



Exploring The Link Between Work Environment And Wellbeing Among Nigerian Mental Health Professionals

Igbende Dorothy Aumbur¹

Florence Nansubuga²,

Leonsio Matagi³

Samuel Terzungwe Anhange⁴

Joyce M. Terwase⁵

Article's History

Received: 22 February 2026;

Revised: 25 March 2026;

Accepted: 04 April 2026;

Authors' Affiliation

^{1,4,5}Department of Psychology
Benue State University P.M.B.
102119 Makurdi, Nigeria

^{2,3}School of Psychology
Makerere University P.O. Box
7062 Kampala, Uganda

*Corresponding:

abelladorothy@gmail.com,

igbendedorothy@gmail.com,

+2348060256440,

[https://orcid.org/0009-0002-](https://orcid.org/0009-0002-0559-615X)

0559-615X

ABSTRACT

There has been a growing focus on the wellbeing of mental health practitioners, highlighting the critical connection between practitioners' wellbeing and their capacity to function effectively within their work environments. Recognising that the quality of the practice environment is equally as vital as individual wellbeing, this study employed a phenomenological approach to explore how poor work environment impacts the wellbeing of mental health practitioners in Nigeria. Twenty-eight participants participated in in-depth interviews, with data transcribed verbatim, systematically analyzed, and presented through matrices, direct quotations, and causal networks. The findings revealed that adverse work environment, including high temperatures, excessive noise, inadequate office space, insufficient equipment and lighting, and unpleasant odors from patients undermine practitioners' wellbeing. Poor work environments were linked to decreased concentration, motivation, cognitive functioning, and performance, as well as increased fatigue, diagnostic and prescription errors, and persistent dissatisfaction. The study concludes that targeted interventions such as fostering positive mindsets, providing adequate office facilities with improved ventilation and noise reduction, and employing security personnel with mental health training are essential to enhance practitioners' wellbeing. Ultimately, improving work environment conditions and promoting a positive mindset are imperative for enabling mental health practitioners to perform their duties effectively and maintain optimal wellbeing.

Keywords: mental health practitioners, poor work environment, psychiatric hospitals, qualitative study, wellbeing

Introduction

The wellbeing of mental health practitioners has been affected by the nature of their practice environment (Lorenzo et al., 2025). Certain factors are responsible for those challenges they experience, affecting patient treatment, care and practitioners' wellbeing, resulting in inadequate service delivery to patients (Harri et al., 2025; Jang et al., 2022). Practising in an environment where there are a lot of inadequacies is so devastating and discomfoting (Cranage & Foster, 2022; Ferreira et al., 2021), and that leads to feelings of distress, insecurity and dissatisfaction in an environment where patients display unpredictable agitations intermittently (Jang et al., 2022; Peter et al., 2024). Attempts such as changing leadership and employing more practitioners in an environment with limited facilities and a lot of inadequacies have failed to address issues of poor environmental conditions. Besides, the work environment conditions in these settings discourage many upcoming mental health practitioners who wish to specialise in psychiatry (Abdelhadi et al., 2025), given that the government and nongovernmental organisations have failed to give adequate attention to psychiatry, unlike other areas of medicine (Haddad et al., 2020; Peter et al., 2024). Thus, there is a need to address the poor work environmental conditions to improve service delivery and practitioners' wellbeing in the mental health settings.

The Experience of Poor Work Environment Across the Globe

Globally, poor work environment conditions for mental health practitioners in psychiatric hospitals are associated with challenging circumstances, excessive workloads, and systemic inadequacies. For example, in the United Kingdom, unfavourable psychiatric work environments are characterized by high workloads, inadequate staffing and resources, leading to burnout, dissatisfaction, and reduced quality of patient care (Langton & Morley, 2025). Across Europe, mental health practitioners face anxiety, depression, burnout, poor work-life balance, job dissatisfaction, and diminished overall health and wellbeing, all of which impair their ability to function effectively (Aiken et al., 2024). According to Fowler et al. (2025) in New Zealand, practitioner wellbeing is compromised by patient violence, underreporting of attacks (regarded as routine), invalidation, and limited personal safety advocacy. Furthermore, lack

of support from senior staff in New Zealand discourages incident reporting and perpetuates conflict and stigma within psychiatric settings, often linked to historical abuse and ongoing violence. Cranage & Foster (2022) reported that in Australia, practitioners contend with aggression, violence, suicidal behaviours, property destruction, absconding patients, poor communication, strained relationships, insufficient support, work overload, time constraints, medication shortages, inadequate staffing and training, and ineffective management plans. These factors contribute to distress, anxiety, depression, post-traumatic stress disorder, and physical injuries, sometimes necessitating extended medical leave (Cranage & Foster, 2022; Havaei et al., 2021). In Canada, emotional exhaustion among practitioners is common, reducing their functioning (Havaei et al., 2021).

Social workers in various countries report that physical and mental demands, work overload, and inadequate staffing result in mental suffering, physical pain, exhaustion, and job dissatisfaction, ultimately impairing performance (Buzalova et al., 2024). Workplace violence, with prevalence rates ranging from 11.4% to 97.6%, further exacerbates discomfort and poor outcomes, indicating that, shift work, patient diagnoses, emotional intelligence, and personality traits influence exposure to workplace violence, leads to depression, headaches, injuries, turnover intentions, and diminished professional functioning. Nevertheless, multi-dimensional approaches have demonstrated effectiveness in reducing these distressing experiences (Jang et al., 2022). In the same way, conditions such as violent and aggressive behaviour in the psychiatric settings results to poor concentration and functioning and affects overall wellbeing of practitioners. However, this circumstance shapes the response of professionals towards patient care and their daily duties in Italy (Lorenzo et al., 2025).

