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Adaptation and Implementation of an Employee Mental Health Disclosure Decision Aid Tool in a Real-World Sample

READY Decision Aid Tool in the real-world

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Research Summary

Why was the research done?

Making decisions about disclosing mental health conditions in the workplace is complicated. A previous randomised controlled trial showed that web-based decision aid tool (READY?) helped employees make decisions and improved mental health.

We aimed to evaluate the implementation of this tool and its outcomes when scaled up by a governmental health and safety agency.

What were the key findings?

In a small real-world community sample READY? still facilitates disclosure decision-making and leads to improved mental ill-health.

What does this mean for policy and practice?

Findings of this study and the RCT find that approximately one-third of those with mental ill-health decide to disclose at work. These findings allow key stakeholders to understand where to target funding to increase this disclosure rate as this research suggests that disclosure is likely good for employee's mental ill-health.

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Adaptation and Implementation of an Employee Mental Health Disclosure Decision Aid Tool in a Real-World Sample

Abstract

Background: Making decisions about disclosing mental health conditions in the workplace is complicated. A previous randomised controlled trial showed that web-based decision aid tool (READY?) helped employees make decisions and improved mental health.

Aims: We aimed to evaluate the implementation of this tool and its outcomes when scaled up by a governmental health and safety agency.

Methods: We used website analytics and event data of those using the decision aid tool, and self-report stage of decision making, distress, engagement and usability data from consenting users of READY? over the first year of it being made publicly available.

Results: Over this year 100 adults opted in to be involved in the research evaluation of the program. This study replicated the previous RCT that showed at post-intervention; a later stage of decision making ($t_{1,99} = 6.308, p < 0.001$) with large effect size ($d = 0.87$), and psychological distress was significantly reduced ($t_{1,99} = 3.088, p < 0.001$) with moderate effect size ($d = 0.41$). READY? facilitated disclosure with 36.3% deciding to disclose after use. Disclosure was associated with a greater reduction in mental ill-health symptoms than non-disclosure ($F^{(2,31)} = 18.67, p < 0.001$) with moderate effect size ($d = 0.64$). Engagement, usage and attrition rates were all favourable when comparing to other digital mental health approaches in community samples.

Conclusion: This study shows that READY? is successfully implemented in a real-world sample.

Aligning with the RCT results, for many, disclosure can be positive, research should continue to focus on developing organisation-wide tools to create better supported and safe workplaces that promote disclosure.

Lay Summary

Deciding whether to reveal mental health conditions at work is complex. An earlier study demonstrated that the READY? web-based decision aid tool improved employees' decision-making and mental well-being. This research aimed to assess the tool's implementation and outcomes when introduced in a real-world sample. The results mirrored the previous RCT, showing that after using READY?, individuals were more certain about sharing their mental health status, and experienced reduced distress. The tool facilitated disclosure for users, and sharing was linked to greater reduction in mental health symptoms compared to non-disclosure. Engagement, usage, and dropout rates were

favourable compared to other digital mental health tools, especially those in real-world samples. The study confirms READY?'s successful real-world implementation and emphasizes the potential benefits of promoting open discussions about mental health in workplaces.

Introduction

At a structural level, disclosure of a mental health condition is a necessary first step to help-seeking in the workplace, as employers are not legally obliged to provide individual support before disclosure. However the majority of employees with a mental health condition favour non-disclosure as their preferred option (1), and often disclose only when they are too unwell to continue working (2). The primary reason for non-disclosure is fear of stigmatisation and discrimination (3). When questioned, employees are much less likely to report actual experiences of discrimination compared to their fear of it, possibly reflecting self-stigma (4). Non-disclosure may protect individuals from the negative consequences associated with stigma and/or discrimination (5).

