

BMJ Open Measuring professional stigma towards patients with a forensic mental health status: protocol for a Delphi consensus study on the design of a questionnaire

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ABSTRACT

Introduction Negative attitudes towards individuals with a mental illness and/or criminal background are widely studied, but empirical interest in the attitudes towards patients with a forensic mental health status is lacking. Negative attitudes among mental healthcare (MHC) professionals can have a significant impact on treatment outcomes and hence, affect patients' rehabilitation. This study will elaborate an instrument to assess stigmatising attitudes among community MHC professionals towards patients with a forensic mental health status.

Methods and analysis The instrument will be developed by means of a Delphi study and depart from pre-existing instruments that assess public and professional stigma towards individuals with a mental illness and/or criminal background. Relevant instruments were identified through a targeted literature review. A longlist of items has been selected for the Delphi survey. Five expert panels (ie, academic experience in stigma or forensic MHC, clinical experience in community or forensic MHC or patient experience in forensic and community MHC) will be asked to score the relevance of each item on a 7-point Likert scale and to agree on the wording (yes/no). Participants will be provided with the option to suggest additional items or alternative wording. Adapted Delphi methodology will be applied with an expectation of at least three rounds to achieve consensus: ≥60% of the participants of at least four of five expert panels rank the item in the top three (inclusion) or bottom three (exclusion). Items will be reworded for a consecutive round based on a 'yes minus no' score and participants' suggestions.

Ethics and dissemination This study has been approved by the ethics committee of Fundació Sant Joan de Déu. Dissemination of results will be through peer-reviewed publications, presentations and (inter-)national academic conferences. A summary of the results will be shared with the participants and key persons in community and forensic MHC.

INTRODUCTION

Forensic mental healthcare (FMHC) is aimed at improving patients' mental health, reducing their risk of recidivism and ultimately a secure reintegration into society. In general terms, FMHC offers treatment to individuals who are both mentally disordered and

STRENGTHS AND LIMITATIONS OF THIS STUDY

- ⇒ Patients' experiential knowledge on professional stigma is incorporated through a patient expert panel; this may improve the credibility of the outcomes and offer invaluable additional insights.
- ⇒ The online Delphi survey will facilitate the involvement of experts from various disciplines and geographical areas, and will reduce the impact of dominant individuals as all responses (ie, anonymous) will be weighted equally.
- ⇒ To make the survey manageable in terms of total items to evaluate, the authors had to create a longlist; hence, make a preselection of relevant items.
- ⇒ Each round will require considerable time investment from both the participants (ie, to evaluate all items) and the researchers (ie, to consolidate all outcomes).
- ⇒ The Delphi technique allows reaching consensus on item selection, but further research will be needed to develop the questionnaire and assess the psychometric properties.

whose behaviour has led or could lead again to offending.¹ FMHC focuses on rehabilitative activities, as well as individualised care pathways, in order to increase the possibilities of a successful reintegration and return to their social environment.² Treatment is typically provided on a continuum from highly specialised FMHC wards (within penitentiary settings) to (supported) community mental healthcare services (CMHC). CMHC services, however, seem reluctant to admit patients stigmatised by the label 'forensic'.³ As a consequence, patients in FMHC may become subject to prolonged inpatient admissions, fostered institutionalisation and eventually a frustrated rehabilitation. To improve the rehabilitation options for patients in FMHC, a better liaison and understanding between FMHC and CMHC is needed. A first step in this direction could be to understand the attitudes CMHC professionals have towards

patients with a forensic status. Research has shown, for instance, that CMHC professionals mention stereotypical pictures of ‘criminals’ and ‘dangerous criminals’ when asked about patients with a forensic status.⁴ Others found that patients with a history of offending were particularly associated with stereotypes of dangerousness and aggression,⁵ and they could count on less public sympathy than non-offending patients.⁶ Further believed most of the public (including police officers and psychiatrists) that these patients would not voluntarily undergo treatment and they were opposed to the idea to let them receive community-based treatment.⁷

