Stigma by Association in Mental Health Nursing

Final report • April 2025

Produced through a partnership involving:

See Me
End mental health discrimination

NHS SCOTLAND
NHS RESEARCH SCOTLAND

Abertay University

MENTAL HEALTH FOUNDATION

See Me is the national programme to end mental health stigma and discrimination in Scotland. Guided and supported by people with experience of mental health problems, See Me takes an intersectional whole system approach to challenging mental health stigma and discrimination. The programme aims to influence changes in attitudes, behaviours, cultures and systems so that people with experience of mental health problems are respected, valued and empowered to achieve outcomes important to them. A priority for the programme is to better understand and address the mental health stigma that is disproportionately experienced by particular groups of people in Scotland.

The Mental Health Foundation is the UK's leading charity for everyone's mental health. We are home to Mental Health Awareness Week and, with prevention at the heart of what we do, we aim to find and address the sources of mental health problems so that people and communities can thrive. Alongside its role as managing partner, the Mental Health Foundation (MHF) works in partnership with See Me to deliver its research, learning and evaluation functions. This includes the delivery of primary research, evaluation, evidence reviews and knowledge exchange to inform programme development.

The Mental Health Nurse Leads are a key strategic leadership group for Mental Health Nursing in Scotland. The Leads Group brings practical and strategic expertise and experience of mental health nursing to this project and are the sponsor of the research. NHS Scotland is committed to working closely with partners in local authorities and the third sector. This is crucial to achieving our ambitions for a healthier Scotland and to meeting the challenges of the years ahead. Read more here.

Abertay is a modern and friendly university in the heart of Dundee, Scotland, with a strong focus on teaching and preparing our graduates for the world of work. This is combined with excellence in research and knowledge exchange. Our Mental Health Nursing and Counselling researchers respond to the growing needs within society concerning challenges to mental health and wellbeing, and the provision of mental health care.

Contents

Abbreviations

CAMHS	Child and Adolescent Mental Health Services
CASS	Clinician Associative Stigma Scale
ECT	Electroconvulsive Therapy
EUPD	Emotionally Unstable Personality Disorder
MHN	Mental Health Nurse (or Nursing)
NHS	National Health Service

Figures

Tables

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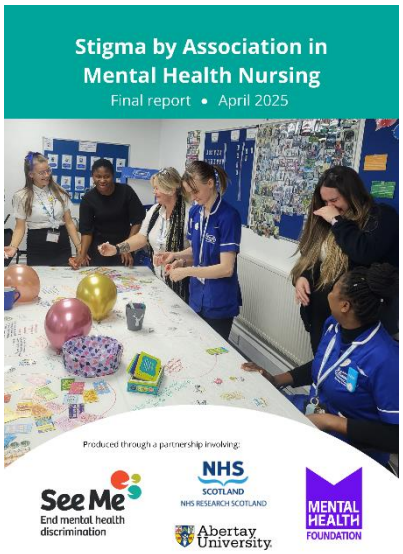

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Foreword

The Mental Health Nurse Leads Group Scotland is a key strategic group providing leadership and direction for mental health nursing. The unseen impact of stigma by association has been a significant concern for the group and we are delighted to have had the opportunity to work in partnership with See Me and the Mental Health Foundation on this research project.

The ability of mental health nurses to develop therapeutic relationships supports them to deliver holistic, person-centred care using evidence-based interventions tailored to individuals' needs, preferences, and goals to support people through their recovery. They work with people of all ages and often collaborate with other professionals and families to ensure comprehensive care. Mental health nurses have a prominent and important role in challenging stigma and discrimination and delivering human rights-based care. However, mental health nurses and student mental health nurses face stigma by association both in their day-to-day roles and wider social and family lives. This important research brings the experiences of stigma by association into focus, and we are fully supportive of the recommendations set out in the study.

We'd like to thank colleagues from See Me, the Mental Health Foundation and Abertay for their commitment to working with us, their skills, expertise, patience, kindness and compassion. It has been a hugely rewarding experience. We'd also like to thank colleagues in the Mental Health Directorate and Chief Nursing Officer Directorate in Scottish Government for their support in taking the research forward. Finally, we would like to thank all the current and former mental health nursing students and mental health nurses who completed the survey, participated in the interviews and helped shape this important work.

Keith Russell, Nurse Director and **Karen Ozden**, Nurse Director, on behalf of the **Mental Health Nurse Leads**

Stigma and discrimination surrounding mental health and mental illness continue to be an issue across Scotland. People with mental illness continue to experience stigma and discrimination that affects their ability to access and experience positive outcomes when engaging with mental health services (Scottish Mental Illness Stigma Study, 2022). The National Review of Mental Health Nursing provided an opportunity to look at the extent to which prevailing stigma and discrimination surrounding mental illness impacts on mental health nurses' experiences at a personal level, when training or working within different care environments.

This study provides strong evidence of stigma by association as experienced by student and qualified mental health nurses, highlighting the significant impact of stigma by association, the influence it has on mental health nurses' perceived value, job satisfaction and ultimately their career choices. As well as highlighting the need to do more to address public and personal perceptions of mental illness, the data shines a light on structural, cultural, and organisational factors that need to be addressed within health and mental health care services. The study also highlights differences in experience when nurses face mental health stigma alongside other forms of discrimination.

See Me looks forward to supporting action to address the challenges raised by this research.

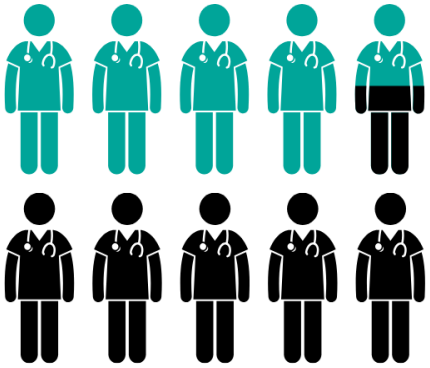
Wendy Halliday, Director of **See Me**

Executive Summary

This research study commissioned by See Me on behalf of Scottish Government and the Mental Health Nursing Leads Group contributes to addressing current challenges in the recruitment and retention of mental health nurses by investigating if (and how) stigma surrounding mental health nursing is a factor in recruitment and retention of the workforce. This research forms the first stage of a three-phase project to understand and address stigma by association in mental health nursing. The study described in this report explores the nature and scale of stigma by association within Scotland's mental health nursing workforce, the extent to which it impacts on nurses' experiences and what can be done to address it. The research study comprises a mixed-methods survey, and follow-up focus groups and interviews with people who have previously or are currently working in or studying mental health nursing in Scotland.

Key Findings

The findings reveal that mental health nurses face significant stigma, which affects their professional and personal lives. Survey results showed that participants experience a notable level of stigma, with 44% of survey respondents agreeing or strongly agreeing that they had encountered stigma at work or university.



44%

Mental health nurses have experienced stigma related to their profession at work or university

The findings of this study show that when mental health nurses reveal that they work with people with serious mental illness, they are commonly met with the reaction "I could never do that type of work". Additionally, over 73% of participants mentioned that if they told people outside of the mental health field about their work, the response would sometimes or often be expressing concerns for the nurse's safety.

9%

Mental health nurses have left a job, placement or course because of stigma by association

Survey results show that while students and practitioners experience similar levels of stigma overall, their experiences differ. Students face more stigma related to negative stereotypes about their effectiveness as professionals and about people with mental illness, whereas practitioners experience more stigma related to feeling uncomfortable disclosing their profession. Both groups report similar levels of stigma regarding concerns over mental health professionals' own wellbeing.

The report identifies several key themes:

1. **Direct Stigma Towards Mental Health Nurses and Students**: Mental health nurses and mental health nursing students frequently encounter direct stigma that undermines their skills and the validity of their profession or study. Participants in the study described regularly hearing comments that minimised

their responsibilities and questioned the legitimacy of their work. For example, mental health nursing was often perceived as easier and less valid than other forms of nursing, particularly adult nursing. This perception was reinforced by comments from other medical professionals, friends, and family members, who often joked that mental health nurses "just sit and drink cups of tea and colour in". Such remarks contribute to a sense of being undervalued and can lead to feelings of frustration and demotivation among mental health nurses and students.

2. **Stigma Towards Patients**: Stigma towards people with mental health problems also contributes to the stigma experienced by mental health nurses. Participants described encountering stigmatising comments based on the belief that mental health patients are dangerous or difficult to work with. This stigma extends more acutely to specific areas of practice, such as forensic services and addictions, where patients are perceived to be more highly stigmatised. The stigma towards patients can make it challenging for mental health nurses to build therapeutic relationships and provide compassionate, effective and timely care.
3. **Impact on Mental Health Nurses' Own Mental Health**: Mental health nurses face significant stigma when it comes to their own mental health. This stigma comes from both the public and within the profession itself, creating an environment where seeking help is often seen as a weakness rather than a necessity. Nurses reported feeling pressured to hide their mental health struggles, fearing that it would undermine their credibility and lead to judgement from colleagues and patients. This stigma can lead to increased stress, anxiety and burnout, further exacerbating the challenges faced by mental health nurses.
4. **Intersectional Stigma**: Stigma is experienced differently based on intersecting characteristics such as age, gender, race, and sexual orientation. Participants described encountering age-related stigma, with younger nurses often facing scepticism about their abilities and experience. Gender-related stigma was also prevalent, with male nurses being more frequently called upon to handle patients who are acting aggressively and female nurses feeling less valued. Additionally, participants recounted experiences of racism and homophobia, which further compounded the stigma they faced as mental health nurses. These intersecting forms of stigma can have a profound impact on the wellbeing and professional experiences of mental health nurses.

The study highlights the need for a system-wide approach to tackle mental health stigma and discrimination, emphasising the importance of understanding and addressing the stigma faced by mental health nurses to improve their wellbeing, retention, and recruitment

Introduction

Pre-Covid estimates placed the annual prevalence of mental illness at approximately one quarter of Scotland's population (Christie & Wilson, 2019). Reviews since the start of the pandemic have demonstrated the negative impact of Covid on the nation's mental health (Public Health Scotland, 2020; O' Conner et al., 2021; Mental Health Foundation Scotland, 2020). Additionally, nurses across the UK themselves have a high incidence of mental health issues; the NHS acknowledges that *"almost one quarter of sickness absence for nursing staff is due to anxiety, stress, depression, or other psychiatric illness. The level of suicidality in nurses is also estimated to be around 23% higher than the national average, with female nurses particularly affected." (NHS website).* A survey of registered nurses in 2023 by the Nursing & Midwifery Council showed that more than 50% of people leaving the profession have done so before they planned to. Reasons for leaving the profession commonly related to mental health (physical and mental health; burnout or exhaustion), and stigma and discrimination.

Alongside these growing pressures on the workforce, Scotland is facing a critical shortage of mental health nurses. The past decade has brought a sharp UK-wide fall in the number of mental health nurses and for the past three years, Scottish universities have been unable to fill places on mental health nursing courses (Royal College of Nursing, 2023; 2024). If these trends continue, this will severely impact access to and quality of care, patient safety, and treatment outcomes for people with mental illness, and negatively impact staff wellbeing and morale.

A combination of factors contributes to these recruitment and retention challenges, including working conditions, salary, emotional exhaustion and burnout (Adams et al., 2021). One of these factors is stigma by association. This term describes the stigma experienced by mental health nurses due to their association with people experiencing mental illness. International studies have identified high prevalence rates of stigma by association among mental health professionals and trainees ranging across countries from 41.5% to 100%, with impacts including job dissatisfaction, low resilience, professional burnout, unwillingness among students to specialise in mental health, and a desire among current staff to work in other sectors of health (Njaka et al., 2023). Stigmatisation of mental health professionals has also been linked to detrimental impacts on service-users, including increased self-stigma, negative attitudes towards mental health services, reduced treatment adherence and increased service withdrawal (Njaka et al., 2023).

At present, we lack sufficient evidence to understand the scale and nature of how stigma by association impacts on the mental health nursing profession in Scotland, and whether this is a barrier to entering and staying in the profession. According to a recent systematic review, high-quality peer-reviewed research into stigma by association among mental health professionals has been conducted in only nine countries (Njaka et al., 2023). No research from Scotland has yet investigated how such stigma by association impacts on mental health nurses and their career choices. More research is therefore needed to provide crucial data to develop interventions to reduce stigma by association, and contribute to improvements in workforce wellbeing, retention and recruitment, and patient outcomes. This need is reflected in Scotland's

Mental Health and Wellbeing Strategy which includes ensuring that ‘mental health and wellbeing careers are attractive… [and] all are respected, empowered, and valued for their work’’ as a workforce pillar (Scottish Government & COSLA, 2023; p.36), and calls for action to ‘‘remove… any perceived stigma associated with working in mental health and wellbeing’’ (p.38).

Aims

The primary objective of this research is to increase understanding of how stigma by association impacts on the mental health nursing workforce in Scotland. This aims to explore the nature and scale of mental health stigma and discrimination experienced by mental health nurses in Scotland, the extent to which these experiences impact on nurses, and set out key recommendations for actions which address it.

Methods

This study employed a mixed-methods approach, including a survey with scale and open-text questions, followed by focus groups and interviews with a subset of survey respondents.

Ethics

This study was granted ethical approval by the University of Abertay Research Ethics Committee (EMS8839) and was granted NHS board approval (IRAS Project ID: 340696).

Participants

The study targeted the Scottish adult population, specifically current and former mental health nurses and mental health nursing students in Scotland. Power calculations determined a target of recruiting 269 students and 380 mental health nurses to complete the survey. The study also aimed to recruit participants to take part in depth focus groups or interviews, with recruitment continuing until thematic saturation was reached.

Materials

Survey

The online survey was developed using Smart Survey, in consultation with mental health nurses and people with lived experience of mental health related stigma and discrimination. The survey included information, consent and demographics, alongside a series of routing questions related to mental health nursing role. The core of the survey comprised a series of questions relating to participants’ experiences of associated stigma and discrimination, including the Clinician Associative Stigma Survey (CASS, Yanos et al., 2017; see below), alongside wider experiences of stigma and discrimination. Participants were also provided with the

option to opt in to take part in further aspects of the study, with consent obtained for those that chose to take part[1].

The Clinician Associative Stigma Scale is an 18-item self-report measure of stigma experienced by mental health professionals as a result of their work. The CASS scale examines four key aspects of stigma by association: negative stereotypes about people with mental illness, concerns about professional effectiveness, stigma related to mental health professionals' own wellbeing, and discomfort with disclosing their role[2]. The scale poses questions as experience statements (e.g. I have heard people outside of the mental health field express the view that mental health nurses don't know what they are doing/ can't really help.) Respondents are asked to rate the frequency of experiences on a 4-point Likert scale ranging from Never (1) to Often (4), giving a possible score range of 18 – 72, with higher scores indicative of a greater level of associated stigma. The scale consists of four equally weighted subscales: 1) negative stereotypes about professional effectiveness, 2) discomfort with disclosure, 3) negative stereotypes about people with mental illness and 4) stereotypes about professionals' mental health. CASS has demonstrated good internal consistency (α=.85), and convergent and discriminant validity with a range of measures (Yanos et al., 2017). With consent from the scale authors, four copies of this survey were developed, for current and former mental health nurses and mental health nursing students.

Focus groups/interviews:

Materials included an information sheet, consent form, demographics form, interview schedule, and debrief statement which provided information on a range of organisations that can offer mental health support, in addition to contact details for the research team. The interview schedule comprised a series of open questions around mental health nursing and experiences of associated stigma. Questions were designed to explore themes arising from the survey findings in depth.

Procedure

Recruitment

Participant recruitment employed non-probability, convenience sampling. Survey participants were recruited through partners' websites and social media channels, direct communications with partners' contacts, existing networks, Scottish universities, and NHS Scotland boards. A communications and engagement pack was produced to facilitate recruitment.

Survey participants were invited to opt-in for future qualitative research phases. All those who opted in were contacted with details of the focus group/interviews and asked if they consented to take part. Those who consented were then asked to identify their preferences for when/how to take part.

[1] Contact details were collected for those who opted-in to being contacted, via a separate Smart Survey form comprising of participant information, consent, contact details (name, email, phone number), and a debrief statement.

[2] Psychometric testing on this current sample supported the validity of the CASS measure and confirmed the existence of four sub-scales, similar as in the original study Yanos et al. (2017).

Survey

The survey was launched in June 2024, and remained open until February 2025. Participants accessed it online after a 24-hour consideration period. Contact details were collected separately to maintain anonymity. The survey took an average of 13 minutes to complete.

Focus groups/interviews

Focus groups (N=2) and interviews (N=12) were run online via MS Teams (N=13) or in person (N=1), between December 2023 and January 2024. All session were facilitated by the Mental Health Foundation research team, and MHF safeguarding procedures were followed throughout. Researchers used a semi-structured interview schedule to guide the questions. With the consent of participants, all sessions were recorded. Interviews[3] lasted between 26 and 82 minutes.

Analysis

All data analysis was carried out by the research team from the Mental Health Foundation.

Quantitative Data Analysis

Incomplete survey data were removed listwise in line with withdrawal procedures. All data were cleaned in Excel, and any identifiers removed prior to analysis in SPSS.

Analyses explored descriptive aspects of the measures and differences in reported stigma based on demographic variables and wider stigma experiences, as well as differences between current and former professionals and students. The psychometric properties of CASS were also examined.

Qualitative Data Analysis

Focus group and interview recordings were transcribed and anonymised before analysis. Transcripts and open-ended survey responses were analysed separately using thematic analysis to identify common themes. To triangulate findings, one researcher analysed open-ended comments per survey participant, and the other researcher analysed comments per survey question. A sub-section of transcripts were coded by two researchers. Themes were compared across the data sources to identify commonalities and differences.