In the developing countries, the experience of hazardous working conditions (being exposed to patient attacks, piercing needles), work overload, short deadlines, conflicting relationships with colleagues and patients has been identified as an indicator of poor psychiatric work environment conditions, resulting in illnesses and mental distress in Brazil. Such encounters also lead to anxiety, lack of motivation, poor attention and concentration, mood disorder, body aches, ulcers, insomnia, fatigue, migraines, irritability, musculoskeletal disorders and alteration of menstrual flow affecting the practitioners' functioning and wellbeing in

Brazil (Pereira et al., 2024). Similarly, excessive workload, deadline pressure, high demands, inflexibility, inadequate personnel and rest breaks, repetitive tasks, communication gap, inadequate equipment, poor cooperation and support for professional development are indicative of an unfavourable workplace, leading to headache, body pain, back pain, vision disorders, and affecting the functioning and health of practitioners in Brazil (Ferreira et al., 2021). Nevertheless, ensuring workers' safety and quality of care for users would improve their wellbeing (Ferreira et al., 2021). In China, 19.06% of mental health practitioners experience dissatisfaction with their overall practice environment due to inadequate staffing, resources, support, poor leadership styles and participation in hospital affairs, and poor collegial relationships. In view of that, 24.34% practitioners show dissatisfaction in hospital affairs, signalling the influence of a poor work environment on work engagement, turnover intentions and quality of care in the mental health settings (Huang et al., 2021).

Furthermore, in the African contexts, the needs of healthcare professionals in their practice environment have not received adequate attention. Particularly, there is considerable stress due to long working hours, heavy workloads, and limited resources, leading to psychological distress. As a result, practitioners become more distressed when the measures to address their challenges are limited, affecting their mental, physical and general wellbeing (Harri et al., 2025). Similarly, the situation of health practitioners in Uganda is distressful due to high patient volumes, inadequate supervisory support, limited resources, exposure to infectious diseases, and socioeconomic challenges. Consequently, 40% of practitioners in Uganda experienced high levels of burnout and sleep-related problems, affecting functioning and quality of life (Kabunga et al., 2024). Besides, mental health practitioners in South Africa have been challenged with inadequate safety measures (to handle violent behaviour from patients, and ineffective security measures), inadequate resources (like poor conditions of infrastructure and building, lack of essential drugs to manage serious mental disorders resulting in patient relapse, insufficient budget to run the psychiatric hospital), high workload, shortage of trained mental healthcare nurses and psychiatrists and lack of strategies to deal with this distressful experience in the mental health settings. As a result, they experienced anxiety, fear, work-related stress, burnout, and had difficulty in providing effective patient care and other duties (Mulaudzi et al., 2020).

Additionally, the mental health practitioners in Nigeria have faced distressful moments due to the complex nature of the psychiatric hospital, following inadequate staff, facilities and resources, unavailability of drugs, poor support, inadequate government and institutional funding, and neglect of the mental health hospitals, resulting in workplace dissatisfaction and poor service delivery in Kano (Haddad et al., 2020). In the same way, practitioners in Abeokuta encountered issues of poor funding from the government, lack of free space and supportive work environment, staff safety, time constraint, inadequate resources and the nature of the working environment as factors that hinder a good therapeutic environment and recovery rate for patients, affecting their psychological health and functioning (Oluwatosin et al., 2021). Moreover, in Yaba Federal Neuro-psychiatric Hospital, giving care to patients is challenging due to heavy workload and limited resources, personnel and equipment, resulting in care burden, distress and poor functioning (Chinonye et al., 2024) and practitioners' overall wellbeing.

Theory of Poor Work Environment Conditions

The demand–resources–support model by Karasek (1979) centres on developing workers' welfare, stating the relationship between the demands faced in the job and workers' sense of control. The model specifies that high demands (such as high work pressure, an unfavourable physical environment, and emotionally demanding interactions with clients), while lacking control engenders unfavourable work environment resulting in negative psychosomatic consequences. The demand-resources-support model assumes that the negative consequences felt by employees are the result of poor work environment and a low sense of control (arising from insufficient resources, competences and a lack of decision-making capacity) (Karasek, 1979). Hence, poor work environment results from the unfavourable circumstances in the psychiatric work environment and inadequacies that the practitioners are unable to handle; such experiences as high temperatures, noise, inadequate lighting, insufficient offices and equipment, and unpleasant smells coming from unkempt patients and patient halls in the mental health setting, leading to stress, dissatisfaction, poor functioning and wellbeing among mental health practitioners.

Nevertheless, the demand–resources–support model was proposed purely on the general male working population in Sweden and the USA. This model was definite in its conclusions, yet the poor work environment in the African and Nigerian

contexts would differ, given that every setting, precisely the psychiatric hospital, has distinctive experiences. In view of that, this model did not provide contextual justifications and, as such, prompted the need for this study.

Research Question

Method

Design

The researchers used a phenomenological design in this study based on interpretation. Notably, phenomenology is a qualitative research tradition rooted in philosophy that emphasises the exploration of human experiences as they are lived and perceived by individuals (Haque & Ahmad, 2025; Morrison, 2025). Accordingly, this study used a phenomenological research design to deepen understanding of the lived experiences of mental health practitioners in mental health settings.

