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Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

RNAO Nurse Educator

Mental Health and Addiction Resource

Integrating Mental Health and Addiction into the Undergraduate Nursing Curriculum

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RNAO Nurse Educator Mental Health and Addiction Resource

Integrating Mental Health and Addiction into the Undergraduate Nursing Curriculum

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Declarations of Interest

Declarations of interest that might be construed as constituting an actual, potential, or apparent conflict were made by all members of the Registered Nurses' Association of Ontario expert panel, and members were asked to update their disclosures throughout the development process. Information was requested about financial, intellectual, personal, and other interests and documented for future reference. No limiting conflicts were identified.

Further details are available from the Registered Nurses' Association of Ontario.

SECTION ONE

Introduction to the RNAO Nurse Educator Mental Health and Addiction Resource

1.1. Overview of the RNAO Nurse Educator Mental Health and Addiction Resource

Resource Purpose and Target Audience

The purpose of the RNAO Nurse Educator Mental Health and Addiction Resource is primarily to support educators with effectively integrating mental health and addiction knowledge and skills into the undergraduate nursing curriculum. The resource is based on the Canadian Association of Schools of Nursing (CASN) and the Canadian Federation of Mental Health Nurses (CFMHN) Entry-to-Practice Mental Health and Addiction Competencies for Undergraduate Nursing Education in Canada (2015) and supporting research. Each section of the resource has been intentionally aligned with the competencies. Please see Appendix A for a chart showing this alignment. Integration of core concepts, competencies and best practices found in this resource will raise the profile of psychiatric and mental health practices for nurses as an essential component and integral part of holistic person-and family-centred care across all sectors.

As such this resource is also relevant to nurse educators working in clinical environments to support nursing students, new graduate nurses and other nurses in integrating best practices related to mental health and addiction. Other beneficiaries of this resource include nursing students, nurses, other health care providers, and, ultimately, the person and their family receiving care.

1.2 How to use the RNAO Nurse Educator Mental Health and Addiction Resource

The resource is divided into nine sections that are outlined on page 10. Most sections are structured consistently, with some exceptions, to provide:

- Corresponding CASN/CFMHN (2015) Entry-to-Practice Mental Health and Addiction Competencies and Indicators;
- Outcomes to assist faculty with learning goals;
- Teaching and learning activities to support curricula design;
- Learner engagement questions to spark dialogue and knowledge advancement;
- Evaluation suggestions to ensure quality knowledge and skill development;
- Self-reflection suggestions and tools to ensure development of new knowledge and skills, and to promote higher levels of understanding, decrease stigma and increase confidence; and
- Resources to provide additional materials to support curricula development.

Faculty are invited to use this document for:

- Self assessment to determine their mental health and addiction knowledge and skill levels;
- Curriculum and specific course assessment to determine the type and amount of mental health and addiction content and any gaps;
- Development of specific curriculum, year, course, and lesson plan objectives;
- Development of in-class application sessions, in particular using the case studies;
- Preparation of content and application sessions in courses and specific classes;
- Development of the clinical practice component of the curriculum including design of specific clinical placements and simulation experiences; and
- Development of evaluation indicators, tools and strategies.

In using this resource, educators will be able to support nursing students, new graduates and nurses to:

- Meet the *CASN/CFMHN Entry-to- Practice Mental Health and Addiction Competencies (2015)*;
- Bring mental health, illness and addiction knowledge and skills to clinical practice;
- Understand the nurse's role across care setting in supporting persons' mental health, illness and addiction needs;
- Support persons and their families experiencing mental health, illness and addiction issues to receive optimal care in their encounters with the health-care system;
- Contribute to decreasing stigma and improving the health-care environment milieu with regards to mental health, illness and addiction;
- Contribute to the creation of a clinical culture of evidence and knowledge-based practice;
- Contribute to person- and family-centred care that is timely, informed and responsive to their mental health needs; and
- Improve the overall outcomes of clinical care.

The resource is designed to be user-friendly with topic areas easily accessible for review and use. Tools can be completed online or in a paper version and reproduced for curriculum and day-to-day use.

It is recommended to review this resource by examining the table of contents and bookmarking areas for further review or use at critical points in education and practice activities. On the other hand one may identify key areas right away to review in more depth and get started. Others may wish to use the resource as a reference and/or a validation resource. Regardless of how this document is used, there is much satisfaction to be found in expanding knowledge and skill levels in mental health and addiction and working to enabling others to do the same.

SECTION ONE: Introduction

Section one provides the user with the background information for the creation of this resource for nurse educators in entry-level nursing education programs, as well as nursing educators in clinical environments. The section also facilitates understanding of fundamental concepts to mental health and addiction.

SECTION TWO: Learning and Teaching Resources to Support Integration of Mental Health and Addiction in Curricula

Section two includes pre-planning assessment tools that enable educators to assess and identify areas for improvement and ongoing development of their teaching practice in a mental health context.

SECTION THREE: Nurse Faculty and Nurse Educator Teaching Modalities and Reflective Practice

Section three includes a discussion of common collaborative, student-centred and strengths-based pedagogies. This section also addresses teaching activities for mental health and addiction nursing that promote reflective practice, as well as techniques to facilitate preceptorship and mentorship.

SECTION FOUR: Student Reflective Practice and Self-Care in Mental Health and Addiction Nursing Education

Section four focuses on incorporating self-reflective practice and self-care into mental health and addiction content.

SECTION FIVE: Foundational Concepts and Mental Health Skills in Mental Health and Addiction Learning Advancement

Section five highlights mental health, illness and addiction foundational concepts and skills for incorporation into undergraduate nursing curricula.

SECTION SIX: Legislation, Ethics and Advocacy in Mental Health and Addiction Nursing Practice

Section six provides educators with information about key concepts related to mental health and addiction legislation in Canada. Aspects addressed include the relationship of legislation, human rights and autonomy within an ethical framework.

