# Mental Health Stigma Towards Offenders and Juror Decision Making

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## Thesis Abstract

**Background:** Mental health stigma within the criminal justice system is poorly researched despite there being a wider breadth of research into the stigma associated with mental health conditions. Similarly, there is very little research considering the joint stigma that derives from both offending and mental health conditions. One potential impact of such stigma could be within the context of decision making by a jury.

**Method:** The systematic review aimed to understand the prevalence of mental health stigma towards offenders and how such stigma was measured. Selected studies varied in location and samples, including the general public, students and mental health professionals. The empirical paper focused on how the impact of stigma and the provision of mental health information given to a juror affected their decision making in an online mock criminal trial.

**Results:** Twelve studies were included in the systematic review, of which five were compared with control groups with neither mental health or offending histories, and most demonstrated that stigma towards offenders with mental health difficulties was higher. Psychometric tools chosen to measure offender mental health stigma were extremely varied and this prevented full comparisons. The empirical study found that the provision of mental health information (both symptoms and a diagnostic label) reduced the probability of a juror giving a guilty decision by almost 6 times. It also found those with higher stigma were in some cases 50% more likely to give a guilty verdict (where stigma scores increased by one standard deviation).

**Conclusions:** Offender mental health stigma is prevalent across the globe. Such stigma may influence the decision making processes that lead to a juror's verdict in a mock trial. The way in which information about a mental health difficulty is presented may also impact such decision making. Limitations, implications and recommendations for future research are considered.

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**General Orientation**

The thesis portfolio consists of a systematic review and an empirical paper on the topic of mental health stigma and juror decision making. The systematic review brings together the current literature around stigma towards those with mental health conditions and a criminal or offending history. A bridging chapter joins the narrative of the systematic review with the start of the empirical study. The empirical paper focuses on the impact of mental health stigma and the presentation of mental health information on juror decision making demonstrated in an online mock criminal trial. It also focuses on a particular mental health diagnosis, schizophrenia, to understand how the provision of information relating to this diagnosis and individual stigmatic attitudes also towards this diagnosis may impact on a juror's verdict. The empirical project was a joint research project with another trainee, who has focused on a different set of research questions and the impact of a separate topic, mental health literacy, on juror decision making (please see Appendix A for further information).

CHAPTER ONE

Systematic Review

Prepared for submission to Psychology, Crime and Law

(See Appendix B for author guidelines)

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**A Systematic Review of Offender Mental Health Stigma: Summary of the Literature, Psychometric Measures and Differential Diagnosis**

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**Abstract**

Stigmatising attitudes appear to vary across different mental health diagnoses, and offenders with mental illness have been shown to elicit more negative stigmatic attitudes than offenders without mental illness. Stigma and discrimination can have detrimental effects on an individual's recovery, treatment and even employment opportunities. This systematic review aimed to report the state of contemporary research into stigma towards offenders with mental health conditions, to explore if different mental health diagnoses were associated with differential rates of stigma in offenders, and to ascertain which psychometric measures have been used to capture such stigmatic attitudes. Twelve studies were included in the review with varied populations and study locations. The vast majority reported negative stigmatic attitudes towards offenders with mental illness when compared to control groups, with neither a criminal history nor a mental illness. Results also indicated that the diagnoses with particularly high levels of stigma were psychopathy and schizophrenia. Psychometric measures used to capture stigma varied considerably and rarely was the same measure used across studies which limited comparisons. A frequently employed measure was the attribution questionnaire (Brown, 2008). This review highlights a number of key points for advancing research in the area which are discussed along with strengths and limitations.

*Keywords:* Stigma, offenders, criminal history, mental health stigma, negative attitudes.

**Stigma in Mental Health**

Stigma can be conceptualised in a number of ways, but regardless there is broad agreement that it is a multifaceted concept (Fox et al., 2018; Link & Phelan, 2001). Previous literature describes the importance of operationalising the type of stigma that is being explored, as many research studies use varying terms for the same concepts. The Mental Illness Stigma Framework by Fox et al. (2018) proposed a structure for understanding and researching factors that make up stigma. The framework differentiates between stigma that occurs from two different perspectives, that of the stigmatised and their own internalised stigma, and the 'public stigma' of the stigmatiser (Fox et al., 2018). The latter encompasses related terms including stereotypes, prejudice and discrimination and the consecutive order of these terms has been argued to be the process in which stigma develops (Corrigan et al., 2004). This literature is significant due to the damaging effects stigma has on those with mental illness, which include, but are not limited to, an increased prevalence of suicide (Schomerus et al., 2014), reduced employment and housing opportunities, and barriers to accessing healthcare and treatment (Overton & Medina, 2008). The latter points have been hypothesised to be at least partly because health professionals may share similar stigmatic attitudes as the general public (Jorm et al., 1999; Lauber et al., 2006).

Of course, public stigma and internalised stigma are likely to be closely connected; stigma can be internalised by the stigmatised and have further negative impact on an individual's mental health (West et al., 2014; Wood et al. 2014). Thus, in reducing public stigma it is conceivable this may also reduce self-stigma. For these reasons, various anti-stigma campaigns have aimed to reduce public stigma. For example, 'Time to Change 2009' in England has shown some improvements in aspects of stigma such as intended behaviour and a small improvement in attitudes through education and raising awareness about mental

health (Corrigan et al., 2012; Evans-Lacko et al., 2013). This provides hope that efforts to

increase the public understanding of stigma may be productive.

**Differential Mental Health Diagnoses**

Stigmatising attitudes appear to vary across different mental health diagnoses (Crisp

et al., 2000; Parle, 2012). The most stigmatised diagnoses have frequently been found to be

schizophrenia (Read et al., 2006; Wood et al., 2014) and Borderline Personality Disorder

(BPD) (Catthoor et al., 2015). There has been less research into public stigmatic attitudes

towards BPD than that of schizophrenia but perceptions of frustration and fear amongst the

public toward personality disorders have been found (Adebowale, 2010). Research has shown

that negative public attitudes towards those with a diagnosis of schizophrenia often involve

beliefs around dangerousness and unpredictability (Angermeyer & Matschinger, 2003; Crisp

et al., 2000). It is thought that schizophrenia might be particularly stigmatised due a small

minority of people with this diagnosis behaving dangerously and the media exaggerating the

link between schizophrenia and violence (Crisp et al., 2000). As a result these perceptions are

generalised to all individuals with the condition (Crisp et al., 2000). On the other hand, Wood

et al.'s (2014) study found anxiety to have the least amount of stigma from the general public.

**Stigma Towards Offenders**

Stigma towards offenders, or those who have previously committed a crime, has also

been associated with the development of wider stereotypes of dishonesty and danger

(Hirschfield & Piquero, 2010). Research shows that violent behaviour may be a particular

source of stigma (Hardcastle et al., 2011) and that sex offenders are amongst the most highly

stigmatised subgroup of offenders (Tewskbury & Lees, 2006). Public attitudes towards

offenders are more negative towards those convicted of sexual offences than other non-sex

offences (Craig, 2005). Of course, one difference between offenders and people with mental health diagnoses is that offenders generally *have* demonstrated behaviour that may reasonably lead others in society to experience fear of harm. Arguably, however public stigmatic attitudes frequently extend beyond the actual risk of danger likely caused and may serve to paradoxically prevent an offender from exiting the circumstances or factors that maintain the offending.

**Joint Stigma**

Given the aforementioned research, having both a psychiatric diagnosis and a criminal history is likely to exacerbate negative stigmatic attitudes. Indeed, offenders with mental illness have been shown to elicit more negative attitudes than offenders without mental illness (Rade et al., 2016). Similarly, once arrested, offenders with mental illness have been found to be held in custody for longer periods than those without (Solomon & Draine, 1995). Therefore, multiple stigmas appear to be at play for individuals with a criminal history who experience mental health difficulties. This may be of particular relevance to the patients of forensic psychiatric services (West et al., 2014), and to those in prison, where the rates of mental health problems are high (Diamond et al., 2001).

The interaction between offending and mental health problems as sources of stigma is important to consider in the context of the relationship between offending and mental health. Whilst there is a higher likelihood of offenders experiencing mental health problems than the general community, only a minority of people with mental health conditions are violent or have a history of offending and they are more likely to be a victim than a perpetrator of violent crime (Brekke et al., 2002). Despite this, some specific mental health disorders are more strongly associated with crime, at least on a group level. For instance, having a psychotic disorder increases the prevalence for being convicted of a crime (Morgan et al.,

2013), although the relationship between violence and certain types of symptoms (e.g. persecutory delusions) may be overall more important (Coid et al., 2013). Therefore, this complex relationship likely creates conflicting attitudes and potentially high levels of stigma.

West et al. (2014) and Rade et al. (2016) commented on the sheer lack of research into the stigmatisation of forensic psychiatric groups and the focus of stigma research on single sources of stigma. It is unclear whether the interaction between the two stigmatised labels may trigger greater levels of stigma than both concepts in isolation or whether the presence of one acts to mitigate the other. This could be possible if, for instance, mental health problems were seen as a less 'personal' explanation for offending, and perhaps more amenable to change through treatment (Morgan et al., 2013). It is also unclear how best to measure this complex relationship. In a critical review of mental illness stigma measures, over 400 were identified, a situation that has been described as 'overwhelming' (Fox et al., 2018). However, specific measures of stigma towards offenders are far less common.

**Aims**

To the author's knowledge, there has not been a systematic review of the literature surrounding offenders with mental health problems from the perspective of the stigmatiser. Therefore, the current systematic review aimed to understand how common stigma towards offenders with mental health conditions was (research question one); ascertain which measures have been used to capture such stigma (research question two) and determine if different mental health diagnoses were associated with differential rates of stigma in offenders (research question three).

## Method

This systematic review was registered on the International Register of Prospective Systematic Reviews (PROSPERO) (registration number: CRD42020191145, 17/09/20).

**Eligibility**

*Inclusion Criteria*

The current paper sought empirical research which met identified criteria that aligned with the aims of the systematic review. All criteria had to be met to be included. The inclusion criteria were:

(a) empirical research studies which developed or applied a measure of stigma adopting a quantitative stigma score (studies which adopted tools measuring stigma without a quantitative aspect were excluded). The measure had to be stigma 'of another', i.e., studies that considered 'self-stigma' were excluded.

Studies were required to have considered stigma in relation to offenders with mental health difficulties:

(b) the term 'offender' did not need to be specifically mentioned but could be implied through phrases such as 'history of a criminal conviction', 'residing in a forensic psychiatric hospital or prison', 'contact with the criminal justice system'; (c) a phrase such as 'mental health condition' or 'mental health difficulty' could be explicitly used or a specific mental health diagnosis such as schizophrenia or depression was also considered sufficient; (d) studies were required to measure stigma of offenders with mental health conditions and therefore the inclusion of both offender and mental health dimensions was required within the study. This could have been evidenced through a vignette including information about criminal history and the use of a mental health stigma questionnaire or a specific questionnaire investigating offender mental health stigma, for example; (e) stigma as a concept was considered to include broader negative attitudes and stereotypes but was required to be multifaceted (with more than one facet of stigma) to be included. This was due to the vast range of constructs described in the literature as defining stigma and the commonality amongst them was a multifaceted approach. The division between them was

that they did not agree on the same facets to define stigma. For example, studies that focused on one facet of stigma, such as sympathy or dangerousness were not included. However, studies which included a broader measure of stigma and a measure of dangerousness were included where data was only extracted from the broader measure. Data derived from the additional single faceted measures was excluded from the current review; (f) articles must have been published in peer reviewed journals only; (g) articles must have been written in the English language; (h) articles must have been published after January 2009; (i) participants included in the research studies must have been aged 18 years or over.

### *Exclusion Criteria*

In addition to the inclusion criteria, studies were excluded under additional specific circumstances: (a) addiction in relation to drug or alcohol use was not considered a primary or secondary mental health condition; (b) current or historical sexual offence or offence related to sexual abuse (to avoid including stigma that was specific to this form of offending); (c) qualitative measures of stigma or negative attitudes including individual experiences of stigma such as self-stigma or anticipated stigma; (4) any description of a learning disability, brain injury, dementia, cognitive impairment or neurodevelopmental condition in any given vignettes; (d) research involving 'exonerees' defined as individuals who have previously been wrongfully convicted. These criteria were to ensure that stigma solely in relation to offenders with psychiatric diagnoses was considered as the focus of the current review.

### Search Strategy

The following databases were searched; MEDLINE, PsycINFO, EMBASE, PsyArticles, ProQuest criminal justice and the National Criminal Justice Reference Service (NCJRS) as they were considered significant in relation to mental health, stigma and offender

research. The search terms used were (Stigma* or stereotype* or prejud* or "negative attitude*" or discrim* or "public attitude*") AND (Schizo* or Psycho* or "personality disorder*" or depress* or bipolar or "mood disorder" or "mental health" or "mental illness") AND (Offend* or forensic or prison* or probation or "secure unit" or crim* or justice). The NCJRS did not have capacity for searching articles using "OR" terms and was therefore searched using the least restrictive option using broad terms and the results were manually searched by the primary author. For the remaining journals the abstract and title searches were carried out with a date limitation of the start of 2009- July 2020. Reference lists were also checked of key research articles; however, this did not yield any further studies that had not already been identified within the main searches. Searches were conducted on the 3rd August 2020.

**Identification and Selection of Studies**

To identify and select studies relevant to the systematic review questions, the search strategy outlined above was employed. The titles and abstracts of the search results were screened by the primary author against the inclusion and exclusion criteria previously described. Duplicate articles across journals were also removed, see Figure 1 for further detail. All data extraction was completed by the primary author. The final studies were checked against eligibility criteria by a fellow named author in order to reduce bias. Both authors agreed that all of the selected studies met the eligibility criteria.

**Studies Included in the Review**

Figure 1 shows a PRISMA flow chart describing the overall process of study selection. This began with initial screening where 3196 studies were identified, and a further 99 from the NCJRS. Following the removal of duplicates this resulted in 1584 studies to be

screened along with an additional 98 from the NCJRS as due to its setup it was not possible

to remove duplicates digitally. Following the screening of titles of abstracts, 157 full text

articles were screened against eligibility criteria resulting in 12 eligible studies.

**Figure 1.**

*PRISMA Study Selection Flowchart*
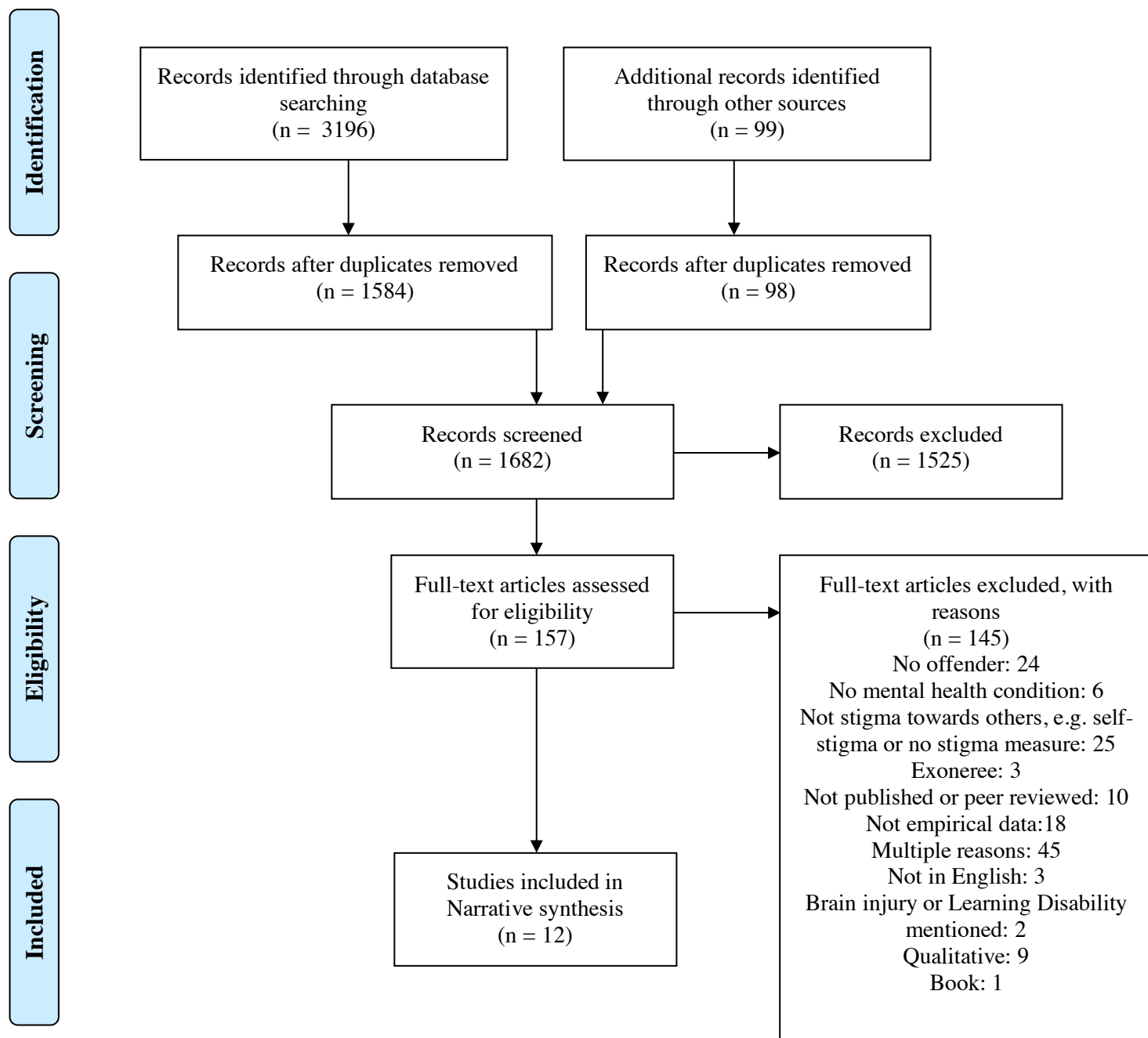
**Data Extraction**

Data was extracted in three parts, broadly following each research question. The first

detailed the demographics of the study including the sample, research aims, findings in

relation to stigma and study location. The second detailed the measures used in each study,

relevant psychometrics and mean stigma scores (total and subscales). In order to understand

if there was a presence of stigma towards offenders with mental health conditions, stigma

scores were compared with that of control groups (where neither an offending history nor

mental health condition was present). Where studies were applying a previously validated

measure (as opposed to developing a novel measure), comparisons were made with control

groups (when provided or where possible) using $t$ tests to understand if differences between

the means were statistically significant. In order to ensure a consistent approach to

identification of an appropriate comparison sample, and to use a sample that was most

comparable to the identified sample, a brief protocol was employed (see Figure 2).

**Figure 2.**

*Flowchart Describing the Selection of Comparative Research Studies*
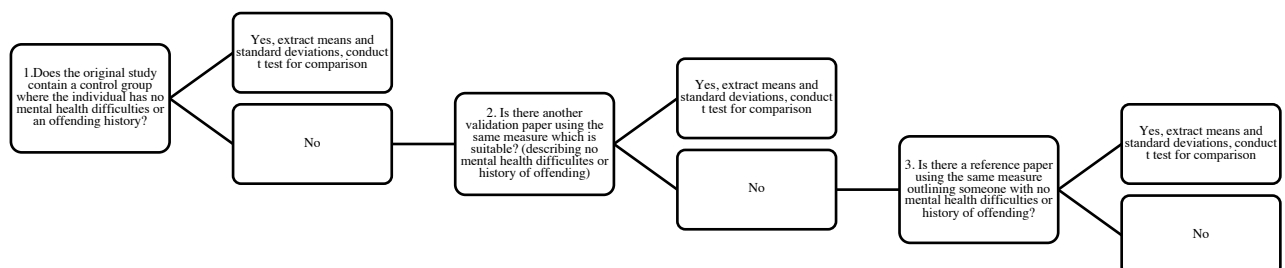
**Methodological Quality Assessment**

Study quality assessment was completed using the Appraisal Tool for Cross-sectional studies (AXIS tool) for quantitative research (Downes et al., 2016). The AXIS tool consists of 20 questions to critically appraise observational research studies; examples include sample size justification, a clearly defined target population and statistical methods to allow for replication. The AXIS tool does not have a numeric scale or a final score. Instead, it asks for the presence or absence of each quality area. However, previous research employing this tool has reported how many of the 20 criteria were met, giving a score out of 20 (e.g. Wong et al., 2018) and therefore this was replicated in the current review (see Table 1).

