Psychology, Society & Education (2025) 17(2), 1-14

Psychology, Society & Education

www.uco.es/ucopress/ojs/index.php/psye

Useful strategies for reducing mental health stigma in healthcare settings: a Delphi study

Lorena Paola Chávez[1], Sara Zamorano*[2], Clara González-Sanguino[3] & Manuel Muñoz[2]

[1] *Universidad Nacional de Córdoba, Córdoba (Argentine)*
[2] *Universidad Complutense de Madrid, Madrid (Spain)*
[3] *Universidad de Valladolid, Valladolid (Spain)*

Keywords

Communication skills
Discrimination
Education
Health professionals
Psychology

Abstract

Healthcare settings' stigma towards mental health problems is a public health phenomenon that is attracting increasing research interest. Our aim was to identify useful strategies for reducing stigma towards mental disorders in healthcare settings. A qualitative study was carried out to reach an inter-judge agreement among experts on these strategies, with a $n = 23$ experts in mental health stigma and clinical practice from Argentine and Spain. Consensus was reached on useful strategies for mental health stigma reduction in health and social contexts. Training in communication skills and empathy is the most useful strategy reported, followed by multidisciplinary work and supervision of clinical practices. It is advisable to promote the implementation of communication and empathy strategies during the education and training of health and social professionals to reduce stigma.

Estrategias útiles para reducir el estigma de la salud mental en los entornos sanitarios: un estudio Delphi

Palabras clave

Habilidades de comunicación
Discriminación
Educación
Profesionales de la salud
Psicología

Resumen

El estigma en contextos sanitarios hacia los problemas de salud mental es un fenómeno de salud pública que cada vez suscita mayor interés en la investigación. El objetivo del estudio fue identificar estrategias útiles para la reducción del estigma hacia las personas con trastornos mentales en entornos sanitarios. Se realizó un estudio cualitativo para llegar a un acuerdo entre expertos en estas estrategias, con una $n = 23$ personas expertas en estigma en salud mental y en práctica clínica de Argentina y España. Se detectaron estrategias útiles para la reducción del estigma en salud mental en contextos sociosanitarios. El entrenamiento en habilidades de comunicación y empatía es la estrategia señalada como más útil, seguida del trabajo multidisciplinar y la supervisión de las prácticas clínicas. Es conveniente promover la implementación de este tipo de estrategias en la formación y entrenamiento del personal de atención sociosanitaria para reducir el estigma en estos contextos.

* *Corresponding author:* Sara Zamorano. Department of Personality, Assessment and Clinical Psychology, Faculty of Psychology, Complutense University of Madrid, Campus de Somosaguas, Ctra. de Húmera, s/n 28223, Pozuelo de Alarcón, Madrid. Spain. sarazamo@ucm.es
Cite this article as: Chávez, L. P., Zamorano, S., González-Sanguino, C., & Muñoz, M. (2025). Useful strategies for reducing mental health stigma in healthcare settings: a Delphi study. *Psychology, Society & Education, 17*(2), 1-14. https://doi.org/10.21071/psye.v17i2.17269
Received: 17 July 2024. *First review*: 11 December 2024. *Accepted:* 22 December 2024.

ISSN 1989-709X

Stigma in mental health involves associating a mark (diagnosis), with undesirable traits such as dangerousness and violence (Corrigan et al., 2014; Thornicroft et al., 2022). Stigma comprises three factors: stereotypes (misinformation and lack of knowledge about mental health problems, like perceptions of weakness or instability), prejudices (negative emotional reactions, like fear or pity), and discrimination (behaviors towards people with mental health problems, like exclusion and rejection) (Thornicroft et al., 2022).

Challenging stigma and discrimination related to mental health problems has been considered a complex strategy within healthcare service (Knaak et al., 2014). To understand the processes surrounding stigmatization, it is necessary to consider whether there is a relationship between health and social professionals' beliefs and attitudes about health/illness, and patients' difficulties in accessing services (Corrigan et al., 2014; Knaak et al., 2017). Therefore, it is necessary to emphasize that stigma manifests itself at various levels of behavior, providing a framework for social exchange that leads to a differentiation between "them" (patients) and "us" (professionals) (Cova et al., 2024; Fox et al., 2018).

The stigmatization processes experienced by people with mental health problems generate various adverse conditions, leading to their exclusion in terms of health. Link and Phelan (2001) suggested that much of the research in this area has focused on aspects of the individual experience of the person with a mental health problem. This implies neglecting the analysis of the structural aspects and social determinants that influence the processes of exclusion. In recent years, there has been growing interest in the effect of stigma on healthcare professionals. Initially this interest focused on attitudes and behavioral manifestations in the general population (Chin & Balon, 2006). However, research suggests that it is a misconception that health and social professionals have more positive attitudes towards people with mental health problems. These providers display paternalistic, infantilizing, and overprotective behaviors, as well as pessimism regarding recovery (Carrara et al., 2019). For instance, professionals have been reported to perceive people with mental health problems as violent, in addition to having expressed a degree of social distance towards them (Carrara et al., 2019; Nyblade et al., 2019). Practitioners have also expressed doubts about the ability of this group to adapt socially and about their capacity to adhere to treatments (Corrigan et al., 2014; Cova et al., 2024). Stigmatizing attitudes have also been observed to become more acute as professionals advance in their training (Agrest et al., 2015; Henderson et al., 2014). Also, there is a certain professional deformation effect, especially in psychiatric practitioners. They are more prone to be the target of negative stereotypes and stigmatizing attitudes than other mental health professionals (Gaebel et al., 2014).

The most significant consequences for people with mental disorders, derived from stigma in social-health contexts, are related to a considerable decrease in the quality of their health care, with deficiencies in care for medical pathologies (Knaak et al., 2017). Additionally, stigma causes unnecessary referrals of patients to mental health centers and reluctance to refer them to other specialties unrelated to their mental health problem. Stigma is identified as the main barrier to help-seeking, causing patients not to attend health services (Thornicroft et al., 2022).

A recent review (Thornicroft et al., 2022) highlights key elements for reducing mental health stigma. These include integrating programs into professional training, using direct contact with people with mental health problems and involving people with lived experience in the design and implementation of interventions. These approaches help increase professionals' knowledge, reduce negative attitudes, and enhance self-efficacy and clinical skills, especially when combining educational training plus direct contact. The review also recommends using mixed methods by incorporating qualitative research to strengthen the evidence base (Thornicroft et al., 2022). At a global level, a recent systematic review and meta-analysis (Lien et al., 2021) also found 18 studies testing the efficacy of interventions aimed at reducing the stigma of mental disorders among health professionals. Interventions combining education with social contact are the most effective against stigma in healthcare settings. At the national level, an intervention with family physicians has been developed in Spain to address the stigma associated with depression, reporting positive changes in attitudes (Manzanera et al., 2018). The Obertament Campaign (Eiroa-Orosa et al., 2021) includes a specific intervention with primary care professionals, based on psychoeducation and contact.