Findings

Quantitative Findings

Demographics

A total of 636 eligible responses were collected in the survey, comprising 393 practising mental health nurses (MHNs) and 223 MHN students. Among practising MHNs, the majority (79%) were employed full-time, while 21% worked part-time. The target sample for practising MHNs was fully achieved (100%), whereas the student

[3] Focus groups and interviews will be referred to as ‘interviews’ for short throughout the report

group reached 83% of the intended target. A breakdown of participant directories is presented in Table 1.

Key demographics of participants were as follows:

- Sex: 81% identified as female
- Sexual orientation: 81% identified as heterosexual, 9% as bisexual and 7% and homosexual
- Race: 97% white, with a small proportion identifying as African (2%) or belonging to other ethnic backgrounds

Religious beliefs: 66% reported having no religious affiliation, 29% identified as Christian and 5% had other religious affiliations.

Table 1: Participant Directory

NHS Health Board (MH Nurses)	#
NHS Ayrshire and Arran	23
NHS Borders	2
NHS Dumfries and Galloway	14
NHS Fife	30
NHS Forth Valley	13
NHS Grampian	40
NHS Greater Glasgow and Clyde	65
NHS Highland	26
NHS Lanarkshire	25
NHS Lothian	73
NHS Shetland	4
NHS Tayside	64
NHS Western Isles	3
Private sectors	2
Care home	1
NHS 24	4
Other	4

University (MHN Students)	#
Abertay University	57
Edinburgh Napier University	8
Glasgow Caledonian University	39
Robert Gordon University	40
University of Dundee	11
University of Stirling	26
University of the Highlands and Islands	6
University of the West of Scotland	13
Other	1
Unclear	22

In relation to health status, 25% of respondents reported having a disability and/or a long-term health condition, while 47% indicated that they had a mental health condition. Notably, the prevalence of disabilities, long-term health conditions, and mental health conditions was higher among MHN students compared to practising MHNs. A detailed summary of demographic data is presented in Table 3 (Appendix 1).

47%

of respondents reported lived experience of a mental health condition

Descriptive Statistics

Clinician Associative Stigma Scale (CASS)

The Clinician Associative Stigma Scale (CASS) was used to measure stigma experienced by mental health professionals and students. The scale includes 18 questions, with scores ranging from 18 to 72 with higher score indicating more stigma experienced. Psychometric analysis conducted during this study found CASS to be a valid measure of associated stigma for this sample (see appendix for details).

55%

of participants experienced stigma on more than half of the stigma experiences measured by the CASS

What level of stigma are MHNs experiencing?

Participants (n=466[4]) had an average CASS score of 45.7 (± 9.4[5]), significantly higher than the midpoint of 36. This is slightly higher than the level of stigma reported in the original paper outlining the measure. This indicates that many participants experienced a notable level of stigma in their profession. More than half (55%) reported facing stigma in at least half of the situations described in the questionnaire.

What do experiences of stigma look like for MHNs?

The range of scores across different stigma-related items shows how experiences varied across different aspects of stigma. The least common experience, reported by 25% of participants, was feeling reluctant to discuss their work with other mental health professionals who did not work with individuals with serious mental illness. In contrast, the most common experience, reported by over 97% of participants, was that when the participant told someone (who did not work in mental health nursing) that they were a mental health nurse, the person's reaction would be 'I could never do that job'.

97%

of respondents said that when people found out that they were working or studying to work with individuals with serious mental illness, the other person would say 'I could never do that type of work'

Table 2: Percentage of survey respondents endorsing the top 4 CASS items

Item	N	Experienced sometimes/ often
I heard people outside of the mental health field express the view that mental health nurses don't know what they are doing/ can't really help.	636	73%
When I told them about the work that I do/am intending/intended to do, people outside of the mental health field expressed concern for my safety related to my intention to work with people with serious mental illness.	635	77%
When I told them about the work that I do/am intending/was intending to do, people outside of the mental health field remarked that the work must be "scary."	633	87%
When people found out that I work/am studying/was studying to work with individuals with serious mental illness, they told me they could never do that type of work.	633	97%

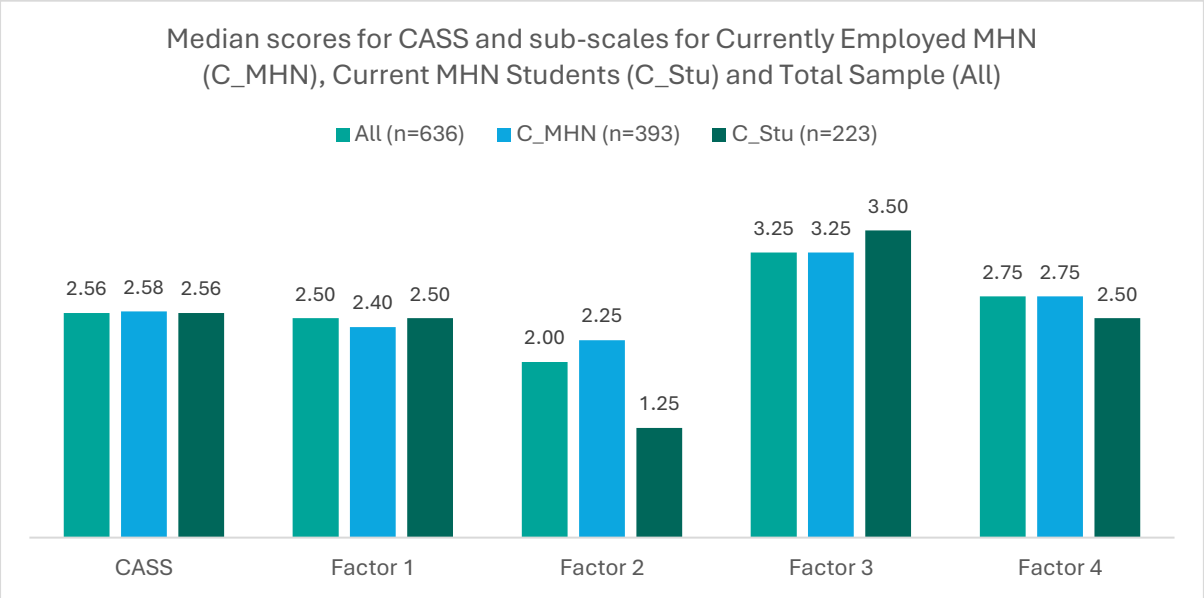
[4] When only examining the cases with no missing value, 466 cases remained.
[5] Standard Error (SE) is reported in brackets following averages

The CASS scale examines four key aspects of stigma by association: negative stereotypes about people with mental illness, concerns about professional effectiveness, stigma related to mental health professionals' own wellbeing, and discomfort with disclosing their role[6]. Across all groups, the strongest stigma aspect reported was related to negative stereotypes about people with mental illness, while the least common stigma experience was discomfort with disclosing their role as a mental health professional. These findings highlight that stigma towards people with mental illness remains the most pervasive issue among mental health professionals and students. Additionally, stigma surrounding the mental health of professionals themselves and doubts about their effectiveness continue to be prominent challenges. The relatively lower endorsement of discomfort with disclosure suggests some openness in professional identity, though this varies across groups and individuals.

87%

of respondents have experienced people telling them that their work must be 'scary'

Figure 1: Median scores for CASS and sub-scales for different nursing groups



Note. Factor 1 - Negative stereotypes about professional effectiveness, Factor 2 - Discomfort with disclosure, Factor 3 - Negative stereotypes about people with mental illness, Factor 4 - Stereotypes about professionals' mental health.

How do experiences of stigma vary for nurses and students?

Statistical testing (see Appendix 3) revealed that there were **no significant differences** in overall **stigma by association** (U = 41,029, p = .189) between the mental health nursing and student groups in this study. However, significant differences emerged in three of the four subscales. Across the four groups of participants, practising mental health nurses (MHNs) had the highest stigma scores, followed by MHN students. Those who had previously worked or studied in mental

[6] Psychometric testing on this current sample supported the validity of the CASS measure and confirmed the existence of four sub-scales, similar as in the original study Yanos et al. (2017).

health nursing had significantly lower stigma scores, though the sample size for this group was small.

While students and practitioners had similar overall stigma levels, their experiences differed. Students faced more stigma related to negative stereotypes about their effectiveness as professionals and about people with mental illness, whereas practitioners experienced more stigma related to feeling uncomfortable disclosing their profession. Both groups reported similar levels of stigma regarding concerns over mental health professionals' own wellbeing.

These findings highlight the ongoing challenges mental health nurses face due to stigma. Addressing these issues can help improve support for those in the field and reduce the negative perceptions that may impact their work and wellbeing.

How do experiences of stigma vary for other demographic groups?

Correlation and group comparison tests were conducted to examine the relationship between the CASS stigma scale and demographic variables. Results indicated some weak but significant relationships. There was a small inverse correlation between **CASS scores** and **age** ($r = -.24$, $p < .001$), such that experiences of stigma decrease with increasing age. CASS scores were significantly lower for **females than males** ($U = 23{,}412$, $p < .01$, $r = .11$), and for those experiencing **mental health conditions** ($U = 39{,}761$, $p < .05$, $r = .09$). No significant differences in **CASS scores** were found across **sexuality or religious groups[7],** or between those with and without **disabilities/long-term health conditions**. These findings align with those reported by Yanos et al. (2017). It is worth nothing that sample sizes for many of the demographics reported were too small to conduct meaningful analyses, and that where analyses were conducted, large differences in sample size (e.g. between sexual orientations) impacts the confidence level of these results.

Experience and impact of stigma

44%

agreed or strongly agreed that they had encountered stigma at work or university

A series of follow-up questions on the survey explored participants' experiences of stigma in more detail. In this section, participants reported varying experiences of stigma related to their profession as mental health nurses or students in the field. Overall, 44% of respondents agreed or strongly agreed that they had encountered stigma at work or university (Mdn = 3.0± 1.3). Across the four groups, the median scores remained largely consistent. Statistical analysis found no significant differences between groups, aligning with the results of the CASS scale, suggesting that experiences of direct stigma were relatively comparable across professional and student populations.

Perceptions of workplace culture, however, revealed greater variability. 23% of participants agreed or strongly agreed that their workplace environment was stigmatising (Mdn = 3.0±1.2). This perception was more pronounced among former MHNs and current MHN students, while those currently employed as MHNs reported

[7] No religion vs Christian – all other groups too small to conduct analyses

significantly lower levels of workplace stigma. These group differences were statistically significant[8], suggesting that students and former practitioners may be more attuned to—or affected by—systemic stigma within their workplace, compared to those actively working in the field.

Sources of stigma and discrimination

When asked about the sources of stigma and discrimination, *colleagues outside the mental health profession* emerged as the most frequently cited source, with 55% of participants reporting that they 'often' or 'sometimes' experienced stigma from this group. Amongst current MHNs, stigma was also commonly reported from *patients and their loved ones*, with 48% indicating they experienced it 'sometimes' or 'often'. Additionally, *wider acquaintances* were identified as a prominent source of stigma, with 45% of students and 44% of MHNs stating they had encountered stigma from this group at least 'sometimes'. These findings suggest that stigma by association is not confined to healthcare settings but extends into broader social interactions, affecting MHNs and students both professionally and personally.

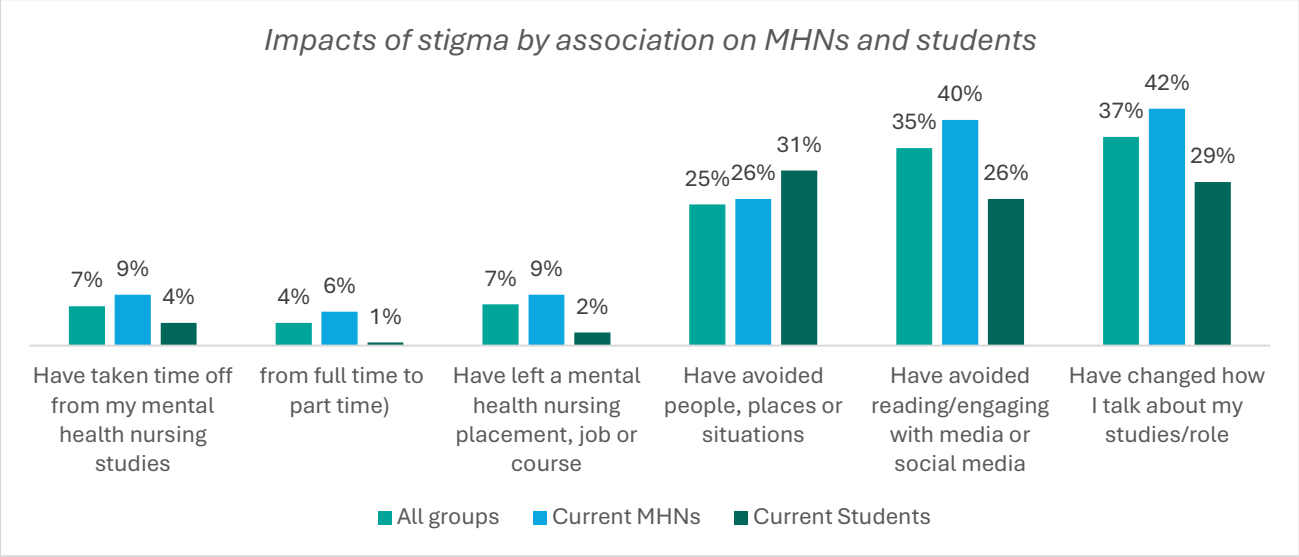
Impact of Stigma by association

Regarding the impacts of stigma and discrimination, approximately 1/3 of participants reported avoiding media, certain people and situations, as well as altering how they spoke about their jobs or studies (see Figure 1). These effects were most pronounced in the current MHN group, where over **40%** adjusted how they discussed their roles and avoided engagement with social or mainstream media. Additionally, **9%** of this group had taken time off work or left a mental health nursing job or workplace due to stigma-related experiences.

9%

of current mental health nurses have taken time off work or left a mental health nursing job or workplace as a result of stigma

Figure 2: Impacts of stigma by association on MHNs and students

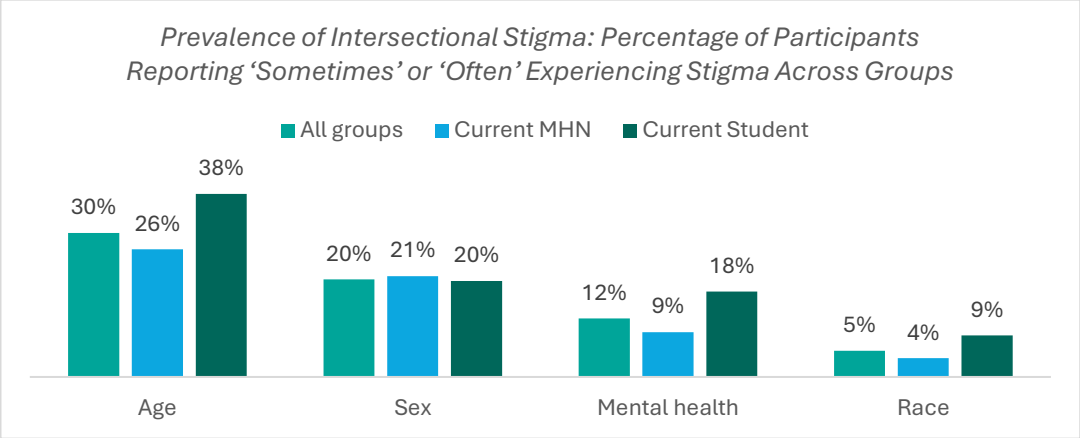


[8] see details in Appendix.

Wider stigma

Participants identified age, sex, and mental health status as the top three aspects of identity affected by intersectional stigma. Age was the most commonly reported factor, with 30% of respondents indicating they experienced age-related stigma "often" or "sometimes." Sex and mental health status followed, affecting 20% and 12% of participants, respectively. Notably, students reported higher levels of stigma related to Age, Mental Health and Race compared to those currently working in the field (see Figure 2). Additional statistical analysis also confirmed that stigma, as measured by the CASS scale, was more strongly associated with younger age, female gender, and participants with mental health problems (see Appendix for further details). However, no significant differences in CASS scores were found across sexuality groups or between those with and without disabilities/long-term health conditions. These findings align with those reported by Yanos et al. (2017).

Figure 3: Prevalence of Intersectional Stigma: Percentage of Participants Reporting 'Sometimes' or 'Often' Experiencing Stigma Across Groups



For all other aspects of identity—including religion, sexual orientation, marital status, physical disability, economic status, and pregnancy/maternity—over 90% of respondents stated they had "never" experienced intersectional stigma in relation to their role or studies as an MHN.

Impact of wider stigma

More than 20% of participants reported having avoided people, places, or situations, changed how they talk about their role or studies, or avoided engaging with media or social media due to the wider stigma associated with aspects of their identity.