Participants

The researchers used purposive sampling based on expert recommendations to select 28 participants (doctors, nurses, pharmacists, psychologists, social workers, and occupational therapists as shown in Table 1) who undertook an

1. How does poor work environment conditions influence mental health practitioners in psychiatric hospitals in Nigeria?

in-depth interview regarding their experiences in the mental health setting. Only practitioners who have interacted with the patients and have treated and cared for mentally ill patients in psychiatric hospitals in Nigeria were included. For in-depth interviews, Marques & Mccall (2005) recommended as many as 10 individuals for a phenomenological study. However, recent studies have exceeded this margin with sample sizes like 18 participants (Güler et al., 2025), 31 participants (Lievesley et al., 2025), 30 participants (Leekuan et al., 2022), and 46 participants (Al-Asad et al., 2026). These saturation points explain the selection of 28 participants for this study. Additionally, the sample size in this study depended on the saturation point, where fresh data no longer sparked new insights, and so, at the 28th participant, we stopped data collection because new ideas were no longer emerging.

Table 1: A Table Showing the Participants' Information

S/N	Participants	Number of Participants for each group	Number of Female Participants	Number of Male Participants	Number of Single Participants	Number of Married Participants	Age	Qualification
1	Doctors	5	2	3	1	4	43,48,37,33, & 30	PhD, & 1 st Degree
2	Nurses	6	2	4	0	6	49,42,52,51,37, & 52	Diploma, 1 st Degree, & Masters
3	Pharmacists	6	2	4	2	4	25,40,50,48,31, & 31	1 st Degree, Masters, & PhD
4	Psychologists	3	2	1	0	3	37,56,&41	Masters
5	Social workers	4	1	3	0	4	46,42,41, &39	Masters, & PhD
6	Occupational Therapists	4	1	3	0	4	31,41,49, &35	Diploma, 1 st Degree & Masters
Total	6 Participants	28 Participants	10 Females	18 Males	3 Singles	25 Married		

Procedure

This study obtained ethical approval from the three data collection locations with reference numbers PH/A.864/Vol. XVII/133 for Benin, FNPH/HTR/REA/VOL.11/482 for Enugu, and FNPH/122020/REC062 for Maiduguri federal neuropsychiatric hospitals. Participants were informed of the study's purpose, and participation

was voluntary since they had the right to refuse participation at any point. Participants signed the informed consent form before the in-depth interviews commenced, and confidentiality was assured as participants' details were codified and their transcriptions were made unidentifiable. Moreover, there was no conflict of roles between the participants and the researchers.

Qualitative interview appointments were scheduled with potential study participants, convenient venues were selected, and in-depth interviews were conducted using an interview guide, an audio recorder, pens, notebooks, and a laptop for backing up audio files. The researchers paid particular attention to details in probing and note-taking during data collection. Consequently, higher responses were achieved, and rich information from the participants was captured.

Data Analysis

The authors carefully listened to the audio clips and transcribed word for word to ensure accuracy in the data-gathering process. Case and content analysis, data display methods, problem/cause and solution methods, direct quotations, and thematic analysis were done. Using the ideas of Braun and Clarke (2006), we

familiarized ourselves with the data, generated initial codes, searched for themes, reviewed themes, defined and named themes, and produced reports. Furthermore, we used data display methods, such as quotation, matrix and causal network (Miles & Huberman, 1994), in this study.

Result

Poor work environment conditions and their unfavourable influence on mental health practitioners in Nigeria's psychiatric hospitals were studied based on practitioners lived experiences in these settings. These experiences were constructed around high temperatures, inadequate lighting, noise, inadequate offices and equipment, and stench from patients. The results of poor work environment conditions and their effects on mental health practitioners are in Table 2 and Figure 1.

Table 2: Showing How Poor Work Environment Influences Mental Health Practitioners

Latent Variables	Experiences /Challenges	Causes	Outcomes/ Effects	Coping strategies	Proposed solutions	Responsible actors
Poor work environment conditions	1. High temperature 2. Inadequate lighting 3. Noise 4. Inadequate offices & equipment 5. Stench from dirty patients	• Poor ventilation • Changes in season • Limited Windows • Vandalization of electrical Connections • Noise from patients & generators • Management inattention • Patients Mental State	• Perspiration • Reduced concentration • Diagnostic & prescription errors • Fatigue • Illness condition • Office congestion/ dissatisfaction • Stinky work area	• Take water frequently • Opening the windows • Ward rounds in open space • Relax for some time • Exercise • Take stress relief drugs	• Add more windows • Provide regular electricity • Install noise proofs • Increase security staff • Provide adequate offices &equipment • Enforce hygiene discipline	• Management • Government • Mental health practitioners

High Temperatures

As indicated in Table 2, high temperatures in the mental health environment is due to poorly ventilated patient halls, changes in season, limited windows, inadequate power supply to energise the cooling systems, and heat generated from an overcrowded number of patients. As a result, mental health practitioners experience increased levels of perspiration, fatigue, office congestion, headache, poor concentration, diagnostic and prescription errors, and constant feelings of dissatisfaction, which reduce functioning, affecting their wellbeing. Nonetheless, participants suggested that the government should give more attention to psychiatric hospitals by constructing more federal mental health facilities to reduce congestion, error and improve patient care. In addition, the management should provide regular electricity to

power the cooling systems already on the ground to ensure good concentration and adequate service delivery. Below are some of the narratives illustrating the experiences of two mental health practitioners:

We have not had light for a while now. When the generator had a problem, it was really hot so, we have to open the window, and fresh air was coming in. I was all sweaty and wasn't focusing at that point; anything could have happened. I could have given the patient the wrong drug because I wasn't in my element and I wasn't composed. When you are hot and the whole place is stuffy, you just need to do and go somewhere and relax. I am not sure I put the patients' interests at heart; I just wanted to dispense and go. So, I was

just rushing to clear my desk.
(PhNF31M02)

