community Mental Health Journal*, *50*(8), 886–895. https://doi.org/10.1007/s10597-014-9720-0

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

Sampogna, G., Bakolis, I., Evans-Lacko, S., Robinson, E., Thornicroft, G., & Henderson, C. (2017). The impact of social marketing campaigns on reducing mental health stigma: results from the 2009–2014 Time to Change programme. *European Psychiatry*, *40*, 116–122. https://doi.org/10.1016/j.eurpsy.2016.08.008

Schmidt, A. F., & Finan, C. (2018). Linear regression and the normality assumption. *Journal of Clinical Epidemiology*, *98*, 146–151. https://doi.org/10.1016/j.jclinepi.2017.12.006

Scott, G., Keitel, A., Becirspahic, M., Yao, B., & Sereno, S. C. (2018). The Glasgow Norms: Ratings of 5,500 words on nine scales. *Behavior Research Methods*, *51*(3), 1258–1270. https://doi.org/10.3758/s13428-018-1099-3

Sprecher, S., Treger, S., & Wondra, J. D. (2012). Effects of self-disclosure role on liking, closeness, and other impressions in get-acquainted interactions. *Journal of Social and Personal Relationships*, *30*(4), 497–514. https://doi.org/10.1177/0265407512459033

Steenkamp, J., De Jong, M., & Baumgartner, H. (2010). Socially Desirable Response Tendencies in Survey Research. Journal of Marketing Research, 47(2), 199–214. https://doi.org/10.1509/jmkr.47.2.199

Stenbacka, C. (2001). Qualitative research requires quality concepts of its own. *Management Decision*, *39*(7), 551–556. https://doi.org/10.1108/eum0000000005801

Stewart, D., Burrow, H. M., Duckworth, A., Dhillon, J., Fife, S., Kelly, S., Marsh-Picksley, S., Massey, E. K., O'Sullivan, J. D., Qureshi, M., Wright, S., & Bowers, L. (2014). Thematic analysis of psychiatric patients' perceptions of nursing staff. *International Journal of Mental Health Nursing*, *24*(1), 82–90. https://doi.org/10.1111/inm.12107

Street, R. L., O'Malley, K. J., Cooper, L. A., & Haidet, P. (2008). Understanding Concordance in Patient-Physician Relationships: Personal and Ethnic Dimensions of Shared Identity. *Annals of Family Medicine*, *6*(3), 198–205. https://doi.org/10.1370/afm.821

Suitor, J. J., Keeton, S., & Pillemer, K. (1995). When Experience Counts: The Effects of Experiential and Structural Similarity on Patterns of Support and Interpersonal Stress. *Social Forces*, *73*(4), 1573–1588. https://doi.org/10.1093/sf/73.4.1573

Summers, R. F., & Barber, J. P. (2003). Therapeutic Alliance as a Measurable Psychotherapy Skill. *Academic Psychiatry*, *27*(3), 160–165. https://doi.org/10.1176/appi.ap.27.3.160

Tabachnick, B. G., Fidell, L. S., & Ullman, J. B. (2013). Using multivariate statistics (Vol. 6, pp. 497-516). Boston, MA: pearson.

Thomas, E., & Magilvy, J. K. (2011). Qualitative Rigor or Research Validity in Qualitative Research. *Journal for Specialists in Pediatric Nursing*, *16*(2), 151–155. https://doi.org/10.1111/j.1744-6155.2011.00283.x

Thornicroft, G., Brohan, E., Kassam, A., & Lewis-Holmes, E. (2008). Reducing stigma and discrimination: candidate interventions. *International Journal of Mental Health Systems*, *2*(1), 3. https://doi.org/10.1186/1752-4458-2-3

Truong, V. D. (2014). Social Marketing. *Social Marketing Quarterly*, *20*(1), 15–34. https://doi.org/10.1177/1524500413517666

Verhaeghe, M., & Bracke, P. (2011). Stigma and trust among mental health service users. *Archives of Psychiatric Nursing*, *25*(4), 294–302. https://doi.org/10.1016/j.apnu.2011.02.001

Verkoeijen, P. P. J. L., Polak, M., & Bouwmeester, S. (2018). A Practical Illustration of Methods to Deal with Potential Outliers: A Multiverse Outlier Analysis of Study 3 from Brummelman, Thomaes, Orobio de Castro, Overbeek, and Bushman (). *Collabra*, *4*(1). https://doi.org/10.1525/collabra.118

Warriner, A. H., Kuperman, V., & Brysbaert, M. (2013). Norms of valence, arousal, and dominance for 13,915 English lemmas. *Behavior Research Methods*, *45*(4), 1191–1207. https://doi.org/10.3758/s13428-012-0314-x

Xiao, Y., & Van Bavel, J. J. (2019). Sudden shifts in social identity swiftly shape implicit evaluation. Journal of Experimental Social Psychology, 83, 55–69. https://doi.org/10.1016/j.jesp.2019.03.005

Yan, K. K., Anderson, J. R., & Burn, A. (2022). Review: School‐based interventions to improve mental health literacy and reduce mental health stigma – a systematic review. *Child and Adolescent Mental Health*, *28*(2), 230–240. https://doi.org/10.1111/camh.12543

Yang, B. X., Stone, T. E., Petrini, M. A., & Morris, D. L. (2018). Incidence, Type, Related Factors, and Effect of Workplace Violence on Mental Health Nurses: A Cross-sectional Survey. *Archives of Psychiatric Nursing*, *32*(1), 31–38. https://doi.org/10.1016/j.apnu.2017.09.013

Appendix A

Overview of Participants' Demographic Characteristics and MH Histories

Table A1

Sample General Demographics - Age, Ethnicity, Education, Source of Recruitment

	Mean - SD / Number of Observations - %							
	Control Group (n=84)		Intervention Group (n=92)		Full Sample (N=176)		Balance Checks	
	n / M	% / SD	n / M	% / SD	n / M	% / SD	Results	*p*-value
Age	36.15	13.58	36.16	14.30	36.15	13.92	$U = 3907.5$, $z = -0.13$[a]	.897
Gender								
Female	47	55.95	73	79.35	120	68.18	-[b]	< .001**
Male	33	39.29	19	20.65	52	29.55		
Other	4	4.76	0	0	4	2.27		
Ethnicity								
White	73	86.9	84	91.3	157	89.2	-[b]	.195
Asian	3	3.57	5	5.43	8	4.55		
Black	1	1.19	1	1.19	2	1.14		
Mixed Race	4	4.76	2	2.17	6	3.41		
Other	3	3.57	0	0	3	1.70		
Highest Education Level								
Below GCSE	1	1.19	1	1.09	2	1.14	-[b]	.990
GCSE	8	9.52	11	11.96	19	10.80		
A-Level	11	13.10	12	13.04	23	13.07		
Undergraduate	34	40.48	37	40.22	71	40.34		
Postgraduate	29	34.52	29	31.52	58	32.95		
Other	1	1.19	2	2.17	3	1.70		
Source of								

	Mean - SD / Number of Observations - %							
	Control Group (n=84)		Intervention Group (n=92)		Full Sample (N=176)		Balance Checks	
	n / M	% / SD	n / M	% / SD	n / M	% / SD	Results	*p*-value
Recruitment								
Prolific	47	55.95	51	55.43	98	55.68	-[b]	.317
Call for Participants	12	14.29	11	11.96	23	13.07		
Mental Health Charity	1	1.19	1	1.09	2	1.14		
Social Media	4	4.76	13	14.13	17	9.66		
Survey Circle	16	19.05	11	11.96	27	15.34		
Survey Swap	2	2.38	1	1.09	3	1.70		
Other	2	2.38	4	4.35	6	3.41		

Note. N=176.

* $p < .05$, ** $p < .01$

[a] Mann-Whitney U test used to check the balance of continuous variables between the Control and Intervention group. Non-parametric test used due to violation of the normality assumption.

[b] Fisher's Exact test used to check the balance of categorical/nominal variables between the Control and Intervention group. Used as expected cell counts were low.

Table A2

Sample MH Demographics - Mental Health Services, Disorders, Total Number of Services Used, Total Number of MH Concerns Experiences, Ongoing Support, Helpfulness, Previous Disputes, Dispute Severity

	Mean - SD / Number of Observations - %							
	Control Group (n=84)		Intervention Group (n=92)		Full Sample (N=176)		Balance Checks	
	n / M	% / SD	n / M	% / SD	n / M	% / SD	Results	*p*-value
Type of Mental Health Service								
Mental Health Charity	31	36.90	44	47.83	75	42.61	$\chi^2(1) = 2.14^c$	.143
Counselling/ Psychotherapy	77	91.67	74	80.43	151	85.80	$\chi^2(1) = 5.55^c$	.05*
Support Groups	11	13.10	15	16.30	26	14.77	$\chi^2(1) = .36^c$	.672
Community Mental Health Teams (CMHT)	15	17.86	29	31.52	44	25.00	$\chi^2(1) = 4.37^c$	.055
Social Care	9	10.71	6	6.52	15	8.52	$\chi^2(1) = .99^c$	.420
Residential Care	0	0.00	3	3.26	3	1.70		.247
Crisis Intervention	7	8.33	13	14.13	20	11.36	$\chi^2(1) = 1.47^c$	.245
Hospital Outpatient	4	4.76	12	13.04	16	9.09	$\chi^2(1) = 3.64^c$	.068
Hospital Inpatient	5	5.95	7	7.61	12	6.82	$\chi^2(1) = .19^c$	.769
Other	7	8.33	10	10.87	17	9.66	$\chi^2(1) = .32^c$	.618
TOTAL	166		213		379			
	Control Group (n=84)		Intervention Group (n=92)		Full Sample (N=176)		Balance Checks	
	n / M	% / SD	n / M	% / SD	n / M	% / SD	Results	*p*-value
Type of Mental Health Disorder								

	Mean - SD / Number of Observations - %							
	Control Group (n=84)		Intervention Group (n=92)		Full Sample (N=176)		Balance Checks	
	n / M	% / SD	n / M	% / SD	n / M	% / SD	Results	*p*-value
Depression	57	67.86	70	76.09	127	72.16	$\chi^2(1) = 1.48^c$	.242
Anxiety	67	79.76	74	80.43	141	80.11	$\chi^2(1) = .12^c$	.911
Bipolar Disorder	1	1.19	7	7.61	8	4.55	-[b]	.066
Schizophrenia	0	0.00	1	1.09	1	0.57	-[b]	1.0
Post-Traumatic Stress Disorder Complex-Post-Traumatic Stress Disorder (PTSD/ C-PTSD)	10	11.90	23	25.00	33	18.75	$\chi^2(1) = 4.94^c$	.033
Obsessive Compulsive Disorder (OCD)	12	14.29	11	11.96	23	13.07	$\chi^2(1) = .21^c$	.662
Eating Disorder	16	19.05	15	16.30	31	17.61	$\chi^2(1) = .23^c$	.694
Substance Abuse/ Addiction	2	2.38	5	5.43	7	3.98	-[b]	.447
Attention Deficit Hyperactivity Disorder (ADHD)	2	2.38	4	4.35	6	3.41	-[b]	.684
Autism Spectrum Disorder (ASD)	1	1.19	3	3.26	4	2.27	-[b]	.622
Emotionally Unstable Personality Disorder	1	1.19	3	3.26	4	2.27	-[b]	.622

	Mean - SD / Number of Observations - %							
	Control Group (n=84)		Intervention Group (n=92)		Full Sample (N=176)		Balance Checks	
	n / M	% / SD	n / M	% / SD	n / M	% / SD	Results	*p*-value
(EUPD)								
Other	9	10.71	5	5.43	14	7.95	$\chi^2(1) = 1.67$[c]	.266
TOTAL	178		221		399			
	Control Group (n=84)		Intervention Group (n=92)		Full Sample (N=176)		Balance Checks	
	n / M	% / SD	n / M	% / SD	n / M	% / SD	Results	*p*-value
Number of MH Services Used (Average Per Participant)	1.99	1.3	2.32	1.38	2.16	1.35	$U = 3213.5$, $z = -2.03$[a]	.043*
Number of MH Concerns Experienced (Average Per Participant)	2.12	0.96	2.38	1.19	2.26	1.09	$U = 3440.5$, $z = -1.33$[a]	.184
Ongoing Support								
Yes	34	40.47	36	39.13	70	39.77	$\chi^2(1) = 0.03$	.855
No	50	59.52	56	60.87	106	60.23		
Helpfulness Ratings of MH Services	65.83	22.19	63.02	22.20	64.36	22.18	-[b]	.274
Previous Disputes								
Yes	66	78.57	70	76.09	136	77.27	$\chi^2(1) = 0.15$	.694
No	18	21.43	22	23.91	40	22.73		
Ratings of Dispute Severity	39.61	24.85	34.73	27.16	36.92	25.93	$U = 222$, $z = -0.65$[a]	.514

Note. N = 176

* $p < .05$, ** $p < .01$

[a] Mann-Whitney U test used to check the balance of continuous variables between the Control and Intervention group. Non-parametric test used due to violation of the normality assumption.

[b] Fisher's Exact test used to check the balance of categorical/nominal variables between the Control and Intervention group. Used as expected cell counts were low.

[c] Chi-Square test used to check the balance of categorical/nominal variables between the Control and Intervention group.

Table A3

Mean, Standard Deviations, and Spearman Rho Correlations Between Outcome Variables and Predictors

Variable	Mean	SD	1	2	3	4	5	6	7	8	9	10	11	12	13
1. D-Score	.33	.43	-												
2. 4-POASR Score	33.5	6.95	.16*	-											
3. Age	36.16	13.92	-.04	.07	-										
4. Gender[a]	1.73	.5	.14	.03	-.13	-									
5. Ethnicity[b]	2.25	3.18	.08	-.12	-.3**	.08	-								
6. Education[c]	3.98	1.03	.03	.08	.02	.02	.21**	-							
7. Recruitment Source[d]	2.35	1.83	.06	-.05	-.43**	.10	.25**	.35**	-						
8. Total Services	2.16	1.35	.02	-.24**	.10	-.05	-.15*	.01	-.07	-					
9. Total Disorders	2.26	1.1	.05	-.22**	-.01	.11	-.07	-.11	.03	.43**	-				
10. Ongoing Support[e]	1.60	.49	-.13	-.03	-.05	.03	-.03	.08	.01	-.26**	-.13	-			
11.Helpfulness Ratings	64.36	22.18	.12	.76**	.11	.04	-.08	.10	-.03	-.17*	-.14	-.01	-		
12. Previous Disputes[f]	.23	.42	.13	-.06	-.03	-.05	.02	.12	.1	.21**	.08	-.2**	-.08	-	
13. Dispute Severity	36.93	25.93	-.25	-.19	-.08	.05	.11	-.12	.06	-.02	.02	.34*	-.14	-	-

Note. N = 176.

* $p < .05$, ** $p < .01$

I selected Spearman Rho analysis as Kolmogorov-Smirnov tests indicated that several variables did not

follow a normal distribution.

[a] Coded as 1 = Male, 2 = Female, 3 = Other

[b] Coded as 1 = White British, 2 = White European, 3 = Other White Background, 4 = South Asian, 5 = Chinese,

6 = Arab, 7 = Black Caribbean, 8 = Black African, 12 = White and Black Caribbean, 13 = White and Black African, 14 = White and Asian, 15 = Other Ethnic Background.