Experiences of poor mental health

When asked, "*In the past 12 months, do you feel that you have concealed or hidden your own experiences with poor mental health?",* more than half of participants reported doing so 'sometimes' or 'often' across different social and professional contexts. Among current MHNs, nearly 30% reported 'often' and 21% 'sometimes' concealing their mental health struggles from wider colleagues, while the percentage was lower when considering colleagues within the mental health nursing field. The

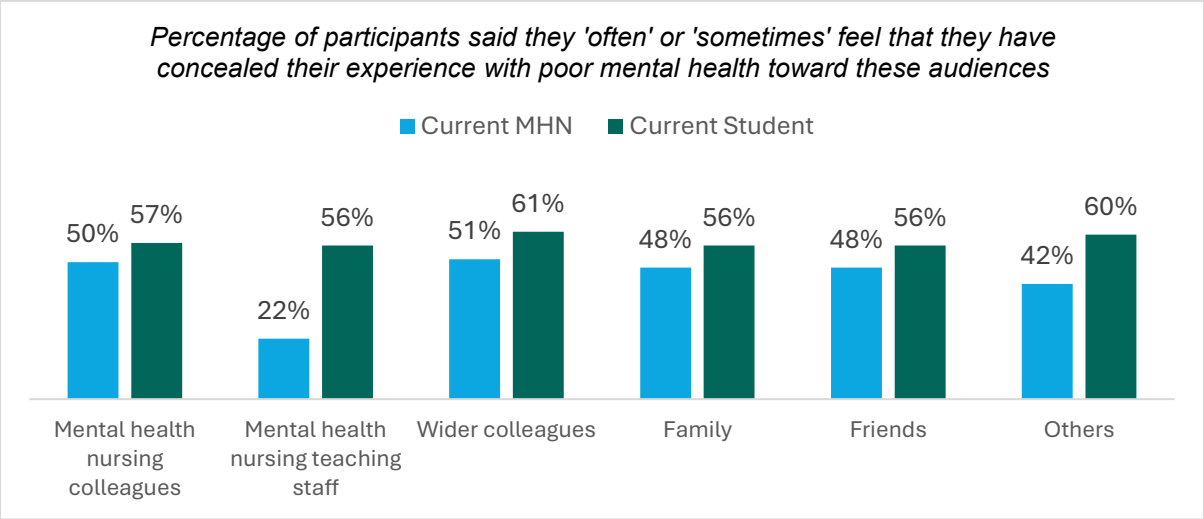
lowest reported concealment was among friends, yet still, nearly 20% of MHNs indicated they ‘often’ hid their struggles from them.

This pattern was even more evident among students, with 33% reporting they ‘often’ and 28% ‘sometimes’ concealed their mental health experiences from wider colleagues. Additionally, more than 56% reported hiding their struggles from their mental health nursing colleagues and teaching staff, as well as from friends and family. These findings suggest that both MHNs and students experience significant discomfort in disclosing mental health struggles, with students demonstrating greater reluctance across all groups (see Figure 4).

56%

of mental health nursing students reported hiding their personal mental health challenges from colleagues and teaching staff

Figure 4: Concealment of mental health experiences among MHNs and Students



Psychometric testing

Psychometric testing on this current sample supported the validity of the CASS measure. Internal consistency of the measure was good (α = .85), and CASS total scores correlated significantly with participants’ responses to the overarching question ‘I experienced stigma and/or discrimination related to mental health nursing whilst at work/on placement or at university’ (ρ=.188, p<.001), demonstrating concurrent validity of these measures of stigma by association. Exploratory factor analysis (EFA) of the CASS scale supported the four-factor structure identified by Yanos et al. (2017), accounting for 59.9% of the total variance. For full results of the psychometric testing, see Appendix 3.

Qualitative Findings

In total, 14 people participated in focus groups (n=2) or 1:1 interviews (n=12), of which nine completed a demographics survey. Respondents ranged in age from early 30s to 60, were predominantly female (n=6) and white Scottish or British (n=5). Participants also included some from black and other white backgrounds[9]. Two thirds (n=6) reported lived experience of a mental health condition, whilst one third had a disability or long-term health condition.

This section presents the qualitative findings from the interviews and open-text comments from the online survey. Several themes emerged from the transcripts and survey comments, which are explored in the following order:

- Motivations for entering the mental health nursing profession or study
- Experiences of stigma
- Stigma towards people with mental health problems which contributes to profession-associated stigma
- Sources of stigma
- Reasons for stigma
- Observed changes over time
- Intersecting characteristics and their impact on stigma
- Emotional and psychological impacts of stigma related to the profession
- Consequences of psychological impacts of stigma
- Support and coping mechanisms
- Proposed changes

Motivations for entering the Mental Health Nursing profession or study

Participants shared various motivations for pursuing a career in mental health nursing, highlighting personal connections and experiences as significant factors. The desire to help others and a sense of personal calling emerged as strong themes.

Desire to help others: Many participants expressed a profound wish to support individuals facing mental health challenges, often driven by personal experiences or witnessing struggles within their families and friends. Some described this motivation as a fundamental aspect of their character.

> "I always had that caring, compassionate heart for people, but really people's heart was what was motivating me, supporting people, and young people in particular." [Interview participant]

Personal experiences and inspiration: Several interviewees were influenced by their own mental health journeys or those of close family members, which shaped their understanding and commitment to the profession. This connection often provided a sense of purpose and healing.

> "That was part of my healing journey, I think, and seeing how mental health [sic] destroyed generation after generation within my family, and I didn't want to go down the same fate as my mum. It terrified me, so I was like, 'How can I best equip this?' I

[9] numbers not reported to maintain participant confidentiality

> think part of my trauma healing as well is to make other people feel better. I think that's where I get a lot of my self-worth." [Interview participant]

Interactions with mental health nurses or other caring professionals who supported them or family members were inspirational for some. One participant shared that their daughter had seen mental health nurses within CAMHS, and as a result the participant thought she might be suited to the profession.

Others reflected that although not considered a factor at the time, personal and familial experiences with mental health subconsciously influenced their decision to pursue a career in mental health nursing. This underscores the deep-rooted motivations that drive individuals towards this profession, often without their realisation at the time.

> "I think in retrospect I went back and made sense that I'm someone who's probably been affected - not probably, has been affected - and therefore it makes sense that I was drawn into the profession, but I didn't do that knowingly at the time." [Interview participant]

> "Only after I did my training and then other things came to pass, I found out that my mum probably had EUPD... Lots of things fell into place then after I did my training, so there was probably a subliminal thing there that put me down that path as well." [Interview participant]

These quotes also illustrate how entering the profession allowed participants to retrospectively identify and understand mental health problems within their families, that they might not have recognised before. This insight highlights the therapeutic aspect of their profession, as they come to terms with their own and their families' mental health experiences.

Financial and practical considerations: Some participants mentioned financial motivations, such as the provision of student bursaries, which made pursuing a nursing career more accessible.

> "What swung it for me was we had a bursary…So if I was going to do law…I'd accrue quite a bit of student debt. Whereas for nursing, they were going to pay me essentially, and I thought, that sounds like a good start, we'll go with that." [Interview participant]

Others described positive work experiences which led them to want to join the profession.

> "I worked as a support worker in housing support for a charity […] It was predominantly people with mental health issues. So I really quite enjoyed that kind of work. Then it was actually my boss at the time, was basically saying me, 'Oh, why don't you apply to be a nurse, and particularly in mental health, that's obviously where you quite enjoy working.'" [Interview participant]

It is also important to note that these work experiences, while initially practical, often led to a deeper understanding and appreciation of the mental health nursing profession. The sense of vocation and calling described by the participants indicates a strong alignment between their personal values and professional aspirations.

Experiences of stigma

The following section details the ways in which mental health nurses experience stigma. This has been grouped into the following areas:

- Stigma directed towards mental health nurses (MHNs)
- Stigma towards people with mental health problems that is associative to MHN
- Stigma towards people with mental health problems
- Stigma around specific areas of practice or locations in mental health nursing

Stigma towards mental health nurses:

Perception that MHN is not 'proper' nursing: A particularly strong theme within the data was the perception that mental health nursing is less valuable, 'real' or 'proper' than other nursing fields. Many participants described regularly hearing comments undermining and minimising the skills and responsibilities of mental health nurses, and in turn the legitimacy of the profession.

> "I have been told that myself and all other mental health nurses 'just sit and drink cups of tea and colour in'. I have also been told that mental health nurses are not 'proper' nurses in that we do not help save lives, it is an 'easy' yet 'boring' profession and I would be better becoming an adult (general) nurse because there are more skills to learn for treating patients." [Interview participant]

Such stigma not only comes from the public but also from friends, family and other medical professionals. Other nurses were the most frequently referenced source of such comments.

> "[From] general nurses, the sense that mental health nurses weren't real nurses, (…) I suppose I was aware of that in my training, so if you were doing both placements and you might be in a general placement, and they would talk about your mental health placement, 'Yes, but that's not really real, and you just sit around drinking tea. This is real nursing.' " [Interview participant]

Participants reported that derogatory or demeaning comments like these are commonly made in jest, or as 'banter', often using the motif of 'drinking tea' to represent laziness or incompetence. For example:

> "I think we've always been seen as the poorer or the lazier profession, if you like. I just even remember training 30 years ago, and colleagues who I trained alongside with, it was always - the mental health nurse was always the butt of the jokes. It was done in humour at the time but actually, sometimes you could tell that they actually believed that. It was like, 'Oh, you're not the real nurse. You just sit around drinking cups of tea with people all day." [Interview participant]

What may be perceived as joke by others however can significantly affect mental health nurses' self-esteem and professional identity.

Stigma related to the stereotype that MHNs all have mental health problems themselves: Respondents described encountering the stereotype that mental health nurses are likely to have mental health problems themselves to work in the profession. For example:

> “Going back to the whole, 'You must be as crazy as the patients.' That's a comment that I get every single time I bring it up [...] that you must be some sort of perverse and sick individual that wants to wallow in other people's pity and other people's sadness.” [Interview participant]

The language used in the examples given by participants perpetuates stigma around people with mental health problems which is in turn projected onto professionals who work with people who are experiencing mental health problems. Throughout the interviews and survey responses, participants drew a very clear link between mental illness stigma and stigma associated with people who work in the field of mental illness.

MHNs receiving blame for patients’ outcomes: Both in interviews and survey responses, participants described feeling high levels of blame regarding patient outcomes. This blame comes from various sources, including other healthcare professionals, patients’ relatives, the media and the public, and was particularly prevalent in relation to substance abuse and addictions. For example, one survey respondent working in addiction services mentioned that staff are stigmatised just as much as the patients and are blamed if patients are not “fixed”. Another participant expressed that addiction staff are seen as ineffective and are blamed for continued drug and alcohol use in society, which is often highlighted in the media:

> “I do not read the papers as I feel addiction staff are seen as ineffective/blamed for continued drug and alcohol use in society. Every year we make the headlines for drug deaths.” [Survey response]

Another respondent said:

> "I've been told ‘their blood will be on your hands’ if someone harmed themself or ended their life.” [Survey response]

The respondent then contrasts this blame with the treatment of cardiology teams, who the participant believes are not held to such a high level of accountability if a patient dies from a heart attack after not complying with treatment. These quotes illustrate the perceived double standards and unfair judgement and expectations placed on MHNs.

Disparities in career opportunities and pay: A small number of participants emphasised dissatisfaction about inequities in pay and career opportunities for mental health nurses in comparison to professionals in other medical fields. One survey respondent highlighted the physically and emotionally demanding nature of mental health nursing work, which is often carried in “highly socialised environments”, yet comes with “less pay and fewer opportunities for progression”. Another respondent noted a disparity in pay and responsibilities between mental health nurses and psychology professionals:

> “A band 6 nurse takes higher levels of cases, risk and complexity and line management whereas band 6 psychology take neither for the same pay.” [Survey response]

Additionally, the financial strain and related stress experienced by mental health nurses was also noted:

> “It is also hard with finances. Yes we get a bursary but it’s never enough, so working on top of studying it’s stressful. You have to balance things and it’s not easy. Nobody tells you this before you start studying.” [Survey response]

As discussed previously, the provision of bursaries was influential in students choosing to study nursing. However, this comment illustrates that whilst bursaries are helpful for students, they may still face financial challenges and balancing work on top of their studies can cause additional pressures.

Stigma around mental health nursing in specific locations: At least three interview participants, and more survey respondents, expressed views that mental health services in specific parts of Scotland were subject to higher levels of negative public opinion and stigma. These negative attitudes often originated from reports that were critical of mental health services. For example, one report into mental health services in a specific area of Scotland was frequently mentioned or alluded to by interview participants as being highly influential in shaping attitudes towards those services. This sometimes meant participants were reluctant to tell people about which hospital they worked in, for fear of judgement.

> “I would say, 'Oh, I'm in mental health,' but I wouldn't say, 'I work in [hospital],' to somebody I didn't know, because it's seen very negatively.” [Interview participant]

Participants were aware of the negative public opinions that centred around mental health services in specific places, and the impact this had on their own views towards the place.

For some, the negative attention and reports put them off working in that place. Others (if they worked somewhere which was subject to negative reports) felt that the negative attention could unfairly detract from the examples of good practice.

> "Some times the physical workplace within mental health are stigmatised as a result of negative press or reports. If you say you work in a certain hospital it can be associated with previous negative reports and others at time fail to see past 1 report. It can be difficult to showcase and share all the excellent work that happens." [Survey response]

It was clear that the stigma attached to the mental health services in specific locations had a potentially demoralising impact on staff, feeling that a lot of the positive work was overlooked.

Stigma towards people with mental health problems which contributes to profession-associated stigma

Mental health nursing perceived to be a ‘dangerous’ or ‘scary’ job: Participants in the study reported encountering negative comments and fears from others regarding the perceived dangers of their profession, reflecting the broader societal misconception that individuals with mental health issues are more dangerous than the general population.

> "People have told me they could never do my job. People have said I am brave to do this. I have had many comments about my work being scary and having to protect

> myself. I have heard many people call the service users I work with mental or mad." [Survey response]

As in the quantitative responses, this manifestation of stigma associated with the profession was strongly emphasised throughout the qualitative data. Participants recollections strongly highlight the inherent link between publicly held attitudes and beliefs about mental illness, and the stigma experienced by professionals who work with people experiencing mental health problems.

Role strain due to task-shifting from non-mental health staff: Participants reported observing general nurses avoiding dealing with patients who had mental health issues by automatically passing responsibility onto the mental health nurses or students, regardless of whether it was appropriate or fair.

> “In my adult placement (…) Any time a patient was in that had mental health issues or were aggressive during the handover nurses would say ‘that patient is yours then’ and laugh.” [Survey response]

Resultingly, respondents expressed feeling a subconscious pressure to take on any patients with mental health problems. This reflects role strain, where the expectations of their position become stressful or overwhelming due to the way others shift responsibility onto them. The uncertainty about whether to take it as a compliment or an unfair burden also suggests emotional labour, as they must navigate the emotional weight of this dynamic.

> "I was like, 'Am I being a scapegoat here?’ Is it like, 'I don't want to have to deal with this patient?' I kind of feel, whenever I do mention I'm a mental health nurse, it's immediately like, 'These are your patients,' almost. [...] I don't know whether to take it as a compliment or they're just not wanting… [...] Then it's tiring on me." [Interview participant]

Stigma around specific areas of practice or locations within mental health nursing

Therapeutic interventions: The practice of safe-holding, or restraint, within mental health nursing was perceived to be a practice which was met with significant controversy and conflicting feelings. Participants described feeling ashamed that people might think they would regularly restrain or even assault patients. One participant shared:

> "I remember feeling really ashamed that she (my gran) would think that I would do stuff like that (restrain and assault patients), but I also understand how she would come to that conclusion." [Interview participant]

Participants also reflected on the conflicts these practices could bring to their profession and the relationships they had with patients, presenting ethical dilemmas which require nurses to balance patient autonomy with patient safety. One participant emphasised the importance of discussing incidents with patients afterward to reduce stigma:

> "Restraint is a big one, or safe-holding, apologies. It's so difficult. As a professional, that's hard because you're like, this isn't why I got into nursing. I got into nursing because I care, not because I want to hold people. You understand the reason why you're doing it, but for the patient as well, I'm a very big advocate of discuss what's

> happened with the patient afterwards. Do a debrief. Go, 'Do you want to talk about what happened, so we can both discuss this?' Particularly, if you've had to use safe-holding, its really good practice to try and reduce that stigma, that I'm not here to hurt you or make you feel scared, or restrict thing from you; I'm actually here because I care." [Interview participant]

Trust and communication between nurses and patients were felt to be crucial in mitigating the negative effects of restraint. Participants also described the ways in which staff culture in clinical settings could influence the use of physical restraint, and how this could make some staff feel uncomfortable and isolated. One participant noted:

> "There was an attitude in the area where I worked that physical restraint was used to control patients. I didn't think that, and I never said that, and I didn't use language that was used by others, so I was frequently isolated in the ward area, not by everybody, but by a specific group of people, who culturally controlled what the ward felt like." [Interview participant]

Specialties and diagnoses which are more acutely stigmatised: Participants reported encountering stigma which was more frequent or intense in a few specific areas of practice within mental health nursing. These included:

- Child and Adolescent Mental Health Services (CAMHS)
- Older adults
- Forensic services
- Acute wards
- Addictions

Participants described how stigma clusters around specific areas of practice. This stigma could be directed towards nurses themselves, or it could be directed towards patients which indirectly impacts nurses.

> "I worked in forensic services for a long time, and there was so much stigma on the offending behaviour as well as the mental health issue (…) I worked in a medium secure unit, and it was very difficult to try and get that therapeutic relationship started, because you were restricting so many freedoms for your patients because of legislation, because of their detention, because of the risk that that patient posed to keep them and others safe. That was quite stigmatising, where you're trying to build a relationship to help treat and promote recovery." [Interview participant]

Many of the areas of practice which were seen to carry higher levels of stigma were extensively linked to groups of patients with diagnoses which attracted more intense levels of stigma. Participants frequently mentioned patients with personality disorders (particularly EUPD), addictions and dementia. Patients with repeat admissions for self-harm or suicide attempts were also perceived as being more stigmatised across a variety of clinical settings. A particular narrative came across that patients with personality disorders are frequently characterised by medical professionals, including mental health nurses, as being particularly challenging to work with, 'manipulative' and attention seeking.