Another mental health practitioner from a different profession, but in the same hospital, narrated a similar experience as follows;

With the hot weather, life has not been easy. At the end of the day, you end up taking drugs that may also have side effects. Physically, you feel that you are sick because you cannot sleep at home. By the time you sweat, you are not comfortable, you are not even concentrating because emotionally you are not balanced, you become restless, you can't even concentrate on your job very well. (PsNF41M05)

Inadequate Lighting

From the above Table, inadequate lighting in the mental health setting is due to limited windows, vandalization of electrical connections by insurgents, and management inattention to the welfare of practitioners and their patients. Consequently, practitioners are exposed to a lot of distress, low levels of concentration, diagnostic and prescription errors, dissatisfaction and reduced performance, thereby affecting patient treatment and care, and wellbeing of the mental health practitioners. Conversely, participants proposed that management should add more windows to allow brightness and air into the hospital halls, provide regular electricity to enable lighting, reduce errors, and improve the quality of service delivered to these patients. Some of the narratives below illustrate the experiences of two mental health practitioners:

When the light went off, we had to use a touch light to check the patients' blood pressure, while my health attendant held the touch light for me with hope that the other patients were sleeping but unknown to us, one patient broke through the door and ran out in the middle of the night. We had to search; the security men helped us too, but we could not find this patient so I had to wait to see the ward manager and HOD, and because of that, I didn't go home till about 10.30am the next morning to resume work at about 6 pm. Imagine the stress I went through. The stress was too much. Sometimes, when you don't have enough manpower and you don't have the necessary things to work with, you will find it difficult to perform. (NSF42B07)

Another mental health practitioner from a different profession and hospital narrated a similar experience as follows;

Recently, because of the advent of the insurgency, the power source that was coming to the state was vandalised some time ago for about 3 or 4 months now. Having problem with electricity has definitely affected the services we render here, including our patients. (NNM52M09)

Loud Noise

As demonstrated in Table 2, loud noise in the psychiatric work environment is a result of patients' mental state, noise from patients and generators. This distressing circumstance leads to poor concentration, fatigue, illness condition (headache), diagnostic and prescription errors, and constant feelings of dissatisfaction, reduced functioning and performance, deteriorating the practitioner's wellbeing. Nevertheless, practitioners suggested that the management should install noise proof to control noise around the offices. In the same way, management should increase the number of security personnel to help organize the patients to avoid distractions and improve concentration, to reduce errors, and enable the practitioners to achieve their daily goals. Below are some of the narratives illustrating the experiences of two mental health practitioners:

When the generators are on there is a lot of noise. I cannot open the windows because they are right behind the windows. The sound from the generator distracts from the work that has to be done and puts us under a lot of stress. (DSF43B05)

Another mental health practitioner from a different profession and hospital narrated a similar experience as follows:

We've had loud noises even coming from patients shouting on other people or their relation. The patients at times shout and at times the noise could come at night when a patient wakes up and starts singing aloud, waking other patients and at times they form alliance to disturb the peace of the whole ward. This noise can last for 10, 20, 30 minutes, depending on the number of patients involved and can lead to distractions, stress and headaches. (NEM52E01)

Inadequate Offices and Equipment

As shown in Table 2, Inadequate offices and equipment (such as Electroconvulsive therapy (ECT), Electroencephalogram (EEG), and Electrocardiogram (ECG) machines, chairs, tables,

fan and air-conditioner) in the mental health setting is due to management inattention to the needs of the practitioners and patients. Consequently, mental health practitioners experienced office congestion, distress, fatigue, illness conditions (such as headache and high blood pressure), diagnostic and prescription errors, lack of concentration, and constant feelings of dissatisfaction about the psychiatric work environment, affecting their performance and overall wellbeing. However, mental health practitioners suggested that the management should provide adequate offices and equipment in the mental health setting to encourage efficient discharge of duties and make their work environment conducive for the practitioners and patients. Below are some of the narratives illustrating the experiences of two mental health practitioners:

*What is needed to carry out this job includes good office, seats, tables, and at least air conditioned office. We need comfort to attend to patients and their needs, a good therapeutic environment for any therapy to be carried out. Lack of supply of ECT (Electroconvulsive therapy) machine, EEG (Electroencephalogram) machine, ECG (Electrocardiogram) machine reduces patient care. All these machines are needed for treatment and patient care. Even the MMPI, Like the one we are using in our office now cost # 6million naira. If the CMD is not interested in it, it may not be available. Once those things are not there; stress is already there both for the patient and the therapist” (PSEM56E08) *CMD= Chief medical Director*

Another mental health practitioner from a different profession, but the same hospital, narrated a similar experience as follows:

A consulting room for instance needs a functioning AC and fan but, in most cases, it is not the case. We work in a strenuous environment, and it affects our output because we won't be able to coordinate. Being mentally fatigued you know, but you still need to attend to the patients because that is what you are paid for. (DEM37E09)

Stench from Dirty Patients

As presented in Table 2, stench from dirty patients is due to poor ventilation and patients' mental state, which does not allow them to keep

personal hygiene. As a result, mental health practitioners experience a stinky work area, stomach upset, a feeling of vomiting, distress, poor concentration, and become dissatisfied with their work environment, thus affecting functioning. Nonetheless, practitioners suggested that the management, supervisors, nurses, and social workers should give hygiene education and enforce discipline to ensure hygiene and give adequate attention to the unkempt patients, thereby improving the conditions in the psychiatric work environment. Below are some of the narratives illustrating the experiences of two mental health practitioners:

