**Stigma and Discrimination in Mentally Disordered Offender Patients – a comparison with a non-forensic population**.

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Word Count 3398

**Abstract**

High levels of stigma and discrimination are reported by individuals with mental health problems. Aim. To assess self reported levels of stigma and discrimination in forensic psychiatric patients, with psychotic illness, compared with a general adult psychiatric patients with psychosis. Hypothesis. Individuals with a history of violent offending, as well as severe mental illness, report more stigma and discrimination, than non offender patients, as a result of them being perceived as dangerous and unpredictable. Method. Experiences of stigma and discrimination were compared in 32 forensic and 32 non forensic general psychiatric patients, with schizophrenia or schizoaffective disorder, using the Stigma and Discrimination Scale (DISC). Results. Stigma and discrimination were widely reported by all patients, particularly affecting relationships with family, intimate relationships and friendships. No significant difference emerged between the forensic and non forensic patients, in experienced or anticipated stigma. Conclusions; We suggest that the lower level of psycho pathology, longer inpatient stays and intensive rehabilitation for forensic patients, may reduce the extent to which these patients experience stigma and discrimination.

**Background**

Social stigma refers to the rejection of an individual by society, as a result of them having an attribute that is discredited by that society (Goffman 1986). Individuals who have been diagnosed with a mental disorder frequently encounter high levels of stigma and discrimination; a diagnosis of schizophrenia is associated with greater stigma and discrimination, than other diagnostic groups (Angermeyer et al 2004, Thornicroft et al 2009, Rose et al 2011, Lasalvia et al 2013, Henderson and Thornicroft 2013, Corker et al 2013). Stigma impacts on all areas of the individuals life, identity and functioning, but particularly on domains related to interpersonal relationships, friendships, family, intimate relationships and marriage (Thornicroft et al 2007, Rose et al 2011).

Stigma, as experienced by individuals with mental disorders, represents problems of knowledge, attitudes and behaviour (Thornicroft et al 2007). Three inter-connected constructs of stigma have been identified: experienced stigma, perceived stigma and self-stigma (Brohan et al 2010). Self-stigma represents “the internalisation of shame, blame, hopelessness, guilt and fear of discrimination, associated with mental illness*'* (Corrigan and Watson 2002). Discrimination is the behavioral consequence of stigma, which is designed to exclude and create a social distance between the afflicted and non-affected members of society (Link et al 1999, Martin et al 2000, Angermeyer et al 2006).

As well as being distressing to the individual concerned, stigma is associated with feelings of isolation and social exclusion and may result in a reluctance to seek or engage in treatment and delayed recovery (Boardman et al 2010, Royal College of Psychiatrists 2009, Rusch and Thornicroft 2014, Clement et al 2015). There are currently few interventions that have been developed to challenge stigma and discrimination, although it has been suggested that it may be possible to modify social attitudes through a combination of contact, education and protest (Thornicroft et al 2017, Betton et al 2015)

Forensic psychiatric patients are mentally disordered individuals, whose behaviour has led, or could lead, to offending (Mullen 2000, Rutherford and Duggan 2007).Treatment within secure psychiatric facilities is considered necessary, to manage their risk to the public, or to themselves, until they can be safely discharged into the community. Such treatment is generally involuntary, under the provisions of the Mental Health Act 1983 (as amended in 2007). Following discharge, they generally remain subject to conditions, requiring their continuing engagement and adherence to treatment, until they are well enough, or sufficiently low risk, to engage in treatment, on a voluntary basis.

There is limited research on stigma affecting forensic psychiatric patients. surveys of public attitudes suggest that fear, intolerance and prejudice towards individuals, who are both mentally ill and have a history of violent offending is widespread (TNS 2007, Brooker and Ullman 2008). Such attitudes and negative stereotypes are likely to increase stigma and discrimination (Rose et al 2011) and social exclusion (Angermeyer et al 2006, Link et al 1999, Martin et al 2000, Mezey et al 2010, Mezey et al 2012).

