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ORIGINAL ARTICLE

Mental health nursing practice in rural and remote Canada: Insights from a national survey

***Martha L.P. MacLeod,*[1] *Kelly L. Penz,*[2] *Davina Banner,*[1] *Sharleen Jahner,*[2] *Irene Koren,*[3] *Alexandra Thomlinson,*[4] *Pertice Moffitt*[5] *and Mary Ellen Labrecque*[2]**

[1]*School of Nursing, University of Northern British Columbia, Prince George, British Columbia,* [2]*College of Nursing, University of Saskatchewan, Saskatoon, Saskatchewan,* [3]*School of Nursing, Laurentian University, Sudbury, Ontario,* [4]*Health Research Institute, University of Northern British Columbia, Prince George, British Columbia, and* [5]*Aurora Research Institute, Yellowknife, Northwest Territories, Canada*

ABSTRACT: *Access to and delivery of quality mental health services remains challenging in rural and remote Canada. To improve access, services, and support providers, improved understanding is needed about nurses who identify mental health as an area of practice. The aim of this study is to explore the characteristics and context of practice of registered nurses (RNs), licensed practical nurses (LPNs), and registered psychiatric nurses (RPNs) in rural and remote Canada, who provide care to those experiencing mental health concerns. Data were from a pan-Canadian cross-sectional survey of 3822 regulated nurses in rural and remote areas. Individual and work community characteristics, practice responsibilities, and workplace factors were analysed, along with responses to open-ended questions. Few nurses identified mental health as their sole area of practice, with the majority of those being RPNs employed in mental health or crisis centres, and general or psychiatric hospitals. Nurses who indicated that mental health was only one area of their practice were predominantly employed as generalists, often working in both hospital and primary care settings. Both groups experienced moderate levels of job resources and demands. Over half of the nurses, particularly LPNs, had recently experienced and/or witnessed violence. Persons with mental health concerns in rural and remote Canada often receive care from those for whom mental health nursing is only part of their everyday practice. Practice and education supports tailored for generalist nurses are, therefore, essential, especially to support nurses in smaller communities, those at risk of violence, and those distant from advanced referral centres.*

KEY WORDS: *cross sectional studies, mental health services, nurses, remote, rural.*

Correspondence: Martha L.P. MacLeod, School of Nursing, University of Northern British Columbia, Prince George, British Columbia, 3333 University Way, Prince George, BC V2N 4Z9, Canada. Email: martha.macleod@unbc.ca

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Martha L.P. MacLeod, PhD, RN.
Kelly L. Penz, PhD, RN.
Davina Banner, PhD, RN.
Sharleen Jahner, PhD, RN.
Irene Koren, MSc, RN.
Alexandra Thomlinson, BSc.
Pertice Moffitt, PhD, RN.
Mary Ellen Labrecque, RN(NP) PhD.

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INTRODUCTION

While mental illness is a significant cause of morbidity globally (Steel *et al*. 2014), rural and remote communities are disproportionately impacted by mental health concerns and face unique barriers to accessing timely mental health services (Beks *et al*. 2018; Canadian Institute for Health Information [CIHI] 2019; Happell *et al*. 2012; Mental Health Commission of Canada 2020). Internationally, mental healthcare in rural areas is described as disjointed and inconsistently funded, sporadic, and prioritizes acute management (Perkins *et al*. 2019). In Canada, people in rural and remote areas often need to travel great distances to access the healthcare they need, with some having to rely on ice roads, seasonal ferries, or roads that are impassable in winter and spring. Indigenous peoples face unique needs for mental health services due to complex intergenerational trauma created by Canada's colonialist history and ongoing oppressive policies and discrimination (Mental Health Commission of Canada 2020).

The need for mental health services has intensified during the COVID-19 pandemic given the increased likelihood of individuals with long-term conditions manifesting mental health symptoms (Buneviciene *et al*. 2021) along with reduced access to mental health services due to system strains (Warfield *et al*. 2020) and geographical limitations in rural and remote areas (Lyne *et al*. 2020; Moffitt *et al*. 2020; Summers-Gabr 2020). The COVID-19 pandemic has also strained the resources available to rural and urban mental health providers, as well as increased occupational demands related to workload and service adaptations, leading to an increased risk of burnout and turnover (Sklar *et al*. 2021).

Mental health services and supports in rural and remote communities are shaped by the availability of generalist and specialized health human resources, as well as a complex interplay of factors including cultural inequities, socio-economic conditions, and stigma associated with mental illness and seeking psychological help (Beks *et al*. 2018; Caxaj 2016; Crowther & Ragusa 2011; Happell *et al*. 2012; Hirsch & Cukrowicz 2014). Nurses are central providers of healthcare services in these settings, including mental health illness prevention, treatment of mental health disorders, and mental health promotion (Beks *et al*. 2018; Happell *et al*. 2012; Huy *et al*. 2018; Kidd *et al*. 2012). Although access to mental health services (CIHI 2019) and information about nurses who specialize in mental wellness are increasing (CIHI 2019; Sutarsa *et al*. 2021), the nursing workforce who provides mental health services throughout rural and remote Canada is not well understood.

AIM

The aim of this study is to explore the characteristics and context of practice of the regulated nurse workforce in rural and remote areas of Canada, who provide care to those experiencing mental health concerns.

In Canada, the delineation of rural and remote is still in flux, unlike Australia, for example, where urban, rural, and remote areas are classified in terms of accessibility (Subedi *et al*. 2020). Among Canadian nurses, the term, 'rural and remote', is seen to be more encompassing than rural alone (Kulig *et al*. 2008). In this study, rural and remote refer to all rural settings, defined as being outside the commuting zones of communities with a population of 10 000 (du Plessis *et al*. 2001) and all settings in the three northern territories (Yukon, Northwest Territories, and Nunavut).

