

#### A STUDY ON WORKPLACE STRESSORS AND IMPLEMENTING STRATEGIES TO PROMOTE EMPLOYEE WELL-BEING, RESILIENCE, AND PRODUCTIVITY

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#### **ABSTRACT:**

There is widespread recognition that workplace stress can have profound negative impacts on nurses' well-being and practice. Resilience is a process of positive adaptation to stress and adversity. This study aimed to describe mental health nurses' most challenging workplace stressors, and their psychological well-being, workplace resilience, and level of caring behaviours, explore the relationships between these factors, and describe differences in workplace resilience for sociodemographic characteristics. In a descriptive correlational study using convenience sampling, data were collected from N = 498 nurses working in mental health roles or settings in Victoria Australia via an online cross-sectional survey. Key findings included weak to strong (r = 0.301 to r = 0.750) relationships between workplace positive resilience with psychological well-being across categories (consumer/carer; all stressor colleague; organizational role; and organizational service). Psychological well-being was moderately high, but lower for nurses indicating consumer/carerrelated stressors as their most stressful challenge. There were weak to moderate (r = 0.306 to r = 0.549) positive relationships between workplace resilience and psychological well-being, and no relationship between resilience and caring behaviours. Workplace resilience was lower (P < 0.05) for less experienced nurses compared with those with >5years' experience, and lower for younger nurses compared with those aged  $\geq 40$  years. To improve their resilience and prevent psychological distress, there is prime opportunity to support nursing students with well-being and resiliencebuilding strategies during their undergraduate education, and to support new graduates with

similar programmes when they enter the workforce.

**KEY WORDS:** workplace resilience, wellbeing, mental health nursing, workplace stress, practice

#### **INTRODUCTION**

Internationally, mental health nursing is recognized as a demanding and potentially highrisk occupation due to workplace stressors associated with working with colleagues, consumers, and carers, in the context of environments, requirements, organizational structures, and processes (Foster et al. 2018a). Key sources of stress include occupational violence. There are consistent reports that the vast majority (88.6-100%; Itzhaki et al. 2018; Kelly et al. 2016; McKinnon & Cross 2008) of mental (MHNs) have experienced health nurses consumer-related verbal aggression. Up to 70% of MHN report physical aggression (Itzhaki et al. 2018; Kelly et al. 2016; Niu et al. 2019). Bullying by colleagues (Chen et al. 2009) and conflict between colleagues (Fahy & Moran 2018; McTiernan & McDonald 2015) are further concerns. Mental health nurses report that high acuity (Tonso et al. 2016), high workloads coupled with lack of resources (McTiernan & McDonald 2015), and lack of supportive management and effective leadership (Gabrielsson et al. 2016) are key organizational challenges. In this paper, mental health nurses' most challenging workplace stressors, and the relationship between these and their well-being, resilience, and caring practices, are described.

#### BACKGROUND

In the wider field of nursing, workplace stress has been found to have a significant effect on nurses' performance and quality of work practice (Roche et al. 2011) and is an important influence on patient care and outcomes (Sarafis et al. 2016). Workplace stress is known to exert a strong negative influence on nurses' psychological wellbeing and practice, and has been negatively correlated with nurses' caring behaviours. For instance, conflict with colleagues has been found to predict lower caring practice (Sarafis et al. 2016). Stress is also known to have a profound negative impact on retention of the nursing workforce (Lamont et al. 2017).

In mental health nursing, verbal and physical aggression by consumers has been correlated with job stress (Itzhaki et al. 2015) and experienced as stressful and traumatic, leading to emotional exhaustion, burnout, and difficulty performing nursing work (Fahy & Moran 2018). Challenges in providing quality mental health nursing care due to time constraints, negative team culture, unsupportive leadership, and lack of organizational resources can result in distress and frustration, with some nurses choosing to leave the work setting (Gabrielsson et al. 2016). Consistent with the wider field of nursing, MHNs who perceive their work to be stressful report lower work satisfaction (Itzhaki et al. 2018), leading to higher turnover intention and attrition (Alsaraireh et al. 2014; Yanchus et al. 2017). Due to attrition, the ageing workforce, and low recruitment, there is a projected shortfall of the MHN workforce of 18 500 by 2030 (Health Workforce Australia, 2014).