This study aimed to compare experiences of stigmatisation and discrimination in forensic and general adult psychiatric patients, using a validated measure of self-reported stigma, the Discrimination and Stigma Scale (DISC; Thornicroft et al 2009, Brohan et al 2010, Brohan et al 2013). We hypothesised that forensic psychiatric patients with a psychotic illness, would report higher levels of stigma and discrimination, compared with individuals with a psychotic illness, recruited from general adult (non forensic) psychiatric services.

**Method**

**Participants**

32 male and female forensic psychiatric patients (inpatient and community) and 32 general adult psychiatric patients, matched by diagnosis, were recruited from a South London NHS Mental Health Trust. Inclusion criteria for the forensic psychiatric patients were that they had a diagnosis of Schizophrenia, or Schizo-Affective Disorder. They were all either currently detained in a low or medium secure forensic setting, or had been in secure psychiatric provision within the previous three years, but were currently under the care of the Forensic Psychiatric Community Team.

The general adult psychiatric patients were either currently an inpatient, or had been an inpatient in the past three years under the care of general adult psychiatric services.

All patients had to be considered well enough by their clinical team, to participate in the interview and had to be able to communicate in English.

**Recruitment**

Potential participants were identified by consultants, ward managers or care co-ordinators. These patients were then provided with an information sheet describing the nature and purpose of the study, following which they were seen by the researchers, in order to obtain informed consent. All participants were paid £10.00 in recognition of their time. Ethical approval was obtained through NRES ( 13/LO/1153).

**Measures**

Data was collected from both electronic case records and standardised instruments through interviews with members of the research team who are experienced clinicians..

*Electronic Case records*

The following data were collected: socio-demographic information, diagnosis, duration of illness, convictions.

*Discrimination and Stigma Scale* (DISC -12; Thornicroft et al 2009, Brohan et al 2013).

This is a 32 item, self report measure comprising four subscales: unfair treatment, stopping self; overcoming stigma and positive treatment. Questions are rated on a 4 point Likert scale: not at all (0); a little (1); moderately (2); a lot (3) The service user is invited to give examples of stigmatisation or discrimination they may have experienced in the specific area identified. The measure is designed to be used over different time frames, however in this study individuals were asked about lifetime experiences. The scale has been shown to have good reliability, validity and acceptability (Brohan et al 2013).

For the purpose of this paper, only the subscales of unfair treatment (experienced stigma) and stopping self (corresponding to anticipated stigma) will be presented. These subscales were selected as they are the most widely reported in the literature as having a potentially negative impact on recovery and rehabilitation (Thornicroft et al 2007, Brohan et al 2013)

*Brief Psychiatric Rating Scale* (Overall and Gorham 1962 Ventura et al., 1993).

This is an observer rated measure of psychiatric symptoms such as [depression](http://en.wikipedia.org/wiki/Depression_%28mood%29), [anxiety](http://en.wikipedia.org/wiki/Anxiety), [hallucinations](http://en.wikipedia.org/wiki/Hallucinations) and unusual behaviour. Each symptom is rated on a scale of 1 – not present, to 7 – severe on a total of 18 separate items. The Total BPRS score is calculated by summing all 18 items resulting in a possible score between 18 and 136, higher scores indicating more severe symptomatology. This is a widely used measure with established psychometric properties.

**Sample size and statistical analysis**

The sample size was chosen to balance the needs of the proposed analysis and the numbers of available participants. Recruiting 32 participants in each group ensured that the analysis had 80% power to detect a difference between the mean DISC Global scores of the two groups of 0.28 or greater, assuming a standard deviation of 0.4 (Brohan et al 2013) and a 5% significance level.