Some of the patients, when referred to us, still have poor personal hygiene. A client who was an outpatient came, and the stench from the client was so much that I knew the assignment given to me at that point I didn't take it. I just had to manage, try to make a sense of humor out of many of the things so that I will even forget that I perceived something. Occasionally when the patient has to do something and I feel I am now about to throw up, I will just give him something to do, walk away and come back and so, we've had that experience, but we try to manage. I saw it as a challenge that made me uncomfortable and I couldn't concentrate on giving care to the patient. (PSSF37B08)

Another mental health practitioner from a different profession but the same hospital, narrated a similar experience as follows:

A client had sores on his leg, so unkempt, then the medical director directed us to bring in that patient and cater for him. So, we took him to the occupational therapy unit where they bathed him, cut his hair, and changed his clothes. Those who participated in that exercise lost appetite because the sight of the situation was irritating. However, when you are able to get this person back to near normalcy, it gives you that psychological happiness and sense of fulfillment and that makes one eager to do more if the resources and conduciveness of the environment is there. (SWSM42B09)

The circumstances above are discomfiting and bring about distress, fatigue, dissatisfaction, reduced motivation, concentration and functioning, as illustrated in Figure 1

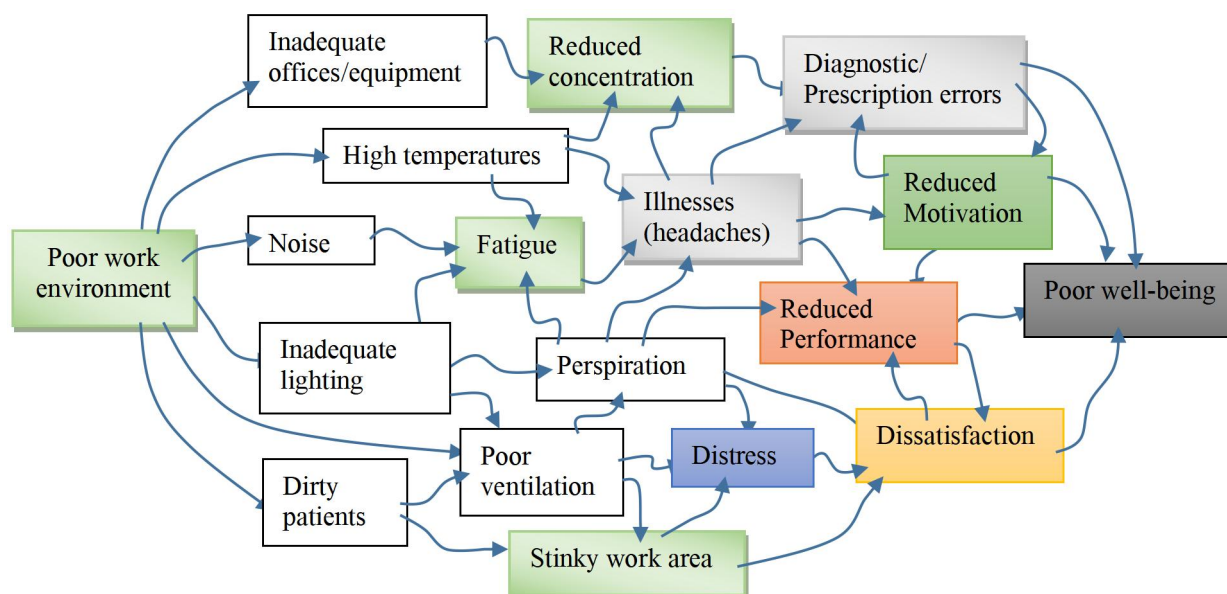


Figure 1: Causal Networks Showing How Poor Work Environment Influences Mental Health Practitioners in Nigeria

Figure 1 illustrates how a poor work environment can affect mental health practitioners (see details in Table 2). Figure 1 shows that mental health practitioners face poor work environment conditions such as inadequate offices and equipment, high temperatures, noise (from patients and generators), inadequate lighting, and stench from dirty patients resulting from seasonal changes, patients' mental state, management's inattention, limited windows, vandalised electrical connections, and poor ventilation. These conditions are detrimental to mental health practitioners' health, motivation, performance, and well-being, indicating that practitioners face issues of poor work environment conditions in their day-to-day tasks. These unfavourable circumstances in the mental health settings are linked to distress, fatigue, illness conditions (headache), perspiration and a stinky work area, inability to think and concentrate on their work, diagnostic and prescription errors, constant feelings of dissatisfaction, and, in turn, this makes the mental health practitioners unproductive in their duties.

Discussion

Mental health practitioners practicing in the psychiatric hospitals experienced poor work environment conditions that influenced them in so many ways, causing devastating effects on their performance and wellbeing. Mainly, practitioners in the mental health setting experienced high temperatures in a facility with inadequate offices and equipment, inadequate power supply, poorly ventilated offices and patient halls (with overcrowded patients). Consequently, practitioners

were exposed to perspiration, fatigue, illness conditions (headache, dehydration), distress, confusion, lack of concentration and motivation, leading to reduced brain function, diagnostic and prescription errors, and dissatisfaction thus, affecting their general wellbeing. This finding indicates that high temperatures influence the wellbeing of mental health practitioners. Consistent with this finding is the study by Aiken et al. (2024), which states that poor work environment leads to job dissatisfaction, overall poor health and wellbeing, and threatens the practitioners' ability to function. A similar study indicated that poor work environment conditions result in fatigue, migraines, lack of motivation, attention and concentration and affects functioning and wellbeing of mental health practitioners (Pereira et al., 2024).