[c] Coded as 1 = Below GCSE, 2 = GCSE, 3 = A-Level, 4 = Undergraduate, 5 = Postgraduate, 6 = Other.

[d] Coded as 1 = Prolific, 2 = Call for Participants, 3 = MH charity, 4 = Social Media, 5 = SurveyCircle, 6 = SurveySwap, 7 = Other.

[e] Coded as 1 = Yes, 2 = No

[f] Coded as 0 = No, 1 = Yes

Appendix B

Full Experimental Questionnaire (Including Information Sheet, Consent Form, and Debrief Sheet)

INFORMATION FOR PARTICIPANTS

A New Perspective: Understanding mental health service users' perceptions of mental health services

Researcher: *Removed for Anonymity*
Psychological & Behavioural Sciences, London School of Economics & Political Science

Thank you for considering participating in this study which will take place in June 2023.

1. What is the research about?

The current research study aims to investigate mental health service users' perceptions of mental health services and staff members.

2. Participation criteria:

To participate in this study, you **must**:

1. Be 18+ years of age.
2. Have used mental health services (e.g. - mental health charities, counselling, mental health hospitals, etc.) in the United Kingdom in the past 5 years.
3. Be fluent in English.
4. Have access to a *computer or laptop*. This study is not compatible with mobile devices.

You cannot participate in this study if you are currently working in the mental health field or have previous professional experience in mental health services.

3. Do I have to take part?

Participation is **voluntary**. It is up to you to decide whether or not to take part. You do not have to take part if you do not want to. If you do decide to take part, you can tick the "I agree to take part" box in the next window.

4. What will my involvement be?

The study will take approximately 10 minutes.

You will have the option to enter a lottery to win one of five £10 Amazon gift vouchers for your participation.

The study will involve the following tasks:

1. Word-matching task
2. Rating your agreement/disagreement with different statements relating to mental health services/staff.
3. Answering open-ended questions about your opinion of mental health services and staff.

If you are participating in this study via SurveyCircle or SurveySwap, you will be able to gain free credits upon completion.

5. How do I withdraw from the study?

You can withdraw from the study at any point until the **26th of June 2023** (when the data analysis will begin) without having to give a reason. Simply email the lead researcher, *Removed for Anonymity*, at *Removed for Anonymity*@lse.ac.uk.

Withdrawing from the study will have no negative consequences. If you withdraw from the study, no information that you have given will be retained unless you give permission.

6. What will my information be used for?

The collected data will be used as part of an MSc dissertation project. The results may be presented at conferences or reported in academic journals, however, all data will be anonymous, without any means of identifying the individuals involved.

7. Will my taking part and my data be kept confidential? Will it be anonymised?

The records from this study will be kept as confidential as possible. Only the lead researcher (*Removed for anonymity*) will have access to the files. No personally identifiable information (name, date of birth, email) will be collected. Your data will be anonymised – no personally identifiable information will be used in any reports or publications resulting from the study. All digital files, transcripts and summaries will be given non-personally identifiable codes. Any hard copies of research information will be kept in locked files at all times.

You may provide your email in a separate survey link if you wish to be entered into the Amazon voucher lottery. This information will be kept confidential, and will not be used in conjunction with the main results for analysis.

8. Who has reviewed this study?

This study has undergone ethics review in accordance with the LSE Research Ethics Policy and Procedure.

9. Data Protection Privacy Notice

The LSE Research Privacy Policy can be found at:
https://info.lse.ac.uk/staff/divisions/Secretarys-Division/Assets/Documents/Information-Records-Management/Privacy-Notice-for-Research-v1.1.pdf

The legal basis used to process your personal data will be legitimate interests. The legal basis used to process special category personal data (e.g. data that reveals racial or ethnic origin, political opinions, religious or philosophical beliefs, trade union membership, health, sex life or sexual orientation, genetic or biometric data) will be for scientific and historical research or statistical purposes.

To request a copy of the data held about you please contact: glpd.info.rights@lse.ac.uk

10. Questions/Complaints

If you have any questions regarding this study please contact the researcher, *Removed for anonymity*, on *Removed for anonymity*@lse.ac.uk.

If you have any concerns or complaints regarding the conduct of this research, please contact the LSE Research Governance Manager via research.ethics@lse.ac.uk.

Consent Form

Participation in this research is **VOLUNTARY**.

1. I have read and understood the study information. I have been able to ask questions about the study and my questions have been answered to my satisfaction.
2. I consent voluntarily to be a participant in this study and understand that I can refuse to answer questions and that I can withdraw from the study at any time up until 26th of June 2023, without having to give a reason.
3. I understand that the information I provide will be used for an MSc Dissertation project titled 'A New Perspective: Understanding mental health service users' perceptions of mental health services' and that the information will be anonymised.
4. I agree that my anonymised information can be quoted in research outputs.
5. I understand that any personal information that can identify me will be kept confidential and not shared with anyone other than the lead researcher and supervisor.
6. I give permission for the anonymised information I provide to be deposited in a data archive so that it may be used for future research.

If you have read all of the information above, and are happy to participate, please choose 'Yes, I AGREE to participate':

Yes, I **AGREE** to participate

No, I **DO NOT** agree to participate

Eligibility Criteria

- I am ±18 years of age
- I have used mental health services in the United Kingdom within the past 5 years (e.g. - charities, therapy, counselling services, mental health hospitals, etc.).
- I am fluent in English.
- I am able to complete this study on a computer or laptop (no mobile devices).
- I haven't worked in the mental health sector professionally.

I **CONFIRM** that I meet all of the above criteria.

NEXT PAGE: POSTER STIMULI (INTERVENTION GROUP ONLY)

You will be shown a total of three posters:

In a few words, please describe your initial thoughts upon seeing this poster.

Characters remaining: 500

>>

NEXT PAGE: POSTER STIMULI (INTERVENTION GROUP ONLY)

You will be shown a total of three posters:

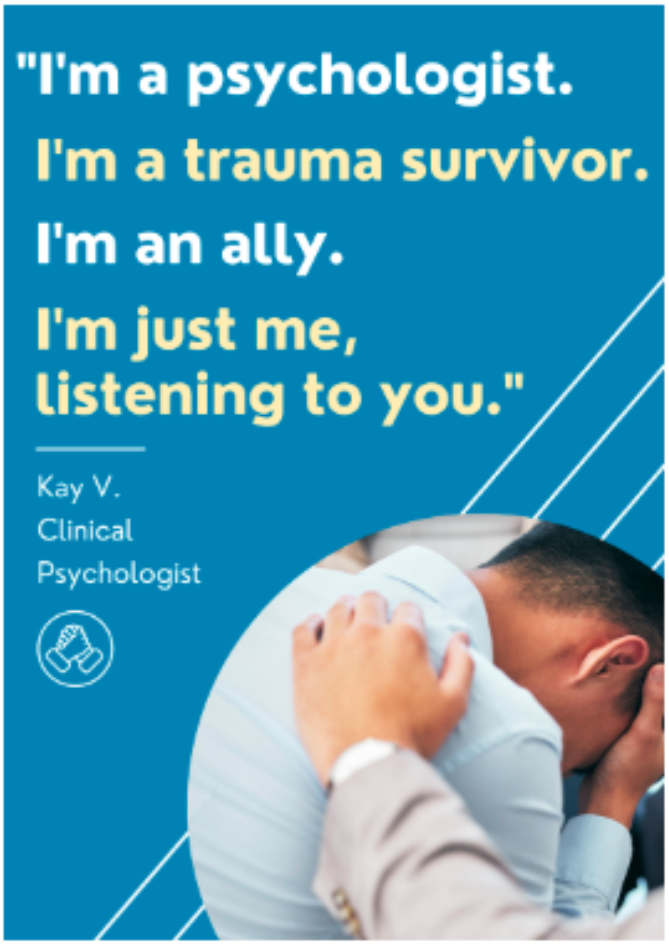
In a few words, please describe your initial thoughts upon seeing this poster.

Characters remaining: 500

>>

NEXT PAGE: POSTER STIMULI (INTERVENTION GROUP ONLY)

You will be shown a total of three posters:



In a few words, please describe your initial thoughts upon seeing this poster.

Characters remaining: 500

>>

NEXT PAGE: IMPLICIT ASSOCIATION TEST

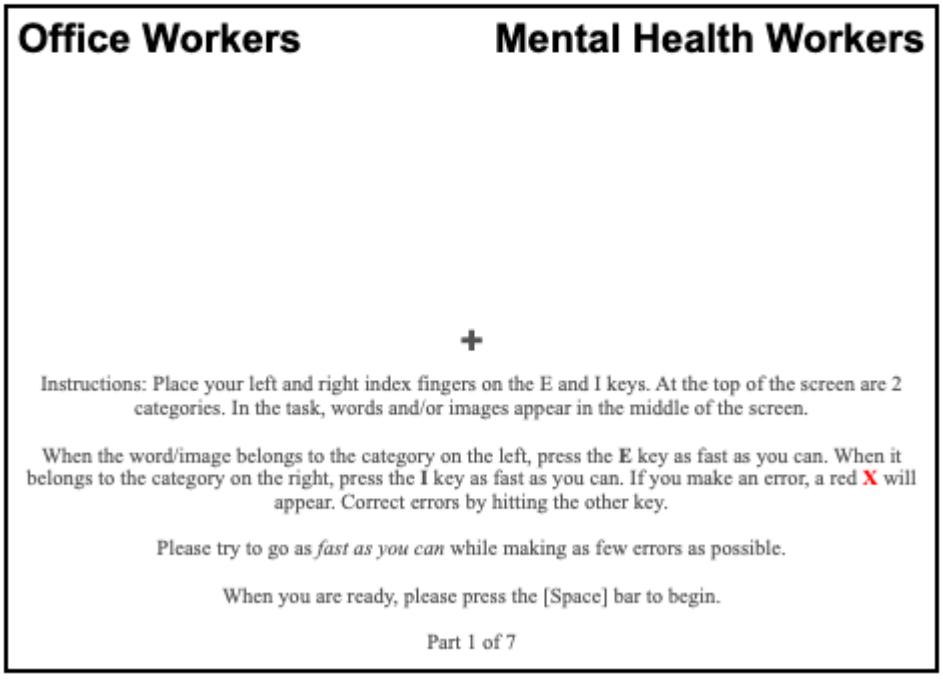
You will now be presented with a timed word-matching task.

Please read the instructions on the next page carefully.

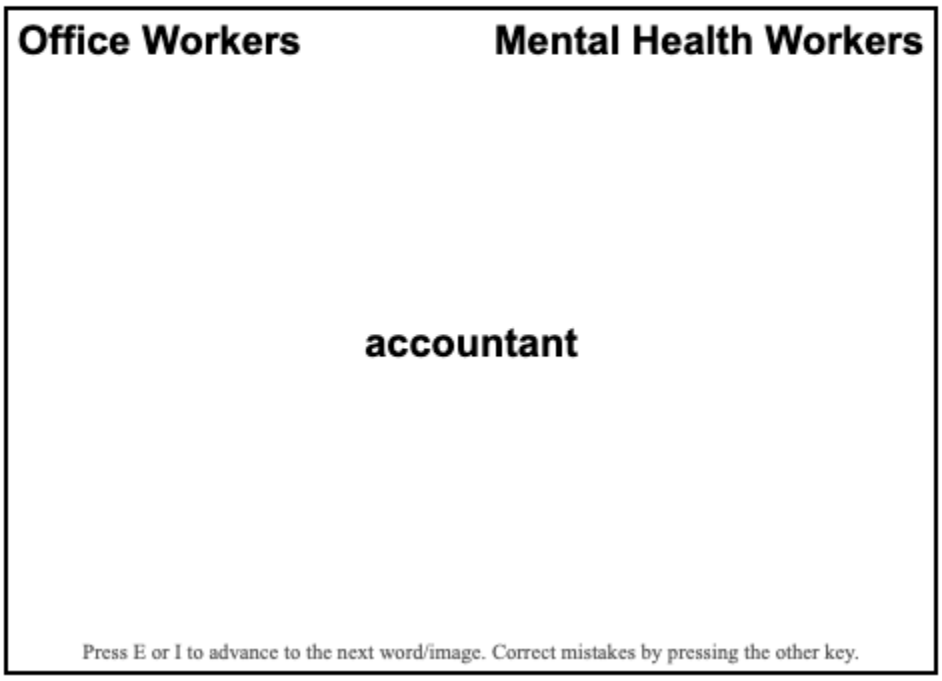
(Note: You will have to use the 'E' and 'I' keys on your keyboard. If 'E' is incorrect then press 'I' to correct your mistake, and vice versa)

Please click the '>>' button to proceed.

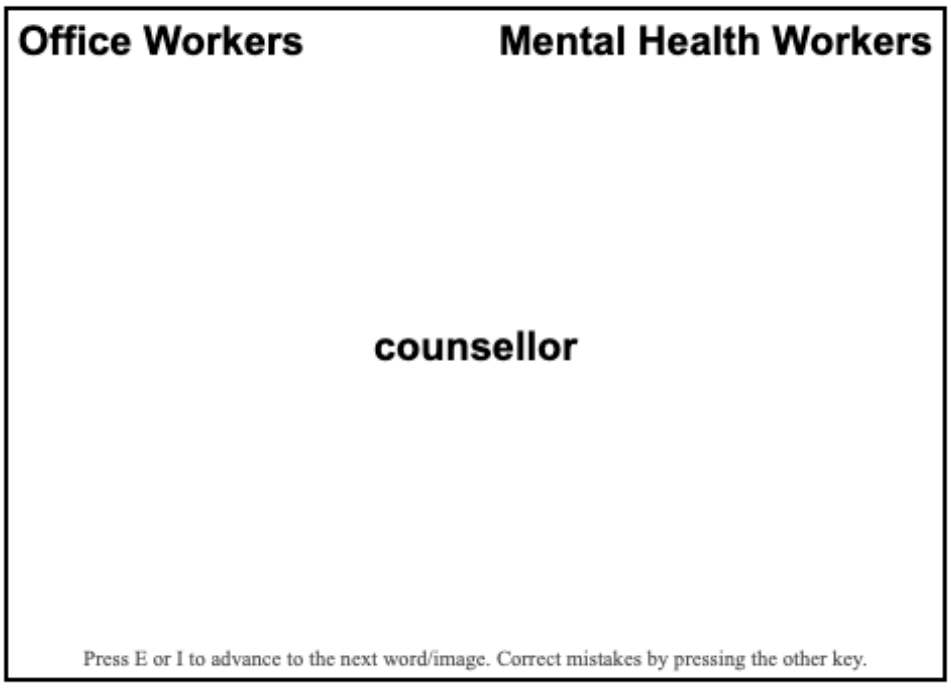
NEXT PAGE: IMPLICIT ASSOCIATION TEST CONTINUES



NEXT PAGE: IMPLICIT ASSOCIATION TEST CONTINUES



NEXT PAGE: IMPLICIT ASSOCIATION TEST CONTINUES



- IMPLICIT ASSOCIATION TEST CONTINUES FOR SEVEN BLOCKS -

NEXT PAGE: 4-POINT ORDINAL SELF-REPORT

You will now be presented with a series of statements.