**Analysis**

The data was analysed using a narrative synthesis model to describe the literature at present regarding offender mental health stigma, to understand the measures used to capture this information and to suggest future research ideas. This was based on Popay et al. (2006) guidance which involved identifying and refining the review question, extracting data and quality assessment before bringing together the main findings. Where possible the impact of differential mental health diagnoses on levels of stigma in offenders was also considered.

## Results

12 studies were identified as eligible and therefore included in the final dataset for the current systematic review.

**Study Characteristics**

Population samples in the studies varied and included the general public ($n=5$), university students ($n=4$), healthcare professionals ($n=3$) and one study included legal

professionals (judges, prosecutors and public defendants). Study locations included the

United States of America (USA) (*n*=5), the United Kingdom (*n*=3), India (n=1), Ghana (*n*=1),

Switzerland (*n*=1) and an international study including participants from across Europe, Asia

and the USA. The majority of studies selected mental health stigma questionnaires and the

use of a vignette to specify a criminal offence or background. Two studies employed a

specific offender mental health stigma questionnaire called Attitudes Towards Mentally Ill

Offenders (ATIMO) (Church et al., 2009).

**Participant Characteristics**

The study sample sizes ranged from 58 to 2207 (*N*= 4696). Females were over-

represented in the review (see Table 1), 11 out of 12 studies had more than 50% female

participants with the exception of a single study conducted with legal professionals (Batastini

et al., 2017) in which the majority (70.30%) were male. Where reported *(n*=9), the mean age

ranged from 21.65 years (*SD*=2.60) to 52.18 years (*SD*=16.08).

**Quality Assessment**

The selected studies scored highly against the AXIS criteria (range= 18-20) with two

studies scoring the full 20 out of 20. The majority of studies lacked justification of a sample

size, such as the use of a power analysis or lacked a statement around the size chosen for the

study. Another criterion often unmet was a description around measures taken to categorise

non responders from study samples. Table 1 gives an overview of all of the studies included

in the review.

**Table 1.**

*Overview of the Final studies Selected for the Current Review*

| Study ID | Authors of study | Sample size gender split and mean age (*SD*) | Participant type/job role | Study location | Research aims/questions | Summarise main findings in regard to stigma | Quality of study AXIS criteria /20 |
|---|---|---|---|---|---|---|---|
| 1. | Nee & Witt (2013) | 243 (total) 70% female 30% male<br><br>35 (13.18)yrs | General Public | UK | This study predicted: "(i) those with mental health problems would be seen as more likely to commit crime; (ii) participants' own familiarity with mental health problems and/or criminal behaviour would result in a less negative, stereotypical response towards individuals with mental health problems. (iii) increased participant age will result in a less negative, stereotypical response to individuals with mental health problems." | "The sample were significantly more likely to think that a character would 'possibly' commit future crime if he had mental illness in comparison to the control, but crimes were expected to be minor" | 20 |
| 2. | Garcia et al. (2020) | 290 (total) 53% female 47% male <1% prefer not to say<br><br>37.31(11.52)yrs | General public | United states | "To understand public perceptions of the relationship between mental illness, perceived criminality and race. Increase understanding of stigmatization of mentally ill. Hypothesis: Vignettes depicting mental illness would be associated with higher levels of criminality; familiarity with mental illness or criminality would be associated with lower levels of stereotypical beliefs." | "The presence of a mental health diagnostic label elicited higher levels of risk of criminality. The public appear to view individuals with mental illness as being more dangerous, it was not specific to mental health diagnosis." | 19 |
| 3. | Rao et al. (2009) | 108 (total) 86% female 14% male<br><br>43.2 (1.2)yrs | Health professionals 58% qualified nurses 13% healthcare assistants 9% did not state profession 20% doctors | South East, England, UK | "Aimed to assess stigmatized attitudes among health professionals. Research Questions: 1. Do health professionals have more stigmatizing attitudes towards schizophrenia than brief psychotic episodes? 2. Do health professionals have more stigmatizing attitudes towards patients admitted to a secure hospital than somebody who has been diagnosed with schizophrenia alone?" | "Participants had highly stigmatized attitudes towards patients from a forensic hospital. This suggested that health professionals have stigmatized attitudes towards an illness such as schizophrenia and this is worse towards patients from a secure hospital." | 19 |

| 4. | Sowislo et al. (2017) | 2207 (total)<br>61.5% female<br>38.5% male<br><br>43.4 (13.4)yrs | General Public | Basel-Stadt, Switzerland | Compared stigma in relation to psychiatric symptoms, to that related to the type of psychiatric service use. "Compared stigma around BPD with schizophrenia and alcohol dependence. Understood differences in stigma between different psychiatric inpatient services such as forensic settings." | "Desired social distance was significantly lower in relation to psychiatric service use than to psychiatric symptoms. Overall, symptoms of alcohol dependency, behaviour endangering others, and the fictitious character's being male tend to increase stigmatization. The character being hospitalized in a psychiatric unit at a general hospital and also respondent and familiarity with psychiatric services tend to decrease stigmatization" | 18 |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 5. | Adjorlolo et al. (2018) | 113<br>65% female<br>35% male<br><br>75% <30yrs<br>35% >30yrs | Qualified Mental Health Nurses | Ghana | "This study investigated mental health nurses' attitudes toward mental illness, as well as punishment-oriented attitudes (i.e., conviction proneness and punitiveness) as predictors of their attitudes toward offenders with mental illness. Second, the study examines whether mental health nurses' demographic backgrounds, namely, gender, age, and years of practice, have significant influence on their attitudes toward offenders with mental illness." | "The nurses' scores in conviction proneness and criminal blameworthiness significantly predict negative attitudes toward the offenders even after controlling for their attitudes toward mental illness." | 18 |
| 6. | Lammie et al. (2010) | 58<br>50% 29 female<br>41.4% 24 male<br>8.6% 5 prefer not to say<br><br><21yrs =0<br>21-30yrs =19<br>31-40yrs =16<br>41-50yrs =15<br>51+yrs =4<br>Unknown=4 | Nursing Disciplines in forensic wards | UK | "To examine practitioner attitudes towards patients within forensic mental health care; to identify whether qualitative and quantitative approaches provide different insights. that participants who work within the medium secure unit would rate the fictitious patient less favourably than those who work within the low secure unit, due to their contact with patients who are considered to require a higher level of security. Stigma hypotheses:<br>• That male nurses, across both sites, would rate the fictitious patient higher on all factors, with the exception of fear and danger, than female nurses.<br>• That older participants would be less fearful of the fictitious patient and rate him lower on the factor of dangerousness than younger participants." | "Significant minority of negative attitudes in relation to desire for social distance. Quantitative results showed high stigma scores for avoidance and segregation. There were no significant differences in attitudes between medium and low secure settings. However overall, males reported more negative attitudes in relation to blame and avoidance and younger participants demonstrated more negative attitudes than older participants in relation to fear and danger. While fear and blame were low overall, males reported more blame and younger practitioners reported more fear. This may indicate that experience (contact) reduces stigma in forensic settings although we cannot assume this from the study." | 20 |

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|---|---|---|---|---|---|---|
| 7. | Frailing & Slate (2016) | 196 (total) 55% female 45% male<br><br>119 Florida 60% female 40% male<br><br>82% 18-25yrs | Students | Southern Texas & Florida | "This research reported on the measurement of criminal justice and criminology students' attitudes towards people with mental illness, before and after a class on criminalisation of mental health in offenders." | The "results indicate that criminal justice and criminology students' attitudes toward people with mental illness, offenders with mental illness, and community-based mental health services were significantly more positive at the conclusion of our classes than they were at the beginning. These outcomes were unaffected by choice of instrument or research location." | 18 |
| 8. | Perkins et al. (2009) | 404 (total) 67% female 33% male<br><br>52.18 (16.08)yrs | General public | Indiana | "1.An adult male with schizophrenia who is actively engaged in competitive, wage-based community employment will elicit less social distance than one who is unemployed. 2. An adult male with schizophrenia who has a past history of misdemeanor criminal conduct will elicit less social distance than one with a past history of felony criminal conduct." | "The individual who was gainfully employed (vs. unemployed), or who had a prior misdemeanour (versus felony) criminal offense, elicited significantly less stigma. Employment may destigmatize a person coping with both psychiatric disability and a criminal record." | 19 |
| 9. | Batastini, Bolanos, & Morgan (2014) | 465 (total) 66.7% female 33.3% male<br><br>Not reported 18-24yrs – 84% 25-34yrs-12.1% 35-44yrs- 2.2% 45-54yrs -1.8% | University psychology students | West Texas | Hypothesised that regardless of education or experience, the job applicant with a history of both mental illness and criminal involvement will be rated the least desirable candidate for the job. They hypothesized that "prior experience with a mentally ill or criminal justice involved person would be associated with less stigmatized attitudes toward the respective job applicant." | "Applicants with a history of both mental illness and criminal behaviour were perceived as the least acceptable candidates for employment. However, this finding did not hold true when participants (i.e., the hypothetical employers) were exposed to a brief explanation about the benefits of employment." | 18 |
| 10. | Durand et al. (2017) | 116 50.9% female 49.1% male<br><br>26.8 (10.77)yrs | General public | International but most common Europe, North America & Asia | The study "hypothesized a negative relationship between high expression of psychopathic traits and stigmatization towards psychopaths, and also hypothesized that this negative relationship would be strongest within interpersonal-affective features due to their association with fearlessness." | "The presence of psychopathic traits, particularly those related to boldness, was negatively correlated with the degree of stigmatizing behaviours towards psychopaths." | 18 |
| 11. | Weaver et al. (2019) | 358 77% female 23% male<br><br>28.49 (9.02)yrs | College students majoring in social work (35%) or criminal justice (65%) | University of Southern Mississippi, US | "This study investigates attitudes toward offenders living with mental illness among a cross-section of college students." | "Results indicated that Social Work students were less likely to have negative stereotypes (than criminal justice students) toward offenders with mental illness and tended to be more supportive of their potential for rehabilitation. The two groups of students appeared to share ambivalence regarding the | 19 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | dangerousness and culpability of offenders living with mental illness." | |
| 12 | Batastini, Lester, & Thompson (2017) | 138 29.7% female 70.3% male 49.43 (12.84)yrs | 23.1% Judges, 24.3% Prosecutors, 52.7% Public Defendants | Mississippi | The "primary purpose of this study was to identify the prevalence of stigmatizing beliefs among judges, prosecutors, and public defenders. It was hypothesized that defence attorneys would self-report significantly less biased and stigmatizing attitudes about mental illness in general and seriously mentally ill defendants than both judges and prosecutors." | "Public defenders, relative to both judges and prosecutors, endorsed more compassionate attitudes about defendants with mental illnesses. While judges and prosecutors endorsed more negative stereotypes about mental illness and perceived mentally ill defendants as a greater risk to the community, mean scores across groups suggested moderately positive attitudes overall." | 19 |

**Research question 1. How Common is Stigma Towards Offenders with Mental Health**

**Conditions?**

To understand the specific stigma deriving from offending and mental health conditions, ideally stigma scores from vignettes describing offenders with mental health conditions would be compared with vignettes describing non offenders with or without a mental health condition. Unfortunately, rarely were many of the studies set up in this way. However, two studies compared offenders with and without mental health difficulties, producing similar results. In both Garcia et al. (2020) and Nee & Witt (2013), those without mental health difficulties had significantly lower scores on sympathy subscales and higher stigma in comparison to those with a mental health difficulty. In Nee & Witt's (2013) study it appeared that the offending history with and without mental health diagnosis was associated with higher levels of stigma in comparison to a control group therefore showing the impact of offending history on stigma levels. Alternatively, Garcia et al. (2020) found that participants judged the likelihood of a future crime as greater when a mental health diagnosis was added to a vignette containing otherwise the same offending history, suggesting that the mental health condition was associated with an increase in stigma.

In considering the question of how common stigma towards offenders with mental health conditions is from another perspective, the protocol previously outlined (Figure 2) was followed and five studies were selected. Table 2 shows comparisons between the samples obtained and control samples. The comparisons revealed that in a study amongst hospital staff, stigmatised attitudes were higher towards those admitted to a forensic hospital than those admitted to hospital with schizophrenia or a brief psychotic episode (Rao et al., 2009). Another study had similar findings where higher levels of social distance were desired when vignettes described a forensic unit in comparison to a general hospital with a psychiatric unit (Sowislo et al., 2017). A further study found significantly higher stigmatic levels on a

fear/dangerousness subscale for a vignette with an offender with bipolar in comparison to a control group who had neither an offending nor a psychiatric history (Batastini et al., 2014). However, the responsibility subscale between these groups scored in the opposite direction indicating significantly more responsibility was given to the control group (Sowislo et al., 2017). The results taken together indicate a somewhat mixed message of stigma. There was no difference on a scale of willingness to help or social distance between the groups.

Often studies found significantly more stigma for a forensic group than a control group with neither (mental health or offender) labels (Batastini et al., 2014; Durand et al., 2017; Rao et al., 2009). The specific subscales found to have greater stigma towards offenders with mental health difficulties in comparison to control groups were 'fear/danger', 'responsibility' (Batastini et al., 2014; Durand et al., 2017) likelihood of future crime (Nee & Witt, 2013'; Garcia et al., 2020) and 'Trust' (Nee & Witt, 2013). Subscales showing little difference between the two groups were 'social distance and perceived dangerousness, 'willingness to help' (Batastini et al., 2014) and 'rehabilitation potential' (Nee & Witt, 2013). An exception was a study where offenders were diagnosed with psychopathy; this induced significantly higher levels of fear/dangerousness when compared to a control group (Durand et al., 2017).

**Table 2.**

*Mean Stigma Scores of Identified Studies and Comparison Groups*

| Authors of study | Name and reference of measure | Direction of score | Brief description of what measure operationalises | Mean Score | Comparison/ control group mean score | T test | Is offender mental health stigma significantly higher than control? |
|---|---|---|---|---|---|---|---|
| Nee & Witt (2013) | No name (5 questions) | 10-point Likert<br>Higher scores=less stigma for trust and sympathy and rehab potential.<br>Higher scores=more stigma for likelihood and severity of future crime | Vignettes included an offender with a mental health condition of either depression/schizophrenia | Mean response % categorised by depression or schizophrenia | Control group (no mental illness no criminal background) | | |
| | | | **Subscales:** | | | | |
| | | | Trustworthiness | 65.00 ($SD$=17.85, $n$=44)<br>69.46($SD$=15.47, $n$=37) | 72.79 ($SD$=16.52, $n$=43) | $t$ (85)=2.11, $p$ = 0.04*<br>$t$ (78)=0.93, $p$ = 0.36 | Yes for depression |
| | | | Sympathy | 72.27 ($SD$=16.82, $n$=44)<br>74.59($SD$=23.99, $n$=37 | 53.02 ($SD$=22.20, $n$=43) | $t$ (85)= 4.58, $p$< .001*<br>$t$ (78)= 5.17, $p$ <.001* | Yes for depression & schizophrenia |
| | | | Likelihood future crime (scores reported are possibility to definitely commit crime) | 5.02 ($SD$=2.61, $n$=44)<br>4.81($SD$=2.95, $n$=37) | 2.65 ($SD$=2.70, $n$=43) | t (85)=4.16, $p$ <.001*<br>t (78)=3.42, $p$ <.001* | Yes for depression & schizophrenia |
| | | | Severity of future crime (minor crime category) | 4.21 ($SD$=1.86, $n$=32)<br>4.12($SD$=1.91, $n$=24) | 3.38 ($SD$=1.54, $n$=16) | $t$ (46)=1.54, $p$=0.13<br>$t$ (38)=1.29, $p$=0.20 | No |
| | | | Rehab potential | 67.8 ($SD$=19.13, $n$=32)<br>75.00($SD$=16.55, $n$=26) | 75.29 ($SD$=20.65, $n$=17) | $t$ (47)=1.27, $p$=0.21<br>$t$ (41)=0.05, $p$=0.96 | No |

| Authors of study | Name and reference of measure | Direction of score | Brief description of what measure operationalises | Mean Score | Comparison/ control group mean score | T test | Is offender mental health stigma significantly higher than control? |
|---|---|---|---|---|---|---|---|
| Garcia et al., (2020) | No name (5 questions as used in Nee & Witt, 2013) | 10-point Likert (1=lower stigma/positive, 10=higher/negative) | Perceptions: sympathy, trustworthy, future crime likelihood and severity, rehab potential. Means reported for only one subscale: | Schizophrenia condition only one reported. Other categories are grouped as 'mental illness' | | | |
| | | Higher stigma for both mental illness and schizophrenia for future crime | Likelihood of future crime | Mental Illness grouped 5.11 (*SD*= 2.09, estimated *n*=217) | Control Group from Nee & Witt (2013) | *t* (258)=6.69, *p* <.001* *t* (113)= 5.90, *p*<.001* | Yes for mental illness grouped and for schizophrenia specifically |
| | | | | Schizophrenia 5.23 (*SD*=1.97, estimated *n*=72) | 2.65 (*SD*=2.70, *n*=43) | | |
| Rao et al. (2009) | Attitude to Mental Illness Questionnaire (AMIQ) Luty et al. (2006) | 5-point Likert (max +2 min -2, neutral/don't know 0) Total score between -10 and +10 Lower scores indicate negative attitudes, higher=positive | Stigmatised attitudes | Admitted to forensic hospital – Broadmoor No subscales reported | Control group- general public from Luty et al. (2006) validation study | | |
| | | | | -1.2 (*SD*= 3.12, *n*=108) | 5.86 (*SD*= 2.40, *n*=879) | *t* (985)= 27.83, *p* <.001* | Yes |
| Batastini, Bolanos, & Morgan (2014) | Attribution Questionnaire (AQ-27) Corrigan, 2008/ Brown (2008) subscales | 9-point Likert Higher score=higher stigma (Some subscales reverse scored) | Stigma/stereotypes using Brown's (2008) subscales (Fear/dangerousness, help/interact, responsibility, forcing treatment, empathy). | Non psychoeducation group Bipolar I disorder and theft jail sentence | Control group | | |
| | | | | | | | Yes |
| | | | Fear/Danger | 22.23 (*SD*=11.59, *n*=56) | 16.16 (*SD*=9.32, *n*=55) | *t* (109)= 3.04, *p*=.003* | |
| | | | Responsibility | 13.25(*SD*=4.80, *n*=56) | 16.60 (*SD*=4.11, *n*=55) | *t* (109)= 3.95, *p*< .001* | Yes |
| | | | Help/interact | 22.55 (*SD*=9.14, *n*=56) | 21.16 (*SD*=8.18, *n*=55) | *t* (109)= 0.84, *p*=.40 | No |

| Authors of study | Name and reference of measure | Direction of score | Brief description of what measure operationalises | Mean Score | Comparison/ control group mean score | T test | Is offender mental health stigma significantly higher than control? |
|---|---|---|---|---|---|---|---|
| | Social Distance Scale Link et al. (1987), Martin et al. (2000) | 4-point Likert Higher scores=more desired social distance | Social distance | 13.92 (SD=4.29, n=56) | 12.71 (SD=3.42) | t (109)=1.64, p=.10 | No |
| Durand, et al., (2017) | Attribution Questionnaire (AQ-20) Corrigan et al. (2003) / Brown (2008) Subscales | 9-point Likert Higher scores=higher stigma | Stigma, originally developed to measure schizophrenia but was replaced psychopathy Split into Brown's (2008) subscales: | Psychopathy with conviction of theft | Control Bastastini et al. (2014) | | |
| | | | Fear/dangerousness | 22.48 (SD=12.00, n=116) | 16.16 (SD=9.32, n=55) | t (169)=3.44, p <.001* | Yes |
| | | | Help/interact | 37.21 (SD=8.70, n=116) | 21.16 (SD=8.18, n=55) | t (109)=10.01, p<.001* | Yes |

*Note.* Asterisk denotes a significant difference (p<.05) between groups

**Research Question 2. Which Measures Are Used to Capture Stigma Towards Offenders with Mental Health Conditions?**

This review also intended to understand which measures have been used to capture offender mental health stigma in the literature. An overview of all the stigma measures used in the included studies can be found in Table 3. Out of a total of 12 studies, only a maximum of three used the same measure which was the Attribution Questionnaire (AQ, Brown, 2008; Corrigan et al., 2003) and the Community Attitudes to Mental Illness (CAMI, Högberg et al., 2008; Taylor & Dear, 1981) and both included different versions. Most measures were only adopted by a single study. Table 4 shows each measure selected in the current review and associated psychometrics.

