ORIGINAL ARTICLE

Mental health nurses' experience of challenging workplace situations: A qualitative descriptive study

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ABSTRACT: Mental health nursing is acknowledged internationally as being a demanding profession; however, little is known about the range of experience and complexity of workplace challenges or their impacts on mental health nurses (MHN). This qualitative descriptive study aimed to examine and describe the range of challenging workplace situations experienced by MHN and is reported according to the Standards for Reporting Qualitative Research. An online cross-sectional survey collected demographic data and open-ended descriptions of workplace challenges experienced by n = 374 Australian MHN. Using a modified a priori framework, four categories of experience were derived through content analysis: consumer-related, colleague-related, nursing role-related, and organizational service-related challenges. Many accounts described a complex interplay of challenges. The findings extend prior knowledge on MHN experiences. Frequent workplace challenges included violence and aggression from consumers, bullying from colleagues, low staffing levels, and poor skill mix. Further extending the evidence, key challenges rarely described in prior literature were the psychological impacts of suicides and murder; the personal nature of threats from consumers; moral distress and concerns with colleagues' quality of practice; and exacerbation of practice-related issues by lack of support from colleagues and/or the organization. These have important implications for the profession and can inform targeted strategies to reduce stressors where possible, build staff well-being, support workforce retention, and improve the provision of quality care. The implementation of targeted policy and initiatives that focus on reducing key stressors and supporting practice are vital to staff retention and ensuring a high standard of practice in complex mental health workplaces.

KEY WORDS: mental health nursing, qualitative, stressors, well-being, workplace.

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INTRODUCTION

Mental health nursing is acknowledged internationally as being a demanding profession due to workplace stressors and challenges (Abdalrahim 2013; Tuvesson & Eklund 2017; Yao *et al*. 2020). These can have significant negative impacts on mental health nurses' (MHN) physical and psychological health and well-being, their practice, and on workforce retention (Foster *et al*. 2020; Hasan *et al*. 2018). In addition to the poor physical and psychological health and well-being of MHN, in Australia, there is a significant national shortage of

MHN, with a projected shortage of approximately 18,500 by 2030 (Health Workforce Australia 2014). The important issue of workplace stress for MHN, the largest group of the mental health workforce, requires further exploration in respect to the range of experience of workplace challenges to inform targeted strategies to strengthen the well-being of the MHN workforce, and initiatives to reduce stressors and support retention and help ensure that Australia has skilled health professionals to provide specialized care for mental health consumers.

BACKGROUND

Nursing has long been recognized as high-stress occupation (Santos *et al.* 2003). Mental health is a unique specialty in nursing, with a developing body of knowledge on work-related stress and well-being. A key facet of MHN work is the therapeutic nurse–consumer interpersonal relationship as the foundation of practice. This involves substantial levels of emotional labour (Delgado *et al.* 2020; Edward *et al.* 2017). In their practice, mental health nurses often manage crisis situations that are complex, unpredictable, and with high incidences of conflict, violence, and aggression (Tonso *et al.* 2016). This role complexity means that while the nature of work-related stressors may have similarities with that of the wider field of nursing, MHN can experience stressors of differing intensity or regularity. Workplace violence, for example, is a prominent stressor in mental health nursing (Abdalrahim 2013). Al-Azzam *et al.* (2017) revealed that more than 80% of MHN (*n* = 110) had experienced workplace violence in the previous two years. As Gerace *et al.* (2018) report, this form of conflict can disrupt the therapeutic nurse–consumer relationship, and nurses need to employ and demonstrate empathy to manage risk, maintain safety, and support the therapeutic relationship in conflictual situations with consumers. Other workplace stressors include workplace bullying by colleagues (Foster *et al.* 2021), the high acuity of consumers MHN often care for in inpatient settings (Tonso *et al.* 2016), and organizational factors such as staff shortages, poor skill mix, lack of inpatient beds (Al-Azzam *et al.* 2017), and lack of supportive management and leadership (Gabrielsson *et al.* 2016).

Workplace stress has been found to impact negatively on staff's health and well-being. Prior research has identified that stress has a substantial negative impact on MHNs' mental health and well-being, often leading to burnout and compassion fatigue (Bell *et al.* 2019; Brown *et al.* 2017). Further, Tonso *et al.* (2016) identified a significant relationship between occupational violence and psychological distress. Violence has been associated with trauma and risk of psychological sequelae including post-traumatic stress disorder (PTSD) (Hilton *et al.* 2021). Other psychological impacts included anxiety, depression, self-doubt, and substance misuse. In addition, ongoing workplace stress can cause prolonged stress responses that result in physical concerns including insomnia and exhaustion (Hasan & Tumah 2019; Tema *et al.* 2011).