SECTION SEVEN: Clinical Placements and Simulations in Mental Health and Addiction Nursing Education

Section seven provides educators with evidence-based insights into mental health and addiction practice and simulation learning modalities.

SECTION EIGHT

Section eight provides the bibliography as a supplement to those references cited throughout the document.

SECTION NINE: Appendices and Case Studies

Section nine includes appendices, a glossary of terms and case studies. This section provides the educator with tips and tools to integrate best practices related to mental health, illness and addiction into curricula. Case studies represent a spectrum of mental health and addiction scenarios, including individuals of various ages and genders, in a range of clinical settings with an array of mental health, illness and addiction conditions.

1.3 Background of the RNAO Nurse Educator Mental Health and Addiction Resource

Understanding the Link Between Mental Health, Illness and Addiction

Mental health and illness affects all Canadians of all ages, education, income levels and culture. According to the Mental Health Commission of Canada (MHCC), mental illnesses are more common than heart disease and cancer (MHCC, 2013). In fact, in Canada 2.2 million individuals are living with Type 2 diabetes while 6.7 million people are living with a mental illness (MHCC, 2013).

The impact of mental health and illness is complex and far-reaching. A report from the Canadian Chronic Disease Surveillance System (CCDSS): Mental Illness in Canada (2015) demonstrates a relationship between mental illness and chronic diseases (CCDSS, 2015). For example, a higher prevalence of asthma and chronic obstructive pulmonary disease (COPD), ischemic heart disease, diabetes and hypertension, were observed among people using health services for a mental illness than among those using services for other diseases or conditions (CCDSS, 2015). Furthermore, 20 percent of individuals who experience mental illnesses are also experiencing addiction, indicating a high rate of concurrent disorders (mental health and addiction) that presents a further complexity in care (Rush et al, 2008).

The relationship between mental illness, chronic disease and addiction is still poorly understood, despite the fact that individuals with mental illness (e.g., depression, anxiety) are more likely to have a co-morbid chronic condition (e.g., asthma, cardiovascular disease) and that individuals affected by chronic diseases are more likely to experience anxiety and/or depression (CCDSS, 2015).

WHO'S AT RISK

- ❑ **One in five Canadians experiences a mental health problem or illness, with the cost to the economy of more than $50 billion (Smetanin P., et al 2011).**
- ❑ **Eight percent of adults will experience a major episode of depression once in their lifetime (Pearson et al, 2013); five percent will experience anxiety disorders; one percent will experience bipolar disorder; and another one percent, schizophrenia (CMHA, 2016).**
- ❑ **Up to 70 percent of young adults living with mental illness report that the symptoms appeared in childhood (Public Health Agency of Canada, 2006).**
- ❑ **Suicide accounts for 24 percent of all deaths among 15-24 year olds; 16 percent among 25-44 year olds (Open Minds, Healthy Minds, 2011).**
- ❑ **Most of the 4,000 Canadians who commit suicide every year are coping with a mental health problem (Statistics Canada, 2011).**

- ❑ **Eighty percent of employers claim that mental health and illnesses are among the top three drivers of both short- and long-term disability claims (Sairanen. Matzanke & Smeall, 2012; Towers, Watson, 2012).**
- ❑ **The life expectancy of people with severe mental health problems is 25 years less that of adults in the general population. The cause of death is most often cardiovascular disease (Laurence, D.Kisely & Pais, 2010).**

Impact on Nursing Education

Given the prevalence of mental illness across the age spectrum and the relationships associated among mental health, illness, addiction and other related conditions, it is evident that nurses across all practice settings will care for clients with mental health and illness conditions (Nadler-Moodie, 2010). Nurses are ideally situated across the continuum of care, to provide timely assessments and evidence-based interventions to individuals who may have either a diagnosed or undiagnosed mental illness.

As referred by CASN/CFMHN, "The complexity of concurrent disorders supports the need for entry-level undergraduate nursing education in Canada to prepare all new RNs to identify, care for and manage these disorders" (Kent-Wilkinson, Blaney, Groening, Santa Mina, Rodrigue & Hust, 2016, p. 8). This resource is designed to help make that a reality.

Project Background

The following timeline shows the key stakeholder and interest groups keenly involved in championing and developing this resource.

Mental Health Nurses Interest Group developed and presented resolution (#4) at the Annual General Meeting of the Registered Nurses' Association of Ontario. The resolution spoke to the significant impacts of mental health on the lives of Canadians and spoke to the need to strengthen undergraduate mental health and addiction education, including: development of core competencies, consistency in mental health and addiction theory and clinical practicum in psychiatric/mental health nursing.

Canadian Federation of Mental Health Nurses (CFMHN) released a Position Paper entitled, **"Core Competencies in Psychiatric Mental Health Nursing for Undergraduate Nursing Education,"** (Tognazzini, Davis, Kean, Osborne, & Wong, 2009) to provide context of the current Canadian nursing education system with respect to mental health and addiction nursing curricula. The Federation also recommended that all undergraduate nursing programs include a required stand-alone theory course in psychiatric and mental health nursing with clinical experience in a psychiatric or mental health/addiction care setting.

RNAO's Mental Health and Addiction Initiative commissioned an Environmental Scan. The environmental scan found that supports were needed among nursing faculty to integrate best practices related to mental health and addiction care. Furthermore, it was recommended that core competencies should be developed to support a consistent approach to mental health and addiction undergraduate nursing education. **Findings from the environmental scan also demonstrated that RNAO should work towards increasing supports and enhancements to undergraduate mental health and addiction nursing education by developing an evidence-based resource to support the uptake and implementation of best practices.**

RNAO initiated a systematic literature review with the Nursing Best Practice Research Centre to determine the most effective ways to deliver mental health education in undergraduate nursing programs to support clinical excellence. RNAO also engaged in conversations with the CASN to discuss these issues and what could be done to support nursing students and faculty.