The Pan American Health Organization (PAHO, 2022) and The Chair Against Stigma UCM-Grupo 5 offer an online self-learning course, "Understanding and acting against mental health stigma in health contexts", hosted on PAHO's virtual campus, aimed at instructing health professionals in identifying and reducing stigma. In Argentine, the Suma Project has addressed this issue, identifying stigma as a key barrier to help-seeking and promoting recovery-based, community-centered care (Agrest et al., 2015; Geffner & Agrest, 2021; Geffner et al., 2021). The *Good Practice Guide Against Stigma* (Chair Against Stigma UCM-Grupo 5, 2022) also recommends consulting experts for the design of stigma-reduction interventions. Regarding these types of interventions (Heim et al., 2019), it is stated that stigma reduction programs have a lack of training in specific communication skills, empathy, and clinical skills for professionals.

The present study

Within the health professional stigma reduction interventions that have been developed, it is important to assess the views of professionals and their specific needs. For this reason, the aim of this study was to identify useful strategies for the reduction of stigma towards people with mental disorders in social-health contexts both in Spain and Argentine. To address this issue, a Delphi design study was carried out. Delphi is a qualitative, systematic research technique based on an iterative process whit several phases. Its aim is to obtain the consensus of a group of experts on a topic of interest (Linstone & Turoff, 2002). This qualitative research technique has been widely used in health sciences education research to assist in the formula-

tion of recommendations regarding the education and training of health professionals (De Villiers et al., 2005).

Method

Participants

The first Delphi phase sample consisted of n = 18 (71.3% women; M = 23 years; *SD* = 11.67) experts, with a representation of 60% from Spain and 40% from Argentine. In the second Delphi phase, the sample was *n* = 23 (69.6% women; *M* = 19.3 years of experience; *SD* = 10.98), with 65.2% from Spain and 34.8% from Argentine. According to the literature, the Delphi method allows to enlarge the sample in the subsequent phases to get a larger number of opinions and improve the quality of the process, and a panel of 23 experts produces stable results (Akins et al., 2005). In the third phase, the response rate was 91.3%, with 21 professionals responding. Regarding the respondents' degree of expertise, calculations were systematically performed using the Expert Competence Coefficient, scored between 0-1 (Cruz-Ramírez et al., 2012).

The panel of experts was composed of people from different disciplines, dedicated to professional practice (nursing, psychiatry, psychology, management of social services centers), with 38.1% of the total, or to academic practice (university professors of psychology and psychiatry), with 61.9% of the total. This group heterogeneity facilitates a greater degree of perspective on the topic (Jorm, 2015; Mead & Moseley, 2001).

Procedure

This study is part of two larger, collaborative research studies carried out at the Complutense University of Madrid (Spain) and the National University of Córdoba (Argentina). This work presents a first study, with independent objectives, hypotheses, methodology, sample, and results. The study is part of the design of an intervention to reduce stigma in health and social care professionals, which will be implemented specifically in the Spanish and Argentinean contexts. The analysis considers the advice of a group of experts from both countries, with the aim of identifying key variables in these specific contexts.

The first phase consisted of conducting an online questionnaire with four open-ended questions with the experts' panel, who were contacted via email. Incident sampling was carried out by convenience, considering as inclusion criteria that they were experts in 1) stigma in health settings, 2) research and teaching on stigma, or 3) health professionals.

The aim of the first phase was to identify key concepts regarding the stigma of social and health professionals towards people with mental health problems. Responses were collected and analyzed through content analysis. Two independent judges participated in the analysis, and the intervention of a third judge was requested in case of a lack of consensus. A total of 254 content units extracted from the four open questions were analyzed, 13 categories were extracted, and an ad-hoc questionnaire was constructed for the second phase. The initial four questions and the categories are included in the Appendix I.

The second phase consisted of a questionnaire including 21 items of strategies identified in the previous content analysis, scored on a Likert-type scale from 1 = *Not useful* to 10 = *Very useful*. This questionnaire was sent to the experts' panel, responses were collected, and inter-judge agreement was analyzed (Finn, 1970). In addition, seven items related to variables influencing professional stigma were included, with a Likert-type scale from 1 = *Strongly Disagree* to 6 = *Strongly Agree*. The questionnaire is presented in Table 1.

Finally, during the third phase, an iterative process was applied. The experts were sent their individual scores for the stigma reduction strategies, along with the group median, so that they could consider their responses with feedback from the other experts. Finally, the *rWG* (Finn, 1970) inter-judge agreement analysis was repeated for the strategies found. All phases were performed by telematic means using Google Forms. The workflow is summarized in Figure 1.

The study was conducted in accordance with the Declaration of Helsinki and was approved by the Ethics Committee of the Faculty of Psychology of the Complutense University of Madrid (Ref: CE_20220317-07_SAL) and the Institutional Committee from the Hospital Nacional de Clínicas, Córdoba, Argentine (Ref: 046-10082023). Participants completed the appropriate informed consent forms, and anonymity was maintained among respondents. This study has complied with APA ethical standards in the treatment of the sample.