The forensic and general adult groups were compared with respect to socio-demographic and clinical variables using independent samples t-tests for continuous normally distributed variables, and χ2 analysis for categorical variables (Fishers Exact tests used where appropriate). Analysis of covariance (ANCOVA) models are used to test for a difference between the forensic and general adult groups while controlling for those socio-demographic and clinical variables that vary between the groups and may be associated with DISC scores, the dependent variables. It was anticipated that the different length and nature of inpatient stays between forensic and general adult groups may mask some of the difference between these groups with respect to DISC scores. Therefore Model B was fitted to explore if by controlling for inpatient/community setting differences between the groups may be uncovered. Pearson correlation coefficients (with 95% confidence intervals (CI)) are calculated to assess the association between age, BPRS and the DISC scores. All analysis was conducted using IBM SPSS Statistics v22.

**Results**

**Description of Subjects**

Sixty four patients were recruited between August 2013 and February 2015. Only two patients who were approached by the researchers, declined to be interviewed, making a compliance rate of 97%. Thirty two general adult psychiatric patients were recruited from four acute inpatient wards and four community teams across five London Boroughs. The forensic inpatients were recruited from three medium secure wards and one low secure ward. There was no missing data.

The majority of participants (84%) were male. Their ages ranged from 19 to 72 years, with a mean age of 40.3 years. Just over half (53%) were White, 23% were Black, 13% Asian and 11% other ethnic groups. Seven (11%) patients were married or in a relationship, five (8%) had been married but were currently divorced, separated or widowed and 52 (81%) were single. The duration of illness ranged from 14 months to 40 years, with a mean of just under 15 years. Duration of illness was missing for 4 patients. Seventy two percent of participants had a primary diagnosis of schizophrenia; 28% were diagnosed with schizoaffective disorder.

Twenty four (75%) of the forensic sample and 12 (38%) from the general adult services were inpatients. Participants recruited from the forensic service were significantly younger (difference in means 8.5 years; 95% CI 2.6 – 14.2), p=0.005. As was expected, the forensic sample had a much higher rate of convictions, p<0.001. The mean BPRS score for the sample was 34.6 (SD: 12.2). The forensic patients scored lower than the general adult patients on the BPRS by nearly 9 points (difference in means 8.9 points; 95% CI 3.2 – 14.6), indicating less severe current psycho-pathology, p=0.003 (Table 1). There were no other significant clinical or socio-demographic differences between the groups.

Table 1: Socio-demographic and clinical variables split by forensic and general services (values are n and (%) unless otherwise specified)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Variable** | **Label** | **Total** | **Forensic** | **General** | **Significancea** |
| Gender | Male | 54 (84%) | 28 (88%) | 26 (81%) | 0.5, 1 p=0.731 |
| Female | 10 (16%) | 4 (12%) | 6 (19%) |
| Age (years), mean (SD) | | 40.3 (12.3) | 36.1 (9.8) | 44.5 (13.2) | 2.9, 62 p=0.005 |
| Ethnicity | White | 34 (53% | 16 (50%) | 18 (56%) | Exact p=0.293 |
| Black | 15 (23%) | 9 (29%) | 6 (19%) |
| Asian | 8 (13%) | 2 (6%) | 6 (19%) |
| Other | 7 (11%) | 5 (16%) | 2 (6%) |
| Marital status | Single | 57 (89%) | 29 (91%) | 28 (88%) | Exact p=1.000 |
| Married / in a relationship | 7 (11%) | 3 (9%) | 4 (12%) |
| Convictions | None | 32 (50%) | 3 (9%) | 29 (91%) | Exact p<0.001 |
| Property | 14 (22%) | 14 (44%) | 0 (0%) |
| Violence | 6 (9%) | 5 (16%) | 1 (3%) |
| Property & violence | 5 (8%) | 4 (13%) | 1 (3%) |
| Other | 7 (11%) | 6 (19%) | 1 (3%) |
| Duration of illness (months), mean (SD) | | 178.5 (131.0) | 162.0 (115.3) | 198.0 (146.8) | 1.1, 58 p=0.291 |
| BPRS Total score, mean (SD) | | 34.6 (12.2) | 30.2 (12.2) | 39.1 (10.5) | 3.1, 62 p=0.003 |

a - values are χ2 statistic, degrees of freedom and p-value when comparing groups with respect to categorical variables, exact p-value only when Fishers Exact test required, t-statistic, degrees of freedom and p-value for normally distributed variables.

