**Supplementary File 1 Extended Introduction**

**Introduction**

Recent decades have seen significant changes in mental health service delivery, with the *recovery paradigm* progressively instantiated in policies and guidelines, particularly in English-speaking countries of the Global North (1-3). Mental health services for people diagnosed with serious and persisting mental health problems increasingly prioritise *personal recovery*, which has been defined as “a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness” (Anthony, 1993, p.527). From a research viewpoint, there has been burgeoning interest in systems, services, and treatment regimens for factors that may facilitate or impede personal recovery (5-7). Two findings are particularly relevant to the present project.

*Involuntary treatment experience*

Personal recovery may be important not solely in terms of adjusting to direct limitations arising from illness, but also those associated with treatment. Particularly notable in this respect are that persons may experience episodes of involuntary treatment, such as forced treatment in hospital or mandated community treatment. A number of studies have found that involuntary treatment can be detrimental to the integrity of the self and impede agency and autonomy, as well as reinforcing prevailing, negative mental illness stereotypes (8-11). These findings inform questions about clinical efficacy and social benefit (12-15) and contribute to the sustained controversy regarding the ethics of involuntary treatment (16, 17). Still, involuntary treatment remains a common intervention in many countries (18-21).

*Mental illness internalised stigma*

Advocates for mental health law reform assert that involuntary treatment practices are inherently stigmatising and discriminatory (20, 22), and serve to reinforce the prevailing negative stereotypes about mental illness (i.e., that persons with mental illness are dangerous, incompetent, and unable to care for themselves) (23, 24). Internalised stigma, the process of endorsing, internalising, and applying mental illness stereotypes to oneself (25-28), may therefore be important in understanding the interactive effect of contact with recovered peers and involuntary treatment on recovery. Narrative accounts of service-user experiences provide support for this assertion, with reported consequences of involuntary treatment including feeling devalued, stigmatised, and dehumanised, and experiencing impaired self-esteem, agency, and autonomy (8, 9). Involuntary treatment experiences and perceptions of coercion in community treatment have been linked to harmful stigma processes, including perceived devaluation and discrimination (19), which in turn have been associated with internalised stigma (27). In a separate study of 186 individuals with serious mental illness and a history of recent involuntary hospitalisation, stigma stress, shame, and self-contempt independently predicted internalised stigma and decreased empowerment, after controlling for symptoms, diagnoses and sociodemographic variables (29).

*Contact with recovered peers*

On the other side of the coin, there is evidence that one clinically-important facilitator of recovery may be contact with peers further along the recovery pathway, or contact with recovered peers (8, 30, 31). In this context, identification as a peer is derived from matching the stigmatised minority status of people with mental illness and having shared mental health-related experiences (32). Unlike involuntary treatment, reported benefits of contact with recovered peers include countering the impact of stigma and discrimination by challenging mental illness stereotypes and offering service users a “road map for how to navigate their recovery journeys” through vicarious experiential learning (8, 9, 33). Randomised controlled trials evaluating peer-led services for people with severe mental illness have demonstrated that peer support was associated with positive effects on clinical, subjective and social outcomes, including hope, control, agency and empowerment (34-37). Extensive qualitative investigation with mental health service users has further highlighted the integral role of peers in transforming illness identities, engendering hope and belonging, and modelling self-management of one’s own recovery (9, 34, 38, 39). Quantitative investigation of whether contact with recovered peers buffers the disempowerment experienced through involuntary treatment experiences that contributes to internalised stigma is therefore an important next step.

*Self-efficacy for personal recovery*

Self-efficacy, a view of oneself as capable and agentic (40), represents a further self-evaluative mechanism that may be important for explaining how involuntary treatment, contact with recovered peers and internalised stigma impact recovery. Both internalised stigma and self-efficacy are robust predictors of personal recovery (27, 41-44), and have been previously identified as possible mechanisms through which contact and disempowering service experiences may influence recovery (9, 10). Multiple studies have shown that internalising stigma acts as a barrier to recovery by undermining self-efficacy, with lower levels of internalised stigma predicting greater self-efficacy, empowerment and recovery (27, 45, 46). Further, researchers have argued that involuntary treatment approaches contravene the core values of recovery-oriented care, including shared decision-making, self-determination, and promoting self-agency and autonomy (47), which may serve to undermine self-efficacy.

These findings suggest that disempowering service experiences (i.e., involuntary treatment) and contact with recovered peers may interact to influence recovery, and further, that this relationship may be mediated by internalised stigma and self-efficacy. To date, no systematic exploration of these relationships has been conducted. Consequently, the field is challenged by a lack of measurement and conceptual clarity. Additionally, investigations of the relationships between internalised stigma, self-efficacy and recovery have previously relied on general measures of self-efficacy or singular aspects of recovery, including social connectedness, empowerment, and self-management (48-50). A personal recovery-specific measure of self-efficacy is better aligned with Bandura’s self-efficacy theory, which specifies that self-evaluative beliefs are specific to tasks or domains (51, 52). In the context of serious mental illness, specific domains pertaining to personal recovery and self-management can be summarised by the CHIME acronym and include: developing and maintaining supportive relationships (connectedness); feeling motivated and believing in one’s ability to enact change (hope); developing positive personal and social identities beyond a stigmatised ‘passive patient’ role (identity); living a subjectively meaningful and purposeful life (meaning); and accessing agency and autonomy in recovering one’s life (empowerment) (53).

*The present study*

In order to advance the scientific study of service user experiences in mental health services, the aim of the present study was to systematically examine the interactive relationshipbetween involuntary treatment experience and contact with recovered peers, and the intrapersonal mediating processes that may help to explain their impact on personal recovery. We hypothesised that: (H1) contact with recovered peers moderates the effect of involuntary treatment on internalised stigma; (H2) conditional internalised stigma (i.e., moderated by contact with recovered peers) mediates the indirect effect of involuntary treatment on recovery-specific self-efficacy; and (H3) self-efficacy mediates the conditional indirect effect of internalised stigma on recovery. The full complexity of this moderated multiple-mediation model was tested using conditional process analysis (i.e., ordinary least squares regression-based path analysis), and our predictions are captured in the conceptual models of Figure 1. In the hypothesised (conditional) models, only the effect of involuntary treatment on internalised stigma is moderated by contact with recovered peers.

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