Figure 1

Delphi workflow diagram

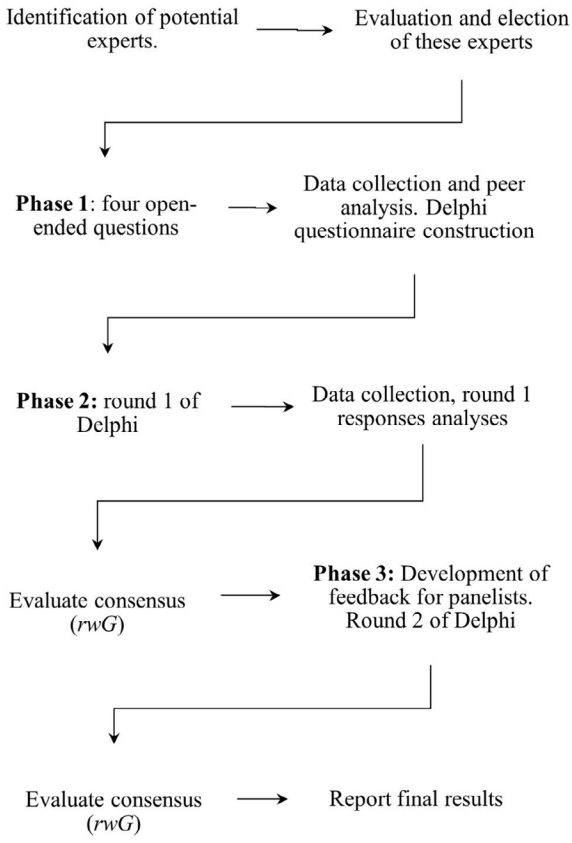

Table 1

Delphi questionnaire extracted from content analysis

Items on variables detected by experts
1. Severe mental disorders are less stigmatized than other mental health problems. 2. Therapeutic pessimism (negative beliefs about recovery) is a consequence of stigma. 3. Health/social professionals, regardless of their specific discipline, benefit from supplementing their training with more information about mental disorders. 4. Stigmatizing attitudes and behaviors of health/social professionals increase if they engage in activities with patients outside the usual context of care. 5. Professional burnout predisposes oneself to stigmatizing emotions and behaviors towards people with mental disorders. 6. Emergency units and those not specialized in mental health are more stigmatizing environments than the rest. 7. The precariousness of working conditions leads to professional burnout and therefore a greater predisposition to stigmatization of mental health problems.
Items on strategies mentioned as useful by the experts
1. Training health/social professionals to identify stereotypes and misconceptions associated with mental disorders is a useful strategy to reduce stigma. 2. Training health/social professionals to identify stigmatizing emotions or prejudices (e. g., fear, rejection) is a useful strategy to reduce stigma. 3. Training health/social professionals to identify stigmatizing or discriminatory behaviors (e. g., paternalism, servility, overprotection) is a useful strategy to reduce stigma. 4. To generate spaces for reflection about myths and stigmatizing beliefs about mental disorders among health/social professionals is a useful strategy to reduce stigma. 5. Training health/social professionals from a biopsychosocial perspective that highlights the multi-causality of mental disorders is a useful strategy to reduce stigma. 6. Training health/social professionals from a therapeutic recovery perspective is a useful strategy to reduce stigma. 7. To what extent does the participation of people with mental disorders in their treatment decisions enhance the effectiveness of health treatment? 8. To what extent are stigma reduction strategies more effective if there is some involvement of people with mental disorders (peers or assistants) during their development? 9. Group and multidisciplinary work are useful strategies to minimize the stigma associated with mental disorders. 10. Having health/social professionals rotate through mental health facilities during their training period is a useful stigma reduction strategy. 11. Monitoring and supervision of health/social interventions is useful to identify stigmatizing attitudes in professionals. 12. Establishing working spaces on good practice in reference to stigma towards mental disorders is a useful and feasible practice in health/social contexts. 13. Implementing specific training on stigma towards mental health disorders is useful to reduce the stigma associated with them. 14. Direct, meaningful, and satisfying professional contact with people with mental disorders is a useful stigma reduction strategy. 15. Listening to and interacting with the testimonies of patients and their families is a useful stigma reduction strategy. 16. Indirect contact with people with mental disorders (through videos, role plays, experience stories…) is a useful stigma reduction strategy that can be implemented in training. 17. Training health/social professionals in communication techniques and empathic care (e. g., mirroring, pointing, feedback, human rights, dignifying the patient) is a useful strategy to reduce stigmatizing behavior. 18. Training professionals in techniques to manage professional burnout (e. g., relaxation, emotional regulation, healthy habits, limit setting, coping skills, assertiveness, conflict resolution, etc.) is a useful strategy to reduce stigma. 19. Training professionals in self-care techniques (physical, emotional, and social) is a useful stigma-reduction strategy. 20. Keeping mental health services in separate areas or buildings from those of other specialties is a useful strategy to reduce stigma. 21. Making the diagnosis explicit and using specific terms (e. g., schizophrenia, major depression, bipolar disorder) is a useful strategy against stigma.
Which of these theoretical perspectives do you find most stigmatizing? • Biological/Biopsychosocial.
Which of these theoretical perspectives do you find most stigmatizing? • Dimensional/Categorical.

Data analysis

To select the experts' panel, the Expert Competence Coefficient was calculated (Cruz-Ramírez et al., 2012). Professionals with a competence higher than 0.7 were included, with a mean of 0.77. The process is detailed in the Appendix II. Once the interviews were conducted, a qualitative content analysis, a descriptive analysis of the sample characteristics, and an analysis of the level of agreement with the items under study were carried out. Analyses of measures of central tendency and response frequencies were also performed for the specific items of stigma reduction strategies. Considering the potential cultural differences between both populations, non-parametric analyses (Mann-Whitney U test for independent samples) were conducted to assess *mean differences* for all variables, using country of origin as the grouping variable. No significant mean differences were found, so the analyses were combined for all variables. The results can be found in the Appendix III. Finally, the inter-judge agreement index *rWG* (Finn, 1970) was calculated. This index reports significant inter-judge agreement with at least 10 judges responding on Likert-type scales of at least five points. An *rWG* agreement > .8 is considered strong agreement, an *rWG* between .7 and .8 indicates moderate agreement, between .7 and .6 is low agreement, and an *rWG* agreement < .6 is considered unacceptable.

Results

Variables influencing the development of stigma

Experts identified several variables that influence health and social professionals to experience higher levels of stigma towards people with mental health problems. First, they mentioned severe mental health problems as the most stigmatized, with 95.7% of professionals agreeing with this statement. Furthermore, 86.9% of the experts considered that stigma results in therapeutic pessimism, understood as attributing to users a lower capacity for recovery. They also considered that having negative care experiences with people with mental health problems, especially if they are chronic or severe problems, generates stigma. Nearly 96% of the experts considered as more stigmatizing those social and health care settings not specialized in mental health (primary care, general medicine, emergencies). As for the inherent characteristics of the task, they pointed to burnout and professional precariousness (86.9%) as variables that accentuate the dehumanization of care and promote stigmatization.

Experts also mentioned the relevance of training in mental health and specifically in issues related to stigma. About 98% of professionals considered that addressing mental health problems from a dimensional perspective, attending to multiple biopsychosocial factors, reduces stigma. They also noted that those health and social professionals who have had close contact with people with mental health problems may express lower levels of stigma (69.6%). Additionally, they considered that professionals who apply recovery-based treatment perspectives that go beyond the deficit or symptom in their daily work have better attitudes. Several experts highlighted how multidisciplinary work, in which professionals from different fields collaborate, reduces discrimination. Also, experts agreed that making professionals aware that stigma exists and influences their clinical practice is a way to reduce it.

Strategies detected for stigma reduction in social and health contexts

The content analyses revealed several strategies that the experts noted as useful. These strategies included training health professionals on stereotypes, prejudice, and discrimination in mental health. Additionally, applying a biopsychosocial and recovery-focused view of mental disorders was considered helpful in reducing stigma. Experts also highlighted the need for participation of people with mental health problems, arguing that they have to be involved in decision-making about their treatment and in the design of stigma reduction strategies.

Work in multidisciplinary teams was emphasized, as well as follow-up and monitoring of health interventions. Direct and indirect contact with people with mental health problems were also mentioned as useful strategies for stigma reduction. Finally, skills training strategies that could be useful in reducing stigma were mentioned. These strategies included communication and empathy and, to a lesser extent, stress management training and self-care strategies. Table 2 shows the results for these variables.

The strategies considered most useful in reducing mental health stigma were training professionals in communication skills and empathy ($M = 9.76$), monitoring and supervision of health/social interventions ($M = 9.38$), and training professionals in recovery-based treatment approaches ($M = 9.33$); all of them reached high levels of inter-judge agreement ($rWG > .8$).

Other strategies considered useful were training social and health professionals in relation to stereotypes ($M = 9.29$), prejudice ($M = 9.24$), and discrimination ($M = 9.29$). Having spaces where professionals could address good practices against stigma was also considered highly useful ($M = 9.24$). For these strategies, agreement rates among experts were also high ($rWG > .8$). Additionally, training professionals in a biopsychosocial perspective of mental health ($M = 9.29$) with moderate agreement ($rWG = .76$) was also considered a useful strategy. Listening to patient and family testimonies by professionals ($M = 9.33$) was considered useful, also having a moderate level of agreement ($rWG = .71$).