To address the detrimental impacts of workplace stress on MHNs' well-being and practice, there has been growing attention on supporting their resilience. In the workplace, resilience is defined as a process of recovery following adverse events, which involves Cognitive, Affective, and Behavioural Self-Regulatory responses that support positive adaptation and restoration of psychological well-being and functioning (McLarnon & Rothstein 2013). Further to personal or trait-based resilience characteristics such as a stable sense of self and self-discipline, these Self-Regulatory responses can facilitate individuals' ability to experience less distress, be more considerate of others' perspectives, and be more resourceful in the face of adversity (Rothstein et al. 2016). Workplace resilience is therefore considered an active process by which psychological well-being is restored rather than

an outcome following adversity (McLarnon & Rothstein 2013). Psychological well-being can be understood as positive psychological functioning, which includes self-acceptance, a sense of autonomy, purpose and mastery, personal growth, and positive relationships with others (Ryff, 1989b).

Empirical evidence from systematic review of mental health nursing literature indicates that MHNs' personal resilience is predominantly lowmoderate across studies. Resilience has been positively correlated with life and work satisfaction, coping self-efficacy, self-esteem, and hardiness (Foster et al. 2019). One study investigated the workplace resilience of mental health nurses, measuring this pre/post a resilience-building programme. There was a reported strong level of workplace resilience following the intervention (Foster et al. 2018a). Another study investigated sociodemographic characteristics of MHN (e.g. age, gender, and years' experience) and reported higher resilience amongst older and more experienced nurses 2017). Australian MHNs' (Zheng et al. experience and the practice environment have been found to be linked to therapeutic engagement (Roche et al. 2011), and in the United States, MHNs' age, experience, qualifications, practice environment, and the hospital characteristics were linked to burnout, quality of care, and adverse events (Hanrahan et al. 2010a, 2010bb). Systematic review of the literature indicates emergent evidence that greater personal resilience and self-regulation can improve relationships MHNs' practices and with consumers, carers, and colleagues (Foster et al. 2019). Use of effective Cognitive, emotional, and Behavioural self-regulation and responses in stressful interactions and situations improves MHNs' ability to respond more effectively and to provide better quality care (Foster et al. 2018b; Warelow & Edward 2007). Caring practice is an integral aspect of mental health nursing work. Warelow and Edward (2007) contend that caring requires nurses to be resilient and to use Cognitive, emotional, and technical skills to perform quality practice.

There is limited knowledge, however, on mental health nurses' workplace stressors in the Australian context. Further, the relationship between workplace stressors and psychological well-being, workplace resilience, and caring practices of mental health nurses is unknown. The interplay between these factors and sociodemographic characteristics is yet to be explored. Therefore, given the current state of knowledge, the aims of the current study were to describe mental health (i) nurses' sociodemographic characteristics. most challenging workplace stressors, psychological well-being, workplace resilience, and caring behaviours; (ii) explore the relationships between these factors; (iii) explore differences between the most challenging workplace stressors and psychological well-being, workplace resilience, behaviours; and (iv) explore and caring workplace resilience differences in for sociodemographic characteristics (gender, age, locality, role, qualification, and experience).

# **METHODS**

# **Research design**

This quantitative study is part of a larger mixed methods study investigating mental health nurses' workplace stress, resilience, and resilient practice. The current study was conducted using a cross-sectional descriptive correlational survey design, which collects data about a group of interest at one point in time (Lavrakas 2008). In the current study, the group of interest were mental health nurses. The study is reported using network recommendations EOUATOR for quantitative (STROBE) data (Vandenbroucke et al. 2007). 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 online survey was distributed to nurses working in mental health roles and mental health services across Victoria, Australia. Data were collected over a 3-month period in 2018, with several rounds of follow-up. The combined nursing workforce in Victoria is ~85 325 (Australian Government Department of Health 2019), of which approximately 6000 (~7%) nurses indicate mental health as their principal area of work (Australian Government Department of Health 2017). In public Victorian mental health services, both registered and enrolled nurses provide care in acute, subacute, specialist, supported residential, community, and forensic mental health settings (Department of Health & Services [DHHS] 2018a). Human Across

metropolitan, regional, and rural Victoria, the majority of mental health service is provided through 21 public adult area mental health services, 17 aged public mental health services, and 13 child and adolescent public mental health services (DHHS 2018a). Nurses account for approximately two-thirds of the clinical mental health workforce in Victoria (DHHS 2016).