While there is growing international evidence on stressors for MHN, much of this is quantitative in nature and does not provide understandings of nurses' experiences. It is important to understand the range of experiences of workplace challenges for mental health nurses to inform the development of targeted strategies that help reduce stressors and their impacts on MHN and help improve MHN well-being. While there have been some qualitative studies on specific stressors, there is a knowledge gap on the range of experience and complexity of workplace challenges for MHN. The aim of this study was to examine and describe the range of challenging workplace situations experienced by Australian MHN. This was for the purpose of gaining a greater understanding of the nature, range, and complexity of challenges experienced by mental health nurses to extend knowledge and inform future targeted workplace strategies to prevent or mitigate impacts on the well-being and practice of this essential mental health workforce group.

METHODS

Research design

This qualitative descriptive study is part of a larger mixed methods study of Australian MHN, which used a cross-sectional survey design to describe the relationship between MHNs' stressors, psychological well-being, resilience, and caring behaviours (Foster *et al.* 2020, 2021). The current study is reported according to the Standards for Reporting Qualitative Research (SRQR) (O'Brien *et al.* 2014) and comprises analysis of open-ended responses where participants were asked to describe a challenging workplace situation they had experienced. Ethics approval was gained from the relevant University Human Research Ethics Committee (2017-265E). Completing the online survey implied informed voluntary consent.

Study setting

The survey was distributed to participants in digital format and completed online (Foster *et al.* 2020). Collection of data occurred over a three-month period in 2018, with follow-up collection over several months. The mental health nursing workforce (registered and enrolled nurses) within Victoria in 2016-2017 was 4180 (Royal Commission into Victoria's Mental Health System 2019).

Participants

Registered and enrolled nurses working in Victorian mental health roles and/or services were eligible to participate. Convenience and snowball sampling were employed to recruit participants (see Foster *et al.* 2020 for full description of the process). The survey was distributed via several avenues including to Directors of Nursing in public mental health services, and by the Victorian branch of the Australian Nursing and Midwifery Federation (ANMF) and the Health and Community Services Union (HACSU) to their members (Foster *et al.* 2020). A total of $n = 374$ participants completed the open-ended question on challenging situations.

Data collection

In an open-ended question, participants were asked to describe a challenging workplace situation they had experienced. Written self-report offered anonymity to participants, allowing for candid responses that might normally be withheld (Polit & Beck 2017). Further, online self-report data eliminated interviewer bias (Polit & Beck 2017). Sociodemographic characteristics were collected including gender, age, location, professional role, specialist postgraduate qualification, current setting, primary role in current setting, and years working in mental health.

Data analysis

Data were analysed using directed content analysis. This analytic approach is used to validate or extend prior theoretical frameworks or theory (Hsieh & Shannon 2005). The approach was appropriate as the current study extends prior research by Foster and colleagues (2020), where an *a priori* framework for workplace stressors was developed. This was used in the current study to initially categorize workplace challenges. Data were coded by the first author according to Saldana's (2014) process, which involved reading and re-reading participant responses and applying codes. First Cycle coding involved reading textual data and highlighting sections of text that appeared related to the predetermined categories identified by Foster *et al.* (2020). Codes were initially categorized based on the *a priori* framework of organizational (service and role), consumer-related, and nurse-related workplace challenges. Following this, in vivo coding was employed, generating codes using wording that closely matched participant responses.

Second Cycle coding involved using focused coding, including recognition of earlier identified content, and new content, which were coupled with analytic memos, which provided useful insights into the rationale for coding (Saldana 2014). During this process, constant comparison was applied to the data to refine coding. This involved each piece of data being extracted and coded, with similar data grouped and categorized. The coded categories were then compared (Whittemore & Knafl, 2005). Initial coding and categories were reviewed by the second author and discussed. An iterative process of refining categories was then conducted by both authors. Some coded segments did not fit within the initial *a priori* categorical matrix, and some categories were subsequently redefined, with new subcategories inductively created (Elo & Kyngas 2008). Searches for the most frequent or significant initial codes were also undertaken to develop categories. Data that could not be coded were highlighted and analysed later to determine whether they represented a new category or a subcategory of an existing category (Hsieh & Shannon 2005). Unclear responses were excluded ($n = 16$), resulting in the final count of $n = 645$ codes, as some participants described situations in detail, and/or described more than one situation. These included challenges that were relevant to more than one category.