> "I have worked in a variety of placement areas. In many of them, when service users have been demonstrating challenging behaviour, particularly in areas supporting those with dementia, often staff have said "these patients know what they are doing," or "this is behavioural.". I have also been in areas that have supported a large number of people with EUPD. A lot of the attitudes from staff I have encountered are that this patient group is manipulative, attention seeking and ultimately many nurses do not like supporting this group." [Survey response]

One survey respondent expressed a view this stigma means that patients can be overlooked and assumed to have certain conditions without a proper assessment. This impacts both the patient, as they may receive a lower standard of care due to stigma, as well as the nurse who may be belittled for showing a higher level of belief in how the patient is presenting:

> "There is a strong hierarchy and culture to discredit patients struggling and assume they have personality disorders and/or using substances. This has frequently been used as a reason not to assess them and I've found crisis teams will make you, as the referring nurse, feel like a naive and inexperienced nurse that ‘falls’ for the patients [sic] presentation." [Survey response]

Participants also mentioned the effect that the stigma around EUPD can personally have on them, with one participant mentioning that the negative language they overheard from others around the diagnosis made it harder for them to be themselves.

> "There is a lot of stigma around EUPD and it’s a diagnosis I have. It can sometimes be hard to open up to people when you hear the way they talk about others with the same condition." [Survey response]

This demonstrates a cyclical and complex link between stigma towards people with mental health problems and stigma by association experienced by MHNs. The negative attitudes and beliefs about mental health issues also affect the way the mental health nurses are perceived. Negative comments about people with specific mental health diagnoses can be internalised by mental health professionals. It was clear from the survey and interviews that this can also have an impact on the way mental health patients are treated by medical professionals. Patients (particularly those with the most stigmatised conditions) are less likely to be treated with the appropriate levels of respect and dignity by professionals in clinical settings, and unfortunately will encounter stigma and discrimination in settings which are designed to support and treat them. Increased stigma towards patients is often linked to staff feeling unsupported or burned out, which exacerbates negative attitudes and treatment approaches towards challenging patient groups. Furthermore, it has negative impacts on staff as they may feel unable to be discuss their own experiences and diagnoses at work.

Derogatory attitudes towards patients accessing services: In addition to stigma attached to patients with specific conditions, participants identified more generalised negative attitudes towards patients accessing services and/or people with mental health problems. One frequent example related to patients with frequent admissions being name-called ‘frequent flyers’ or ‘career patients’ by professionals. Such

behaviour was often reported to be displayed by professionals both within and outwith the mental health field. For example:

> "I have found and seen there is a lot of discrimination that remains within healthcare and this profession in particular. For example, dismissing patients as attention seeking or functional or behavioural." [Survey response]

> "The language used by non mental health professionals about the patient who is distressed in almost always negative i.e. ‘they're attention seeking’ ‘they're at it’, ‘they're drug seeking;, ‘they're crazy, I don't know how you do it’, ‘they're selfish’." [Survey response]

Sources of stigma

Throughout the qualitative data, various sources of stigma related to the mental health nursing profession were identified. Participants had told us who or where stigmatising comments towards mental health nurses often came from.

Stigma from general nurses towards mental health nursing: Stigmatising comments and attitudes from general nurses or nurses working in specialities other than mental health were heavily emphasised as a source of stigma throughout the interviews and survey. This was described by seven interview participants and touched on very frequently in the survey comments.

These types of attitudes were encountered by MHNs from the start of their mental health nursing career, often beginning within nursing studies. Mental health nursing student participants detailed encountering stigma from general nurses or general nursing students, and current mental health nurses frequently recalled having encountered stigma from these groups when they were students on placements with general nurses.

Student mental health nurses described encountering stigma when on placements, particularly within general adult settings. Student mental health nurses described hearing remarks made by adult nurses about not knowing what skills they could teach to mental health nursing students on placement. This reflects a perception amongst general adult nurses that mental health nursing students may not have relevant skills to learn in general settings. For example:

> [Describing a reaction from an adult nurse on placement] “Oh what are we going to actually teach her, I mean, she’s a mental health nurse, what is she going to learn here?” [Interview participant]

These comments often featured the previously described stereotypes and misconceptions about mental health nursing, such as not being ‘real’ nursing, or just sitting about drinking tea.

> “When I first stated my intention to train [sic] in mental health, the general nurses laughed that it wasn't real nursing and I'd be drinking coffee all day.” [Survey response]

Participants also described being encouraged by general nurses to switch from mental health nursing to adult nursing, again serving to de-value the profession:

> “Adult nursing professionals tend to make comments about my forthcoming mental health profession. I have been told on various occasions that I am ‘wasting my time’ studying mental health nursing and that I would benefit from changing my field of nursing to adult because it would be more stimulating and that there are more jobs in adult nursing than mental health.” [Survey response]

One participant described the subtle ways in which mental health nurses feel looked down upon by their general nursing counterparts on joint courses.

> "I think definitely from other students, they believe that whenever we are having like combined courses, it's like, these guys, they don't know anything, so it feels like there's that kind of segregation. Even when you're in a class together, like when you are doing a combined unit, it's as if everybody don't want to sit together. You can see from their reaction, their body language that it's like you are not up to our standard. I think with my conversations with colleagues that are already qualified, I believe they also testify to that. Even at work as well, it'll be like, 'Oh, you don't know what you are doing.'" [Interview participant]

Current mental health nurses also described encountering stigma when working with general nurses in ways that de-legitimise the skills mental health nurses have.

> “General nurses have been quite dismissive of my work or role. Occasionally, as I work with patients with dementia I have heard comments about how I am not as skilled as 'proper' nurses." [Survey response]

It can be noted that there were more examples of stigma from general nurses happening towards mental health nursing students rather than qualified mental health nurses. It is unclear whether this is due to qualified mental health nurses having fewer interactions with general nurses, or whether general adult nurses would feel less emboldened to make such comments to qualified MHN, or for other reasons.

Stigma from other groups

Nurses’ friends and families: Participants described receiving comments from friends and family that would stigmatise the role,

> “I've had friends and family experience saying, 'Oh, I don't know how you could work in mental health. Oh, I don't know how you could do that.' Being quite derogatory towards patients that maybe access the services and things like that.” [Interview participant]

Many participants reported receiving comments from friends and family that stigmatise their role, such as expressing disbelief at the difficulties they encounter or suggesting that their job is dangerous and scary. For example, one nurse shared that their friends who work in other industries cannot comprehend the work done by mental health nurses and often react with shock and disbelief:

> "I give an example of a situation to one of my friends back home who works nine to five in a bank, is earning three times as much money, and I'm telling them about a real life issue that they can't comprehend, and then they're like, 'Oh my God, how do you even deal with that?' whereas to me, that's a standard day. It might be a relatively easy day, but it's as if I have this person lives in my hands." [Interview participant]

Another nurse mentioned that their family sees their job as incredibly dangerous and has even advised them to find a different profession.

> "Outwith my working environment, I feel my family and friends see me as doing an incredibly dangerous and scary job where it could not be further from the truth. I have been told by my family to find a different profession." [Survey response]

These comments reflect a broader societal fear and misunderstanding of mental illness, which in turn stigmatises professionals who work with people experiencing mental health problems.

The impact of these stigmatising comments is multifaceted. They contribute to the devaluation of the mental health nursing profession, making nurses feel undervalued and demotivated. When friends and family express derogatory views about the profession, it could have the potential to lead to feelings of isolation and a lack of support from their social circles. Comments like these also reinforce negative stereotypes about mental health nursing, such as the belief that it is a dangerous job or that mental health patients are inherently more dangerous than the general population. This perpetuates the stigma associated with the profession and contributes to the emotional and mental strain experienced by mental health nurses.

Stigma from patients towards MHN: A small number of participants described relationships with patients that could stigmatise the mental health nurse. For example, one interview participant mentioned that patients would sometimes tell them that they were 'doing nothing' and that their job was 'very easy'.

Other participants described feeling blamed by patients:

> "You can build great relationships with service users, but you can also feel that they really dislike you, and they don't think you're doing a good job, and they blame you for lots of things." [Interview participant]

The same participant explained that the hierarchical structure within healthcare could lead to patients perceiving mental health nurses as less competent or less important compared to doctors and psychologists. This perception is reflected in comments such as:

> "There can be that sense that you're just a nurse. I need to see a doctor. I need to see a psychologist. So there's that hierarchical bit, which I think can be quite stigmatising." [Interview participant].

Such remarks indicate that patients may internalise the hierarchical dynamics of the healthcare system, which was perceived to place doctors or psychologists higher than mental health nurses. This hierarchical mindset can contribute to the devaluation of the mental health nursing profession. When patients express a preference for seeing a doctor or psychologist over a nurse, it reinforces the notion that mental health nurses are less capable or less valuable.

Stigma from other professionals: Participants frequently described encountering stigma from other professionals, such as police officers, social work and other medical professionals.

This was reported by participants to be in the form of criticising the service provided or clinical decisions. For example:

> "Other services i.e. social work, education have openly criticised [the] service provided. This often can be in context of clinical risk i.e. where risk is high, view that patient needs more support i.e. medication, hospitalised." [Survey response]

Participants also noted that police and other emergency responders could be stigmatising towards individuals experiencing distress, and that these stigmatising attitudes could also be echoed by mental health nurses.

> "So we work very closely with the police, and the police are at their wits' end with mental health, putting it lightly because the amount of calls they get from frequent flyers. I know that's politically incorrect, so forgive me. It's just a good way of describing a certain demographic that are well known to the system, but they get loads of call-outs for certain individuals across [location], and then they'll ring us and some of the comments they make and some of the comments we give back are again, are what's going on." [Interview participant]

Sources of stigma towards mental health patients

Participants spoke about where the stigma towards the mental health patients they're interacting with often comes from.

Stigma from mental health nurses towards patients: Several participants recounted examples of witnessing stigmatising attitudes and behaviours towards mental health patients from mental health nurses. Survey respondents frequently mentioned that they had observed inappropriate language being used to describe patients with personality disorders and patients who had repeated contact with mental health services.

> "Some mental health staff's attitudes towards patients can be surprisingly stigmatising and they can be less keen to engage with the patient. Particularly towards those that use substances and those with personality disorders." [Survey response]

One participant spoke of the staff culture in a mental health ward they had once worked which could be highly stigmatising towards patients. They recalled a particularly concerning example of this, where a patient was assaulted by a mental health nurse, and whilst they were investigated and dismissed from their role, they were still able to continue practicing as a mental health nurse.

> "So, one male nurse in particular assaulted a patient, and it was reported to the police. The police didn't uphold any criminal charges, but nonetheless it was reported, and he was subsequently investigated and fired from [location]. He wasn't struck off, so he's still a registered nurse, and that gives me the fear thinking that he's out there being a registered mental health nurse somewhere looking after people." [Interview participant]

Participants described the ways in which they felt medical professionals from outwith mental health could dismiss patients who were potentially experiencing mental health problems.

> "I remember on the general ward, there was a girl in there and she kept coming back because she kept on feeling like she had issues. They had her written off. Oh, she's back again. I thought, has any of you actually sat down and talked to her and found out what's actually happening? But they don't have time for that. They just want to medicate and get them out. If you're not physically, if you don't have a broken arm, or a broken liver, or whatever, needing something specific, then let's get you out." [Interview participant]

Survey comments also detail examples of other medical professionals using derogatory language to describe patients with mental health problems, calling them 'attention seeking'.

Reasons for stigma

Lack of understanding of mental health nursing role

Participants identified a significant lack of understanding about the role of mental health nurses as a key driver of stigma. This misunderstanding often leads to misconceptions and undervaluation of their work. One participant noted:

> "I think the greatest stigma around being a mental health nurse is people not really understanding the role." [Interview participant]

Additionally, participants highlighted that the public often perceives mental health nurses as merely sitting with patients and offering them tea, without recognising the complexity and depth of their responsibilities. One participant shared:

> "I think just maybe a lack of understanding of what a mental health nurse does. I think a lot of the time, people say, 'Oh, you're just sitting with a cup of tea with a patient. You're not actually doing much for them, or you're just basically giving them medication.' They don't see the background of things that are actually happening, like what's involved in the job." [Interview participant]

Lack of exposure from adult nurses in mental health nursing work

Across many different interviews, it was felt that a contributing factor to stigma was that other nurses had little opportunity to work or do placements within mental health settings, so were unable to gain a sufficient understanding of the role and the experiences of supporting mental health patients.

> "I think because adult nurses don't really venture into mental health units very often they'll never really get an understanding of what that role entails, unlike mental health nurses who'll usually be in A&E, or they'll be down at physiotherapy, or they'll be dealing with their patients going for a CT scan, etc, like that. I think there's not that crossover from both aspects. I think that may be something to do with it." [Interview participant]

Broader stigma related to mental health as a cause of profession-associated stigma

Across the qualitative data, participants believed broader societal attitudes and beliefs around mental health and illness to be a significant driver of stigma related to the profession. Participants shared that a historic and continued lack of visibility around mental illness contributed to a lack of understanding around mental health, and subsequently the mental health nursing role.

> “I also feel like another reason of that is because mental health was hidden for so long, and that doesn't help. That stigma is not just for the student nurses, or the nurses; it's also for the people suffering from mental health. If you are constantly being hidden behind a door, no one is going to really know what you are about.” [Survey response]

Across the interviews, people voiced the opinion that pervasive stigma surrounding mental illness within society, and a continuing view that physical health is more important than mental health, contributes to people’s opinions of mental health nursing.

> "I think there's been a really harmful message about people not being allowed to be mentally unwell because it's seen as weak, and I think the same is true in the profession as well. " [Interview participant]

Workplace culture and burnout

Many participants spoke of workplace cultures within mental health nursing which reinforced stigma.

> "I just feel the culture itself, if I could say what is causing the stigma, it's the culture and it's the culture within, it's not the public, it's the nurses themselves. It's not the patients, it's the staff." [Interview participant]

Participants touched on a feeling that higher levels of stigma towards patients can occur when staff feel unsupported or burned out.

> "A lot of what could be seen as discrimination and stigma towards patients from staff, particularly people with personality disorders. Staff are like, 'I can't deal with them. They drive me mental. I cannot deal with that patient.' It is known to be difficult for us to manage them. However, the staff are not supported enough to be able to deal with them, and then what happens is the staff member becomes burned out." [Interview participant]

Participants touched on a sense that there was a generational difference in nursing practice and culture, and talked about an ‘old school’ nursing style which was seen to be less compassionate towards patients. This culture could be dominant in certain wards or units, which could contribute to stigma towards patients.

> “It would be quite blunt with that older school way of dealing with things where it's tough love, which I think was quite prominent back then. I think, to stereotype the career, I think a lot of it was medicated but authoritarian. Yes, just blunt, cold, for the greater good, but not really as compassionate as modern times and not as person centred.” [Interview participant]]

Within the workplace, participants recognised that stigma and discrimination can be exacerbated by high levels of workplace stress and burnout, particularly in the years after the Covid-19 pandemic, which presented acute pressures on staff.

> "Compassion fatigue, post-Covid recovery, constraints in budget, short staffing, unmanageable expectations, unrealistic workload. I think it's burnout and compassion fatigue. As students, we're trying to go in and combat that, and we're trying to be that fresh face. It's demoralising facing that culture sometimes, and it's hard to stay resilient and positive." [Interview participant]]

It was noticed that this burnout could lead to a negative cycle of poor staff culture which in turn led to reduced quality of care for patients and poorer health outcomes.

> “The environment and staff mentality (compassion fatigue, organisational trauma, sanctuary trauma) all contribute to hostile environments and escalation and exacerbation of symptoms. [sic]” [Survey response]

Staff experiencing compassion fatigue or burnout were seen as more like to exhibit stigmatising attitudes and discriminatory behaviour towards mental health patients. Participants believed that not enough support was available for staff to prevent this negative cycle from occurring.

> "The burnout is real, and burnout itself is not managed, and I suppose that's relevant. So a lot of what could be seen as discrimination and stigma towards patients from staff...the staff are not supported enough to be able to deal with them, and then what happens is the staff member becomes burned out." [Interview participant]

Media driving negative attitudes to related to MHN and mental health patients

Participants frequently mentioned the role of the media in driving negative attitudes towards mental health nursing.

Media depictions were considered by some participants to contribute to false stereotypes around mental health nurses as just sitting about all day.

> “It comes down to people's perceptions, people's views of what they see in the media. As I mentioned, documentaries, newspaper articles. People will see that as, you do nothing, there's nothing you can do to help. You just all sit about and drink cups of tea all day. That's one I've heard a few times.” [Interview participant]

Participants drew on old-fashioned misconceptions about what the role involves, often driven by inaccurate depictions in the media.

> "I think mental health nursing is not understood to be what it is. I think a lot of people think we still have straitjackets, that you can tie people up and contain them, and we don't. TV shows that people get injected and they fall asleep instantly like propofol. No, it doesn't. That doesn't happen.” [Interview participant]

Other participants explained how before they began working in mental health nursing, they had been influenced by media portrayals of individuals with mental illness, portraying them as scary or dangerous. However, the participant explained that the misconception was dispelled once they actually started working with individuals who had schizophrenia, proving the effectiveness of social contact in reducing stigma.