'Mental health workers' include a range of professionals such as support workers, volunteers, mental health nurses, clinical psychologists, psychiatrists, and many more.

Whilst thinking of mental health workers in general, and your own experiences, please rate your opinion of the following statements on a scale ranging from "Strongly Disagree" to "Strongly Agree".

I have been feeling better since mental health workers have been treating me.

Strongly Disagree	Slightly Disagree	Slightly Agree	Strongly Agree

I feel I understand the mental health workers who work with me.

Strongly Disagree	Slightly Disagree	Slightly Agree	Strongly Agree

I feel that mental health workers and I understand my problems in the same way.

Strongly Disagree	Slightly Disagree	Slightly Agree	Strongly Agree

I am comfortable with the relationship I have with mental health workers.

Strongly Disagree	Slightly Disagree	Slightly Agree	Strongly Agree

- 4-POINT ORDINAL SELF-REPORT CONTINUES -

If you are paying attention, please select the 'slightly agree' option.

Strongly Disagree	Slightly Disagree	Slightly Agree	Strongly Agree

I have a better understanding of the symptoms of my illness since using mental health services.

Strongly Disagree	Slightly Disagree	Slightly Agree	Strongly Agree

I feel that mental health workers and I work together as a team.

Strongly Disagree	Slightly Disagree	Slightly Agree	Strongly Agree

I think that mental health workers give clear explanations.

Strongly Disagree	Slightly Disagree	Slightly Agree	Strongly Agree

I believe that mental health workers are helping me.

Strongly Disagree	Slightly Disagree	Slightly Agree	Strongly Agree

I feel that mental health workers really understand me.

Strongly Disagree	Slightly Disagree	Slightly Agree	Strongly Agree

I feel I can count on mental health workers.

Strongly Disagree	Slightly Disagree	Slightly Agree	Strongly Agree

I feel that mental health workers want me to get better.

Strongly Disagree	Slightly Disagree	Slightly Agree	Strongly Agree

NEXT PAGE: OPEN-TEXT QUESTIONS

Please describe your overall opinion of mental health ***workers*** in 200 words or fewer:

Please describe your overall opinion of mental health ***services*** in 200 words or fewer:

>>

NEXT PAGE: MENTAL HEALTH HISTORY QUESTIONNAIRE

You will now be asked a few questions relating to your mental health history.

Please note that all answers are fully anonymous and confidential.

Which type(s) of mental health services have you interacted with in the past 5 years? Please select all that apply.

- Mental health charities/helplines
- Psychotherapy/counselling services
- Support groups
- Community Mental Health Teams (CMHT)
- Social/community care
- Residential care
- Crisis intervention
- Hospital out-patient
- Hospital in-patient
- Other (please specify):

- MENTAL HEALTH HISTORY QUESTIONNAIRE CONTINUES -

Which of the following mental health concerns have you experienced or are currently experiencing? Please select all that apply.

- Depression
- Anxiety
- Bipolar Disorder
- Schizophrenia
- Post-Traumatic Stress Disorder (PTSD)
- Obsessive-Compulsive Disorder (OCD)
- Eating disorders
- Substance abuse/addiction
- Other (please specify):

- MENTAL HEALTH HISTORY QUESTIONNAIRE CONTINUES -

Are you currently receiving ongoing support from mental health services?

Yes

No

Please rate the helpfulness of your experience with mental health services on a scale from 0 (Extremely unhelpful) to 100 (Extremely helpful).

Extremely unhelpful — Neither helpful nor unhelpful — Extremely helpful

0 10 20 30 40 50 60 70 80 90 100

Have you been involved in disputes with mental health workers in the past five years?

If yes, please rate the severity on a scale from 0 (Extremely minor) to 100 (Extremely severe).

If no, please select the "Not applicable" box.

Extremely minor — Moderate — Extremely severe

0 10 20 30 40 50 60 70 80 90 100

☐ Not Applicable

>>

NEXT PAGE: DEMOGRAPHICS QUESTIONNAIRE

You will now be asked a few questions relating to your background.

Please note that all answers are fully anonymous and confidential.

Please generate your anonymous six-digit participant code.

This includes the first letter of the town/city you were born in, the last three digits of your phone number, and the number of your month of birth.

Example 1: London, 766, September = L76609
Example 2: Berlin, 434, June = B43406

What is your age?

18 26 34 43 51 59 67 75 84 92 100

What is your gender?

Male

Female

Other (please specify)

- DEMOGRAPHICS QUESTIONNAIRE CONTINUES -

What is your ethnicity?

- English, Welsh, Scottish, Northern Irish or British
- Irish
- Gypsy or Irish Traveller
- Roma
- Indian
- Pakistani
- Bangladeshi
- Chinese
- Arab
- Caribbean
- African
- White and Black Caribbean
- White and Black African
- White and Asian
- Any other ethnic background (please specify)

- DEMOGRAPHICS QUESTIONNAIRE CONTINUES -

What is your highest obtained education level?

- Below GCSE
- GCSE
- A-Level
- Undergraduate
- Postgraduate
- Other (please specify)

Which platform did you access this study through?

- MQ Mental Health
- Call for Participants
- A mental health charity
- Social media
- SurveyCircle
- SurveySwap
- Other (please specify)

>>

NEXT PAGE: DEBRIEF SHEET

A New Perspective: A visual intervention to improve mental health service users' attitudes towards mental health workers

Thank you very much for participating in this study!

Study Aims:
The present study aims to assess mental health service users' conscious and subconscious attitudes toward mental health workers (via questionnaires and an Implicit Association Test (word-matching task) respectively). The study specifically assessed whether posters depicting workers' experiences could improve service users' attitudes, because research has shown that perceived similarity can foster positive perceptions. As such, some participants were shown posters before completing the attitude tasks, whilst some were not. Please find the range of posters below:

Additional Support:
If you have any questions, concerns, or would like to withdraw from the study, please contact the Lead Researcher, *Removed for Anonymity* at *Removed for Anonymity*@lse.ac.uk.

Please note that you can withdraw from this study up until the 26th of June, 2023.

If you feel that you would like further mental health support, please contact your primary mental health service, or get in touch with charity organisations such as Mind UK (https://www.mind.org.uk/).

Please remember not to share any information about the study with others who might participate in future.

IMPORTANT: SurveyCircle / SurveySwap / Prolific Users Only
For SurveyCircle users (www.surveycircle.com): The Survey Code is: SJFK-SS8H-JXJT-B9TL
Redeem Survey Code with one click: https://www.surveycircle.com/SJFK-SS8H-JXJT-B9TL/

For SurveySwap users (SurveySwap.io): Go to: https://surveyswap.io/sr/BR7C-9521-YWG6 or, alternatively, enter the code manually: BR7C-9521-YWG6 to claim your credits.

For Prolific Users: CIZT3724

Thank you once again for participating in this research! **Please click the '>>' button to save your responses and follow the weblink to participate in an Amazon Voucher Lottery.**

NEXT PAGE: LOTTERY SIGN-UP LINK

0% Survey Completion 100%

LSE THE LONDON SCHOOL OF ECONOMICS AND POLITICAL SCIENCE

Thank you for your time spent taking this survey. Your response has been recorded.

To enter a **lottery to win one of five £10 Amazon vouchers**, please follow this link:

https://lse.eu.qualtrics.com/jfe/form/SV_dbDM6d0eoQCejv8

END OF SURVEY

Appendix C

Stimuli Words for the Implicit Association Test

Table C1

Target and Attribute Stimuli Words for IAT

Category				
Target Category	Mental Health Worker-Related Words	Valence Rating	Office Worker related-Words	Valence Rating
	Psychologist	5.05	Secretary	5.18
	Psychiatrist	4.11	Programmer	5.05
	Nurse	5.41	Journalist	5.3
	Counsellor	5.71	Technician	5.65
	Therapist	4.43	Clerk	4.76
	Psychoanalyst	5.35	Receptionist	5.37
	Psychotherapist	-	Administrator	5.32
	Support Worker	-	Accountant	5.19
Attribute Category	Positive Words	Valence Rating	Negative Words	Valence Rating
	friend	7.74	pollute	1.85
	delight	8.26	poison	1.98
	cheer	8.10	pain	2.13
	joyful	8.22	failure	1.70
	pleasure	8.38	despise	2.03
	friend	7.74	hatred	1.98
	happy	8.25	rotten	2.26
	excellence	8.38	hurtful	1.90
	admired	7.81	humiliate	2.24
	triumph	7.80	betray	1.68

Note. Valence ratings for 'Target Category' words were obtained from Warriner et al. (2013), and 'Attribute Category' words were obtained from Bradley and Lang (1999). Stimuli words in both categories were rated

on a scale of 1 (extremely negative) to 9 (extremely positive) for valence. The database contained insufficient words relating to MH workers, therefore, 'psychotherapist' and 'support worker' were added.

Appendix D

4-Point Ordinal Alliance Self-Report Scale Items

You will now be presented with a series of statements.

'Mental health workers' include a range of professionals such as support workers, volunteers, mental health nurses, clinical psychologists, psychiatrists, and many more.

Whilst thinking of mental health workers in general, and your own experiences, please rate your opinion of the following statements on a scale ranging from 1 (Strongly Disagree) to 4 (Strongly Agree).

1. I believe that mental health workers are helping me.
2. I am comfortable with the relationship I have with mental health workers.
3. I have a better understanding of the symptoms of my illness since using mental health services.
4. I have been feeling better since mental health workers have been treating me.
5. I feel I can count on mental health workers.
6. I feel I understand the mental health workers who work with me.
7. I feel that mental health workers really understand me.
8. I think that mental health workers give clear explanations.
9. I feel that mental health workers want me to get better.
10. I feel that mental health workers and I work together as a team.
11. I feel that mental health workers and I understand my problems in the same way.

Appendix E

Intervention Poster Stimuli

Figure E1

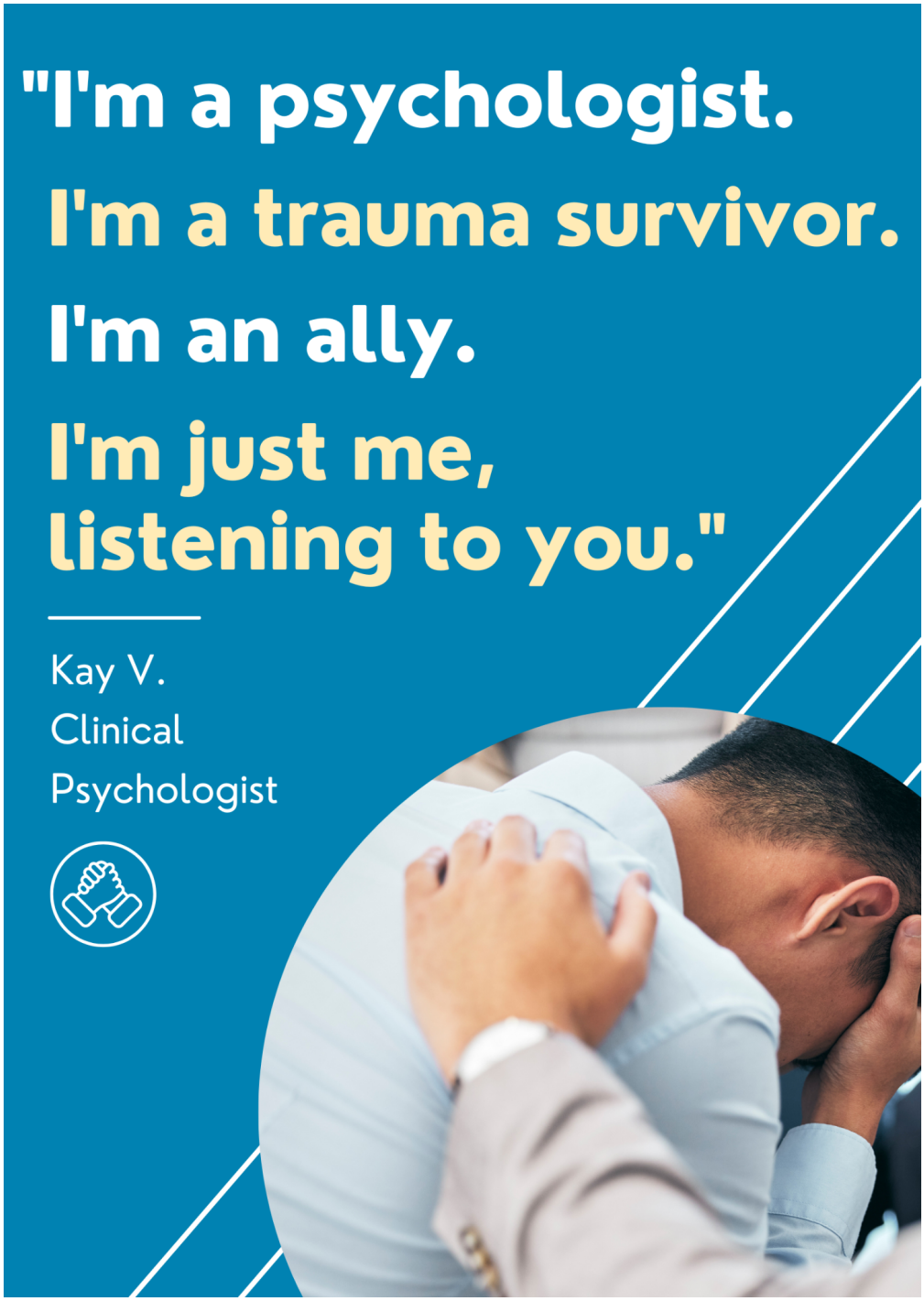
Poster 1: Nurse's Quote

Figure E2

Poster 2: Support Workers' Quote

Figure E3

Poster 3: Clinical Psychologist's Quote



Appendix F

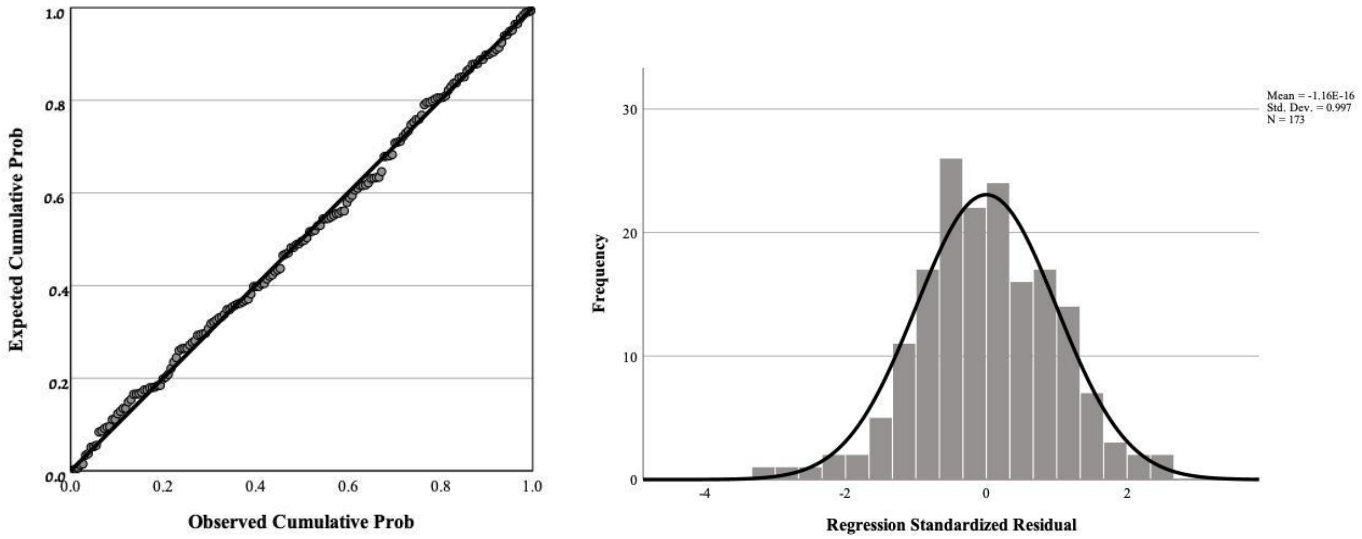
R1: D-Score Simple Linear Regression Assumption Checks

Durbin-Watson Test

The data met the assumption of independent errors as the Durbin-Watson value was close to 2 (Durbin-Watson value = 1.94).