BACKGROUND

The nursing workforce providing care for those with mental health concerns varies across the world. For example, in Australia approximately 7% of registered and enrolled nurses provide mental health services, working principally as mental health nurses and of those, over 85% are registered nurses (Australian Institute of Health & Welfare [AIHW] 2021). In Canada, registered nurses (RNs), nurse practitioners (NPs), and licensed practical nurses (LPNs) provide mental healthcare in all 10 provinces and 3 northern territories. Registered psychiatric nurses (RPNs) are regulated nurses in the four western provinces (Manitoba, Saskatchewan, Alberta, British Columbia) and one northern territory (Yukon).

Education for mental health nursing varies internationally, with some countries, such as Australia and the United Kingdom, providing undergraduate registered nurse programmes with a specialization in mental health nursing. In Canada, nurse education is generalist in nature, with the RPN programme offered only in the four western provinces. Entry to practice for RPNs in Canada is a 2-year diploma with both diploma and baccalaureate programmes available (CIHI 2020).

In 2019, in Canada, 6.6% of regulated nurses (2.6% of NPs, 5.5% of RNs, 4.8% of LPNs, 100% of RPNs) specialized in mental health or worked in mental health facilities (CIHI 2020). In both Australia and Canada, countries with highly dispersed populations, a lower proportion of nurses work in mental health in more

rural and remote areas (AIHW 2021; CIHI 2019; Sutarsa *et al*. 2021).

In rural and remote areas, nurses assume critical roles in the delivery of healthcare services and practice across many settings, from dedicated acute care facilities to geographically isolated community clinics and outposts (Berry 2018; Jansson & Graneheim 2018). Rural and remote nurses provide care to varied patient populations, often practising in relative isolation, with limited access to specialized resources, professional supports, and training (Beks *et al*. 2018; Kidd *et al*. 2012; Moore *et al*. 2010; Skinner & Phillip 2010).

Ready access to a range of appropriately resourced and trained mental health professionals in rural and remote communities is often absent (Beks *et al*. 2018; Caxaj 2016). As a result, nurses in rural general acute care are considered the 'front line' providers (Beks *et al*. 2018) for patients presenting with acute or long-term mental health concerns (Kidd *et al*. 2012; Reed & Fitzgerald 2005). Many rural and remote nurses report having limited resources and a lack of confidence in their skills to help people seeking mental health support (Beks *et al*. 2018; Happell *et al*. 2012; Huy *et al*. 2018; Jansson & Graneheim 2018; Link *et al*. 2019). They report personal and professional challenges in providing psychosocial care overall (Kenny & Allenby 2013), often feeling isolated, unprepared, and unsupported when delivering care to persons living with a mental health concern (Crowther & Ragusa 2011).

A continuing and increasing problem expressed by rural and remote nurses and those caring for persons with mental health issues, is their experience of violence and aggression (Havaei *et al*. 2020), including ongoing concerns about personal safety (Jahner *et al*. 2020; Lenthall *et al*. 2018; Wressell *et al*. 2018) and when transporting patients from isolated settings (Beks *et al*. 2018; Jansson & Graneheim 2018; Soomaroo *et al*. 2014). Nurses consistently identify the need for concrete practice supports, along with continuing education on how to assess and manage patients with diverse mental health needs (Beks *et al*. 2018; Jahner *et al*. 2020; Lenthall *et al*. 2018; MacLeod *et al*. 2008; Moffitt *et al*. 2020; Perkins *et al*. 2019; Skinner & Philip 2010).

Despite a growing body of literature exploring the rural and remote nursing workforce and related practice issues, little is known about the nurses who provide care to persons living with mental health concerns and their practice settings. Without this knowledge it will be challenging to appropriately tailor supports for nurses in both specialized and generalized settings, as well as plan for a sustainable mental health workforce in rural and remote communities. To make advances on this knowledge gap, this study explored the characteristics and context of practice of rural and remote RNs, LPNs, and RPNs in Canada who provide care to those experiencing mental health concerns.

METHODS

Research design

The data in these analyses were accessed from the Nursing Practice in Rural and Remote Canada (RRNII) pan-Canadian cross-sectional survey of regulated nurses residing in rural and remote communities (MacLeod *et al*. 2017). Full details on the RRNII method, survey questionnaire development, and sampling frame are available in MacLeod *et al*. (2017). Ethics approvals were gained from six universities and three territorial organizations. Each participant provided informed consent. The STROBE Checklist was used as the reporting guideline for the study.

Study setting and participants

From a systematically stratified target sample of 10 072 nurses, 9622 nurses were eligible to participate (450 were ineligible due to incorrect address or working urban), with a total of 3822 completed surveys returned for a statistically significant response rate of 40% (3822/9622) from all provinces and territories. The sample was comprised of RNs, LPNs, and RPNs in rural and remote communities in all 10 provinces, all NPs in rural and remote communities, and all regulated nurses in the 3 northern territories. The sampling frame was designed to achieve statistically significant (confidence level of 95% and a margin of error of 0.05) results provincially, territorially, and nationally.

Respondents worked in the full range of practice settings including primary care, acute care, community health, home care, mental health and addictions, and long-term care. The subsample ($N = 3457$) for the present analysis consisted of rural and remote RNs ($n = 1937$), LPNs ($n = 1313$), and RPNs ($n = 207$) employed as staff nurses, managers, and clinical nurse specialists who indicated that mental health was an area of current practice. Due to small sample sizes, NPs and nurses who were retired and occasionally employed in nursing were excluded from this analysis.