> “Before I started doing support work, I was a wee bit scared to work with people with mental health issues, but then particularly people with schizophrenia and stuff. Again, the media portrays them as running about quite manically and things like that. I thought that's what people with schizophrenia was like, and then when I started working with people like that, I was just like, actually they're just like me and you. They aren't like they are on the TV or in films, it's not like that at all.” [Interview participant]

Media representations of specific treatments were also considered to contribute to the stigma surrounding certain therapies, such as Electroconvulsive Therapy.

> “As an ECT Nurse people are shocked that ECT is still done or state how ‘barbaric’ it is... One Flew Over The Cuckoo’s Nest is still frequently quoted despite the film being 50+ years old!” [Survey response]

The controversy around ECT was felt to be driven by inaccurate or exaggerated media depictions.

Observed changes over time

Changes in stigma and culture: Interview and focus group participants were asked how they perceived stigma and discrimination to have changed over time. Overall, participants tended to agree that attitudes were improving slowly, but that there was more work to be done.

> “It's definitely shifted. I think it's definitely shifted. We are moving in the right direction, but I do think that we still do have a long way to go.” [Interview participant]

Where participants were able to give examples of positive changes that they had observed, these were largely focused on localised changes, such as a change in staffing.

> “Things had already started to change on the ward that I had worked in positively. People's language was changing. We were starting to speak about trauma a lot on the wards, so people's approaches were changing. The use of restraint was becoming less and, like I said before, these men had left, either quit, fired, struck off, whatever, through various means, they had left.” [Interview participant]

Or personal changes, such as a shift in location or change in role.

> “There is that more larger awareness of mental health as a whole, and because nursing roles are changed [sic]. I'm in a very privileged position where I'm an advanced nurse practitioner, so my role's changed significantly over the past few years.” [Interview participant]

Covid was also identified as playing a positive role in changing stigma directed towards the profession, by bringing people together over a shared purpose and a sense of ‘we’re all in it together’.

> "I do think, over Covid again, I saw that definitely relationships between nursing profession - parts of the family became better because we were all in the same position. It didn't matter whether you were working in a Covid ICU, if you were working in psychiatry, if you were working in a medical unit. We were all in the same position of we were out working, we weren't with our families, we weren't in lockdown. We were continuing to go about our day-to-day job as if things didn't change, because it really didn't in a sense." [Interview participant]

Some participants didn’t feel that they had perceived any significant changes in stigma, and those who did share examples of small positive changes often followed them up with examples of where stigma did still exist. For example, the same person who spoke of positive changes during Covid, spoke of how stigmatising language was still the norm.

> “Some of the language used to describe our profession, and also our patient group. We continue to see that now. That's not something that has changed drastically in the past few years. It does continue. It's on a smaller scale, but it does still happen.” [Interview participant]

Many participants spoke of a culture of stigma within particular workplaces, and how these could be perpetuated by a small number of individuals.

> “On the topic of culture, she was running a community team. She was a team leader, and if that's what your manager's like, that obviously comes down through the chain. If that's their perception of mental illness, although it's changed and it's evolved, if that's how your manager is speaking, that obviously runs down, that people think that's acceptable and professional of someone.” [Interview participant]

Intersecting characteristics and their impact on stigma

Stigma is experienced differently according to the different intersecting characteristics that a person may hold, and this was particularly apparent within the research. Gender, age, race and ethnicity, sexual orientation, disability and pregnancy were all mentioned as playing a role in the types of stigma that were experienced by mental health nurses and students.

Age-related stigma and discrimination: Participants frequently described receiving comments which displayed scepticism over their ability and experience if they were a younger member of staff or student. Often, nurses felt that their role was undermined by patients who felt that they were too young to have acquired adequate skills and experience to support them:

> “I am a young female working in MH nursing and have had patients/relatives/staff make comments that I am too young to be able to do my job despite being just as capable as older staff (albeit I may have less experience) and not taken me as seriously because of my looks.” [Survey response]

> (Describing a nurse to another young MHN student) “'Oh, you would've been better going waiting tables before you came and did nursing. You would have had a lot more experience before you came here.' It was very derogatory, and it really upset her. She's probably in her 20s. She said they were horrible to her on that ward.." [Interview participant]

Whilst some participants felt they could understand why people might doubt their experiences if they were younger, the impact of having their skills and experience questioned because of their age was felt to be upsetting.

Gender-related stigma discrimination: Participants described different experiences of gender or sex-related stigma or discrimination within mental health nursing. Male participants described being more frequently expected or called upon to resolve situations where patients had become aggressive or violent, especially if they were the only male nurse on shift. This was felt by some participants to place an unfair burden on male nurses.

> “Being only male on shift and expected to deal with aggressive patients.” [Survey response]

Female participants also commented on this expectation, and how it contributed to them feeling less valuable.

> "If a situation had escalated and a patient was aggressive, you'd be calling for help, people would call for men, and that was the call that went out, it was men, so it made me feel less than and that I wasn't valued because I'm a woman." [Interview participant]

One male interview participant gave an anecdote of a distressing situation in a previous student placement in which their placement supervisor found their personal journal and read it with two other nurses, who then mocked him for the content of the journal. The nurse felt that the lack of respect and mockery he faced had been tied to his gender and the idea that it was unusual for young men to keep a reflective journal.

> "It was absolutely mortifying as you can imagine […] it was an invasion of privacy, among many other things, and I think part of it was the fact that I was male, and I was in first year, I was a student nurse, and I was essentially keeping a diary." [Interview participant]

Female nurses also described encountering sexism and misogyny in mental health nursing. For example:

> "When I was employed to that area, I was told that I was employed because I was a woman, and these were my male colleagues that told me that, which wasn't the case at all, but that's the narrative that they had. It was very misogynistic, the culture that I worked in [...] They would frequently undermine you. So, if you were the nurse in charge and were making clinical decisions, it wouldn't be unusual for the healthcare support workers to say, 'We'll wait until such-and-such comes on shift,' which is a man." [Interview participant]

> "I found the culture inherently misogynistic. I was struck by the higher than normal gender ratios (favouring men) in [location redacted] inpatient MH nurses (having worked in [location redacted] previously). Often, and frequently (daily), it was reinforced that 'two males' should be on duty at all times, regardless of skill/experience. This was perpetuated by colleagues at all levels, inclusive of healthcare support workers and registrants, up to and including senior nurses/managers. Agency staff were frequently sanctioned to meet these gender needs. When I asked what literature supported this, there was never an answer. When I started working in a [location redacted] hospital, I was told repeatedly (by healthcare support workers and registrants) that I was hired because I'm a woman. I felt stigmatised for being a woman in nursing." [Interview participant]

When female nurses or students described encountering gender-related stigma, this was often linked to also being young and perceived to lack experience or resilience.

> "Experienced stigma for being a young female in mental health, have been told I won't be successful in this field for being small, young, and female. Told that I will be too sensitive and not strong enough" [Survey response]

Gender-related stigma was also found to be exhibited towards female patients, negatively characterising them as too emotional and hysterical. with potentially

serious and harmful consequences. One participant described how this misogynistic outlook was pervasive and normalised within the ward:

> “When the female patients started being admitted, there was a view across the board on the ward that the women were worse, female patients were the worst. That was the opinion, they were worse than men because they were emotional and they were hysterical, and all the rest of it. I remember nursing one woman in particular; she was our first female patient that we ever had, and she was menstruating. I remember that a male nurse refused to nurse her because she was menstruating. He refused to provide - it wasn't even personal care, it was literally just giving her food, meeting her basic needs - but he refused to nurse her because she was menstruating, so that's how misogynistic the ward was! He said this in a handover, so it was normalised so much that this man felt able to just hand that over as that was like a normal thing to discuss.” [Interview participant]

This concerning example of discriminatory practice towards patients gives an insight into the ways in which wider societal forms of stigma and discrimination can directly intersect with stigma in mental health, in a way that can have harmful impacts on patient dignity and care.

Race/ethnicity related stigma and discrimination: Participants recounted particularly shocking experiences of encountering racism within mental health nursing. For example, one participant who was interviewed described repeated instances of racist verbal abuse from patients, and patients refusing to be treated by a black nurse on account of their race. The participant described the conflicting feelings they had towards patients when this happened – acknowledging that this behaviour may have been caused by mental illness, but also that this was symptomatic of racism in wider society.

> “You can imagine looking after a patient and they're calling you 'black monkey. Go back to your country.' Yes, sometimes you'll be like, okay, these people - well, probably because it's mental illness, but you realise that sometimes it's not just because of mental illness. Yes, we can give - like allow that to pass sometimes because maybe they are not mentally stable. Yes, but sometimes you realise that even when they get better, the patient that is about to go home, and he's still using such derogatory statements or remarks…” [Interview participant]

The same participant also spoke of the emotional impact that the racism can have on black students on placements. Added to this was a lack of trust in reporting processes, with a feeling that reporting would not lead to any action.

> “Actually, being a black person, most of the students, every placement, they always complain a lot. I'm like, 'Guys, one thing I will just encourage you is that just pretend as if it doesn't happen and move on with it because sometimes even when you report it, nothing gets done.' Yes, it's painful when you want to give a medication and someone is telling you that 'I don't want a black man or a black person to give me medication.” [Interview participant]

Another interview participant spoke of how whilst he hadn’t experienced racism himself, he did notice racist attitudes towards students from Zimbabwe from nurses. The comments painted these students as less capable than non-racialised nurses.

> “As a student, I didn't really have a problem. I think because of my age and my maturity I never was questioned, but I did see other comments, shall we say, from other nurses […] There were comments passed on certain members of my course who were particularly from Zimbabwe, who had basically comments said about how they were more stupid or how they seemed to be incapable to follow instructions. I knew that the people that they were talking about were actually pretty switched on, so I think in that side of it, there was a racist side to some people.” [Interview participant]

Experiences of racism towards black students and nurses were also identified in survey responses.

> “My race is black African, while on placement I have been treated differently when compared to my Scottish student colleagues we’ve been on placement together at the same place.” [Survey response]

Other forms of racism were identified in the qualitative evidence, which touched on the idea that people from other countries were less capable or intelligent.

> “People have commented because of my background, my ethnicity, my nationality, using the expression, 'Oh, because you're Irish,' which is we're known for being stupider. I think there's an expression it's got like, 'Are you Irish? Are you thick?'” [Interview participant]

Furthermore, participants shared how they had received mocking or discriminatory comments based on their accents.

> “My accent mocked by someone for my whole placement in the past as I am a non national. This made me feel annoyed at times but I didn’t dwell on it for long.” [Survey response]

The discrimination based on a nurses’ accent included anti-English sentiments, with nurses detailing examples of verbal abuse.

> "Occasional discrimination based on my accent, I have a well spoken English accent, and this has led to comments from patients such as 'you're another English c**t oppressing the Scots'.” [Survey response]

Homophobia and transphobia: Survey respondents gave examples of homophobia or transphobia they encountered, both from patients and also from within the nursing or medical profession itself.

> “Being gay and a younger senior nurse I've experienced discrimination in relation to both these factors. Age - ‘too young to know anything’, ‘you're a boy what would you know, ‘you've no life experience’, ‘not talking to him he's a poof’, ‘he's not giving me my depot, he'll just look at my arse’ etc.” [Survey response]

> “Sex/Gender reassignment: I've heard staff from placements say transphobic things or make fun of trans people in the news/media, I have never felt comfortable enough to tell anyone on placement that I am trans.” [Survey response]

These comments contributed to nurses not feeling they could be themselves and had to hide parts of their identity at work.

Disability and long-term conditions related stigma: Survey respondents shared the ways in which they felt that a disability or long-term condition they had affected the ways in which they experienced stigma as a mental health nurse or student. This included participants feeling reluctant to tell others about their disability for fear of judgement.

> "Not wanting to tell people about my disability as they judge you." [Survey response]

Other respondents described a staff culture which lacked acceptance or support for nurses whose ability to perform tasks was impacted by a long-term condition.

> “I have type 1 diabetes and was often berated if unable to immediately do a task due to hypoglycaemia (from fellow senior nurses)” [Survey response]

Participants also described the difficulties presented by negative attitudes towards neurodiversity, and a particular lack of support for nurses who were on assessment waiting list but did not yet have a formal diagnosis for a neurodivergence.

> “I am currently on the waiting list to be assessed for ADHD. I often hear sarcastic or criticising comments about the way I work and the supports I need to do my job from different members of staff. For a unit who deal with and manage people with neurodiversity, we are not very accepting or understanding of staff who are neurodivergent. There are no supports for those who are seeking diagnosis but on the waiting list either. If you don’t have the diagnosis, you can’t access the support” [Survey response]

Stigma related to MHNs experiencing mental health problems: Many participants gave examples of the ways in which their own mental health experience as a mental health nurse or student were stigmatised.

Participants articulated a common trope they encountered, which was that in order to be an effective mental health nurse, they cannot suffer from poor mental health themselves. For example:

> “Comments have been made, ‘if you are mentally unwell, how can you help others’.” [Survey response]

Another participant shared how as a student nurse on a mental health ward, they felt that negative attitudes and treatment towards them began when they disclosed that they had a mental health condition. The student felt that the impact of this resulted in them failing the placement.

> “I was on a ward at a local mental health hospital. I told them I had bipolar they asked me if it was ok to tell the manager and charge nurse of this. I found the ward’s attitude to me changed because of this. I was appalled .I had to leave the plac3ement [sic] due to illness both physical and mental because of their attitude and I did really badly on the ward , they did not give me a mid term and I only found out I had failed the ward when I looked on Turas." [Survey response]

Other participants spoke about how vicarious trauma working in mental health nursing had impacted them, and that they felt there was very little genuine support or understanding of the mental health impacts of this. Participants described a culture in which they felt they should expect and accept traumatic experiences and that

should ‘just get on with it’. This often led to a lack of empathy and understanding towards nurses who had experienced traumatic events at work, such as being assaulted or verbally abused.

> “There’s a lot of my friends, my colleagues, family who will say, ‘I don’t understand why so many nurses can be off with anxiety. How can they be anxious? They know what to do. What did they expect? Why are they anxious about dealing with mentally unstable people? That’s what they wanted to do.’ Basically, like, you chose this job, so you should have gone into it expecting to get battered by patients. You should have expected to be shouted at by relatives, and we have that expectation on psychiatry far more than any other branch of nursing.” [Interview participant]

Participants also described a perception that mental health nurses who opened up about how traumatic experiences had affected them were seen as weak.

> “I think there’s a thing with mental health nurses as well, is that you’re not allowed to say that you are affected by what you saw, because you’re seen as weak.” [Interview participant]

One focus group participant shared their experiences of how mental health stigma had impact them in their role as a mental health nursing student, and how feeling like they couldn’t seek mental health support contributed to a distressing period of poor mental health, during which they had attempted suicide.

> “The stigma and just not being able to reach out, and just feeling like I should be able to deal with this myself. If I can’t help myself, how can I… A lot of my stigma probably comes from myself with influences from other places, but I do believe potentially the stigma and not feeling like I can reach out for help potentially allowed me to get to such a place of distress, potentially.” [Interview participant]

The same participant got in touch with researchers again around three months after the focus group. They explained that they had withdrawn from the mental health nursing course. Their practice supervisor had highlighted a concern about their wellbeing, which led to their removal from their placement. The participant was left feeling confused about where the concern about their wellbeing had come from, and felt heavily stigmatised. They believed that the protective measures taken by the university actually isolated them and sent them into a downward spiral of self-criticism.

> “I ended up having a really bad time on my placement not long after the research call, my practice supervisor highlighted a concern about my wellbeing, nothing about my behaviour or professionalism, so as a safeguarding approach I was removed from my placement and an alternative placement was arranged as the uni didn’t have any concerns about my wellbeing. The confusing thing is that the nursing practice is centred on reflective practice, yet I was given no tangible information on what the concern was, in order to adopt the culture of continual professional development. Reflecting on it I had mentioned I had post natal depression 2 days prior, in an informal conversation with a member of staff. So I took it to the university that I was being stigmatised against, and the protective measures that took place were actually to isolate me and send me into a downward spiral of critic trying to figure out what I done wrong.

> “So I decided that I no longer wanted to be part of a profession who treats others like that. So I applied for my [different university course] out of anger and embarrassment, and I actually got accepted” [Email follow-up from interview participant]

The participant also explained that they had recently started the new course they applied for.

The experience of this participant illustrates why mental health nursing students may be reluctant to share their own experiences with mental health, for fear of consequences that seem punitive. This experience also touched on a perceived lack of transparency around safeguarding measures, and the rationale as to why they had been removed from a replacement without adequate support, which they felt was at odds to the course’s emphasis on reflective practice. Furthermore, when the participant attempted to raise the stigma and discrimination they were experiencing, the consequence was that they were further isolated. The consequences of this were that the student withdrew from the mental health nursing programme altogether, contributing to overall dropout rates in mental health nursing.

Pregnancy and maternity related stigma and discrimination: Mental health nurses face intersectional stigma and discrimination related to pregnancy and maternity, which can profoundly impact their professional and personal lives. Several survey respondents shared their experiences, highlighting the challenges they had encountered. This included being unable to secure job opportunities while pregnant. One respondent shared:

> “I was openly passed over for a job as I was pregnant and told I was best at interview but as I was pregnant I could have the next promotion if I came back.” [Survey response]

One participant also recalled receiving stigmatising comments from others when they were pregnant regarding the safety of them and their unborn child. This directly illustrates how the derogatory attitudes towards people with mental illness can lead to stigma towards professionals who work with people experiencing mental health problems and seep into multiple aspects of their lives, even impacting how people react to a MHN being pregnant.