## Participants

All nurses (i.e. registered and enrolled) working in mental health roles and/or services in Victoria were eligible to participate. Participants were recruited using convenience and snowball sampling (Bryman 2012). The study was distributed by email from the Department of Health and Human Services to Directors of Nursing in Victorian public mental health services for distribution to staff. The study was also distributed via the Australian Nursing and Midwifery Federation (ANMF) (Victorian Branch) and Health and Community Services Union (HACSU) websites, e-newsletters, and/or social media. Eligible participants were able to forward the online survey web link to other Victorian MHN in their networks and via social media. Nurses were offered the opportunity to enter a draw for one of 10 9 \$100 AUD vouchers. The required sample size was based on exploring differences between eight sociodemographic characteristics of interest and the primary dependent outcome variable, workplace resilience. Using a conservative (i.e. higher observed power b and effect size f) a priori approach to determine sample size, a total sample of 432 was required to conduct eight ANOVAs (G\*Power 3.1, Ftest, a = 0.05, b = 0.90, f = 0.5, n = 54). A total of 539 surveys were received with 43 (8%) excluded as no survey items were completed. The final sample comprised N = 498nurses working in Victorian mental health roles or settings.

## Data collection

A 94-item literature-informed online crosssectional survey collected data about nurses' sociodemographic characteristics (e.g. gender, age, location, professional role, specialist MHN postgraduate qualification, current setting, years working in current setting, and years working in mental health); most challenging workplace stressors; psychological well-being; workplace resilience; and caring behaviours. Workplace stressors were identified by participants listing their top three most challenging workplace stressors using free text responses. There were a total of N = 1355 responses. Many participants included only one or two stressors, and consequently, the top-ranked stressor (n = 413)was included for analysis with other measures. Examples of stressors include 'violence consumer to staff'; 'working with unmotivated peers'; 'sustained high caseload'; and 'high demand for beds'. Further examples and frequency counts for each category are provided in Table 1. Psychological well-being was measured with Ryff's 18-item Scales of Psychological Well-Being (RPWB, Ryff 1989a) comprising six subscales (Autonomy, Environmental mastery, Personal growth, Positive relations with others, Purpose in life, and Self-acceptance). Each subscale has three items and includes reverse phrased items. Participants were asked to rate from 'strongly disagree' (value of 1) to 'strongly agree' (value of 6). Higher ratings indicate more positive self-attitude, trusting relationships with others, selfdetermination and independence, sense of mastery and direction, and openness to selfimprovement (Ryff 1989b). The subscales are reliable measures of psychological well-being (Cronbach's alpha range = 0.77-0.88; Foster et al. 2018a; Ryff 1989b). Workplace resilience was measured with the Self-Regulatory Processes subscales (i.e. Affective, Behavioural, and Cognitive; S-RP:A, S-RP:B, S-RP:C) of the Workplace Resilience Inventory (WRI, 23 items, McLarnon & Rothstein 2013). Self-Regulatory processes mechanisms related are to understanding, controlling, and regulating ineffective and negative: emotions (Affect): actions (Behavioural): and thoughts (Cognitive) in response to adverse events (McLarnon & Rothstein 2013). Items were rated from 'strongly disagree' (value of 1) to 'strongly agree' (value of 5) and included reverse phrased items. Higher ratings indicate a stronger ability to understand and control negative and ineffective behaviours, emotions, and thoughts (McLarnon & Rothstein 2013). The Self-Regulatory Processes subscales of reliable measures Self-Regulatory are processes of workplace resilience (Cronbach's alpha range = 0.75-0.90; Foster et al. 2018a; McLarnon & Rothstein 2013). Caring behaviours were measured with the 24-item Caring Behaviour Inventory (CBI-24; Wu et al. 2006)

comprising four subscales: Respectfulness (courteous regard and attending to the dignity of Connectedness the person); (positive connectedness person's experience); to Knowledge and skill (proficient, informed and skilled competence); and Assurance (being available and present for person's needs; Wolf et al. 1994; Wu et al. 2006). Items were rated from 'never' (value of 1) to 'always' (value of 6) and included reverse phrased items. Higher ratings indicate greater caring practice for each subscale. The CBI-24 has strong reliability (Cronbach's alpha = 0.96) and convergent validity (r = 0.62; Wu et al. 2006) for measuring self-report caring behaviours.