CASN partnered with the CFMHN to develop a national, consensus-based framework of essential discipline-specific, entry-to-practice mental health and addiction competencies and indicators. The purpose of the framework is to promote the integration of core content related to mental health and addiction.

RNAO and CASN co-hosted an Educator Stakeholder Forum in Toronto, ON with nursing faculty, nursing students, nurses and people with lived experience across Canada. The stakeholder forum provided an overview of best practices in mental health and addiction education for undergraduate nurses and reviewed the CASN/CFMHN Entry-to-Practice Mental Health Competencies for Undergraduate Nursing Education in Canada (2015). The forum provided clear direction to RNAO on how to support the implementation of the competencies in undergraduate nursing programs.

RNAO formed an expert panel to support the development of a Nurse Educator Mental Health and Addiction Resource to support the uptake of the CASN/CFMHN Entry-to-Practice Mental Health Competencies for Undergraduate Nursing Education in Canada (2015).

CFMHN released its third position statement with respect to mental health and addiction nursing curricula in Canada which: "Recommends that the curricula of all undergraduate nursing programs in Canada include entry-to-practice mental health and addiction competencies in both theoretical knowledge and clinical practice. The CFMHN recommends delivering mental health and addiction core competencies through a designated (stand-alone) theory course and a dedicated clinical experience. Regardless of pedagogical method, the obligatory outcome for undergraduate nurses is a strong knowledge-base in mental health and addiction as outlined in the CFMHN practice standards [CFMHN, 2016]" (Kent-Wilkinson et al, 2016, page 17).

Publication of the RNAO Nurse Educator Mental Health and Addiction Resource to assist educators to develop a current, relevant, evidence-informed curriculum to support integration of the competencies. This resource is the result of collaborative efforts of RNAO, educators and practitioners who shared the goal of enhancing mental health and addiction practice and education in keeping with the work of CASN/CFMHN, health-care system realities, needs of the population and best evidence.

SECTION TWO

Learning and Teaching Resources to Support Integration of Mental Health and Addiction in Curricula

OUTCOMES

PURPOSE

This section supports the educator to gain awareness of key assessment processes, tools and other resources that will assist in integrating CASN/CFMHN *Entry-to-Practice Mental Health and Addiction Competencies for Undergraduate Nursing Education in Canada* (2015) alongside best practices into the nursing undergraduate curricula.

At the end of this section, the educator will:

- Understand the extent to which mental health, illness and addiction knowledge and skills are currently integrated throughout the undergraduate nursing curricula.
- Identify areas in the nursing undergraduate curriculum that require integration of mental health, illness and addiction knowledge, concepts, attitudes and skills, based on the curriculum assessment tool.
- Develop a personal learning plan for the advancement of one's own mental health, illness and addiction knowledge and skills.

2.1 Mental Health and Addiction Faculty Assessment Tools

In order to effectively integrate mental health and addiction competencies into entry-level nursing curricula—and contribute to an environment that supports knowledge integration—it is important that faculty evaluate existing curricula content and engage in a personal self-assessment of mental health, illness and addiction knowledge to understand strengths and areas for improvement.

This resource provides two assessment tools, each designed to assist with identifying and addressing gaps in existing educational content, knowledge and skills. Both assessment tools have no demonstrated psychometric properties and are intended to support, stimulate and advance the ongoing development of nursing education in mental health and addiction.

- **The Curriculum Assessment Gap Analysis Tool** enables the assessment of content, structures and processes within current curricula in relation to the CASN/CFMHN entry-to-practice domains and competencies. The tool also assesses associated knowledge, concepts, attitudes and skills pertaining to the promotion of mental health and the prevention, assessment and management of mental illness and addiction across the lifespan.
- **The Educator Self Assessment Tool** enables the personal evaluation of educators knowledge and skills required for teaching and promoting mental health and for assessing, preventing and managing mental illness and addiction.

Who should use these tools?

These tools are most useful to curriculum development committees to promote the integration of mental health content, concepts, attitudes and skills across all courses in the undergraduate nursing program, and to nursing faculty and educators for assessment and integration of and within individual courses.

2.2 Tool: Curriculum Assessment Gap Analysis

This tool aims to assist educators with evaluating existing curricula for integration of the knowledge and skills related to the use of *CASN/CFMHN Entry-To-Practice Mental Health and Addiction Competencies (2015)* and the content related to the RNAO Nurse Educator Mental Health and Addiction Resource in the following domains:

- Professional responsibility and accountability
- Knowledge-based practice
- Ethical practice
- Service to the public
- Self-regulation

INSTRUCTIONS: On the assessment tool (on page 19) indicate whether students are currently learning and applying the following theory, skills and tools, list courses where this is applied or planned to be applied and outline course learning objectives that align with the application and/or tool. At the end, develop an action plan to address gaps.

A) Professional Responsibility and Accountability

	YES	COURSE NAME (S) (E.G. NURS 371)	PLANNED	COURSE NAME (S)	CURRENT COURSE LEARNING OBJECTIVES NAME (S)	NO	PLAN FOR FUTURE OFFERINGS
Understands and applies mental health related legislation.							
Upholds rights and autonomy of persons with mental health conditions and/or addiction.							
Recognizes and responds to stigmatizing and discriminating attitudes regarding mental health conditions and addiction as well as the impacts on health-care outcomes.							
Applies principles of mental health promotion, and mental illness and prevention of injury principles.							
Knowledge of voluntary and involuntary care.							
Discusses clients' and others' protection from self harm when safety is at risk, while maintaining client dignity and human rights.							