> “Others expressed concerns whilst pregnant in work, 'not safe, your baby will be mentally unwell surrounded by those inpatients’” [Survey response]

Additionally, one survey respondent shared a particularly upsetting experience just after they had experienced a miscarriage, in which they were asked to assess a patient who had just had a stillbirth. The nurse faced intense questioning by other professionals when they said that they felt unable to proceed with the assessment.

> “I had a miscarriage and on return to work was asked to assess a lady who just had a stillbirth with baby still with her. I was unable to do this and was interrogated by multiple staff from receptionists to ward managers as to why.” [Survey response]

Religion-related stigma:

Further to this, participants described their religious beliefs (or assumptions about their religious beliefs) being stigmatised, and the effect this can have on them. One participant explained the ways in which patients draw assumptions and conclusions about a nurse's religious beliefs based on their nationality. This can have negative implications on the relationship between nurses and patients.

> "As I am Irish it is assumed I am catholic, which I do identify as. Lots of difficulties have come up with patients who identify as 'ranger' [sic] and 'Celtic' fans and they either attempt to push boundaries or become aggressive." [Survey response]

Other survey respondents detailed ways in which their religious beliefs had been questioned or mocked, both by patients and fellow nurses. One respondent explained that they had been mocked for their religion and told that they were 'silly' for believing in a god. Another respondent stated that they had experienced bullying for their religion (although did not expand on who was bullying).

Emotional and psychological impacts of stigma related to the profession

Participants were asked about how stigma has affected them, and they detailed the mental and emotional impacts that it can have. It is clear that stigma related to the profession can lead to a range of negative outcomes.

Feeling devalued and 'less than': Many mental health nurses reported that the stigma associated with mental health nursing left them feeling undervalued, often resulting in a significant loss of confidence and self-doubt regarding their career choice. Participants shared how they often felt less than nurses in other fields:

> "I have felt like rubbish, devalued and felt like a less qualified nurse compared to other fields" [Survey response]

Feeling undervalued can lead to other psychological consequences. For example, another nurse expressed in the survey that they "often have low mental wellbeing, do not want to come into work, feel unappreciated and undervalued".

Poor psychological safety:

Multiple areas of poor psychological safety as a result of stigma and discriminated associated with mental health nursing were identified. These included:

- Feeling isolated
- Feeling uncomfortable or unsafe in the work environment
- Feeling powerless and unable to challenge stigma

Participants spoke of the feelings of isolation that stigma and discrimination can bring, and nurses or students feeling unable to ask for support:

> "The stigma and just not being able to reach out, and just feeling like I should be able to deal with this myself [...] I think I was just feeling isolated and all." [Interview participant]

Survey respondents also detailed how the stigma and undervaluing of mental health nurses made them feel isolated, and that their 'professional opinion, practice and judgement were insignificant'. They also stated how trying to challenge stigma or

discrimination in workplaces is difficult and can lead to the person feeling more isolated.

This sense of being undervalued can lead to frustration and irritation, as another participant noted:

> "They can make me feel undervalued, upset, frustrated and at times question whether long term this is a good career for my mental health." [Survey response]

Participants also reported feeling uncomfortable or unsafe in within clinical environment where they worked or were on placements, often due to the impact of stigma and discrimination on workplace culture. This was heavily tied to a lack of faith in reporting structures and a toxic culture.

> “I keep myself to myself. Never really say much about what I think. I would not feel comfortable reporting any kind of incident because you are absolutely not backed up by anyone. I do not trust others around me and do my job and disconnect from anyone when not in. I am lucky to have some other people around me that are in the job, that I can talk to and vent about experiences and placement. But I don't see a bright future working in hospitals and I am stressing about what kind of job I could do to not work in a poisonous environment like the one I will have to be working soon.” [Survey response]

Another survey respondent expressed concern about future support and protection, stating:

> “It makes me worry about how I will be supported and protected as a nurse once qualified. It feels like there is a blame culture for mental health nurses when things go wrong. I feel as though mental health nurses are not taken seriously, as though they are not trained well enough or to the standard of adult nurses and we are not treated with the respect.” [Survey response]

Another participant discussed the culture in a hospital where they previously worked, which they experienced as toxic and misogynistic. They disclosed that this had resulted in the overuse of physical restraint, which in turn led to a higher frequency of patients assaulting nursing staff.

> “I felt like because of the attitudes and behaviours on the ward, I felt like the prevalence of physical restraint was really high, and therefore I felt like I got assaulted a lot. I feel like you get assaulted a lot if you are going in to physically intervene with someone.” [Interview participant]

The participant shared that they no longer work in mental health nursing, but they still feel the ongoing psychological impacts from feeling unsafe when they worked in mental health nursing.

> “I sit in an office now, and when I started working here, not long after, maybe a couple of months later, there was this loud bang in the corridor. I'm just in a room full of computers and colleagues, so I shot up from my seat and went to run. Then I looked around and I realised that no one else had stood up and went to run, and I went, oh, you're not on a mental health ward anymore. You don't have to run because there's a loud noise, whereas, to me, I was like, well, I'm so conditioned to,

> like, you're on edge. That's what it is, you're constantly hypervigilant, and I think I've only just lost my hypervigilance." [Interview participant]

The poor psychological safety is both resulting from and sustained by nurses or students feeling powerless to challenge stigma. Participants explained that they don't feel listened to. This, combined with a lack of faith in reporting structures, creates an environment where stigma and discrimination go unchallenged and become part of a culture.

> "You can imagine a mental health nurse going to work every day, has been facing a lot of stigma from staff because of maybe age, whatever reasons, and, at the end, you are not able to unleash that. You are not able to say that out [sic]. No one is listening to you. Before you know it, it's going to lead to stress and burnout." [Interview participant]

Participants also discussed how this lack of confidence in reporting and challenging could, in some cases, be seriously detrimental to patients.

> "I witnessed abuse of patients and assault of patients, and not just one-offs, regularly, and then I noticed the cover up of that, and I felt powerless to be able to speak about that (…) these men were so good at what they were doing, because they would never hit a patient in front of me. They would wait until they were on shift together, and then there was a whole story constructed about it. How do you go and tell somebody? You know it's happening, and I knew that was happening, and I can think of one patient in particular who ended up with a black eye, and I know that a nurse punched him, and I know that because that nurse told someone who told me, but I'm powerless to do anything about that.
>
> It makes me really sad that the warning signs were there, these people weren't managed appropriately, and they actually went on to cause harm to others. Even though they were causing harm all the way along, it just so happens that inevitably at the end, they have been caught, and that could have happened in 2014, or at anytime in the timeframe. So, I think I'm forever angry about that, that there were warning signs for this stuff." [Interview participant]

This distressing recollection speaks to a culture in a particular clinical setting where stigma, discrimination and abuse went unchallenged for years because nurses felt unable to speak out. This resulted in serious harm to patients, and other negative psychological consequences for nurses who were witnessing the harm but felt powerless to stop it.

Frustration: Many participants emphasised the feeling of frustration as an emotional response to stigma. This included frustration with friends or relatives who lacked an understanding of the role of a mental health nurse:

> "Myself and my husband have little moments where I become quite irate with going, 'You don't understand what I do for a living, do you?!' He's an engineering manager, and he's like, 'I had a really hard day.' I'm like, 'So did I.' It's like, 'You're just sat around drinking tea.' I'm like, 'I beg your pardon?!'" [Interview participant]

Other participants mentioned feeing frustration towards the medical system and the lack of esteem that mental health nursing is held in. One survey respondent noted

that that they “feel frustrated that mental health nursing is not recognised as the expert role that it is”.

Additionally, participants described feeling frustrated with the wider system and drew on the challenges of working within a system that felt overloaded:

> "The system is on its knees and there's waiting lists in every area, and then the way I see it, excuse me, some of the time we pick up the pieces, we would speak to people overnight, we'd speak to people on the weekends when things might fall down." [Interview participant]

> "The difficult parts of my working culture are reflective of the challenges working for the NHS as a whole ie a working environment that is not fit for its purpose, frustrations around waiting times, frustrations around medical capacity." [Survey response]

The frustration of working in a system that felt unfit for purposes had the potential to be demoralising for nurses and students, with a feeling that the task was too big to make a difference.

Feeling demotivated: Participants spoke about the impact that stigma related to the profession could contribute to feeling demotivated in work, or lead to increased feeling of anxiousness which made them reluctant to go to work.

> “At times it’s made me not want to go to placement or made me over think things and made my anxiety rocket and restless sleepless nights. I am an anxious person at the best of times so it doesn’t help.” [Survey response]

One survey respondent shared:

> “It is upsetting. Sometimes can be brushed off, other times when it’s ongoing can be overwhelming and undermining. It can cause great upset, anxiety and other feelings and impact on motivation and confidence.” [Survey response]

This feeling of demotivation amongst nurses and students presents a clear challenge to the recruitment and retention of mental health nurses.

Trauma: Further to this, participants spoke about the impact of trauma or vicarious trauma at work, and feeling unsupported when trying to navigate or heal from the trauma.

> “When you get exposed to multiple extremely traumatic things on their own in very quick succession, over a period of days, not even years. Some people don't see that in their entire career. Whereas we're exposed to it in a matter of days. That depletes your resilience really fast and rather than try and rebuild it, you're questioned on it. So you're not supported, you're quizzed. 'Why has this affected you? What is it about this one? You've dealt with four suicides. Why is this suicide any different?' You're almost expected to have the answer because you're the expert and we don't always have the answer.” [Interview participant]

Participants spoke about a lack of support available for mental health nurses, and a tacit acceptance that they should just be able to deal with them impact of trauma themselves.

> "I worry a lot about what support is actually out there for mental health nurses. I think there's a thing with mental health nurses as well, is that you're not allowed to say that you are affected by what you saw, because you're seen as weak. Mental health, there's this attitude that you have to be okay with aggression and stuff. You just make light of it, even if you get punched, because sometimes I did get punched. There's this whole attitude of, oh, shake it off." [Interview participant]

The experiences shared by participants highlight the significant emotional and mental toll that dealing with traumatic events at work can have on mental health nurses. The lack of support and the stigma associated with expressing vulnerability, as well as an expectation to develop 'a thick skin' further exacerbate these challenges.

Positive emotional impacts: Despite the significant challenges, participants described the ways in which stigma related to the mental health nursing profession can foster resilience and increased motivation among nurses. Participants also explained that the experience of working in mental health nursing and supporting patients with mental illness had helped to dispel any misconceptions or stigma they once may have had towards people with mental illness. This can have a positive impact of tackling stigma, not just for the mental health nurse or student, but also for other people in their lives:

> "I suppose it just gave me a greater compassion [for people with mental health challenges]. It could be anyone. Like those girls today who had to be fed through the tube. That could have been my daughter, but it's somebody's daughter. […] . I think I've probably passed a lot of that things [sic] on to my kids as well, how you see people." [Interview participant]

Many mental health nurses described using negative comments and misconceptions as fuel to work harder in their careers and demonstrate the value of their profession. One participant shared:

> "I use the negative comments as fuel to work harder in my career and show people that mental health nursing is a career to be proud of." [Survey response]

Participants also explained that trying to tackle stigma and discrimination in mental health can lead to them feeling a greater level of empathy and compassion towards patients. When survey respondents were asked how they feel when they had been impacted by stigma and discrimination in their role, one participant explained that they "would take opportunity to try and engender more compassionate and trauma informed approach to our service users and workforce who try to support them". This emphasises the importance of social contact for tackling stigma and discrimination, both towards people experiencing mental illness and also for people who work with them.

Consequences of psychological impacts of stigma

Impacts on career: It was evident from interview and survey responses that stigma associated with the profession could have major career implications for many mental health nurses and students.

In the workplace, stigma can manifest in various ways, impacting both job satisfaction and career progression. Mental health nurses often face a lack of managerial support, which can exacerbate feelings of frustration and burnout. One participant shared:

> "There's an overall lack of support from management. Sometimes we deal with really traumatic situations with patients and there's no emotional support available." [Survey response]

This lack of support can lead to decreased motivation and a diminished sense of pride in their work. Furthermore, concerns about future placements and career prospects are common, with some nurses considering switching to other nursing specialities to avoid the constant judgement and stigma associated with mental health nursing.

> “I am now considering switching to adult nursing as I feel it is more respected and I won’t face this constant judgement.” [Survey response]

> “I can tell you just a few weeks ago we finished our placement, just before Christmas. Some of the students that are supposed to have finished their course by July can't finish because they faced a lot of prejudice at placement, and because of that, they failed. They can't cope because it's not everybody that can have the mental strength to go through such thing.” [Interview participant]

Some participants described feeling at times regretful over the career path they had chosen.

> “Its [sic] impacted my self confidence and at times made we [sic] wish I hadn't pursued this career path. I've felt that my knowledge and skills have been devalued by colleagues and patients because of my job title - re the word 'nurse’.” [Survey response]

One participant spoke of feeling hopeless about the wider mental health system, commenting on a perceived lack of effective provision for early intervention. Whilst the participant noted that they felt some slight optimism around potential changes to legislation and guidance, they were uncertain whether they felt they could stay in the profession long enough for sufficient change to occur.

> "I don't think I can do this within a nursing role now, though. I have reflected and am thinking about going and doing a master's in public policy and other avenues, because I don't believe that I could fix this within my role as a mental health nurse. I think it needs wider representation, I think, and different perspective. […] I just can't see a way of making change, but I know I want to make a change. I just think there's no early intervention or anything as well. I think that's where it stems from, is that you need to be at a crisis point to get any sort of help. There's just flaws all over the system, to be fair, just systemic flaws. I feel slightly optimistic, because I think the Mental Health Act and strategy and stuff, that's getting a bit of a revamp and they're looking at differences to the roles of the mental health nurse. I think it's heading in the right direction. It's just everything within the NHS takes forever, and I don't know if I'm willing to stay around to see if it will be a good place." [Interview participant]

These examples illustrate the emotional and professional struggles faced by mental health nurses, including feelings of being undervalued, career dissatisfaction, and

the desire for systemic change. They also highlight the importance of addressing these issues to improve the wellbeing and retention of mental health nurses.

Impacts on learning and development: MHN students participating in the study felt that because MHN is not taken as seriously as other nursing specialisations, they receive fewer learning opportunities and consequently a diminished sense of professional identity:

> "It's almost like a surprise [that a MHN is interested in areas of general clinical aspects], like, 'Why would you be asking that? Why are you interested in that?' I wonder if it stunts our journey as students if people aren't taking us as seriously as maybe an adult nurse, and if they're not treating us the same." [Interview participant]

The stigma extends to practical learning experiences, where students often find themselves overlooked or excluded. Participants recounted being denied hands-on training that general nursing students received:

> "I felt stigmatised as a student from mental health nursing as opposed to other students that were doing general or adult nursing. I wasn't probably given as much learning opportunities because I wasn't pursuing that path." [Interview participant]

Another student shared how they had to actively push for opportunities:

> "They wouldn't really consider unless you put yourself forward. You'd be overlooked." [Interview participant]

This lack of support can leave students feeling isolated and hinder their professional development.

Self-limiting behaviours: The stigma associated with mental health nursing can lead to significant behavioural changes among professionals in the field. Many mental health nurses report engaging in self-limiting behaviours, such as avoiding discussions about their work with friends or family. One nurse mentioned in the survey, "I generally don't tell people what I do as I don't want to talk about my job and deal with all the ridiculous stereotypes and questions". Many participants also mentioned that they often do not tell people that they are a mental health nurse, just that they are a nurse.

These withdrawals from discussion about work with friends and family were a strong theme throughout the interviews too. One participant stated:

> "I think there's lots of stigma to do with the career. Some personal examples, maybe me going home to visit friends or family, explaining what I do, friends and family being absolutely shocked and appalled. I don't really talk about what I do for that reason. I think some of the stuff that I encounter isn't normal. It's not your normal day-to-day job. It could be quite upsetting, stressful." [Interview participant]

This reluctance to share their professional experiences can result in feelings of isolation and a lack of support from their social circles.

Compassion fatigue, burnout and quiet-quitting: Other participants shared how the stigma and discrimination they have experienced related to the role has led to burnout and total demotivation:

> “When you go out every day to try and help people with a real drive to do that in the worst circumstances sometimes and people are still cross and angry at you and think you're not doing a good job, that's hard. That's incredibly hard. [...] day and day [sic] just facing angry parents and people thinking you weren't doing a good enough job and feeling very stuck in a system that wasn't helping always was just… It was a complete burnout, really.” [Interview participant]

Further to this, there was a sense that mental health nurses attract criticism from every angle, and that good work is never rewarded or celebrated.

> "I’m just really tired and burnt out. I came in to this job because I really believed that it was something important and worthwhile but it doesn’t take long for that to be beaten out of you. Everything feels futile. The stigma and discrimination of my role is frequent and really changes the way you see things, the wins are few and far between when you actually feel like you’ve done a good job because the criticism from every direction (including government, media, management, patients, the public). Doesn’t feel worth it." [Survey response]

Increased advocacy for the profession and people with mental health challenges: Stigma can also drive mental health nurses to become advocates for their profession and challenge discrimination. By confronting and addressing stigma, nurses can educate others about the importance and complexity of their work. One nurse expressed pride in their role, stating:

> "I take pride in my role as a mental health nurse and see it as my duty to educate others about the variety of skills we develop in supporting and advocating for people who can be vulnerable and stigmatised against due to mental illness" [Survey response].

One interview participant echoed this sentiment, describing how the experiences of encountering stigma and discrimination made them feel compelled and feel responsible for changing perceptions about the role.