Decision-making around disclosure of a mental health condition in the workplace is often complex and highly individual. During the process of considering disclosure, individuals gather information and weigh up the positives and negatives. Decision aid tools are designed to help individuals make considered and deliberate choices. In the mental health context, we developed a web-based decision aid tool (READY) to facilitate mental ill-health disclosure decisions for employees. Results from the RCT (6) which compared READY to a widely used disclosure information website provided by a leading mental health charity, demonstrated that it was effective in reducing decisional conflict, facilitated decision making, and reduced mental ill-health symptoms in those who disclosed.

Is RCT evidence enough?

RCT's are the gold standard, and should remain so, when evaluating new interventions effectiveness. While digital approaches have shown efficacy in RCTs addressing mental health concerns in employees (7, 8), there is limited evidence of their effectiveness in 'real-world' settings after the RCT phase. For instance, it is estimated that as few as 2% of smartphone applications for depression have reasonable evidence base outside of RCTs (9). However, RCT results alone do not ensure the intervention can have meaningful impact on the wider population (10). Three potential issues arise when scaling up RCTs into real-world populations. First, in RCTs, people meet pre-defined eligibility criteria and consent to take part in the trial, which makes them a highly selected sample and potential selection bias, although this bias may be less pronounced in digital interventions (11).

The second issue, particularly pertinent to digital interventions in non-trial contexts is low uptake, as seen in the example of MindSpot. A free online supported mental health assessment and treatment website (<https://www.mindspot.org.au/>). Over six-years, uptake of the online guided mental health treatment program was low with 18.7% of assessed users enrolled, lower than most RCTs (12).

Thirdly, RCTs should be viewed as the start of the journey not the end point. True translation into practice occurs when researchers build collaboration with key stakeholders throughout the design and implementation (13) to deliver and evaluate the long-term use of interventions in a real-world setting. This study evaluates the effectiveness and integration of READY in this real-world setting.

Methods

Setting and Recruitment: In an Australian context, a "Government health and safety agency" refers to a government organisation or authority responsible for overseeing and regulating health and safety matters in the workplace. In Australia, workplace health and safety are critical areas of concern, and there are specific government agencies at the federal and state/territory levels that are dedicated to ensuring the safety and well-being of workers. These agencies play a crucial role in setting standards, providing resources, and enforcing regulations to protect workers' health and safety in various industries and workplaces throughout Australia. The Recovery @ Work Toolkit, hosted by the State Insurance Regulatory Authority (SIRA), is a state initiative that offers evidence-based online resources to support mentally healthy workplaces for employers and employees. As part of this initiative, the READY tool was implemented and made accessible to individuals who visited the Recovery @ Work website. The recruitment period for participants extended over one year, from August 2021 to September 2022. The target population consisted of employed working-age adults with a mental health condition who were considering their options regarding disclosure in the workplace.

Recruitment, data collection, and all aspects of the study were conducted entirely online. Detailed information about the READY observational data collection was provided in the Participant Information Statement, which was provided upfront upon entry of the website and available for download. The study received ethical approval with the reference number (XXX). To participate, potential participants were required to complete an online form integrated into the READY tool, signifying their consent to take part in the study.

Intervention: The original content of READY used in the RCT was developed in a co-design approach fashion based upon currently available disclosure materials (14), guided by an international expert group. The content of READY was developed in focus groups with employees who had disclosed mental ill-health in the workplace and key occupational decision makers (3, 15) and further tested in an iterative fashion. The wording was specifically designed to be understandable by those with low literacy and has a Flesch-Kincaid Grade level of 6.6; i.e., understandable by the average 11-year-old (16).

The final program (READY) was based around a motivational interviewing approach and consisted of seven self-guided modules which enabled the user to consider potential consequences of (non)disclosure, module 1: weighing advantages and obstacles, module 2: needs for disclosure i.e.,

workplace accommodations, module 3: values to consider when disclosing i.e., being open and honest, module 4: when is the best time to tell, module 5; reflecting on past disclosures, module 6: who to tell, and module 7: providing the user with an interactive summary their responses. The tool was designed to take approximately five to ten minutes to complete. The program was carefully worded to avoid promoting any specific decision as the “correct” one. It was evaluated in an RCT (6) which found positive outcomes on the facilitation of disclosure and reducing mood and stress symptoms.