B) Knowledge-based Practice

	YES	COURSE NAME (S) (E.G. NURS 371)	PLANNED	COURSE NAME (S)	CURRENT COURSE LEARNING OBJECTIVES NAME (S)	NO	PLAN FOR FUTURE OFFERINGS
KNOWLEDGE, ASSESSMENT and PLANNING CARE							
Defines and discusses mental health, developmental and situational transitions, and the spectrum of mental health condition and addiction across the lifespan.							
Discusses how mental health co-morbidities affect individual health, levels of disabilities and use of mental health services.							
Describes key elements of the following theories: - Stress - Coping - Adaptation - Developmental - Harm Reduction - Crisis intervention - Recovery - Loss and grief -Trauma-informed care							

	YES	COURSE NAME (S) (E.G. NURS 371)	PLANNED	COURSE NAME (S)	CURRENT COURSE LEARNING OBJECTIVES NAME (S)	NO	PLAN FOR FUTURE OFFERINGS
Applies the following theories in clinical practice: - Stress - Coping - Adaptation - Developmental - Harm Reduction - Crisis intervention - Trauma-informed care - Recovery - Loss and grief							
Provides opportunities to understand the interrelationship of physiology, pathophysiology and mental health and addiction.							
Discusses complementary therapies and mental health conditions and addiction.							
Provides knowledge of medications used to treat addiction and withdrawal.							

	YES	COURSE NAME (S) (E.G. NURS 371)	PLANNED	COURSE NAME (S)	CURRENT COURSE LEARNING OBJECTIVES NAME (S)	NO	PLAN FOR FUTURE OFFERINGS
Provides knowledge and experience to perform a mental status exam.							
Provides an opportunity to apply therapeutic relational skills.							
Identifies clients' emotional, cognitive and behavioural states, anxiety levels, indices of aggression, self-harm, suicide, risk to others, competency for self-care, signs of substance abuse, addiction and withdrawal.							
Includes the role of social determinants of health on mental health outcomes.							
Discusses treatment and management of mental disorders and addiction.							

	YES	COURSE NAME (S) (E.G. NURS 371)	PLANNED	COURSE NAME (S)	CURRENT COURSE LEARNING OBJECTIVES NAME (S)	NO	PLAN FOR FUTURE OFFERINGS
Provides opportunities for care planning in collaboration with persons impacted by mental health concerns.							
Discusses the negative effects of violence, abuse, racism, discrimination, colonialization, poverty, homelessness and early childhood maltreatment on mental health.							
Recognizes impact of trauma and uses a trauma-informed approach to plan care with clients.							

Application of Knowledge

	YES	COURSE NAME (S) (E.G. NURS 371)	PLANNED	COURSE NAME (S)	CURRENT COURSE LEARNING OBJECTIVES NAME (S)	NO	PLAN FOR FUTURE OTFFERINGS
Integrates relational care practices and mental health promotion skills within all clinical placements.							
Provides a mental illness and/or addiction clinical placement.							
Communicates therapeutically with persons and families who are experiencing a range of mental health conditions, addiction, abuse, bereavement or crisis.							
Uses self-therapeutically in providing health promotion, prevention, and supportive care.							
Engages in strengths-based care to promote resilience.							

	YES	COURSE NAME (S) (E.G. NURS 371)	PLANNED	COURSE NAME (S)	CURRENT COURSE LEARNING OBJECTIVES NAME (S)	NO	PLAN FOR FUTURE OTFFERINGS
Engages in advocacy for persons experiencing mental health condition or addiction.							
Engages individuals and families in education regarding their mental health, illness and/or addiction.							
Applies principles of recovery oriented, trauma-informed care, social determinants of health and harm reduction with clients.							
Administers medication used to treat mental illness and/or addiction safely, monitors for therapeutic effects, side effects, adverse reactions and intervenes appropriately.							

C) Ethical Practice

	YES	COURSE NAME (S) (E.G. NURS 371)	PLANNED	COURSE NAME (S)	CURRENT COURSE LEARNING OBJECTIVES NAME (S)	NO	PLAN FOR FUTURE OFFERINGS
Provides safe and respectful environment to clients receiving voluntary or involuntary care seeking or receiving treatment for a mental health condition and/or addiction.							
Assists persons with a mental health condition and/or addiction to make informed decisions about their care.							
Demonstrates understanding of cultural competency and cultural safety.							

C) Service to the Public

	YES	COURSE NAME (S) (E.G. NURS 371)	PLANNED	COURSE NAME (S)	CURRENT COURSE LEARNING OBJECTIVES NAME (S)	NO	PLAN FOR FUTURE OFFERINGS
Demonstrates knowledge of the health-care system.							
Recognizes impact of organizational culture on the provision of mental health care and acts to ensure appropriate services are delivered safely.							
Facilitates and engages in collaborative inter- and intra-professional and intersectoral practice.							

D) Self-regulation

	YES	COURSE NAME (S) (E.G. NURS 371)	PLANNED	COURSE NAME (S)	CURRENT COURSE LEARNING OBJECTIVES NAME (S)	NO	PLAN FOR FUTURE OFFERINGS
Evaluates individual practice and knowledge when providing care to clients experiencing mental illnesses and/or addiction.							

	YES	COURSE NAME (S) (E.G. NURS 371)	PLANNED	COURSE NAME (S)	CURRENT COURSE LEARNING OBJECTIVES NAME (S)	NO	PLAN FOR FUTURE OFFERINGS
Identifies one's own morals, values, attitudes, beliefs and experiences and the effect these have on care.							
Identifies learning needs related to mental health promotion and mental illness and addiction assessment, management and prevention.							
Seeks new knowledge, skill, supports related to nursing persons and families with mental health conditions and addiction.							
Evaluates self-learning related to mental health promotion and mental illness and addiction care.							

Recommendations:

Action plan for integration:

2.3 Tool: Educator Self-Assessment

INSTRUCTIONS: Evaluate personal knowledge and skills regarding mental health and addiction in nursing education and practice with the following Self-Assessment Tool (on page 30). At the end, add up the score for each section and then the total score. See scoring guide at the end for assessing strengths and weaknesses.