Experts also reported the need to create spaces for reflection among professionals to normalize and address stigma, and the need to generate multidisciplinary work teams to share information with other disciplines ($M = 9.14$). In reference to personal treatment with patients, they considered it useful to involve them in their therapeutic decisions to reduce stigma ($M = 9.14$). Adding stigma-specific content in the formal studies (higher/university) of health and social professionals was also considered useful ($M = 9.05$). In all these strategies, experts reached high agreement rates ($rWG > .8$). It was also considered very useful for health and social care providers to be able to rotate

Table 2

Strategy scores and inter-judge agreement

	Phase 2				Phase 3			
Variables	*M*	*Mdn*	*SD*	*rwG*	*M*	*Mdn*	*SD*	*rwG*
Empathy and communication training	9.35	10	0.94	.79	9.76	10	0.77	.86*
Clinical practice monitoring and supervision	9.13	9	1.01	.75	9.38	9	0.6	.92*
Recovery perspective	9.13	9	1.1	.71	9.33	9	0.8	.85*
Discrimination training	9	9	1.17	.67	9.29	9	0.56	.93*
Stereotype training	9.13	9	0.92	.8*	9.29	9	0.64	.9*
Prejudice training	9.09	9	1	.76	9.24	9	0.77	.86*
Working on good practices against stigma	9.17	9	0.89	.81*	9.24	9	0.77	.86*
User involvement in therapeutic decisions	9.13	9	0.85	.84*	9.14	9	0.66	.9*
Multidisciplinary work	8.83	9	1.5	.46	9.14	9	0.79	.85*
Spaces for reflection among professionals	8.87	9	1.29	.6	9.14	9	0.91	.8*
Stigma-specific training	8.74	9	1.05	.73	9.05	9	0.74	.87*
Biopsychosocial perspective	8.91	10	1.38	.55	9.29	10	1.01	.76
Working with peers or assistants	8.96	9	1.22	.64	8.9	9	1.3	.6
Rotations through care facilities	8.83	9	1.53	.44	9.05	9	1.02	.75
Meaningful direct contact	9.17	10	1.11	.7	9.24	10	1.09	.72
First-person testimonies	9.26	10	1.14	.69	9.33	10	1.11	.71
Indirect contact with users	8.61	9	1.34	.59	8.76	9	1.18	.67
Training in managing emotional exhaustion	8.57	9	1.53	.44	8.9	9	1.3	.6
Training in self-care	8.43	9	1.56	.42	8.67	9	1.39	.54
Segregation of mental health services	2.65	2	2.17	-.12	1.81	1	1.08	.72
Explicit diagnosis	3.13	3	1.84	.19	2.62	3	1.12	.7

Note. * Indicates the strategies with a strong inter-judge agreement (rWG > 0.8).

through facilities other than those of their specialty, including mental health, although experts reached a moderate agreement rate (*rWG* = .75).

Other strategies such as indirect contact with people with mental health problems or the use of peers or assistants in anti-stigma interventions were also identified as useful. However, they reached only low levels of inter-judge agreement (*rWG* < .7). Experts also scored unacceptable levels of agreement on strategies such as the use of emotional distress management techniques or self-care.

Discussion

This study allowed the identification and description of key variables and strategies to reduce mental health stigmatization among health professionals based on the contributions of experts from Spain and Argentine.

A major consensus in relation to healthcare settings is that health and social professionals sometimes attribute low resilience to users. Additionally, experts interpret that stigma is directed primarily at people with severe mental disorders. These factors are exacerbated in primary care, general practice, on-call, and emergency settings. These findings are consistent with previous literature (Cova et al., 2024; Henderson et al., 2014; Zamorano et al., 2023) that has identified stereotypes among social/health professionals towards populations with severe mental disorders, such as schizophrenia. These stereotypes include conceptions of dangerousness and lower expectations of treatment adherence. It has also been observed that social rejection tends to be greater for people with mental disorders that are associated with greater personal responsibility, a sense of dangerousness, and behavioral oddity (Stone et al., 2019).

In addition, the experts' panel pointed to factors inherent to the environment surrounding the care task as predisposing to the development of dehumanizing care behaviors. Previous studies have identified professional burnout, precariousness, and work overload as contextual factors that contribute to attitudes of social distancing and poorer quality care practices (Fontesse et al., 2021; Knaak et al., 2017; Solmi et al., 2019). Regarding this, in this study experts identify emergency care and on-call settings as environments more conducive to emotional overload and, sometimes, to loss of identification with the task. Previous research has pointed out how the daily routine of the emergency department and its massiveness hinders having time for reflection and evaluation of clinical practices

to facilitate more thoughtful care decisions (Clarke et al., 2014). Anxiety and other unpleasant feelings in health and social professionals are an important aspect of how mental health-related stigma manifests, so increasing confidence and reducing anxiety through skills training appears to be an effective way to reduce stigma in these contexts (Grandón et al, 2021; Pettigrew & Tropp, 2008).

Experts also highlight that multidisciplinary work and the use of a biopsychosocial perspective that transcends deficits or symptoms are factors that mitigate mental health stigma. In this regard, some studies (Larkings et al., 2018; Thornicroft et al., 2022) suggest how stigma reduction strategies may require providers and advocates to shift toward an emphasis on competence and inclusion. This previous research also highlights how a neurobiological conception generates a more stigmatizing perspective.

Another strategy identified as beneficial by this study is specific training on stigma, considering it appropriate to add relevant content to academic training. In addition, experts emphasize the need to implement follow-up and supervision of clinical practices. Similarly, Corrigan & Shapiro (2010) suggest targeting stigma reduction strategies on key groups, such as health professionals, as this is more effective.

However, training professionals in interpersonal communication skills and empathy presented the highest levels of usefulness among participants in this study as a stigma reduction strategy. The need to train professionals in both clinical and communication skills within the implementation of anti-stigma strategies has been noted in previous studies (Grandón et al., 2021; Heim et al., 2019). This type of training has been highlighted as a promising strategy to address stigma, but it has also been suggested that most studies developing stigma reduction strategies currently lack training in specific clinical and communication skills (Heim et al., 2019).

The present study reveals that a care approach focused on recovery and not only on symptomatic processes is a training need for professionals. These findings are in line with Agrest (2016), who argues that incorporating recovery stories into anti-stigma programs can reduce the bias of professionals who work with people during the exacerbation of their symptoms. In addition, the development of spaces for reflection among professionals where information is shared with other disciplines stands out as a relevant strategy for stigma reduction. In this line, an intervention with medical residents (Amsalem et al., 2020) that included contact with people with mental disorders, followed by supervised small group discussions, showed to be effective in reducing stigmatizing perceptions among these professionals.

Experts in the present study also included elements that have been mentioned as key to effective interventions in previous studies (Knaak et al., 2014), such as (a) social contact with a trained peer speaker who has lived experience of mental disorder; (b) indirect interventions such as video, where different interlocutors are presented. Of note, they did not consider the separation of services or the use of explicit diagnosis helpful in reducing stigma. However, there is consensus that diagnosis should be a designation used to ensure treatment and guide care, but never to explain and/or predict behavior (Mascayano et al., 2015).

To our knowledge, this is the first Delphi study focused on identifying useful strategies to reduce mental health stigma in social-health contexts in Spain and Argentine. A strength of the study is that it involved professionals from two countries, allowing cultural implications to be weighed. The use of telematic means of data collection was an advantage, since it allowed remote access to professionals from different geographic locations. The study was rigorously conducted following the Delphi methodology, the major strength of which is the ability to achieve consensus in a complex topic. The experts, coming from diverse backgrounds (clinicians, academics), bring a wide range of direct knowledge and experience on the matter. This allows the development of practical recommendations for implementation in national social-health care systems. Additionally, the expertise of the experts' panel was strictly evaluated. Furthermore, the heterogeneity of the group made it possible to obtain richer data from different perspectives.