Furthermore, some practitioners who experienced inadequate lighting could not attend to their patients in the dark and failed to carry out their tasks appropriately. These practitioners were constantly perspiring and fatigued and as such, they experienced reduced concentration, illness condition (headache), and committed diagnostic and prescription errors, they became distressed and lacked the motivation to perform their duties in the mental health setting. As a result, they were dissatisfied with their job and could not perform their duties, and that affected their overall wellbeing. The finding of this research suggests that poor lighting in psychiatric hospitals is associated to deterioration in the wellbeing of practitioners. This outcome agrees with those of Buzalova et al. (2024), that poor working conditions result in

fatigue, dissatisfaction with the work environment and affects performance. In addition, unfavourable work environments are distressful, and limited resources reduce function and quality of life (Kabunga et al., 2024). A similar study showed that inadequate resources, like poor conditions of infrastructure and buildings in the psychiatric hospital leads to stress and poor care to patients (Mulaudzi et al., 2020). Besides, unfavourable practice environment results in dissatisfaction due to inadequate resources and foundation for quality care (Huang et al., 2021).

Additionally, many practitioners who encountered noise in the psychiatric hospitals experienced lots of distractions and confusion in their day-to-day tasks. These practitioners were distressed, fatigued, could not concentrate on their job and lacked the motivation to do their work. As a result, practitioners were troubled with headaches and committed diagnostic and prescription errors; they constantly felt dissatisfied, performed inadequately, and this affected their overall wellbeing. Thus, specifying that noise most probably affects the practitioners' wellbeing. This finding is consistent with those of Jang et al. (2022), that an unfavourable work environment is associated with work related outcomes like headache, body pain and poor functioning in the mental health setting. Poor work environment reduces concentration and affects wellbeing (Lorenzo et al., 2025).

Moreover, mental health practitioners who were faced with issues of inadequate offices and equipment (such as electroconvulsive therapy, electroencephalogram, and electrocardiogram machines) experienced congestion and poor concentration in carrying out their duties in the psychiatric hospitals. As a result, these practitioners were distressed, committed diagnostic and prescription errors, felt dissatisfied and lacked the motivation to perform their daily tasks, affecting functioning and wellbeing. The result implies that inadequate offices and equipment lead to poor performance in these settings. This study is in line with Langton & Morley (2025) that inadequate resources results to dissatisfaction and inadequate patient care. Similarly, uncomfortable circumstances in the mental health environment give rise to irritability, illness conditions and mental distress (Pereira et al., 2024). Consistent with Ferreira et al. (2021), poor work environment conditions such as insufficient work instruments lead to headache and affects functioning. Poorly equipped work environment result to dissatisfaction (Fowler et al., 2025). In the same way, limited

resources leads to psychological distress, poor wellbeing and functioning (Harri et al., 2025).

Besides, many mental health practitioners who were exposed to stench from dirty patients in the psychiatric hospitals failed to concentrate on their day-to-day tasks, as such they experienced illness conditions (headache, throwing up), worked in poorly ventilated and stinky work areas, and became distressed and dissatisfied with their daily duties. Consequently, these practitioners could not perform adequately thus, affecting their wellbeing. This finding shows that stench from dirty patients worsens the wellbeing of practitioners in the mental health setting. In line with this finding, Havaei et al. (2021) found that, discomforting work environment conditions leads to stress and emotional exhaustion that affect service delivery. Consistent with this study, exposure to unsafe situations (unpleasant smell) results in dissatisfaction (Fowler et al., 2025).

The findings of this study is also in line with the demand–resources–support model, which indicates that high demands of work with a lack of control results in poor work environment conditions and its associated negative psychosomatic consequences (Karasek 1979). The researchers, therefore, concluded that poor work environment conditions cause a great deal of discomfort that affects the mental health practitioners' performance, functioning and wellbeing.

Practical Implications

This study revealed that poor work environment conditions affect mental health practitioners who are responsible for helping mental health patients. These practitioners experienced high temperatures, faced inadequate lighting, noise, inadequate offices and equipment, and perceived stench from unkempt patients and their halls as they discharge their daily duties in the mental health setting. The study indicates that practitioners are constantly distressed, fatigued and dissatisfied with their day-to-day tasks in psychiatric hospitals. Accordingly, the findings showed that providing adequate offices and equipment to maintain functionality, providing regular electricity, more windows to increase lighting, and cooling systems to normalize temperatures, and improve ventilation will reduce stress and improve adequate patient treatment and care. Similarly, installing noise proof to control noise and improve concentration could reduce diagnostic and prescription errors and improve the general working conditions in psychiatric hospitals. Besides, increasing security to keep the patients in check and organized, and enforcing hygiene discipline, and having a positive

mindset will address issues of poor work environment conditions, reduce illness conditions and improve their overall wellbeing in these settings.

These findings are original and contribute to the literature on poor work environment conditions as experienced by practitioners in mental health settings, providing insight that can inform policies and practices for improving the practitioners' ability to function adequately. Moreover, these study findings have theoretical and practical implications for the health and wellbeing of practitioners.

Limitations

This research utilized a phenomenological design, which provides a rich and comprehensive information on human experiences, with results emerging from the data. Nevertheless, it is based on the participants' articulateness and requires the researcher's interpretation, which is tasking and time-consuming. Moreover, the qualitative sample for this work comprised only of mental health practitioners who work in federal neuropsychiatric hospitals. Besides, because qualitative samples are smaller, outcomes from the study may not represent the experiences of other mental health practitioners practicing in general medical settings.