RESULTS

Sample descriptors are shown in Table 1. Of the 374 participants, 279 (75%) were female and 310 (85%) were aged over 30 years. A total of 233 (62%) were located in metropolitan areas, and 335 (90%) were registered nurses. The majority worked in community and inpatient mental health settings ($n = 310$; 83%) and had worked in mental health for at least 10 years ($n = 237$; 67%).

Nurses reported a wide range of challenging situations, with responses ranging from a sentence outlining the situation through to more detailed narrative descriptions. One-third of participants described two or more types of challenges in the one situation, identifying a complex interplay of challenges. Content analysis resulted in four main categories, with sub-categories, describing challenging workplace situations: consumer and carer-related; colleague-related; nursing role-related; and organizational service-related, with frequency counts for codes in each category (Hsieh & Shannon, 2005). See Table 2 for frequencies of situations in each category and for sub-categories within each category.

TABLE 1 *Sample descriptors* (N = 374)

Descriptor	Category	n (%)
Gender	Female	279 (75)
	Male	93 (25)
	Other	1 (<1)
	Missing	1
Age	21-29	56 (15)
	30-39	71 (19)
	40-49	84 (23)
	50-59	106 (29)
	>60	49 (14)
	Missing	8
Location	Metropolitan	233 (62)
	Regional	107 (29)
	Rural	31 (8)
	Other	2 (<1)
	Missing	1
Professional role	Registered Nurse	335 (90)
	Enrolled Nurse	38 (10)
	Missing	1
Specialist MHN postgraduate qualification (n = 336)	Yes	229 (68)
	No	107 (32)
Current setting	Community	140 (37)
	Inpatient	170 (46)
	All other settings†	63 (17)
	Missing	1
Primary role in current setting	Nurse	122 (36)
	ANUM/NUM/ Senior role	86 (26)
	All other roles‡	128 (38)
	Missing	38
Years working in mental health	<1-4	57 (16)
	5-9	62 (17)
	10-14	49 (14)
	>14	188 (53)
	Missing	18

†All other settings: assessment/short stay, emergency department, general hospital, general practice, primary care services, forensic, education, and counselling.

‡All other roles: clinical nurse consultant, clinical nurse educator, clinical nurse specialist, nurse academic, nurse educator, nurse practitioner, private practitioner, researcher, and quality and risk assessment.

TABLE 2 *Workplace stressor categories and sub-categories frequency* (n = 645)

Category	Sub-categories	n (%)
Consumer/carer: Includes addressing consumer/carer needs, challenging or confrontational behaviours, suicide, self-harm, and nursing interactions with consumers and carers	Violence and aggression (n = 196, 62%) • Physical and Aggressive Behaviour • Verbal Aggression • Threats Suicidality (n = 46, 15%) • Completed Suicide • At Risk of Suicide • Suicidal Behaviour Client Death (n = 6, 2%) Self-Harm Behaviour (n = 20, 6%) Challenging Behaviour (n = 47, 15%) • Substance Affected • Inappropriate Sexual Behaviour • Absconding • Destruction of Hospital Property • Challenging Behaviours in Practice	315 (49)
Colleague: Includes negative staff interactions (inclusive of emergency services staff), communication, relationships and conflict, poor behaviour/ professional misconduct, poor quality of practice, issues with team and managerial support	Management; Bullying, Behaviour & Support (n = 48, 28%) • Bullying by Management • Perceived Poor Behaviour by Management • Lack of Support by Management Colleagues; Bullying, Behaviour & Support (n = 68, 41%) • Bullying by Colleagues • Perceived Poor Behaviour by Colleagues • Lack of Collegial Support Quality of practice (n = 49, 29%) • Perceived Poor Quality of Colleague Practice • Dilemmas in Practice Other (n = 4, 2%) • Managing Staff Complaints • Death of Colleague	169 (26)
Nursing role: Includes practice-related concerns in the nurse performing their role, quality of care, and maintaining standards of practice while managing personal well-being	Time Constraints & Workload Demands (n = 41, 65%) • Stressful Workloads • Multiple Demands at One Time • Working Alone Quality of Care (n = 9, 14%) • Lack of Management Plan • Lack of Medication Other (n = 13, 21%) • Personal Well-being • Supporting Colleagues • Managing Work/Life Balance • Job Insecurity • Unpredictable Events	63 (10)

