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Well-being, turnover intention, and stigma attitudes of mental health transition-to-practice nurses: A cross-sectional study

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Abstract
There is global recognition that mental health nursing can be stressful and have detrimental effects on nurses' well-being and retention. With substantial nursing shortages, there is an urgent need to attract and retain nurses to sustain this workforce and provide effective mental healthcare. Mental health transition programs provide vital recruitment pathways and support novice registered nurses, enrolled nurses and experienced registered generalist nurses moving into this field. There is little evidence, however, on the well-being, resilience, and retention of nurses transitioning into mental health. The primary aims for this cross-sectional study were to describe demographic characteristics, perceived stress, well-being, resilience, mental illness stigma attitudes, work satisfaction, and turnover intention of four nurse cohorts entering mental health transition programs: generalist registered nurses, graduate and post-graduate registered nurses, and enrolled nurses; to explore relationships between these variables; and explore differences between these four nurse cohorts. Findings (n=87) included overall moderate perceived stress, moderate well-being and resilience, high work satisfaction, low stigma, and low turnover intention. Higher turnover intention was associated with lower age and work satisfaction, and higher perceived stress. Generalist RNs had significantly higher stress and stigmatizing attitudes than Enrolled Nurses. Secondary analysis of well-being scores identified 14 nurses with scores indicating depression, with significantly lower resilience and work satisfaction, and significantly higher stress than the rest of the sample. To help prevent attrition, it is vital that mental health services provide tailored well-being initiatives during transition and intervene early to provide support for nurses with mental distress.

KEYWORDS
cross-sectional survey, mental health nursing, nursing graduates, transition-to-practice, well-being

INTRODUCTION

Nurses comprise the largest mental health workforce globally (WHO, 2021), with workforce shortages widely reported, including in the United Kingdom (Adams et al., 2021), Sweden (Holmberg et al., 2018) and the United States (Alexander et al., 2015; Rice et al., 2019). In Australia, by 2030 the national projected shortfall of nurses will be highest in the mental health sector (State of Victoria, 2019). The situation is similar in England where health services have been unable to fill projected mental health nurse quotas for around a decade, resulting in a deficit of over 12 000 mental health nurses (Brimblecombe, 2023).

Workforce shortages are due to several key factors. The workforce is ageing, and there is high turnover

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and attrition with increasing numbers of nurses leaving the mental health sector, and difficulty attracting staff (Brimblecombe, 2023; State of Victoria, 2019). Mental health nursing work is recognized as stressful due to structural factors such as staff shortages and poor skill mix (Foster et al., 2019), as well as the interpersonal nature of the work itself, which involves high emotional labour (Delgado et al., 2022) and exposure to interpersonal trauma, aggression and conflict (Cranage & Foster, 2022). These stressors can have detrimental impacts on mental health nurses' (MHN) mental health, well-being, and attrition; however, they can be mitigated through the reduction of stressors and strengthening of staff well-being and resilience (Foster et al., 2019). There is an urgent need to attract and retain nurses in the field of mental health to sustain the nursing workforce and provide effective mental healthcare for consumers.

In respect to attracting staff, however, mental health nursing is not a popular choice for most undergraduate/pre-registration nursing students and their decision not to work in the field on graduation can be influenced by stigmatizing attitudes towards people with mental illness (Happell et al., 2018). Until recently in Australia, recruitment has typically been through Graduate Nurse transition programs for undergraduate students entering the workforce as novice registered nurses, and through recruitment of overseas registered nurses (State of Victoria, 2019). More recently, to extend pathway options into the field and build the workforce, enrolled nurses and experienced generalist registered nurses (i.e. nurses who have worked in general nursing) have also been actively recruited to transition into mental health. In the context of workplace stress in mental health, and to support practice, enhance retention and provide tailored support for their well-being during transition, it is important to understand the characteristics and needs of all nurses entering the field. There is no current evidence, however, on mental health transition nurses' stress, well-being, resilience, turnover intention, and mental health stigma attitudes.