Future research should explore the underlying issues associated with poor work environment conditions and their effects on practitioners in mental health settings using focus group discussion. It would be of great interest to examine the impact of poor work environment conditions on mental health practitioners using a mixed-method design. Also, future researchers should explore and enrich more on the extent of the effect of poor work environment conditions on the wellbeing of mental health practitioners using a longitudinal approach.

Conclusions/Recommendations

This research revealed the mental health practitioners' experiences of poor work environment conditions as they carry out their tasks in the mental health settings. Poor work environment conditions are distressing and dissatisfying, affecting practitioners' performance and wellbeing. Besides, the study's supporting literature showed that practitioners face poor work environment conditions in various forms, specifying that unfavourable work environment is devastating, frustrating and discomforting. However, these can be reduced if psychiatric hospitals are given adequate attention by the government, management, and practitioners, who

can ensure an encouraging atmosphere for the practitioners and their patients.

Furthermore, regarding high temperatures and inadequate lighting, the management should provide regular electricity and add more windows to patient halls to increase ventilation, normalize temperature, and improve brightness in the buildings. That will reduce illness conditions and encourage performance which will enhance the overall wellbeing of practitioners in the mental health settings. Also, due to the noise experienced in the mental health settings, the management should install noise proofs to control noise and improve concentration and performance.

Additionally, due to poor work environment conditions in the psychiatric hospitals, the practitioners should open the windows to their offices and patient halls to receive fresh air and brightness, take stress relief drugs to reduce heat, stress, errors and improve service delivery. Besides, training for a positive mindset, encouraging frequent water intake, hygiene discipline, ward rounds in open space, exercise, and rest breaks will reduce stress and increase energy, health, concentration, and adequate functioning in these settings.

Compliance with Ethical Standards

All procedures involving human participants were in accordance with the ethical standards of federal neuro-psychiatric hospitals and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.

Conflict of Interest

The authors declare none.

References

- Abdelhadi, I. A., Mohammed, O. A., Babikir, S. K., Bedri, E. A. M. A., & Abdelhadi, A. A. (2025). Is mental health contagious? Depression, anxiety, stress and burnout among mental health professionals in Sudan. *BMC Psychiatry*, 25(1), 148. <https://doi.org/10.1186/s12888-025-06571-3>
- Aiken, L. H., Sermeus, W., Mckee, M., Lasater, K. B., Sloane, D., Pogue, C. A., Kohnen, D., Dello, S., Maier, C. B. B., Drennan, J., & Mchugh, M. D. (2024). Physician and nurse well-being, patient safety and recommendations for sectional survey in interventions: Cross-hospitals in six European countries. *BMJ*, 14, 1–10. <https://doi.org/10.1136/bmjopen-2023-079931>

Al-Asad, Z. R., Dostipashakolaei, M., Farzan, F., &

- Abedi, M. (2026). A phenomenological study exploring the factors influencing technological advancement in Iraqi swimming. *Journal of Studies and Researches of Sport Education*, 36(1), 309–324. <https://doi.org/https://doi.org/10.55998/jsrse.v36i1.1195>
- Basińska-Zych, A., & Springer, A. (2017). The concept of preventing negative consequences of work overload based on positive interactions between work and life, and promotion of workers' healthy behaviors. *The Central European Review of Economics and Management*, 1(2), 45–75. <https://doi.org/https://doi.org/10.29015/cerem.408>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/https://doi.org/10.1191/1478088706qp063oa>
- Buzalova, S., Vansac, P., Tomanek, P., & Rottermund, J. (2024). Mental health and work-life balance among workers in social services. *Clinical Social Work and Health Intervention*, 15(5), 5–15. <https://doi.org/10.22359/cswhi>
- Chinonye, A. B., Abiodun, A. O., Oluwapelumi, Alakija Oluseyi Abiodun, B. O., & Ademola, S. O. (2024). Association between work environment, burden of care and mental health status of healthcare providers at neuropsychiatric hospital, Yaba, Lagos. *Ife Psychologia*, 32(2), 57–64. <https://doi.org/DOI:https://dx.doi.org/10.4314/ife.v32i2.6>
- Cranage, K., & Foster, K. (2022). Mental health nurses' experience of challenging workplace situations: A qualitative descriptive study. *International Journal of Mental Health Nursing*, 31(3), 665–676. <https://doi.org/10.1111/inm.12986>
- Ferreira, J. N. D. S., Medeiros, R. L. S. F. M. De, Bezerra, Y. C. P., Oliveira, G. S., & De-Quental, O. B. (2021). Community health workers: Working conditions and occupational health. *Rev Bras Med Trab*, 19(4), 437–444. <https://doi.org/http://dx.doi.org/10.47626/1679-4435-2021-622>
- Fowler, L., Vara, A., & Ng, L. (2025). Psychiatric trainees' experiences of workplace violence: Qualitative analysis. *BJPsych Bulletin*, 49, 132–137. <https://doi.org/10.1192/bjb.2024.6>
- Güler, K. G., Uzun, S., & Emirza, E. G. (2025). Secondary traumatic stress and coping experiences in psychiatric nurses caring for trauma victims: A phenomenological study. *Journal of Psychiatric and Mental Health Nursing*, 32, 402–413. <https://doi.org/10.1111/jpm.13121>
- Haddad, M. M., Ashiru, F. A., Murtala, H. H., Anyebe, E. E., Umar, M. U., Suleiman, A. D., & Usman, A. (2020). Challenges faced by psychiatric nurses in managing psychiatric patients in Kano State, Nigeria. *Ife Psychologia*, 28(1), 51–58. <https://doi.org/ISSN:1117-1421>
- Haque, I. M., & Ahmad, E. (2025). Phenomenology as a research methodology: Exploring lived experiences in teacher education and contemporary educational research. *International Journal for Multidisciplinary Research*, 7(4), 1–12. <https://doi.org/www.ijfmr.com>
- Harri, B. I., Ogunboye, I., Okonkwo, A., Yakubu, A., Kung, J. Y., Fofah, J., Masseyferguson, O. T., & Eboreime, E. (2025). Addressing the mental health needs of healthcare professionals in Africa: A scoping review of workplace interventions. *Cambridge Prisms: Global Mental Health*, 12(31), 1–24. <https://doi.org/https://doi.org/10.1017/gmh.2025.19>
- Havaei, F., Ma, A., Staempfli, S., & Macphee, M. (2021). Nurses' workplace conditions impacting their mental health during COVID-19: A cross-sectional survey study. *Healthcare*, 9(84), 1–14. <https://doi.org/https://doi.org/10.3390/healthcare9010084>
- Huang, X., Wang, L., Dong, X., Li, B., & Wan, Q. (2021). Effects of nursing work environment on work-related outcomes among psychiatric nurses: A mediating model. *J Psychiatr Ment Health Nur*, 28(2), 186–196. <https://doi.org/10.1111/jpm.12665>
- Jang, S. J., Son, Y., & Lee, H. (2022). Prevalence, associated factors and adverse outcomes of