**Experienced and Anticipated Stigma**

The areas in which participants experienced most stigma were: making or keeping friends, family, mental health staff, being avoided or shunned. In the ‘stopping self’ subscale many participants had concealed or hidden their mental health problem from others (Figure 1). This picture is very similar to that described in the original Brohan et al validation paper

Figure 1: Distribution of DISC item responses, n=64

The mean values of the DISC Mean Global score and subscales (Table 2) indicates a ‘minimal’ to ‘low’ level of experienced and self-stigma using the criteria suggested in Brohan et al. (2010).The forensic and general adult groups did not differ significantly on the DISC Global scales or either of the subscales using both the Mean and Count versions of the scoring system. In Model A, age and BPRS are included in the ANCOVA as they both differ between the forensic and general adult groups. Model B adds in the setting and service\*setting interaction term.

Table 2: Comparison of DISC scores between Forensic and General patients, n=64 (values are mean (SD), and ANCOVA results)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Forensic** | **General** | **Model A** | **Model B** |
|  | **mean (SD)** | **mean (SD)** | **F (p-value)** | **F (p-value)** |
| **DISC – mean** | | | | |
| **Global score** | 0.9 (0.5) | 0.9 (0.4) | 0.4 (0.509) | 0.1 (0.753) |
| **Unfair treatment** | 0.8 (0.6) | 0.9 (0.6) | 0.2 (0.657) | 0.2 (0.669) |
| **Stopping self** | 1.0 (0.9) | 1.1 (0.7) | 0.0 (0.987) | 0.0 (0.987) |
| **DISC – count** | | | | |
| **Global score** | 10.5 (5.3) | 11.1 (4.6) | 0.0 (0.801) | 0.5 (0.480) |
| **Unfair treatment** | 6.2 (4.0) | 6.7 (3.9) | 0.1 (0.701) | 0.3 (0.560) |
| **Stopping self** | 1.4 (1.0) | 1.7 (0.9) | 1.4 (0.243) | 1.0 (0.319) |

Model A - F statistic (1 degree of freedom throughout) and (p-value) for Forensic/General Service effect in Analysis of Covariance model; age, BPRS total score included as covariates

Model B - F statistic (1 degree of freedom throughout) and (p-value) for Forensic/General Service effect in Analysis of Covariance model; age, BPRS total score, Inpatient/Community Setting and Service\*Setting interaction term included as covariates

Age was not significantly correlated with DISC scores (Table 3) but there was weak evidence of a negative correlation (r=-0.18, p=0.165)) between age and Stopping self – count score, suggesting that, as people get older, the range of areas in which their mental health problems stop them participating reduces. BPRS, severity of psychopathology, had a moderate positive correlation (r=0.23 to 0.35) with all Global and subscale scores, indicating that greater severity of psychopathology is associated with higher levels of experienced and self-stigma. These correlations were significant at the 5% level for all but the Global – count score.

Table 3: Association between age, BPRS and DISC scores, n=64 (values are Pearson correlation coefficients and 95% CI)

|  |  |  |
| --- | --- | --- |
|  | **Age** | **BPRS** |
| **DISC – mean** | | |
| **Global score** | 0.05  (-0.20, 0.29) | 0.35a  (0.11, 0.55) |
| **Unfair treatment** | 0.09  (-0.16, 0.33) | 0.34 a  (0.10, 0.54) |
| **Stopping self** | -0.08  (-0.32, 0.17) | 0.35 a  (0.11, 0.55) |
| **DISC – count** | | |
| **Global score** | 0.05  (-0.20, 0.29) | 0.23  (-0.02, 0.45) |
| **Unfair treatment** | 0.10  (-0.15, 0.34) | 0.26 a  (0.02, 0.48) |
| **Stopping self** | -0.18  (-0.41, 0.07) | 0.27 a  (0.03, 0.48) |

a Correlation coefficient significantly different from 0, p<0.05

**Discussion**

This study found very similar levels of experienced and anticipated stigma in the general adult and forensic psychiatric patients and, consistent with other studies, most stigma was reported in relation to the interpersonal domains (Rose et al 2011, Brohan et al 2013). No significant difference was found between the general adult and forensic psychiatric patients, in experienced or anticipated stigma. There was also no difference found between experienced and anticipated stigma in terms of inpatient versus community setting.