BACKGROUND

There is international recognition that working in mental health can be stressful and emotionally taxing (Lopez-Lopez et al., 2019). Nurses' emotional exhaustion from the demands of their work has been positively associated with high turnover intention (Yanchus et al., 2017). Stressors include staff shortages, workload demands and constraints, violence and aggression, and staff conflict (Foster et al., 2019). Transitioning into the workplace can be especially stressful for novice nurses, who may feel overwhelmed and experience lower psychological well-being (Jarden, Jarden, Weiland, Taylor, Brockenshire, & Gerdtz, 2021), particularly in the first year of transition (Hooper et al., 2016). All these factors have the potential to result in staff burnout (Lopez-Lopez et al., 2019), poorer mental health (Foster et al., 2021), job dissatisfaction and rapid staff turnover (Alenezi et al., 2019). In an already struggling healthcare sector, mental health services cannot afford to lose staff who they already have difficulty recruiting.

In mental health there is a growing body of evidence on the impacts of workplace stress, which is known to negatively impact nurses' mental health (Foster et al., 2021), and psychological well-being (Delgado et al., 2021). Well-being involves life purpose and meaning, autonomy, personal growth and development, self-acceptance, mastery of life situations, and positive relationships with others (Ryff, 2014). Mental health nurses' psychological well-being has been positively associated with resilience (Delgado et al., 2021), which plays an important role in mitigating the impacts of workplace stress. Resilience is a process of positive adaptation and recovery from stress and adversity that involves interaction between personal protective characteristics and environmental resources (Foster et al., 2019). Resilient nurses can respond to stressful or adverse situations while maintaining their sense of self and ability to emotionally regulate, which leads to restoration of their psychological well-being (Delgado et al., 2019; Foster et al., 2019). International review findings indicate that MHNs report moderate–high levels of resilience, with resilience positively associated with self-esteem, coping strategies and work and life satisfaction, and negatively associated with depression, stress, and burnout (Bui et al., 2023; Foster et al., 2019). Little, however, is known about mental health transition nurses' well-being and resilience. Importantly, in the context of workplace stress, nurses' well-being and resilience can be cultivated and health services can develop supportive strategies including programs and well-being strategies to support staff and help improve retention (Foster, Cuzzillo, & Furness, 2018).

In Australia, most nurses entering the mental health field have been tertiary graduates/novice registered nurses (RNs). Enrolled Nurses (ENs) also work in the field and have different levels of educational qualification and scope of practice to registered nurses. RNs undertake a tertiary nursing degree and receive national endorsement to practice upon graduation (Australian Nursing & Midwifery Accreditation Council [ANMAC], 2016). Practicing under the supervision of RNs, an Enrolled nurse (EN) undertakes a two-year diploma qualification, which is also endorsed by the accrediting body (ANMAC, 2016). Due to the lack of mental health-specific nursing content and clinical placements in comprehensive undergraduate degree programs (Happell et al., 2018) graduate transition-to-practice programs have traditionally and most commonly been developed for novice registered nurses to meet the specialist knowledge and skills required for mental health nursing practice. More recently, however, transition programs have a dual role:

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to support novice registered nurses in their transition to working in the field and provide a supportive program for other nurses such as enrolled nurses and experienced registered general nurses to make a specialty transition (Hampton et al., 2021). A further aim is to provide a channel for recruitment and retention of staff (Blay & Smooth, 2020). The most recent international reviews of mental health transition programs have focused primarily on graduate/novice nurses and their satisfaction and experience including with placements (Hooper et al., 2016; Procter et al., 2011; Tingleff & Gildberg, 2014). Reviews identified high graduate attrition overall, and a predominance of qualitative studies (Hooper et al., 2016; Tingleff & Gildberg, 2014). Limited available quantitative evidence indicates graduates' intention to remain in mental health is positively correlated with retention (Cleary et al., 2009), with high levels of transition program satisfaction and effectiveness reported (Procter et al., 2011). There are also, however, reports of negative clinical experiences (Hooper et al., 2016). Hazelton et al. (2011) found that novice RNs/graduates in mental health can struggle to fit into a clinical environment that is demanding and stressful and that senior staff often adversely impact this process through a lack of acceptance and support.