Mental Health Foundational Concepts

RATE YOUR PROFICIENCY IN THE USE OF:	BEGINNER			ADVANCED	
	1	2	3	4	5
Therapeutic relationships					
Suicide and self-harm assessment and interventions					
Trauma and trauma-informed care					
Crisis intervention					
Recovery orientated approach					
Harm reduction theory and approaches					
Mental health continuum					
Mental health including: Resiliency Stress Coping Adaptation Developmental Loss and grief Recovery Relationships with significant others, family, health care professionals etc.					

Mental illnesses/disorders Schizophrenia and other psychotic disorders Anxiety disorder Behavioural and conduct disorders Bipolar disorders Depressive disorders Eating disorder Sleeping disorders Substance-related and addictive disorders Trauma- and stressor-related disorders Personality disorders Delirium and dementia					
Cultural competency and cultural safety					
TOTAL					

Mental Health and Illness Approaches

RATE YOUR PROFICIENCY IN THE USE OF:	BEGINNER			ADVANCED	
	1	2	3	4	5
Mental health promotion and prevention of mental health condition approaches					
Assessment and management of mental illness (i.e., DSM 5, Mental Status Exam, Cultural Formulation Interview for Cultural Assessments)					
Knowledge about psychological, sociological, physiological and pathophysiological aspects of mental health and illness, including co-morbidities					
Pharmacological and psychosocial interventions for mental illness, addiction and co-occurring disorders					
Applying a collaborative, strength-based recovery-oriented approach to assessing, planning and evaluating care of person and families experiencing mental illness and/or addiction					
TOTAL					

Professional Responsibility and Accountability

RATE YOUR PROFICIENCY IN THE USE OF:	BEGINNER			ADVANCED	
	1	2	3	4	5
Mental health and addiction legislation and acts at the provincial, federal, territorial and international level					
Proficiency on professional standards and regulatory standards when promoting mental health and preventing or managing mental health conditions and addiction					
CNA(2008)Code of Ethics					
Knowledge regarding recognition, response and impacts to care regarding stigmatizing and discriminating attitudes regarding mental health conditions and addiction					
Techniques for protection from client self harm when safety is at risk					
TOTAL					

Ethical Practice

RATE YOUR PROFICIENCY IN THE USE OF:	BEGINNER			ADVANCED	
	1	2	3	4	5
Knowledge on voluntary and involuntary admission and how to provide safe and respectful environment to clients with mental illness and addiction					
Providing individuals with mental illness and addiction the support they require for making informed decisions about their care					
Understanding and applying principles of cultural competency and cultural safety when caring					
Application of self-reflection when working clients experiencing mental health conditions and/or addiction					
TOTAL					

Service to the Public

RATE YOUR PROFICIENCY IN THE USE OF:	BEGINNER			ADVANCED	
	1	2	3	4	5
Knowledge of the Canadian health-care system and application to daily practice					
Impact of organizational culture on the provision of mental health care and acts to ensure appropriate services are delivered safely					
Facilitation and engagement technique to establish and maintain collaborative inter- and intra-professional and intersectoral practice					
TOTAL					

Self-regulation

RATE YOUR PROFICIENCY IN:	BEGINNER			ADVANCED	
	1	2	3	4	5
Evaluation of individual practice and knowledge when providing care to clients with mental health conditions and/or addiction					
Identifies one's own morals, values, attitudes, beliefs and experiences and the effect these have on care					
Identify learning needs related to mental health promotion, and the assessment, management and prevention of mental illness and addiction					
Seek new knowledge, skill, supports related to mental health conditions and addiction					
TOTAL					

SCORING

Mental health overview ..... /45

Mental health and illness approaches ..... /25

Professional responsibility and accountability ..... /25

Ethical practice ..... /20

Service to the public	/15
Self-regulation	/20
TOTAL	**/150**

SCORING GUIDE

0 - 50 — Novice educator

There is great potential for ongoing learning and future growth.

Next steps:

- Knowledge development should be a priority. Recommend self-study, beginning with resources listed in this toolkit, RNAO Best Practice Guidelines and associated resources.
- Seek supervision and assistance from peer mentors with more advanced expertise.
- Solicit student feedback and guidance.
- Develop a personal learning plan that focuses on key knowledge domains.
- Use this resource to guide learning plans.

51 – 100 — Intermediate level experience and expertise

Continue to build on base knowledge and skills, and develop teaching practice.

Next steps:

- Recommend self-study focused on knowledge gaps and peer learning with more expertise.
- Develop confidence in testing out innovative, evidence informed approaches.
- Use RNAO Best Practice Guidelines and associated resources as well as this resource to build capacity.

101-150 — Well-developed knowledge base and expertise

Continue to seek challenging opportunities to maintain and advance knowledge.

Next steps:

- Be sure to share knowledge and experiences with peers.
- Engage in leadership activities.
- Offer support and encouragement to faculty with novice and intermediate-level expertise.

SECTION THREE

Faculty Teaching Modalities and Reflective Practice

OUTCOMES

PURPOSE

This section provides educators with the knowledge and skills to support collaborative student-centred pedagogies in mental health and addiction nursing curricula. Resources and tools also support faculty to engage in and promote self-reflective practice, as well as highlight how faculty can maintain student safety in the learning environment and promote self-care. Finally, this section also focuses on the role of preceptorship, mentorship as a source of nursing faculty supports.

At the end of this section, the educator will have achieved the following:

- Understand pedagogical approaches to teaching and learning that are student centred, collaborative and consistent with recovery-oriented mental health practice.
- Embrace a collaborative 'learning together' approach with students and become increasingly comfortable and competent applying this philosophy to teaching practice.
- Understand the importance and promote reflective practice and self-care for both the faculty and student.
- Adopt teaching and learning strategies, activities and techniques that promote student self-reflection and self-care.
- Understand how to support a positive learning environment that supports student safety (i.e., self disclosure).
- Understand how preceptorship and mentorship can be a source of support and professional development for faculty who teach mental health and addiction.
- Understand how to integrate the lived experience advocate in a non tokenistic manner.