Data collection

The survey was mailed with the assistance of the provincial and territorial nursing regulatory bodies between June 2014 and August 2015. The Dillman method was adopted, including repeated follow-up (Dillman *et al.* 2014), with both paper and online survey formats available in English and French.

The comprehensive (91 item) survey questionnaire of the RRNII study (MacLeod *et al.* 2017) was informed by a previous national survey (Stewart *et al.* 2005) and was developed by the 16-member research team and a 19-member advisory group of nurse leaders in rural and remote practice and policy from all provinces and territories. Areas examined in this analysis were individual (demographic and professional), work community characteristics, practice responsibilities, and workplace factors. The selection of the study variables was informed by our previous analysis (MacLeod *et al.* 2017), as well as insights garnered from the advisory group and contemporary literature. Variables chosen were individual variables (nurse type, age, gender, current primary position, primary place of employment, province/territory of residence); work community characteristics (population size, distance from advanced referral centre); practice responsibilities (promotion, prevention, and population health/mental health programmes; assessment/mental health assessment); and workplace factors (job resources, job demands, experience of violence, witness to violence).

In relation to the occupational stress and motivational research traditions (i.e. Job Demands-Resources Theory) (Bakker & Demerouti 2017), overall job-related resources and job-related demands were measured with the 24-item Job Resources in Nursing (JRIN) Scale and the 22-item Job Demands in Nursing (JDIN) Scale (Penz *et al.* 2019). The JRIN had total summated scores ranging from 24 to 120, interpreted from low (24–56), medium (57–88). and high (89–120) levels of work-related resources. Similarly, the JDIN's total summated scores ranged from 22 to 110, interpreted as low (22–51), medium (52–80), and high (81–110) levels of work-related demands. The mean score for each of the six subscales within each scale was interpreted from a low level of agreement on that particular subscale (1.0–3.0) to a high level of agreement (>3.0) consistently with the originally published version of the scales (Penz *et al.* 2019).

Analysis

Quantitative data were analysed with IBM SPSS Statistics 24. Sample characteristics were examined with descriptive statistics (frequencies and proportions). Group differences were evaluated with the χ^2 test for categorical variables and Student's t-test for interval variables, and z-tests for significance ($P < 0.05$). A total of 132 responses (ranging 61–511 words each) from an open-ended question asking what it means to be a nurse in rural and/or remote Canada were analysed for similarities and differences, coded, and organized into broad categories using a codebook. The most common challenges and concerns regarding provision of mental health services and the context of this care in rural and remote communities were identified.

RESULTS

A total of 9.8% ($n = 338$) of the sample of registered nurses (RNs), licensed practical nurses (LPNs), and registered psychiatric nurses (RPNs) indicated mental health as their sole area of practice or one of their areas of practice from a list of nine practice areas. The responses were clustered into two distinct groups. One group ($n = 182$; 5.3%) comprised nurses who indicated their area of practice to be mental health only. The second, mental health plus group, ($n = 156$; 4.5%) included nurses who indicated their area of practice to be mental health and at least one other area of practice, most frequently, acute care, hospice/end of life/palliative care, or long-term care (See Fig. 1). Over half of the mental health only group were RPNs (54.4%, $n = 99$), followed by RNs (32.4%, $n = 59$), then LPNs (13.2%, $n = 24$). Close to half of those within the mental health plus group were RNs (46.8%, $n = 73$), followed by LPNs (30.8%, $n = 48$), then RPNs (22.4%, $n = 35$). Of the total sample of 134 RPNs, 73.9% ($n = 99$) were in the mental health only group and 26.1% ($n = 35$) were in the mental health plus group. Of the 132 RNs, 44.7% ($n = 59$) were in the mental health only group and 55.3% ($n = 73$) were in the mental health plus group. Of the 72 LPNs, 33.3% ($n = 24$) were in the mental health only group and 66.7% ($n = 48$) were in the mental health plus group.

Characteristics of nurses

The majority of nurses who described their area of practice as mental health only or mental health plus

other areas were female, over 44 years of age, and held a staff nurse position (Table 1). Mental health only nurses were significantly more likely to be over the age of 54, while mental health plus nurses were more likely to be in the 35–44 year age range. Significant differences were found in place and region of employment. Most of the mental health only nurses were employed in mental health or crisis centres (50.3%) or hospitals (34.8%), while most of the mental health plus nurses were employed in a hospital (47.4%) or in primary care (23.4%). More mental health only nurses worked in the four western provinces where RPNs were registered (Manitoba, Saskatchewan, Alberta, and British Columbia); and more mental health plus nurses worked in the three northern territories (Yukon, Northwest Territories, Nunavut). There were also significant differences in both size of community and distance to advanced referral centre. Relatively few mental health only nurses worked in a community with a population of less than 1000, with most working in communities with over 10 000 people. Subsequently, more of the mental health only nurses were in closer proximity to an advanced referral centre. In reference to comparing services provided between the two groups, significantly more nurses in the mental health only group provided mental health programmes (e.g. education, wellness groups, support groups) in their nursing practice, and were responsible for mental health assessments (e.g. addictions, depression, suicide, committal).

The average summated scores for the JRIN and JDIN scales indicated medium work-related resources and medium work-related demands overall for both groups. That is, resources were not critically low and demands were not critically high for both groups. Small, but significant differences between groups on particular subscales were noted. The nurses in the mental health plus group had significantly lower perceived work-related resources overall compared to the mental health only group, particularly in the two main job resource areas of staffing and time; as well as training, professional development, and continuing education. Overall work-related demands were similar for both groups with one significant difference in job demands. Nurses in the mental health plus group had significantly higher demands related to comfort with their working conditions. More than half the nurses in both groups either experienced violence and/or witnessed violence in the workplace in the previous four weeks.