Figure F1

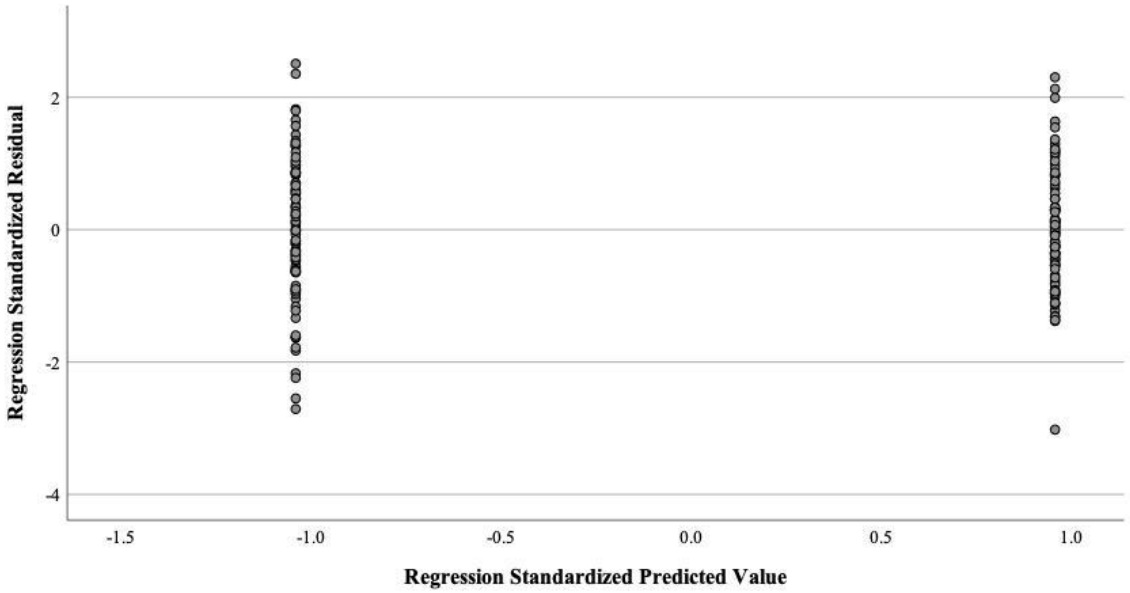
Normal Probability Plot and Histogram for Standardised Residuals of D-Score



Note. The data met the assumption of normality as the normal probability plot illustrated that the standardised residuals of D-Score closely followed the normality line. Additionally, the histogram of standardised residuals followed a normal, bell-curve distribution.

Figure F2

Scatter Plot of Standardised Residuals for D-Score



Note. The data met the assumptions of homoscedasticity and linearity as points appeared randomly distributed.

Appendix G

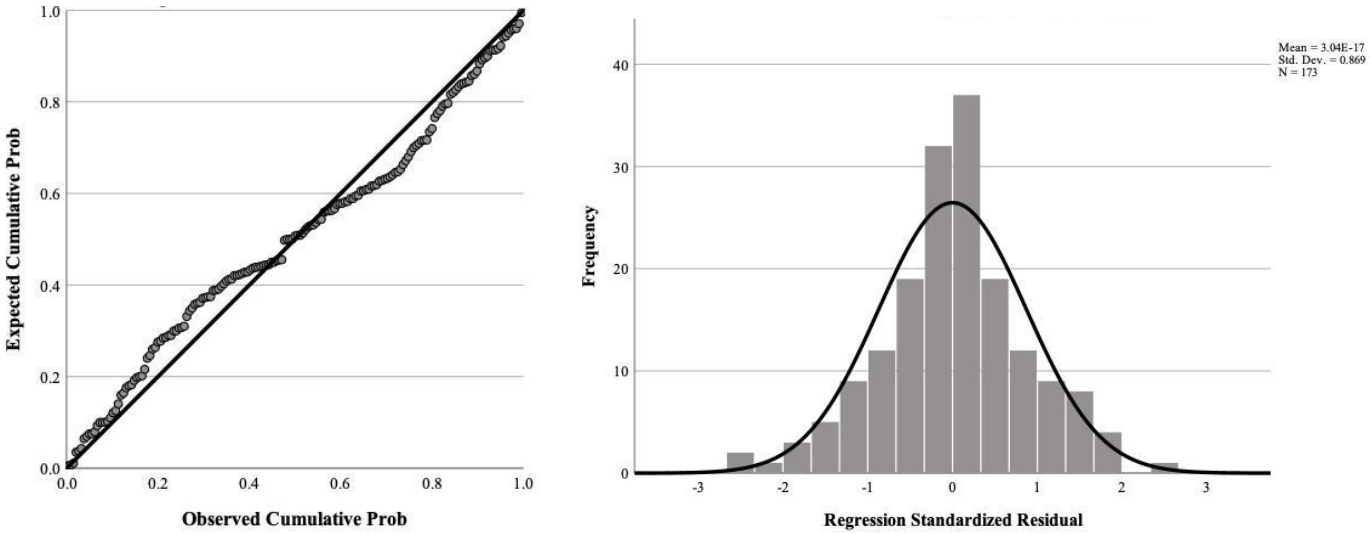
R2, R3, R4, and R5: D-Score Multiple Linear Regression Results, Assumption Checks, and Robustness Checks

Durbin-Watson

The data met the assumption of independent errors as the Durbin-Watson value was close to 2 (Durbin-Watson value = 1.77).

Figure G1

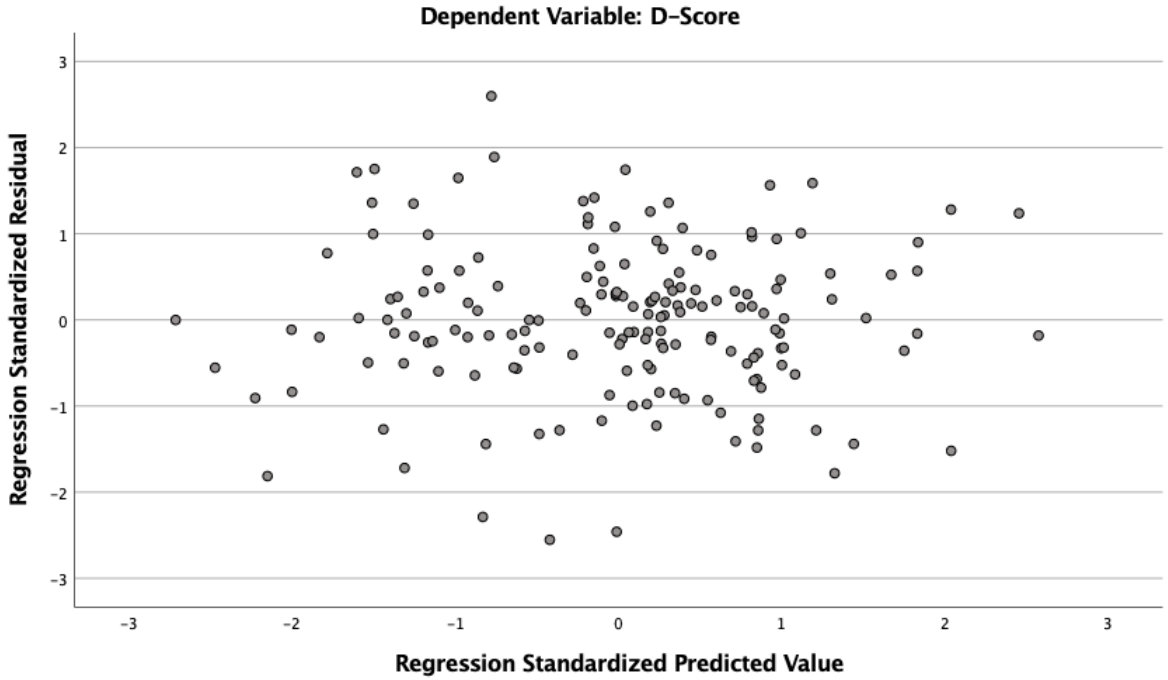
Normal Probability Plot and Histogram for Standardised Residuals of D-Score



Note. The data did not meet the assumption of normality as the normal probability plot illustrated that the standardised residuals of D-Score did not closely follow the normality line. Additionally, the histogram of standardised residuals had a peak which was higher than the normal distribution.

Figure G2

Scatter Plot of Standardised Residuals for D-Score



Note. The data met the assumptions of homoscedasticity and linearity as the points were randomly distributed with no apparent funnelling or curvature.

Table G1

Variance Inflation Factors (VIFs) for D-Score Predictors

Variable	VIF
Condition - Intervention	1.35
Age	1.73
Gender - Male	1.41
Gender - Other	1.26
Ethnicity - Asian	1.22
Ethnicity - Black	1.18
Ethnicity - Mixed Race	1.38
Ethnicity - Other	1.17
Education - Below GCSE	1.23
Education - GCSE	1.67
Education - A-Level	1.51
Education - Postgraduate	1.53
Education - Other	1.56
Source of Recruitment - Call for Participants	1.75
Source of Recruitment - MH Charity	1.18
Source of Recruitment - Social Media	1.69
Source of Recruitment - SurveyCircle	1.61
Source of Recruitment - SurveySwap	1.20
Source of Recruitment - Other	1.38
MH Service - Charity	1.60
MH Service - Counselling/Psychotherapy	1.76
MH Service -Support Group	1.59
MH Service - Community Mental Health Team	1.91
MH Service - Social Care	1.54
MH Service - Residential Care	1.24
MH Service - Crisis Intervention	1.86
MH Service - Hospital Out-Patient	1.40
MH Service - Hospital In-Patient	1.56
MH Concern - Depression	1.21

Variable	VIF
MH Concern - Anxiety	1.33
MH Concern - Bipolar Disorder	1.52
MH Concern - Schizophrenia	1.28
MH Concern - Post-traumatic Stress disorder/Complex Post-Traumatic Stress Disorder	1.82
MH Concern - Obsessive Compulsive Disorder	1.67
MH Concern - Eating Disorder	1.59
MH Concern - Substance Abuse	1.34
MH Concern - Attention Deficit Hyperactivity Disorder	1.44
MH Concern - Autism Spectrum Disorder	1.47
MH Concern - Emotionally Unstable Personality Disorder	1.32
Receiving Ongoing Support	1.42
Rating of Service Helpfulness	1.25
Previous Disputes	4.00
Dispute Severity	3.47

Note. The data met the assumption of having no multicollinearity as all VIFs were below the maximum upper limit of 10, and ranged from 1.17 to 4.0 (James et al., 2021).

Table G2

R2: Regression Analysis Results of Intervention Group and All Covariates' Impact on D-Score

Variable	*B*	*SE*	95% CI	β	*t*	*p*
(Intercept)	0.43	0.25	[-0.07, 0.93]	0.00	1.71	.089
Condition - Intervention	0.21	0.07	[0.06, 0.36]	0.24	2.80	.006**
Age	-0.0006	0.003	[-0.007, 0.006]	-0.02	-0.19	.852
Gender - Male	-0.04	0.08	[-0.20, 0.13]	-0.04	-0.46	.649
Gender - Other	0.18	0.24	[-0.29, 0.66]	0.06	0.76	.447
Ethnicity - Asian	0.04	0.17	[-0.30, 0.37]	0.02	0.21	.832
Ethnicity - Black	0.31	0.33	[-0.33, 0.96]	0.08	0.96	.337
Ethnicity - Mixed Race	0.14	0.22	[-0.31, 0.58]	0.05	0.61	.544
Ethnicity - Other	-0.24	0.27	[-0.77, 0.28]	-0.07	-0.91	.362

Variable	*B*	*SE*	95% CI	β	*t*	*p*
Education - Below GCSE	0.01	0.33	[-0.65, 0.67]	0.003	0.03	.973
Education - GCSE	-0.19	0.13	[-0.45, 0.08]	-0.14	-1.40	.163
Education - A-Level	-0.09	0.12	[-0.33, 0.14]	-0.07	-0.80	.426
Education - Postgraduate	-0.06	0.08	[-0.22, 0.11]	-0.06	-0.65	.514
Education - Other	-0.16	0.31	[-0.77, 0.44]	-0.05	-0.53	.595
Source of Recruitment - Call for Participants	0.01	0.13	[-0.24, 0.27]	0.010	0.10	.923
Source of Recruitment - MH Charity	-0.72	0.46	[-1.62, 0.19]	-0.13	-1.56	.121
Source of Recruitment - Social Media	0.02	0.14	[-0.26, 0.30]	0.01	0.14	.890
Source of Recruitment - SurveyCircle	0.17	0.11	[-0.05, 0.39]	0.15	1.54	.125
Source of Recruitment - SurveySwap	-0.28	0.27	[-0.81, 0.26]	-0.08	-1.02	.307
Source of Recruitment - Other	-0.02	0.21	[-0.43, 0.39]	-0.009	-0.10	.921
MH Service - Charity	-0.09	0.08	[-0.25, 0.07]	-0.11	-1.12	.267
MH Service - Counselling/Psychotherapy	-0.22	0.12	[-0.46, 0.03]	-0.17	-1.75	.082
MH Service - Support Group	0.11	0.11	[-0.11, 0.34]	0.09	1.00	.319
MH Service - Community Mental Health Team	-0.07	0.10	[-0.27, 0.13]	-0.07	-0.65	.516
MH Service - Social Care	0.14	0.14	[-0.14, 0.42]	0.09	0.97	.336
MH Service - Residential Care	0.10	0.33	[-0.56, 0.76]	0.03	0.30	.764
MH Service - Crisis Intervention	-0.24	0.14	[-0.52, 0.03]	-0.18	-1.74	.085
MH Service - Hospital Out-Patient	0.02	0.13	[-0.25, 0.29]	0.01	0.15	.880
MH Service - Hospital In-Patient	0.006	0.16	[-0.32, 0.33]	0.003	0.03	.973
MH Concern - Depression	-0.02	0.08	[-0.17, 0.14]	-0.02	-0.20	.844
MH Concern - Anxiety	0.03	0.09	[-0.15, 0.22]	0.03	0.37	.710
MH Concern - Bipolar Disorder	-0.35	0.20	[-0.74, 0.05]	-0.16	-1.73	.086
MH Concern - Schizophrenia	0.12	0.48	[-0.82, 1.07]	0.02	0.26	.797
MH Concern - Post-traumatic Stress disorder/Complex Post-Traumatic Stress Disorder	0.13	0.11	[-0.09, 0.35]	0.12	1.15	.251
MH Concern - Obsessive Compulsive Disorder	0.07	0.12	[-0.17, 0.32]	0.06	0.61	.542
MH Concern - Eating Disorder	-0.12	0.11	[-0.33, 0.08]	-0.11	-1.18	.239
MH Concern - Substance Abuse	0.04	0.19	[-0.34, 0.41]	0.02	0.19	.848