Regarding limitations, the telematic application is considered to restrict the exchange between the research group and the experts' panel. Thus, the emergence of additional elements or feedback is reduced. The richness that could have been added by having an expert panel composed of people with first-hand experience of mental health problems is also considered. Construction of some concepts may be restricted by academics or professionals who have not had first-hand experience with mental disorders. For future research, it would be necessary to include this perspective. In addition, it is assumed that the data collected in this paper are context-specific to the countries where they have been collected. The social situations and culture of Spain and Argentine, although similar, encompass different characteristics. Nevertheless, an analysis of the difference in means by country for the different strategies identified was conducted, and no significant differences were found.

Conclusions

In summary, this Delphi study suggests that training social-health professionals in communication skills and empathy may be a central strategy for stigma reduction. This reaffirms what has been proposed in previous studies (Grandón et al., 2021; Heim et al., 2019; Sarikoc et al., 2017), which highlight the positive effects of training professionals in empathy and communication skills on stigmatizing attitudes and behaviors. This would require focusing on behavioral change by instructing skills that help social-health providers to know what to do and how to address mental health situations in different contexts (Knaak et al., 2014). Moreover, the implementation of spaces to reflect on stigma and to follow-up on social or clinical interventions is highlighted. Promoting a biopsychosocial perspective that focuses on recovery and not only on the resolution of symptomatic processes is also important. Furthermore, it is recommended to target these strategies especially to professionals in training and those working in the most stigmatizing contexts, such as primary and emergency

care. This study helps to understand the educational and training needs of social-health professionals with respect to stigma towards mental disorders. This allows for more appropriate and context-specific stigma reduction interventions.

Future research lines should consider cultural factors related to the strategies applied, depending on the country and area of application. It would also be important to implement discussion and reflection groups among experts, whether professional or first-person. A complementary line of research could be based on analyzing separately which strategies are most useful for academics and which are most useful for clinicians. Also, it is necessary to continue studying the efficacy of communication skills training for stigma reduction through a rigorous methodology with randomized controlled trials.

Author contributions

Conceptualization: M.M., S.Z.
Data collection and data curation: S.Z., L.P.C.
Formal analysis: S.Z., L.P.C., C.G.S.
Funding acquisition: M.M., S.Z.
Methodology: M.M., S.Z.
Project administration: M.M., C.G.S.
Supervision: M.M., C.G.S.
Writing – Original draft: S.Z., L.P.C.
Writing – Review & editing: C.G.S, M.M., S.Z., L.P.C

Funding

This work has been funded by Comunidad de Madrid [PIPF-2022/SAL-GL-25433, 2022]. This funding source had no role in the design of this study, data collection, management, analysis, and interpretation of data, writing of the manuscript, and the decision to submit the manuscript for publication.

Acknowledgments

We appreciate the contributions of all the experts who participated in the project, as without them it would not have been possible to carry out this study.

Declaration of interests

The authors declare that there is no conflict of interest.

Data availability statement

The data that support the findings of this study are available on request from the corresponding author.

References

Agres, M. (2016). Narrativas en primera persona: ¿Qué es lo nuevo para un profesional de la salud mental? [First person narratives: Is there anything new in them for a mental health professional?]. *Vertex*, *XXVII*(128), 274-279.

Agrest, M., Mascayano, F., Ardila-Gómez, S. E., Abeldaño, A., Fernandez, R., Geffner, N., Leiderman, E. A., Susser, E. S., Valencia, E., Yang, L. H., Zalazar, V., & Lipovetzky, G. (2015). Mental illness stigma research in Argentina. *BJPsych International, 12*(4), 86-88. https://doi.org/10.1192/s2056474000000623

Akins, R. B., Tolson, H., & Cole, B. R. (2005). Stability of response characteristics of a Delphi panel: Application of bootstrap data expansion. *BMC Medical Research Methodology, 5*, Article 37. https://doi.org/10.1186/1471-2288-5-37

Amsalem, D., Gothelf, D., Dorman, A., Goren, Y., Tene, O., Shelef, A., Horowitz, I., Dunsky, L. L., Rogev, E., Klein, E. H., Mekori-Domachevsky, E., Fischel, T., Levkovitz, Y., Martin, A., & Gross, R. (2020). Reducing stigma toward psychiatry among medical students: A multicenter controlled trial. *The Primary Care Companion for CNS Disorders, 22*(2), Article 19m02527. https://doi.org/10.4088/PCC.19m02527

Carrara, B. S., Ventura, C. A. A., Bobbili, S. J., Jacobina, O. M. P., Khenti, A., & Mendes, A. C. (2019). Stigma in health professionals towards people with mental illness: An integrative review. *Archives of Psychiatric Nursing, 33*(4), 311-318. https://doi.org/10.1016/j.apnu.2019.01.006

Chair Against Stigma UCM-Grupo 5 (2020). *Good Practice Guide Against Stigma* (2nd ed.). Reproexpres Ediciones.

Chin, S. H., & Balon, R. (2006). Attitudes and perceptions toward depression and schizophrenia among residents in different medical specialties. *Academic Psychiatry: the Journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, 30*(3), 262-263. https://doi.org/10.1176/appi.ap.30.3.262

Clarke, D., Usick, R., Sanderson, A., Giles-Smith, L., & Baker, J. (2014). Emergency department staff attitudes towards mental health consumers: A literature review and thematic content analysis. *International Journal of Mental Health Nursing, 23*(3), 273-284. https://doi.org/10.1111/inm.12040

Corrigan, P. W., Mittal, D., Reaves, C. M., Haynes, T. F., Han, X., Morris, S., & Sullivan, G. (2014). Mental health stigma and primary health care decisions. *Psychiatry Research, 218*(1-2), 35-38. https://doi.org/10.1016/j.psychres.2014.04.028

Corrigan, P. W., & Shapiro, J. R. (2010). Measuring the impact of programs that challenge the public stigma of mental illness. *Clinical Psychology Review, 30*(8), 907-922. https://doi.org/10.1016/j.cpr.2010.06.004

Cova, F., Monreal, V., & Grandón, P. (2024). Estigma en el nivel secundario de atención en salud mental hacia personas con diagnóstico psiquiátrico. *Psykhe*.

Cruz-Ramírez, M. L, & Martínez C., Mayelín C. (2012). Perfeccionamiento de un instrumento para la selección de expertos en las investigaciones educativas. *Revista Electrónica de Investigación Educativa, 14*(2), 167-179.