One of the ramifications of adverse workplace experiences is difficulty retaining new staff in mental health (Hazelton et al., 2011; Hooper et al., 2016), with some services experiencing high staff attrition one to two years following entry to the workforce (Hooper et al., 2016; Procter et al., 2011). Retention may also be influenced by stigmatizing attitudes to people with mental illness. Stigma involves stereotypical and prejudicial attitudes where people are collectively assigned negative characteristics associated with conditions such as mental illness, resulting in discrimination and prejudice (Corrigan & Wassel, 2008). Some mental health nurses have been found to hold negative attitudes towards people with mental illness (Hsiao et al., 2015), which has implications for their quality of practice and the mental health care consumers receive (Holder et al., 2019).

There are minimal studies on enrolled nurses transitioning into mental health. Quinn and Ryan (2016) found an EN transition program in forensic mental health increased ENs' mental health knowledge and skills and enhanced their retention. Porter et al. (2016), in a process evaluation, found that mental health transition programs increased ENs' confidence in their work. In summary, although there is some evidence on novice RNs/graduates' experiences transitioning into mental health nursing, most of this is more than seven years old, with minimal literature on enrolled nurses (ENs) transitioning into the field, and no published studies on generalist RNs transitioning to mental health, or on mental health transition nurses' well-being, resilience, and mental health stigma attitudes. To address these gaps in knowledge and gain foundation evidence that can be used to better support these nurses in the context of workplace stress and transition into the field, the primary aims for this cross-sectional study were to describe demographic characteristics, perceived stress, well-being, resilience, mental illness stigma attitudes, work satisfaction, and turnover intention of four nurse cohorts entering mental health transition programs: generalist registered nurses, graduate and post-graduate registered nurses, and enrolled nurses; to explore relationships between these variables; and explore differences between these four nurse cohorts.

METHODS

Research design

A cross-sectional descriptive correlational survey design was used (Lavrakas, 2008) to collect data from registered and enrolled nurses in the mental health transition-to-practice (hereafter transition) programs at the beginning of their program. The study is reported using EQUATOR network recommendations for quantitative (STROBE) data (Vandenbroucke et al., 2007). Ethics approval was granted by the relevant Human Research Ethics Committee (QA2022011).

Study setting

The setting was a large metropolitan public mental health service in Victoria, Australia, with participants in four mental health nurse transition programs: generalist RN; graduate RN, post-graduate RN, and enrolled nurse (EN). Data were collected from March to April 2022. The *generalist RN* program (n=40 cohort) was an 18-month combined program commencing with a six-month short course of intensive study for RNs with experience in nursing who wanted to transition into mental health. At the completion of the short course, these nurses move directly into a post-graduate Diploma of Mental Health Nursing. The *graduate RN* program (n=39 cohort) comprised novice registered nurses transitioning into the field. The program involved full-time employment, clinical rotations, study days, and coursework to receive recognition of prior learning towards a post-graduate Diploma of Mental Health Nursing. The *post-graduate program* (n=49 cohort) comprised nurses who had already completed a graduate program or RN transition program and were in their second or subsequent year working in the field. The *enrolled nurse (EN)* program (n=19 cohort) was a one-year program of training and education including 6 months of formal education with study days and assessment tasks, with the aim of specializing as psychiatric enrolled nurses. Some ENs have already been working in mental health but do a transition program

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to gain recognized education. All four programs involved a range of mental health clinical placements, study days, with the RN transition programs obtaining recognition of prior learning towards a mental health nursing qualification.

Participants

All nurses enrolled in the four transition programs at the mental health service were eligible to participate. In the first 4 weeks of their program participants were sent an email with a REDCap online survey link via their program coordinator inviting them to complete the survey, with several follow-up emails. They were also offered QR codes linking to the survey at program study days. Participation was voluntary, and consent was implied by completion of the survey. Sample size was based on study population. The final sample comprised $n=87$ usable surveys from the eligible population of 147 transition nurses, resulting in a 59% response rate.