It appeared that general mental health stigma measures were frequently used in conjunction with a vignette which depicted someone with a mental health problem and a criminal conviction in order to understand forensic stigma (see Table 4). This was the case for all but two studies (Batastini et al., 2017; Weaver et al., 2019), where a measure specifically designed to measure stigma in offenders called ATIMO developed by Brannen et al. (2004) was used. This speaks to a debate by Fox et al. (2018) about the frequent use of different measures in the stigma literature and outlines the significantly high number of stigma measures.

**Table 3.**

*Quick Reference List of Stigma Measures*

| Measure | | | | | | Study | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | ADJORLOLO 2018 | BATASTINI 2014 | BATASTINI 2017 | DURAND 2017 | FRAILING 2016 | GARCIA 2020 | LAMMIE 2010 | NEE 2013 | PERKINS 2009 | RAO 2009 | SOWISLO 2017 | WEAVER 2019 |
| Attitudes toward mentally ill offenders (ATIMO, Brannen et al., 2004) | | | ✓ | | | | | | | | | |
| Adapted versions of: ATMIO (Church et al., 2009) | | | | | | | | | | | | ✓ |
| Attitude to mental illness questionnaire (AMIQ) Luty et al. (2006) | | | | | | | | | | ✓ | | |
| Attitudes and beliefs about psychopathy (ABP) Smith et al., (2014) | | | | ✓ | | | | | | | | |
| Attribution questionnaire (AQ-27, Corrigan et al., 2003) | | | | | | | ✓ | | | | | |
| Attribution questionnaire (Brown, 2008) | | ✓ | | ✓ | | | | | | | | |
| Community attitudes toward mental illness (CAMI) (Taylor & Dear, 1981; Swedish version) | | | ✓ | | ✓ | | | | | | | |
| CAMI adapted 20 item version (Högberg et al., 2008) | ✓ | | | | | | | | | | | |
| Bogardus social distance scale (Bogardus, 1925) | | | | | | | | | | | ✓ | |

| Measure | ADJORLOLO 2018 | BATASTINI 2014 | BATASTINI 2017 | DURAND 2017 | FRAILING 2016 | GARCIA 2020 | LAMMIE 2010 | NEE 2013 | PERKINS 2009 | RAO 2009 | SOWISLO 2017 | WEAVER 2019 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Modification of Self-stigma of mental illness scale (Corrigan et al., 2006) Stereotype subscale only | | | ✓ | | | | | | | | | |
| Social distance scale (Link et al. 1987) | | ✓ | | | | | | | ✓ | | | |
| Survey of attitudes (Steadman & Cocozza 1977) | | | | | ✓ | | | | | | | |
| 5 questions by Nee & Witt (2013) | | | | | | ✓ | | ✓ | | | | |

**Table 4.**

*Psychometrics for Each Measure Included in the Review*

| Authors of study selected for review | Name and reference of measure | Psychometric of the measure α = Cronbach's alpha (Validation study) | Mental health condition referred to | Vignette |
|---|---|---|---|---|
| Nee & Witt (2013) | No name (5 questions) | Not reported | Depression schizophrenia | Yes |
| Garcia et al. (2020) | No Name (5 questions, as used in Nee & Witt, 2013) | Not reported | Grouped as 'mental illness' (referring to depression & schizophrenia) | Yes |
| Rao et al. (2009) | Attitude to Mental Illness Questionnaire (AMIQ) Luty et al. (2006) | α = 0.933 (Luty et al. 2006) | Admitted to forensic hospital (Broadmoor) | Yes |
| Sowislo et al. (2017) | Modification of the Bogardus social distance scale (Bogardus, 1925) | α = 0.92 (von dem Knesebeck et al., 2013) | Psychiatric hospital with forensic unit (borderline personality disorder and acute psychosis) | Yes |
| Adjorlolo et al., (2018) | Community attitude toward mental illness (CAMI) Högberg et al. 2008 | Open-mindedness α = 0.77 Fear/avoidance α =0.81 Community mental health α =0.67 Total α =0.79 | Schizophrenia | Yes |
| Lammie et al. (2010) | Attribution Questionnaire- (AQ-27) Corrigan et al. (2003) | α = .70 to 96 Corrigan et al. (2003) | Schizophrenia | Yes |
| Weaver et al. (2019) | ATMIO Brannen et al. (2004) | Negative Stereotypes α = .86 Rehabilitation/Compassion α =.70 Community Risk α = .61 Diminished Responsibility α = .56 (Church et al., 2009). | Mentally ill | No |

| Authors of study selected for review | Name and reference of measure | Psychometric of the measure α = Cronbach's alpha (Validation study) | Mental health condition referred to | Vignette |
|---|---|---|---|---|
| Frailing & Slate (2016) | Survey of attitudes Steadman & Cocozza (1977) | α = .63 to .82 (Steadman & Cocozza, 1977) | Mental illness | No |
| | Community Attitudes towards Mentally Ill (CAMI) adapted version Taylor & Dear (1981) | α = .86 (Thompson et al., 2014). | Mental illness | No |
| Perkins et al. (2009) | Social Distance questions (Link et al. 1987) | α = 0.87 (Perkins et al., 2008) | Schizophrenia | Yes |
| Batastini, Bolanos, & Morgan (2014) | Attribution Questionnaire (AQ-27) (Brown, 2008) subscales | Fear/dangerousness α = 0.93 Help/interact α =0.82 Responsibility α = 0.60 (Brown, 2008) | Bipolar I disorder | No |
| | Social Distance Scale Link et al. (1987), Martin, Pescosolido & Tuch, 2000) | α = 0.87 (for 6 item version, Martin et al., 2000) | Bipolar I disorder | No |
| Durand et al. (2017) | Attribution Questionnaire, (AQ-20) Corrigan et al. (2003) / Brown (2008) Subscales | α = 0.53 to 0.93 (Durand et al., 2017) | Psychopathy | Yes |
| | Attitudes and Beliefs about Psychopathy (ABP) Smith et al., (2014) | α =0.50 to 0.86 (9 subscales, Durand et al., 2017) | Psychopathy | No |
| Batastini, Lester, & Thompson (2017) | Adapted version of: Attitudes Toward Mentally Ill Offenders (ATMIO) Church et al. (2009); Brannen et al. (2004) | α = .73 to .88 (Church et al., 2009). | Mentally ill | No |
| | Community Attitudes towards Mentally Ill (CAMI) adapted version Taylor and Dear (1981) | α = .86 (Total score, Thompson et al., 2014). | Mentally ill | No |

**Research Question 3. Are Different Mental Health Diagnoses Associated with Differential Rates of Stigma in Offenders?**

The most commonly specified mental health diagnosis used across all of the studies was schizophrenia (*n*=5), followed by the generic descriptor 'mental illness' (*n*=4). Other examples less often used included, depression (*n*=2), 'forensic hospital patient' (*n*=2), bipolar disorder (*n*=1), and psychopathy (*n*=1). It should be noted that on some occasions multiple diagnostic labels were included in one research paper.

Due to the lack of consistent use of stigma measures, comparing results across studies with different diagnostic labels was not possible for most of the selected studies. However, two of the studies did investigate differential diagnoses as part of their research question and therefore will be considered in more detail here. The first was Nee and Witt (2013) who compared the impact of changing the mental health condition from schizophrenia to depression. The results found that stigma scores were significantly higher on a scale of 'likelihood to commit a future crime' for vignettes that included mental health diagnoses in comparison to a control group (Nee & Witt, 2013). Sympathy levels were high for both schizophrenia and depression, and significantly higher than a control group (with no mental illness or criminal background). Neither of the two diagnostic categories induced significantly different from scores from one another on most questions indicating that the diagnoses type did not, in isolation, induce stigmatised views (Nee & Witt, 2013). The exception was 'rehabilitation potential' where participants felt offenders with schizophrenia had higher potential for rehabilitation than those with depression, however no difference was found in comparison to a control group. When comparisons were made against someone with a past criminal conviction and no mental health condition, the only significant difference in stigma scores was on the sympathy subscale, where the presence of a mental health label appeared to receive higher levels of sympathy than someone without a diagnostic label (Nee

& Witt, 2013). A similar finding of higher sympathy for those with schizophrenia was found using the same stigma questions as Nee and Witt (2013) by Garcia et al., (2020). Schizophrenia in addition to an offending history, was found to have higher levels of future crime in comparison to a control group and to someone with the same offending history, showing the impact of this particular diagnostic label (Garcia et al., 2020).

**Discussion**

The current systematic review aimed to summarise the available literature in offender mental health stigma and consider whether different mental health diagnoses were associated with differential rates of stigma towards offenders. The studies selected were from a wide variety of countries across the world such as Ghana, the United States and the United Kingdom. The review also set out to understand which measures had been used in the literature to capture such stigmatic attitudes towards this population.

This is the first systematic review to approach the stigma of offenders with mental health difficulties, from the perspective of the stigmatiser. From the eligible studies included in this review, there was strong evidence of stigma towards offenders with mental health conditions. Moreover, the amount of stigma towards offenders with mental health difficulties appeared to be notably higher than that towards people without mental health difficulties or a history of offending. In regards to the question of the impact of different diagnostic terms, it is noted that most studies adopted a general term such as 'mental illness' rather than specific diagnostic labels, which is an important finding given the evidence of stigma attached to specific diagnostic terms (Pescosolido et al., 1999). Those which did specify a diagnosis suggested that schizophrenia and psychopathy were more stigmatised when compared to other mental health conditions, such as depression or neutral control groups. Finally, the measures used to capture stigmatic attitudes were unfortunately inconsistent between studies.

Infrequently was the same measure used in more than one study (Table 3). Due to this variance, only limited comparisons across research studies were possible.

The findings speak to the presence of a possible 'double stigma' towards the combined effect of an offending history and mental health difficulty. It begs the question of whether the combination of offending and a diagnostic label induces higher stigmatic attitudes, or if the presence of one of the two factors has a dominating influence on stigma. Unfortunately, there was not enough data to explore this fully. Future research should delve deeper into better understanding the combination of offender and mental health stigma, and how it affects public attitudes. To do this, the same stigma measure could be applied to different contexts and settings with results offering some agreement about which psychometric factors  make up the key elements of stigmatic judgement in those populations. In addition, research should include specific mental health diagnoses rather than general terms, as well as different types of offending. These research topics would necessitate large scale sampling and a range of experimental studies. Research in these areas would support measurable attitudinal change as targeted by anti-stigma intervention research. Once there is a basis of research in these areas, it would be important to understand how stigmatic attitudes could go on to affect an individual's behaviour.

Frequently, the tools used to measure offender mental health stigma were primarily mental health stigma questionnaires, but with the addition of a vignette to specify a particular mental health condition or an offending history. A problem for the literature, highlighted by this review, and congruent with previous research, is that the field is at saturation point with around 400 different stigma measures available (Fox et al., 2018). There is very little consensus about which measures are most suitable for which types of research question, and little evidence of replication across different samples. Some of the selected papers used specific offender mental health stigma measures, which did not rely on the use of a vignette

or adaptation. The most frequently used measures were the Attribution Questionnaire by Corrigan et al. (2003) with an adapted factor structure by Brown (2008) and the Community Attitudes to Mental Illness (CAMI) by Taylor & Dear (1981) and adapted by Högberg et al. (2008). Link et al. (2004) highlight the importance of selecting measures based on the concept that is of interest and also the availability of validated measures. In the first instance they advocate for adapting previously validated measures before considering the development of a new measure (Fox et al., 2018; Link et al. 2004). It seems necessary to highlight this viewpoint given its downstream impact on the current study and other researchers seeking to meta analyse or systematically review multiple studies.

There are also competing views around whether measures for mental health stigma should be adapted with specific diagnoses in mind (Pescosolido et al., 2007). Certainly, the current review suggested some evidence of a difference in public stigma between different diagnoses. Therefore, it would be important to research the use of diagnosis specific measures of stigma in relation to offenders to better understand these differences. This could be done through group comparisons with a variety of symptoms associated with different mental health difficulties, where it might be possible to see the impact of particular elements of a diagnostic presentation eliciting a particular response, such as fear. It would then be possible to compare if these emotional or stereotypical responses are aligned with the known risks of those particular symptoms or associated mental health difficulties. Further research into the combining effect of offender and mental health diagnoses would inform the necessity for specific or generalised terms when measuring mental health stigma.

Despite a vast majority of negative stigmatic attitudes, there was some positive evidence. Reassuringly, three studies found social work and criminology students, as well as public defenders, were less likely to have negative stigmatic attitudes and demonstrated compassionate views (Batastini et al., 2017; Frailing et al., 2016; Weaver et al., 2019).

However, this was not held constant amongst students from other courses or amongst judges and prosecutors (Batastini et al., 2017; Weaver et al., 2019). Both of these specific populations appeared to have higher levels of education and training in relation to offending and even mental health, therefore education may have the potential to mitigate levels of stigma (Batastini et al., 2017; Frailing et al., 2016; Weaver et al., 2019). Understanding positive evidence is supportive in developing anti-stigma programs that act to reduce levels of stigma in the wider community.

**Strengths and Limitations**

As highlighted, the current review included studies completed across the globe, including Ghana, Texas and the UK showing the diversity of the sample but unfortunately also the spread of negative stigmatic views across continents. In addition, the selected studies had diverse populations, from the general public to mental health professionals, and whilst the amount of stigma reported differed, the vast majority had negative stigmatic attitudes. Due to the wide variety of stigma measures it was not possible to fully compare measures across studies and the use of highly specific offender mental health stigma measures meant that neutral control groups for comparisons were not available. This demonstrates an advantage of using adaptable vignettes in stigma research which would allow for previously validated measures to be easily compared to one another even with differential diagnostic and offending labels. A limitation to the review was that it focused on studies printed in the English language which inevitably has excluded some international research. An additional limitation was that searching was limited to articles published in the last ten years. The justification for limiting the publication date was to provide an up-to-date account of the current literature and to answer the research question around the commonality of offender

mental health stigma research. Original authors of measures have been referenced as well as validation studies for the measures which are listed and in some cases they pre-dated 2009.

**Conclusions and Recommendations**

Given this review is the first to combine research in understanding the literature around stigma towards mental health and offenders, it highlights a number of key points for advancing research in the area. Firstly, it suggests a high level of stigma towards individuals with a psychiatric and an offending history. Further research is needed to better understand this complex relationship. Research could include studies where multiple conditions are compared, similar to the methodology used by Nee and Witt (2013). Secondly, the current review also re-emphasises the importance of selecting available validated measures, either specific to offender mental health stigma or with an adaption such as a vignette to allow for comparisons between studies and also within groups in large scale studies. Finally, findings of this review contribute to measuring and understanding stigma towards those in vulnerable positions. It encourages further intervention-based research to bring about change and reductions in stigma. This is not only important for public stigma and the way individuals are treated in the community, but also for reductions in self-stigma which all together have ramifications to an individual's recovery and rehabilitation.

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CHAPTER TWO

Bridging Chapter

**Bridging Chapter**

Chapter one revealed that stigmatic views towards offenders with mental health difficulties are relatively common within the general public. It also outlined the need to consider particular factors in stigma research such as stigma in relation to specific mental health conditions and the selection of validated and specific measures of stigma which, where possible, are already in existence. This is to prevent repetition and unnecessary increases in the number of stigma measures which at present saturate the literature. It also highlighted how the term 'offender' appeared to exacerbate stigma and that despite the literature on the impact of differential mental health labels on stigma, many studies included the generic term 'mental illness' instead (Pescosolido et al., 1999).

Given the knowledge that the general public possess stigmatic views towards both offenders and mental health difficulties as described in chapter one, one could reasonably wonder whether stigma towards offender with mental health difficulties would be impactful in a court room. Jurisdictions in England provide written direction to jurors to prohibit them from using information that is not presented in the trial to make their decision (part 26 of Criminal Procedure Rules). It provides specific written notice of prohibitions against '*conduct by a juror which suggests the juror intends to try the case <u>otherwise than on the evidence</u>*' (p2, part 26.3b(iii) of Criminal Procedure Rules; my emphasis). This emphasises the seriousness with which the law views the potential impact of 'extra-legal' factors on decision making. The issue here is that the implicit bias of negative stigmatic judgements has the potential to work against this rule and therefore threatens valid and fair decision making within the legal system.  The fact that jurors might be unaware of such biases is of no comfort to the pursuit of fair justice, and indeed arguably acts to prevent action to mitigate against them. Consequently, research to better understand the impact such implicit biases have on

decision making will be important in ensuring that defendants with mental health conditions receive fair and just treatment in the English criminal legal system.

Whilst there is mitigation against stigma that might arise from a defendant's previous offending history (in the fact that courts will routinely not disclose a history of previous offences to a jury; they can be adduced as evidence of 'bad character' under the Criminal Justice Act 2003, s.101, and there are certain other exemptions), a defendant's mental health condition will often be routinely disclosed to a jury. This could be directly by the defendant themselves, by an expert or professional witness who has worked with or assessed the defendant, by the defence barrister seeking to obtain a more sympathetic response from a judge or juror or to provide an account for a defendant's actions, or implied through the behaviour of the defendant in relation to the offence. Within the criminal process, there is very little control therefore of this source of stigma, and it is therefore particularly unfortunate that the question of the impact of stigma arising from defendants who present with mental health conditions significantly lacks research interest.

The following chapter will therefore present an empirical paper which begins by outlining relevant research in relation to mental health stigma and juror decision making, and how the latter could potentially be impacted by personal stigmatic beliefs towards mental health diagnoses. The empirical study aims, methodology, research findings and a discussion will follow before concluding with an overall critical review of the thesis as a whole.

CHAPTER THREE

Empirical Study

Prepared for submission to Psychology, Crime and Law

(See Appendix B for author guidelines)

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**The Effect of Mental Health Information and Stigma on Juror Decision Making**

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**Abstract**

Mental health stigma has been heavily researched in the literature and a diagnosis particularly susceptible to stigma is schizophrenia. In legal research, factors that exert unwanted influence on decision-making are called extra-legal factors. It is unclear whether individual levels of stigma, or the nature of mental health information provided to a juror, could influence their verdict. This study explored how the provision of mental health information and negative stigmatic attitudes may, taken together, affect a juror's verdict. To explore this, participants watched an online video mock trial and were asked to determine whether the case being presented was found guilty or not guilty. Participants were randomised to one of three conditions which varied by the nature of mental health information provided, specifically whether a description of symptoms and/or a diagnosis of schizophrenia was provided. Compared to a control group, providing mental health symptoms reduced the probability of a guilty verdict by almost three times, and the addition of diagnostic a label almost halved this probability again. An increase of one standard deviation in stigma predicted more than a 50% probability of a guilty verdict. This research has implications for jury selection and providing mental health information in court.

*Keywords:* Stigma, juror, extra-legal, schizophrenia, mental health, criminal justice

**Stigma Towards Mental Health Difficulties**

Link & Phelan (2001) define stigma as *"the convergence of interrelated components [existing] when elements of labelling, stereotyping, separation, status loss and discrimination occur together in a power situation that allows them."(p 377)*

As highlighted in the introductory chapter of this thesis portfolio, definitions of mental health stigma tend to be multifaceted (Fox et al., 2013) and can be considered to include pejorative attitudes and beliefs which can lead to discrimination towards people with mental health conditions (Link & Phelan, 2001).

The relationship between stigma and behaviour can be understood from different perspectives. Structural stigma is an external view of someone based on cultural or societal formed norms (Corrigan et al. 2003). Corrigan et al. (2003) describes how the development of structural stigma is built on three components, 1) recognising a cue that someone has a mental health problem, 2) stereotype activation and 3) discrimination or prejudice towards that person. Another alternative theory of stigma is Social identity theory (Goffman, 1963) which posits that mental health stigma is formed through a virtual social identity when a person becomes disfavoured by society and as a result are socially distanced.