Adaptation: As it is a rarity for digital mental health digital to make it past RCT phase (9), we undertook extra measures necessary to ensure maximum uptake and engagement are reached via further co-design approaches (15) before implementing READY into the real-world. We conducted three participatory focus groups via Zoom with SIRA’s lived experience reference group. Using aspects of our previous framework (15), participants were provided with the online version of READY that was used in the RCT. The focus groups were not recorded, minutes were taken and required adaptations were agreed upon by all parties involved in the focus groups.

Outcome Measures Embedded in the tool:

Gender, age and workplace relationships : a) do you have a good relationship with your boss; b) do you have a good relationship with your co-workers? (both yes, no response)

Primary: Stage of Decision Making. This is a 5-question scale with a multiple choice selection for pre and post tool use, measures individual readiness to engage in decision making (17). Participants selected their stage from ‘I have not yet thought about the options’ = 1 to ‘I have already told my employer’ = 5.

Psychological Distress. The Kessler Psychological Distress Scale (K10) is 10-item questionnaire intended to yield a 10-50 measure of distress based on questions about anxiety and depressive symptoms. A score <20 indicates participants are well, score from 20-24 indicates mild mental disorder, 25-29 indicates moderate mental disorder and >30 indicates severe mental disorder (18, 19).

Usefulness. Three final questions were assessed after use a) did you find this tool useful; b) would you recommend this tool to a co-worker; and c) any other feedback.

Usage and Attrition was automatically collected by the website and defined as the number of modules completed.

Statistical Analysis: All data was analysed using RStudio. Primary and secondary analyses were undertaken on an intention-to-treat (ITT) and per protocol (completers) basis with all consenting users. To ensure that an ITT approach is appropriate we examined the baseline differences between completers verses non-completers by using t-tests for continuous and Chi-squared for binary measures. Only per protocol analysis was undertaken on one secondary analysis – comparing those who did and did not choose to disclose.

MICE (Multivariate Imputation via Chained Equations) was used to impute missing data for the ITT analysis by creating multiple imputations as compared to a single imputation (such as mean) takes care of uncertainty in missing values. MICE assumes that the missing data are Missing at Random (MAR), which means that the probability that a value is missing depends only on observed value and can be predicted using them. It imputes data on a variable by variable basis by specifying an imputation model per variable and is considered a conservative approach (10). Sensitivity analysis was used to compare ITT and completers change scores.

Effectiveness was analysed by calculating changes between baseline and post-intervention scores using paired samples t-tests for key decision and mental health variables. Cohen's d was calculated by comparing the baseline scores to the postintervention difference in mean. According to Cohen, $d=0.2$ can be considered small, $d=0.5$ a moderate effect and $d=0.8$ a large effect (20). Independent sample t-tests or Pearson's r were used to evaluate whether there were differences in change scores between those completers that chose to disclose or not. Analysis of covariance (ANCOVA) was used to explore change scores while adjusting for baseline scores.

Usage, module use, and disclosure rates are presented using means and standard deviation or prevalence rates where appropriate.

Results

Several adaptations were made after the focus groups regarding the language, look and feel and content of READY?.

Language: Overall, a preference not to use the term "mental health conditions". To address this we decided to simply use the term "mental health" throughout the tool. The phrase "tell" was considered inappropriate and the words "share" or "talk" were used when referring to disclosing.

Imagery: The original RCT version of READY? had images behind the text on each landing page. A majority of the focus group members advised this made the text difficult to read. We decided to remove the images from behind the text and have a plain background.

In the one-year period, $n=100$ users opted into the research and became study participants, of whom $n=33$ (33%) provided follow-up data. While it might be deemed low within a clinical trial, it's crucial to comprehend real-world adoption in a naturalistic sample. Thus, this follow-up rate shouldn't equate to a clinical trial setting.