Data collection

Outcome measures

Demographics included gender, age, professional role (i.e., RN or EN), transition program, years in nursing and years in MHN. *Well-Being* was measured with the World Health Organization – Five Well-Being Index (WHO–5), which measures subjective psychological well-being with 5 items on a 6-point Likert scale from 0 (at no time) – 5 (all of the time). The WHO – 5 is a widely used, reliable and valid measure of positive well-being (Cronbach's alpha = 0.90; Halliday et al., 2017) and a valid screening tool for depression. Total raw scores equal to or less than 12 are considered indicative of clinical depression (Topp et al., 2015). *Resilience* was measured with the Brief Resilience Scale (BRS), a valid and reliable measure (Cronbach's alpha 0.70–0.95; Windle et al., 2011) that averages the score on 6 items using a Likert scale from 1 (strongly disagree) to 5 (strongly agree), where higher scores indicate greater levels of resilience. Mean scores of 3–4.30 indicate moderate resilience, mean scores below 3.00 are considered low, and mean scores above 4.30 are considered high (Smith et al., 2013). *Turnover Intention* was assessed with the 4-item Turnover Intentions Scale (Kelloway et al., 1999), a reliable measure with high internal consistency (Cronbach's alpha = 0.92–0.93; Kelloway et al., 1999). Four items are rated on a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree) then summed. Higher scores indicate greater turnover intention. *Mental Health Stigma* was measured with the Opening Minds Scale for Health Care Providers (OMS-HC), a reliable measure (Cronbach's alpha = 0.79; Modgill et al., 2014) of mental health stigma attitudes among health professionals (Sastre-Rus et al., 2019). This 15-item measure is scored on a 5-point Likert Scale from 1 (strongly disagree) to 5 (strongly agree) and produces a total stigma score (Modgill et al., 2014). Higher scores suggest a more stigmatizing attitude. *Stress* was measured with the Perceived Stress Scale (PSS-10; Cohen et al., 1983) where higher scores indicate more perceived stress. Scores 0–13 are considered low stress, scores 14–26 are considered moderate, and scores 27–40 are considered high. This is a valid and reliable measure (Cronbach's alpha = 0.83; Cohen & Williamson, 1988) with 10 items rated on a 5-point unipolar scale from 0 (never) to 4 (very often). *Work satisfaction* was measured with a single item: "I am satisfied with my work life" rated on a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree), developed by Millear et al. (2008) and used in prior research with mental health nurses (Foster, Shochet, et al., 2018).

Data analyses

Continuous outcomes were described with means and standard deviations. Categorical outcomes were described with frequencies (n) and percentages (%). Pearson's and, for non-normal data, Spearman's correlation analyses were conducted to explore the associations between the outcome variables: age, years in nursing, years in mental health nursing, well-being, resilience, turnover intention, stigma, stress and work satisfaction. Differences between the four nurse cohorts for continuous variables were determined with one-way ANOVAs or, if non-normal, the Kruskal–Wallis (H) test. A secondary analysis of depression cutoff scores (WHO-5) was conducted. Differences between two groups, such as depressed versus not depressed groups on the WHO-5, for continuous variables were determined with the independent sample t-test or, if non-normal, the Mann–Whitney U test. Effect size for independent sample t-test was reported as Cohen's d and for Mann–Whitney U was reported as rank-biserial correlation r. Significance was accepted at $p \leq 0.05$. A few demographic items and some measures were not answered by some participants. There was no imputation of missing data. Data were analysed with SPSS Version 29.

RESULTS

Demographics

Demographics for the four nurse cohorts and in total are shown in Table 1. There were $n=61$ (70.1%) females, $n=24$ (27.6%) males and 2 (2.3%) participants who identified as non-binary. Of the 87 participants, $n=69$

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TABLE 1 Demographic characteristics.

Demographic	Generalist RN n (%)	Graduate RN n (%)	Postgraduate RN n (%)	EN n (%)	Total n (%)
Gender					
Male	8 (29.6)	5 (20.0)	7 (41.2)	4 (22.2)	24 (27.6)
Female	19 (70.4)	20 (80.0)	10 (58.8)	12 (66.7)	61 (70.1)
Other	–	–	–	2 (11.1)	2 (2.3)
Age (years)					
20 to <30	9 (33.3)	11 (44.0)	9 (52.9)	9 (50.0)	38 (43.7)
30 to <40	13 (48.1)	10 (40.0)	4 (23.5)	5 (27.8)	32 (36.8)
40+	3 (11.1)	3 (12.0)	4 (23.5)	3 (16.7)	13 (14.9)
Missing	2 (7.4)	1 (4.0)	-	1 (5.6)	4 (4.6)
Time working in nursing					
Less than 1 year	7 (25.9)	18 (72.0)	1 (5.9)	12 (66.7)	38 (43.7)
1 to <5 years	15 (55.6)	5 (20.0)	12 (70.6)	5 (27.8)	37 (42.5)
5 to <10 years	1 (3.7)	1 (4.0)	3 (17.6)	1 (5.6)	6 (6.9)
10+ years	4 (14.8)	1 (4.0)	1 (5.9)	0 (0.0)	6 (6.9)
Time working in mental health					
Less than 1 year	24 (88.9)	22 (88.0)	3 (17.6)	17 (94.4)	66 (75.9)
1 to <5 years	2 (7.4)	2 (8.0)	13 (76.5)	1 (5.6)	18 (20.7)
5 to <10 years	1 (3.7)	1 (4.0)	1 (5.9)	0 (0.0)	3 (3.4)