Research suggests that stigma towards people with mental health conditions within the general public is often founded on stereotypes about their potential for dangerous and unpredictable behaviour (Cechnicki, et al., 2011; Jorm et al., 2012). Diagnostic terms or 'labels' have been found to further intensify stigma by increasing the public's sense of 'differentness' from those with mental health conditions (Corrigan, 2007). Previous research has found that the presence of a mental health label increases expectations of a vignette character committing a crime in the future, compared to a character without a mental health label. (Nee & Witt, 2013). Pescosolido et al. (1999) found providing the diagnostic label of schizophrenia meant participants reported increased perceptions of violence compared to

someone with depression or who was described as distressed. They also found that when the vignette included the term schizophrenia, participants rated them less able to make treatment decisions and to manage their money, compared to someone with depression or described as distressed (Pescosolido et al., 1999). It is important to note that there is controversy surrounding the use of the term 'schizophrenia' from the perspective of clinical validity (Bentall et al., 1988; Bentall, 1990; Moncrieff, 2015; Van Os, 2016) however the focus of the present paper is to consider the potential for, and impact of stigmatic judgements associated with use of this term, which remains commonplace within health services (Schizophrenia Commission Report, 2012).

Research into stigma has even demonstrated that health professionals may themselves not be protected from the influence of stigmatic judgements in relation to schizophrenia (Rao et al., 2009). Similarly, Lam et al. (2016) explored the influence of a personality disorder label on mental health professionals' clinical decision making. They found that the presence of a diagnostic label alone resulted in the mental health professionals having more negative impressions of the patient despite the behavioural descriptions of that person's difficulties remaining the same (Lam et al., 2016).

According to research, a common stereotype held by the general public towards schizophrenia is that of dangerousness (Jorm et al., 2012; Pescosolido et al., 1999), which is perhaps facilitated through the way in which such presentations might be portrayed by the media and film industry (Lipczynska, 2015; Vahabzadeh et al., 2011). This belief is countered by the fact that only a minority of people with mental illnesses are ever violent and that they are 14 times more likely to be victims of a violent crime than to be arrested as the perpetrator (Brekke et al., 2002). Further, a mental health diagnosis is a poor predictor of violence (Monahan, 1988), yet people with serious mental health conditions are often charged with more serious crimes than others arrested for similar behaviours (Tellier & Felizardo,

2011). This is not to say there is no relationship between mental illness and violence, but it appears to be a complex one, with some symptoms such as command hallucinations perhaps particularly important; but this risk must be understood on an individual, rather than a group or diagnostic level (McNiel et al., 2002).

**Mental Health Stigma and the Impact on Legal Processes**

In England and Wales, most adults can be called for jury service at any time (Juries Act, 1974). When considering factors that might influence the decision making of jurors, there is a modest body of research into the role of 'extra-legal factors' with various personal characteristics such as gender, race and attractiveness being identified as relevant to the jury decision making process (Bagby et al., 1994; Guy & Edens, 2003). There are very few articles published on the role of mental illness information and juror decision making or stigma as an extra-legal factor despite the of stigmatised attitudes within the general public. Mossiere and Maeder (2016) describe the absence of research into stigma in trial proceedings and the need for additional research to examine societal perceptions of violence and mental health diagnoses. Previous limited literature is specific to countries other than England and Wales and their different legal structures such as Canada (Mossiere & Maeder, 2015), the United States, (Greene & Cahill, 2012) and Australia (Jorm et al., 2012). Whilst jurors are asked to make an objective verdict based on the legal information presented to them (Criminal Procedure Rules), research on a mock jury has found that decisions were significantly associated with beliefs about mental ill health and criminal responsibility (Roberts et al., 1987).

Perhaps one of the most significant opportunities for stigmatic judgements to influence decisions comes in the way in which information about a defendant with mental health problems is presented to a juror by a clinician acting as an expert witness. There are

limited protocols or structures for the content of information that should be presented to a jury or included in a written report. This may vary greatly depending on the training, background, personal experiences and beliefs of the clinician. Outside of stigma, some research has explored how the content of such information can influence decision making. For instance, Greene and Cahill (2012) found that Computerised Tomography (CT) head scans in addition to a diagnosis of psychosis, meant that fewer mock jurors gave a death sentence in comparison to a group given the same diagnosis without the scans. This is particularly concerning given the fact that neuroimaging is not routinely used in clinical work for mental health assessment or intervention and has not been found suitable to diagnose psychiatric illness (Agarwal et al., 2010).

Previous research involving jurors has often involved written vignettes of trials with samples of lay people (Guy & Edens, 2003). The gold standard for a sample within this literature would be an unused jury, a group of people called for jury service who are ultimately not required to participate in court that day (Sloat & Frierson, 2005; Thomas, 2020). However, this methodology has rarely been used in England and Wales due to the complexity, collaboration required with justice systems to recruit, and resources necessary to obtain a large sample. Thus, most research into juries has recruited 'proxy' juries, typically trading some generalisability of the sample for accessibility and convenience. Further, most research investigating juror decision making has used individual juror verdicts (Jung, 2015; Roberts & Golding, 1991) rather than 'collective' jury decisions (Greene & Cahill, 2012). This approach in particular is more appropriate when trying to understand the impact of a specific factor on an individual's decision making and thus was adopted in the present study. Finally, in terms of considering the actual sample characteristics, previous research into juries has often used a sample of psychology students on undergraduate courses which is unlikely to generalise well to the wider population (Kendra et al., 2012). However other research has

found that student and community samples do not always give different results (Bornstein, 1999). This dilemma will also be explored within the present study.

**Current Study**

The current research sought to understand if stigmatic attitudes towards a specific mental health difficulty would impact on juror decision making. Schizophrenia was chosen due to the large amount of research on stereotypes and stigma surrounding this diagnosis. The study also sought to investigate if the amount of information provided about schizophrenia would affect the juror's decision. As the study was interested in these specific factors, a proxy jury was used where individual juror decisions were considered. Both students and members of the community were recruited in order to contribute to the literature around the representativeness of student populations in jury research. Two dependent variables were measured: a stigma measure specific to schizophrenia and the verdict guilty or not guilty. The nature of the mental health information provided (symptoms and a label of schizophrenia, symptoms of schizophrenia only and a control group with no mental health information) to the proxy jury was the independent variable which had three levels. The study was run online to allow for recruitment of a large sample, some participants were recruited through Prolific (www.prolific.com) to allow for a more population representative sample, with the addition of a mock video trial to improve ecological validity.

**Aims of the Current Study**

The primary aim of the current study was to investigate whether the provision of mental health information, as well as levels of individual stigma in proxy jury members could predict the verdict given in a mock criminal trial. Given the effect of other extra-legal factors impacting on decisions made in court, it was important to understand the possible impact of

individual stigmatising attitudes. Furthermore, due to the variability in the presentation of mental health information within a trial, this was manipulated to better understand if it could also impact a juror's verdict. It was hypothesised that the nature of mental health information provided, and levels of stigma would affect the juror's verdict. Specifically, belief in dangerousness was hypothesised to have an affect on a juror's verdict. As secondary research questions the study also wished to consider if the sample (a student versus a community sample) differed in terms of baseline levels of stigma or guilty verdicts. Finally, as sensitivity analyses, the total scoring and the two different factor structures of the Attribution Questionnaire by Corrigan et al. (2003) and Brown (2008) were compared to understand if the differing subscales impacted the results.

## Method

### Design

The categorical dependent variable was verdict with two levels (guilty or not guilty). The independent variables were condition, a categorical variable with three levels (control, condition 1 (symptoms only) or condition 2 (diagnostic label and symptoms) and stigma (total score) a continuous variable scored on a nine-point Likert scale questionnaire.

### Participants

A total of 330 participants were recruited, of whom 11 did not pass manipulation check questions (to ensure they were attending to the vignette, see Appendix C) and 76 did not fully complete the study therefore their data was excluded to ensure compliance with ethics. This resulted in a sample of 243 participants included in data analysis, 91 from Prolific and 152 from mailing lists and email bulletins. Females were somewhat over-represented in the sample (67.5% female, 30.9% male, 0.8% declined to say) in line with

other social sciences research. Participant age ranged between 18 and 75 years with a mean of

34.68 (*SD*=14.75) years (see Table 5 for further demographics).

**Table 5.**

*Participant Demographics*

|                                     | Total number  | Percentage of sample % |
|-------------------------------------|---------------|------------------------|
| **Age**                             |               |                        |
| Mean (*SD*)                         | 34.68 (14.75) |                        |
| Range                               | 18-75         |                        |
| **Education History**               |               |                        |
| Primary/secondary/GCSE or lower     | 14            | 5.7                    |
| A Level                             | 73            | 30.0                   |
| Foundation Degree                   | 12            | 4.9                    |
| Undergraduate Degree                | 93            | 38.3                   |
| Masters Level or higher             | 51            | 21.0                   |
| **Student Status**                  |               |                        |
| Current student                     | 79            | 32.5                   |
| Not current student                 | 164           | 67.5                   |

This was a joint study with another researcher who had separate research questions and an

additional questionnaire measuring mental health literacy which will not be discussed further

in this paper (see Appendix A for further information).

**Recruitment**

Recruitment was broken into two stages. The first stage involved advertising to a

university research study mailing list. The mailing list included members of the public as well

as interested university students and staff.  The study was also advertised via university email

bulletins (see Appendix D). In addition, an online crowdsourcing tool, designed for social

science research (Prolific, www.prolific.com) was used to support recruitment of the general

public. Similar tools have been used previously (Shapiro et al., 2013) such as Mechanical

Turk (www.mturk.com; Buhrmester et al., 2011). However Prolific has a number of specific

advantages, outlined by Palan & Schitter (2018) that make it suitable for use in the current study. Participants recruited in stage one were paid a small amount as a token for completing the study (if recruited via Prolific) or were entered into a prize draw with the chance of winning an e-voucher. When this stage closed, the second stage began with the only modification being that participants were not entered into a draw to gain a monetary reward. A study specific Twitter account was also used during the second stage to promote the study using a link via Qualtrics (https://www.qualtrics.com). Recruiting through these varied approaches aimed to increase the diversity of the sample and generalisability to a real jury population. To ensure representativeness, eligibility criteria were included in the consent and demographic form and aligned closely with English and Welsh requirements for participation in jury service (Juries Act, 1974) (see Appendix E & F).

**Materials and Measures**

*Demographics*

Participants were asked to report age, sex, educational level and whether they were a student at the time of the study and where applicable were asked to provide their job title (see Appendix F).

*Stigma*

The Attribution Questionnaire (AQ-27, Corrigan et al., 2003) is a self-report questionnaire, consisting of 27 items that measure nine factors thought to be involved in stigmatising attitudes (blame, anger, pity, help, dangerousness, fear, segregation, coercion and avoidance). These constructs are derived from the attributional model of stigma (Corrigan et al., 2003). The questionnaire starts with a vignette about 'Harry' who is

described as 'schizophrenic'. After reading this the participant is asked to rate their agreement to each of the 27 statements (for example, how scared of Harry would you feel?) on a 9-point Likert scale (see Appendix G). The AQ-27 is well established as described by Fox et al. (2018), and the AQ-21 (a shorter version) has been used in at least one UK sample (Luty et al., 2006). The AQ-27 was selected as it is the only known 'other stigma' measure specific to schizophrenia. Fox et al. (2018) report that mental illness stigma may manifest differently depending on disorder label, therefore it is important to consider a disorder-specific measure. Corrigan and colleagues (2003) report test-retest reliabilities where 6 out of 9 factors are $r$>.75.

Whilst Corrigan et al.'s (2003) original validation study does not report Cronbach's alpha for internal consistency, other papers have demonstrated strong reliability for the scale, although there has been some suggestion of an alternative factor structure being more meaningful. For instance, Brown (2008) completed an exploratory factor analysis of the AQ-27 in a 744-student sample and suggested an alternative factor structure. Brown (2008) grouped 6 factors as fear/dangerousness (defined as fear of mentally ill), help/interact (defined as willingness to help the mentally ill), 'forcing treatment' (defined as forcing treatment on the mentally ill and included questions such as giving treatment against someone's will and suggestions of people being 'kept away' in a psychiatric hospital as better for the community), empathy (defined as empathy towards the mentally ill), responsibility (defined as being primarily responsible for own mental illness) and negative emotions (defined as negative emotions towards the mentally ill such as 'how angry would you feel at Harry'). These subscales comprised of 26 out of the original 27 items. Alpha reliabilities for these revised subscales ranged from 'fair' (.60) to 'good' (.93). Brown (2008) states that the measurement of responsibility and empathy is particularly problematic, but he does not suggest excluding these subscales. Based on the literature and guidance by Fox et al. (2018)

around selection of measures, the current study used Brown's (2008) AQ factor structure and total score in the main analyses. Empathy and help/interact subscales were reverse scored to keep the direction of effect consistent, where higher scores meant higher levels of stigma. The relatively large sample provided an opportunity to consider differential performance between two methods of scoring the AQ , and this was considered through a sensitivity analysis of the main findings.

### *Mental Health Literacy Scale* (O'Connor & Casey, 2015)

This questionnaire was used solely for analysis by a separate researcher and therefore will not be discussed here (see Appendix A).

### *Vignettes*

The video vignette was filmed at the University of East Anglia (UEA) with actors dressed as barristers and a judge. The case was written with support from a senior legal academic to ensure it represented that of a real-life court trial. In the video, participants heard from the prosecution, the defence barrister and the judge. Video vignettes lasted between 6.17 and 9.40 minutes depending on which of the three conditions participants were randomly assigned to. The content of the video vignette involved an offence of criminal damage contrary to s.1 of the Criminal Damage Act (1971) and was developed with a senior legal academic to ensure it was a good representation of a court trial (please see Appendix H for verbatim texts).

The control condition did not receive any information relating to the defendant's mental health; they received general background information such as family and education history. Condition 1 (symptoms only) was the same as the control but with the addition of contextual information regarding the defendant's mental health such as the presence of

hallucinations and delusions; a relationship between the mental health condition and offending behaviour was implied however no diagnostic label was given. Condition 2 (diagnostic label and symptoms) received the same information as the symptom only condition with the addition of the diagnostic term 'paranoid schizophrenia' used to describe the identified mental health problem as shown in the following quote from the mock trial (see Appendix H for verbatim scripts).

**Condition 1 (Symptoms)**. *"We, the defence, argue that Mr Greene is not guilty of this offence.  We argue that he did not intend to cause the damage to the hospital's property and was not aware that the damage would result from his behaviour. Our case is that due to his delusional beliefs, Mr Greene believed that he was saving everyone…"*

**Condition 2 (Diagnostic Label and Symptoms).** *"We, the defence, argue that Mr Greene is not guilty of this offence. We argue that he did not intend to cause the damage to the hospital's property and was not aware that the damage would result from his behaviour. Our case is that due to his paranoid schizophrenia, Mr Greene believed that he was saving everyone…"*

**Procedure**

The procedure was based on research by Lam et al. (2016) with some significant adaptions. To start, participants followed an online link and were given study information and eligibility criteria. The whole study was run online using the Qualtrics platform (https://www.qualtrics.com). Participants were told that their contribution was anonymous and confidential and that they could withdraw from the study at any time by closing their browser window. They were asked to complete a consent form and a short demographic questionnaire (see Appendices E and F respectively).

Once consent had been given participants were randomly assigned to one of three conditions described above and watched the appropriate video vignette for their condition. Following the video, participants were asked if they found the defendant guilty or not guilty of criminal damage. They were also asked to indicate their confidence in their verdict on a Likert scale however this was for a separate researcher and will not be reported further here. To address this question with the correct legal test (Criminal Damage Act, 1971, s.1(1)), participants were asked to consider if the defendant acted recklessly. Next the participants completed a manipulation check which involved three multiple-choice questions about the trial to ensure they were engaged in watching the video (see Appendix C). Consistent with other research (Mossiere & Maeder, 2015) participants were required to answer all three questions correctly on the manipulation check to be included in the final dataset.

Participants were asked to complete the AQ-27 stigma measure, where they read a short description of a man named Harry and were asked to give their views about him. Participants also completed a mental health literacy questionnaire to assess their knowledge of mental health conditions (this was completed as part of a parallel project conducted by another researcher), which was always given after the AQ-27. The order of presentation of the questionnaires (before or after the video vignette) was counterbalanced to control for potential bias or priming from the video. Finally, participants were provided with a debrief form (see Appendix I), detailing sources of support if needed, as well as researcher and ethics committee contact information.

**Data Analysis**

Preliminary analyses were run to check if there was an impact of gender, age and condition on stigma measures. As a result, further analysis was run to understand if the order of when the stigma measure was completed (either before or after the video vignette)

impacted on the level of stigma, despite the order being counterbalanced to try to reduce this bias. For the main analysis, a logistic regression was used as the dependent variable (verdict) was categorical with two levels (guilty or not guilty). The independent or predictor variables were condition with three levels (control, condition 1 (symptoms only) or condition 2 (diagnosis and symptom) and a total score of stigma, which was a continuous variable. The condition variable was not dummy coded as SPSS automatically treated it in this way. Secondary research questions were analysed using the relevant nonparametric test as the stigma datum was not normally distributed. Sensitivity analyses repeated the analysis using the original factor structure of the AQ-27 by Corrigan et al. (2003) to establish whether this affected the main findings which used Brown's (2008) factor structure. A power analysis for a logistic regression (Concato et al., 1996) suggested a minimum sample size of 100, based on a conservative estimate (0.2) of the number of positive cases or guilty verdicts (formula N = 10k /p).

Due to more than one hypothesis being tested, the Holm (1979) alpha correction was applied to adjust $p$ values. The Holm alpha correction works by ordering the $p$ values under .05 and making adjustments relative to the number of hypotheses and rank number. To support interpretation, $p$ values under .05 are reported at their original level with a notation of the Holm (1979) adjustment.

**Ethical Considerations**

The current study received ethical approval from the Faculty of Medicine and Health Sciences at the University of East Anglia (see Appendix J). Participants were recruited online and provided with an information sheet (see Appendix K) and a debrief form, which included resources for further support if required. Due to the online nature of the study, participants could withdraw from the study at any time by closing their browser window.

**Results**

Participants were split evenly into three conditions, table one shows the proportion of guilty verdicts in each group. The total numbers (124 guilty verdicts; 119 not guilty) suggest that the whole sample were evenly split. In order to understand the impact of stigma, the total stigma score was calculated from the AQ using the factor structure identified by Brown (2008) which consisted of 26 questions. The mean total stigma score was 81.11 (SD= 28.37; range 31 - 166). This was not normally distributed as the results of the Kolmogorov-Smirnov were significant ($D$ (243) = .09, $p<$ .001) and therefore do not indicate normality.

Preliminary analyses indicated no substantive differences between the total stigma score for either gender or age, and so these factors are not included in the following analyses (see Appendix K for further detail). Stigma scores within the different conditions were not significantly different however scores between two of the conditions showed some unexpected differences and this was considered with further analysis.

A one-way between-groups analysis of variance was conducted to compare the total mean stigma scores between the three conditions (control, condition 1 and 2). Unexpectedly, there was a statistically significant difference between the groups although the effect size was modest $F$(2, 240)= 4.32 , $p=$ .01, (.03 eta squared). Post hoc comparisons (Tukey HSD test) revealed that only the control group (no mental health information) and condition 2 (diagnostic label and symptoms) were significantly different from one another ($p=$ .01), condition 1 (symptoms only) did not differ significantly from either the control group or condition 2 ($p=$ .34, $p=$ .29) (see Table 6). The difference in stigma scores was unexpected thus to better understand the differences, a second ANVOA was conducted to investigate the potential impact of ordering effects from the stigma measure (given either before or after the video vignette). This ANOVA $F$(5, 240)= 2.54, $p=$ .03, found a significant difference of order between two groups. Post hoc comparisons (Tukey HSD test) revealed participants in the

control condition who completed the stigma measure after the video vignette had significantly lower stigma (*M*=73.15, *SD*=24.34) than those in condition 2 (*M*=93.10, *SD*=28.04) who completed it following the vignette (*p*= .01). This appears to show that the video vignette in the trial may have primed participants completing the stigma measure after the video, and subsequently increased levels of reported stigma. The remaining comparisons did not reach significance, these are detailed in Appendix L.

**Table 6.**

*Frequency, Percentage of Verdicts and Stigma Scores per Condition and Order of Stigma Measure Completion*

|  | Control (no mental health information) (*n*=81) | Condition 1 (Symptoms only) (*n*=79) | Condition 2 (Diagnosis + Symptoms) (*n*=83) | Total |
|---|---|---|---|---|
| Not Guilty | 26 (32.1%) | 43 (54.4%) | 55(66.3%) | 124 |
| Guilty | 55 (67.9%) | 36 (45.6%) | 28(33.7%) | 119 |
| Total | 81 | 79 | 83 | 243 |
| Mean (SD) stigma score | 74.40 (24.35) | 80.92 (29.48) | 87.54 (29.80) | 81.11(28.37) |
| Mean (SD) stigma if completed first | 76.30 (24.57) | 78.63 (30.50) | 82.12 (30.79) | - |
| Mean (SD) stigma if completed last | 73.15 (24.34)* | 83.39 (28.54) | 93.10 (28.04)* | - |

*Note*. 'Stigma completed first' denotes before the video vignette, 'last' denotes after the video vignette. Asterisk denotes a significant difference (p<.05) between groups.