The average age was 41.02 (SD=10.17) years. Predominately female $n=72$ (72%). Majority reported having a good relationship with their boss $n=71$ (71%) and colleagues $n=81$ (81%). At Baseline on

average participants were at a level of “I am considering my options” on the stage of decision-making scale and reported a moderate level of distress (19) (Table 1).

Only one baseline item differed between participants who persisted with the study (study completers) and those lost to follow up; non-completers reported better relationships with their colleagues (Table 1).

Table 1. Baseline Characteristics of READY participants comparing study completer vs non-completers

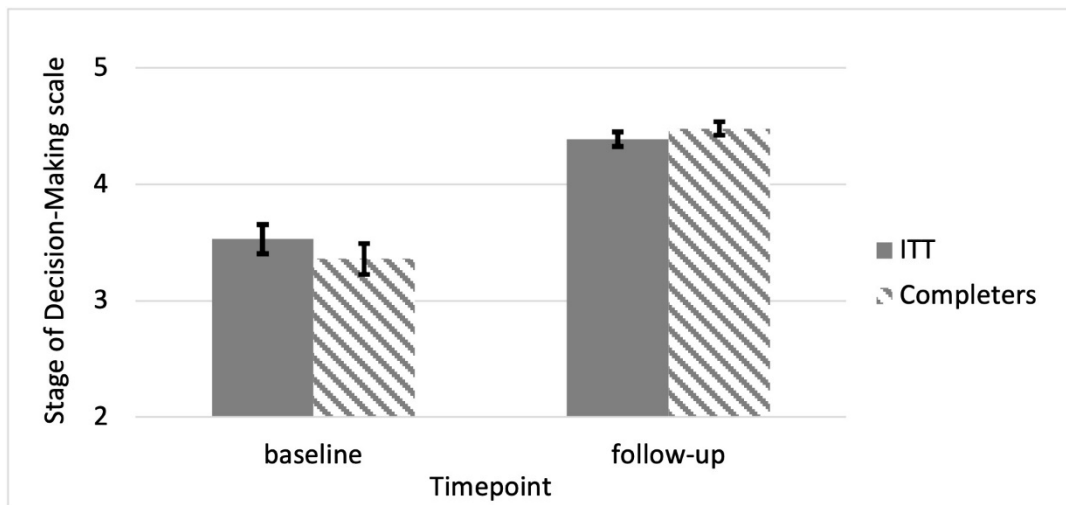
Variable	Overall (n=100)	Completers (n=33)	Non-completers (n=67)	significance
	N (%)	N (%)	N (%)	Chi-squared
Gender (female)	72 (72.00)	20 (60.61)	52 (77.61)	$\chi^2=3.287$, $p=0.070$
Good relationship boss (yes)	71 (71.00)	23 (69.70)	48 (71.64)	$\chi^2=0.100$, $p=0.751$
Good relationship colleagues (yes)	81 (81.00)	23 (69.70)	58 (86.57)	$\chi^2=4.542$, $p=0.033$
	M (SD)	M (SD)	M (SD)	t-test
Age	41.02 (10.17)	42.52 (10.03)	40.27 (10.23)	$t=1.034$, $p=0.304$
Stage of Decision-making (SDM)	3.53 (1.24)	3.36 (1.31)	3.61 (1.21)	$t=0.939$, $p=0.350$
Psychological Distress (K10)	28.09 (9.12)	27.36 (8.69)	28.45 (9.37)	$t=0.557$, $p=0.579$

All participants (n=100) started the intervention, Module 1 was completed by 68 of the participants (68%), Modules 2 and 3 by n=51 (51%), Modules 4 to 7 by n=36 (36%). On average users completed 2.8 (SD = 2.1) modules.

Usefulness. Almost all respondents found READY useful (n=25, 75.76%), or possibly useful (n=7, 21.21%). Similarly, n=24 (72.73%) participants stated they would recommend READY to a colleague, n=8 (24.24%).