Abbreviations: EN, enrolled nurses; RN, registered nurses.

TABLE 2 Means, standard deviations, and comparable means.

Measure	Scale range	Mean (SD)	Norms or comparable means
WHO–5: Well-being index (n=79)	0–25	16.04 (4.04)	15.24 (5.89)[a]
BRS: Resilience (n=77)	1–5	3.58 (0.62)	3.46 (0.61)[b]
TIS: Turnover intention (n=79)	4–20	7.25 (3.34)	–
OMS-HC: Stigma (n=77)	15–75	29.14 (7.01)	33.70 (6.60)[c]
PSS-10: Perceived stress (n=77)	0–40	14.69 (5.04)	12.10 (5.90)/13.70 (6.60)[d]
Work satisfaction (n=87)	1–5	4.15 (0.74)	3.4 (1.0)[e]

[a]Janzarik et al. (2022) (72 general nurses in Germany).
[b]Chang et al. (2019) (201 general nurses in Singapore).
[c]Modgill et al. (2014) (238 mental health nurses and psychologists in Canada – see Additional File 4).
[d]Cohen and Williamson (1988) (norms for n=2387 in the United States, first values (M=12.10, SD=5.90)=males and second set (M=13.70, SD 6.60)=females.
[e]Foster, Cuzzillo, & Furness (2018); Foster, Shochet, et al. (2018) (24 mental health nurses in Australia).

(79.3%) were registered nurses. The majority had been in nursing less than 5 years (n=75; 86.2%) and n=66 (75.9%) had less than a year's experience working in mental health.

Descriptive statistics and comparisons with relevant norms and means are presented in Table 2. Means indicated overall moderate perceived stress, moderate resilience and moderate well-being across the sample. In respect to work-related measures, there was overall high work satisfaction and low turnover intention. In respect to stigma attitudes, the overall mean indicated low stigma.

A group of 14 participants scored below the cut-off for depression on the WHO-5 (Topp et al., 2015). This was an important finding which was explored in a secondary analysis. Compared to those scoring above the depression cut-off, these nurses had significantly higher perceived stress (mean difference=−6.6, Cohen's d=−1.5, p<0.001), and lower resilience (mean difference=0.56, Cohen's d=0.963, p=0.002), and work satisfaction (mean difference=0.53, Cohen's d=0.730, p=0.015). There was no significant difference in turnover intention between nurses whose scores met the cut-off for depression and those who did not

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(mean rank difference = 442, rank-biserial correlation $r = 0.029$, $p = 0.865$).

Comparing means between transition nurse cohorts

Results of the cohort comparisons are presented in Table 3. Some key between-group differences: Generalist RNs reported significantly higher stigma (mean difference = 7.01, Cohen's $d = 0.99$, $p = 0.001$) and stress (mean difference = 4.38, Cohen's $d = 0.363$, $p = 0.006$) than ENs, and significantly higher stigma than postgraduate RNs (mean difference = 5.66, Cohen's $d = 0.800$, $p = 0.010$). Postgraduate RNs also had significantly higher stress than ENs (mean difference = 3.76, Cohen's $d = 0.776$, $p = 0.025$).