For the main analyses, to address the first two research questions interested in the effect of stigma and the provision of mental health information on juror decisions, a binary logistic regression was used. The regression assessed the impact of two predicting factors; total stigma score (Brown, 2008) and condition, on the likelihood that participants would give a guilty verdict. Entering both factors into the regression meant that it was possible to

understand the impact of each variable whilst controlling for the other. The multicollinearity assumption required for a logistic regression was not violated (tolerance and VIF= 1.0), which did not exceed cut offs suggested by Tabachnick and Fidell (2007). The full regression model consisting of both predictor variables, total stigma and condition, was statistically significant ($\chi^2$ (3, 243) = 33.72, $p <.001$) and was able to correctly categorise 66.3% of verdicts which could explain between 13.0% (Cox and Snell R square) and 17.3% (Nagelkerke R Square) of the variance. Both of the independent predictor variables (condition and total stigma score) made statistically significant contributions to the model.

**Provision of Mental Health Information.** Participants in condition 1 (symptoms only) were 2.96 times more likely to give a not guilty verdict in comparison to those in the control group (no mental health information). Providing a combination of symptoms and a diagnostic label of schizophrenia (condition 2) was also associated with a not guilty verdict (5.68). The odds of participants who were given both symptomatic information and the diagnostic label (condition 2) giving a not guilty verdict were almost twice (1.92) those of participants given only symptomatic information (condition 1). Furthermore, the odds of participants giving a not guilty verdict were more than five times (5.68) those of controls who were given neither symptomatic information nor a diagnostic label.

**Impact of Stigma.** Stigma was positively associated with a guilty verdict, where individuals with higher levels of stigma were more likely to give a guilty verdict. For every 1 unit increase in a stigma score, participants were 1.02 times more likely to give a guilty verdict. This means that the odds of a participant giving a guilty verdict were 56.74% (28.37 x .02 (*SD* x *Odds Ratio* x 100)) higher than those of another participants' whose stigma score was one standard deviation lower than the first participant's. Table 7 summarises the regression model.

**Table 7.**

*Logistic Regression Comparing Total Stigma and Condition on the Probability of a Guilty Verdict*

| | B | S.E. | Wald | *p* | | Odds Ratio |
|---|---|---|---|---|---|---|
| Total Stigma (AQ, Brown 2008) | .09 | .005 | 12.63 | .000* | | 1.02 |
| Control | | | 24.13 | .000* | | |
| Condition 1 (Symptoms only) | -1.08 | .34 | 10.11 | .001* | | .34 |
| | | | | | *(inverted)* | 2.96 |
| Condition 2 (Symptom & Diagnostic label) | -1.74 | .36 | 23.61 | .000* | | .18 |
| | | | | | *(inverted)* | 5.68 |

For the purpose of understanding the impact of stigma and condition on guilty verdicts in a visual format, the total stigma data was grouped. The grouping consisted of low, medium and high total scores, using a cumulative percentage frequency. The lowest (<33.3%) of total stigma scores formed 'low', the middle scores (33.4 - 66.6%) formed 'medium' and the highest stigma scores (>66.7%) formed 'high'. The histogram (Figure 3) displays how the increase in mental health information appears to reduce the likelihood of a guilty judgement, an interaction between variables It also shows that those with high mental health stigma appear to respond differently to the mental health information which includes a diagnostic label, this results in a larger percentage of guilty verdicts. Those with high stigma also showed a lower proportion of guilty verdicts than either the low or the medium stigma group when they are not given any information regarding an individual's mental health. This figure represents a potential interaction between variables which was considered as posteriori hypothesis, future research would benefit from exploring this in more detail.

**Figure 3.**

*Percentage of Guilty Verdicts Across Conditions and Grouped Stigma Levels*
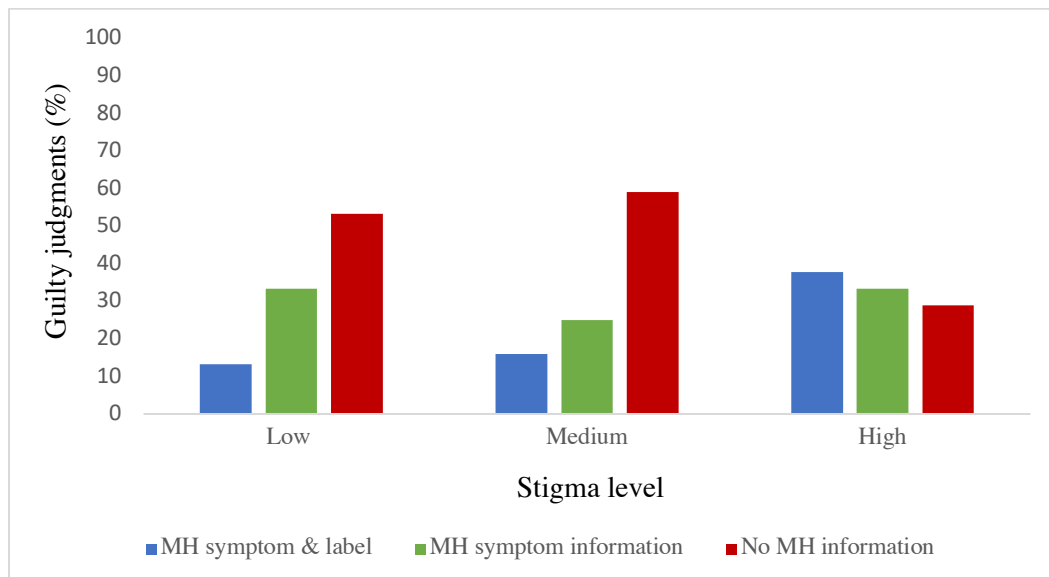


*Note: 'MH' denotes 'Mental Health'*

To test the hypothesis that stigma attributions related to dangerousness (specifically) affected juror verdicts, the regression model used previously was repeated using the subscales identified by Brown (2008). Table eight includes the descriptive statistics for each individual subscale.

**Table 8.**

*Stigma Descriptive Statistics including Subscales (N=243)*

| AQ Brown (2008) Stigma Subscales | Mean (*SD*) | Maximum score | Skew | Kurtosis |
|---|---|---|---|---|
| Fear/Danger | 21.21(11.80) | 59 | 1.07 | .60 |
| No Help/Interact | 22.66(10.21) | 52 | .49 | -.30 |
| Responsibility | 7.56(3.88) | 20 | .83 | .31 |
| Forcing Treatment | 12.19(6.42) | 36 | .96 | .75 |
| Negative Emotions | 6.75(3.97) | 27 | 1.26 | 2.21 |
| No Empathy | 10.74(5.14) | 27 | .73 | .38 |
| Total | 81.11(28.37) | 234 | .74 | .05 |

The regression assessed the impact of condition and six subscales (Fear/dangerousness, help/interaction, responsibility, 'forcing treatment', empathy and negative emotions) as predictor variables on the likelihood that participants would give a guilty verdict. The multicollinearity assumption required for a logistic regression was not violated (tolerance and VIF =1.00). The full model including the aforementioned predictor variables was statistically significant $\chi^2$ (8, $N$=243) = 44.525, $p$ <.001) and could correctly categorise 67.9% of verdicts, explaining between 16% (Cox and Snell R square) and 22.3% (Nagelkerke R Square) of the variance. The regression is reported in Table 9, showing that the independent predictor variables which made statistically significant contributions to the model were, as before, condition (1 and 2) and also two of Brown's (2008) subscales (no 'help/interact' and 'forcing treatment', the latter defined as forcing treatment on the mentally ill). Fear/dangerousness and responsibility appeared to be marginally significant ($p$= .096, $p$= .092 respectively) in predicting guilty verdicts. This indicates that the remaining subscales did not make statistically significant contributions to the model and therefore are unlikely to have predicted verdicts.

'Forcing Treatment' and 'Not Helping' were the only two subscales which made statistically significant contributions to the model. Both had odds ratios of above 1, which suggested for every one unit increase in scores in these subscales, the likelihood of a guilty verdict increased by 25.68% (6.42 x .04 (*SD* x *Odds Ratio* x 100)) and 81.68% (10.21 x .08 (*SD* x *Odds Ratio* x 100)) respectively. This means those who were less willing to help someone with schizophrenia were more likely to give a guilty verdict, where an increase of one standard deviation on this subscale predicted an 80% probability of a guilty verdict. The help/interact p value did not survive Holm (1979) correction. A table summarising these

scores can be found in Appendix L. As before the strongest predictor in the model was

condition 2 recording a similar odds ratio of 5.81.

**Table 9.**

*Logistic Regression: Mental Health Information Condition and Brown's (2008) Stigma Subscales as Predictors of a Guilty Verdict*

| | b | Standard Error | Wald | p | | Odds Ratio |
|---|---|---|---|---|---|---|
| Control (no mental health information) | | | 23.70 | .000 | | |
| Condition 1 (symptoms) | -1.14 | .35 | 10.45 | **.001*** | | .32 |
| | | | | | *(inverted)* | *3.13* |
| Condition 2 (symptoms & diagnosis) | -1.76 | .37 | 22.99 | **.000*** | | .17 |
| | | | | | *(inverted)* | *5.81* |
| Fear/Dangerousness | -.03 | .02 | 2.77 | .096 | | .97 |
| No Help/Interact | .04 | .02 | 4.44 | **.035** | | 1.04 |
| Responsibility | .07 | .04 | 2.83 | .092 | | 1.07 |
| Forcing Treatment | .08 | .03 | 5.31 | **.021*** | | 1.08 |
| Negative Emotions | .02 | .05 | .13 | .717 | | 1.02 |
| No Empathy | .02 | .03 | .32 | .572 | | 1.02 |
| Constant | -1.00 | .55 | 3.33 | .068 | | .37 |

*NB: No help/interact p value did not meet Holm correction of p<.025*

*\*Denotes p values reaching statistical significance following Holm adjustment*

To address secondary research questions, and particularly whether the different

sources of participants (students versus community) behaved similarly in regard to verdict,

participants were split into two groups, student or community. Of the 243 participants, 79

were students (51.9% not guilty; 48.1% guilty) and 164 were not a current student and

considered part of the community sample (50.6% not guilty; 49.4% guilty). A chi square test

for independence (with Yates continuity correction) indicated no significant association

between verdict and student status ($\chi^2(1, n=243) = .003, p = .96$, phi = .01). This was the

same when comparing recruitment method (Prolific $n=91$ 48.4% not guilty, 51.6% guilty,

versus recruited via other methods $n=152$, 52.6% not guilty, 47.4% guilty), also indicating

there was no significant difference in verdicts between these groups ($\chi^2$ (1, $n=243$) = .26 $p=$

.61, phi = -.04).

Similarly, the two sampling routes were considered in terms of total stigma score.

Here, a Mann-Whitney U Test did not reveal a significant difference in the level of stigma for

those who were students ($Md=70$, $n=79$) compared to those who were not students ($Md=83$,

n=164), $U=$ 5747, z= -1.42, $p=$ .15. The same statistics were completed to compare

recruitment method. The Mann-Whitney U found that there were significantly higher levels

of stigma reported in those recruited via prolific ($Md=86$, $n=91$) in comparison to non-prolific

($Md=72$, $n=152$) ($U=$ 5644, $z=$ -2.40, $p=$ .016, $r=$ .15) indicating a small effect size.

**Sensitivity Analyses.** The main analysis of the primary research questions was

repeated in order to test if the factor structure of the Attribution questionnaire as proposed by

Corrigan et al. (2003) affected the results. In a sensitivity analyses, the logistic regression was

repeated to compare the total score as calculated by Corrigan et al. (2003) including all 27

questions. The multicollinearity assumption was not violated. Very similar results were found

as expected. The full model consisting of both predictor variables was statistically significant

($\chi^2$ (3, $N=243$) = 30, $p <$.001), categorising 64.2% of verdicts and explaining between 11.6%

and 15.5% of the variables. The results closely resembled the previous model, where both

predictor variables made significant contributions to the model and the same variables

resulted in similar odds ratios (5.37 for condition 2). The regression model was repeated for

the subscales as originally identified by Corrigan et al. (2003) however none of the subscales

were found to be significant predictor variables in affecting the likelihood of a guilty or not

guilty verdict. A detailed regression table can be found in Appendix L.

## Discussion

This study set out to investigate how mental health stigma towards schizophrenia, as well as variations in the way mental health information was presented, might affect a juror's verdict. The primary finding was that the presentation of mental health information given to the jurors significantly impacted the verdict they gave. When any information was provided regarding mental health, significantly more jurors voted not guilty. Specifically, the addition of the diagnostic label paranoid schizophrenia meant jurors were over five times more likely to give a not guilty verdict than those with symptom only information or those in the control group. This suggests that, in general, the diagnosis of paranoid schizophrenia, in the context of a criminal case being tried in court, is more likely to elicit a sympathetic rather than punitive response from jurors. An additional primary aim was to understand the impact of individual stigmatic attitudes on the verdict given. Here, higher levels of stigma towards schizophrenia (as measured by the AQ, Brown 2008) were associated with a tendency to give more guilty verdicts. The third main outcome was that belief in dangerousness did not appear to impact on the verdict given. Secondary findings demonstrated that the population sample did not impact on the verdict and therefore supports the finding that student populations could be recruited for research in mock trial formats.

As described, the primary finding was that the greater the provision of mental health information, the higher the likelihood jurors voted not guilty when compared to a control group receiving no mental health information. Indeed, the impact of symptom information reduced the probability of a guilty verdict by nearly three times, but the combination of both a diagnostic label and symptom information reduced the probability by almost half again. It appeared that the diagnostic label worked to validate the integrity of the defendant's mental health difficulty, leading to a higher probability of a not guilty verdict.

From one perspective, this is perhaps a surprising finding. It cannot be easily explained by structural stigma theory, which would predict that the diagnostic label cues stereotypical attitudes and leads to discrimination. Nor does it seem to fit with other research (Wood et al., 2014) suggesting more stigmatising judgements in relation to a diagnosis of schizophrenia.

This finding could, however, be understood in a number of other ways. One possibility is that the sample had lower levels of stigma than the general public but this does not seem borne out in the data. The sample is characterised by relatively large standard deviations and varied stigma scores, and thus it seems that this would be unlikely. Another explanation could be that the mental health description was not powerful enough to evoke stereotypical attitudes (it is noted that the diagnostic label alone was a very small additional manipulation). However, the diagnostic label and descriptions about symptoms were provided clearly throughout the mock trial and evidently they were strong enough to lead to an impact in decision making, though in the opposite direction. Alternatively, it could suggest that people with low to mid-range stigmatic beliefs were not influenced by the mental health information and therefore stereotypes were not activated. Demonstrating that the individuals with different beliefs respond differently to the provision of mental health information. This is borne out to some extent in Figure 3 which highlights a tendency for people with *higher* levels of stigma to be impacted by mental health information in the opposite direction (i.e., the lowest guilt ratings in this group were for participants who had received limited or no mental health information).

Indeed, the role of stigma is worth specific consideration and there was, overall, a general positive relationship between stigma levels and the tendency to give guilty verdicts. For each standard deviation increase in stigma score, the odds of a guilty verdict increased by 53.9%. This is much more easily accounted for by the structural stigma theory, in that it appears the provision of information triggered negative stereotypes and therefore influenced

the verdict. This finding shows the impact of personal characteristics on individual decision making, which highlights that jury members are susceptible to such personal biases and this in turn can affect the verdict. This demonstrates that stigma should be seriously considered as an extra-legal factor.

The final primary research question was around belief in dangerousness as measured by Brown's (2008) subscale. This appeared to only marginally impact on the verdict, demonstrating that this particular subscale may not by itself be of sufficient importance in affecting a juror's decision. However, stigma as a multifaceted concept made up of a cluster of aspects of negative evaluations does impact the verdict. This group of stereotypes included responsibility, lack of empathy and negative emotions and beliefs about 'forcing treatment'. Unexpectedly, stronger influencing subscales were 'forcing treatment' and 'not helping' as measured by Brown's (2008) subscale.

Following preliminary analyses, it is noted that the order of when the stigma measure was given may have affected the stigma response, though, overall, the fact that a counterbalanced design was adopted should have prevented this from impacting on the validity of the whole-group level analyses. This unexpectedly displayed modest significant differences in total stigma scores between the control group and condition 2. Further analysis revealed an order effect, where those who received the stigma measure following the video vignette in condition 2 had significantly higher levels of stigma than those in the control group. This suggests that the video vignette may have primed participants and increased levels of reported stigma. It is worth noting that the order did not cause large differences in stigma scores for participants within the same condition. Furthermore, the video vignette and the stigma measure were not based on the same character but the same diagnosis. This finding highlights the importance of counterbalancing attitudinal measures of stigma when

using a video vignette or considering the use of behavioural observations of stigma which are less susceptible to social desirability bias.

Pleasingly, sampling characteristics seemed to have a limited impact on the overall findings. No differences were found when comparing verdicts between both current students and non-current students, as well as between participants recruited via Prolific versus other recruitment strategies. There was a significant difference in stigma levels between those recruited via Prolific and elsewhere; indicating that student samples may not always be widely representative of the general public in terms of attitudinal measures of stigma. However, these differences were small and therefore their contribution should not be discounted and could be used sensitively in future research, particularly in the area of the impact of mental health information in the legal sphere, where research is embryonic. Taken together these findings show that important and meaningful data regarding jury and stigma research data can be taken from samples of university students, and online sampling can be a meaningful and pragmatic solution to the difficulties of sampling jurors from real-life or unused jury samples.

**Strengths and Limitations**

A possible limitation is that stigma levels in the present sample were lower than in the general population, especially given that the sample had higher than average levels of education (Corrigan & Watson, 2007). In addition, the levels of stigma were measured in a separate vignette with a different character as opposed to the character described in the mock trial. Future research may consider adaptations to stigma measure vignettes to be consistent with the character described in the trial. This reflects similarly to other extra-legal factors such as race, found in previous research (West et al., 2014).

Previous research involving juries have used a psychology undergraduate student sample, which has been criticised for being biased (Kendra et al., 2012). However other research has found contradictory data that student and community samples do not differ (Bornstein, 1999). The present study adds to this debate in the literature around samples used in mock jury research. It supports the latter point, where no significant differences between student and community samples in relation to their verdict or their level of stigma were found. A strength of the study is its relatively large sample size and therefore suggests that the recruitment of students for mock jury research. Unfortunately like many social science research, female dominance in research samples is over-represented in comparison to the general public and therefore must be considered when interpreting the data.

It also noted that individual juror decision making was the focus of this study and a limitation of this is that this is not how a real jury would be organised, this process would involve group discussions. Previous research has highlighted the differing processes involved in group jury decision making, such as open conflict and deliberation (Constanzo, 2003). However, it is reasonable to hypothesise that biases could impact positively on group decision making or negatively where the impact of being within a group mitigates against individual high stigma scores or alternatively the group setting could amplify such biases within the group. Previous research also suggests that the verdict made by individual jurors prior to deliberation is the most accurate prediction of their verdict post-deliberation (Sandys & Dillehay, 1995). Future research may look to compare group jury and individual juror decision making in relation to stigma.

**Implications**

This study has important implications for the presentation of mental health information in court given that there is no formal guidance given to professionals on what

information is provided to a jury regarding mental health. It suggests that very small changes in wording could have a significant impact in how a client with mental health issues is perceived by a jury, or at least by individual jurors.  In addition, some countries such as the United States use a process of jury selection in order to reduce juror bias which is different to England and Wales were jurors are randomly selected. The findings of the current study would be relevant in understanding the levels of stigma held by prospective jury members and also describes the impact of presenting mental health symptoms and diagnostic labels.