Stigma and stigmatising attitudes are widespread. It involves stereotyping and devaluing individuals based on their belonging to a certain social group.^{8,9} In this regard, individuals with a mental illness are often associated with dangerousness, rarity, responsibility, incompetence, weakness of character, dependence, unpredictability, inferiority and vulnerability.^{5,10,11} Patients with a forensic status may be subject to *simultaneous* or *multiple stigmas*,¹² as they also have a history of criminal offending. Hence, they further may be considered evil, mean, unintelligent, psychologically maladjusted, immature, inconsiderate and dishonest.¹³ *Stereotypes* refer to the beliefs or ‘knowledge’ structures about the characteristics and behaviours of a group of people.^{14,15} They are the cognitive component underlying stigma and stigmatising attitudes. *Prejudice*, understood as ‘the emotional reaction or feelings that people have toward a group or member of a group’,¹⁶ is the affective component. For instance, the stereotype of dangerousness may lead to feelings of fear or may be experienced as anxiety. Prejudice towards individuals with a mental illness includes fear, pity and anger,¹¹ but this may vary per mental illness.¹⁰ For instance, the majority of the public feel sorry for individuals with mental illness, particularly for those with depression; however, they report uneasiness, uncertainty and fear towards individuals with schizophrenia and rejection towards individuals with drug abuse and alcoholism. Importantly, prejudice involves an active (cognitively and affectively) evaluative response, resulting in a negative emotional reaction. This means that people can be aware of stereotypes but not endorse them. This is especially important when fighting discrimination, the behavioural component of stigma. *Discrimination* is the unfair or unjust behaviours towards a social group or its member(s) (out-group) or exclusively favourable behaviour towards the members of one’s own group (in-group).^{11,14} Discriminatory behaviours exist along a continuum from subtle to overt and when it concerns individuals with a mental illness, withholding help, avoidance, segregation and coercion are most often described.¹¹ Others also mentioned rejection, social distance,¹⁰ and exclusion.¹⁷

Although mental healthcare (MHC) professionals might be expected to have more positive attitudes towards individuals with a mental illness, research has shown that they too are susceptible to the negative attitudes endorsed in the general public.^{15,18–23} Despite their training,

professional knowledge and experience with people with mental illness, they report, for instance, a desire for social distance comparable to the public.^{24–26} Psychiatrists seem to have more negative attitudes than general practitioners and clinical psychologists;²⁷ however, when comparing the attitudes of students, doctors and nurses, the nurses held the least favourable attitudes towards patients with a mental illness.¹⁷ Regarding long-term treatment outcomes, psychiatrists seem more pessimistic than the general public,²⁷ and also other medical professionals express low expectations of recovery.²⁴ Lammie and colleagues²⁸ assessed practitioner attitudes towards patients in medium and low secure forensic mental health settings. Even though the overall responses were positive, a significant minority of professionals reported to hold negative attitudes like recovery pessimism, pity, fear, anger, a desire for social distance, avoidance and blame. Notably, the negative attitudes were expressed more subtle. Meaning that professionals with mental health training seem to show positive explicit attitudes, but negative implicit attitudes, which may reflect unconscious emotions related to mental illness.²⁹

Stigmatising attitudes towards individuals with mental illness have been associated with negative outcomes such as reduced self-esteem,³⁰ social isolation,³¹ chronic stress,³² delayed help-seeking³³ and loss of personal relationships.⁵ Also a history of criminal offending may have negative consequences including hindered access to services like housing and education, fewer employment opportunities³⁴ and reduced social networks and supports.⁵ Of note, reverse outcomes have been shown to decrease the likelihood of recidivism and increase the likelihood of successful community re-entry.^{34,35} Here it is important to distinguish *public stigma*—which refers to the reaction of the general population or large social groups towards another or smaller social group, thereby endorsing stereotypes about and acting against them^{36,37} from *self-stigma* or *internalised stigma*—which refers to the extent to which an individual turns negative stereotypes and prejudice against oneself.^{11,37} Stigmatisation of a group of people can thus result in the internalisation of the stigmatising beliefs. This on its turn can affect recovery and negatively impact mental illness coping mechanisms and treatment engagement.⁵ *Self-stigma* has, furthermore, been associated with more severe psychiatric symptoms and a history of incarceration and homelessness,³⁸ reduced coping strategies and feelings of shame, guilt, anger and distrust of others,³⁹ as well as a risk factor for reoffending.⁴⁰ Stigmatisation among professionals or *professional stigma* can be even more detrimental than by the public. It can have a significant impact on treatment outcomes and the patient’s quality of life.^{5,41} Among long-term patients with impoverished relationships, 76% named their healthcare professional as the most important person in their lives.⁴² Professionals’ negative attitudes may reduce treatment-seeking behaviours because patients anticipate their discrimination towards them,^{9,19} and the negative affective reactions and desire of social distance can lead to