CASN/CFMHN COMPETENCIES: 1.3, 1.6, 6.1, 6.2, 6.3, 6.4, 6.5

3.1 Pedagogy in Mental Health and Addiction Nursing Curricula

Best practice pedagogy underlying mental health and addiction content in nursing curricula is diverse. Some of the diversity is reflected in the nature of the language used to talk about mental health, or psychiatric nursing, or whether a medical model or psychosocial framework is used. The need to prepare nursing students for mental health and addiction practice should motivate and inspire educators' interest in developing students' critical thinking and skills in all areas of mental health. In such, educators should also keep an outlook for new pedagogies to stimulate learning.

Methods of best practice teaching approaches are limited, but some approaches include the following.

1. Blended Learning: There is evidence that the blended learning model, which combines traditional face-to-face learning and e-learning, is an effective structural approach to help mental health nursing students recognize and resolve clinical, theoretical and ethical dilemmas. The practice of blended learning provides students with a useful ability to observe the process of supervision and use information technology to enhance clinical skills (Rigby et al, 2012).

2. Problem Based Learning (PBL): Learning through the experience of solving an open-ended problem is an active pedagogy shown to be useful for teaching mental health nursing students. It may have the added benefit of impacting practice post-graduation. Furthermore, students who have been exposed to PBL may require fewer hours of theory to attain learning outcomes, such as positive attitudes toward mental illness, among others (Cooper & Carver, 2012; Happell, B., Moxham, L. & Platania-Phung, C (2009).

3. Inquiry Based Learning (IQL): While similar to PBL in that it is open-ended learning, IQL follows different steps starting with the sudent exploring a theme and choosing a research stream to focus on; formulating a question and pursuing a plan of research that is rooted on critical thinking, which is applied to the central question. Educators play a pivotal role in IQL, assisting in a collaborative manner with planning, assessment for learning and the advancement of individual as well as class-wide understanding of personally meaningful content and ideas (Fielding, 2012).

4. Simulation: Simulation is a pedagogy that involves a range of activities that imitate something real, a state of affairs or a process to achieve educational goals (SIM-one, 2016). The purpose of simulation aims to improve safety, effectiveness and efficiency in healthcare (SIM-one, 2016). Simulation is actively used in some curricula however there is considerable variation in nursing programs in terms of: a) the amount of use; b) how it's used and c) when in the nursing program SIMS is used. For more information, please see Section 7.2.

A range of teaching and learning opportunities and use of different pedagogy is best to impart mental health, illness and addiction knowledge to students. Some teaching approaches rely heavily on the experiential and relational component of mental health nursing in an effort to understand stigma and other attitudinal factors that are part of the mental health work of nurses (Waugh, McNay, Dewar & McCaig, 2014; Stuhlmiller, 2006). The use of case studies as well as online discussions can help facilitate experiential and relationship components (Silva, Furegato & Godoy, 2008). Most educators would agree that a relational nurse who is aware of the role that stigma plays in the experience and care of individuals with mental health concerns is not enough, and that excellence in mental health nursing includes a sound knowledge base of the current theories and best practices of mental illness, as well as the complex interplay of psycho-social-health determinants on the experience of clients and their treatment.

Educators should utilize 'learning together' approach with students where educators use active and experiential learning, keeping an open mind when educating nursing students. Teachers are also learners, they learn from students, clients and family.

Educator learning approaches checklist

- ❑ Adopts and develops a collaborative, strengths-based, student-centred "learning together" approach to teaching (Gros, 2007).
- ❑ Acts as a facilitator, stimulator, coach, motivator of student learning.
- ❑ Creates an open, supportive and safe learning environment: "My role is to help you learn and succeed."
- ❑ Uses interactive teaching approaches to make learning fun and engaging.
- ❑ Supports student life, outside interests/recreation; attends student/faculty social events.
- ❑ Fosters self-awareness, insight, self-assessment for themselves and the student, supports student initiative, autonomy and decision-making.
- ❑ Is sensitive to student work load/stress levels and responds accordingly.
- ❑ Keeps readings and course work to a minimum.
- ❑ Sets realistic expectations (collaborates with students to set goals).
- ❑ Offers choice/self-selection of clinical placements.
- ❑ Remains available and accompanies students throughout the course and clinical stage: "This is a journey; We're in this together."
- ❑ Acknowledges student stressors and work load issues; responds accordingly.
- ❑ Acknowledges uncertainty and anxiety re: clinical stage; focus on learning process.
- ❑ Begins where students are "at"; proceeds at student pace; breaks down learning objectives into small, achievable goals.
- ❑ Fosters co-operative peer learning and support, and a non-competitive class environment.
- ❑ Remains flexible and works to accommodate student needs and interests.
- ❑ Supports student self-reflective practice.
- ❑ Supports students active participation in class activities, understanding students' comfort level while further developing students' skills.

3.2 The Importance of Reflective Practice for Educators and Students

Nurses have a professional obligation to ensure their practice is consistent with the College of Nurses of Ontario (CNO) or local jurisdictional college standards of practice and guidelines as well as legislation. This includes maintaining competence and refraining from performing activities that they are not competent in (CNO, 2002). As well, nurses need to ensure the appropriate education,

support and supervision when acquiring new knowledge and skills to ensure they provide safe, effective and ethical care (CNO, 2002). The CNO further indicates that nurses must assume responsibility for their own professional development and participate in learning processes to enhance their own practice. In order to meet all of CNO's requirements, it is recommended that nurses engage in reflective practice and seek opportunities to incorporate reflective practice into their practice (CNO, 2002).

Reflective practice is defined as the ability to examine ones actions and experiences with the outcome of acquiring a new understanding and appreciation of the situation, and developing one's practice and clinical knowledge (Boud, Keogh, & Walker, 1985; Caldwell, 2013). Reflective practice is associated with positive learner outcomes including but not limited to: improved situational awareness, changed perspectives, and a greater appreciation for the value of their practice (Glaze, 2001). As well, reflective practice contributes to development of new knowledge and skills, and promotes higher levels of understanding, can decrease stigma and increase confidence (RNAO, 2015d and RNAO, 2016e).