(Continued)

TABLE 2 (Continued)

Category	Sub-categories	n (%)
Organizational/ service: Inadequacies within organizational policy and process, organizational change, staffing, resource availability, and work environment	Staffing (n = 47, 48%) • Staff Shortages • Lack of Experienced Staff • Lack of Regular Staff • Staff Overtime Resource Availability (n = 33, 34%) • Lack of Resources • Insufficient Training/Handover Other (n = 18, 18%) • Organizational Change • Ward Acuity • Enforcing no-smoking policy	98 (15)

Consumer- and carer-related challenges

The most frequent group of challenging situations described by nurses were consumer or carer behaviours. These were predominantly with consumers, and primarily verbal and/or physical aggression, suicide, and self-harm. Other challenges included sexual behaviours, absconding, and destruction of hospital property. A few situations (n = 5) were with carers who were described as hostile, aggressive, or making threats towards staff through frustration with perceived poor care of their loved one.

The most frequently described challenge was physical aggression, which was experienced directly or observed to occur with other staff. Behaviours ranged in severity from being hit, punched, and assaulted with a weapon, to on several occasions witnessing or being aware of a colleague being severely injured or killed:

> I suffered assault several times... Also worked in as ANUM [associate nurse unit manager; experienced nurse responsible for clinical leadership in ensuring safe and effective provision of care] in an acute inpatient unit where a doctor was stabbed to death and numerous serious assaults occurred with several staff never returning to work.

Nurses experienced both emotional and physical impacts from aggression. Emotional effects included short-term emotional distress to long-lasting psychological impacts including post-traumatic stress disorder, anxiety, and depression. For some, trauma from the violent incident resulted in long periods of leave, the need for ongoing psychological support, and ultimately, in considering resigning from nursing altogether:

> [I experienced consumer] aggression and sustained physical injury and emotional distress...an extremely stressful first few weeks... myself and the other graduate I was working with went home crying and stressed every day, almost quitting then and there.

Nurses identified physical impacts ranging from minor to serious injury including fractured limbs requiring medical treatment, hospital admissions, and/or leave from work:

> ...[I was] physically assaulted by a patient on an inpatient unit resulting in injury and two weeks off with Workcover.

Nurses also experienced verbal aggression that ranged from swearing to relentless verbal abuse, stalking, and threats of physical harm or to kill staff and/or their families. Verbal and physical aggression often occurred together. Personal threats and behaviours were particularly distressing:

> [I experienced] prolonged (3 months) daily verbal abuse and physical aggression from clients, repeated threats to stalk and kill [me] once discharged.

Other challenges included attempted and completed consumer suicides and self-harm behaviour. These were traumatising for many nurses and led to significant distress through witnessing the acts and/or aftermath. Nurses were often the first to find the consumer post-attempt. Attempted and completed suicides occurred in inpatient and community settings, and at times during a nursing interaction such as a triage call. Completed suicides were often violent in nature. Observed self-harm behaviour was considerable and required nurses to provide emergency care for the injuries. Deliberate self-harm included self-mutilation:

> Recently two of my patients self-harmed on the same shift. I walked in on one in the act. This was the first time I'd had this experience and it was very confronting. I got little if any support, reassurance or guidance from the nurse in charge, and minimal guidance from a colleague. This impacted my shift and I felt like I had made so many mistakes.

Aggressive behaviours by substance affected (including methamphetamine) consumers were also consistently described. Other challenges included sexually inappropriate behaviour ranging from public masturbation, exposure of genitals, through to sexual assault of staff, and other consumers. Some absconding attempts and destruction of hospital property were also identified.