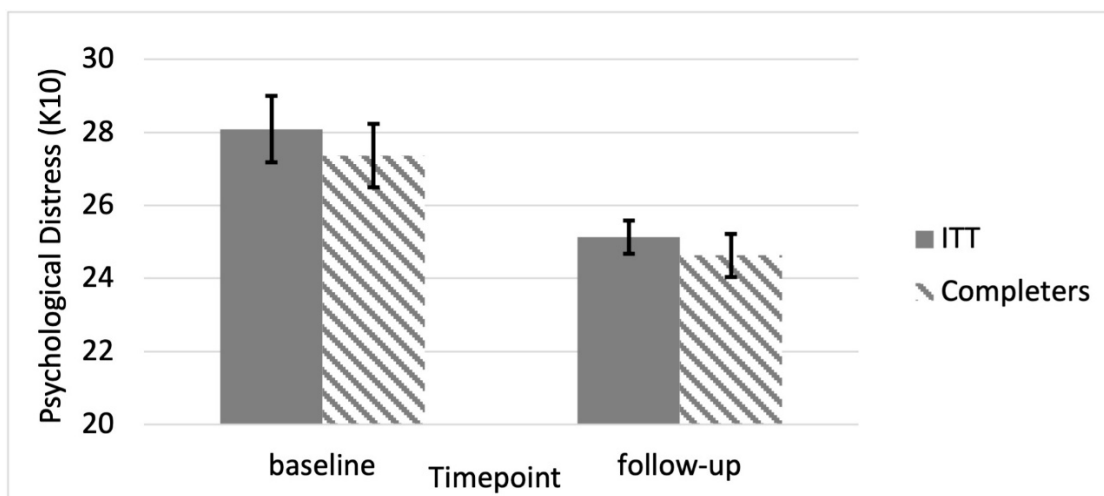
At post-intervention, participants were at a later stage of decision making moving on average to “I am close to making a decision” utilising a conservative ITT approach ($t_{1,99} = 6.308$, $p<0.001$) with a large effect size of ($d=0.87$) (Figure 1). Similar results were observed in those that completed the follow-up ($t_{1,32} = 4.501$, $p<0.001$) (Figure 1). Sensitivity analysis shows there was no significant difference in change scores between ITT and completers ($t_{2,98} = 1.350$, $p=0.180$).

Figure 1 Changes in stage of decision-making mean scores and standard errors over the observation period.



Psychological distress was significantly reduced at post-intervention in the ITT sample ($t_{1,99} = 3.088$, $p < 0.001$) with a moderate size of ($d = 0.41$). In the overall ITT analysis participants on average moved from the upper end of moderate levels of distress ($M = 28.09$, $SD = 9.12$), to lower end of the scale of moderate symptoms of distress ($M = 25.13$, $SD = 4.51$). A score from 25 to 29 indicates a moderate mental disorder (19) (Figure 2). Replicating the reduction in mental ill-health symptoms observed in the RCT (6). Sensitivity analysis shows there was no significant difference in change scores between ITT and completers ($t_{2,98} = 0.037$, $p = 0.970$).

Figure 2 Changes in psychological distress scores estimated marginal mean scores and standard errors over the observation period.