Correlations between demographics and measures

All correlations are shown in Table 4. Given the prior literature in mental health nursing, our primary interest was in exploring the variables associated with well-being, resilience, and turnover intention for these transition nurse cohorts. Higher well-being was associated moderately with older age ($r = 0.34$), moderately with higher work satisfaction ($r = 0.49$), weakly with turnover intention ($r = -0.22$), moderately with resilience ($r = 0.40$), and strongly with lower perceived stress ($r = -0.65$). Higher resilience was associated moderately with older age ($r = 0.30$), weakly with higher work satisfaction ($r = 0.26$), and moderately with lower stigma ($r = -0.35$) and strongly with perceived stress ($r = -0.65$). Higher turnover intention was associated weakly with lower age ($r = -0.24$), moderately with lower work satisfaction ($r = -0.44$) and weakly with higher perceived stress ($r = 0.27$).

DISCUSSION

The aims for this study were to describe demographic characteristics, perceived stress, well-being, resilience, mental illness stigma attitudes, work satisfaction, and turnover intention of four nurse cohorts entering mental health transition programs; to explore relationships between these variables; and explore differences between the four cohorts. This is the first study to report on the characteristics of different groups of registered and enrolled nurses entering mental health transition programs and provides several new key findings.

Overall, there was moderate perceived stress of transition nurses. The mean was slightly higher than US population means (Cohen & Williamson, 1988), but substantially lower than some other mental health nurses (Masa'deh et al., 2017) and indicates that on entry

TABLE 3 Comparisons between transition nurse cohorts.

Measure	Generalist RN Mean (SD)	Graduate RN Mean (SD)	Postgraduate RN Mean (SD)	EN Mean (SD)	*p*-value	Comment[a]
WHO-5: Well-being ($n = 79$)	16.1 (3.8)	16.2 (3.8)	14.8 (4.8)	16.9 (3.9)	0.502[b]	No differences between cohorts
BRS: Resilience ($n = 77$)	3.4 (0.7)	3.6 (0.7)	3.5 (0.3)	3.8 (0.6)	0.205[b]	No difference between cohorts
TIS: Turnover intention ($n = 79$)	8.3 (3.4)	6.4 (2.7)	7.9 (4.5)	6.2 (2.1)	0.173[c]	No difference between cohorts
OMS-HC: Stigma ($n = 77$)	33.0 (7.7)	29.4 (5.5)	27.3 (6.4)	25.9 (6.4)	0.007[b]	Generalist RN > Postgraduate RN ($p = 0.010$) Generalist RN > EN ($p = 0.001$)
PSS-10: Stress ($n = 77$)	16.3 (5.2)	14.7 (4.4)	15.6 (4.7)	11.9 (4.9)	0.036[b]	EN < Postgraduate RN ($p = 0.025$) EN < Generalist RN ($p = 0.006$)
Work satisfaction ($n = 87$)	4.2 (0.6)	3.9 (1.0)	4.1 (0.6)	4.5 (0.6)	0.088[b]	No difference between cohorts

Abbreviations: EN, enrolled nurses; RN, registered nurses.
[a]Based on LSD post-hoc test.
[b]One-way ANOVA.
[c]Kruskal–Wallis test used as variable not normally distributed.

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TABLE 4 Correlations.

	1	2	3	4	5	6	7	8	9
1. Age[a] (n=85)	–								
2. Years in nursing[a] (n=87)	0.39*	–							
3. Years in MH nursing[a] (n=87)	0.24*	0.58*	–						
4. WHO-5: Well-being (n=79)	0.34*	−0.04	−0.21	–					
5. BRS: Resilience (n=77)	0.30*	−0.05	−0.07	0.40*	–				
6. TIS: Turnover intention[a] (n=79)	−0.24*	0.16	0.08	−0.22	−0.09	–			
7. OMS-HC: Stigma (n=77)	0.11	−0.01	−0.14	0.18	−0.35*	0.07	–		
8. PSS-10: Stress (n=77)	−0.26*	0.16	0.16	−0.65*	−0.65*	0.27*	0.14	–	
9. Work satisfaction (n=87)	0.22*	0.01	0.01	0.49*	0.26*	−0.44*	0.00	−0.36*	–

*Significant at $p<0.05$.