augmented disempowerment.⁴³ The distinction between *public/professional* and *self-stigma* is important for understanding, explaining and building strategies to change stigmatising attitudes.³⁶ Increased awareness of stereotypes or knowledge about FMHC, for instance, might be instrumental in combating prejudice or discrimination. A better understanding of CMHC professionals' attitudes towards patients with a forensic status may therefore give indications on how to improve the liaison between FMHC and CMHC. Measures such as education programmes and awareness-raising events can be suggested to reduce stigmatising attitudes, and eventually increase the rehabilitation options for patients with a forensic status.

To the author's knowledge, there is no instrument specifically designed for the assessment of professional stigma towards patients with a forensic mental health status. Stigma assessment is complex as it involves an individual's attitude towards a target population, and this attitude might be influenced by experiences, prejudices, stereotypes and knowledge. A Delphi study, as means for consensus building, allows to consider this interplay of factors through the involvement of experts that understand (1) the perspective of the perceiver (ie, professionals working in CMHC), (2) the target population (ie, patients, professionals and academics experienced in FMHC) and (3) stigma as an empirical construct (ie, academics investigating stigma). Departing from the many instruments that assess the attitudes towards individuals with mental illnesses, and in a lesser extent towards individuals with a history of criminal offending, this method enables to utilise the knowledge from international experts to select the most relevant items for the assessment of CMHC professionals' attitudes towards patients with a forensic status.

AIMS

The aim of this study is to reach expert consensus on items to assess stigmatising attitudes among community MHC professionals towards patients with a forensic mental health status. By means of a modified Delphi approach, consensus is sought on items that were selected and adapted from instruments that assess stigma towards individuals with either a mental illness or a history of criminal offending.

METHODS AND DESIGN

This study will be conducted using a modified version of the Delphi technique. The Delphi technique is an iterative multistage approach to seek consensus among 'experts' on a certain subject.⁴⁴ Rather than having experts to meet physically, the Delphi technique can be conducted online, which allows the involvement of international experts. Within the context of mental health research, the Delphi technique has been applied for a great variety of purposes, among which the development of questionnaires.⁴⁵ Contrary to a classical Delphi study,

the first stage will not consist of a complete open round to obtain all qualitative input. Instead, we will apply a modified Delphi study,⁴⁶ meaning that we will depart from a preselected longlist of items drawn from various stigma assessment instruments, and ask the experts to complete the list in case important items are missing. The anticipated rounds for achieving consensus are presented in figure 1.

Development of the Delphi questionnaire

Literature review—search strategy and study selection

To identify the instruments that measure stigma among the public, health professionals and students, a targeted literature review was conducted in PubMed using the following terms 'stigma*' OR 'stereotyp*' OR 'prejud*' OR 'attitude' OR 'discrim*'. The search strategy was further constructed by combining these with terms related to mental illness (ie, 'mental*' OR 'psychiatr*' OR 'psychol*' AND ('disorder*' OR 'illness*')) or criminal background (ie, 'offend*' OR 'forensic' OR 'prison*' OR 'secure unit' OR 'crim*' OR 'justice') and assessment (ie, 'assess*' OR 'measure*' OR 'question*' OR 'instrument'). Finally, a third search included all terms. To obtain the most recent scientific evidence, the search was limited to studies published in 2011 or later. Additionally, we reviewed related papers referenced in selected studies, especially development articles, and consulted websites (ie, Indigo Network, www.indigo-group.org) related to stigma assessment.