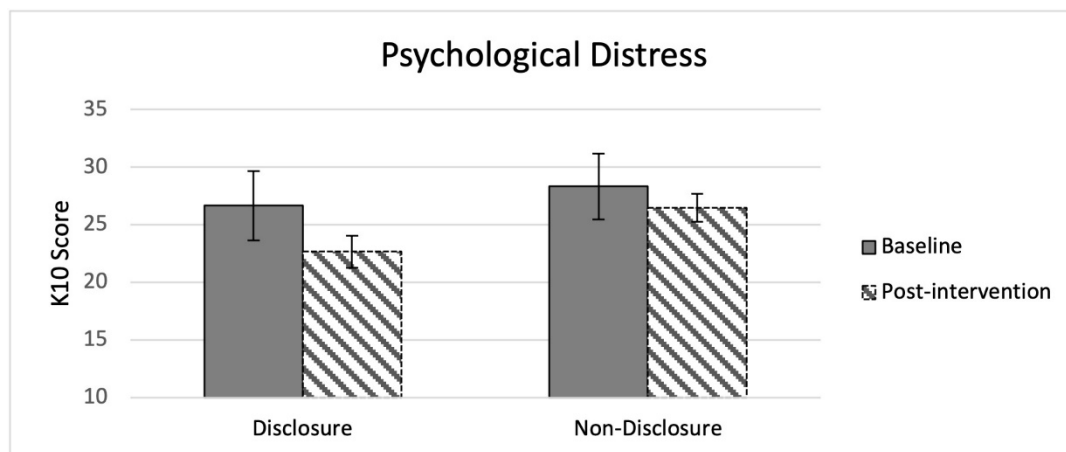
Similar results were observed in those that completed the follow-up ($t_{1,32} = 2.620, p=0.007$) (Figure 3). Of the 33 participants that completed the post-intervention questions, 13 (39.4%) had made a disclosure decision, of whom 12 decided to disclose, and one decided not to disclose. Those not deciding were assumed to have not disclosed. There were no significant differences at baseline in those that disclosed compared to those that did not disclose (Table 2).

Table 2. Baseline differences in Disclosure verses Non-disclosure groups.

Variable	Disclosure (n=12)	Non-disclosure (n=21)	significance
	N (%)	N (%)	Chi-squared
Gender (female)	6 (50.00)	14 (66.70)	$\chi^2=0.888, p=0.346$
Good relationship boss (yes)	9 (75.00)	14 (66.70)	$\chi^2=0.683, p=0.711$
Good relationship colleagues (yes)	9 (75.00)	17 (81.00)	$\chi^2=1.088, p=0.580$
	M (SD)	M (SD)	t-test
Age	44.67 (9.89)	41.29 (10.14)	$t=0.929, p=0.360$
Stage of Decision-Making (SDM)	3.48 (1.21)	3.17 (1.53)	$t=0.643, p=0.525$
Psychological Distress (K10)	26.67 (9.02)	28.33 (8.56)	$t=0.844, p=0.405$

Disclosure was associated with a greater reduction in mental ill-health symptoms (Mean difference = - 4.00) than non-disclosure (Mean difference = -1.23), ($F^{(2,31)}=18.67, p<0.001$) with moderate effect size ($d=0.64$) (Figure 3). The group who disclosed improved clinically from moderate to mild psychological distress.

Figure 3 Mean Change Scores Psychological Distress Disclosure (n=12) vs Non-disclosure (n=21)



Discussion

This study presents the results of the implementation of a mental ill-health disclosure decision aid tool in a real-world setting. We replicated the findings from the earlier RCT (6) that the use of READY enabled participants to move to later stage of decision making and was associated with a reduction in psychological distress. Most of the participants who completed READY found it useful and would recommend to a colleague.

This represents the only real-world study of an online mental health disclosure decision aid tool, bringing greater insight into use and effectiveness outside the constraints of a research trial. However, there are limitations. There were 768 unique users over a one-year period of whom fewer than one in seven provided informed consent to take part in the evaluation. As such we do not know whether these results generalise to the other users. Since only a fraction of the users provided informed consent, it would be helpful to know more about the characteristics of those who consented and how they compared to the larger user population. This would provide additional insights into the generalisability of the findings and should be consideration for the future use of this, or similar tools.

There was a 66% non-completion rate, potentially causing attrition bias, although this seemed unlikely from the baseline comparison, and partially addressed by the analytic method. Further, retention rates in this sample (33%) are significantly improved compared to other naturalistic comparisons where as little as 0.5% response rate to non-compulsory data is reported (21). We hypothesise that this is because a) users are a specific group who are motivated to seek and answer for their questions, b) the intervention is designed for one-time-use and is much shorter than other interventions, c) our study collected follow-up data soon after completion which may have resulted in an increased rate of retention.