Variable	*B*	*SE*	95% CI	β	*t*	*p*
MH Concern - Attention Deficit Hyperactivity Disorder	0.13	0.21	[-0.29, 0.54]	0.05	0.61	.543
MH Concern - Autism Spectrum Disorder	0.05	0.26	[-0.46, 0.56]	0.02	0.19	.851
MH Concern - Emotionally Unstable Personality Disorder	0.24	0.24	[-0.24, 0.72]	0.08	0.98	.329
Receiving Ongoing Support	-0.11	0.08	[-0.26, 0.05]	-0.12	-1.39	.166
Rating of Service Helpfulness	0.001	0.002	[-0.002, 0.005]	0.07	0.81	.417
Previous Disputes	0.32	0.16	[0.009, 0.63]	0.31	2.04	.044*
Dispute Severity	-0.004	0.003	[-0.01, 0.002]	-0.19	-1.39	.167

Note. Results: $F(43,129) = 1.13$, $p = .300$, $R^2 = .27$

Unstandardized Regression Equation: D-Score = 0.43 + 0.21ConditionIntervention - 0.0006*Age - 0.04*Gender_Male + 0.18*Gender_Other + 0.04*Ethnicity_Asian + 0.31*Ethnicity_Black + 0.14*Ethnicity_Mixed - 0.24*Ethnicity_Other + 0.01*Education_BelowGCSE - 0.19*Education_GCSE - 0.09*Education_Alevel - 0.06*Education_Postgraduate - 0.16*Education_Other + 0.01*Recruitment_CallForParticipants - 0.72*Recruitment_Charity + 0.02*Recruitment_SocialMedia + 0.17*Recruitment_SurveyCircle - 0.28*Recruitment_SurveySwap - 0.02*Recruitment_Other - 0.09*MHService_Charity - 0.22*MHService_CounsellingPsychotherapy + 0.11*MHService_Supportgroup - 0.07*MHService_CMHT + 0.14*MHService_SocialCare + 0.10*MHService_ResidentialCare - 0.24*MHService_CrisisIntervention + 0.02*MHService_HospitalOutPatient + 0.006*MHService_HospitalInPatient - 0.02*MHConcern_Depression + 0.03*MHConcern_Anxiety - 0.35*MHConcern_BPD + 0.12*MHConcern_Schizophrenia + 0.13*MHConcern_PTSD_CPTSD + 0.07*MHConcern_OCD - 0.12*MHConcern_EatingDisorder - 0.04*MHConcern_SubstanceAbuse + 0.13*MHConcern_ADHD + 0.05*MHConcern_ASD + 0.24*MHConcern_EUPD - 0.11*Ongoing_Support_No + 0.001*HelpfulnessRating + 0.32*PreviousDisputes - 0.004*DisputeSeverity

* $p < .05$, ** $p < .01$

Table G3

R3, robustness check: Regression Analysis Results of Intervention Group and General Demographic Interaction Terms' Impact on D-Score

Variable	*B*	*SE*	95% CI	β	*t*	*p*
(Intercept)	0.23	0.07	[0.08, 0.37]	0.00	3.13	.002
Condition - Intervention	0.20	0.10	[0.02, 0.39]	0.24	2.14	.034*
Gender - Male	-0.10	0.10	[-0.30, 0.09]	-0.11	-1.06	.290
Ethnicity - Mixed Race	0.23	0.27	[-0.29, 0.76]	0.09	0.88	.382
Education - Below GCSE	0.02	0.43	[-0.83, 0.87]	0.006	0.05	.956
Education - GCSE	-0.07	0.16	[-0.39, 0.25]	-0.05	-0.45	.651
Education - Other	-0.41	0.43	[-1.26, 0.43]	-0.13	-0.96	.337
Source of Recruitment - Call for Participants	0.07	0.15	[-0.23, 0.37]	0.05	0.47	.641
Source of Recruitment - SurveyCircle	0.15	0.12	[-0.09, 0.39]	0.13	1.21	.228
Source of Recruitment - Survey Swap	-0.27	0.30	[-0.87, 0.33]	-0.08	-0.88	.380
Condition x Gender Male	0.04	0.15	[-0.26, 0.33]	0.03	0.24	.812
Condition x Ethnicity Mixed Race	-0.16	0.41	[-0.96, 0.64]	-0.04	-0.39	.694
Condition x Education - Below GCSE	0.46	0.60	[-0.73, 1.65]	0.08	0.76	.447
Condition x Education - GCSE	0.07	0.21	[-0.35, 0.49]	0.04	0.35	.729
Condition x Education - Other	0.86	0.53	[-0.18, 1.90]	0.21	1.63	.105
Condition x Source of Recruitment - Call for Participants	-0.15	0.21	[-0.56, 0.27]	-0.08	-0.70	.488
Condition x Source of Recruitment - SurveyCircle	-0.12	0.19	[-0.49, 0.25]	-0.07	-0.63	.527
Condition x Source of Recruitment - SurveySwap	0.46	0.52	[-0.57, 1.49]	0.08	0.88	.378

Note. Results: $F(17,155) = 1.37$, $p = .160$, $R^2 = .13$

Unstandardized Regression Equation: D-Score = 0.23 + 0.20*ConditionIntervention - 0.10*Gender_Male + 0.23*Ethnicity_Mixed + 0.02*Education_BelowGCSE - 0.07*Education_GCSE - 0.41*Education_Other + 0.07*Recruitment_CallForParticipants + 0.15*Recruitment_SurveyCircle - 0.27*Recruitment_SurveySwap + 0.04*ConditionxGender_Male - 0.16*ConditionxEthnicity_Mixed + 0.46*ConditionxEducation_BelowGCSE + 0.07*ConditionxEducation_GCSE +

0.86*ConditionxEducation_Other - 0.15*ConditionxRecruitment_CallForParticipants - 0.12*ConditionxRecruitment_SurveyCircle + 0.46*ConditionxRecruitment_SurveySwap

Predictors showing high multicollinearity were removed.

* $p < .05$, ** $p < .01$

Table G4

R4, robustness check: Regression Analysis Results of Intervention Group and MH Demographic Interaction Terms' Impact on D-Score

Variable	*B*	*SE*	95% CI	β	*t*	*p*
(Intercept)	0.19	0.06	[0.07, 0.31]	0.00	3.21	.002
Condition - Intervention	0.25	0.08	[0.09, 0.41]	0.29	3.07	.003**
MH Concern - Obsessive Compulsive Disorder	0.11	0.13	[-0.14, 0.37]	0.09	0.87	.384
MH Concern - Eating Disorder	-0.03	0.12	[-0.26, 0.20]	-0.03	-0.24	.812
MH Concern - ADHD	0.24	0.30	[-0.35, 0.83]	0.10	0.80	.427
Previous Disputes	0.05	0.11	[-0.18, 0.28]	0.05	0.43	.670
Condition x MH Concern - Obsessive Compulsive Disorder	-0.24	0.19	[-0.62, 0.14]	-0.14	-1.24	.218
Condition x MH Concern - Eating Disorder	-0.13	0.17	[-0.47, 0.21]	-0.08	-0.75	.456
Condition x MH Concern - ADHD	-0.22	0.37	[-0.94, 0.51]	-0.08	-0.58	.559
Condition x Previous Disputes	0.12	0.16	[-0.19, 0.43]	0.09	0.76	.449

Note. Results: $F(9,163) = 2.08$, $p = .034$, $R^2 = .10$

Unstandardized Regression Equation: D-Score = 0.19 + 0.25*ConditionIntervention + 0.11*Disorder_Obsessive-Compulsive Disorder (OCD) - 0.03*Disorder_EatingDisorder + 0.24*Disorder_ADHD + 0.05*PreviousDisputes - 0.24*ConditionxMHConcern_OCD - 0.13*ConditionxMHConcern_EatingDisorder - 0.22*ConditionxMHConcern_ADHD + 0.12*ConditionxPreviousDisputes

Predictors showing high multicollinearity were removed.

* $p < .05$, ** $p < .01$

Table G5

R5, robustness check: Regression Analysis Results of a Better Fitting, Exploratory Model's Impact on D-Score

Variable	*B*	*SE*	95% CI	β	*t*	*p*
(Intercept)	0.17	0.14	[-0.10, 0.44]	0.00	1.23	.221
Condition - Intervention	0.22	0.06	[0.09, 0.35]	0.26	3.39	< .001**
Ethnicity - Black	0.31	0.29	[-0.26, 0.89]	0.08	1.08	.284
Ethnicity - Mixed Race	0.17	0.19	[-0.20, 0.54]	0.07	0.92	.359
Ethnicity - Other	-0.12	0.24	[-0.60, 0.35]	-0.04	-0.51	.613
MH Service - Charity	-0.07	0.07	[-0.21, 0.07]	-0.08	-1.00	.319
MH Service - Counselling	-0.13	0.09	[-0.31, 0.06]	-0.10	-1.38	.170
MH Service - Social Care	0.11	0.12	[-0.14, 0.35]	0.07	0.87	.387
MH Service - Crisis Intervention	-0.25	0.11	[-0.47, -0.03]	-0.19	-2.29	.023*
MH Concern - Bipolar Disorder	-0.24	0.17	[-0.58, 0.09]	-0.11	-1.44	.151
MH Concern - Post-traumatic Stress disorder/Complex Post-Traumatic Stress Disorder	0.12	0.08	[-0.05, 0.28]	0.11	1.38	.170
MH Concern - Emotionally Unstable Personality Disorder	0.18	0.21	[-0.24, 0.61]	0.06	0.85	.397
Ratings of Helpfulness	0.002	0.001	[-0.0005, 0.005]	0.12	1.66	.099
Previous Disputes	0.26	0.12	[0.02, 0.50]	0.25	2.17	.032*
Dispute Severity	-0.004	0.003	[-0.009, 0.001]	-0.18	-1.52	.131

Note. Results: $F(14,158) = 2.51$, $p = .003$, $R^2 = .18$

Unstandardized Regression Equation: D-Score = 0.17 + 0.22*ConditionIntervention + 0.31*Ethnicity_Black + 0.17*Ethnicity_MixedRace - 0.12*Ethnicity_Other - 0.07*MHService_Charity - 0.13*MHService_CounsellingPsychotherapy + 0.11*MHService_SocialCare - 0.25*MHService_CrisisIntervention - 0.24*MHConcern_Bipolar Disorder + 0.12*MHConcern_PTSD_CPTSD + 0.18*MHConcern_EUPD + 0.002*HelpfulnessRating + 0.26*PreviousDisputes - 0.004*DisputeSeverity

Predictors showing high multicollinearity were removed.

* $p < .05$, ** $p < .01$

Appendix H

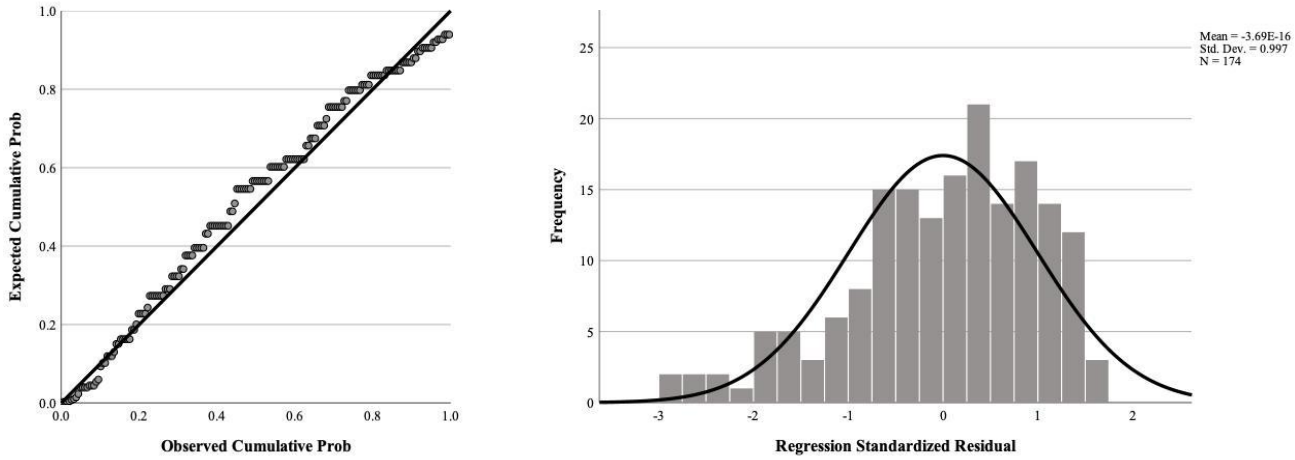
R6: 4-POASR Score Simple Linear Regression Assumption Checks

Durbin-Watson Test

The data met the assumption of independent errors as the Durbin-Watson value was close to 2 (Durbin-Watson value = 2.25).

Figure H1

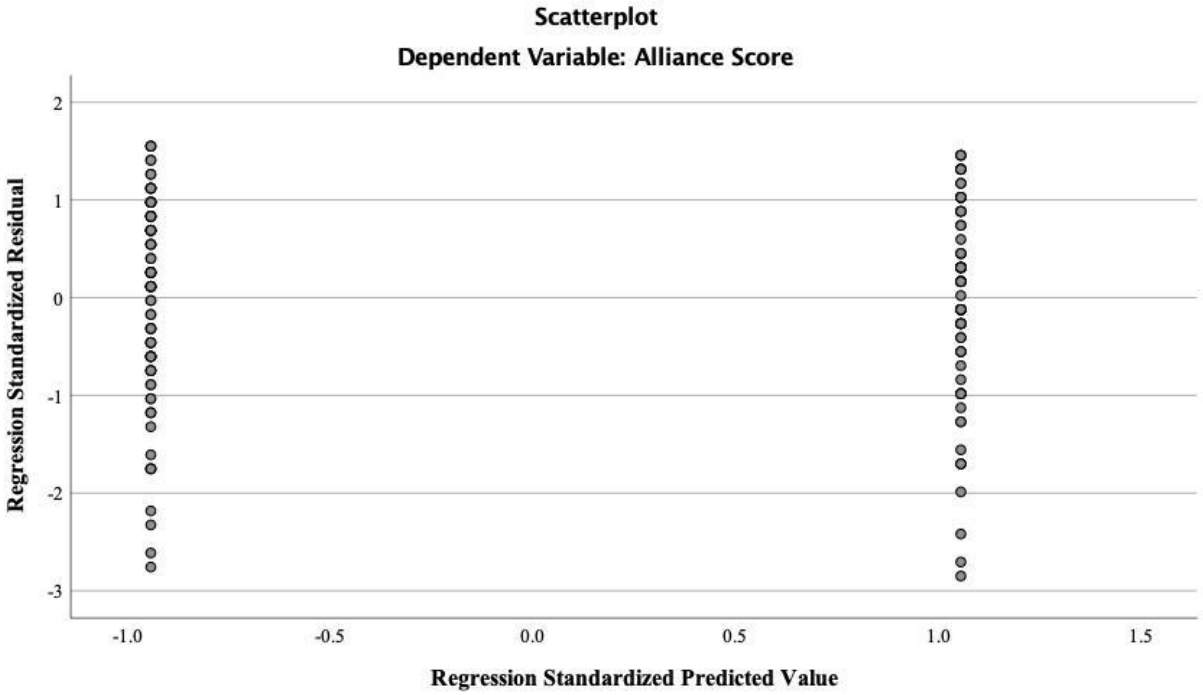
Normal Probability Plot and Histogram for Standardised Residuals of 4-POASR Score



Note. The data did not meet the assumption of normality as the normal probability plot illustrated that the standardised residuals of 4-POASR Score did not closely follow the normality line. Additionally, the histogram showed that standardised residuals did not follow the normal bell-curve.