The study eligibility criteria were as follows:

1. *Type of studies*: quantitative studies with statistical analysis and with a validated measurement instrument, including papers on the development and psychometric evaluation of instruments relevant to our study.
2. *Construct of interest*: only studies measuring *public stigma* or *professional stigma* were eligible. Stigma could be measured in a broad sense, so measures of beliefs, attitudes and behaviours were included.
3. *Target population*: samples composed of Mental Health Practitioners (psychiatrists and psychologists), General Practitioners, Primary care and/or medical students. The population stigmatised had to be adults with mental illness a/o a history of criminal offending.
4. *Language*: only English and Spanish papers were selected.

Excluded were studies with non-validated or non-specified measurement instruments, studies focussing on the assessment of perceived stigma, associative stigma and stigma towards specific disorders, or studies assessing the impact of an intervention aimed at reducing stigma. Finally, also studies whose sample were children or adolescents, or whose stigma was directed towards this type of population were discarded of the eligibility process.

Literature review—results

The three searches together yielded 6939 articles, after removing duplicates. Inspection of abstracts and titles found that 6769 did not fulfil the inclusion criteria. A

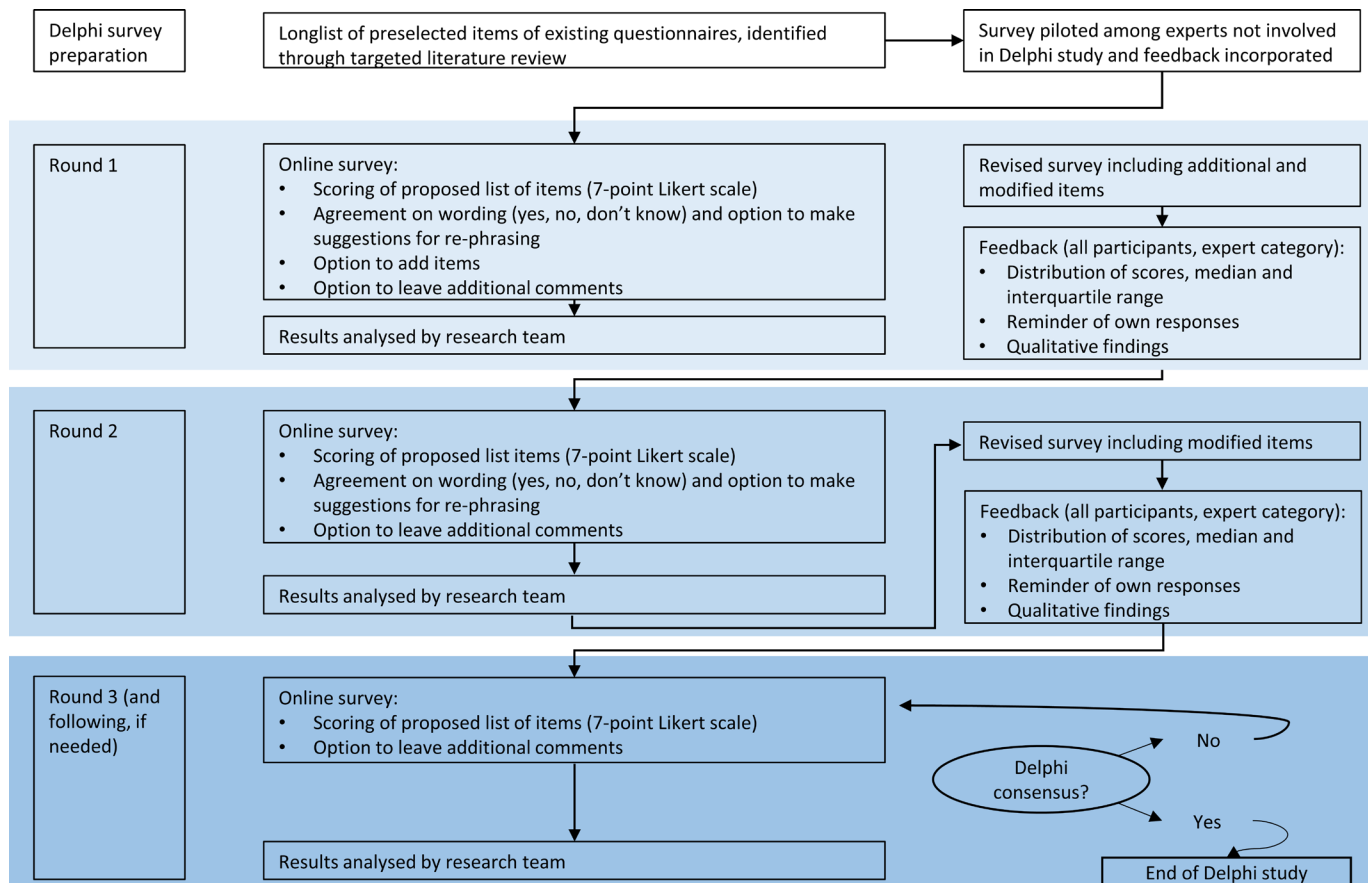


Figure 1 Structure of the Delphi procedure.