Colleague-related challenges

Another frequent source of challenges was with colleagues. This included other nurses, managers, multi-disciplinary staff including consultants, police officers, and emergency services personnel. The most frequent were interpersonal issues including bullying, perceived poor behaviour, and lack of support. Situations encompassed poor communication, strained relationships, and conflict. Perceived poor quality of practice by colleagues, and differences in opinion on quality of care, were further challenges. In a few cases, dealing with the death of a colleague and managing staff complaints were also identified. Perceived poor behaviour included that of other nurses, consultants, and emergency services staff. Nurses described being threatened, belittled, experiencing verbal aggression, undermining behaviour, victimization, and having their concerns about clinical risks ignored:

> I was faced with a huge workload with both community visits and ED [emergency department] assessments. I had to send a very junior staff member to do visits on her own while I attended the ED to complete three assessments. When notified of a fourth assessment arriving at ED with section 351 status [powers of a police officer to apprehend a person who appears to have a mental illness] and police in attendance, I called the consultant on call to request permission to have the psychiatric registrar assist me... When I rang, the consultant suggested that I was lazy and should work harder.

Nurses also identified manager behaviours including being belittled and embarrassed in front of colleagues and intentionally excluded from discussions. They described having practice concerns disregarded, complaints dismissed, being threatened for reporting risks in practice, having their clinical judgement and decision-making overridden, and being undermined by their manager. In a few cases, staff were directly threatened:

> Threatened at work by manager with physical violence because I spoke publicly on clinical risk and changes this manager brought that placed staff at increased risk in the workplace.

Bullying by one or more staff was commonly reported. In some cases, this was prolonged and included exclusion from information and meetings. Bullying of younger staff by senior staff involved intimidation and active exclusion from meetings, and multiple incidents of bullying by senior staff often related to differences in opinion on clinical judgment:

> A particularly violent incident [was] the attempted homicide of a consultant by a patient. Before the incident I expressed concern that the patient was planning something. Other staff disagreed with me in some of the most detrimental ways I have ever experienced. Following the incident as well as the usual feelings of trauma and guilt, I experienced prolonged bullying and intimidation from some of the staff who had disagreed with me. I still feel and will always feel that the incident could have been avoided if staff had listened to my concerns.

Nurses reported they were often overworked, with little to no support or reassurance regarding clinical decision-making from managers. Lack of support included premature discharge of clients, pressure to admit inappropriate clients, pressure to cease seclusion, and constant negative feedback:

> Departure of long-term manager and incoming new manager who has demoralised our team, making decisions and changes without discussion and is unsupportive and critical of our work which is so disheartening and disappointing.

The quality of colleagues' practice was a prominent challenge and included perceived poor quality of care and dilemmas in practice and failing to provide safe and effective clinical care. Practice situations included colleagues withholding medication, poor provision of evidenced-based practice, ignoring early warning signs of consumers' deteriorating health, poor management of mental and physical deterioration, and perceived overuse, or in some cases lack of, observation and restrictive interventions (e.g. seclusion and restraint). These were compounded by lack of resources such as adequate staffing and skill mix. Nurses reported being distressed by colleagues' practices, experiencing conflict with colleagues about their practice, and being concerned about the effect of perceived poor practice on consumer experiences and outcomes:

> Inadequate/suboptimal treatment of a client where a consultant practiced least restrictive and client-focused treatment despite repeated expressions of distress from family and clear failure of the client to improve. Later that night the client overdosed and died. I have been called recalcitrant and an old-school nurse and not recovery-focused by colleagues. It has changed the trajectory of my career and the situation led to a lot of distress.

Nurses also experienced dilemmas in practice in relation to conflicts with colleagues when adhering to policy and procedure, felt distressed about this, and sometimes struggled to maintain the safety and well-being of themselves and/or others. These included differences in opinion within the team regarding consumer management, adhering to policy, pressure to take inappropriate admissions, and perceived insufficient skillset of colleagues:

> Working with a peer whose practice was questionable and clinically underperforming in a senior role. Raising my concerns via the appropriate forums only to be told to "let it go" and then be expected to manage this colleague's behaviour. Which was compounded by my peer's apparent emotional fragility to be able to understand the risk this could cause consumers and the organisation.

Nursing role-related challenges

Challenges in performing their nursing role and practice were less prominent in terms of frequency and were related to organizational and structural issues in nurses' workplaces. They described time constraints, managing high workloads, working alone, and concerns about being able to provide a quality standard of care. Challenges included managing high caseloads, having to complete multiple psychiatric assessments on a shift, managing multiple admissions, and competing demands including multiple deteriorating clients at one time and clients in seclusion. Nurses consistently highlighted that during these situations, there was insufficient time to meet documentation requirements:

> … I started at 4 am due to no staff overnight. There were eight people waiting for psychiatric assessment, no beds, complex cases and no time to properly document care and behaviours

Working alone was particularly challenging when managing deteriorating patients and those at high risk of harm to others:

> Left alone in HDU [high dependency unit] with a particularly violent and aggressive schizoaffective client my first year working in mental health whilst everyone else in handover.