**Future Research**

What is unclear from the current study is whether participants were primed by the video vignette, which elicited stronger levels of stigma than perhaps an individual may have had prior to the study. Or alternatively it could be argued that if given first, the stigma measure primed participants to focus on mental health information and therefore contributed to lower levels of guilty verdicts. It is also unclear if participants scoring highly in the stigma measure had preconceived negative attitudes that were triggered in the conditions where mental health descriptions were provided. Future research could explore this with a larger sample size and multiple groups, comparing the order of stigma measures to understand the impact of a mock trial and establish the direction of effect. Given the impact an increase in the amount of information (symptoms and a diagnostic label) regarding mental health impacted on juror verdicts, future research could include an expert witness providing a psychological formulation where more detailed information is provided, such as the development and maintenance of an individual's mental health difficulties. Furthermore, stigma towards schizophrenia was measured however stigma towards offenders with other mental health conditions was not considered. Differential levels of stigma have been found depending on particular diagnostic labels (Pescosolido et al., 1999), therefore future research

may explore the impact of differential mental health diagnoses on stigma and juror verdicts. In addition, the crime committed in the mock trial was criminal damage and therefore did not cause direct physical harm, it may be that the legal question posed in this study also contributes to the verdict and level of stigma. Future research could incorporate these ideas to consider the impact they may have on juror decision making.

**Conclusion**

This study aimed to explore how the provision of mental health information and negative stigmatic attitudes may impact on a juror's verdict in a mock trial. It found that the provision of mental health symptomatic information reduced the probability of a guilty verdict by almost three times, and the combination of symptoms and a diagnostic a label almost halved this probability again. In the opposite direction it, found that having particularly high levels of stigma increased the probability of a guilty verdict by 50%. It appears that individual characteristics such as stigma as well as information provided about a mental health condition, significantly impact on a juror's verdict. This could mean that jurors' verdicts have the potential to change considerably solely based on their own stigmatic beliefs and/or the amount of mental health information provided in a mock trial. Future research could replicate the current procedure with an unused jury similar to research by Thomas (2020) and beyond this consider the impact of differential mental health diagnoses on stigma and information presented to a jury. This research study fulfilled its aim of contributing to a better understanding of sources of bias and the influence of stigma on juror decision making as well as the impact of providing mental health information in a mock criminal trial.

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CHAPTER FOUR

Discussion and Critical Evaluation

## Discussion and Critical Evaluation Chapter

The overall purpose of this thesis was to contribute to the literature around mental health stigma in offenders, including the prevalence of such stigma and the psychometric tools that have been used to measure such stigma. The empirical paper also considered the impact of mental health stigma on behaviour. According to structural stigma theory (Corrigan et al., 2004), mental health stigma can result in discrimination. Research in this area is lacking, and the systematic review is the first to review research into offender mental health stigma from the perspective of the stigmatiser. It appeared that some mental health difficulties were associated with higher levels of stigma than others, namely, psychopathy and schizophrenia. These mental health difficulties also had an association with dangerousness and violence (Durand et al., 2017; Pescosolido et al., 1999), despite there being a relatively low chance of being convicted of a crime when experiencing mental health difficulties (Brekke et al., 2002).

Convictions for those accused of a crime are decided by a jury if they reach a Crown Court and consequently the jury discuss the evidence and give a verdict. Therefore, the empirical paper sought to understand if stigma towards individuals with schizophrenia specifically, could impact on their behaviour through decisions made in an online mock trial. It found that increasing the provision of mental health information was associated with more not guilty verdicts especially when a diagnostic label and symptomatic information was provided. However, individuals with particularly high levels of stigma had a higher chance of giving a guilty verdict, and this increased when more diagnostic and symptomatic information was given. This outlined that if negative stereotypes are present then mental health information can act to increase the chances of it affecting a juror's verdict and therefore causing bias. The finding that different people (i.e., high versus low stigma) will respond to the same mental health information in very different ways is important and speaks

to research surrounding extra-legal factors where external influences unrelated to the trial may influence or impact on a juror and their verdict.

**Stigma**

More broadly within the field of stigma research, there is little consensus on the definition of stigma and therefore what constitutes stigma is widely debated. Stigma research covers a number of perspectives, including experienced stigma (defined as experiences of stereotypes and discrimination (Cechnicki et al., 2011; Fox et al., 2018)), anticipated stigma (also known as felt stigma, which can be defined as the expectation someone has that they will be stereotyped, judged or discriminated against in the future due to their mental health (Quinn & Warnshaw, 2011); this stigma can occur without prior experience simply because negative stereotypes lead to such stigma being expected (Fox et al., 2018). Self-stigma or internalised stigma has been defined as the process in which an individual with a mental illness internalises stigmatising attitudes (Fox et al., 2018; Link et al., 2001). Research has also focused on the interaction of these different types of stigma and ideas for developing anti-stigma campaigns such as through targeting public stigma in order to reduce self-stigma (Evans-Lacko et al., 2014). Unfortunately, due to the number of definitions, this results in multiple measurement tools for each definition. A comprehensive systematic review of stigma measures with associated stigma mechanisms was compiled by Fox et al. (2018) of which many are highlighted as lacking psychometric validation, echoing the findings of the present review. This is despite each of the mechanisms they identify as contributing to stigma having at least one well validated measure available (Fox et al., 2018). These issues can make research in this area somewhat challenging and perhaps off putting for prospective researchers despite the clinical implications such research has for individuals with mental health difficulties, their relatives, clinicians and also legal professionals. Therefore, the

current thesis aimed to incorporate some of the suggestions made by Fox et al. (2018) reflected in; the selection of a previously validated stigma measure in the empirical paper which was also diagnostic specific; including a summary of specific offender mental health stigma measures as well as their psychometric properties in the systematic review, and operationalising the stigma term used throughout the thesis which was consistently from the perspective of the stigmatiser and referred to as public stigma or stigma towards another for clarity. It is hoped that demonstrations of research into stigma which build upon previous research suggestions may instigate others to follow suit and consider their contributions to the field.

Although the current thesis focused on the impact of implicit biases on individual decision making, it would also be reasonable to consider extra-legal factors or bias held by other representatives within the court room such as the barrister, the judge, and clinicians acting as expert witnesses. There is no reason that the findings found in the current empirical study might not extend to these other groups, although replication would be necessary to confirm this. Their individual implicit biases may also impact them in their role in the court process. As researched by West et al. (2014), race, mental health difficulties and a criminal history can all act as stigmatising factors and future research might consider the role of stigma within the aforementioned professions and their conduct in a trial. A particular potential consideration must be given to the potential for judges – particularly in the Magistrates courts – to be vulnerable to some of the same stigmatic attitudes and consequential biases. The current study was focused on jurors, who only appear in the Crown Courts; yet 95% of criminal cases are finalised in a Magistrates court where the decision is made by a judge (Courts and Tribunals Judiciary, 2021). As above, there is no particular reason why such judges might not be subject to the same biases and prejudice, but clearly further research is warranted.

**Strengths and Limitations**

A strength of the thesis is that the two papers clearly inform one another, and both make unique contributions to the stigma literature and the under researched field of jury decision making. Furthermore, the empirical study was completed in collaboration with another trainee colleague who researched mental health literacy and its role in juror decision making; this permitted a jointly recruited sample that allowed more advanced methodological considerations to be given (i.e., two conditions being contrasted against a control condition). Mental health literacy is the understanding or knowledge about mental health, and this has been found to impact on stigma (Holmes et al., 1999). It is possible that the diagnosis of schizophrenia has particularly high levels of stigma because it is more well-known within the general public and therefore the public's mental health literacy is higher (Furnham et al., 2015). A limitation was that the relationship between mental health literacy and stigma was not explored due to limits of the thesis. However, it would be interesting to review how mental health literacy interacts with stigma given the research showing that mental health professionals, perhaps reasonably assumed to have higher levels of mental health literacy than most, have been found to have relatively high levels of stigma. Literacy may therefore not buffer against stigma, and it is possible that an important consideration here is a more fundamental one of what 'literacy' is; for instance if one presumes that literacy means endorsement of a biomedical model, then one might expect literacy to enhance stigma, given the evidence that such explanations are not associated with reductions in stigmatised judgements (Read et al., 2006). Future research may seek to understand the relationship between mental health literacy and stigma and how the combination may impact decisions made by a jury.

In England a collective group of eligible jurors would make individual decisions in a group format before reaching a verdict. This is different from the methodology used in the

empirical paper where individuals did not meet as a collective prior to making a decision, which could be viewed as a limitation to the study. A group format would have been the most realistic way to research the impact of stigma, such as through the use of prospective jurors who were selected for jury service but were not required, however very few studies have been able to do this (Sloat and Frierson, 2005; Thomas, 2020). The interaction between jurors, deliberations and discussions may too impact on the verdicts given, separately and beyond the biases and prejudices that might act to influence an individual juror's decision making. There may be two possibilities, one that the group discussions may mitigate extreme stigmatic viewpoints and the other that this process exacerbates group stigma levels. It may well depend on who the 12 members of the jury are, and on other factors such as who holds the persuasive power within the group, how confident individual jurors are in their beliefs, and the extent to which a particular legal problem overlaps with personal biases and stereotypes. Nevertheless, individual decision making is not distinct or separate from this group process as jurors are encouraged to reach their own decision. Future research may seek to explore if or how the group jury process affects juror stigma and therefore impacts on the verdicts reached.

**Overall Conclusions**

Research into the impact of negative stigmatic views towards offenders with mental health difficulties is lacking in the literature, despite the well-researched and documented negative effects of mental health stigma. Furthermore, this thesis highlights the strong influencing role that these implicit biases have on individual decision making, and when this is understood in a legal context of course these decisions or verdicts have a significant impact on individuals' lives. Moreover, the integrity of jury processes is challenged when individuals could be seen to reach a verdict where, albeit subconsciously, it is not solely reliant on the

evidence presented. Although in the early stages, the research in this portfolio has implications for jury selection processes, especially in jurisdictions where this is not randomised and also for the nature of information provided in court to a jury. It has also suggested a number of future research topics to advance the literature on better understanding the impact of mental health stigma in court, but also the twofold stigmatising effect of having a mental health difficulty and a criminal history.

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## Appendices

## Appendix A: Summary of Linked Project

**Research Study Summary**

Data for the empirical study was collected jointly with another trainee who had separate research questions, these are stated below. The other trainee measured mental health literacy and used a continuous measure of guilt to answer their questions, these are different from my research questions which are focussed on stigma and a categorical measure of guilt.

Questions:

1. Is There an Interaction Between Mental Health Literacy Scale Scores and the mental health Information Presented in a Mock Criminal Trial?
2. Does the Presentation of a Behavioural Description of Schizophrenia, or a Behavioural Description as Well as the Diagnostic Label of Schizophrenia Affect the Verdict of a Jury in a Mock Criminal Trial?
3. Does Jurors' Level of Mental Health Literacy Affect Their Verdict in a Mock Criminal Trial?
4. Do a Student and a Community Sample Differ in Mental Health Literacy Scale scores or Verdict in a Mock Criminal Trial?

Participants completed the mental health literacy (MHL) questionnaire (O'Connor & Casey, 2015) to assess their knowledge of mental health conditions which was always given after the stigma measure that I was using (Attribution Questionnaire, Brown, 2008). Participants also gave a rating following their categorical verdict of guilty or not guilty, to indicate how guilty they felt the defendant was on a scale of 0-100, again this was specifically for the other researcher.

**Appendix B: Psychology, Crime and Law Author Guidelines**

**Journal Author Guidelines for 'Psychology, Crime and Law'**

**About the Journal**

*Psychology, Crime & Law* is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's Aims & Scope for information about its focus and peer-review policy.

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*Psychology, Crime & Law* accepts the following types of article: Article, Registered Report, Book Review, Editorial, Erratum.

Registered Reports (RR) differ from conventional empirical articles by performing part of the peer review process before researchers collect and analyse data. Unlike the more conventional process where a full report of empirical research is submitted for peer review, RRs can be considered as proposals for empirical research, which are evaluated on their merit prior to the data being collected. For detailed guidance on how to prepare RR submissions please read the author and reviewer guidelines here.

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**Structure**

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

**Word Limits**

Please include a word count for your paper. There are no word limits for papers in this journal.

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Please refer to these quick style guidelines when preparing your paper, rather than any published articles or a sample copy.

Any spelling style is acceptable so long as it is consistent within the manuscript.

Please use single quotation marks, except where 'a quotation is "within" a quotation'. Please note that long quotations should be indented without quotation marks.

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Papers may be submitted in Word or LaTeX formats. Figures should be saved separately from the text. To assist you in preparing your paper, we provide formatting template(s).

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**Checklist: What to Include**

1. **Author details.** All authors of a manuscript should include their full name and affiliation on the cover page of the manuscript. Where available, please also include ORCiDs and social media handles (Facebook, Twitter or LinkedIn). One author will need to be identified as the corresponding author, with their email address normally displayed in the article PDF (depending on the journal) and the online article. Authors' affiliations are the affiliations where the research was conducted. If any of the named co-authors moves affiliation during the peer-review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after your paper is accepted. Read more on authorship.
2. Should contain an unstructured abstract of 200 words.
3. **Graphical abstract** (optional). This is an image to give readers a clear idea of the content of your article. It should be a maximum width of 525 pixels. If your image is narrower than 525 pixels, please place it on a white background 525 pixels wide to ensure the dimensions are maintained. Save the graphical abstract as a .jpg, .png, or .tiff. Please do not embed it in the manuscript file but save it as a separate file, labelled GraphicalAbstract1.
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   This work was supported by the [Funding Agency] under Grant [number xxxx].
   *For multiple agency grants*
   This work was supported by the [Funding Agency #1] under Grant [number xxxx]; [Funding Agency #2] under Grant [number xxxx]; and [Funding Agency #3] under Grant [number xxxx].
7. **Disclosure statement.** This is to acknowledge any financial interest or benefit that has arisen from the direct applications of your research. Further guidance on what is a conflict of interest and how to disclose it.
8. **Data availability statement.** Authors are required to provide a data availability statement, detailing where data associated with a paper can be found and how it can be accessed. If data cannot be made open, authors should state why in the data availability statement. The DAS should include the hyperlink, DOI or other persistent

identifier associated with the data set(s), or information on how the data can be requested from the authors. Templates are also available to support authors.

9. **Data deposition.** If you choose to share or make the data underlying the study open, please deposit your data in a recognized data repository prior to or at the time of submission. You will be asked to provide the DOI, pre-reserved DOI, or other persistent identifier for the data set.

10. **Geolocation information.** Submitting a geolocation information section, as a separate paragraph before your acknowledgements, means we can index your paper's study area accurately in JournalMap's geographic literature database and make your article more discoverable to others. More information.

11. **Supplemental online material.** Supplemental material can be a video, dataset, fileset, sound file or anything which supports (and is pertinent to) your paper. We publish supplemental material online via Figshare. Find out more about supplemental material and how to submit it with your article.

12. **Figures.** Figures should be high quality (1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour, at the correct size). Figures should be supplied in one of our preferred file formats: EPS, PS, JPEG, TIFF, or Microsoft Word (DOC or DOCX) files are acceptable for figures that have been drawn in Word. For information relating to other file types, please consult our Submission of electronic artwork document.

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14. **Equations.** If you are submitting your manuscript as a Word document, please ensure that equations are editable. More information about mathematical symbols and equations.

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## Appendix C: Manipulation Check Questions

Manipulation Check questions

What crime was Mr Greene accused of committing?
1. Murder
2. Criminal Damage
3. Blasphemy

Where was Mr Greene accused of having committed the crime?
1. A hospital
2. A train station
3. A doctor's surgery

What was Mr Greene accused of damaging?
1. Water pipes
2. A car
3. A shop window

**Appendix D: Recruitment Advertisements**

**Advertisement One for First 100 Participants from UEA Bulletins**

**Ever wondered how jurors make decisions in criminal trials?**
**Help us find out and be in with a chance to win a**
**£5 Amazon voucher**

You are invited to take part in a study researching how juries make decisions based on the information provided during a mock criminal trial.

This online study allows you to be a juror on a mock criminal trial from the comfort of your own home. You will be asked to complete some questionnaires and watch a 5 to 10-minute video of a mock court case as though you were sitting in the jury. Just like a member of a jury, you will then be asked to give a verdict (guilty or not guilty) for the defendant. Completing the study should take around 30 minutes.

One in every five people who take part will receive a £5 Amazon voucher as a thank you for taking part.
For more information or to take part please click here.

**Advertisement Two for The Remaining Participants**

**Ever wondered how jurors make decisions in criminal trials?**
**Help us find out!**

You are invited to take part in a study researching how juries make decisions based on the information provided during a mock criminal trial.

This online study, open to both students and staff, allows you to be a juror on a mock criminal trial from the comfort of your own home. You will be asked to complete some questionnaires and watch a 10-minute video of a mock court case as though you were sitting in the jury. Just like a member of a jury, you will then be asked to give a verdict (guilty or not guilty) for the defendant. Completing the study should take around 30 minutes.

For more information or to take part, please click here.

## Appendix E: Consent Form

**Consent Form** (06.12.19 V2)
Investigating mock juror decision making

FMH Ethical Approval Number: 2019/20-040

**CONSENT FORM**

Title of Project: An Investigation of Juror Decision Making in A Mock Criminal Trial

Name of Researcher: Cliodhna O Leary and Rachel Tremlin

Please check the box if you agree with each statement:

1.  I confirm that I have read the information sheet dated 06.12.19 (version 2) for the
    above study. I have had the opportunity to consider the information and am satisfied that
    I understand it.

2.  I understand that my participation is voluntary and that I am free to withdraw at any time prior to
    submission of my responses without giving any reason.

3.  I understand that the information collected about me will be used to support
    other research in the future and may be shared anonymously with other researchers.

4.  I agree to take part in the above study.

**Appendix F: Demographic Questions**

**Demographics**
Age: _____years

Gender: Male/Female/Prefer not to say/ Other, please specify: _____

Ethnic background: _____

Highest level of education (please check the box that applies):

☐ Primary school

☐ GCSE or equivalent

☐ A-Level or equivalent

☐ Foundation degree

☐ University undergraduate

☐ University post-graduate- Masters level

☐ University Doctoral or PhD level.

Are you currently a student (under-grad or post grad) enrolled at university? Y/N,
If Yes which level are you studying for (please check the appropriate box):

☐ Foundation degree

☐ University undergraduate

☐ University post-graduate- Master's level

☐ University Doctoral/PhD level.
Please specify the name of course you are currently on, e.g. BSc Psychology: _____

If you are currently in work including a paid or voluntary position, please provide your current job title: _____

Would you describe yourself as having experienced/are currently experiencing a mental health condition? Y/N
Do you know someone who has a MH condition? Y/N,
If yes please indicate your relationship to this individual: e.g. (sister, partner, friend, acquaintance, uncle etc.) _____

**Eligibility criteria**
In order to participate in this study, you must be eligible to be selected for jury service in the United Kingdom, please see the information provided below:

To be eligible for jury service you are required to:
-be between 18-75 years of age
-have lived in the UK for a period of at least 5 years since you were 13 years old

Individuals would not be eligible for jury service if they are:
-currently a resident in hospital due to mental health difficulties.
-currently on bail in criminal proceedings
-currently in prison or have been in prison in the last 10 years, including a community order.

**Please check the box if you agree to the below statement:**

☐ I confirm that I meet the eligibility criteria for jury service outlined above.

**Appendix G: Attribution Questionnaire (AQ)**

AQ-27

Name or ID Number_____ Date
_____

**PLEASE READ THE FOLLOWING STATEMENT ABOUT HARRY:**

Harry is a 30 year-old single man with schizophrenia. Sometimes he hears voices and becomes upset. He lives alone in an apartment and works as a clerk at a large law firm. He had been hospitalised six times because of his illness.