[a]Spearman's correlation coefficient used as variable not normally distributed.

to mental health transition programs our sample felt moderately overloaded but not overwhelmed by stress (Cohen & Williamson, 1988). There was overall moderate well-being and resilience across this group of transition nurses. The finding on resilience is generally consistent with scores reported across studies in mental health nursing, which were moderate-high (Bui et al., 2023). There are no directly comparable *transition* findings in mental health nursing, but these findings are also somewhat consistent with general graduate transition programs in nursing; however, the prevalence of well-being and resilience of graduates in the review of transition programs by Jarden, Jarden, Weiland, Taylor, Bujalka, et al. (2021) (using different measures) was reported as high (rather than moderate). We also found moderate positive associations between well-being and resilience, which is generally consistent with review findings on mental health nurses' well-being and resilience across studies (Bui et al., 2023), and with those of Delgado et al. (2021) although they reported strong positive associations. The weak negative association between well-being and turnover intention is broadly consistent with the wider transition literature (Jarden, Jarden, Weiland, Taylor, Bujalka, et al., 2021) but not previously reported in mental health nursing literature and warrants further investigation. Our findings indicate there is opportunity to further support well-being and resilience for mental health transition nurses. There are no prior reports on ENs' well-being in transition programs and the current study provides new evidence on the characteristics of both RNs and ENs transitioning into mental health.

The well-being and resilience findings in this study are as might be expected and hoped for with transitioning nurses, most of whom were newly entering the field. However, the finding that a sub-group (n=14) of nurses (across the 4 transition cohorts) had scores indicating depression with significantly lower well-being, resilience, and work satisfaction, and significantly higher perceived stress than the larger group, is concerning. Further, three of those 14 nurses had scores indicating major depression (Topp et al., 2015). The poor mental health of mental health nurses has been reported previously (Foster et al., 2021); however, this finding in respect to transition nurses is new. Depression is a high prevalence condition in Australia (Australian Institute of Health & Welfare, 2022), and it is well-recognized that some nurses come to mental health with their own pre-existing mental health concerns (Joyce et al., 2009; Oates et al., 2018), and this is likely to account for this finding overall. The evidence that some nurses transitioning into mental health have their own substantial mental distress needs urgent attention as it has implications for nurses' retention, their ability to provide effective mental healthcare, and for their well-being and functioning over time. For these reasons, healthcare organizations need to be aware that some staff will be experiencing mental health concerns, and need to have specific well-being policy, processes, and strategies to effectively support transition staff as well as experienced staff with mental distress. It is important to acknowledge that most existing workforce well-being and resilience interventions are designed as universal prevention strategies (Foster, Cuzzillo, & Furness, 2018). They are not interventions for mental distress.

There was overall high work satisfaction of nurses in our study, as might be expected at this early stage of transition. This finding is broadly consistent with wider graduate transition findings (Jarden, Jarden, Weiland, Taylor, Bujalka, et al., 2021) and is higher than prior reports on work satisfaction of other mental health nurses (Foster, Shochet, et al., 2018). We also found higher turnover intention was associated with lower work satisfaction, which is consistent with findings from prior MHN studies (Alsaraireh et al., 2014). Turnover intention was substantially lower compared to some other nursing groups (e.g. Pang et al., 2022). The low turnover intention reported in the current study, however, is not consistent with reports of attrition in other mental health transition studies (Hooper et al., 2016; Procter et al., 2011). Our study was conducted early in transition, and it would be unusual at this stage to find nurses were not satisfied with their

work or were considering leaving the field. Turnover intention is the strongest predictor of actual turnover (Lazzari et al., 2022). It will be important to track the outcomes of mental health transition nurses over time to see whether they change. As Jarden, Jarden, Weiland, Taylor, Bujalka, et al. (2021) found in their wider review of graduate transition programs, intention to stay in nursing is influenced by skill acquisition and proficiency, feeling accepted by colleagues, and being clear about what their nursing role entails. In mental health transition (Hooper et al., 2016), turnover is also related to having positive attitudes towards mental health nursing and positive clinical placement and work experiences during transition.

In respect to their practice, our findings indicated transition nurses held low stigmatizing attitudes overall, and slightly lower than those reported from other nurses in mental health (Modgill et al., 2014). This is a positive finding in the early stage of nurses' transition to the field and has implications for their provision of effective mental healthcare, and potentially, for their retention in the field. There were, however, significant differences between the transition programs, with generalist RNs reporting higher stigmatizing attitudes than postgraduate RNs and ENs. Generalist RNs are transitioning into mental health and may not have had recent mental health education or experience with people with mental illness. They have been found in other studies to hold stigmatizing attitudes towards people with mental illness (e.g. Al-Awadhi et al., 2017). With further mental health education, and greater clinical exposure to mental health consumers, their attitudes are likely to improve. The difference in attitudes between generalist RNs and ENs may also be related to ENs having increased mental health content and education in their diploma programs (Dalton et al., 2015), which may have positively impacted their attitudes towards people with mental illness. Follow-up investigation over time on generalist nurse attitudes towards people with mental illness during their transition into mental health is needed.