The mean BPRS score of participants in this study was 34.6, compared with 43 in the Brohan et al (2013) DISC validation paper. The lower level of psycho-pathology in the participants in this study may because this study, unlike the Brohan et al study, recruited forensic, as well as general adult psychiatric patients. General adult psychiatric patients had a mean BPRS score of 8.9 higher than the forensic patients in this study (95%CI 3.2 - 14.6).

We had anticipated that experienced and anticipated stigma would be greater in individuals with paranoid symptomatology. More severe psychopathology was weakly associated with experienced and anticipated stigma. However there was still no significant differences in DISC scores, between the general and forensic psychiatric patients, after controlling for psycho-pathology.

Chronic schizophrenia is associated with progressive cognitive and functional impairment, which might be expected to limit social participation. However, this study found that, increasing age of participants was associated with a reduction in anticipated stigma. One explanation for this may be that individuals with severe mental illness lower their expectations in terms of what they might participate in or achieve, as they age. Moreover, this could suggest that experienced stigma results in a progressive narrowing of aspirations, expectations and social participation over time (Corrigan and Watson 2002).

As noted by Thornicroft et al (2007) the areas of participants’ lives most affected, were the interpersonal domains. Over half of the total study population reported having experienced unfair treatment by family members, neighbours or mental health staff, difficulty in making friends and being avoided or shunned because of mental illness. The most frequently described areas of anticipated stigma were: concealing their mental illness, stopping themselves applying for work and avoiding close relationships.

Although national anti-stigma campaigns have attempted to dispel widespread myths and prejudices relating to mentally ill individuals (Changing Minds Campaign 1998, Time to Change 2007) members of the public still tend to associate mental illness with dangerousness and unpredictability (Martin et al. 2000, TNS 2007, Angermeyer et al 2006). Forensic psychiatric patients are amongst the most severely ill and come from the most deprived and socially excluded sections of society. They tend to have experienced high rates of childhood abuse and neglect and insecure attachments, which predispose them to viewing the world as hostile and rejecting (Mezey et al 2010, Rose et al 2007). They are more likely, because of what they have done and their perceived dangerousness, to be both ‘shunned’ (Thornicroft 2006, Rose et al 2012 ) and socially excluded ( Mezey et al 2010). Unlike the majority of general adult psychiatric patients, they tend to be subject to involuntary treatment and detention, which are stigmatising, as well as socially sanctioned exclusion and discrimination, such as being excluded from voting (McIntyre et al 2012).

We had therefore expected to find more stigma and discrimination in forensic psychiatric patients across all domains, as a result of poor knowledge, greater public stigma and more structural discrimination in terms of restrictions on relationships, vocational and employment opportunities, accommodation and freedom of movement (Rose et al 2007). Surprisingly, however, this study did not find any increased stigma and discrimination in forensic psychiatric patients, compared with a non-forensic psychiatric population.

How can the lack of a difference between the two groups be best explained? It may be that, having a diagnosis of paranoid schizophrenia effectively cancels out any other differences between the non-forensic and forensic populations, in that for many people the diagnosis is, in itself, synonymous with violence, regardless of the individual’s actual level of risk, or their history (TNS 2007). An alternative explanation may be offered by the nature of forensic services. The duration of inpatient treatment for forensic patients is considerably longer than for general adult psychiatric patients: the average length of stay for forensic psychiatric patients in medium secure psychiatric provision is 751.5 days , whilst the average duration of stay for general adult psychiatric inpatients is 54.1 days (HSCIC 2014). Forensic psychiatric inpatients therefore have more opportunities for intensive rehabilitation, including a greater focus on social recovery and inclusion. At the point of discharge they are likely to be more stable and settled, better able to cope in the community, less likely to be exhibiting unusual or strange behaviours and therefore less likely to encounter hostile or fearful responses from members of the public.