# Data analyses

Participant sociodemographic characteristics and the most challenging workplace stressors were described with count (n) and/or frequency (%). The top-ranked workplace stressors were subjected to content analysis, used for systematic and objective quantification of written data (Rourke & Anderson 2004). Manifest content in the textual responses was systematically coded and grouped based on an initial coding scheme comprising consumer/carer-related, colleaguerelated, and organizational-related stressors. Data were coded independently by three researchers. Coding was then reviewed, and the category 'Organizational' was further collapsed into organizational role, and organizational service. Consensus discussions were held on coding within and across categories to reach agreement. Frequency counts were conducted for each category. Unclear responses were excluded (n = n)40), resulting in the final count of n = 413.

Psychological well-being, workplace resilience, and caring behaviours were described with count (n), mean, and standard deviation. To describe differences between the four workplace stressor categories (independent variables), one-way ANOVAs (with Tukey's honestly significant difference) and Kruskal-Wallis ANOVAs were computed for the dependent variables: (i) workplace resilience, (ii) caring behaviours, and (iii) psychological well-being. Relationships of workplace resilience to caring behaviours and psychological wellbeing were described with correlations (Pearson's r). The relationship of workplace resilience to caring behaviours and psychological well-being for each workplace stressor category was described with Pearson's r,

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followed by ANOVA (with Tukey's honestly significant difference) to assess group differences where workplace stressor category was the independent variable. To describe differences sociodemographic between characteristic (independent variables) and the three WRI (dependent variables). subscales one-way ANOVAs (with Tukey's honestly significant difference) or independent t-tests were computed. Data were analysed with the SPSS 22.0 for Windows (IBM, Armonk

TABLE	1:	Workplace	stressor	category
explanatio	n and	verbatim ex	emplars (N	= 413)

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Connectory Tables driving connect over each dalling or orderational following and arring researches	Unions and agenesis in v 45, 1980	110.0%
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NY, USA). Significance was set at a = 0.05. Magnitude of difference was described with partial eta squared ( $\eta 2$ ) and effect size (d).

## RESULTS

Top-ranked workplace stressors are shown in Table 1. The organizational service category was most prevalent with n = 152 (37%) responses followed by the consumer/carer category with n = 116 (28%). Within the consumer/carer category, top-ranked stressors were attributed to violence and aggression (87/75%). Within the organizational role category, top-ranked stressors were attributed to time constraints and workload demands (68/66%).

Sample descriptors are shown in Table 2. Of the 498 respondents, 366 (74%) were female and 77 (16%) were aged between 21 and 29 years. A total of 321

### **JNAO** Vol. 12, No. 2, (2021) TABLE 1: (Continued)

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Mining		40

(65%) nurses were located in metropolitan areas of Victoria and 439 (88%) were registered nurses. Most nurses had been working in mental health for at least 10 years (n = 318; 64%). The majority worked in community and inpatient mental health settings (n = 412; 85%). Psychological well-being was moderately high (mean  $\geq 4.3$  for all subscales). The range of workplace resilience was from a mean of 3.1 to 3.3. Caring behaviours were positive (mean > 5.0 for all subscales). Relationships between workplace resilience, caring behaviours, and psychological well-being are shown in Table 3. There were weak (r = 0.306),  $P \le 0.01$ ) to moderate (r = 0.549;  $P \le 0.01$ ) relationships between positive workplace resilience and psychological wellbeing. There were no relationships between workplace resilience and caring behaviours (r = 0.057 to r =0.144).