It is important that nursing faculty as well as nursing students engage in reflective practice and provide opportunities to integrate the use of reflection. Furthermore, it is imperative that educational institutions promote opportunities for faculty to engage in reflection related to the development of their teaching experiences and expertise, and that they support the ongoing development of teaching and learning activities that integrate use of reflection with students (RNAO, 2016e). Faculty can promote self- and student-reflective practices through a variety of ways, including the use of journaling, learning circles, peer sharing.

Please see Resources in this section for more information and ideas on ways to support self reflection with nursing students. Also, see Section 4.1.

3.3 Preceptorship and Mentorship for Nursing Faculty

In order to effectively support nursing students in acquisition of knowledge that is evidence- and best practice-based, nursing faculty themselves must receive adequate professional development and support to be up to date on the evidence (RNAO, 2016e). Faculty and educator perceived knowledge and expertise in the subject area has been linked to playing a key role in the optimal promotion of mental health knowledge (Lang & Hahn, 2013). Educational institutions should be aware of the extent of clinical experience and education among faculty, understand whether theoretical and clinical education is current and provide ongoing professional development opportunities either through the practice setting or educational institution to promote the continued transfer of theory to practice (RNAO, 2016e).

Successful preparation of nursing educators requires a combination of education, experience, knowledge and assessment skills that must be supported through allocated time for initial and ongoing professional development (RNAO, 2016e). Professional development opportunities should

incorporate education regarding best practices in theoretical components of nursing education, provide opportunities to enhance leadership skills, and provide best practices on clinical teaching strategies, adult learning theories and strategies for student evaluation. Such educational opportunities ensure faculty has the competence and confidence necessary to support students and has been demonstrated to improve quality of work satisfaction (RNAO, 2016e). Effective models of professional development can include preceptorship and mentorship for nursing faculty.

What is preceptorship?

Preceptorship is a formal process of providing guidance and support to another. The relationship is led by an experienced and competent nurse who facilitates the learning and development of the learner (Canadian Nurses Association [CNA], 2004). A preceptor is a one-on-one relationship of a predetermined length, between two individuals designed to adjust to and perform a new role (CNA, 2004).

Preceptorship:

- Is assigned to facilitate a preceptee's learning goals.
- Is assigned for a set period of time, usually short-term.
- Is assigned with a focus on learning related to knowledge and skill.
- Is acting as a role model, during regular working hours.
- Can evolve into a mentorship relationship.

Registered Nurses' Association of Ontario. (ND). Presentation from RNAO: Preceptorship and mentorship for nurses: Theories, concepts & practical application. Toronto, ON: Registered Nurses' Association of Ontario.

Who is the preceptee?

A preceptee can be a nurse with five, 10 or even 15 years' clinical experience, but who is new to a different teaching area, unit and to caring for a different population of patients. A preceptee may have limited clinical experience and most of those experiences are in the more supported student/school role.

Preceptor responsibilities

Preceptors act as guides or mentors to the preceptee. To facilitate the learner's acquisition of the nursing knowledge and skills for safe, competent and ethical practice, preceptors must display certain characteristics and be able to demonstrate the competencies required to teach and role model professional behaviours, nursing skills and values.

Key characteristics of effective preceptors include:

1. Competence in the practice role.
2. Experienced in the role.
3. Strong leadership and conflict management skills.
4. Enthusiasm.
5. Strong teaching, role-modeling and facilitation skills.
6. Patience and a positive attitude.
7. Excellent oral and written communication skill.
8. An ability to coach and provide constructive feedback.

Preceptors and Clinical Supervision

Preceptors may provide clinical supervision and have a responsibility to provide clinical teaching, instruction and formal evaluation (RNAO, 2016). Clinical supervision is "a formal process of professional support and learning, which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex clinical situations" (Department of Health, 1993, p.15). It provides regular protected time for health-care practitioners to come together to reflect on clinical practice and examine areas of personal and professional growth and work towards achieving these goals. It can occur using a variety of models that include, one-on-one support, peer support, groups and include use of technology such as online supports and telephone supports. For more information on clinical supervision, please see Resources in this section.

What is mentorship?

According to the CNA (2004) definition, mentoring involves a voluntary, mutually beneficial and usually long-term professional relationship. In this relationship, one person is an experienced and knowledgeable leader (mentor) who supports the maturation of a less-experienced person (mentee) with leadership potential.

Mentorship:

- Is chosen or selected by the mentee.
- Is usually selected by the mentee to support their professional advancement for an extended period of time.
- Focuses on individual growth and development.
- Is a nurturing and role-modeling relationship, usually during personal time.

Source: Registered Nurses' Association of Ontario. (2010). Preceptorship and Mentorship for Nurses Presentation. Toronto, ON.

For additional tools and resources please refer to Resources in this section.

3.4 Student Safety and Mental Health

It is important for educators to be aware of the various educational approaches and the risks they may pose to student safety and mental health. Since 20 percent of the Canadian population will experience a form of mental illness in their lifetime, this is also true for nursing students.

In recent years, some social science and child education practitioners have begun to recognize the detrimental role that trauma can play in learning (Crosby, 2015). To that end, an emerging trend in education are trauma-informed educational practices that recognize the role that trauma plays in learning.

Given the potential for trauma in course work and clinical placements and the risk for vicarious trauma or retraumatization (Carello & Butler, 2015) among nursing students, the emotional safety of students is paramount. The art for nurse educators is balancing the need to hold students accountable to meet the necessary professional competencies, while at the same time creating learning environments that are safe for learning.

The development and application of pedagogies consistent with a 'caring curriculum' and with collaborative, student-centred approaches to teaching and learning, serve to promote student mental health and safety while modelling processes basic to collaborative, strengths-based clinical practice and recovery-oriented mental health care.