De Villiers, M. R., De Villiers, P. J., & Kent, A. P. (2005). The Delphi technique in health sciences education research. *Medical Teacher, 27*(7), 639-643. https://doi.org/10.1080/13611260500069947

Eiroa-Orosa, F. J., Lomascolo, M., & Tosas-Fernández, A. (2021). Efficacy of an intervention to reduce stigma beliefs and attitudes among primary care and mental health professionals: Two cluster randomised-controlled trials. *International Journal of Environmental Research and Public Health, 18*(3), Article 1214. https://doi.org/10.3390/ijerph18031214

Finn, R. H. (1970). A note on estimating the reliability of categorical data. *Educational and Psychological Measurement, 30*(1), 71-76. https://doi.org/10.1177/001316447003000106

Fontesse, S., Rimez, X., & Maurage, P. (2021). Stigmatization and dehumanization perceptions towards psychiatric patients among nurses: A path-analysis approach. *Archives of Psychiatric Nursing, 35*(2), 153-161. https://doi.org/10.1016/j.apnu.2020.12.005

Fox, A. B., Earnshaw, V. A., Taverna, E. C., & Vogt, D. (2018). Conceptualizing and measuring mental illness stigma: The mental illness stigma framework and critical review of measures. *Stigma and Health, 3*(4), 348-376. https://doi.org/10.1037/sah0000104

Gaebel, W., Zäske, H., Zielasek, J., Cleveland, H. R., Samjeske, K., Stuart, H., Arboleda-Florez, J., Akiyama, T., Baumann, A. E., Gureje, O., Jorge, M. R., Kastrup, M., Suzuki, Y., Tasman, A., Fidalgo, T. M., Jarema, M., Johnson, S. B., Kola, L., Krupchanka, D., Larach, V., … Sartorius, N. (2015). Stigmatization of psychiatrists and general practitioners: results of an international survey. *European Archives of Psychiatry and Clinical Neuroscience, 265*(3), 189-197. https://doi.org/10.1007/s00406-014-0530-8

Geffner, N. I., & Agrest, M. (2021). Estudio sobre el estigma percibido y el estigma experimentado según los usuarios de servicios de salud mental en la ciudad de Buenos Aires: Su impacto en la recuperación. *Revista Iberoamericana de Psicología, 14*(2), 21-32. https://doi.org/10.33881/2027-1786.rip.14203

Geffner, N. I., Agrest, M., & Garber Epstein, P. (2021). Relato de la experiencia en Argentina de la adaptación de un programa estandarizado guiado por la recuperación en salud mental. *Revista Iberoamericana de Psicología, 14*(2), 57-68. https://doi.org/10.33881/2027-1786.rip.14206

Grandón F. P., Bustos N. C., Cova S. F., Saldivia B. S., Ramírez V. R., Vaccari J. P., Vielma A. A., & Turenne, E. (2021). Resultados del programa "Igual-Mente" de reducción de estigma en profesionales de atención primaria de salud hacia personas con diagnóstico de trastorno mental grave. *Psykhe*.

Heim, E., Henderson, C., Kohrt, B. A., Koschorke, M., Milenova, M., & Thornicroft, G. (2019). Reducing mental health-related stigma among medical and nursing students in low- and middle-income countries: A systematic review. *Epidemiology and Psychiatric Sciences, 29*, Article e28. https://doi.org/10.1017/S2045796019000167

Henderson, C., Noblett, J., Parke, H., Clement, S., Caffrey, A., Gale-Grant, O., Schulze, B., Druss, B., & Thornicroft, G. (2014). Mental health-related stigma in health care and mental health-care settings. *The Lancet Psychiatry, 1*(6), 467-482. https://doi.org/10.1016/S2215-0366(14)00023-6

Jorm, A. F. (2015). Using the Delphi expert consensus method in mental health research. *The Australian and New Zealand Journal of Psychiatry, 49*(10), 887-897. https://doi.org/10.1177/0004867415600891

Knaak, S., Mantler, E., & Szeto, A. (2017). Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions. *Healthcare Management Forum, 30*(2), 111-116. https://doi.org/10.1177/0840470416679413

Knaak, S., Modgill, G., & Patten, S. B. (2014). Key ingredients of anti-stigma programs for health care providers: A data synthesis of evaluative studies. *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie, 59*(1), 19-26. https://doi.org/10.1177/070674371405901s06

Larkings, J. S., & Brown, P. M. (2018). Do biogenetic causal beliefs reduce mental illness stigma in people with mental illness and in mental health professionals? A systematic review. *International Journal of Mental Health Nursing, 27*(3), 928-941. https://doi.org/10.1111/inm.12390

Lien, Y. Y., Lin, H. S., Lien, Y. J., Tsai, C. H., Wu, T. T., Li, H., & Tu, Y. K. (2021). Challenging mental illness stigma in healthcare professionals and students: A systematic review and network meta-analysis. *Psychology & Health, 36*(6), 669-684. https://doi.org/10.1080/08870446.2020.1828413

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27,* 363-385. http://dx.doi.org/10.1146/annurev.soc.27.1.363

Linstone, H. A., & Turoff, M. (2002). *The Delphi method: techniques and applications*. Addison-Wesley Pub. Co.

Manzanera, R., Lahera, G., Álvarez-Mon, M. Á., & Alvarez-Mon, M. (2018). Maintained effect of a training program on attitudes towards depression in family physicians. *Family Practice, 35*(1), 61-66. https://doi.org/10.1093/fampra/cmx071

Mascayano, F., Lips-Castro, W., Mena-Poblete, C., & Manchego-Soza, C. (2015). Estigma hacia los trastornos mentales: características e intervenciones. *Salud Mental, 38*(1), 53-58.

Mead, D., & Moseley, L. (2001). The use of the Delphi as a research approach. *Nurse Researcher, 8*(4), 4-23. https://doi.org/10.7748/nr2001.07.8.4.4.c6162

Nyblade, L., Stockton, M. A., Giger, K., Bond, V., Ekstrand, M. L., Lean, R. M., Mitchell, E. M. H., Nelson, R. E., Sapag, J. C., Siraprapasiri, T., Turan, J., & Wouters, E. (2019). Stigma in health facilities: Why it matters and how we can change it. *BMC Medicine, 17*(1), Article 25. https://doi.org/10.1186/s12916-019-1256-2

Pan American Health Organization (2022). *Understanding and acting against mental health stigma in health contexts*. Chair Against Stigma UCM-Grupo 5, Complutense University of Madrid.

Pettigrew, T. F., & Tropp, L. R. (2008). How does intergroup contact reduce prejudice? Meta-analytic tests of three mediators. *European Journal of Social Psychology, 38*(6), 922-934. https://doi.org/10.1002/ejsp.504

Sarikoc, G., Ozcan, C. T., & Elcin, M. (2017). The impact of using standardized patients in psychiatric cases on the levels of motivation and perceived learning of the nursing students. *Nurse Education Today, 51*, 15-22. https://doi.org/10.1016/j.nedt.2017.01.001

Solmi, M., Granziol, U., Danieli, A., Frasson, A., Meneghetti, L., Ferranti, R., Zordan, M., Salvetti, B., Conca, A., Salcuni, S., & Zaninotto, L. (2020). Predictors of stigma in a sample of mental health professionals: Network and moderator analysis on gender, years of experience, personality traits, and levels of burnout. *European Psychiatry: the Journal of the Association of European Psychiatrists, 63*(1), Article e4. https://doi.org/10.1192/j.eurpsy.2019.14

Stone, E. M., Chen, L. N., Daumit, G. L., Linden, S., & McGinty, E. E. (2019). General medical clinicians' attitudes toward people with serious mental illness: A scoping review. *The Journal of Behavioral Health Services & Research, 46*(4), 656-679. https://doi.org/10.1007/s11414-019-09652-w

Thornicroft, G., Sunkel, C., Alikhon Aliev, A., Baker, S., Brohan, E., El Chammay, R., Davies, K., Demissie, M., Duncan, J., Fekadu, W., Gronholm, P. C., Guerrero, Z., Gurung, D., Habtamu, K., Hanlon, C., Heim, E., Henderson, C., Hijazi, Z., Hoffman, C., Hosny, N., … Winkler, P. (2022). The Lancet Commission on ending stigma and discrimination in mental health. *Lancet, 400*(10361), 1438-1480. https://doi.org/10.1016/S0140-6736(22)01470-2