**NOW ANSWER EACH OF THE FOLLOWING QUESTIONS ABOUT HARRY. CIRCLE THE NUMBER OF THE BEST ANSWER TO EACH QUESTION.**

1. I would feel aggravated by Harry.

**1      2      3      4      5      6      7      8      9**
not at all                                                          very much

2. I would feel unsafe around Harry.

**1      2      3      4      5      6      7      8      9**
no, not at all                                                yes, very much

3. Harry would terrify me.

**1      2      3      4      5      6      7      8      9**
not at all                                                          very much

4. How angry would you feel at Harry?

**1      2      3      4      5      6      7      8      9**
not at all                                                          very much

5. If I were in charge of Harry's treatment, I would require him to take his medication.

**1      2      3      4      5      6      7      8      9**
not at all                                                          very much

6. I think Harry poses a risk to his neighbours unless he is hospitalized.
**1      2      3      4      5      6      7      8      9**
none at all                                                         very much

7.  If I were an employer, I would interview Harry for a job.

    **1**      **2**      **3**      **4**      **5**      **6**      **7**      **8**      **9**
not likely                                        very likely

8.  I would be willing to talk to Harry about his problems.

    **1**      **2**      **3**      **4**      **5**      **6**      **7**      **8**      **9**
not at all                                      very much

9.  I would feel pity for Harry.

    **1**      **2**      **3**      **4**      **5**      **6**      **7**      **8**      **9**
none at all                                   very much

10. I would think that it was Harry's own fault that he is in the present condition.

    **1**      **2**      **3**      **4**      **5**      **6**      **7**      **8**      **9**
no, not at all                               yes, absolutely so

11. How controllable, do you think, is the cause of Harry's present condition?

    **1**      **2**      **3**      **4**      **5**      **6**      **7**      **8**      **9**
not at all under                               completely under
personal control                           personal control

12. How irritated would you feel by Harry?

    **1**      **2**      **3**      **4**      **5**      **6**      **7**      **8**      **9**
not at all                                      very much

13. How dangerous would you feel Harry is?
    **1**      **2**      **3**      **4**      **5**      **6**      **7**      **8**      **9**
not at all                                      very much

14. How much do you agree that Harry should be forced into treatment with his doctor even if he does not want to?

**1**    **2**    **3**    **4**    **5**    **6**    **7**    **8**    **9**
not at all                             very much

15. I think it would be best for Harry's community if he were put away in a psychiatric hospital.

**1**    **2**    **3**    **4**    **5**    **6**    **7**    **8**    **9**
not at all                             very much

16. I would share a car journey with Harry every day.

**1**    **2**    **3**    **4**    **5**    **6**    **7**    **8**    **9**
not likely                           very much likely

17.  How much do you think psychiatric residential care, where Harry can be kept away from his neighbours, is the best place for him?

**1**    **2**    **3**    **4**    **5**    **6**    **7**    **8**    **9**
not at all                             very much

18. I would feel threatened by Harry.

**1**    **2**    **3**    **4**    **5**    **6**    **7**    **8**    **9**
no, not at all                        yes, very much

19. How scared of Harry would you feel?

**1**    **2**    **3**    **4**    **5**    **6**    **7**    **8**    **9**
not at all                             very much

20. How likely is it that you would help Harry?
**1**    **2**    **3**    **4**    **5**    **6**    **7**    **8**    **9**
definitely                            definitely
would not help                     would help

21. How certain would you feel that you would help Harry?

**1**     **2**     **3**     **4**     **5**     **6**     **7**     **8**     **9**
not at all certain                               absolutely certain


22. How much sympathy would you feel for Harry?

**1**     **2**     **3**     **4**     **5**     **6**     **7**     **8**     **9**
none at all                                 very much


23. How responsible, do you think, is Harry for his present condition?

**1**     **2**     **3**     **4**     **5**     **6**     **7**     **8**     **9**
not at all                                 very much
responsible                                 responsible


24. How frightened of Harry would you feel?

**1**     **2**     **3**     **4**     **5**     **6**     **7**     **8**     **9**
not at all                                 very much


25. If I were in charge of Harry's treatment, I would force him to live in a group home.

**1**     **2**     **3**     **4**     **5**     **6**     **7**     **8**     **9**
not at all                                 very much


26. If I were a landlord, I probably would rent an apartment to Harry.

**1**     **2**     **3**     **4**     **5**     **6**     **7**     **8**     **9**
not likely                                 very likely


27. How much concern would you feel for Harry?

**1**     **2**     **3**     **4**     **5**     **6**     **7**     **8**     **9**
none at all                                 very much

**Appendix H: Transcripts of Video Vignettes**

**Video Vignette Transcripts**

**Control Condition**

PROSECUTION:

Mr Greene is charged with damaging property contrary to section 1 of the Criminal Damage Act 1971.

The particulars of the offence are that Mr Greene, on the 16th May 2019, without lawful excuse, damaged property belonging to another, namely parts of a hospital building belonging to the Storbridge NHS Trust. The property damaged included water pipes, walls and floors. The prosecution argues that Mr Greene intended to damage such property or was being reckless as to whether such property would be damaged.

The cost of the damage to the property is estimated to be approximately £20,000

The facts are as follows.

On the 16th of May 2019 the police were called to the hospital by security staff who reported that a man had locked himself inside an area of the hospital which contains the water mains and the controls for the hospital's electrical systems. A member of maintenance staff had tried to enter the area and had not been able to open the door. The member of staff knocked on the door to try and gain entry. Mr Greene shouted from inside the room for this man to "Go away! The poison is not all gone yet". At this point the member of staff alerted the security staff, who in turn called the police.

Whilst inside the maintenance room Mr Greene turned off the taps controlling the entry of water to the building. He hit the water pipes several times using a sledge hammer that he had brought with him. As a result of his actions the pipes fractured and water escaped.

Once the police arrived, Mr Greene was arrested and taken to the police station. Mr Greene did not resist arrest and appeared calm, being described by the officers as almost euphoric on their arrival.

We, the prosecution argue that Mr Greene was fully aware of what he was doing at the time of the crime and that he caused the damage intentionally or recklessly, being aware of a risk that damage would result from his behaviour. In law, that is enough to convict the defendant of criminal damage.

We argue that this crime was premeditated, as evidenced by his arrival at the hospital with a sledgehammer and that Mr Greene had spent a lot of time planning it. Mr Greene had gone to the hospital on two occasions prior to 16th May 2019, in order to find out where he could access the mains water supply controls within the building.

Water supply to the hospital was cut off completely for two hours and the damage that was done to the pipes meant that an alternative water supply had to be found and set up. This resulted in disruption to every part of the hospital and further disruption for a number of days due to the temporary water supply being less efficient than the mains supply. There was also significant water damage and flooding to the mains room.

The prosecution's case is that Mr Greene either intended to cause the damage to the hospital's building, or was at least reckless about damage resulting. We put it you, members of the

jury, that he was at least aware of a risk that the damage to the hospital's property would result from his actions.

DEFENCE:

We, the defence, argue that Mr Greene is not guilty of this offence. We argue that he did not intend to cause the damage to the hospital's property. We argue that he was not aware that the damage would result from his behaviour. Our case is that Mr Greene believed that he was helping everyone within the hospital by preventing them from being harmed by a contaminated water supply.

Mr Greene believed that the water supply had been contaminated as he had heard a story on the news that a sewage plant nearby had leaked into surrounding areas including a river that flowed passed the hospital.

Mr Greene is 35 years old. He attended a further education college and later graduated with a degree. Following this he worked in a local supermarket and has worked there ever since. Mr Greene is currently living alone in a rented flat within the city centre. He has regular contact with his parents and younger brother who lives at their family home.

We put it to you members of the Jury, that Mr Greene was not intending to cause damage but was in fact intending to save people. We argue that he did not consider that his actions would result in damage to the hospital's property.

TRIAL JUDGE'S DIRECTION TO THE JURY:

Members of the jury, in order to find Mr Greene guilty of the offence of criminal damage, you must be sure, beyond reasonable doubt, of several things.

You must be sure that he did in fact damage property belonging to the hospital.

If you are sure that he did in fact damage property belonging to the hospital, you must also be sure that Mr Greene intended to cause that damage or was reckless about causing that damage. You may be asking what I mean by "intention" or acting "recklessly". In law, a person intends a result if he acts in order to bring it about. If you are sure that Mr Greene acted in order to bring about the damage to the hospital's property, then your verdict will be 'guilty'.

If you are not sure that he intended to cause the damage, you must ask yourselves whether he caused the damage recklessly.

In law, a person has acted recklessly if, when he does the act or acts that cause the damage, he was aware of a risk that the damage would occur, and it was, in the circumstances known to him, unreasonable for him to take that risk. If you are sure that Mr Greene was aware of a risk that the damage would occur when he did the acts that caused the damage, your verdict will be 'guilty'.

If you are not sure that he intended to cause the damage and you are not sure that he was reckless about causing the damage, then you must find Mr Greene not guilty of this charge.

**Group 1- Symptom only description**

PROSECUTION: (Remains the same as above)

DEFENCE:

We, the defence, argue that Mr Greene is not guilty of this offence. We argue that he did not intend to cause the damage to the hospital's property and was not aware that the damage would result from his behaviour. Our case is that due to his delusional beliefs, Mr Greene believed that he was saving everyone within the hospital by preventing them from being killed by the poison in the water. We argue that he did not consider that his actions would result in damage to the hospital's property.

Mr Greene is 35 years old. He attended a further education college and later graduated with a degree. Following this he worked in a local supermarket and has worked there ever since. Mr Greene is currently living alone in a rented flat within the city centre. He has regular contact with his parents and younger brother who lives at their family home. Mr Greene has had difficulties with his mental health for several years. Mr Greene's symptoms are managed through the use of prescribed medication, although he does not always take his tablets.

Mr Greene has delusional beliefs that he finds very distressing. Mr Greene's behaviour, particularly when he is not taking medication, can be somewhat unusual and unpredictable. Mr Greene can have beliefs that others do not share, and frequently his paranoia is focussed on the Government, whom he believes is trying to hurt people. Mr Greene has previously held beliefs that the government have been hurting people by poisoning the food sold in supermarkets.

In addition, Mr Greene can experience auditory hallucinations where he hears an authoritative voice which he does not recognise telling him that he is being watched.

An expert mental health clinician, who has a background in the assessment of mental health difficulties in a forensic context, met with Mr Greene before today's trial, so that his mental health difficulties could be assessed. The clinician has submitted a report stating that Mr Greene was experiencing delusional beliefs at the time of the alleged offence. Mr Greene believed that the British Government has a plan to poison people in hospitals so that the burden on the health service will be reduced. According to the clinician's report, Mr Greene stated that he thought the Government had added a poisonous substance to the water supply of the hospital in question, in order, in Mr Greene's words, to "get rid of some sick people so that the hospitals and the health system in general would be able to function better once they had fewer patients". Mr Greene believed that by stopping the water supply he would be saving the lives of patients at the hospital. Mr Greene says he became aware of this Government plan by receiving a number of coded messages in newspapers and through gestures made by TV news presenters that were meant especially for him. He also explained that he had been told of the government's plan by a voice he often hears.

The defence argue that as a result of Tom's mental health difficulties at the time, he did not intend to cause the damage to the hospital and its property and was not aware of the full extent of damage that would result from his behaviour.

Due to his delusional beliefs, he thought that he was helping everyone within the hospital by preventing them from being killed by the poison in the water. Mr Greene turned off the water to keep it from reaching patients and then hit the pipes to stop it being switched straight back on by the government. We put it to you members of the jury, that as a result of Mt Greene's delusional beliefs, he did not appreciate the full extent of damage caused by the flood that would occur to the hospital and it's property.


TRIAL JUDGE'S DIRECTION TO THE JURY :
Members of the jury, in order to find Mr Greene guilty of the offence of criminal damage, you must be sure, beyond reasonable doubt, of several things.

You must be sure that he did in fact damage property belonging to the hospital.

If you are sure that he did in fact damage property belonging to the hospital, you must also be sure that Mr Greene intended to cause that damage or was reckless about causing that damage. You may be asking what I mean by "intention" or acting "recklessly". In law, a person intends a result if he acts in order to bring it about. If you are sure that Mr Greene acted in order to bring about the damage to the hospital's property then your verdict will be 'guilty'.

If you are not sure that he intended to cause the damage, you must ask yourselves whether he caused the damage recklessly.

In law, a person has acted recklessly if, when he does the act or acts that cause the damage, he was aware of a risk that the damage would occur, and it was, in the circumstances known to him, unreasonable for him to take that risk. If you are sure that Mr Greene was aware of a risk that the damage would occur when he did the acts that caused the damage, your verdict will be 'guilty'.

You have heard evidence concerning Mr Greene's mental health difficulties. That is a factor you may want to consider when you are deciding whether Mr Greene intended to cause the damage and whether he appreciated a risk of the damage resulting from his actions.

If you are not sure that he intended to cause the damage and you are not sure that he was reckless about causing the damage, then you must find Mr Greene not guilty of this charge.

### Group 2- Diagnostic label and symptom description

PROSECUTION: (Remains the same as above)

DEFENCE:
We, the defence, argue that Mr Greene is not guilty of this offence. We argue that he did not intend to cause the damage to the hospital's property and was not aware that the damage would result from his behaviour. Our case is that due to his paranoid schizophrenia, Mr Greene believed that he was saving everyone within the hospital by preventing them from being killed by the poison in the water. We argue that he did not consider that his actions would result in damage to the hospital's property.

Mr Greene is 35 years old. He attended a further education college and later graduated with a degree. Following this he worked in a local supermarket and has worked there ever since. Mr Greene is currently living alone in a rented flat within the city centre. He has regular contact with his parents and younger brother who lives at their family home. Mr Greene has had difficulties with his mental health for several years and was diagnosed with paranoid schizophrenia as an adolescent. Mr Greene's symptoms are managed through the use of prescribed medication, although he does not always take his tablets.

Mr Greene has delusional beliefs, consistent with his diagnosis of paranoid schizophrenia that he finds very distressing. Mr Greene's behaviour, particularly when he is not taking medication, can be somewhat unusual and unpredictable. Mr Greene's paranoid schizophrenia means that he can have beliefs that others do not share, and frequently his paranoia is focussed on the Government, whom he believes is trying to hurt people. Mr Greene has previously held beliefs that the Government have been hurting people by poisoning the food sold in supermarkets.

In addition, as a further symptom of his paranoid schizophrenia, Mr Greene can experience auditory hallucinations where he hears an authoritative voice which he does not recognise telling him that he is being watched.

An expert mental health clinician, who has a background in the assessment of mental health difficulties in a forensic context, met with Mr Greene before today's trial, so that his mental health difficulties could be assessed. The clinician has submitted a report stating that Mr Greene was experiencing delusional beliefs related to his diagnosis of paranoid schizophrenia at the time of the alleged offence. Mr Greene believed that the British Government has a plan to poison people in hospitals so that the burden on the health service will be reduced. According to the clinician's report, Mr Greene stated that he thought the Government had added a poisonous substance to the water supply of the hospital in question, in order, in Mr Greene's words, to "get rid of some sick people so that the hospitals and the health system in general would be able to function better once they had fewer patients". Mr Greene believed that by stopping the water supply he would be saving the lives of patients at the hospital. Mr Greene says he became aware of this Government plan by receiving a number of coded messages in newspapers and through gestures made by TV news presenters that were meant especially for him. He also explained that he had been told of the government's plan by a voice he often hears.

The defence argue that as a result of Mr Greene's paranoid schizophrenia at the time, he did not intend to cause the damage to the hospital and its property and was not aware of the full extent of damage that would result from his behaviour.

Due to his paranoid schizophrenia, he believed that he was helping everyone within the hospital by preventing them from being killed by the poison in the water. Mr Greene turned off the water to keep it from reaching patients and then hit the pipes to stop it being switched straight back on by the Government. We put it to you members of the jury, that as a result of Mr Greene's delusional beliefs in relation to his paranoid schizophrenia, he did not appreciate the full extent of damage caused by the flood that would occur to the hospital and it's property.


TRIAL JUDGE'S DIRECTION TO THE JURY:

Members of the jury, in order to find Mr Greene guilty of the offence of criminal damage, you must be sure, beyond reasonable doubt, of several things.

You must be sure that he did in fact damage property belonging to the hospital.

If you are sure that he did in fact damage property belonging to the hospital, you must also be sure that Mr Greene intended to cause that damage or was reckless about causing that damage. You may be asking what I mean by "intention" or acting "recklessly". In law, a person intends a result if he acts in order to bring it about. If you are sure that Mr Greene acted in order to bring about the damage to the hospital's property then your verdict will be 'guilty'.

If you are not sure that he intended to cause the damage, you must ask yourselves whether he caused the damage recklessly.

In law, a person has acted recklessly if, when he does the act or acts that cause the damage, he was aware of a risk that the damage would occur, and it was, in the circumstances known to him, unreasonable for him to take that risk. If you are sure that Mr Greene was aware of a risk that the damage would occur when he did the acts that caused the damage, your verdict will be 'guilty'.

You have heard evidence concerning Mr Greene's paranoid schizophrenia. That is a factor you may want to consider when you are deciding whether Mr Greene intended to cause the damage and whether he appreciated a risk of the damage resulting from his actions.

If you are not sure that he intended to cause the damage and you are not sure that he was reckless about causing the damage, then you must find Mr Greene not guilty of this charge.

## Appendix I: Debrief Form & Helpful Resources

### Debrief Form

Thank you very much for taking part in this study. This information sheet has been designed to explain the reason for undertaking this research. You have taken part in a study that aims to evaluate the effect that stigma, mental health literacy, and the presentation of mental health information has on the verdict of a mock criminal trial.

We asked you to complete a measure of stigma in mental health. This measure looks at people's beliefs about individuals who have mental health difficulties. It aims to measure whether an individual feels negatively or positively about people who have mental health difficulties.

We also asked you to complete a measure of mental health literacy. Mental health literacy is a concept that includes people's knowledge of mental health difficulties, their ability to recognise them and their knowledge of how to help people who experience them.

We would like to evaluate whether people's levels of stigma and mental health literacy effect how they make a decision in a mock criminal trial. We do this by measuring these things and seeing whether people are more likely to vote guilty or not guilty depending on their levels of stigma and mental health literacy.

We were also interested in whether the presentation of mental health information in the mock trial video had an effect on the verdict. We showed some people a trial video in which no mental health information was given, some people one where the symptoms of the mental health difficulty were described but not labelled and some where it was both described and labelled. We are hoping to analyse this data in order to see whether the way the information is presented effects the decision people make.

This information is helpful for us to learn about how people perceive mental health difficulties, how they understand mental health difficulties, and how we might best present mental health-based information in court rooms in order to give the defendant the fairest trial possible.

We hope that the information from this study will help us to improve people's knowledge and understanding of mental health and the experience of those who have mental health difficulties within the criminal justice system.

If you have any questions about this study, please contact the researchers
c.o-leary@uea.ac.uk; r.tremlin@uea.ac.uk or
Director of the Doctorate in Clinical Psychology at the University of East Anglia:
N.Broomfield@uea.ac.uk

### Helpful Resources

Thank you for participating in this study. Some individuals may have found some of the criminal or mental health related information provided distressing. If you feel you have been negatively affected by the information and would like some support with this, please contact the following organisations.

**Samaritans**
A UK based organisation that supports individuals who are feeling distressed
Website: https://www.samaritans.org/          Telephone: 116 123

**Victim Support**
A UK based organisation that supports victims of crimes
Website: https://www.victimsupport.org.uk/ Telephone: 08081689111

**Mind**
A UK based organisation that offer information and support with mental health difficulties
Website: https://www.mind.org.uk/information-support/

## Appendix J: Ethical Approval

Faculty of Medicine and Health Sciences Research Ethics Committee

**UEA**
University of East Anglia

Rachel Tremlin and Cliodhna O'Leary
Clin Psy Doctorate
Faculty of Medicine and Health Science
University of East Anglia
NR4 7TJ

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Email: fmh.ethics@uea.ac.uk
www.med.uea.ac.uk

23rd April 2020

Dear Rachel and Cliodhna

**Title:    Investigating juror decision making in a mock criminal trial**

**Reference:  2019/20-040**

Thank you for your email of 9th March 2020 notifying us of the amendments you would like to make to your above proposal. These have been considered and I can confirm that your amendments have been approved.

Please can you ensure that any further amendments to either the protocol or documents submitted are notified to us in advance, and that any adverse events which occur during your project are reported to the Committee.

Approval by the FMH Research Ethics Committee should not be taken as evidence that your study is compliant with GDPR and the Data Protection Act 2018. If you need guidance on how to make your study GDPR compliant, please contact your institution's Data Protection Officer.

Please can you arrange to send us a report once your project is completed.

Yours sincerely

Prof Alastair Forbes
Chair
FMH Research Ethics Committee

**COVID-19:** *The FMH Research Ethics Committee procedures remain as normal. Please note that our decisions as to the ethics of your application take no account of Government measures and UEA guidelines relating to the coronavirus pandemic and all approvals granted are, of course, subject to these. If your research is COVID-19 related it will naturally be expedited. If the current situation means that you will have to alter your study, please submit an application for an amendment in the usual way.*

## Appendix K: Participant Information Sheets

**Participant Information Sheet** (06.12.19 V2)
Investigating juror decision making in a mock criminal trial
You are invited to take part in this research project which is interested in juror decision making. It is important that you understand the nature of this project before deciding if you wish to participate. Please read this form to support your understanding of what participating in the study will involve.