The relationships between workplace resilience and caring behaviours or psychological wellbeing were explored for each workplace stressor category (Table 4). For the colleague stressor category, there was a strong positive relationship (r = 0.750; P  $\leq$  0.01) between workplace resilience (Cognitive subscale) and psychological well-being (Autonomy subscale). For the organizational service category, there was a moderate positive relationship (r = 0.529: P  $\leq$ 0.01) between workplace resilience (Cognitive subscale) psychological and wellbeing (Environmental mastery subscale). Psychological well-being (Autonomy subscale) was lower for participants who indicated consumer/carerrelated stressors (mean = 4.1, SD = 1.0; (F (3, 341) = 3.65, P = 0.01,  $\eta 2$  = 0.03) to be their most stressful workplace challenge compared with participants that indicated colleague-related (mean = 4.6, SD = 0.9; d = 0.52) and organizational service-related (mean = 4.4, SD = 0.8; d = 0.33) stressors. There were no other differences between stressor category and other outcome measures (P > 0.05).

Differences in workplace resilience for the sociodemographic characteristics of MHN are shown in Table 5. There were differences in workplace resilience ( $P \le 0.05$ ) for years working in mental health and for nurses' age. Workplace resilience (Self-Regulatory Processes; Cognitive subscale) was lower for less experienced nurses (mean = 2.7, SD = 1.0; (F (2, 395) = 7.21, P =0.01,  $\eta 2 = 0.04$ )) compared with nurses with 5–9 years' experience (mean = 3.2, SD = 0.7; d = 0.58) and  $\geq 10$  years' experience (mean = 3.1, SD = 0.8; d = 0.44). Workplace resilience (Self-Regulatory Processes; Cognitive subscale) was lower for younger nurses (mean = 2.8, SD = 0.8;  $(F(2, 389) = 3.68, P = 0.03, \eta 2 = 0.02))$  compared with those aged  $\geq$ 40 years (mean = 3.1, SD = 0.9; d = 0.35). There were no other statistically significant differences between sociodemographic characteristic and workplace resilience.

TABLE 2:	Sample	descriptors	(N = 498)
	Dumpie	acouptors	(1, -1)0)

Female Male Intersex Missing 21-29 30-39	366 (74) 128 (26) 1 (<1) 3
Male Intersex Missing 21–29 30–39	128 (26) 1 (<1) 3
Intersex Missing 21–29 30–39	1 (<1) 3
Missing 21-29 30-39	3
21-29 30-39	
30-39	77 (16)
	91 (19)
40-49	113 (23)
50-59	141 (29)
60-69	64 (13)
$\geq 70$	3(1)
Missing	9
Metropolitan	321 (65)
Regional	134 (27)
Bural	41 (8)
Missing	2
Registered nurse	439 (88)
Enrolled nurse	58 (12)
Yes	46 (81)
No	11 (19)
Missing	1
Ves	290 (66)
No	141 (34)
Missian	6
Community	108 / 411
Lonationt	014 (44)
Engeneration of hereital/	214 (44)
response team	30 (3)
Forensic/correctional	13 (3)
Multiple sites	11 (2)
Other (e.g. education,	11 (2)
Mission	35
DNJBDN	1.0 (02)
KN/RPN	148 (30)
NUM/ANUM/senior role	118 (28)
Nurse practitioner	26 (6)
Academic/research	13 (3)
Clinical educator/specialist/ consultant/coordinator	118 (28)
Missing	75
<1-4	182 (38)
-5-9	114 (24)
10-14	80 (17)
15-19	40 (S)
20-29	44 (9)
30-39	17 (4)
$\geq 40$	2 (<1)
Missing	19
<1-4	90 (18)
5-9	84 (17)
10-14	72 (15)
15-19	40 (8)
20-29	86 (17)
30-39	89 (18)
>40	31 (6)
Missing	6
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**JNAO** Vol. 12, No. 2, (2021) TABLE 2: (Continued)