Zamorano, S., Sáez-Alonso, M., González-Sanguino, C., & Muñoz, M. (2023). Social stigma towards mental health problems in Spain: A systematic review. *Clínica y Salud, 34*(1), 23-34. https://doi.org/10.5093/clysa2023a5

Appendix I. Categories and items

Four open-ended questions from the first Delphi phase:

- What variables, whether personal and/or professional, do you consider to be implicated in the PRESENCE of stigma associated with mental health problems in health and social professionals? Please elaborate on your answer as much as possible.
- What variables, whether personal and/or professional, do you consider to be implicated in the DECREASE of stigma associated with mental health problems in health and social professionals? Please elaborate on your answer as much as possible.
- During the TRAINING PERIOD for health and social professionals, what intervention strategies, training, etc., could be implemented to promote equal and dignified care for people with mental health problems? Please elaborate on your answer as much as possible.
- During the PROFESSIONAL EXERCISE of health and social professionals, what intervention strategies, training, etc., could be implemented to promote equal and dignified care for people with mental health problems? Please develop your answer as much as possible.

Table A

Categories detected by content analysis

Category	Subcategory	Examples of expert verbalizations
Stigma dimensions Stigma is a dynamic social construction process that involves a set of beliefs, prejudices and discriminatory actions shared by a society towards people with mental health problems.	• Stereotypes (cognition). • Prejudice (emotion). • Discrimination (behaviors).	"First, it would be the attribution of **unpredictability/ dangerousness** to people who are diagnosed". "I consider that one of the greatest difficulties when it comes to equal (or equitable) and dignified care for people with mental health problems is **fear** in professional settings that are unfamiliar to these problems". "Avoid the tendency to **paternalism**, to **servility** (to be satisfied with the minimum), to **passivity**".
Normalization of stigma This refers to the recognition by a person or group of people of stigmatizing actions, thoughts and feelings. In this case, being aware of the existence of stigma and raising awareness.		"I think that strategies aimed at **raising awareness** could be very useful". "On the other hand, it would be necessary that, from the institutional level, the presence of mental health problems is **normalized** and this involves making them visible as another problem that affects people". "**Visibilization** and **sensitization** of the population in preventive and assistance programs in all ages and social groups".
Biologicist perspective The theoretical perspective defines a conceptual framework, on which interventions are based. In this case, approaching mental health problems from a biological point of view is stigmatizing.	• Categorical perspective (labeling).	"Offering training away from **biologicist** explanatory models (which generate greater stigma) and close to the biopsychosocial perspective". "**Labeling** of the person with mental illness or disorder, limiting the perception of other qualities of the person beyond the label".
Recovery approach The practitioner bases his or her work on recovery and the ways in which a person deals with a mental health problem by trying to restore or develop a positive sense of identity independent of this problem. Process of change through which individuals improve their health and well-being.	• Severe mental disorder. • Therapeutic pessimism. • Focus on therapeutic recovery.	"**SMD** associated with greater stigma, perception of less possibility of change, greater relapses". "It will be a problem that has no solution, of a **chronic** nature in the face of which the person can do nothing but **resign** themselves and continue with lifelong treatment". "Updated training on **recovery** from a clinical and subjective perspective of people with severe mental disorders (SMD)".
Social inclusion of people with MHPs The participation of a person or persons (devalued) in social interactions and relationships with non-devalued citizens that are culturally normative in quantity and quality. This participation takes place in valued activities, settings or contexts.	• First person. • Dignifying treatment.	"**Listening** to people suffering from mental health problems, letting their message come through, and developing **with them** strategies for social change that involve structural changes". "Inclusion of people with mental disorders in the **representative** bodies of the facilities and services".

Table A (continued)

Methodology of intervention Intervention implies a practical and procedural perspective, which means that its purpose is to carry out a series of actions in a given social environment.	• Teamwork, interdisciplinary work. • Integrative/community vision. • Supervision.	"I would add the importance of insisting on **transdisciplinary** work with regard to Mental Health in the Community (health-social)". "Compulsory **rotations** in different psychiatric units (emergency, medium/long stays), but also in social intervention resources, so that during training one would have an idea of the different needs, difficulties, capabilities that people have". "Monitoring and technical supervision of stigmatizing attitudes within the teams".
Professional education and training Studies and apprenticeships aimed at labour insertion, reinsertion and updating. Its objective is to increase and adapt the knowledge and skills of current and future professionals and includes practice. In this case, it includes training both in mental health and in stigma.	• Lack of mental health training. • Mental health training as an anti-stigma strategy. • Specific training on stigma.	"The **very poor** interdisciplinary training and even within each discipline in health and even in mental health". "**Plural and complete** training with regard to the different theories and practices in the area of Mental Health, which later each professional will deepen according to his or her criteria if he or she wishes". "To include within transversal competences: to generate a non-stigmatizing attitude in university degrees or in professional training degrees that will work in the future in health or social contexts. Include **specific training on stigma** in future health professionals".
Interpersonal contact Close relationship, which may occur within an established framework, by tradition or by mutual agreement. It involves reciprocal interaction. In this case, contact between professionals and people with mental health problems.	• Contact/professional experience. • Personal closeness. • Contact as an anti-stigma strategy.	"The **experience** is very important, which allows a closer contact with the person and the confrontation with myths and preconceived ideas". "Having **relatives or close friends** diagnosed with mental disorders can promote a different vision of mental disorders, also for professionals". "During the training, it would be essential to have **collaborative contact strategies**, with a certain level of intimacy and prolonged contact".
Professional's personal characteristics Professional's own personal characteristics that are mentioned as possible factors affecting the levels of stigma towards people with mental health problems.	• Empathy. • Burnout. • Flexibility.	"**Active and sincere listening**, opening channels of expression that allow to put the voice of people with mental health problems in the foreground, without the needs of organization/functioning of resources overshadowing these manifestations". "But also, indirectly, strategies aimed at reducing **burnout** (let us remember that a symptom of burnout is reification, dehumanization, phenomena closely related to stigma)". "According to the previous thought, more **flexible** belief systems allow that what is different is not threatening".
Personal skills Skills that are more characteristic of everyone. In this case, it is understood as strategies to fight against stigma, whether they are training strategies for the professional or strategies to improve his or her work and personal well-being.		"Training professionals in **stigma, communication** styles, **decision** making, **conflict resolution, emotional** management, setting **limits, self-care**". "Health education workshops with multidisciplinary and intersectoral teams working on content, **attitudes and skills to reduce stigma**".
Professional and/or workplace differences Differences between professionals with respect to stigma, depending on the workplace or professional category.		"In any case, among this group of professionals, a distinction should be made, since those who provide **regular care** in contexts of crisis or decompensation may tend to have more stigmatizing ideas than those professionals who care for these people in times of greater psychopathological stability". "Health or social professionals who work **more directly** with mental health problems versus health or social professionals in general". "Type of profession: for example, nursing or psychology versus emergency medicine or primary care".