Figure H2

Scatter Plot of Standardised Residuals for 4-POASR Score



Note. The data met the assumptions of homoscedasticity and linearity as points appeared randomly distributed.

Appendix I

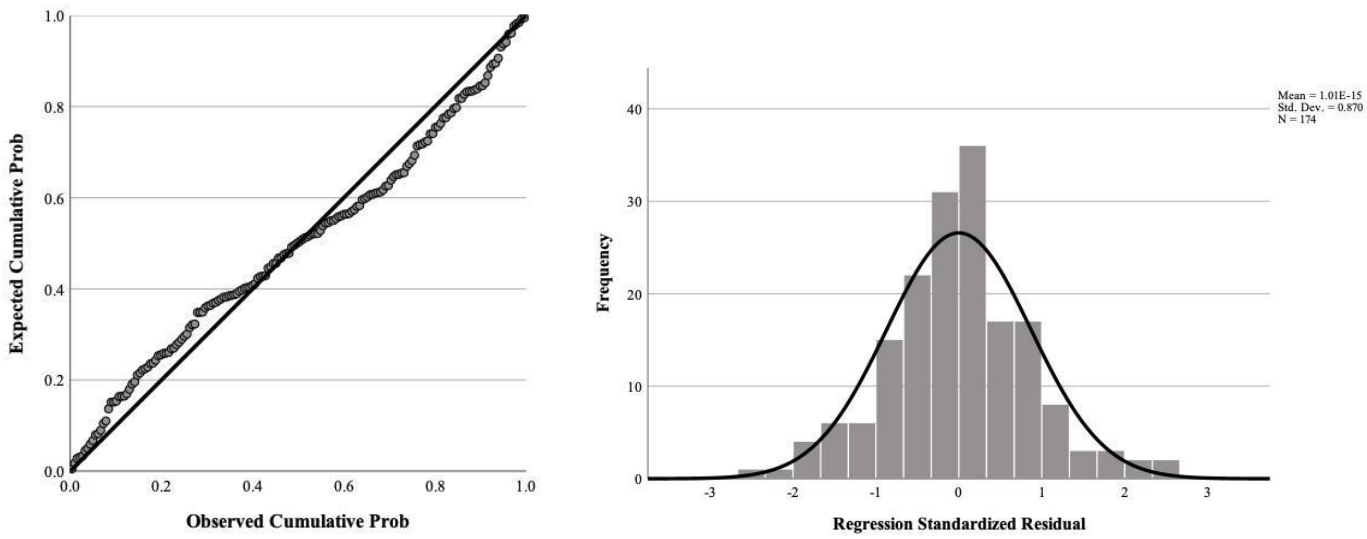
R7, R8, R9, and R10: 4-POASR Multiple Linear Regression Results, Assumption Checks, and Robustness Checks

Durbin-Watson

The data met the assumption of independent errors as the Durbin-Watson value was close to 2 (Durbin-Watson value = 2.06)

Figure I1

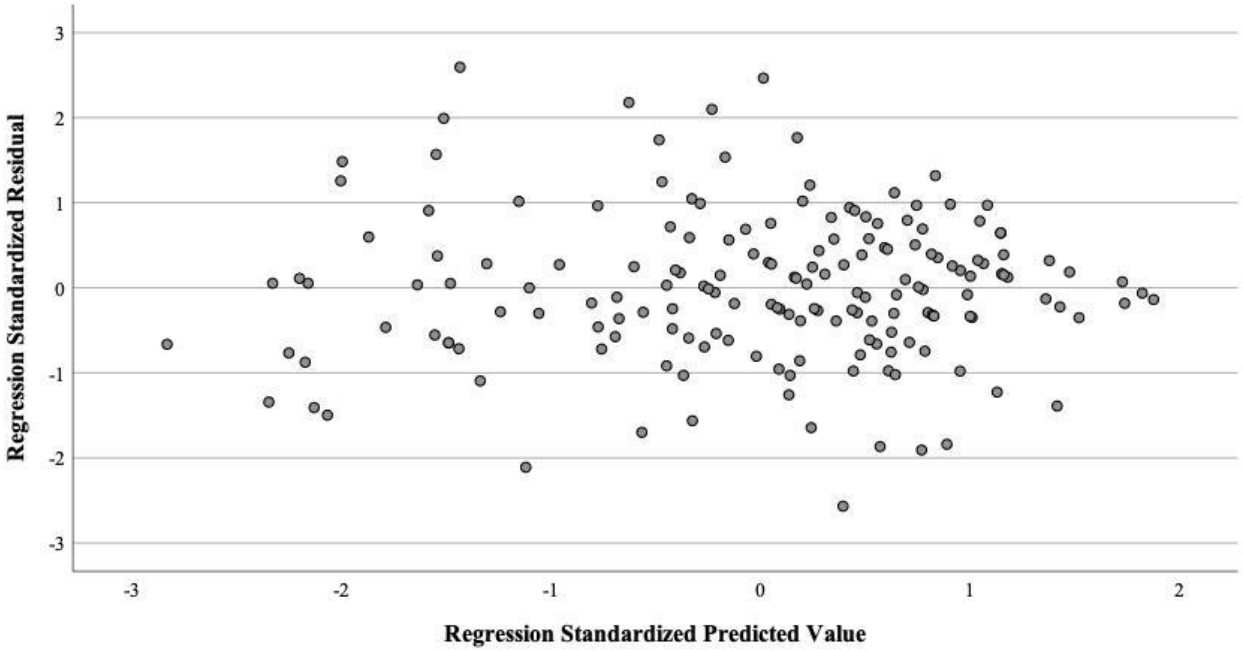
Normal Probability Plot and Histogram for Standardised Residuals of 4-POASR Score.



Note. The data did not meet the assumption of normality as the normal probability plot illustrated that the standardised residuals of D-Score did not closely follow the normality line. Additionally, the histogram of standardised residuals had a peak which was higher than the normal distribution.

Figure I2

Scatter Plot of Standardised Residuals for 4-POASR Score



Note. The data met the assumptions of homoscedasticity and linearity as the points were randomly distributed. To rule out funnelling, I conducted an F test for heteroscedasticity, which showed that the variance of errors was independent of the values of the predictor variables, $F(1, 172) = .025$, $p = .875$.

Table I1

Variance Inflation Factors (VIFs) for 4-POASR Score Predictors

Variable	VIF
Condition - Intervention	1.38
Age	1.72
Gender - Male	1.46
Gender - Other	1.27
Ethnicity - Asian	1.22

Variable	VIF
Ethnicity - Black	1.18
Ethnicity - Mixed Race	1.40
Ethnicity - Other	1.21
Education - Below GCSE	1.23
Education - GCSE	1.67
Education - A-Level	1.58
Education - Postgraduate	1.49
Education - Other	1.56
Source of Recruitment - Call for Participants	1.85
Source of Recruitment - MH Charity	1.52
Source of Recruitment - Social Media	1.69
Source of Recruitment - SurveyCircle	1.60
Source of Recruitment - SurveySwap	1.20
Source of Recruitment - Other	1.38
MH Service - Charity	1.60
MH Service - Counselling/Psychotherapy	1.83
MH Service -Support Group	1.52
MH Service - Community Mental Health Team	1.79
MH Service - Social Care	1.52
MH Service - Residential Care	1.48
MH Service - Crisis Intervention	1.87
MH Service - Hospital Out-Patient	1.43
MH Service - Hospital In-Patient	1.57
MH Concern - Depression	1.23
MH Concern - Anxiety	1.36
MH Concern - Bipolar Disorder	1.51
MH Concern - Schizophrenia	1.28
MH Concern - Post-traumatic Stress disorder/Complex Post-Traumatic Stress Disorder	1.82
MH Concern - Obsessive Compulsive Disorder	1.65
MH Concern - Eating Disorder	1.59
MH Concern - Substance Abuse	1.34

Variable	VIF
MH Concern - Attention Deficit Hyperactivity Disorder	1.47
MH Concern - Autism Spectrum Disorder	1.47
MH Concern - Emotionally Unstable Personality Disorder	1.32
Receiving Ongoing Support	1.42
Rating of Service Helpfulness	1.27
Previous Disputes	4.17
Dispute Severity	3.57

Note. The data met the assumption of having no multicollinearity as all VIFs were below the maximum upper limit of 10, and ranged from 1.18 to 4.17 (James et al., 2021).

Table I2

R7: Regression Analysis Results of Intervention Group and All Covariates' Impact on 4-POASR Score

Variable	*B*	*SE*	95% CI	β	*t*	*p*
(Intercept)	18.22	2.55	[13.17, 23.26]	0.00	7.15	< .001
Condition - Intervention	0.02	0.76	[-1.47, 1.52]	0.002	0.03	.978
Age	-0.006	0.03	[-0.07, 0.05]	-0.01	-0.19	.853
Gender - Male	-0.09	0.85	[-1.77, 1.60]	-0.006	-0.10	.917
Gender - Other	-1.28	2.41	[-6.05, 3.50]	-0.03	-0.53	.598
Ethnicity - Asian	-0.98	1.69	[-4.33, 2.37]	-0.03	-0.58	.565
Ethnicity - Black	-3.01	3.27	[-9.48, 3.46]	-0.05	-0.92	.359
Ethnicity - Mixed Race	-0.06	2.09	[-4.18, 4.07]	-0.001	-0.03	.979
Ethnicity - Other	0.81	3.31	[-5.73, 7.36]	0.01	0.25	.807
Education - Below GCSE	-0.23	3.34	[-6.85, 6.39]	-0.004	-0.07	.945
Education - GCSE	0.88	1.33	[-1.76, 3.51]	0.04	0.66	.511
Education - A-Level	0.37	1.19	[-1.99, 2.73]	0.02	0.31	.757
Education - Postgraduate	-0.08	0.83	[-1.73, 1.57]	-0.006	-0.10	.920
Education - Other	-1.10	3.08	[-7.19, 5.00]	-0.02	-0.36	.722
Source of Recruitment - Call for Participants	0.08	1.29	[-2.47, 2.64]	0.004	0.06	.949
Source of Recruitment - MH Charity	2.45	3.71	[-4.89, 9.80]	0.04	0.66	.510

Variable	*B*	*SE*	95% CI	β	*t*	*p*
Source of Recruitment - Social Media	-1.29	1.41	[-4.07, 1.50]	-0.06	-0.92	.362
Source of Recruitment - SurveyCircle	0.32	1.14	[-1.93, 2.58]	0.02	0.28	.776
Source of Recruitment - SurveySwap	-4.41	2.71	[-9.77, 0.94]	-0.08	-1.63	.105
Source of Recruitment - Other	-1.24	2.07	[-5.33, 2.85]	-0.03	-0.60	.550
MH Service - Charity	-1.27	0.82	[-2.90, 0.36]	-0.09	-1.55	.125
MH Service - Counselling/Psychotherapy	1.11	1.24	[-1.34, 3.56]	0.06	0.90	.370
MH Service -Support Group	-0.50	1.11	[-2.70, 1.70]	-0.03	-0.45	.651
MH Service - Community Mental Health Team	-1.62	0.99	[-3.58, 0.33]	-0.10	-1.64	.103
MH Service - Social Care	-2.67	1.41	[-5.46, 0.13]	-0.11	-1.89	.061
MH Service - Residential Care	6.04	3.01	[0.09, 11.98]	0.11	2.01	.047*
MH Service - Crisis Intervention	2.28	1.38	[-0.45, 5.01]	0.10	1.65	.100
MH Service - Hospital Out-Patient	0.27	1.33	[-2.36, 2.90]	0.01	0.20	.840
MH Service - Hospital In-Patient	-3.52	1.59	[-6.66, -0.37]	-0.13	-2.21	.029*
MH Concern - Depression	0.02	0.80	[-1.57, 1.60]	0.001	0.02	.984
MH Concern - Anxiety	-0.11	0.93	[-1.96, 1.73]	-0.007	-0.12	.903
MH Concern - Bipolar Disorder	3.87	1.88	[0.14, 7.60]	0.12	2.05	.042*
MH Concern - Schizophrenia	0.87	4.81	[-8.64, 10.38]	0.009	0.18	.857
MH Concern - Post-traumatic Stress disorder/Complex Post-Traumatic Stress Disorder	0.02	1.11	[-2.17, 2.20]	0.0009	0.01	.988
MH Concern - Obsessive Compulsive Disorder	-1.48	1.22	[-3.89, 0.93]	-0.07	-1.21	.228
MH Concern - Eating Disorder	-0.09	1.06	[-2.18, 2.01]	-0.005	-0.08	.935
MH Concern - Substance Abuse	-0.65	1.89	[-4.39, 3.10]	-0.02	-0.34	.733
MH Concern - Attention Deficit Hyperactivity Disorder	0.19	2.14	[-4.04, 4.41]	0.005	0.09	.931
MH Concern - Autism Spectrum Disorder	-1.36	2.60	[-6.50, 3.77]	-0.03	-0.53	.600
MH Concern - Emotionally Unstable Personality Disorder	-3.69	2.46	[-8.55, 1.18]	-0.08	-1.50	.136
Receiving Ongoing Support	-0.06	0.78	[-1.61, 1.49]	-0.004	-0.08	.940
Rating of Service Helpfulness	0.25	0.02	[0.22, 0.28]	0.79	15.19	< .001**
Previous Disputes	1.65	1.57	[-1.46, 4.76]	0.10	1.05	.297

Variable	*B*	*SE*	95% CI	β	*t*	*p*
Dispute Severity	-0.03	0.03	[-0.10, 0.03]	-0.10	-1.11	.270