Descriptor	Category	n (%)
Workplace resilience	S-RP:A $(n = 402)$	3.3 (0.6)
inventory (mean and SD)	S-RP:B $(n = 400)$	3.2(0.5)
10 mil 9 05 mil 100 0 0 mil 9 mil 9 0 - 0 / 1	S-RP:C $(n = 400)$	3.1 (0.8)
Caring behaviours	Respectful $(n = 347)$	5.4(0.5)
inventory (mean and SD)	Connectedness $(n = 347)$	5.1(0.7)
	Knowledge and skill	5.5 (0.5)
	(n = 347)	
	Assurance $(n = 347)$	5.3 (0.5)
Ryff scales of	Total score $(n = 390)$	82.3 (12.6)
psychological well-being	AUT $(n = 390)$	4.4 (0.9)
(mean and SD)	EM $(n = 390)$	4.3 (0.9)
	PG $(n = 390)$	4.9 (0.8)
	PR $(n = 390)$	4.6 (1.0)
	PL(n = 390)	4.6 (0.9)
	SA(n = 390)	4.6 (1.0)

ANUM, Associate Nurse Unit Manager; AUT, Autonomy; EM, Environmental mastery; NUM, Nurse Unit Manager; PG, Personal growth; PL, Purpose in life; PR, Positive relations with others; RN, Registered Nurse; RPN, Registered Psychiatric Nurse; SA, Self-acceptance; S-RP:A, Self-Regulatory Processes; Affective; S-RP:B, SelfRegulatory Processes; Behavioural; S-RP:C, Self-Regulatory Processes: Cognitive.

#### DISCUSSION

This is the first study to report on MHN workplace stressors, well-being, resilience, and caring practices in the Australian context. Substantial data were gathered on MHNs' most challenging workplace stressors. The most frequently identified stressor category was organizational service (37%), followed by consumer/carer (28%), organizational role (25%), and colleague-related (10%). These findings correspond broadly with those of McTiernan and McDonald (2015), who also found organizational stressors to be the most prominent concern for n = 69 Irish nurses, with three main stressors being lack of resources, client-related difficulties, and organizational structures/processes. In the current study, staffing shortages and levels of experience were prominent (39%) organizational service stressors. Staff shortages, poor staff skill mix, and low staff-patient ratios are well-recognized risks for poorer quality of care and reduced patient safety (Aiken et al. 2017; DHHS 2018b; DHHS 2018c; Duffield et al. 2011).

Verbal and/or physical aggression was the most frequently reported consumer/carer stressor (75%) in this study. This is consistent with previous international MHN studies (Itzhaki et al. 2018; Kelly et al. 2016) reporting high levels of workplace violence, and an earlier study on workplace violence in the same Australian

TABLE 3: Correlations between workplace resilience, caring behaviours, and psychological well-being

	Workplace resilience inventory				
	S-RP:A	S-RP:B	S-RP:C		
Caring behaviours invento	ory				
Respectful	-0.057	-0.003	0.044		
Connectedness	-0.044	0.010	0.030		
Knowledge and skill	0.014	0.100	0.144*		
Assurance	0.033	0.014	0.134*		
Ryff scales of psychologica	al well-being				
Total Score	0.266*	$0.374^{*,\dagger}$	0.549*-1		
AUT	0.214*	0.248*	0.369**		
EM	0.297*	0.393*,*	0.519**		
PG	0.195*	0.215*	0.344**		
PR	0.131*	0.255*	0.371*1		
PL	0.139*	0.297*	0.390*		
SA	0.196*	0.306*.*	0.477*.		

AUT, Autonomy; EM, Environmental mastery; PG, Personal growth; PL, Purpose in life; PR, Positive relations with others; SA, Self-acceptance; S-RP:A, Self-Regulatory Processes; Affective; S-RP: B, Self-Regulatory Processes; Behavioural; S-RP:C, Self-Regulatory Processes: Cognitive. \*P  $\leq 0.01$ . † Weak relationship. ‡ Moderate relationship.

tate, where 83% of mental health staff (predominantly nursing) reported at least one form of violence in the prior year (Tonso et al. 2016). In the current study, while overall psychological well-being was moderately high, it was lower (Autonomy subscale) for participants who indicated consumer/carer-related challenges to be the most stressful. This suggests that staff confidence in their opinions and their independent functioning may be impacted by consumer/carer-related stress, which in this study was primarily violence-related. It is not clear, however, what the causative relationships are and this issue requires further investigation in longitudinal mixed methods studies.