Variations among nurse types

The characteristics of the mental health only and mental health plus groups were further broken down by nurse type (Table 2). In the provinces with RPNs, the majority of RPNs and a minority of RNs and LPNs described their area as mental health only. For nurses with a mental health plus practice, the majority of RPNs were employed in mental health centres, followed by primary care; the majority of RNs were employed in hospitals, followed by primary care; and the majority of LPNs were employed in hospitals, followed by long-term care.

The primary work community for the majority of mental health only or mental health plus RPNs had a

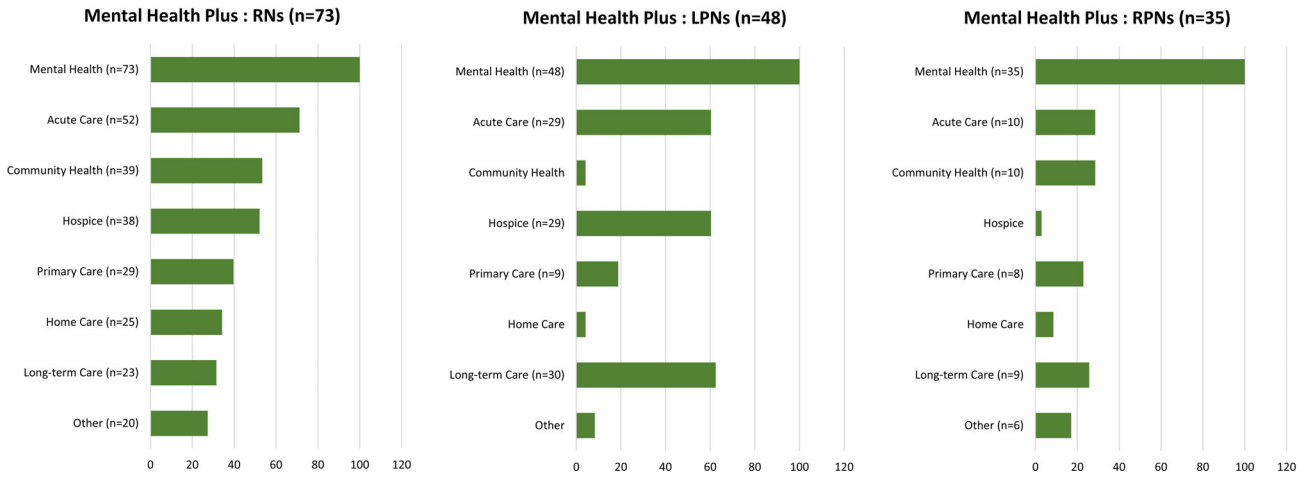

FIG. 1 Areas of practice for Registered Nurses (RNs), and Licensed Practical Nurses (LPNs), and Registered Psychiatric Nurses (RPNs), who worked in mental health plus one or more other areas of practice.

population over 10 000. In the least populated primary work communities, the highest proportion of regulated nurses were the mental health plus RNs. The majority of both mental health only and mental health plus RPNs worked within 200 km of an advanced referral centre. The majority of RNs and LPNs worked at greater distance from an advanced referral centre, with the majority of mental health plus RNs working 500 km or more from an advanced referral centre.

When examined across nurse type, perceived job resources and demands were in the medium range overall for all nurses. The only area in which mental health plus nurses had higher resources were among RNs who perceived themselves to have higher levels of collegial support. Mental health plus LPNs had the lowest perceived work-related resources, with both mental health plus RPNs and LPNs reporting the highest work-related demands. Mental health plus RPNs had the highest work-related demands related to their own safety. Experiencing and witnessing violence within the previous 4 weeks was highest among mental health only LPNs, with mental health plus RPNs reporting more witnessed violence than either RNs or LPNs.

Types of experienced and witnessed violence in the workplace

No statistical differences were found between the mental health only and mental health plus nurses when comparing each type of experienced or witnessed violence in the previous 4-week period. Table 3 details the types of violence experienced and witnessed by both groups. Close to half the nurses in both groups had experienced or witnessed emotional abuse, with a high proportion experiencing and/or witnessing threat of assault. Being witness to physical assault was also high for both groups, with approximately one-fifth of the sample also experiencing physical assault in the previous 4-week period. The patient/client was the most common instigator of violence experienced by nurses in the *mental health only* group: all incidents of threat of assault (n = 61/61), physical assault (n = 37/37); the majority of incidents of emotional abuse (n = 68/81), verbal/sexual harassment (n = 31/32), property damage (n = 9/11), and stalking (n = 3/5). The patient/client was also the most common instigator of all types of violence experienced by the mental health plus *nurses*: all incidents of physical assault (n = 33/33) and the majority of the incidents of threat of assault (n = 43/44), emotional abuse (n = 42/57), verbal/sexual harassment (n = 31/36), property damage (n = 5/7), stalking, and sexual assault.

The patient/client was also the most common instigator of the majority of all types of witnessed violence for the mental health only nurses: emotional abuse (n = 67/78), threat of assault (n = 56/76), physical assault (n = 49/52), verbal/sexual harassment (n = 35/40), property damage (n = 20/22), stalking, and sexual assault. Similar proportions were noted for the mental health plus nurses, with the patient/client as the most common perpetrator of witnessed violence: emotional abuse (n = 49/72), threat of assault (n = 56/64), physical assault (n = 54/58), verbal/sexual harassment (n = 33/38), property damage (n = 7/12), stalking, and sexual assault.