total of 170 articles were identified as potentially relevant, but 13 articles could not be retrieved and 79 were later excluded on closer examination of the full text as they did not match the inclusion criteria. Thus, a total of 78 articles were finally included. A preferred reporting items for systematic reviews and meta-analyses (PRISMA) flow chart reflecting the study selection is presented in [figure 2](#).

Among the selected studies, 47 measured *professional stigma*, 15 measured *public stigma* and 4 measured both; 6 articles were psychometric evaluations and the rest (6) were instrument development or validation papers. The target populations were mainly patients with mental illness, and only one paper studied stigma towards forensic psychiatric patients; highlighting the gap of literature in this field.

The most used scales were Community Attitudes towards Mental Illness Scale,⁴⁷ followed by The Mental Illness: Clinicians' Attitude and its different versions,^{48 49} Opinions About Mental Illness Scale⁵⁰ and Opening Minds Stigma Scale for Healthcare Providers.⁵¹ The Attribution Questionnaire-27⁵² and modified versions of Bogardus Social Distance Scale⁵³ were also commonly used, but these scales were discarded because of the use of vignettes (AQ-27) and because the factor 'Social Distance' was already included in other questionnaires considered more appropriate for the purpose of our study (ie, Community Attitudes towards Mental Illness Scale). An overview of the

instruments that were considered for the development of our Delphi questionnaire is presented in online supplemental material, indicating also the respective items that were selected and/or adapted.

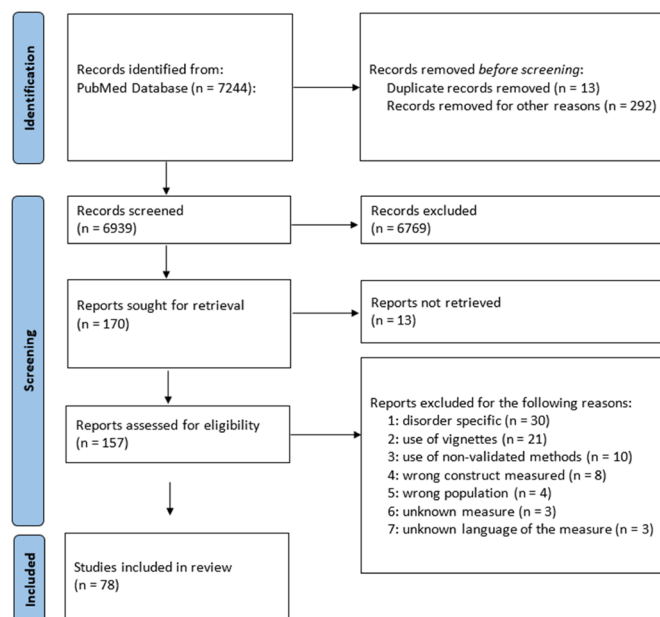


Figure 2 PRISMA flow diagram of the study selection procedure for literature reviews. PRISMA, preferred reporting items for systematic reviews and meta-analyses.