Table A (continued)

Health/social system context variables Variables that are characteristic of the cultural and social environment and are inherent to the nature of individuals. Characteristics of the environment that derive from the characteristics of the health system. Characteristics of the health/social system that in some way have to do with stigma towards mental health problems.	• Precariousness. • Pathologizing health system. • Mental health legislation.	"Basically, the **quality** of employment and the reduction of **burnout**". "Basically, the **lack of resources** and strengthening of Primary Health Care in the community". "It has to do with the treatment these problems receive from the institutional environment. For example, in the hospital environment, the **segregation** of mental health services in different spaces from the rest of specialties, the place where these services are located can reinforce negative ideas towards these problems". "Structural variables: a system of care focused on **disability/pathology**". "From policies seeking the **integration** of Mental Health to Health in general". "In our chair the **Law** and the recommendations constitute a central axis". "Also, it is the physician specialized in psychiatry who bears the weight of the legal (criminal and civil) at the time of the decisions that the Mental Health Team carries out as a whole - by the mere fact of having a medical degree (**Law** of the Practice of Medicine -1967-)".
Contextual factors external to the social-health system Contextual variables that are not related to the health/social system, but which clearly affect the stigmatisation of people with MHPs.	• Media. • Social factors.	"Professionals are no strangers to the information that has traditionally been provided by **the media**, in many cases reporting in a biased way highlighting negative aspects associated with mental health problems". "Participation in **the media** during the training years to learn about real situations and prevent the rejection suffered by people with mental illness". "The fact of living in a **society that stigmatizes** these people means that, to a greater or lesser extent, health or social professionals, members of society after all, have stigmatizing ideas". "**Prolonged exposure to stereotypes** about mental health due to the work context or social environment that favor their internalization".

Note. SMD: Severe Mental Disorders; MHPs: Mental Health Problems.

Appendix II. Expert Competence Coefficient

The expertise index is obtained using the formula K = 0.5 * (kc + ka), where kc is the knowledge from 1 to 10 that the expert assigns to him/herself with respect to the subject of study multiplied by 0.1 (total value of each scale), and ka is the value resulting from adding the sources of this knowledge (professional experience and publications related to the subject of study).

Table B

Sources of argumentation to calculate ka

Sources of argumentation	Degrees of influence of the sources on their knowledge and criteria		
Professional Experience	15 or more years	Between 5 and 10 years	5 or less years
	0.5	0.4	0.25
Publications related to the object of study	Scientific	Divulgative	None
	0.5	0.4	0.25
TOTAL	1	0.8	0.5

Table C

Expert Competence Coefficient calculation

Expert	Stigma Knowledge[1]	Mental health Knowledge[2]	Experience (years)[3]	Publications[4]	Expert Competence Coefficient = 0.5 * (*kc* + *ka*)[5]
1	8	7	14	Scientific/divulgative	*Kcopm* = 0.5 * (0.8 + 1) = 0.9
2	8	8	13	Scientific/divulgative	*Kcopm* = 0.5 * (0.8 + 1) = 0.9
3	10	10	36	Scientific/divulgative	*Kcomp* = 0.5 * (1 + 1) = 1
4	8	9	30	No publications	*Kcomp* = 0.5 * (0.8 + 0.75) = 0.775
5	8	8	52	No publications	*Kcomp* = 0.5 * (0.8 + 0.75) = 0.775
6	7	9	18	Divulgative	*Kcomp* = 0.5 * (0.7 + 0.9) = 0.8
7	7	8	18	Divulgative	*Kcomp* = 0.5 * (0.7 + 0.9) = 0.8
8	7	8	21	Scientific/divulgative	*Kcomp* = 0.5 * (0.7 + 1) = 0.85
9	7	9	17	Scientific	*Kcomp* = 0.5 * (0.7 + 1) = 0.85
10	8	8	5	Scientific/divulgative	*Kcomp* = 0.5 * (0.8 + 0.75) = 0.775
11	7	7	20	Scientific	*Kcomp* = 0.5 * (0.7 + 1) = 0.85
12	7	9	17	Scientific	*Kcomp* = 0.5 * (0.7 + 1) = 0.85
13	8	9	12	Scientific	*Kcomp* = 0.5 * (0.8 * 1) = 0.9
14	8	9	20	Scientific/divulgative	*Kcomp* = 0.5 * (0.8 + 1) = 0.9
15	7	9	40	Scientific	*Kcomp* = 0.5 * (0.7 + 1) = 0.85
16	9	9	18	Scientific/divulgative	*Kcomp* = 0.5 * (0.9 + 1) = 0.95
17	8	9	10	Scientific	*Kcomp* = 0.5 * (0.8 + 0.9) = 0.85
18	8	9	7	Scientific	*Kcomp* = 0.5 * (0.8 + 0.9) = 0.85

[1] On a scale of 1 to 10, what level of knowledge would you say you have regarding the STIGMA associated with mental health problems?
[2] On a scale of 1 to 10, what level of knowledge would you say you have regarding mental health problems in general?
[3] How many years of experience do you have in the study of stigma associated with mental health and/or working in the health and/or social field? Please answer with the exact number of years.
[4] Do you have publications related to mental health-related stigma and/or work in the health or social-health field?
[5] Calculation of the Expert Competence Coefficient: *Kcopm* = 0.5 * *(kc + ka). Kc:* Coefficient of knowledge or information that the expert has about the problem. It is the value that the expert assigns himself on a scale of 1 to 10 to assess the level of knowledge he believes he has on the subject studied. The average of the answers is multiplied by 0.1 (total value of each scale); thus, the evaluation "0" indicates that the expert has no knowledge, while if it is close to 1 it indicates greater expertise. *Ka:* Argumentation coefficient. Value results from adding the degrees of influence that the subject considers that different sources of argumentation have had on the knowledge accumulated by him/her with respect to a particular subject. The range is from 1 to 10.

Appendix III. Mean differences between Spain and Argentina in all relevant variables

Table D

Results of the Mann-Whitney U Test comparing Spain and Argentine on the study variables

Variables	*Spain (Mean rank)*	*Argentine (Mean rank)*	*U*	*Z*	*p*
Empathy and communication training	11.15	10.75	50	-0.28	.78
Clinical practice monitoring and supervision	10.08	12.5	40	-0.98	.32
Recovery perspective	10.65	11.56	47.5	-0.36	.72
Discrimination training	10.31	12.13	43	-0.76	.44
Stereotype training	9.69	13.13	35	-1.37	.17
Prejudice training	10.19	12.31	41.5	-0.85	.4
Working on good practices against stigma	9.73	13.06	35.5	-1.33	.18
User involvement in therapeutic decisions	11.69	9.88	43	-0.73	.46
Multidisciplinary work	9.96	12.69	38.5	-1.08	.28
Spaces for reflection among professionals	11.42	10.31	46.5	-0.45	.65
Stigma-specific training	12.08	9.25	38	-1.17	.24
Biopsychosocial perspective	11.15	10.75	50	-0.16	.87
Working with peers or assistants	12.08	9.25	38	-1.11	.27
Rotations through care facilities	9.31	13.75	30	-1.69	.09
Meaningful direct contact	11.38	10.38	47	-0.4	.69
First-person testimonies	10.23	12.25	42	-0.84	.4
Indirect contact with users	11.12	10.81	50.5	-0.12	.92
Training in managing emotional exhaustion	10.42	11.94	44.5	-0.59	.56
Training in self-care	10.81	11.31	49.5	-0.19	.85
Segregation of mental health services	11.54	10.13	45	-0.55	.58
Explicit diagnosis	9.58	13.31	33.5	-1.41	.16