- workplace violence towards nurses in psychiatric settings: A systematic review. *International Journal of Mental Health Nursing*, 31(3), 450–468. <https://doi.org/10.1111/inm.12951>
- Kabunga, A., Kigongo, E., Okalo, P., Udho, S., Grace, A., Tumwesigye, R., Akello, A. R., Musinguzi, M., Acup, W., Nabaziwa, J., Shikanga, E. M., & Namata, H. (2024). Burnout and quality of life among healthcare workers in central Uganda. *PLoS ONE*, 19(8), 1–14. <https://doi.org/10.1371/journal.pone.0305713>
- Karasek, R. A. (1979). Job Demands, Job Decision Latitude, and Mental Strain: Implications for Job Redesign. *Administrative Science Quarterly*, 24(2), 285–308. <https://doi.org/10.2307/2392498>
- Langton, E., & Morley, E. (2025). Investigating the relationship between burnout, workload, and imposter syndrome for mental health nurses in the UK. *Issues in Mental Health Nursing*, 46(4), 343–350. <https://doi.org/10.1080/01612840.2024.2438892>
- Leekuan, P., Kane, R., Sukwong, P., & Kulnitichai, W. (2022). Understanding sexual and reproductive health from the perspective of late adolescents in Northern Thailand: A phenomenological study. *Reproductive Health*, 19(230), 1–17. <https://doi.org/10.1186/s12978-022-01528-1>
- Lievesley, R., Swaby, H., Stevenson, J., & Harper, C. A. (2025). “ Not offending is easy . The double life, the secrets , the loneliness are the hardest parts I needed help with ”: Understanding the treatment needs of people with attractions to children. *Journal of Sex & Marital Therapy*, 51(1), 22–41. <https://doi.org/10.1080/0092623X.2024.2402320>
- Lorenzo, R. Di, Mucchi, F., Magnani, N., Starace, F., Bonisoli, J., Bottone, C., Ragazzini, I., Ferri, P., & Marrama, D. (2025). Staff attitude towards coercive measures in hospital and community psychiatric settings. *Journal of Clinical Medicine*, 14(9), 1–16. <https://doi.org/https://doi.org/10.3390/jcm14092886>
- Marques, J. F., & McCall, C. (2005). The application of interrater reliability as a solidification instrument in a phenomenological study. *The Qualitative Report*, 10(3), 439–462. <http://nsuworks.nova.edu/tqr%5Cnhttp://nsuworks.nova.edu/tqr/vol10/iss3/3>
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis* (R. Holland (ed.); Second Edi).
- Morrison, T. (2025). Mixed methods interpretative phenomenological analysis: Bridging lived experience and contextual complexity. *International Journal of Qualitative Methods*, 24, 1–11. <https://doi.org/10.1177/16094069251400179>
- Mulaudzi, N. P., Mashau, N. S., Akinsola, H. A., & Murwira, T. S. (2020). Working conditions in a mental health institution: An exploratory study of professional nurses in Limpopo province, South Africa. *Curationis*, 43(1), 1–8. <https://doi.org/https://doi.org/10.4102/curationis.v43i1.2081>
- Oluwatosin, O., Chinedu, A. C., Abimbola, O. E., Adekunle, A. J., Oluwalegan, N., & O, F. O. (2021). Perceived effects of therapeutic milieu on the recovery of depressive patients among nurses at neuropsychiatric hospital Aro, Abeokuta, south-west Nigeria. *Journal of Medical and Dental Science Research*, 8(9), 57–66. <https://doi.org/www.questjournals.org>
- Pereira, M. C., Eberhardt, L. D., & Carvalho, M. De. (2024). Working conditions and mental illness among nursing workers. *Rev Bras Med Trab.*, 22(1), 1–10. <https://doi.org/http://doi.org/10.47626/1679-4435-2022-980>
- Peter, K. A., Voirol, C., Kunz, S., Gurtner, A., Renggli, F., Juvet, T., & Golz, C. (2024). Factors associated with health professionals' stress reactions, job satisfaction, intention to leave and health-related outcomes in acute care, rehabilitation and psychiatric hospitals, nursing homes and home care organisations. *BMC Health Services Research*, 24, 1–20. <https://doi.org/https://doi.org/10.1186/s12913-024-10718-5>