Structure of the Delphi questionnaire

For the structure of the questionnaire, we followed the conceptualisation as proposed by Fox *et al*¹¹, taking into account items related to stereotypes, prejudices and discrimination. All items of the identified instruments were listed and categorised accordingly. Subsequently, all items were put in random order. To shorten the initial list of 468 items, each of the authors scored on a 7-point scale how relevant each item was for the purpose of the Delphi study. Overall, 79 items were selected (mean score of 5.33 or higher). To have a list with consistent wording (eg, type of care or patients), 70 items were reworded. Six items were rephrased; basically, these entailed comparisons between patients with a mental illness and ‘normal people’, we changed them to compare patients with a mental illness and patients with a forensic status. For one item (ie, ATP 36), we included two rephrased items. Finally, five items were added by the authors; these items were based on experiences in daily practice and considered missing in the existing instruments.

Participants

Our general approach is to invite five categories of experts: academics with knowledge about stigma assessment, academics with knowledge about patients with a forensic mental health status, healthcare professionals (eg, psychiatrists, nurses, psychologists, social workers, general practitioners) working in CMHC, healthcare professionals working in FMHC, and patients who are in the position of being or have been transferred from FMHC to CMHC. With regard to the groups of academics and professionals, an initial list of potential participants has been created following the purposive sampling approach.⁴⁴ The authors (ie, GE-R and EV) approached their contacts in the field of FMHC in Europe and the CMHC in Catalonia, Spain. All contacts were asked to present five more potential candidates that met one or more of the following inclusion criteria:

- ▶ either a listed author in at least one publication related to (1) stigma towards patients with a forensic status; (2) stigma towards patients with a mental illness; (3) stigma towards (ex-)offenders; (4) stigma assessment; (5) conceptualisation of stigma; (6) care pathways or treatment in FMHC.
- ▶ and/or with clinical experience in patient care in (1) CMHC or (2) FMHC.

For the identification of the stigma academics, (recurrent) authors of publications about stigma towards individuals with mental illness, (ex-)offenders, or patients with forensic mental health status were listed. With respect to the group of patients, an initial list of potential candidates has been created based on their transfer (history) of FMHC to CMHC. Although there is no widespread consensus about the appropriate sample size per participant category,⁵⁴ a sample of 10–18 participants has been suggested.⁵⁵ On the other hand, the more participants, the higher the reliability of the composite consensus.⁵⁶

We will therefore aim for a minimum overall participation of 50 experts.

Recruitment

Except for the patients, potential participants will be contacted via their work email address, which is either publicly available or provided by the authors’ contacts. They will receive an email explaining the purpose of the Delphi study and an invitation to participate. Experts who confirm their willingness to participate, receive a second email with a link to the internet-based questionnaire and an explanatory letter with instructions on how to complete the questionnaire. The patient candidates will be approached by their (former) treating psychologist (author GE), who will explain the purpose of the study and invite the patients to participate, stressing the completely voluntary nature of participation. Patients who confirm to participate will receive the questionnaire and the instructions printed on paper.

The introductory page of the questionnaire includes a consent clause, explaining that by clicking/marking the ‘I agree’ button, they consent to participate in the Delphi study. In all communications, we will explain the voluntary nature of the study, state that withdrawal is allowed at any time without any consequence for the participant and how personal data protection rights can be exercised. Confidentiality will be protected and individual data will not be shared with other participants or third parties. Each participant will be allocated an automatic random identification number, which will enable us to include the participant’s individual results in the feedback rounds. All other feedback will contain aggregate data to protect the participants’ identities and opinions.

Structure of the Delphi procedure

The Delphi method will consist of several iterative rounds in order to reach consensus, with different activities taking place in each of the consecutive rounds (see [figure 1](#)).