Open-ended comments

A total of 132 participants (108 mental health only; 24 mental health plus) included comments about caring for persons with mental health concerns. The available comments most frequently mentioned challenges in obtaining specialized mental health services, particularly in remote or Indigenous communities. This was followed by comments delineating the scope and scale of their nursing role, with issues arising from caring for people with mental health issues in small communities and concerns about their own safety. Those in the mental health only group identified similar issues with those providing consultative services to remote communities highlighting the demands of extensive travel. Pseudonyms are provided.

Nurses noted difficulties in obtaining services for clients including a lack of resources such as group homes or community agencies; a lack of specialized services or support services such as a social work or occupational therapy; noting 'no psychiatric beds in the community', 'no detox centre' (Alex, MH only, RN). The nurses' work was impacted as they had to '[overcome] barriers when we try to refer clients to the nearest city' (Billie, MH only, RN) or arrange discharge, which 'is often difficult when clients are returning to [even smaller Indigenous] communities where there is no support' (Iris, MH plus, RPN). Limited housing and transportation options placed greater demands on the nurses to find innovative solutions. Both mental health only and mental health plus nurses described the variety and extent of their roles:

TABLE 1 *Characteristics of nurses who describe their area of practice as mental health only or mental health plus other areas*

Variables	Mental health only n = 182 n (%)	Mental health plus n = 156 n (%)	Chi-square P-value	P-value by category (z-test)
Gender			0.992	
Male	26 (14.6)	22 (14.6)		
Female	152 (85.4)	129 (85.4)		
Age			**0.027**	
<35	29 (15.9)	36 (23.1)		0.09692 (−1.6611)
35–44	24 (13.2)	36 (23.1)		**0.01778 (−2.3722)**
45–54	55 (30.2)	37 (23.7)		0.18024 (1.3388)
>54	68 (37.4)	42 (26.9)		**0.04136 (2.0421)**
Province/Territory			**<0.001**	
Provinces with RPNs	119 (65.4)	64 (41.0)		**<0.00001 (4.4805)**
Provinces without RPNs	50 (27.5)	52 (33.3)		0.242 (−1.1702)
Northern territories	13 (7.1)	40 (25.6)		**<0.00001 (−4.6626)**
Primary position			0.285	
Manager	18 (9.9)	24 (15.4)		
Staff Nurse	148 (81.3)	121 (77.6)		
Clinical Nurse Specialist	16 (8.8)	11 (7.1)		
Area of current practice				
Acute care		91 (58.3)		
Primary care		46 (29.5)		
Community health		51 (32.7)		
Long-term care		62 (39.7)		
Home care		30 (19.2)		
Hospice/End of life/Palliative care		68 (43.6)		
Mental health	182 (100.0)	156 (100.0)		
Other		30 (19.2)		
Place of primary employment			**<0.001**	
Primary care	17 (9.4)	36 (23.4)		**0.00046 (−3.4954)**
Mental health centre/Crisis centre	91 (50.3)	17 (11.0)		**<0.00001 (7.6577)**
Hospital	63 (34.8)	73 (47.4)		**0.01928 (−2.3397)**
Nursing home or long- term care facility	5 (2.8)	15 (9.7)		**0.00714 (−2.6864)**
Community-based health care and other	5 (2.8)	13 (8.4)		**0.02144 (−2.2974)**
Population of primary work community			**0.003**	
< 999	11 (6.1)	20 (13.2)		**0.029**
1000–9999	83 (46.4)	85 (55.9)		0.084
≥10000	85 (47.5)	47 (30.9)		**0.002**
Distance to advanced referral centre			**<0.001**	
0–99 km	41 (23.2)	24 (15.8)		0.095
100–199 km	58 (32.8)	34 (22.4)		**0.036**
200–499 km	47 (26.6)	35 (23.0)		0.459
500–999 km	15 (8.5)	20 (13.2)		0.171
≥1000 km	16 (9.0)	39 (25.7)		**<0.001**
Promotion, prevention, and population health				
Mental health programmes	163 (89.6)	99 (63.5)	**<0.001**	**<0.001**
Assessment				
Mental health	167 (91.8)	112 (71.8)	**<0.001**	**<0.001**
Violence				
Experienced violence	104 (58.8)	85 (56.3)	0.652	
Witnessed violence	108 (61.0)	95 (63.8)	0.611	
T-Test[†]	Means (*SD*)			
JRIN summated	82.26 (12.83)	78.42 (12.14)		**0.008**
JRIN subscales				
Supervision, recognition and feedback	3.42 (0.99)	3.22 (0.96)		0.064

(*Continued*)

TABLE 1 (Continued)

T-Test[†]	Means (*SD*)		
Collegial support	3.96 (0.73)	4.01 (0.64)	0.456
Staffing and time	3.13 (0.87)	2.80 (0.89)	**0.001**
Technology	3.32 (0.76)	3.23 (0.83)	0.331
Training, PD, continuing education	3.19 (0.82)	3.00 (0.86)	**0.043**
Autonomy and control	3.51 (0.76)	3.38 (0.78)	0.111
JDIN summated	50.96 (10.26)	52.29 (9.85)	0.311
JDIN subscales			
Work-related travel	2.41 (0.88)	2.45 (0.94)	0.713
Preparedness/Scope of practice	2.36 (0.43)	2.40 (0.44)	0.375
Equipment and supplies	2.36 (0.77)	2.51 (0.80)	0.091
Isolation	2.19 (0.72)	2.31 (0.71)	0.125
Comfort with working conditions	2.63 (0.72)	2.82 (0.66)	**0.012**
Safety	2.68 (0.78)	2.77 (0.86)	0.320

Blank cells indicate Not Applicable.
Bold font indicates significance level of $p \leq 0.05$
[†]Independent samples t-test, two-tailed significance with equal variances assumed.