Note. Results: Results: $F(43,130) = 7.82$, $p < .001$, $R^2 = .72$

Unstandardized Regression Equation: 4-POASR Score = 18.22 + 0.02*ConditionIntervention - 0.006*Age - 0.09*Gender_Male - 1.28*Gender_Other - 0.98*Ethnicity_Asian - 3.01*Ethnicity_Black + 0.06*Ethnicity_Mixed + 0.81*Ethnicity_Other - 0.23*Education_BelowGCSE + 0.88*Education_GCSE + 0.37*Education_Alevel - 0.08*Education_Postgraduate - 1.10*Education_Other + 0.08*Recruitment_CallForParticipants + 2.45*Recruitment_Charity - 1.29*Recruitment_SocialMedia + 0.32*Recruitment_SurveyCircle - 4.41*Recruitment_SurveySwap - 1.24*Recruitment_Other - 1.27*MHService_Charity + 1.11*MHService_CounsellingPsychotherapy - 0.50*MHService_Supportgroup - 1.62*MHService_CMHT - 2.67*MHService_SocialCare + 6.04*MHService_ResidentialCare + 2.28*MHService_CrisisIntervention + 0.27*MHService_HospitalOutPatient - 3.52*MHService_HospitalInPatient + 0.02*MHConcern_Depression - 0.11*MHConcern_Anxiety + 3.87*MHConcern_BPD + 0.87*MHConcern_Schizophrenia + 0.02*MHConcern_PTSD - 1.48*MHConcern_OCD - 0.09*MHConcern_EatingDisorders - 0.65*MHConcern_SubstanceAbuse + 0.19 * MHConcern_ADHD - 1.36 * MHConcern_ASD - 3.69*MHConcern_EUPD - 0.06*OngoingSupport_No + 0.25*Helpfulness + 1.65*PreviousDisputes - 0.03*DisputeSeverity

* $p < .05$, ** $p < .01$

Table I3

R8, robustness check: Regression Analysis Results of Intervention Group and General Demographic Interaction Terms' Impact on 4-POASR Score

Variable	*B*	*SE*	95% CI	β	*t*	*p*
(Intercept)	35.19	1.60	[32.04, 38.35]	0.00	22.03	< .001
Condition - Intervention	-1.66	2.08	[-5.76, 2.45]	-0.12	-0.80	.426
Gender - Male	-0.83	1.72	[-4.23, 2.56]	-0.05	-0.48	.629
Ethnicity - Black	0.19	7.56	[-14.76, 15.13]	0.003	0.02	.980
Ethnicity - Mixed Race	0.54	4.11	[-7.59, 8.67]	0.01	0.13	.895
Education - Below GCSE	6.64	7.33	[-7.85, 21.13]	0.10	0.91	.367
Education - GCSE	-3.15	2.95	[-8.98, 2.67]	-0.14	-1.07	.287

Variable	*B*	*SE*	95% CI	β	*t*	*p*
Education - A-Level	-0.96	2.61	[-6.11, 4.19]	-0.05	-0.37	.712
Education - Postgraduate	-0.88	1.89	[-4.62, 2.86]	-0.06	-0.47	.642
Education - Other	4.64	7.33	[-9.85, 19.13]	0.09	0.63	.528
Source of Recruitment - Call for Participants	-3.38	2.69	[-8.70, 1.94]	-0.17	-1.26	.211
Source of Recruitment - MH Charity	-7.36	7.33	[-21.85, 7.13]	-0.11	-1.00	.317
Source of Recruitment - SurveyCircle	1.45	2.25	[-2.99, 5.89]	0.07	0.65	.519
Source of Recruitment - SurveySwap	-9.84	5.17	[-20.05, 0.38]	-0.18	-1.90	.059
Source of Recruitment - Other	4.22	5.24	[-6.13, 14.57]	0.11	0.81	.421
Condition x Gender Male	0.20	2.58	[-4.90, 5.30]	0.009	0.08	.937
Condition x Ethnicity Black	-14.88	10.50	[-35.63, 5.88]	-0.16	-1.42	.159
Condition x Ethnicity Mixed Race	-3.77	6.69	[-16.99, 9.46]	-0.06	-0.56	.575
Condition x Education Below GCSE	-11.17	10.27	[-31.47, 9.12]	-0.12	-1.09	.278
Condition x Education GCSE	-0.20	3.85	[-7.80, 7.41]	-0.007	-0.05	.959
Condition x Education A-Level	1.07	3.63	[-6.10, 8.24]	0.04	0.30	.768
Condition x Education Postgraduate	3.04	2.69	[-2.28, 8.35]	0.16	1.13	.261
Condition x Education Other	-1.36	8.98	[-19.10, 16.38]	-0.02	-0.15	.880
Condition x Recruitment Call for Participants	2.49	3.68	[-4.78, 9.76]	0.09	0.68	.500
Condition x Recruitment MH Charity	12.34	10.50	[-8.42, 33.10]	0.13	1.18	.242
Condition x Recruitment SurveyCircle	-2.62	3.35	[-9.23, 4.00]	-0.09	-0.78	.436
Condition x Recruitment SurveySwap	13.30	8.86	[-4.20, 30.81]	0.15	1.50	.135
Condition x Recruitment Other	-7.47	6.47	[-20.25, 5.31]	-0.16	-1.15	.250

Note. Results: $F(27,146) = 0.79$, $p = .755$, $R^2 = .13$

Unstandardized Regression Equation: 4-POASR = 35.19 - 1.66*ConditionIntervention - 0.83*Gender_Male + 0.19*Ethnicity_Black + 0.54*Ethnicity_MixedRace + 6.64*Education_BelowGCSE - 3.15*Education_GCSE - 0.96*Education_Alevel - 0.88*Education_Postgraduate + 4.64*Education_Other - 3.38*Recruitment_CallforParticipants - 7.36*Recruitment_MHCharity + 1.45*Recruitment_SurveyCircle - 9.84*Recruitment_SurveySwap + 4.22*Recruitment_Other + 0.20*ConditionxGender_Male - 14.88*ConditionxEthnicity_Black - 3.77*ConditionxEthnicity_MixedRace - 11.17*ConditionxEducation_BelowGCSE - 0.20*ConditionxEducation_GCSE+ 1.07*ConditionxEducation_Alevel + 3.04*ConditionxEducation_Postgraduate - 1.36*ConditionxEducation_Other + 2.49*ConditionxRecruitment_CallforParticipants +

12.34*ConditionxRecruitment_Charity - 2.62*ConditionxRecruitment_SurveyCircle +
13.30*ConditionxRecruitment_SurveySwap - 7.47*ConditionxRecruitment_Other
Predictors showing high multicollinearity were removed.

Table I4

R9, robustness check: Regression Analysis Results of Intervention Group and MH Demographic Interaction Terms' Impact on 4-POASR Score

Variable	*B*	*SE*	95% CI	β	*t*	*p*
(Intercept)	35.29	1.09	[33.14, 37.44]	0.00	32.44	< .001
Condition - Intervention	0.10	1.55	[-2.96, 3.16]	0.007	0.07	.948
MH Service - MH Charity	-1.56	1.72	[-4.95, 1.83]	-0.11	-0.91	.364
MH Service - Support Group	0.06	2.32	[-4.53, 4.64]	0.003	0.02	.981
MH Service - Social Care	-0.50	2.52	[-5.47, 4.47]	-0.02	-0.20	.843
MH Service - Hospital In-Patient	-4.30	3.53	[-11.28, 2.68]	-0.16	-1.22	.226
MH Concern - Obsessive Compulsive Disorder	-2.62	2.19	[-6.94, 1.71]	-0.13	-1.19	.234
MH Concern - Eating Disorder	-2.73	1.98	[-6.64, 1.18]	-0.15	-1.38	.169
MH Concern - ADHD	4.21	4.88	[-5.43, 13.85]	0.11	0.86	.390
Previous Disputes	1.19	2.03	[-2.82, 5.20]	0.07	0.59	.558
Condition x MH Service - MH Charity	-0.02	2.28	[-4.52, 4.48]	-0.001	-0.010	.992
Condition x MH Service - Support Group	-1.49	3.08	[-7.57, 4.59]	-0.06	-0.48	.629
Condition x MH Service - Social Care	7.81	4.07	[-0.23, 15.84]	0.21	1.92	.057
Condition x MH Service - Hospital In-Patient	1.25	4.48	[-7.60, 10.11]	0.04	0.28	.780
Condition x MH Concern - Obsessive Compulsive Disorder	-3.62	3.18	[-9.90, 2.65]	-0.13	-1.14	.255
Condition x MH Concern - Eating Disorder	1.54	2.91	[-4.22, 7.29]	0.06	0.53	.598
Condition x MH Concern - ADHD	-2.55	6.00	[-14.41, 9.31]	-0.06	-0.42	.671
Condition x Previous Disputes	-3.61	2.64	[-8.83, 1.60]	-0.17	-1.37	.173

Note. Results: $F(17,156) = 1.69$, $p = .050$, $R^2 = .16$

Unstandardized Regression Equation: 4-POASR= 35.29 + 0.10*ConditionIntervention - 1.56*MHService_MHCharity + 0.06*MHService_SupportGroup - 0.50*MHService_SocialCare - 4.30*MHService_HositalpInPatient- 2.62*MHConcern_Obsessive-Compulsive Disorder (OCD) - 2.73*MHConcern_EatingDisorder + 4.21*MHConcern_ADHD + 1.19*PreviousDisputes - 0.02*ConditionxMHService_MHCharity - 1.49*ConditionxMHService_SupportGroup + 7.81*ConditionxMHService_SocialCare + 1.25*ConditionxMHService_HospitalInPatient - 3.62*ConditionxMHConcern_Obsessive-Compulsive Disorder (OCD) + 1.54*ConditionxMHConcern_EatingDisorder - 2.55*ConditionxMHConcern_ADHD - 3.61*ConditionxPreviousDisputes

Predictors showing high multicollinearity were removed.

Table I5

R10, robustness check: Regression Analysis Results of a Better Fitting, Exploratory Model's Impact on 4-POASR Score

Variable	*B*	*SE*	95% CI	β	*t*	*p*
(Intercept)	18.51	1.41	[15.72, 21.31]	0.00	13.09	< .001
Condition - Intervention	-0.04	0.64	[-1.31, 1.22]	-0.003	-0.07	.946
Ethnicity - Black	-3.23	2.92	[-9.00, 2.53]	-0.05	-1.11	.270
Source of Recruitment - MH Charity	-1.20	1.09	[-3.36, 0.95]	-0.05	-1.10	.272
Source of Recruitment - SurveySwap	-4.21	2.38	[-8.91, 0.49]	-0.08	-1.77	.079
MH Service - MH Charity	-1.04	0.68	[-2.38, 0.29]	-0.07	-1.55	.124
MH Service - Counselling	0.66	0.96	[-1.22, 2.55]	0.03	0.70	.488
MH Service - Community Mental Health Teams (CMHT)	-1.13	0.78	[-2.67, 0.42]	-0.07	-1.44	.152
MH Service - Social Care	-2.09	1.21	[-4.48, 0.29]	-0.08	-1.73	.085
MH Service - Residential Care	7.55	2.42	[2.76, 12.33]	0.14	3.11	.002**
MH Service - Hospital In-Patient	-2.37	1.31	[-4.96, 0.23]	-0.09	-1.80	.073
MH Concern- Bipolar Disorder	3.77	1.59	[0.64, 6.90]	0.11	2.38	.019*
MH Concern - Obsessive-Compulsive Disorder (OCD)	-1.30	0.99	[-3.25, 0.64]	-0.06	-1.32	.188
MH Concern - Emotionally Unstable Personality Disorder (EUPD)	-3.93	2.12	[-8.12, 0.27]	-0.08	-1.85	.066

Variable	*B*	*SE*	95% CI	β	*t*	*p*
Ratings of Helpfulness	0.24	0.01	[0.21, 0.27]	0.78	16.83	< .001**
Previous Disputes	1.17	1.22	[-1.24, 3.58]	0.07	0.96	.338
Dispute Severity	-0.03	0.03	[-0.08, 0.02]	-0.08	-1.08	.282

Note. Results: $F(16,157) = 23.25$, $p < .001$, $R^2 = .70$

Unstandardized Regression Equation: 4-POASR = 18.51 - 0.04*ConditionIntervention - 3.23*Ethnicity_Black - 1.20*Recruitment_SocialMedia - 4.21*Recruitment_SurveySwap - 1.04*MHService_MHCharity + 0.66*MHService_Counselling - 1.13*MHService_Community Mental Health Teams (CMHT) - 2.09*MHService_SocialCare + 7.55*MHService_ResidentialCare - 2.37*MHService_HospitalInPatient + 3.77*MHConcern_Bipolar Disorder - 1.30*MHConcern_Obsessive-Compulsive Disorder (OCD) - 3.93*MHConcern_Emotionally Unstable Personality Disorder (EUPD) + 0.24*HelpfulnessRatings + 1.17*PreviousDisputes - 0.03*DisputeSeverity

Predictors showing high multicollinearity were removed.

* $p < .05$, ** $p < .01$

Appendix J

Thematic Analysis of Open-Text Answers: Opinions of MH Workers and Services

Table J1

Thematic Analysis of Open-Text Answers with Examples: Opinions of MH Workers and Services

Theme	Sub-Theme	Codes	Number of Excerpts in the Control Group	Number of Excerpts in the Intervention Group	Total Number of Excerpts	Example Excerpts
Wider Systemic Concerns	Accessibility Barriers	Difficulty Accessing Services	30	33	63	"I think mental health services are difficult to access and can be frustrating for this reason."
		Long Wait Times	28	25	53	"Waiting lists are currently too long even if people are in great need of help."
		Resorting to Private Care	7	5	12	"Most people, myself included, have had to go private, as waiting lists for the NHS are too long."
		Expensive Services	4	3	7	"There is also a huge accessibility issue because private mental health providers are very expensive and not affordable to everyone."
	Resource Constraints	Underfunded System	30	28	58	"There is not enough services nor funding to keep up with demand which can lead to a breakdown in services - meaning they are not providing an expected level of care that would have been promised"
		Overburdened System	16	20	36	"They are severely overstretched. In one instance of going into hospital when my partner tried to kill herself a mental health nurse said there was little they could do to help since we were already

Theme	Sub-Theme	Codes	Number of Excerpts in the Control Group	Number of Excerpts in the Intervention Group	Total Number of Excerpts	Example Excerpts
						being seen by a mental health team." "The services are very overwhelmed, making the process very slow."
		Limited Resources	8	10	18	"There aren't the resources to deal with the need so I often feel they're doing their best but their best is limited by the lack of resources."
	Workforce Challenges	Workers Overworked	7	15	22	"They seem often overworked and are only able to offer help within the framework they are forced to work in."
		Staff Shortages	11	11	22	"There are not enough staff to treat the patients coming through in a timely manner."
		Workers Not Supported by the System	6	14	20	"In general, I think the people providing the services genuinely want to help but they are trapped in a restrictive system."
		External Pressures on Workers and Services	1	3	4	"Mental health services are also having to deal with external factors which put even more pressure on their staff (e.g., cost of living crisis impact the public wellbeing, as well as the wellbeing of staff)/"
		Workers Underpaid	1	2	3	"Usually empathetic people mostly paid too little in the NHS."
		Workers Becoming Disillusioned	1	0	1	"I do believe that mental health workers do get into the line of work for the right reasons and their heart is in the right place, but I also think that after a few years

Theme	Sub-Theme	Codes	Number of Excerpts in the Control Group	Number of Excerpts in the Intervention Group	Total Number of Excerpts	Example Excerpts
						on the job, many become disillusioned."
	Neglected System	Poor System Structure	0	3	3	"I don't think the worker are the ones causing the issues with mental health services but rather the way the whole system is structured, advertised, organised, etc."
		Lack of Research	1	2	3	"We need better biological understanding of severe mental illness. I know, biopsychosocial yadda yadda yadda and I think maybe that's more true for depression and anxiety, but we really need to understand better how the brain works. Just shoving drugs at people until one of them works is really not good enough."
		Political Sentiments	1	1	2	"There are huge resource problems, the result of years of heartless Tory rule."
TOTAL			152	175	327	
Positive Sentiments Towards MH Workers	Appreciation and Recognition	Recognising Workers' Hardships	23	29	52	"They face considerable challenges, such as high levels of stress and burnout due to the emotionally demanding nature of their work. Additionally, they may encounter systemic issues such as inadequate funding, staffing shortages, and uneven distribution of resources."
		Appreciation of Workers	18	6	24	"I have a very high opinion of mental health workers, their work isn't always easy or appreciated, yet their services are essential."