Round 1

In the first round, participants will receive a web-based or printed questionnaire with a list of potential items (i=85) randomly ordered to avoid biases.⁵⁷ They will be asked to indicate the relevance of each item for the assessment of stigma by CMHC professionals towards patients with a forensic status, by giving a score on a 7-point Likert scale (1=not important at all to 7=extremely important).⁵⁸ They will further be asked if they agree with the wording of the items (yes/no/do not know); thereby providing the opportunity to make suggestions for alternative wording. Finally, we will ask the participants to add important items that they consider missing and to include any additional comments in an open text box. Round 1 is foreseen to start in March 2022. Participants will be given 4 weeks to complete round 1. Reminders will be sent to non-responders every week following distribution.

Round 2

The responses from round 1 will be aggregated and analysed (cf. data analysis). The aggregated anonymous results (ie, group median and IQR), the participant's own responses and a narrative summary of the suggestions for rephrasing and additional comments will be sent as feedback together with an explanatory introduction for the second round. Items with consensus on inclusion or exclusion will be identified. Newly suggested items (ie, considered missing), newly reworded items and the remaining items will be presented using the same method as in round 1 (ie, 7-point Likert scale). Participants will again be asked if the rewording is adequate (yes/no/do not know) and to make suggestions for improvement. Participants will have the opportunity to leave additional comments. Of note, we will no longer ask for missing items.

Round 3

After analysis of the responses of round 2, participants will receive feedback from rounds 1 and 2 (ie, aggregated anonymous results, narrative summary and own responses), indicating the items that reached consensus on inclusion or exclusion. The items will again be presented on a 7-point Likert scale for reconsideration. Additional comments will be allowed but improvement of phrasing will no longer be sought.

Using the a priori established consensus thresholds (cf. data analysis), we will decide if a fourth round will be needed to reach consensus. If indicated, round 3 will be repeated; otherwise, the Delphi study will end with the consolidated list based on the outcomes of round 3. The Delphi study is foreseen to be finished by December 2022; notwithstanding, this will depend on the number of rounds needed to reach consensus.

Data analysis

To determine consensus, we will use the quantitative data obtained from the 7-point Likert scale. We will calculate descriptive statistics, including central tendency (median) and distribution (IQR) for all participants and per expert category. Following a multigroup consensus approach,⁵⁹ the consensus thresholds will be defined as $\geq 60\%$ of the participants of at least four of the five expert groups ranked the item in the top three (5–7; ie, inclusion) or bottom three (1–3; ie, exclusion) Likert categories. As a secondary measure, we will use the total number of items on which consensus on inclusion has been reached. For the stigma assessment questionnaire to be manageable, we will use a threshold of 30 items.

For the reworded items, a 'yes minus no' score will be calculated (ie, the number of participants who answered a 'yes' on a specific item minus the number of participants who answered a 'no'). For the modified items with low scores on 'yes minus no', new formulations will be proposed based on the suggestions from the participants. These will be included in the questionnaire of the following round (until round 3).

We will conduct thematic content analyses for the qualitative data (ie, the missing items and additional comments). Similar newly suggested items will be combined or reformulated to avoid duplicates.

Data collection and management

All rounds will be conducted using Qualtrics software.⁶⁰ Qualtrics is a secure web application for developing surveys with more complex response formats, methods of distribution or data management. The software complies with the General Data Protection Regulation and with the regulations necessary to process and store protected health information. Qualtrics is ISO 27001 certified and FredRAMP licensed. Qualtrics is a SaaS (software as a service), the software and data are hosted on Information and Communication Technology servers that are accessed via the Internet. Databases extracted from Qualtrics software will be securely stored on the server of Parc Sanitari Sant Joan de Déu. Only pseudonymised data will be exported to SPSS and Excel for further quantitative and qualitative analyses.

Patient and public involvement

Patients will participate as an expert panel in the Delphi study.

ETHICS AND DISSEMINATION

The Delphi consensus study has received ethical approval from the ethics committee of Fundació Sant Joan de Déu (reference number C.I. PIC-186-21) and the institutional research board of Parc Sanitari Sant Joan de Déu (reference number C.R. 66-2021-09). Dissemination of the results will be through peer-reviewed publications, presentations, symposiums and workshops at (inter-)national academic conferences and a summary of the results will be shared with the participants, and key persons in community as well as forensic MHC.

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