The findings on workplace stress support the need for the state-wide initiatives to reduce occupational violence (DHHS 2018d) and mental health service initiatives to improve the safety and well-being of consumers and staff (Fletcher et al. 2017; McKenna et al. 2017). It is important to note that mental health nurses do not necessarily use organizational supports even in times of crisis (Fahy & Moran 2018), and organizations need to be proactive in providing support for MHN wellbeing in order to prevent psychological distress and poorer mental health. Further investigation of MHNs' workplace stress, and the effects on their health and quality of life, turnover intention, and practice, is recommended.

As identified, MHNs' reported psychological wellbeing in this study was moderately high with a total mean score of 82.3 (out of a possible 108). This is lower, however, than previously reported (87.2) with a small sample of Australian MHNs (Foster et al. 2018a). Mental health nurses' positive psychological well-being is broadly consistent with other studies. Using the general health questionnaire, Emmanuel Olatunde and Odusanya (2015) found that 84.5% of mental health nurses (n = 114) reported positive well-being. psychological In nursing. psychological wellbeing has been found to be positively related to empathy (Bourgault et al. 2015), and recognized as key to providing competent and safe care and reducing high turnover and attrition (Tung et al. 2018). There is potential to proactively intervene and prevent lower psychological well-being for MHNs and thus support their empathic practice through, for example, providing informal and formal social support at work (Fahy & Moran 2018), and professional well-being initiatives such as the Nursing and Midwifery Health Program Victoria (http://www.nmhp.org.au/), and the national 24/7 Midwife support Nurse and service (https://www.nmsupport.org.au/).

There was a positive correlation between workplace resilience and psychological wellbeing in this study, which was generally consistent across workplace stressor categories. This finding is supported by the limited prior literature in mental health nursing (Foster et al. 2018a). The Self-Regulatory (Affective, Cognitive, Behavioural) workplace resilience of MHN in this study was moderate, with a mean range of 3.1-3.3 (out of 5) across subscales. This is lower than a previous Australian study with a small sample of MHN, which reported ranges of 3.5–3.7 (Foster et al. 2018a), but consistent with reported ranges of 3.0-3.4 for n = 232undergraduate students (McLarnon & Rothstein 2013). In the current study, younger nurses (aged 21-29 years) had slightly lower Cognitive Self-Regulatory resilience scores (2.8 as compared with 3.0; McLarnon & Rothstein 2013), indicating less ability to understand and control negative thinking in response to adverse events. Lower age and less experience in mental health (sociodemographic characteristics) were

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specifically attributed to lower workplace resilience (Cognitive selfregulation) in this study. This finding is generally consistent with the limited literature measuring resilience in mental health nursing. Zheng et al. (2017) found that older age and more experience correlated with higher MHN resilience. Prior studies have also found that when nurses engage in resiliencebuilding

TABLE 4: Correlation of workplace resilience with caring behaviours and psychological wellbeing, by most challenging workplace stressor category

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	Wald plan and say the story						
	5.88.5	5-82-8	5-8P-0-	6.844	5.824	8.8P/	
Cating Solicitude Investory	101142	10.22	10000		2007	100	
Reported .	-6492	8.112	18.446	-9.(41)		1040	
Commission	6.040	0.100	10.000	0.241	1010	0.000	
Reprinting and dell	4.000	3,111	11.09/P			4.221	
Ascension	10.0005	0.300	-0.080	19.240	10.040	1,804	
to find the second second second	of the law in a						
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AUT, Autonomy; CBI, Caring Behaviours Inventory; EM, Environmental mastery; PG, Personal growth; PL, Purpose in life; PR, Positive relations with others; RPWB, Ryff Scales of Psychological Well-Being; SA, Self-acceptance; S-RP:A, Self-Regulatory Processes; Affective; S-RP: B, Self-Regulatory Processes; Behavioural; S-RP:C, Self-Regulatory Processes: Cognitive; WRI, Workplace Resilience Inventory. \*P  $\leq$  0.01. \*\*P  $\leq$  0.05. † Weak relationship. ‡ Moderate relationship. § Strong relationship

which include programmes Cognitive-Behavioural strategies such as managing negative Self-talk, this can improve their resilience (3.7/pre-4.0/post; self-Regulatory Cognitive subscale; Foster et al. 2018a) and improve their practice (Foster et al. 2018b). To better prepare them for the workplace and the rigours of practice, our study finding indicates nurses could benefit from resilience education in their undergraduate programmes. New graduates who lack experience working in mental health would also benefit from wellbeing education and resilience-building programmes as part of their graduate transition into mental health services, and this may help improve their well-being and practice and prevent future psychological

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distress. There is evidence, for example, that tailored transition programmes in mental health nursing have helped improve graduates' practices in managing challenging behaviours (Cleary et al. 2009).