In this real-world setting 39% decided to disclose after using READY, similar to the rate of disclosure observed in the RCT (6). Although the optimum rate of disclosure is yet to be established, we now have two studies suggesting that disclosure rates may be approximately one-third.

The facilitation of disclosure is particularly important as there is increasing evidence to suggest that disclosing may be a good thing. Being open about mental health conditions reduces self-stigmatisation and increases a sense of power and control (22, 23). Those who used READY both in the RCT (6) and in this study experienced a reduction in mood and stress symptoms. The effect was smaller in those who decided not to disclose, confirming that disclosure appears to be good for employee's mental health. Despite these findings, employees are often faced with stories of negative experiences, and attitudes towards disclosure (24), leaving them reluctant to disclose (23). Our findings highlighting the importance of addressing these negative scenarios in an individualised way by enabling people to consider potential benefits of disclosure. Organisations can play a role in

changing the conversation by flipping the narrative to promoting what employees will have access to, and how they can thrive with support.

In the RCT (6) 46% of participants completed all of the modules, whereas 36% completed all modules in this study. Mean module completion also differed with the real-world group reporting fewer average modules completed (2.8) compared to the RCT (3.9 modules). A potential reason for this is that the RCT group are a highly selected and likely more motivated sample, creating bias.

Interestingly, usage and engagement (for those who provided consent) reported here in a real-world setting is higher than found in systematic review evidence of the uptake of digital mental health approaches in general community settings which suggest that 0.5% to 28% complete all modules (25) compared to the 36% observed in this study. This is likely due to four factors. Firstly, motivation. Users of READY? are looking for information provided on disclosure decision making. READY? is tailored to assist users in making a specific deliberate choice and likely increases motivation to continue use. Motivation is increased in interventions that consider readiness to change and motivational techniques (26) which is the foundation that READY? is built on.

Secondly, sustainability. A key aspect of interventions delivered in the real-world are their ability to be implemented on an ongoing basis in the community by existing providers in a financially feasible way (26). Ongoing collaboration and development with the community and industry groups is critical to ongoing success, particularly with recruitment and advertisement to community groups. Researchers should consider maintaining relationships as a necessity for ongoing successful sustainability and engagement post RCT.

Third, the online tool allows for the freedom and autonomy to access disclosure information anywhere, at any time. Under a shared theoretical framework (27) of motivational interviewing (28) and self-determination theory (29), autonomy is a particularly important part in decision making, as a component of self-determination, or the ability to make one's own decisions. Self-determination has been linked to increased self-confidence, the more control individuals have over the decisions in their life the more confident they feel (30). READY allows employees to make a well-informed decision by autonomous disentangling disclosure decisions. When developing interventions in this space, developers and researchers alike should consider the use of 'client-centred' autonomy to promote the desired change outcome.

Finally, READY was co-designed with end-users for the RCT and when implementing in the real-world setting. This approach doubtlessly resulted in the development of an effective and engaging tool. Using end-user approaches to consider the barriers, facilitators, design and implementation ensured that the tool was effective and useful to the intended target audience (13). Future designs should consider these two design aspects as key to ensure optimum usability, engagement and benefit.

In conclusion, this study offers valuable insights into the real-world implementation of a mental health disclosure decision aid tool. Replicating earlier findings, the READY? tool facilitated more advanced decision-making stages and reduced psychological distress among users. The study's significance lies in being the only real-world investigation of an online mental health disclosure tool, offering insights beyond controlled research settings. While acknowledging limitations such as the low consent rate and potential bias, the study underscores the tool's potential to promote disclosure and its positive impact on mental health. The higher engagement and usage rates observed compared to traditional digital mental health interventions can be attributed to user motivation, sustainability, autonomy, and user-centred design. The study encourages future research to focus on addressing barriers to disclosure, maintaining community relationships, promoting autonomy, and employing user-centred design to ensure the effectiveness and usability of interventions in this crucial area.

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