Nurses also had their own challenges in providing quality care. Identified issues were lack of medication and lack of management plans for consumers. Lack of medication related to medical staff not prescribing adequate PRN, which the nurse perceived compromised

the safety of both consumers and staff. Lack of a risk management plan was challenging due to staff inconsistency in managing consumers' challenging behaviours and aggression:

> BPD [borderline personality disorder] client demanding admission to inpatient services, history states her mental state deteriorates, 'if you let me go I will kill myself'. Nil management plan, nil consultant or doctor able to review but stating over phone they don't want them admitted. Ever changing goal-post as client has previously successfully sued the service.

Other role-related challenges included balancing personal well-being while supporting colleagues (particularly junior staff), and managing work/life balance, job insecurity, and unpredictable events:

> I had completed study for a particular position and was advised that the position would be removed. I ended up leaving a permanent position for a contract position and faced job insecurity. I was not able to use my skills and felt very undervalued.

Organizational service-related challenges

Nurses also described challenges related to their organization. These were primarily issues with staffing and lack of available resources. Staffing was the most prominent, including demanding workloads precipitated by staff shortages, poor skill mix, and under-rostering. Other challenges were organizational change and workplace instability, high ward acuity, and enforcing a no-smoking policy. Lack of experienced staff was commonly reported, including junior staff, new graduates, and casuals:

> Large male client viciously attacked male co-client in HDU [high dependency unit]. Only myself and one other female staff member were available to intervene due to staff mix (short staffed, graduates who were unable to enter the HDU area & older physically compromised staff) until security could be alerted.

Nurses also described a lack of resources centred mainly around lack of available acute inpatient beds, lack of properly functioning equipment, and unavailability of discharge accommodation for consumers. Some referred to lack of training, orientation, and handover to sufficiently meet the demands of their work:

> Particularly unwell, aggressive patient with inadequate staff numbers and inadequately trained staff to care for them and the rest of the inpatient unit safely for staff and patients.

DISCUSSION

This study aimed to examine and describe the range of challenging workplace situations experienced by MHN. This is the first large ($n = 374$) qualitative study internationally to report nurses' descriptions across multiple challenges. Experiences often included a complex interplay of challenges involving both organizational and interpersonal factors. The findings extend prior knowledge and add new evidence on the experience, range, and complexity of workplace challenges and the serious impacts they can have on MHN personal health and well-being, their practice, and retention in the workforce. Organizations are responsible for being proactive in preventing and/or mitigating these challenges.

Interpersonal conflict was a common feature of situations. This included violence and aggression from consumers and bullying from colleagues. Conflictual situations were compounded by organizational factors including low staffing levels and poor skill mix. These findings on conflict and aggression are consistent with prior MHN literature and discussion on common forms of work-related stressors (Foster *et al.* 2020, 2021; McTiernan & McDonald, 2015; Yao *et al.* 2020). It is also important to acknowledge that conflict affects the quality of the therapeutic nurse–consumer relationship and nurses' use of empathy (Gerace *et al.* 2018). To support consumer and staff safety and well-being, conflict-reducing models of care such as Safewards (Bowers *et al.* 2015) are recommended for organizational implementation. In Australia, Safewards strategies including calm-down and talk-down methods have been reported to significantly reduce conflict and containment (e.g. seclusion) when good fidelity occurs (Dickens *et al.* 2020). Staff also report that Safewards helps them prioritize their therapeutic relationship with consumers and speak respectfully, reducing consumers' frustration and the risk of interpersonal conflict (Fletcher *et al.* 2019).

To extend prior knowledge, key findings in relation to MHN well-being and practice will be discussed in further depth as they have had minimal exploration in prior MHN literature. These include the psychological impacts on MHN from suicides and murder/attempted murder, and personal threats from consumers; as well as practice-related issues including moral distress and concerns about colleagues' quality of practice, and lack of practice-related support from colleagues and/or the organization. These experiences were personally distressing and traumatising for MHN and catalysts for some MHNs' decision to leave the profession.