> "I love my job, and I'm really passionate about my job, and probably more defensive about it, if that makes sense, in order to give people a bit of awareness of what you do, and the benefit of your job and your career. I also say that, of going, 'It's a career.' Mental health nurses, particularly trained nurses, have trained really bleeding hard to get where they are, and they're some of the strongest individuals you'll ever meet! Probably, that more passionate about it, and trying to defend the job as well at times. Almost a negative where it's a bit defensive about what you do, because some people can not really understand what you do.” [Interview participant]

This advocacy can help to change public perceptions and reduce stigma over time, creating a more supportive environment for both nurses and patients.

Support and coping mechanisms

Peer support amongst nurses: Peer support was highlighted as an important coping mechanism for many participants.

> “Peer support is such a big thing as well, us all having that bit of open and honesty of, 'I know how you feel. I've been there.' We could say, or we could talk about education, but that peer support is probably the biggest support you're going to have, of going, 'It's not just you. We've all had these. It will get easier. Here's how to

> manage it. Here's how to tackle these conversations about what you do." [Interview participant]

Not all participants felt that they could develop positive peer relationships at work however, and spoke instead of the importance of being able to switch off from work. There was a feeling that peer support and good working relationships were crucial for coping with the impacts of stigma and discrimination, but an acknowledgement that sometimes maintaining this could be difficult when clinical practice felt so pressured.

Additionally, for some participants, a supportive and respectful workplace culture was key in helping to tackle the stigma associated with mental health nursing. Participants described finding solidarity and camaraderie among their colleagues. One survey respondent noted:

> "Work colleagues from various disciplines are kind, caring and professional" [Survey response]

Nursing students also emphasised the importance of strong peer support networks amongst fellow mental health nursing students, particularly whilst on placements.

The potential for peer support to become an unhealthy coping mechanism if not positively managed or facilitated was also acknowledged however:

> "We used to meet up, and we just used to binge drink on our days off, and I smoked at the time, so that was definitely a coping strategy.[…] There was no clinical supervision provision. I didn't seek any external support. I very rarely got any kind of managerial supervision or anything like that, so there was no setup to have a place to talk to, so most of it was peer support with my colleagues, and that would normally be when we were drunk, and that's the truth." [Interview participant]

Talking to friends and family: Many participants emphasised support that they experienced from friends or family in helping the to cope with the psychological impacts of the role. The importance of 'venting' to friends was mentioned as a way to manage feelings of overwhelm or frustration.

Additionally, participants talked about the importance of talking to friends and family about work, but also setting boundaries about this to ensure that they felt they could leave work behind:

> "I also have a rule with my husband that the rants from work last the car journey. If he's had a bad day, or if I've had a bad day, the journey home is our time to rant, and then as we walk through the front door it gets left at the front door." [Interview participant]

Personal resilience: Participants were asked how they cope with the stigma and discrimination they encounter. Many talked of the importance of developing a 'thick skin' or becoming resilient to stigma and discrimination.

> "I have quite a thick skin. Yes, to be honest, I don't think there's probably many people - we accept that people are stressed, people are anxious. They don't know what's happening." [Interview participant]

Some also spoke of the compassion they show towards people who may be acting in a stigmatising way, and using it as an opportunity to educate people on mental health and tackle stigma:

> “What I've learned from that is that every negative things I've received, I've put them together to turn into a positive to see how we can educate people, especially on mental health.” [Interview participant]

Self-care: Many participants spoke about a range of positive coping mechanisms that they employed, such as talking to friends and family, engaging in hobbies, exercise and self-care.

> “The usual stuff that gets you through difficult things and work in your profession, the things that help you keep going, the self-care stuff. I started to walk to the train after work, which was always a great end to the day, stomp down a hill for 20 minutes to wash it all away before I got home.” [Interview participant]

One participant talked about the importance of faith in coping with the intersectional stigma they experienced related to their race:

> “Before I leave the house, 'God, as I'm going today, please give me the grace and the strength to be able to cope with whatever will come my way.' Whatever will come my way could include stigma. Anything. Name-calling. Somebody spitting on you because you're a black nurse. Yes, I've seen that. Just spit on you and all of that. I just ask the Lord. I say, 'Lord, I'm going out to the place. I need your grace and the wisdom to be able to do my work and not to react to people even when they are being nasty and all of that.' So, once that is in place, trust me, personally, that's how I deal with issues of life, so that's - and that has actually worked for me.” [Interview participant]

Proposed changes

When asked what changes are needed to reduce stigma and discrimination towards mental health nursing, answers fell into three broad categories: education, policy, and workplace or cultural changes.

Public Education: People felt that the public need more education both about mental health, and the role of mental health nursing.

> "The biggest thing about removing stigma from mental health is making sure people, two things. One thing, that people aren't mad that have a mental health issue, and the second thing is that 99.999 per cent of patients are not dangerous. They're more a danger to themselves than they are to anybody else, including schizophrenia." [Interview participant]

> “Giving people chances to understand what the role is, who accesses services - might lead to fewer derogatory comments about the job itself.” [Interview participant]

A greater level of understanding in the public consciousness around mental health was felt to be crucial in reducing the indirect impacts of the link between mental health stigma and stigma associated with mental health nursing. Participants also felt that the general public lacked an understanding of the role of mental health nursing, so remedying this was seen to be important in tackling the stigma associated with the role.

Changes within education settings: Interview participants called for more mental health education within general nursing and broader medical professions:

> “I feel that there should be greater representation from all nursing students across the board from the get-go, because as I said before we're living in an ageing population. Anyone who's on an acute ward, an orthopaedic ward, they can see anything from delirium to dementia to distress. I feel that that's probably our way to beat the stigma. We need to start educating all medical professionals from the get-go that the body is one. We don't have physical and mental as two direct opposite streams." [Interview participant]

Participants also called for general nurses to do mental health nursing placements:

> "For student nurses, my thought would be that everyone should have to have a mental health placement. I'm sure my practice education facilitator colleagues, if they heard that, would kick me under a table, no doubt, because they'd have to find more placements, but yes, I think everyone should have to have a mental health placement, whether that be inpatient, outpatient, but they should have some experience of what it is a mental health nurse does day in, day out. As a mental health nurse, I had to do an adult placement to get signed off to be on the register, so I think, in turn, so should they. I know paediatric students have to do an adult placement. So it always sits in my mind as, why do they not do a mental health placement? So that would be one part of it." [Interview participant]

The balance between training clinical skills and mental health-specific skills was also highlighted as an area for improvement, particularly by current students from universities at which mental health nursing is not offered from day one of the course.

> “There's so much more scope for our clinical skills. Obviously, you do obs and you do… I appreciate the skills that we do, but for example we just did IV medications. You don't have IV lines on an acute ward because of the risk of it being a ligature, so we go in, we're learning this skill, whereas there's safety and stabilisation skills. There's decider skills. There's specific communication skills that we could be developing through this time, but we are… It is set by the NMC. It comes down to the NMC, but I just… A wee bit more representation. A wee bit more identity maybe within our university course would give us more identity as mental health nurses, potentially." [Interview participant]

> “What we're seeing at the moment is that being shoehorned into around what the general nurse needs. When we think about our NMC proficiencies that any undergraduate nurse has to meet to be able to graduate, they're all general focused, very general focused. When you look at the NMC proficiencies to become a registered nurse, there's very few that are related to, or actually meets the needs of what a proficient mental health nurse should be.” [Interview participant]

A final point in relation to university education of mental health nurses was a query about whether it is becoming too academic:

> “I think we're missing a cohort of people who would also be really good at the job by doing that, but also I think that by going down that academic route, we're missing some of that relational aspect of the role and preparing people for it.” [Interview participant]

Raising the profile of the profession: Participants talked about how mental health nursing is a ‘Cinderella service’ by doing vital work which often goes unrecognised and called for actions to help the profession become more visible and more widely celebrated.

> “I do think that by not raising the profile of what the mental health profession is to the wider public, I think we're missing out on a lot of people who actually would be like, 'That's for me. That's a really good job for me,' because some of it we just don't want to talk about. We don't want to talk about the aspects of the job that are not great as well because it's not always very good, but I think actually being open and honest and transparent about what we do would be really helpful.” [Interview participant]

Raising the profile of mental health nursing was seen to be key in helping to address challenges with recruitment of mental health nurses. Participants felt that greater public awareness of the role and what it involved would attract more people to the profession.

Cultural/workplace changes: Participants talked extensively about the hierarchical nature of nursing and NHS staff more broadly. Some challenged the clinical nature of the role, arguing that it has become over-medicalised and that it therefore sits uncomfortably within clinical teams.

> "I think the whole numbering thing, maybe not the job titles, the job titles, yes, they're necessary, but I think maybe the number of the banding for the pay scale. There's no reason why that can't just be kept at HR level."[Interview participant]

It was felt that workplace culture, particularly leadership, was felt to be particularly important in supporting mental health nurses and students to challenge stigma and thrive in their roles. Positive reinforcement and support from managers, as well as faith in reporting processes, are crucial in creating an enabling environment where staff feel safe to report stigma and discrimination.

The importance of workplace culture was seen to be particularly significant in supporting mental health nurses and students to challenge stigma and thrive in their roles. It was felt that that this needed to come from leadership first and foremost:

> "I think about the leadership around what messages do we want to convey to people. I think about how we manage people who we can see are outliers to how we want to treat people, so these people who have unhealthy narratives and rhetoric about patients, I think if we picked up on things a lot quicker, our profession would look a lot better. So, if I heard someone negatively talking about a patient, I think those things should be challenged. I don't think they should just be normalised, and I feel like they really are normalised." [Interview participant]

Another participant highlighted the need for positive reinforcement and support from managers through support and supervision, setting out clear expectations of the role and what ‘good’ looks like:

> "They need something to benchmark against to know, yes, I'm doing okay, because again, it's rare that nurses will be told, 'You're doing really good, you're on track.' We tend to only hear from managers if you make a mistake or if there's a complaint. I don't know if they still do the Flying Start programme. They used to do that for newly

> qualified nurses and it's where you were signed off before you did things like run a shift, just to build your confidence and make sure that you're on the right track. So you had a lot of support from a mentor, but once that's finished, you're just booted out the nest and told crack on, and you'll hear from us either at clinical supervision if you get it, or if you make a mistake or there's a complaint." [Interview participant]

Participants also spoke about the importance of having faith in reporting processes when staff or students do encounter stigma and discrimination, and the role that a supportive culture can have to enable this. Participants believed that ensuring reporting leads to action will help other mental health nurses to develop greater levels of trust in the reporting processes. One participant shared:

> "To create an enabling environment where staff/nurses can be able to report and something will be done. At the moment, based on my observation or what I've heard [...] from different nurses, it's like they don't bother to report many things. They just allow it to slide because nobody will do anything about it. So, I think that aspect needs to be looked into so that people don't suffer in silence. [So, when mental health nurses feel that they encounter stigma or discrimination, they should be able to report it and feel that they have trust in the reporting process?] Yes, to report it. Yes, something to be done. " [Interview participant]

Furthermore, having appropriate support in place for mental health nurses was felt to be crucial in tackling stigma related to the profession and its impacts on nurses and patients. This included having structures in place to ensure that regular support, supervision and reflective practice was available to all mental health nurses and students.

Discussion

This study sought to understand how stigma by association impacts the mental health nursing workforce in Scotland. Using a mixed-methods design comprising a survey and follow-up interviews, the project explores the nature and scale of mental health stigma and discrimination experienced by mental health nurses and nursing students across the country. 636 current and former mental health nurses and nursing students participated in this research, sharing their personal experiences and perspectives of how stigma by association affects the profession.

Survey findings revealed that many mental health nurses and mental health nursing students experience a considerable level of stigma related to their profession, with over half (55%) of survey respondents reported facing stigma in at least half of the situations measured using the Clinician Associative Stigma Scale. Levels of stigma were similar for current mental health nurses and nursing students, although the particular experiences of stigma varied slightly. Current nurses reported higher levels of discomfort when disclosing or discussing their job, and greater exposure to stereotypes about mental health nurses' mental health. In contrast, students reported experiencing a greater level of stigma relating to the profession's effectiveness, and more stigma towards people with mental illness. Whilst the survey data consistently revealed that around half of participants feel that they have experienced stigma at work or university, a much higher proportion have had stigmatising experiences such as being told their work must be scary or that they don't know what they're doing. As a result, almost 1 in 10 have taken time off or left a mental health nursing job.

In-depth interviews and open-text survey questions explored these details in more detail. Thematic analysis of the data revealed that whilst many have positive experiences within the profession, the stigma experienced by mental health nurses is frequent and pervasive, with examples of stigma occurring within the workplace, within social and family relationships, and within wider society.

Psychometric testing conducted during this research, as well as analysis of the themes emerging from the qualitative data support the validity of the Clinician Associative Stigma Scale (CASS) as a measure of stigma by association for use with mental health nurses. Themes identified within this report are largely concurrent with the stigma by association factors measured by the CASS scale, however this report identifies two additional components of stigma by association for mental health nursing in Scotland: workplace culture, and intersectional stigma. Each of these is addressed in turn below.

1. **Negative stereotypes about people with mental illness:** recollections recounted by participants demonstrate the close relationship between publicly held stigmatising attitudes and beliefs about people with mental health conditions (e.g. that people with mental health conditions are dangerous), and negative beliefs about mental health nursing (e.g. that it must be a scary job). Survey results revealed negative stereotypes about people with mental illness to be the most commonly experienced aspect of stigma by association for all mental health nursing groups.

Stigma related to mental health professionals' own wellbeing: Mental health nurses also face significant stigma when it comes to their own mental health. This stigma comes both from the public and within the profession itself, creating an environment where seeking help is often seen as a weakness rather than a necessity. Consequently, more than 56% of students in this survey reported hiding their struggles from their mental health nursing colleagues and teaching staff, as well as from friends and family. This highlights the need for a system-wide approach to tackling mental health stigma and discrimination.

Stigma towards people with mental health conditions is therefore recognised as a key driver of stigma by association in mental health nursing.

2. **Concerns about professional effectiveness:** throughout this study, participants recounted frequent exposure to others' perceptions of mental health nursing as less valuable or meaningful than other nursing fields. The **systemic lack of parity** which persists between mental and physical health was recognised to be a key driver of such beliefs. Lack of parity was also perceived by participants as underpinning disparities in resourcing, including funding, training and work opportunities, between mental health nursing and other nursing fields.

Two additional drivers of stigma by association were identified within this study.

3. **Intersectional stigma:** Experiences shared by participants in this study demonstrate how stigma is experienced differently based on intersecting characteristics such as age, gender, race, and sexual orientation. Younger nurses for example often face scepticism about their abilities and experience, male nurses are more frequently called upon to handle aggressive patients, and female nurses feel less valued as a result. Additionally, experiences of racism and homophobia further compound the stigma faced by mental health nurses.
4. **Workplace culture:** 23% of survey participants agreed or strongly agreed that their workplace environment was stigmatising. Interview participants spoke at length about change-resistant 'old school practices' and values inherent within some teams, in which stigmatising attitudes become normalised, and vulnerability, reflection and empathy are not considered strengths. Many additionally described working environments with little emphasis on support or supervision and which uphold a focus on hierarchy and top-down power structures, making it difficult to challenge stigma or to speak openly about challenges when they arise.

Impact and consequences of stigma

The impact of stigma on mental health nurses is significant and multifaceted. As explored in detail throughout this report, mental health nurses face stigma from various sources, including the public, colleagues, and even within the profession itself. Study participants shared their experiences of stress, anxiety, burnout and substantial mental health challenges which had resulted from the stigma they had experienced. The Scottish Mental Illness Stigma Study (SMISS) showed that experiences of stigma can lead those affected to anticipate future negative experiences and withdraw from relationships, social activities and work and

education opportunities as a result. In line with findings from SMISS, this study demonstrates that in many cases, experiences of stigma can lead to withdrawal for mental health nurses. Mental health nurses in this study described avoiding talking about their work and limited social connections with friends, family or colleagues, exacerbating feelings of isolation and a lack of support. Others described withdrawing from opportunities at work; 9% of survey respondents had taken time off or left a mental health nursing job because of stigma by association they had experienced.

Limitations

Several setbacks were experienced during this study, which impacted on the original timeline for the project. Ethical approval and in particular NHS board approval for the study took longer than expected, and this had knock on implications for recruitment timings, which then had to be adjusted to reflect reduced capacity both within the research team and within participant populations over the summer months. Recruitment of mental health nursing students also took longer than expected, and resulted in the original target for this sample being missed by a small number. The number of participants reached was still large enough however to conduct the planned statistical analyses robustly.

The number of survey participants recruited was limited, due to the convenience sampling methods used for recruitment. This resulted in very small numbers of participants from some marginalised communities which limited the analyses and conclusions that could be drawn from such demographics. Future research should seek to rectify this through targeted recruitment of marginalised groups.

The number of participants recruited to participate in interviews and focus groups was also lower than the original target. Several factors impeded efforts in this regard, including the longer than expected window for survey completions, and more participants than initially expected opting to participate in a 1:1 interview rather than a focus group, putting more strain on our research team. The interviews and focus groups that were completed did include participants from a range of demographics, including minority ethnic groups, ensuring that a diversity of perspectives and experiences were heard. There were significant commonalities within the topics discussed by participants across all interviews, suggesting that the interviews conducted were sufficient to capture the majority of key themes.

Conclusions and Recommendations

This study has shown that stigma by association is a pervasive issue, which significantly impacts the mental health nursing workforce in Scotland. Mental health nurses reported a range of negative impacts of this stigma including trauma, stress and demotivation. The consequences of this stigma can be huge. Amongst mental health nurses in Scotland, stigma by association is leading to job dissatisfaction, low resilience and professional burnout. It also affects the recruitment and retention of mental health nurses, contributing to the critical shortage of mental health nurses in Scotland.