> I get to stretch my role across so many different dimensions i.e., I do an assessment, I work with the police & help educate them, I find a housing solution for the patient and maybe direct them to financial aid or other community resources. It can be a very vibrant, multifaceted job and very satisfying. (Chris, MH only, RN)

> We not only act as therapists but also case managers, whereby we support our clients whatever way we can, as well as their loved ones. The community relies on us not only Monday to Friday, but we are also on call the remainder of the time to answer calls or do assessments for the ER [Emergency Room] and RCMP [Royal Canadian Mounted Police]. We also participate in psychological support debriefing for critical incidents. (Jaime, MH plus, RPN)

The demands of being a mental health nurse in a small community was identified by many mental health only nurses. They described the discomfort for both the nurse and those under their care of 'meeting a client who has been in our [detox] service at the liquor store' (Dana, MH only, RN). Nurses also experienced stigma because of their role. As one nurse commented, '[my family] has been told that I am a child stealer, because of collaboration with social services' (Erin, MH only, RPN). Another said they felt 'more isolated to my home since starting to work in Mental Health.... You see patients frequently and are approached for advice'. They continued to note that they felt the stigma and preferred 'not to associate with community as lack of understanding from public relating to mental illness. Any efforts to educate result in negative comments' (Frankie, MH only, LPN).

Mental health only nurses in particular reported concerns about violence and their own safety. One LPN noted, 'I have experienced mental, verbal aggression from patients frequently... I have not always felt safe working, especially evening and nights' (Gale, MH only, LPN). Several nurses mentioned the lack of on-site hospital security or protocols, and sparse staff to respond to a violent incident. In many instances the Royal Canadian Mounted Police (RCMP) was the only available security. Community settings had several common security gaps, 'No alarms at our desks, no plexiglass for reception. We are mixed in with primary health care and have toddlers and infants [together] with some of our clients who have potential for violence or are sexual offenders' (Jaime, MH plus, RPN).

Mental health only nurses who provided services to several geographically dispersed communities described travel issues for patients, along with the burden of long-distance travel for themselves:

> Driving into and out of the remote communities on my own can be difficult both mentally and physically. Weather, road conditions, and animals on the road can be treacherous and I sometimes drive for hours without meeting a single vehicle. I carry a satellite phone to inform others of my location in emergencies, but I'm not sure if the signal always goes through. As I drive, I stop in at Nursing Stations and RCMP [Royal Canadian Mounted Police] detachments along the way, both to give myself a short break and to connect with members, who occasionally have concerns about situations and/or specific individuals in their community. (Kara, MH only, RPN)

TABLE 2 *Characteristics of nurses, presented by nurse type, who describe their area of practice as mental health only or mental health plus other areas*

Variables	Mental health only $N = 182$			Mental health plus $N = 156$		
	RPNs $n = 99$ n (%)	RNs $n = 59$ n (%)	LPNs $n = 24$ n (%)	RPNs $n = 35$ n (%)	RNs $n = 73$ n (%)	LPNs $n = 48$ n (%)
Province/Territory						
Provinces with RPNs	96 (97.0)	18 (30.5)	5 (20.8)	33 (94.3)	19 (26.0)	12 (25.0)
Provinces without RPNs	0 (0)	32 (54.2)	18 (75.0)	0 (0)	23 (31.5)	29 (60.4)
Northern territories	†	9 (15.3)	†	†	31 (42.5)	7 (14.6)
Place of primary employment						
Primary care	10 (10.2)	6 (10.2)	†	7 (21.2)	25 (34.2)	†
Mental health centre/Crisis centre	52 (53.1)	28 (47.5)	11 (45.8)	11 (33.3)	†	†
Hospital	29 (29.6)	24 (40.7)	10 (41.7)	6 (18.2)	34 (46.6)	33 (68.8)
Nursing home or Long-term care facility	†	0 (0)	†	†	†	8 (16.7)
Community-based healthcare/Other	†	†	0 (0)	5 (15.2)	7 (9.6)	†
Population of primary work community						
<999	6 (6.2)	5 (8.6)	0 (0)	†	15 (20.5)	†
1000–9999	42 (43.3)	28 (48.3)	13 (54.2)	11 (33.3)	38 (52.1)	36 (78.3)
≥10 000	49 (50.5)	25 (43.1)	11 (45.8)	19 (57.6)	20 (27.4)	8 (17.4)
Distance to advanced referral centre						
0–99 km	28 (28.6)	7 (12.1)	6 (28.6)	11 (32.4)	7 (9.7)	6 (13.0)
100–199 km	32 (32.7)	22 (37.9)	†	9 (26.5)	12 (16.7)	13 (28.3)
200–499 km	25 (25.5)	16 (27.6)	6 (28.6)	8 (23.5)	15 (20.8)	12 (26.1)
500–999 km	9 (9.2)	†	†	†	8 (11.1)	8 (17.4)
≥1000 km	†	9 (15.5)	†	†	30 (41.7)	7 (15.2)
Violence						
Experienced violence	56 (57.1)	32 (56.1)	16 (72.7)	20 (57.1)	39 (56.5)	26 (55.3)
Witnessed violence	57 (58.2)	34 (59.6)	17 (77.3)	25 (75.8)	42 (60.9)	28 (59.6)