With respect to the findings on ENs, although they are a growing workforce in mental health, and there is some investigation of their transition experiences and satisfaction (Porter et al., 2016; Quinn & Ryan, 2016), there has been no investigation of their well-being and resilience and no direct comparisons can be made. A novel finding in our study was that generalist and postgraduate RNs reported significantly greater stress than ENs. This finding may in part be related to greater demands and responsibilities that RNs have in their roles compared to that of ENs. There is a need for further investigation of the outcomes for both RNs and ENs in mental health transition programs over time. Using mixed methods approaches, which include qualitative data, may provide more comprehensive understandings of factors and experiences influencing outcomes across cohort groups.

This study was exploratory and limited to a relatively small sample of transition nurses in one mental health setting at one time point who were entering transition programs. Due to the lack of prior literature and limited sample sizes across RN and EN transition cohorts we were unable to explain some differences in outcomes between them. Further research is needed with larger samples of mental health transition nurse cohorts over time. The study was conducted during the ongoing COVID-19 pandemic, which may have affected nurses' willingness to respond to a survey. Not all the nurses in the transition programs chose to participate in the study and their characteristics and results may be different. As such, the findings may not be generalizable to other contexts.

CONCLUSION

This study adds valuable new foundation information on the characteristics of RNs and ENs transitioning into the mental health field. Understanding the outcomes of transition nurses is important given the growing emphasis on these programs as pathways for attracting a range of nurses into the field. There has been a dearth of literature on mental health transition programs in recent years, and most of the investigations to date have been small scale studies focused on novice graduate nurses and their satisfaction and experiences with programs, rather than on the well-being, resilience, turnover intention and practice-related characteristics such as mental illness stigma attitudes of the range of nurses coming into the field. Given the importance of transition programs for recruitment and retention, we recommend continuing to investigate well-being, turnover intention, and practice-related outcomes of larger groups of mental health transition nurses over time, and to use mixed methods approaches. As Hooper et al. (2016) found, it is possible that these early, generally positive, characteristics may change over time due to workplace stress and the realities of clinical work in pressured mental health environments, negative organizational cultures, and/or lack of adequate support from managers and organizations.

RELEVANCE TO CLINICAL PRACTICE

Transition programs are a vital source of support and education for nurses entering the mental health field and are key in attracting and retaining nurses. To enhance retention in the context of mental health workplace stress and the known dropout of nurses in their early years of transition (Hooper et al., 2016), as well as to support nurses' mental health and well-being (Foster, Shochet, et al., 2018) the findings of this study highlight the need to incorporate well-being and resilience

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strategies and education as fundamental components of mental health transition programs, to help build nurses' skills in managing their mental health and well-being and to sustain their resilience throughout their career. Well-being and resilience may also be enhanced when programs include opportunities for beginning practitioners to engage in reflective practice including action learning sets (ALS; facilitated group discussions to strengthen critical reflection on practice). These have been found to be supportive for nurses transitioning into mental health and can increase their confidence in their mental health practice (Hopkins et al., 2021). Given the diverse groups of nurses coming into mental health, and to develop their attitudes and practice, it is also recommended that mental health stigma reduction strategies are included, with education by lived experience educators, culturally and linguistically diverse presenters, gender sensitive education and supported clinical placements.

AUTHOR CONTRIBUTIONS

In accordance with the International Committee of Medical Journal Editors guidelines, all authors meet the authorship criteria, and all authors are in agreement with the manuscript.

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CONFLICT OF INTEREST STATEMENT

Professor Kim Foster is a current International Journal of Mental Health Nursing Editor. She took no part in the management, reviewer selection or review outcomes of this paper.

DATA AVAILABILITY STATEMENT

Research data are not shared.

ETHICS STATEMENT

Ethics approval was granted by the relevant Human Research Ethics Committee (QA2022011).

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