TABLE 5: Differences in workplace resiliencefor different sociodemographic characteristics

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Caring behaviours reported by MHNs in this study were high (mean > 5 for all subscales). There are no prior reports of caring behaviour findings in the mental health nursing literature so direct comparison cannot be made. In the wider field of nursing, Labrague et al. (2015) reported ranges of 4.5-4.8 for undergraduate students. With registered nurses, findings range from 4.2 to 5.1 across studies (Geyer et al. 2018; Sarafis et al. 2016; Yau et al. 2018). In the current study, while the mean for the Connectedness subscale was high (5.1), it was the lowest of the four subscale means, which is consistent with Labrague et al. (2015). This subscale refers to nurses' positive connectedness to another's experience and readiness to help. It is not clear what the reasons are for this finding, but it is possible that due to the workload demands and staffing issues reported by MHNs in this study, that these and other factors may be impacting their availability and willingness to connect with consumers. This has implications for MHNs' quality of practice and needs further investigation.

#### Limitations

This study was limited to a cross section of mental health nurses working in one state in Australia. As such, study outcomes may not be relevant for other geographical settings and jurisdictions. The study did not capture detailed information on MHNs' practice environment, so some factors specific to the work context are unknown. Further exploration of workplace practice environments is important to ensure that future support programmes are well-targeted. The study design did not allow for longitudinal data collection, and therefore, the effect of contextual and personal characteristics on outcome measures over time remains unknown. Further research could explore predictors of psychological wellbeing, resilience, and caring behaviours of mental health nurses, including the sociodemographic characteristics identified here. Future investigations may seek to understand how workplace stressors for mental health nurses related to consumer/carers, colleagues, and organizations can be prevented or reduced.

# CONCLUSION

The workplace stressors for MHNs identified in this study have wide implications. Mental health nurses comprise the largest group in the Australian mental health workforce and provide vital clinical care to address the needs of mental health consumers (Australian Institute of Health & Welfare 2016). Yet there is a significant national shortage of MHNs, with a projected undersupply of 18 500 by 2030 (Health Workforce Australia 2014). Attrition is due in large part to stressors including verbal and/or physical aggression, high patient acuity, conflict amongst colleagues, bullying, and high workloads (Tonso et al. 2016; Yanchus et al. 2017). In order to address the looming workforce crisis, MHNs' workplace stress needs to be an urgent priority for governments, industrial organizations, the profession, and mental health services, and assertive measures need to be taken to reduce these stressors and strengthen staff wellbeing and resilience.

## **RELEVANCE TO CLINICAL PRACTICE**

This study has identified specific relationships between workplace stress, resilience, well-being and practice that support initial steps and further explorations to ameliorate or remove workplace stressors. The findings identified specific groups of MHNs where there appears to be stronger need with potentially significant gain. In this case, these were younger and less experienced MHN. Inclusion of well-being strategies and resiliencebuilding education is recommended for all MHN graduate transition programmes. Further. resilience-building programmes are recommended for MHNs across all roles and levels of seniority. The findings therefore have application for managers at all levels but also for frontline MHNs. It is important that managers of mental health organizations ensure MHNs feel positive about and connected to their workplace, experience psychological well-being, and, fundamental to a caring profession, demonstrate caring behaviours. It is equally important that MHNs take up opportunities within their workplace and more widely, to enhance their well-being and strengthen their resilience.

## ACKNOWLEDGEMENTS

The authors thank Emily Wordie-Thompson for her assistance with data extraction and cleaning. The authors would like to thank the Department of Health and Human Services Victoria, the Australian Nursing and Midwifery Federation (Victorian Branch), and the Health and Community Services Union, for their assistance with distributing the study

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