To address these challenges, the report suggests several recommendations.

1. **Education:** Increasing public understanding of mental health and the role of mental health nurses is crucial in reducing stigma. This can be achieved by incorporating mental health education within general nursing and broader medical professions. By educating the public and other healthcare professionals about the importance and complexity of mental health nursing, we can challenge misconceptions and promote a more accurate understanding of the profession
2. **Policy and Workplace Changes:** Implementing policies that promote a supportive and respectful workplace culture can help reduce stigma and improve job satisfaction. This includes creating policies that address intersectional stigma directly, and providing training for staff on how to support colleagues who may be experiencing stigma or discrimination.
3. **Raising the Profile of the Profession**: Actions to make the profession more visible and celebrated can attract more people to the field and reduce stigma. This can be done through public awareness campaigns, highlighting the achievements and contributions of mental health nurses, and promoting the profession as a valuable and rewarding career choice.

By implementing these recommendations, we believe it is possible to create a more supportive environment for mental health nurses, improve their job satisfaction, and ultimately enhance the quality of mental health care provided to patients.

See Me will work with the Mental Health Nursing Review Implementation Group and wider colleagues to consider the survey findings and develop, test, and evaluate stigma-reduction recommendations and interventions, drawing upon learning and evidence of what works.

Appendices

Appendix 1. Demographics data table

Table 3: Participant Demographics.

Demographic		All	Current MHN	Former MHN	Current MHN Student	Former MHN Student
Gender	Female	515	313	15	184	3
	Male	109	76	2	31	-
	Non-binary	4	-	-	4	-
	Prefer not to say	7	4	-	3	-
	Don't know	1	-	-	1	-
Sexuality	Heterosexual (straight)	504	321	14	167	2
	Homosexual (gay)	46	31	-	15	-
	Bisexual	54	23	1	30	-
	Asexual	2	-	-	2	-
	Others	3	-	-	3	-
	Prefer not to say	9	7	1	1	-
	Don't know	3	1	-	1	1
Disability and/or a long-term health condition	Yes	155	88	3	63	1
	No	453	290	13	148	2
	Not sure	10	3	-	7	-
	Prefer not to say	4	3	-	1	-
Mental health condition	Yes	293	165	5	121	2
	No	301	208	11	81	1
	Not sure	20	7	-	13	-
	Prefer not to say	7	3	-	4	-
Race/ Ethnicity	White	608	384	16	205	3
	Asian	1	1	-	-	-
	Mixed or multiple ethnic backgrounds	3	1	-	2	-
	African	14	2	-	12	-
	Caribbean or Black British	1	-	-	1	-
	Other Ethnic Group	1	-	-	1	-
	I do not wish to disclose my ethnic origin	2	-	-	2	-
Religion	None	409	243	7	157	2
	Christian	181	122	9	49	1
	Others	25	14	-	11	-
	Prefer not to say	7	5	-	2	-

Appendix 2. Clinician Associative Stigma Scale (CASS) data tables

Table 4: CASS item frequencies

Items	*n*	*Never*	*Rarely*	*Sometimes*	*Often*
CASS_1. I heard people outside of the mental health field express the view that mental health nurses don't know what they are doing/ can't really help.	636	9%	18%	48%	25%
CASS_2. I heard people outside of the mental health field express the belief that mental health nurses are to blame when people with serious mental health conditions harm themselves or others.	636	18%	21%	40%	21%
CASS_3. I heard people state or joke that work with people with serious mental illness is a job that doesn't require much skill.	635	24%	26%	30%	20%
CASS_4. I heard people state or joke that work with people with serious mental illness is a job that no one would want to do if they had the choice.	478	18%	21%	33%	28%
CASS_5. I heard other people say that the work I do/am studying/was studying to do is useless.	635	44%	26%	22%	8%
CASS_6. I heard other people say that the work I do/am studying/was studying to do is easy/could be done by anyone.	636	35%	28%	23%	14%
CASS_7. When I met a new person at a social gathering, I was reluctant to discuss my work/intention to work with people with serious mental illness.	635	40%	17%	24%	19%
CASS_8. When I was with other mental health professionals who did not work with people with serious mental illness, I was reluctant to discuss work/my intention to work with this population.	634	54%	21%	19%	6%
CASS_9. When I was with friends who work outside of the mental health field, I was reluctant to discuss my work/intention to work with people with serious mental illness.	635	45%	17%	23%	15%
CASS_10. When I was with relatives who work outside of the mental health field, I was reluctant to discuss my work/intention to work with people with serious mental illness.	633	47%	15%	22%	16%
CASS_11. When I told them about the work that I do/am intending/intended to do, people outside of the mental health field expressed concern for my safety related to my intention to work with people with serious mental illness.	635	6%	17%	45%	32%
CASS_12. When I told them about the work that I do/am intending/was intending to do, people outside of the mental health field expressed that it must be sad because people with serious mental illness don't improve in treatment.	634	14%	28%	42%	16%
CASS_13. When I told them about the work that I do/am intending/was intending to do, people outside of the mental health field remarked that the work must be "scary."	633	3%	10%	41%	46%
CASS_14. When people found out that I work/am studying/was studying to work with individuals with serious mental illness, they told me they could never do that type of work.	633	1%	2%	21%	76%
CASS_15. In media depictions that I encountered, mental health nurses are depicted as engaging in unethical behavior (for example, sexual relationships with clients).	635	19%	30%	37%	15%
CASS_16. In media depictions that I encountered, mental health nurses are depicted as having personal psychological problems.	636	13%	23%	42%	22%
CASS_17. I heard people state or joke that mental health nurses help others because they do not want to confront their own psychological problems.	636	25%	23%	34%	18%
CASS_18. When I told someone about the work I do/am intending/intended to do, they asked me if I was analysing them during conversations.	635	15%	18%	39%	28%
Overall	636	24%	20%	33%	23%

Table 5: CASS and sub-scales' descriptive statistics

	Total			*C_MHN*			Fo_MHN			C_Stu			Fo_Stu		
Variables	*n*	*Mdn*	*SD*	*n*	*Mdn*	*SD*	*n*	*Mdn*	*SD*	*n*	*Mdn*	*SD*	*n*	*Mdn*	*SD*
CASS	636	2.56	.53	393	2.58	.53	17	2.17	.48	223	2.56	.52	3	2.00	.83
Factor 1	636	2.50	.74	393	2.40	.73	17	2.00	.62	223	2.50	.74	3	2.00	.67
Factor 2	636	2.00	.95	393	2.25	.98	17	1.75	.76	223	1.25	.78	3	1.75	1.01
Factor 3	636	3.25	.59	393	3.25	.59	17	2.75	.50	223	3.50	.56	3	2.75	.80
Factor 4	636	2.75	.71	393	2.75	.70	17	2.25	.81	223	2.50	.72	3	1.50	1.01

Note. C_MHN – Current MHN, C_Stu – Current student, Fo_MHN – Former MHN, Fo_Stu – Former MHN student, CASS – Clinical Stigma by association Scale, Factor 1 - Negative stereotypes about professional effectiveness, Factor 2 - Discomfort with disclosure, Factor 3 - Negative stereotypes about people with mental illness, Factor 4 - Stereotypes about professionals' mental health.

Appendix 3: Psychometric analysis of the CASS

Prior to hypothesis testing, Shapiro–Wilk tests were conducted to assess normality (Mishra et al., 2019). The results indicated that the CASS total score and all four subscales did not meet the assumption of normality. Consequently, non-parametric alternatives were used for all analyses.

Psychometric testing on this current sample supported the validity of the CASS measure. Internal consistency of the measure was good (α = .85), and CASS total scores correlated significantly with participants' responses to the overarching question 'I experienced stigma and/or discrimination related to mental health nursing whilst at work/on placement or at university' (ρ=.188,p<.001, n=634), demonstrating concurrent validity of these measures of stigma by association.

Factor Structure

Exploratory factor analysis (EFA) of the **CASS scale** was conducted to confirm the underlying structure and shown to yield results similar to Yanos et al. (2017). The Kaiser-Meyer-Olkin measure of sampling adequacy was **.86**, exceeding the recommended threshold of **.50**, and Bartlett's test of sphericity was significant (χ^2 **= 3,370.56, df=153, p < .001**), confirming suitability for factor analysis.

Analysis of the scree plot of the principal axis factoring suggested that the four-component solution was optimal, with the first four components accounting for 59.9% of the total variance (see Figure 5). All seemed to clearly load on the same factors as of the original study (see Table 6) with cross-loading was found in only one item. Cronbach's alpha of the four sub-scales were found to be decent and similar to that of Cronbach's alpha values for the subscales ranged from **.69 to .88**, indicating good internal reliability and similar to values found in the original study (see Table 7).

Table 6: Factor analysis of CASS, alphas, and mean inter-item correlation factors

Items	Factor			
	1	2	3	4
CASS_1. I heard people outside of the mental health field express the view that mental health nurses don't know what they are doing/ can't really help.	0.719			
CASS_2. I heard people outside of the mental health field express the belief that mental health nurses are to blame when people with serious mental health conditions harm themselves or others.	0.484			
CASS_3. I heard people state or joke that work with people with serious mental illness is a job that doesn't require much skill.	0.834			
CASS_4. I heard people state or joke that work with people with serious mental illness is a job that no one would want to do if they had the choice.	0.517		0.322	
CASS_5. I heard other people say that the work I do/am studying/was studying to do is useless.	0.822			
CASS_6. I heard other people say that the work I do/am studying/was studying to do is easy/could be done by anyone.	0.825			
CASS_7. When I met a new person at a social gathering, I was reluctant to discuss my work/intention to work with people with serious mental illness.		0.877		
CASS_8. When I was with other mental health professionals who did not work with people with serious mental illness, I was reluctant to discuss work/my intention to work with this population.		0.761		
CASS_9. When I was with friends who work outside of the mental health field, I was reluctant to discuss my work/intention to work with people with serious mental illness.		0.925		
CASS_10. When I was with relatives who work outside of the mental health field, I was reluctant to discuss my work/intention to work with people with serious mental illness.		0.88		
CASS_11. When I told them about the work that I do/am intending/intended to do, people outside of the mental health field expressed concern for my safety related to my intention to work with people with serious mental illness.			0.751	
CASS_12. When I told them about the work that I do/am intending/was intending to do, people outside of the mental health field expressed that it must be sad because people with serious mental illness don't improve in treatment.			0.543	
CASS_13. When I told them about the work that I do/am intending/was intending to do, people outside of the mental health field remarked that the work must be "scary."			0.806	
CASS_14. When people found out that I work/am studying/was studying to work with individuals with serious mental illness, they told me they could never do that type of work.			0.766	
CASS_15. In media depictions that I encountered, mental health nurses are depicted as engaging in unethical behavior (for example, sexual relationships with clients).				0.796
CASS_16. In media depictions that I encountered, mental health nurses are depicted as having personal psychological problems.				0.823
CASS_17. I heard people state or joke that mental health nurses help others because they do not want to confront their own psychological problems.				0.594
CASS_18. When I told someone about the work I do/am intending/intended to do, they asked me if I was analysing them during conversations.				0.545
Coefficient *alpha*	.807	.888	.741	.685
Mean inter-item correlation	.700	.861	.717	.690

Factor: 1 - Negative stereotypes about professional effectiveness, 2 - Discomfort with disclosure, 3 - Negative stereotypes about people with mental illness, 4 - Stereotypes about professionals' mental health. N=636.

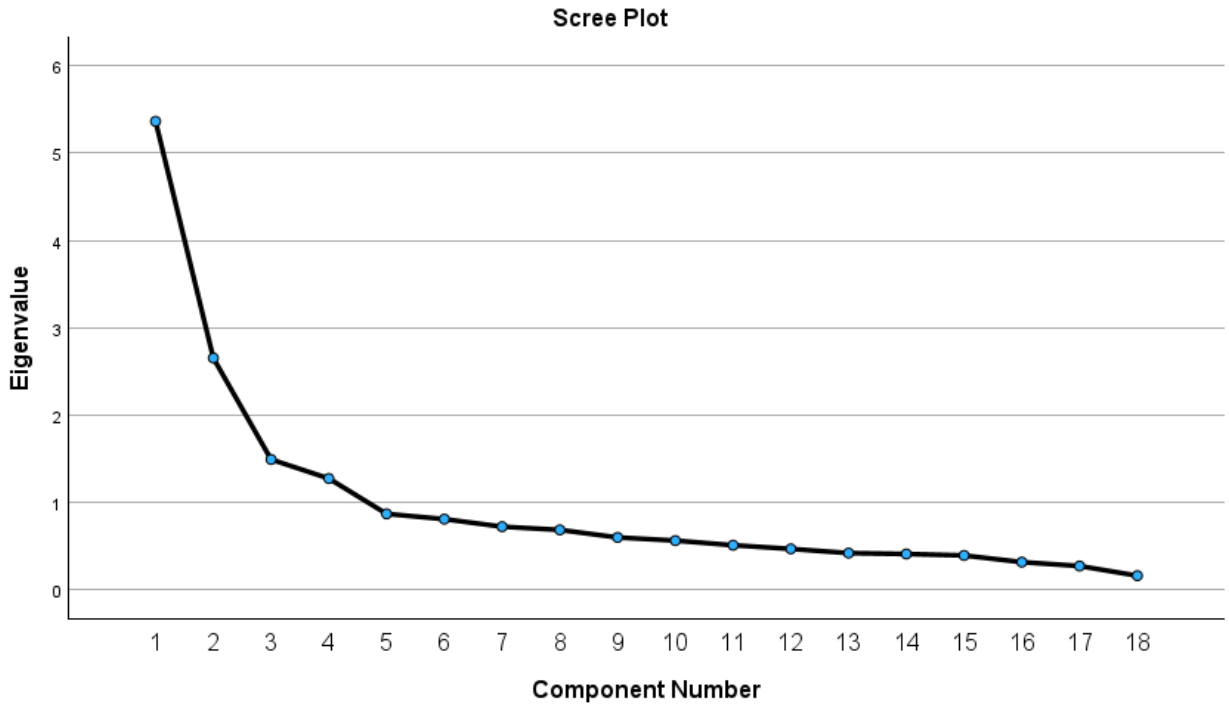


Figure 5: Exploratory Factor Analysis Scree plot

Wilcoxon Signed Ranks tests were conducted to compare stigma levels across the **four subscales**. The results indicated significant differences in endorsement levels across factors of stigma by association (see Table 8). **Negative stereotypes about people with mental illness (Factor 3)** had the highest endorsement (**Mdn = 3.25, SD = 0.59**), significantly higher than all other factors, while **Discomfort with disclosure (Factor 2) had the lowest endorsement** (**Mdn = 2.00, SD = 0.95**).

Table 7: Results of Wilcoxon Signed Rank Test on different factors of CASS

Comparison Pair	*Factor 1*		*Factor 2*		*Factor 3*		*Factor 4*		*Z*	*p*	*r*
	Mdn	*SD*	*Mdn*	*SD*	*Mdn*	*SD*	*Mdn*	*SD*			
Factor 1 – 2	2.50	.74	2.00	.95	3.25	.59	2.75	.71	*9.45*	<.001	0.37
Factor 1 – 3	2.50	.74	2.00	.95	3.25	.59	2.75	.71	*18.84*	<.001	0.75
Factor 1 – 4*	2.50	.74	2.00	.95	3.25	.59	2.75	.71	*5.32*	<.001	0.21
Factor 2 – 3	2.50	.74	2.00	.95	3.25	.59	2.75	.71	*18.66*	<.001	0.74
Factor 2 – 4	2.50	.74	2.00	.95	3.25	.59	2.75	.71	*12.49*	<.001	0.50
Factor 3 – 4	2.50	.74	2.00	.95	3.25	.59	2.75	.71	*16.14*	<.001	0.64

Note. N=636. *Factor 1 - Negative stereotypes about professional effectiveness, Factor 2 - Discomfort with disclosure, Factor 3 - Negative stereotypes about people with mental illness, Factor 4 - Stereotypes about professionals' mental health.*

** Relationship between Factor 1-4 was significant in MHN group, but not significant in student group.*

Appendix 4: Additional statistical testing of stigma scores by nursing group

Stigma by association experience by MHN practitioners and MHN students

Descriptive analyses suggested that practitioners and students might experience different levels of stigma, prompting further statistical testing. Prior to hypothesis testing, Shapiro–Wilk tests were conducted to assess normality (Mishra et al., 2019). The results indicated that the CASS total score and all four subscales did not meet the assumption of normality. Consequently, non-parametric alternatives were used, with Mann-Whitney U tests for between-group comparisons and Wilcoxon Signed Ranks tests for within-group comparisons.

Five Mann-Whitney U tests were performed to examine differences between Practitioners and Students in the CASS higher-order scale and its four subscales. The results showed **no significant difference** in overall **stigma by association** ($U = 41{,}029$, $p = .189$). However, significant differences emerged in three of the four subscales (see Table 5).

Students reported significantly higher stigma related to **negative stereotypes about professional effectiveness** (Factor 1, $U = 37{,}376$, $p = .002$) and **negative stereotypes about people with mental illness** (Factor 3, $U = 34{,}547$, $p < .001$).

Conversely, practitioners reported significantly higher stigma related to **discomfort with disclosure** (Factor 2, $U = 27{,}490$, $p < .001$). No significant difference was found between students and practitioners for **stereotypes about professionals' mental health** (Factor 4, $U = 40{,}416$, $p = .107$).

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