Variables	Means (*SD*)			Means (*SD*)		
	RPNs	RNs	LPNs	RPNs	RNs	LPNs
JRIN summated	82.42 (12.56)	82.23 (14.20)	81.67 (10.94)	77.67 (12.03)	81.63 (11.17)	74.14 (12.48)
JRIN subscales						
Supervision, recognition and feedback	3.36 (1.02)	3.53 (1.04)	3.41 (0.69)	3.11 (1.08)	3.39 (0.93)	3.05 (0.90)
Collegial support	3.97 (0.69)	3.98 (0.79)	3.82 (0.71)	3.98 (0.72)	4.12 (0.58)	3.88 (0.65)
Staffing and time	3.15 (0.86)	3.12 (0.91)	3.08 (0.84)	2.71 (0.81)	2.98 (0.91)	2.60 (0.88)
Technology	3.33 (0.75)	3.19 (0.80)	3.65 (0.60)	3.29 (0.86)	3.24 (0.86)	3.18 (0.78)
Training, professional development, and continuing education	3.23 (0.79)	3.12 (0.85)	3.24 (0.87)	3.03 (0.84)	3.13 (0.94)	2.79 (0.70)
Autonomy and control	3.55 (0.75)	3.56 (0.86)	3.22 (0.42)	3.34 (0.81)	3.67 (0.71)	2.96 (0.69)
JDIN summated	50.41 (10.17)	51.70 (10.85)	51.14 (9.31)	54.81 (9.92)	50.34 (9.14)	53.32 (10.52)
JDIN subscales						
Work-related travel	2.36 (0.84)	2.53 (1.00)	2.34 (0.64)	2.65 (1.02)	2.41 (0.91)	2.36 (0.93)
Preparedness/Scope of practice	2.28 (0.39)	2.38 (0.48)	2.61 (0.41)	2.37 (0.53)	2.45 (0.41)	2.34 (0.44)
Equipment and supplies	2.29 (0.70)	2.38 (0.84)	2.54 (0.85)	2.55 (0.85)	2.45 (0.74)	2.57 (0.85)
Isolation	2.14 (0.67)	2.30 (0.80)	2.15 (0.72)	2.44 (0.79)	2.17 (0.63)	2.43 (0.72)
Comfort with working conditions	2.57 (0.67)	2.69 (0.81)	2.73 (0.66)	2.71 (0.64)	2.86 (0.68)	2.85 (0.64)
Safety	2.74 (0.85)	2.59 (0.72)	2.68 (0.56)	3.01 (0.89)	2.60 (0.86)	2.86 (0.79)

†Data suppressed due to small cell sizes.

DISCUSSION

The characteristics of rural and remote nurses providing care to those with mental health concerns varied across provinces and territories in Canada. In provinces and the territories without RPNs, the majority of the nurses identified mental health as only one of their areas of practice. This was especially the case in

TABLE 3 *Types of violence experienced and/or witnessed in the previous 4-week period by nurses who describe their area of practice as mental health only or mental health plus other areas*

Variables	MH only $N = 182$ n (%)	MH plus $N = 156$ n (%)
Experienced violence		
Emotional abuse	81 (45.8)	57 (37.7)
Threat of assault	61 (34.5)	44 (29.1)
Physical assault	37 (20.9)	33 (21.9)
Verbal/sexual harassment	32 (18.1)	36 (23.8)
Property damage	11 (6.2)	7 (4.6)
Stalking	5 (2.8)	†
Sexual assault	†	†
Witnessed violence		
Emotional abuse	78 (44.1)	72 (48.3)
Threat of assault	76 (42.9)	64 (43.0)
Physical assault	52 (29.4)	58 (38.9)
Verbal/sexual harassment	40 (22.6)	38 (25.5)
Property damage	22 (12.4)	12 (8.1)
Stalking	†	†
Sexual assault	†	†

†Data suppressed due to small cell sizes.

smaller communities, and in communities more distant from advanced referral centres. RPNs were more likely to work in larger communities and communities that were closer to referral areas than were RNs and LPNs. Not surprisingly, nurses who identified their practice only as mental health indicated responsibility for mental health programmes and mental health assessments, and more frequently worked in mental health centres, crisis centres, or hospitals.

In rural and remote settings, nurses find that patients with mental health concerns, who often present with highly complex needs, are challenging to manage; there is little backup, fewer resources (such as detox centres), and no on-hand mental health specialist services (Beks *et al*. 2018; Brunero *et al*. 2018; Caxaj 2016; Kidd *et al*. 2012; Wideman *et al*. 2020). While caring for patients with mental health concerns in general acute care settings has been acknowledged (Beks *et al*. 2018; Kidd *et al*. 2012; Link *et al*. 2019), less recognized is the inclusion of mental health nursing care within nurses' generalist practice in primary care and community settings (Wideman *et al*. 2020) and within LPNs' practice in long-term care. Further exploration in both areas is warranted.

Rural and remote nurses who identified mental health as their only or one of their areas of practice experienced similar and unique issues. The mental health plus nurses identified significantly fewer resources overall than those with more specialized mental health practice, even though the overall workplace demands were similar. The lower resources for training, professional development, and continuing education experienced by the mental health plus nurses in the study is reflected in other studies that note the challenges for rural and remote nurses in accessing and attending continuing education (Link *et al*. 2019; MacLeod & Place 2015; Moore *et al*. 2010). Workplace demands faced by rural and remote nurses are varied and unique (e.g. isolation, workload, safety) and may be linked to negative outcomes such as intent to leave the profession and burnout (Stewart *et al*. 2020). Sufficient work-related resources (e.g. collegial support, supervisory feedback, continuing education) can protect against the impact of high demands, and lead to higher levels of work engagement and organizational commitment (Lenthall *et al*. 2018). Consideration of factors specific to different mental health clinical settings is also needed (Adams *et al*. 2021). As the JRIN and JDIN tool measured job-related resources and job-related demands in nursing practice as a whole (Penz *et al*. 2019), we may not have captured the full complexity of mental health practice challenges or specific resources that are vital to providing quality mental health services in rural and remote settings.