Moreover, forensic psychiatric patients tend to be discharged to highly supportive fully staffed specialist hostels, which provide sheltered and protected environment, with a continued focus on rehabilitation and social recovery. The potential for stigmatising and discriminatory interactions with members of the public are is reduced in the forensic patients, who receive a conditional discharge from a Section 37 /41, by an intervening layer of carers and clinicians, who support and monitor their release from hospital. Thus the majority of discharged forensic psychiatric patients remain subject to recall, under the Mental Health Act, even when they are living in the Community. By contrast the limited resources available to general psychiatric services mean that patients are often discharged after comparatively brief admissions, back to independent living with time limited input from crisis teams.

Finally, we suggest that the apparent lack of any difference between forensic and general adult psychiatric patients in this study, may reflect a limitation of the DISC instrument. Further qualitative studies of mental health service users, with individuals who have a range of diagnoses, could provide further understanding of such experiences and how they impact on individual service users’ lives.

**Implications**

Increasing awareness of the associations between mental illness, offending behaviour, stigma and social exclusion is important to help ensure that services and support can be more appropriately targeted towards the most vulnerable individuals, leading to improved health and social outcomes. Work with service users to increase feelings of self-worth, self-esteem and assertiveness and to cope with stigma and discrimination is necessary to improve social, as well as clinical outcomes.

There is an important role for awareness raising campaigns and the wider social media in reducing the stigma associated with severe mental illness. Clearly there is a need for more work to be done in challenging public misperceptions and negative stereotypes about individuals with mental illness and in particular those with a diagnosis of schizophrenia**.**

There has beenvery little, if any, focus on educating the public about individuals who are both mentally ill and have a history of violence. Indeed, much of the campaigning has been focussed on attempts to dispel widespread myths and prejudices related to mentally ill individuals as being dangerous. Clearly, forensic psychiatric patients reinforce and perpetuate the perception of mentally individuals as violent and unpredictable. There needs to be a way of reconciling these competing discourses, otherwise forensic psychiatric patients will end up being ignored and excluded in the ongoing efforts to combat the stigma and discrimination associated with mental illness.

**Strengths and limitations**

This study is the largest UK study of stigma and discrimination in psychotic patients and the only study looking at forensic as well as general adult psychiatric patients. Data was collected from one trust in London, covering a small urban geographical area, with a highly diverse population. It is possible that different findings would emerge in a larger population, recruited from rural as well as urban settings and with a range of diagnoses.

Validated assessment tools were used in this study. The DISC-12 offers an option as to time frame to be considered. In this study, participants were asked to consider their experiences of stigma since the onset of illness. It may be that this time frame was so wide that it affected individuals’ recall for more significant events. A time frame of the last 12 months may have assisted recall and provided a more accurate picture of patients’ perceptions and experiences of stigma.

There is very little research to date looking at the effects of gender on stigma and discrimination. This study included male and female psychiatric patients; however the small numbers of women prevented us from examining the specific influence of gender, which would be an important focus of any future study.

The original research to validate the DISC-12 (Brohan et al 2013) involved participant focus groups, which considered the overall ease of completion of the DISC-12. One of the recommendations from this exercise was that the wording of some of the DISC-12 items was too complex and needed to be re-written in a simplified form. Although we did not specifically question participants about the acceptability of the DISC-12, participants clearly found some of the questions confusing and often requested further explanation and clarification, before they felt able to answer them. We would suggest that further modification of the some of the questions may be helpful, particularly for use with individuals who have severe mental illness and possible impaired cognitive functioning.

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