Key challenges affecting MHN well-being were the prominent accounts of consumer-related suicide, suicidal behaviour, and self-harm. This is the first Australian study to describe these events together from MHN perspectives. Nurses highlighted the stress and trauma they experienced when being the first to find a consumer who had completed suicide, the violent nature of some suicides, and the nature of significant self-harm behaviours. With ethical reporting considerations in mind, the detailed and graphic nature of these descriptions of suicide and self-harm was not explicitly reported in the Findings. Importantly, nurses often identified they had not received any support from colleagues or the organization following these traumatic events, with potential for unresolved trauma following the event. Observing suicide and significant self-harm behaviours are known to be traumatising for nurses (Hagen *et al.* 2017; Morrisey & Higgins 2021; Sanford *et al.* 2021). Takashashi *et al.* (2011) highlighted that 13.7% of MHN were at high risk of developing PTSD following a case of completed suicide among a large cohort ($n = 292$) of MHN in Japan. Further, 80% of MHN identified there were no staff support programmes implemented following consumer suicide (Takashashi *et al.* 2011). The known detrimental impacts on staff health and well-being due to these events mean that organizations need to not only work to prevent suicidal behaviours but also provide proactive staff follow-up following these critical events, which is inclusive of psychological support. This needs to extend beyond policy on how to clinically manage critical events from a practice perspective. We recommend organizations provide timely post-event psychological support that addresses the potential trauma of witnessing self-harm and suicide, and ongoing clinical supervision. In order to support MHN retention and reduce the risk of PTSD, organizations need to provide evidence-based trauma-informed professional development and self-care strategies to help staff to personally manage their well-being following these events. When psychological support is provided, it is also important nurses avail themselves of the support when offered, as there is evidence (e.g. Fahy & Moran 2018) that MHN do not necessarily access available support.

A further notable finding affecting MHN well-being was the personal nature of verbal aggression by consumers, which in some cases comprised direct threats to the nurse and their family. While consumer-related aggression and violence is well documented (e.g. Hasan *et al.* 2018; Tuvesson & Eklund 2017), few prior studies have reported the emotional impacts on MHN of

threats to self and family. Death threats and threats to harm one's family are personal and move from being contained in the workplace into affecting nurses' personal life. The psychological impacts of these personal threats led to nurses experiencing overwhelming stress, post-traumatic stress, and in some cases, deciding to leave the profession. The only directly comparable research regarding the personal nature of threats to MHN is the prevalence and impact of stalking by consumers, where these experiences were found to impact negatively on nurses' psychological well-being, causing anxiety, depression, sleeplessness, hypervigilance, and avoidance behaviours (Ashmore *et al*. 2006; Hughes *et al*. 2007). Of importance, Ashmore *et al*. (2006) identified that 32.1% of staff were hesitant to report stalking by consumers for fear the situation could escalate further, or due to embarrassment or guilt for assumed responsibility for the behaviour. Given the parallels with personal threats, it may be that some MHN are also not reporting serious threats from consumers for reasons similar to those identified by Ashmore *et al*. (2006). With the high probability of negative psychological impacts from these experiences, this needs to be actively addressed by organizations to minimize harmful impacts and career-ending decisions. Nurses require support by peers and managers to facilitate early disclosure of stalking and threats from consumers, so that they can receive prompt professional intervention and psychological support. These proactive actions can help promote MHNs' psychological well-being and enhance their retention in the workforce.

A further important finding were challenges relating to colleagues' quality of practice and the apparent moral distress MHN experienced through perceived poor quality of care. Moral distress is an emotional state experienced because of conflicts in personal values and ethics in practice that can ultimately lead to moral injury, where psychological trauma is experienced through symptoms of intense guilt, shame, and spiritual crisis (Jinkerson 2016). There is little prior research into MHN' moral distress related to colleagues' quality of practice. Previous literature is limited mainly to measurement of moral distress and associated outcomes (e.g. Christodoulou-Fella *et al*. 2017; Hamaideh, 2013) or descriptions of nurses' own practice (e.g. Austin *et al*. 2003). Literature on others' practice is limited to reporting issues of over-sedation and restrictive practice, where nurses experienced conflict between wanting to reduce restrictive practice versus minimizing risk. Through their involvement in restrictive practices, MHN in these studies experienced