It is alarming that more than half of the nurses in this study experienced or witnessed violence in the previous 4-week period, especially LPNs in mental health only practice, that is more often than in a recent Canadian study (Havaei *et al*. 2020). Gaps in services, inadequate security protocols and supports, and limited backup for nurses in situations of violence are of particular concern, as is the distressing nature of these experiences (Jahner *et al*. 2020; Lenthall *et al*. 2018). Workplace supports and organizational approaches to mitigate risks of violence in rural and remote settings are urgently needed (Jahner *et al*. 2020; Lenthall *et al*. 2018; Moffitt *et al*. 2020; Wressel *et al*. 2018), especially in community-based healthcare settings.

Rural and remote nurses require a considerable range and depth of knowledge and skills to care for the varied patients they encounter with mental health concerns, along with finely tuned skills in de-escalating violence and dealing with unsafe situations. Rural and remote nurses have highlighted the need for education to address various mental health needs of patients, including mothers of newborns and those experiencing long-term disease, as well as managing the span of mental health emergencies (MacLeod *et al*. 2008; Skinner & Philip 2010). Greater integration of mental

health nursing concepts, theory, and practice within undergraduate education programmes is needed as well as dedicated mental health nursing education for rural and remote nurses (MacLeod & Place 2015; Smith & Khanlou 2013).

The open-ended responses from nurses reflected their experiences of the stigma of mental illness and the stigmatization of mental health work. Unlike the literature that discusses this stigma only in the context of professional practice interactions (Brunero *et al*. 2018) or the workplace (Moore *et al*. 2010), the nurses in this study noted how mental health stigma affected their lives in rural and remote communities. Nurses sometimes withdrew from full engagement with their community. Such withdrawal from community engagement may impact retention (Kulig *et al*. 2018), exacerbate long-term nursing shortages, and perpetuate the inequitable provision of care for those with mental health concerns in rural and remote communities (Perkins *et al*. 2019; Sutarsa *et al*. 2021).

Inequitable mental health services in rural and remote communities cannot be addressed without attending to the needs of the nursing workforce in addition to the lived realities of those receiving care (Mental Health Commission of Canada 2020). Community interventions, including education on such topics as reducing the stigma of mental health could make positive contributions to those with mental health concerns as well as to the work lives of rural and remote nurses, whose nursing practice is inextricably intertwined with their lives as community members.

Workable, sustained interventions that actually support generalist nurses to provide care for those with mental health concerns are required, especially interventions that enable practice development and safety. Nurse-focused interventions may include initiatives to strengthen or refine interpersonal or relational skills, collaboration, adequate staffing, and incident debriefing (Jahner *et al*. 2020; Lenthall *et al*. 2018). Approaches such as task sharing through supervision and the creation of partnerships with communities to support generalist nurses' mental health nursing practice merit exploration (Hoeft *et al*. 2018). Additionally, interventions that address workplace and community violence are needed. Without evidence-informed interventions that are valued by nurses and felt to be supportive, offered in partnership with rural and remote communities, the desired improvements in service access and quality, along with supports for providers, cannot be assured.

Limitations

The strength of this analysis is the national, in-depth exploration of the main characteristics and context of practice for generalist and specialized rural and remote nurses who practice in the area of mental health, along with the opportunity to examine and explore their experiences. Limitations are mainly due to the cross-sectional nature and breadth of focus of the national survey along with the few mental health-focused variables initially developed for the original survey tool. This analysis may have underestimated the proportion of rural and remote nurses who are providing mental healthcare services, as they may not have specifically defined 'mental health' as an area of practice.

CONCLUSIONS

Mental health services in rural and remote communities across Canada are provided by many nurses for whom mental health is only part of their everyday generalist practice, particularly in smaller communities that are more distant from advanced health referral centres. Although many rural and remote nurses practice only in the area of mental health, a much larger and more diverse group of RNs, LPNs, and RPNs provide mental health services and practice in other areas such as acute care, primary care, and long-term care. The nurses in both mental health only and mental health plus groups experienced moderate levels of job resources, job demands, and satisfaction with their practice; however, their experiences of violence, concerns with safety, and the stigma of working in mental health require greater attention.

Patients' requirements for mental health services and gaps in those services impact the abilities of rural and remote nurses to provide appropriate and timely care. Especially in light of the needs and perspectives of Indigenous peoples, the COVID-19 pandemic (Foye *et al*. 2021; Moffitt *et al*. 2020), and the opioid crisis, place-based approaches are required (Oelke & Lints-Martindale 2020). Organizations must support nurses' ongoing education and development, as well as provide strong leadership and advocacy, including mitigating the distressing effects of violence. By working with communities, healthcare organizations can provide collaborative community-based care that not only supports persons experiencing mental health concerns but also supports the generalist nurses who care for them.

RELEVANCE FOR CLINICAL PRACTICE

The needs of RNs, LPNs, and RPNs for resources, such as continuing education, specialist consultation, de-escalation training, and the mitigation of violence and its sequelae, vary among nurses exclusively providing mental health services and those with more generalist practice. By understanding 'who are' the rural and remote nurses caring for those with mental health concerns, organizational and practice supports can be tailored to nurses' practice and contextual realities in ways that sustain nurses and assist them to provide better care for people in rural and remote communities.

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