Theme	Sub-Theme	Codes	Number of Excerpts in the Control Group	Number of Excerpts in the Intervention Group	Total Number of Excerpts	Example Excerpts
		Importance of MH Workers	12	9	21	"I think their job is massively important and they are helping those who need to be helped."
	Therapeutic Relationship	Workers Sincerely Want to Help	12	21	33	"Most of them seem like they really care and want to make sure that you are getting better and want you to meet your goals."
		Helpful	13	14	27	"Mental health workers understood me and worked with me and have helped me to get through what was a very dark time for me."
		Caring	18	8	26	"Overall excellent - caring, compassionate and supportive."
		Workers Try Hard	12	12	24	"I think they're incredibly hard working and do the best that they can given the economic circumstances."
		Understanding	11	8	19	"They want to help you and are very understanding of your problems. They are very patient and understanding with a sincere desire to help."
		Empathetic	8	5	13	"They are knowledgeable, empathetic people who want to help others to feel their best."
		Workers have MHSUs Best Interests in Mind	10	1	11	"I believe that they are good people with my best interests in mind."
		Compassionate	7	3	10	"Their knowledge, compassion, and commitment make a massive difference in the lives of the individuals they assist."
		Knowledgeabl	1	9	10	"I have high regard for their

Theme	Sub-Theme	Codes	Number of Excerpts in the Control Group	Number of Excerpts in the Intervention Group	Total Number of Excerpts	Example Excerpts
		e				knowledge and experience in helping me with my issues."
		Good Communication	0	5	5	"They are good in taking the time to explain what the sessions will consist of and what are the aims/goals for the sessions."
		General Positive Sentiments	4	3	7	"I have had a positive experience with mental health workers."
		Non-Judgemental	1	1	2	"Non-judgemental, which is so important when dealing with mental health issues."
		Reassuring that Workers can Relate to SUs	0	1	1	"It is reassuring sometimes to know that they relate,"
TOTAL			150	135	285	
Collaboration Challenges	Inflexible Approaches	Generic Strategies	14	18	32	"I do not think that a one-size fits all approach taken by mental health services is functioning."
		Workers' Rigidity of Thinking	3	5	8	"Some mental health workers are also too stuck in their own patterns/opinions of what works and what doesn't, it makes them inflexible and sometimes intimidating."
		Disconnect Between Theory and Practice	5	2	7	"Support from health professionals feels more like getting advice from a textbook than an exploration of self. It can feel as though counsellors try to pigeonhole you into a category, then solely suggest the few techniques taught

Theme	Sub-Theme	Codes	Number of Excerpts in the Control Group	Number of Excerpts in the Intervention Group	Total Number of Excerpts	Example Excerpts
						to them on how to treat that definition."
	Barriers to Effective Communication	Impersonal Approaches	6	19	25	"Sometimes it can seem like you are just another client to them, and that can make the experience less personal and affective."
		Individual Differences in Care	5	19	24	"I do not always think we are matched with the best possible mental health worker due to differences such as age, gender, origin of country, understandings and so on."
		Workers Unable to Understand	7	8	15	"I also feel that if they haven't actually suffered mental health problems then they can only help so much."
		Workers' Limited Perspective-taking	5	5	10	"There is a significant lack of belief of experiences, feeling, pain levels, by mental health providers and they always tend to jump to immediate conclusions about my own personal impact on my mental health with out considering the incredible amount of work I have done to remove all possible. self-imposed, reasons for mental health issues"
		Collaboration	6	2	8	"It takes work, on both sides, as learning what the needs are and finding the best solutions can take time."
		Communication Challenges	7	1	8	"Lived problems are hard to translate, even to trained professionals."
		Workers Spending	2	5	7	"The workers are kind, supportive and want best for you but they

Theme	Sub-Theme	Codes	Number of Excerpts in the Control Group	Number of Excerpts in the Intervention Group	Total Number of Excerpts	Example Excerpts
		Insufficient Time with MHSUs				don't have enough time to help you."
		Need to Find Own Solutions	3	2	5	"I always feel like I must be my own advocate, research my own symptoms, and come up with ideas for referrals, then be ready to fight my case in appointments, or risk a lack of contact, or discharge from any services."
		Lack of Communication from Services	2	2	4	"From discharging a patient directly following their being put on a new medication to informing the patient when they ask why they were discharged that contacting and staying in touch with the team works differently now - that instead of waiting for them to get in touch with you periodically, you must get in touch with them and if you haven't within a certain period of time they will assume you don't need their services and discharge you, yet the first you're hearing about this change in contact protocall is as they're telling you why you've been discharged."
		Continuously Have to Build New Relationships	2	0	2	"Only having a limited number of sessions free prevents continuing development and often requires people to wait a long period before seeing someone different and having to build a new relationship again."
		Dismissive Services	1	1	2	"Some of the services have been very dismissive and not interested

Theme	Sub-Theme	Codes	Number of Excerpts in the Control Group	Number of Excerpts in the Intervention Group	Total Number of Excerpts	Example Excerpts
						in my issues."
	Stigma	Stigma Relating to Seeking Help	1	3	4	"Little has been done to reduce the stigma associated with seeking use of what little help is available."
		Prejudice and Discrimination	1	3	4	"I have had bad experiences with them and experienced discrimination and them involving their personal views and beliefs."
		Marginalised Groups	1	2	3	"I also feel that there are a lot of blocks and red tape that prevent us helping certain groups of people."
TOTAL			70	94	164	
Quality of Treatment	Effectiveness of Treatment	Low Quality of Care	7	6	13	"Treatment plans are often below the clinical/empirical recommendations."
		Ineffectiveness of Treatments	9	3	12	"I didn't feel that the treatment I had made any positive difference to my condition - I felt that I was just a number, and that the therapist I spoke to had little to no understanding of autistic people or how anxiety and depression affects those with the condition. In the end, I began pretending to understand and be OK just to get away from the sessions I was doing. I've continued to struggle ever since and don't feel there is any real help available in the UK."
		Over-Reliance on Medication	1	5	6	"I feel they often push people towards medication as opposed to more healthy and sustainable

Theme	Sub-Theme	Codes	Number of Excerpts in the Control Group	Number of Excerpts in the Intervention Group	Total Number of Excerpts	Example Excerpts
						treatments and options."
		Poor Diagnosing	1	1	2	"Huge issue with underdiagnosis of less common conditions and problems."
	Treatment Availability	Need to Expand Treatment Options	8	3	11	"We need more face to face services. Lots online which is good for some people but not for everyone."
		Need for Early Intervention	1	2	3	"There needs to be a greater focus on prevention and catching mental illness earlier, rather than only helping people once they deteriorate past a certain point."
	Continuity of Care	Poor Continuity of Care	8	3	11	"After discharge, community facilities such as support groups are few and far between and may or may not be relevant to individual situations."
		Inconsistent Quality of Care	4	1	5	"It is highly dependent on which particular service you end up in as to whether it is helpful or not."
		Good Continuity of Care	0	2	2	"Through the waiting period I was given access to online resources to help me before the talking therapy started. Highly positive to the services I was provided while on the waiting list and during, I also received calls while on the list to make sure I was okay and still wanted the therapy."
TOTAL			39	26	65	
Evaluation of Services as a	General Evaluations	Positive Evaluations	17	11	28	"My own experience has been positive and I have been lucky enough to receive the help I needed."

Theme	Sub-Theme	Codes	Number of Excerpts in the Control Group	Number of Excerpts in the Intervention Group	Total Number of Excerpts	Example Excerpts
Whole						
		Negative Evaluations	3	8	11	"I think that mental health services are an overall negative experience." "Services are very poor and in crisis."
		Neutral Evaluations	3	1	4	"I have had some positive and negative experiences within the mental health services."
	Importance and Impact	Importance of MH Services	5	4	9	"Mental health services are hugely important and needed."
	Improvement Issues	Further Need for Improvement	1	5	6	"Needs major improvement to genuinely help those in need."
		Services are Improving	0	2	2	"I appreciate that they exist and they are always getting better."
TOTAL			29	31	60	
Lack of Therapeutic Relationship	Lack of Empathy and Support	Uncaring	6	11	17	"My opinion is pretty negative, i think as a whole its just a job, there's no real care. You're a name on a list and they want you out the door or 'cured' asap."
		Lack of empathy	8	3	11	"There are some who obviously do not have the right state of mind or empathy to connect with patients, coming off brutish and unsympathetic in a field that often requires delicate touches."
		Unhelpful	6	3	9	"I find it not very helpful at all. some comments/advice I received was more harmful than helpful."
		Patronising	3	1	4	"As a woman with autism I feel very misunderstood and alienated, and this isn't helped by the

Theme	Sub-Theme	Codes	Number of Excerpts in the Control Group	Number of Excerpts in the Intervention Group	Total Number of Excerpts	Example Excerpts
						response of the services I've been involved with, who have either infantilised or patronised me."
		Unsupportive	2	0	2	"I have met a few who felt abrasive and unsupportive which was very off-putting"
		Arrogant	1	0	1	"They are too proud of their own accomplishments and education to truly understand and listen to what they are told by patients; they think they know better than the patient ever could."
	Worker Misconduct	Workers Mistreating MHSUs	1	6	7	"Totally intolerant, shout, disregard issues and make you think that you are wasting their time. This is especially so in hospital. There are staff there who should never be allowed to work in a caring profession."
		Feeling Unsafe Around Workers	0	1	1	"I have had bad experiences with them and experienced discrimination and them involving their personal views and beliefs. I do not feel safe because of this."
	Doubt	Scepticism Towards Workers	3	2	5	"Sometimes I have had feelings that they would rather be somewhere else."
TOTAL			30	27	57	
MHSUs Personal Struggles	Emotional Challenges	Frustration	10	14	24	"I have given up on trying to get help from them."
		Feeling Like a Burden	2	1	3	"I always feel like the problem lies with me, that I am not 'mentally ill' but instead doing something wrong and creating a

Theme	Sub-Theme	Codes	Number of Excerpts in the Control Group	Number of Excerpts in the Intervention Group	Total Number of Excerpts	Example Excerpts
						burden that the service must deal with."
		Loneliness	1	1	2	"I felt and still feel left alone and it's all my fault."
	Lack of Faith in Treatment	MHSUs Becoming Disillusioned	1	4	5	"I have a friend that died after being let down by mental health services. After many cries for help they let it go until it was too late."
		Reluctant to be Treated	1	0	1	"I think if you are reluctant to be treated you can face barriers, it can feel awkward and difficult to engage."
TOTAL			16	23	39	
Staff Training	Insufficient Training	Lack of Adequate Qualifications/ Training	10	8	18	"Then there are the amateurs, who do a more practical course but for free, which means that it's not frequent, it tends to be short courses and ill-equipped to deal with individuals."
	Lack of Knowledge	Limited Knowledge	6	2	8	"Often times (beyond having a listening ear and some availability) largely unknowledgeble."
		Limited Experience	2	1	3	"I found that a lot of them are really young and with little experience, there are not enough psychologists provided by the NHS, and most of the time is a counsellor that has had very little studies behind them and especially experience."
TOTAL			18	11	29	
OVERALL TOTAL			504	522	1,026	

Note. 79 codes within 8 themes and 22 sub-themes.

Appendix K

Thematic Analysis of Poster Feedback

Table K1

Thematic Analysis of Poster Feedback with Example References

Theme	Codes	Number of Excerpts	Example Excerpts
Positive Sentiments	Workers can Relate to SUs	40	"Allows people to relate to the mental health nurse. Showing it is not just some random person, but someone with passion and knowledge (backed by their experiences)"
	Support	38	"This is sweet. It shows that we're in this together and that those of us suffering are supported."
	Inspiring Hope	28	"It provides hope that you can move past depression and look back upon it. It shows you can use that period to help others and provide direction for your life and career."
	Caring	16	"It comes across as caring, I would feel like it is a service I could approach"
	Breaking Down Barriers	11	"The 'it's just me' almost puts the psychologist and client on the same level as it can be intimidating seeing a counsellor or a psychologist and so it almost levels out the status difference between them."
	Similarity to Own Experiences	9	"It is comforting to know that this person may have dealt with similar issues to me and therefore may understand my point of view on the things i'm dealing with more easily"
	Humanising Workers	8	"It humanises staff. Sometimes it can feel like staff are so different to us and don't get what it's like to be the one suffering from trauma but the poster shows that might not always be the case."
	Teamwork & Collaboration	8	"It makes it sound like a team effort to recovery, and not just someone who will talk at you."
	Helpful	6	"Makes me think that the support was useful and helpful in treating/coping with depression since the user of the service is positive about it."
	Improving Perceptions	3	"More encouraging as the nature of the job means that

Theme	Codes	Number of Excerpts	Example Excerpts
	of Workers		they have similar experiences, more confident in their abilities"
	Miscellaneous Positive Sentiments	26	"Emotional and heart warming." "Makes me feel comforted." "Transparent, vulnerable, strong."
TOTAL		193	
Constructive Feedback	Needs Improvement	36	"Inspiring but I think it would be better if these people weren't named" "The words that stand out most to me are the ones in white, especially the first sentence, because of the contrast. I personally am not a fan of the colours and the vibe they give off. The photo is of someone who is a bit too formal. The poster does not seem friendly to me." "I don't love the imagery because it looks like two businessmen rather than a patient/psychologist."
	Positive	23	"It has a caring design and strong imagery to help empathise with the poster" "The hand holding is a nice image and the diversity/them not being white feels very inclusive." "Clear and easy to read. Photograph is positive."
TOTAL		59	
Negative Sentiments	Too Personal	13	"I think there's far too much info about the practitioner's own mental health on this poster."
	Scepticism	9	"Seems like they have their own goals in mind. Like they want to pay it forward but maybe in a selfish way and you may not get personalised treatment."
	Disconnected to Own Experiences	6	"I guess I never felt lonely in recovery while some people definitely might. Feels disconnected to the issues I experienced though"
	Intimidating	6	"Relatable, but the terminology is quite strong and may feel intimidating to someone who hasn't yet come to see how valid their own feelings are"
	Patronising	5	"I bit too 'superhero' persona for me; It feels like 'look at all my accomplishments' and as a person experiencing depression I would think 'they are too good to be wasting their time talking to me.'"
	Miscellaneous Negative Sentiments	10	"I think it's cliche." "I'm not a fan of the 'lets make the journey less lonely

Theme	Codes	Number of Excerpts	Example Excerpts
			together' as it seems a bit too sickly (ie Hallmark card sentiment) for me."
TOTAL		49	
OVERALL TOTAL		301	

Note. 19 codes within 3 themes.