moral distress, were traumatized and burnt out, and left questioning their own and others' practices (Muir-Cochrane *et al*. 2018; Power *et al*. 2020). The current study extends the evidence and identified that the complexity and nature of moral distress related to colleagues' practice goes well beyond over-sedation and overuse of restrictive practices. A notable finding in this study was moral distress related to perceived *under*-use of restrictive practices. MHN also observed poor assessment and management of consumer risk by colleagues' premature discharge of at-risk consumers, ignoring early warning signs of deteriorating mental state including increased paranoia, lowered mood, suicidal thoughts, and self-harm behaviour, and being potentially negligent in practice by not providing adequate treatment and care. Nurses who observed or were involved in these situations experienced guilt and anger, had conflicts with other staff which in some cases resulted in bullying and a negative work culture, were left traumatized, and for a few, meant they intended leaving the profession altogether. Further, several nurses detailed consumer-related impacts of perceived poor quality of care, including attributing the premature death of a consumer to lack of quality care. These are significant clinical risk management and practice issues which have implications for nurses' own health, and crucially, for consumer outcomes. Nurses must feel supported by senior management to identify colleagues' poor quality of practice and have confidence that managers will performance manage staff. All nurses need to be provided with adequate evidence-based education to continually upskill and maintain their practice and relevant policy and procedures are needed for staff to be able to safely and constructively report practice concerns about colleagues. Further research is recommended on the scope and impacts of moral distress in relation to colleagues' quality of practice for these important clinical issues.

Across the situations described by MHN, a common thread was that the negative impacts of these challenges were frequently exacerbated by colleagues' lack of support, including minimizing the event. In some cases, nurses even experienced victim-blaming by colleagues, as well as bullying and intimidation. The negative impacts of this on nurses' psychological health included feeling helpless and hopeless, angry, anxious, less self-confident, and thinking about leaving the profession. Surprisingly, there is little prior MHN research that reports these issues. Bullying and its detrimental impacts on nurses' physical and mental health and

well-being and retention is acknowledged in general nursing (Sauer & McCoy 2017). However it has only recently been documented for MHN, where it was identified as a stressor (Foster *et al*. 2020). Conflict and negative interactions with colleagues can have potentially more harmful impacts than aggression from consumers due to MHN perceiving it as personally directed (Kelly *et al*. 2016). There is a need for development of positive team cultures to prevent and/or mitigate this threat to nurses' psychological health and well-being. Homem *et al*. (2012) found that a positive work culture could be promoted through team-building strategies such as personal, relational, and communicative competencies. Implementation of these strategies has been found to result in effective interpersonal relationships, improved productivity, nurses experiencing greater job satisfaction, and an enhanced quality of care provision (Homem *et al*. 2012).

Limitations

While this study encompassed a large sample of MHN, it was limited to one state in Australia and may not represent the experiences of the wider mental health nursing workforce. Expanding the research to other Australian states and country contexts could provide further insight into the challenges experienced by a wider population of MHN. The survey format meant we were unable to follow-up on responses, and the short open-ended responses did not allow for clarification of experiences. In-depth qualitative studies exploring nurses' experiences of challenging situations are recommended.

CONCLUSION

This is the first Australian study to describe a range of challenging situations experienced by a large cohort of MHN, their complexity, and the long-term impacts they can have on MHN psychological well-being. The findings have important implications for the future of the MHN profession, and as identified in recent Australian reviews of the mental health workforce and services (Productivity Commission 2019; RCVMHS 2019), they have direct implications for MHN well-being and retention. With the projected national shortage of MHN (Productivity Commission 2019), the significant issue of workplace stressors for MHN, the largest group of the mental health workforce, requires urgent attention. To attract and retain MHN in the workforce, as recommended throughout this paper, multi-level

workplace policies and initiatives need to be implemented to reduce stressors and support MHN well-being.

RELEVANCE FOR CLINICAL PRACTICE

This study has implications for the attraction and retention of nurses in the MHN profession. The findings highlight the frequency and complexity of workplace stressors, resulting in both short- and long-term negative impacts to MHN physical and psychological health and well-being. Practical strategies for preventing or mitigating these require commitment at organizational, management, and individual MHN levels. From an organizational perspective, proactive action is required with professional development including trauma-informed education, evidence-based education that aims to strengthen staff well-being, and education that continuously upskills and maintains quality practice. In addition, adequate support following critical events is a priority, inclusive of professional psychological support. Management needs to focus on maintaining open communication and professional relationships with staff that improves team culture, and facilitate regular clinical supervision, early disclosure of threats by consumers, and constructive identification of poor quality practice. Individual mental health nurses can be proactive in engaging in available opportunities including self-care strategies to manage stressors and professional development.

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