**Aim of the research**
This study is interested in how juries make decisions based on the information they are provided with during a mock trial. The study hopes to investigate whether certain factors affect the decisions made. It builds on previous research conducted in various countries and aims to focus on UK law.

**Do I have to take part?**
Your involvement in this study is voluntary, this means it is your choice to partake in the study or to decline. Once you begin the study you can choose to stop at any time prior to submitting your responses. Once your responses have been submitted it will not be possible to withdraw as the responses will be anonymous. In order to take part, you must ensure you do not meet any of the exclusion criteria, as this study is interested in jury decision making, these criteria follow those set by the ministry of justice who enrol jurors in the UK. It is important that people who partake are representative of those who could be called for jury service.

**What will happen if I agree to take part?**
This is an online study in which your identity will remain anonymous, you will not be asked to give your name or any other information by which you could be identified. You will be asked to complete some optional questions about yourself such as age and current job. You will then read a short scenario and complete some questions about your thoughts on this and then you will be asked to complete a short questionnaire. You will then be asked to watch a 10-minute video of a mock court case as though you were sitting in the jury. You will hear from the prosecution, the defence and the judge. A written copy of this information will also be provided so you do not have to remember it all. Just like a member of a jury, you will then be asked to give a verdict (guilty or not guilty) for the defendant. Completing the study should take around 30 minutes.

**What are the possible disadvantages to taking part?**
This study is not anticipated to cause any disadvantages. Some of the information may cause some individuals mild distress but this would not be any more distressing than information encountered in everyday life. *This study involves a description of a criminal damage law case, if you anticipate this causing you distress it is at your discretion to participate.*

**Confidentiality**
All information collected will be kept strictly confidential, and as it is anonymous it will not be possible to identify you from the responses you provide.
We will ask you to provide your email address separately at the end if you would like to be entered into the draw for a voucher. Email addresses will be accessed on a UEA password protected computer. Once the draw has taken place your email address will be deleted.
As the data is anonymous, once you have submitted your responses and finished the study, we will not be able to remove your data.

**Are there benefits to taking part?**
One in every five who take part will be emailed a £5 love to shop voucher. At the end of the study you will be asked to input your email if you would like to be entered into the draw. You will also be contributing to important research into how juries use information presented to them in order to make a decision or verdict.

**What happens if something goes wrong?**
If you have any questions, concerns or would like to speak to someone you can contact any member of the research team, who's details can be found at the bottom of the page. If you have concerns, you would not wish to raise with the research team you can contact the ethics teams using the details provided.

**What will happen to the results of the study?**
Results will be published; however, you will not be identified in any report or publication. If you wish to be given a copy of the published article, please contact one of the researchers.

**Who has ethically reviewed the study?**
Both the faculty of medicine and health sciences and the faculty of psychology at the University of East Anglia have given ethical approval to this study.

**Contacts or further information**
Primary researchers: R.tremlin@uea.ac.uk or C.o-leary@uea.ac.uk, University of East Anglia, Norwich Research Park, Norwich NR4 7TJ.
Faculty of Medicine and Health Sciences ethics: fmh.ethics@uea.ac.uk or Faculty of Social Sciences, School of Psychology ethics: ethics.psychology@uea.ac.uk
Director of the Doctorate in Clinical Psychology Dr Niall Broomfield: N.Broomfield@uea.ac.uk

Thank you for reading this and considering taking part in this research


**Prolific Participant Information Sheet**

**Prolific Participant Information Sheet** (06.12.19 V2)
Investigating juror decision making in a mock criminal trial
You are invited to take part in this research project which is interested in juror decision making. It is important that you understand the nature of this project before deciding if you wish to participate. Please read this form to support your understanding of what participating in the study will involve.


**Aim of the research**
This study is interested in how juries make decisions based on the information they are provided with during a mock trial. The study hopes to investigate whether certain factors affect the decisions made. It builds on previous research conducted in various countries and aims to focus on UK law.


**Do I have to take part?**
Your involvement in this study is voluntary, this means it is your choice to partake in the study or to decline. Once you begin the study you can choose to stop at any time prior to submitting your responses. Once your responses have been submitted it will not be possible to withdraw as the responses will be anonymous. In order to take part, you must ensure you do not meet any of the exclusion criteria, as this study is interested in jury decision making, these criteria follow those set by the ministry of justice who enrol jurors in the UK. It is important that people who partake are representative of those who could be called for jury service.


**What will happen if I agree to take part?**

This is an online study in which your identity will remain anonymous, you will not be asked to give your name or any other information by which you could be identified. You will be asked to complete some optional questions about yourself such as age and current job. You will then read a short scenario and complete some questions about your thoughts on this and then you will be asked to complete a short questionnaire. You will then be asked to watch a 10-minute video of a mock court case as though you were sitting in the jury. You will hear from the prosecution, the defence and the judge. A written copy of this information will also be provided so you do not have to remember it all. Just like a member of a jury, you will then be asked to give a verdict (guilty or not guilty) for the defendant. Completing the study should take around 30 minutes.

**What are the possible disadvantages to taking part?**
This study is not anticipated to cause any disadvantages. Some of the information may cause some individuals mild distress but this would not be any more distressing than information encountered in everyday life. *This study involves a description of a criminal damage law case, if you anticipate this causing you distress it is at your discretion to participate*.

**Confidentiality**
All information collected will be kept strictly confidential, and as it is anonymous it will not be possible to identify you from the responses you provide.
As the data is anonymous, once you have submitted your responses and finished the study, we will not be able to remove your data.

**Are there benefits to taking part?**
Participation in the study is likely to take approximately 30 minutes. Payment will be made in line with Prolific's payment standards and thus you are likely to receive approximately £3.50 for your time.
 You will also be contributing to important research into how juries use information presented to them in order to make a decision or verdict.

**What happens if something goes wrong?**
If you have any questions, concerns or would like to speak to someone you can contact any member of the research team, who's details can be found at the bottom of the page. If you have concerns, you would not wish to raise with the research team you can contact the ethics teams using the details provided.

**What will happen to the results of the study?**
Results will be published; however, you will not be identified in any report or publication. If you wish to be given a copy of the published article, please contact one of the researchers.

**Who has ethically reviewed the study?**
Both the faculty of medicine and health sciences and the faculty of psychology at the University of East Anglia have given ethical approval to this study.

**Contacts or further information**
Primary researchers: R.tremlin@uea.ac.uk or C.o-leary@uea.ac.uk, University of East Anglia, Norwich Research Park, Norwich NR4 7TJ.
Faculty of Medicine and Health Sciences ethics: fmh.ethics@uea.ac.uk or Faculty of Social Sciences, School of Psychology ethics: ethics.psychology@uea.ac.uk

Director of the Doctorate in Clinical Psychology Dr Niall Broomfield:
N.Broomfield@uea.ac.uk

Thank you for reading this and considering taking part in this research

## Appendix L: SPSS Results Tables

**Results Tables**

**Preliminary Analyses**

Gender
Descriptives
FTotal_AQBrownC

| | N | Mean | Std. Deviation | Std. Error | 95% Confidence Interval for Mean | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | Lower | Upper | Min. | Max. | |
| Male | 75 | 84.00 | 30.264 | 3.495 | 77.04 | 90.96 | 33 | 163 | |
| Female | 164 | 80.09 | 27.580 | 2.154 | 75.83 | 84.34 | 31 | 166 | |
| Prefer not to say | 2 | 69.50 | 40.305 | 28.500 | -292.63 | 431.63 | 41 | 98 | |
| other | 2 | 68.50 | 4.950 | 3.500 | 24.03 | 112.97 | 65 | 72 | |
| Total | 243 | 81.11 | 28.372 | 1.820 | 77.53 | 84.70 | 31 | 166 | |

ANOVA
FTotal_AQBrownC

| | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|
| Between Groups | 1386.195 | 3 | 462.065 | .571 | .635 |
| Within Groups | 193411.805 | 239 | 809.254 | | |
| Total | 194798.000 | 242 | | | |

Multiple Comparisons
Dependent Variable: FTotal_AQBrownC
Tukey HSD

| (I) Gender | (J) Gender | Mean Difference | Std. Error | Sig. | 95% Confidence Interval | |
|---|---|---|---|---|---|---|
| | | | | | Lower | Upper |
| Male | Female | 3.915 | 3.965 | .757 | -6.34 | 14.17 |
| | Prefer nottosay | 14.500 | 20.382 | .893 | -38.23 | 67.23 |
| | other | 15.500 | 20.382 | .872 | -37.23 | 68.23 |
| Female | Male | -3.915 | 3.965 | .757 | -14.17 | 6.34 |
| | Prefer nottosay | 10.585 | 20.238 | .953 | -41.77 | 62.94 |
| | other | 11.585 | 20.238 | .940 | -40.77 | 63.94 |
| Prefer nottosay | Male | -14.500 | 20.382 | .893 | -67.23 | 38.23 |
| | Female | -10.585 | 20.238 | .953 | -62.94 | 41.77 |
| | other | 1.000 | 28.447 | 1.000 | -72.60 | 74.60 |
| other | Male | -15.500 | 20.382 | .872 | -68.23 | 37.23 |
| | Female | -11.585 | 20.238 | .940 | -63.94 | 40.77 |
| | Prefer nottosay | -1.000 | 28.447 | 1.000 | -74.60 | 72.60 |

Age
Descriptives
FTotal_AQBrownC

| | N | Mean | Std. Deviation | Std. Error | 95% Confidence Interval for Mean | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | Lower | Upper | Min. | Max |
| Low | 84 | 78.40 | 27.507 | 3.001 | 72.44 | 84.37 | 32 | 166 |
| Medium | 76 | 80.21 | 26.142 | 2.999 | 74.24 | 86.18 | 33 | 163 |
| High | 83 | 84.67 | 31.041 | 3.407 | 77.90 | 91.45 | 31 | 159 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Total | 243 | 81.11 | 28.372 | | 1.820 | | 77.53 | 84.70 | 31 | 166 |

Descriptives
FTotal_AQBrownC

| | N | Mean | SD | Std. Error | 95% Confidence Interval for Mean | | Min | Max |
|---|---|---|---|---|---|---|---|---|
| | | | | | Lower | Upper | | |
| Control Questionnaires first | 40 | 76.30 | 24.571 | 3.885 | 68.44 | 84.16 | 41 | 159 |
| Control Questionnaires last | 41 | 73.15 | 24.337 | 3.801 | 65.46 | 80.83 | 32 | 143 |
| Behavioural Questionnaires first | 41 | 78.63 | 30.498 | 4.763 | 69.01 | 88.26 | 31 | 138 |
| Behavioural Questionnaires last | 38 | 83.39 | 28.538 | 4.629 | 74.01 | 92.77 | 37 | 166 |
| Diagnosis Questionnaires last | 41 | 93.10 | 28.043 | 4.380 | 84.25 | 101.95 | 53 | 163 |
| Diagnosis Questionnaires first | 42 | 82.12 | 30.785 | 4.750 | 72.53 | 91.71 | 42 | 153 |
| Total | 243 | 81.11 | 28.372 | 1.820 | 77.53 | 84.70 | 31 | 166 |

ANOVA
FTotal_AQBrownC

| | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|
| Between Groups | 9909.872 | 5 | 1981.974 | 2.541 | .029 |
| Within Groups | 184888.128 | 237 | 780.119 | | |
| Total | 194798.000 | 242 | | | |

Multiple Comparisons
Dependent Variable: FTotal_AQBrownC
Tukey HSD

| (I) Group | (J) Group | Mean Difference (I-J) | Std. Error | Sig. | 95% Confidence Interval | |
|---|---|---|---|---|---|---|
| | | | | | Lower Bound | Upper Bound |
| Control Questionnaires first | Control Questionnaires last | 3.154 | 6.207 | .996 | -14.68 | 20.99 |
| | Behavioural Questionnaires first | -2.334 | 6.207 | .999 | -20.17 | 15.50 |
| | Behavioural Questionnaires last | -7.095 | 6.327 | .872 | -25.27 | 11.08 |
| | Diagnosis Questionnaires last | -16.798 | 6.207 | .078 | -34.63 | 1.04 |
| | Diagnosis Questionnaires first | -5.819 | 6.171 | .935 | -23.55 | 11.91 |
| Control Questionnaires last | Control Questionnaires first | -3.154 | 6.207 | .996 | -20.99 | 14.68 |
| | Behavioural Questionnaires first | -5.488 | 6.169 | .949 | -23.21 | 12.24 |
| | Behavioural Questionnaires last | -10.248 | 6.289 | .580 | -28.32 | 7.82 |
| | Diagnosis Questionnaires last | -19.951* | 6.169 | .017 | -37.68 | -2.23 |
| | Diagnosis Questionnaires first | -8.973 | 6.132 | .688 | -26.59 | 8.65 |
| Behavioural Questionnaires first | Control Questionnaires first | 2.334 | 6.207 | .999 | -15.50 | 20.17 |
| | Control Questionnaires last | 5.488 | 6.169 | .949 | -12.24 | 23.21 |
| | Behavioural Questionnaires last | -4.761 | 6.289 | .974 | -22.83 | 13.31 |
| | Diagnosis Questionnaires last | -14.463 | 6.169 | .181 | -32.19 | 3.26 |
| | Diagnosis Questionnaires first | -3.485 | 6.132 | .993 | -21.10 | 14.13 |
| Behavioural Questionnaires last | Control Questionnaires first | 7.095 | 6.327 | .872 | -11.08 | 25.27 |
| | Control Questionnaires last | 10.248 | 6.289 | .580 | -7.82 | 28.32 |
| | Behavioural Questionnaires first | 4.761 | 6.289 | .974 | -13.31 | 22.83 |
| | Diagnosis Questionnaires last | -9.703 | 6.289 | .637 | -27.77 | 8.37 |
| | Diagnosis Questionnaires first | 1.276 | 6.253 | 1.000 | -16.69 | 19.24 |

| Diagnosis Questionnaires last<br>34.63 | Control Questionnaires first | | 16.798 | 6.207 | .078 | -1.04 | |
|---|---|---|---|---|---|---|---|
| | Control Questionnaires last | 19.951* | 6.169 | .017 | 2.23 | 37.68 | |
| | Behavioural Questionnaires first | 14.463 | 6.169 | .181 | -3.26 | 32.19 | |
| | Behavioural Questionnaires last | 9.703 | 6.289 | .637 | -8.37 | 27.77 | |
| | Diagnosis Questionnaires first | 10.979 | 6.132 | .474 | -6.64 | 28.60 | |
| Diagnosis Questionnaires first<br>23.55 | Control Questionnaires first | | 5.819 | 6.171 | .935 | -11.91 | |
| | Control Questionnaires last | 8.973 | 6.132 | .688 | -8.65 | 26.59 | |
| | Behavioural Questionnaires first | 3.485 | 6.132 | .993 | -14.13 | 21.10 | |
| | Behavioural Questionnaires last | -1.276 | 6.253 | 1.000 | -19.24 | 16.69 | |
| | Diagnosis Questionnaires last | -10.979 | 6.132 | .474 | -28.60 | 6.64 | |

* The mean difference is significant at the 0.05 level.

## Main Analyses

ANOVA
FTotal_AQBrownC

| | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|
| Between Groups | 1730.913 | 2 | 865.457 | 1.076 | .343 |
| Within Groups | 193067.087 | 240 | 804.446 | | |
| Total | 194798.000 | 242 | | | |

Multiple Comparisons
Dependent Variable: FTotal_AQBrownC
Tukey HSD

| AgeGroup | AgeGroup | Mean Difference | Std. Error | Sig. | 95% Confidence Interval | |
|---|---|---|---|---|---|---|
| | | | | | Lower | Upper |
| Low | Medium | -1.806 | 4.490 | .915 | -12.40 | 8.78 |
| | High | -6.270 | 4.390 | .328 | -16.62 | 4.08 |
| Medium | Low | 1.806 | 4.490 | .915 | -8.78 | 12.40 |
| | High | -4.464 | 4.503 | .583 | -15.08 | 6.16 |
| High | Low | 6.270 | 4.390 | .328 | -4.08 | 16.62 |
| | Medium | 4.464 | 4.503 | .583 | -6.16 | 15.08 |

## AQ-27 Total stigma

AQ-27- Corrigan et al. (2004)

| | B | S.E. | Wald | df | Sig. | Exp(B) | 95% C.I.for EXP(B) | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | Lower | Upper |
| Control | | 23.148 | 2 | | .000 | | | |
| Behavioural | -1.097 | .340 | 10.401 | 1 | **.001** | .334 | .171 | .650 |
| | | | | | | 2.99 | 5.84 | 1.53 |
| Diagnosis | -1.683 | .355 | 22.519 | 1 | **.000** | .186 | .093 | .372 |

|  | B | S.E. | Wald | df | Sig. | Exp(B) | | |
|---|---|---|---|---|---|---|---|---|
|  |  |  |  |  |  | 5.37 | 10.75 | 2.68 |
| AQ27 Stigma | .015 | .005 | 9.412 | 1 | **.002** | 1.015 | 1.005 | 1.024 |
| Constant | -.520 | .471 | 1.217 | 1 | .270 | .595 | | |

## AQ-27 Corrigan subscales

AQ-27 subscales Corrigan et al. (2004)

|  | B | S.E. | Wald | df | Sig. | Exp(B) | 95% C.I.for EXP(B) | |
|---|---|---|---|---|---|---|---|---|
|  |  |  |  |  |  |  | Lower | Upper |
| Control |  |  | 22.945 | 2 | .000 |  |  |  |
| Behavioural | -1.150 | .359 | 10.277 | 1 | .001 | .317 | .157 | .640 |
| Diagnosis | -1.744 | .369 | 22.368 | 1 | .000 | .175 | .085 | .360 |
| AQ-27 Subscales: |  |  |  |  |  |  |  |  |
| Blame | .061 | .039 | 2.420 | 1 | .120 | 1.063 | .984 | 1.149 |
| Anger | .021 | .048 | .187 | 1 | .666 | 1.021 | .929 | 1.123 |
| Dangerousness | -.027 | .070 | .146 | 1 | .702 | .973 | .848 | 1.117 |
| No help | .055 | .032 | 2.903 | 1 | .088 | 1.056 | .992 | 1.125 |
| Fear | -.022 | .061 | .131 | 1 | .718 | .978 | .867 | 1.103 |
| Avoidance | .022 | .035 | .385 | 1 | .535 | 1.022 | .954 | 1.096 |
| Segregation | .016 | .047 | .120 | 1 | .729 | 1.016 | .928 | 1.114 |
| Coercion | .061 | .039 | 2.472 | 1 | .116 | 1.063 | .985 | 1.147 |
| Pity | -.019 | .031 | .391 | 1 | .532 | .981 | .924 | 1.042 |
| Constant | -.651 | .778 | .701 | 1 | .403 | .521 | | |

## Descriptive Statistics AQ26 subscales

|  | Mean | Std. Deviation | N |
|---|---|---|---|
| FearDanger_B2 | 21.21 | 11.801 | 243 |
| NoHelpInteract_B | 22.66 | 10.207 | 243 |
| Responsibility_B | 7.56 | 3.879 | 243 |
| ForcingTreatment_B | 12.19 | 6.424 | 243 |
| NegativeEmotions_B | 6.75 | 3.966 | 243 |
| NoEmpathy_B | 10.7449 | 5.13624 | 243 |

## Dummy Coding Main Analyses

|  | B | S.E. | Wald | df | Sig. 95% | Exp (B) | C.I Exp(B) Lower | Upper |
|---|---|---|---|---|---|---|---|---|
| Step 1a |  |  |  |  |  |  |  |  |
| FTotal_AQBrownC | .018 | .005 | 12.632 | 1 | **.000** | 1.019 | 1.008 | 1.029 |
| Condition1_symptoms(1) | 1.084 | .341 | 10.108 | 1 | **.001** | 2.956 | 1.515 | 5.766 |
| Condition2_SymDiag(1) | 1.739 | .358 | 23.612 | 1 | **.000** | 5.689 | 2.822 | 11.472 |
| Constant | -3.410 | .671 | 25.861 | 1 | .000 | .033 | | |

a Variable(s) entered on step 1: FTotal_AQBrownC, Condition1_symptoms, Condition2_SymDiag.