For more information, please see Resources in this section.

3.5 Engaging Lived Experience

Nursing faculty should integrate persons and families with lived experience or support groups in theoretical and clinical education to understand how to meaningfully engage with these persons and their families. Lived-experience involvement has an important role to play in the education of nurses in addressing fear and demystifying the experience of mental illness (Happell, Gaskin & Byrne, 2015).

For more information, see Appendix H, which aims to support faculty in integrating lived experience.

TEACHING AND LEARNING ACTIVITIES

See Teaching and Learning Activities in Section Four: Student Reflective Practice and Self-Care in Mental Health Nursing Education.

? LEARNER ENGAGEMENT QUESTIONS

The following are thought-provoking and engaging learner questions that can be used to understand and promote the importance of reflective practice and self-care for both the faculty and student. These questions can be used either to stimulate discussion with colleagues or in reflection exercises.

- What are my beliefs, ideas and experiences regarding mental health and mental illness?
- What specific challenges am I facing in nursing studies and practice?
- What are my strengths?
- What areas of practice do I feel most confident in? Least confident in?
- What are my learning needs and goals?
- What would be most helpful to me at this time/in this situation?

EVALUATION MEASURES

- Faculty will engage in self-reflection on an a regular basis.
- Faculty will integrate student feedback into their practice – be open to it and seek it.

RESOURCES

This guide contains an Educator Self-Assessment Tool for faculty to evaluate their knowledge and skills regarding mental health, illness and addiction in nursing education and practice. Faculty may also wish to consider the Learner Engagement Questions (on this page) upon completing the tool.

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TEACHING AND LEARNING RESOURCES

Perese (2002). Integrating psychiatric nursing into a nursing curriculum.

Warelow, P., & Edward, K-L. (2009). Australian nursing curricula and mental health recruitment. International Journal of Nursing Practice, 15(4), 250–256.

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SECTION FOUR

Student Reflective Practice and Self-Care in Mental Health Nursing Education

OUTCOMES

PURPOSE

This section provides educators with an overview of the knowledge and skills required to promote, develop and support ongoing student reflective practice as a key process for advancing learning and clinical practice in mental health and addiction nursing. This section also demonstrates the importance of self-care and mental health promotion strategies that are consistent with practices to enhance student personal and professional resilience and reduce occupational stress in mental health nursing practice.

Outcomes

At the end of this section, educators will support students in the following ways:

- Recognize the importance of reflective practice for developing nursing practice, including seeking new and innovative practices, as well as for engaging in lifelong learning, self improvement and professional development.
- Engage in ongoing critical reflection related to the study and practice of mental health nursing with persons and families across the lifespan.
- Use self-reflection as a primary learning modality for promoting knowledge and skill development in the provision of mental health care.
- Increase understanding and awareness of self-care concepts to enhance ongoing student personal and professional development in mental health nursing practice.
- Increase understanding and awareness about factors that contribute to occupational stress reactions (e.g., acute stress, PTSD, Secondary Stress, burnout) in the context of mental health nursing practice.
- Identify strategies and practices to decrease the impact and manage occupational stress reactions.

CASN/CFMHN COMPETENCIES: 1.3, 6.1, 6.2, 6.3, 6.4, 6.5

4.1 Reflective practice

Reflective practice is a dynamic process that integrates theory with application thereby bridging the gap between professional knowledge and the demands of real-world practice (Tomlinson., Thomlinson, Peden-McAlpine & Kirschbaum, et al.,2002). As such, reflective practice is considered among the most promising teaching and learning modalities for developing mental health nursing care.

Faculty act as facilitators and stimulators of student self-reflection aimed at offering care that is collaborative, strengths-based and recovery-oriented. Faculty should engage in "learning together" approach in which they actively engage with students in the process of critical reflection and thinking about diverse clinical situations. In any case, educators seeking to support and promote the practice of recovery-oriented mental health care should (Meyer, Sellers, Browning, McGuffie, Solomon, & Truog, 2009):

1. Create a safe and trustworthy learning environment.
2. Emphasize ethical and relational dimensions of care.
3. Suspend hierarchy among participants.
4. Value reflection and self-awareness.
5. Honour multiple perspectives.

Reflective practice may occur in individual and group formats; as well as in writing, through interactive discussions or other means. There are multiple strategies for reflection that can assist nursing students to develop the requisite knowledge, skills and competence.

Tools to support reflective practice

The following approaches and tools may be used to support students to engage in ongoing critical reflection.

Journaling. Since the early-mid 1990s, nurse education has embraced the notion of journaling as a way to move the theory of knowledge acquisition of student nurses in active practice. To that end, student nurses have been asked to reflect on their practice in order to make the links between theory and practice and develop critical thinking skills (Epp, 2008), as well as to develop a professional identity (Shapiro, Kassman & Shaffer, 2006). Other writers have used journaling to enhance reflexive practice.

Such journaling, as a form of reflective exercise, creates a safe space for students to critically analyze situations, consider theoretical perspectives and experiences allowing for further insight (Boud, D., Keogh, R., & Walker, D. 1985; Caldwell, L., 2013; Glaze, J. E., 2001). With the increased acuity of health care today, nurses with high level of knowledge and critical application of this knowledge in the lives of patients is key, and journaling is thought of as one way to achieve this objective.

Some authors suggest journaling is a learned skill that begins with descriptions of events and moving to more phenomenological descriptions about their perspectives and analysis of events (Usher, Francis & Tollefson, 2001). This cascading skill is often seen as a hierarchy, though these same authors argue for the beneficial role that different levels of journaling play in nursing practice.

The engagement of teaching faculty in the review of student journals plays a key role in the advancement of student thought. Strategies such as Socratic (critical) questioning and reflections also may be offset by the power differential between the student writer and faculty

evaluator. Awareness of how this plays out in student journals is key, for "we as educators need to appreciate the concept of student/teacher entry negotiation and the power implicit in the game" (Harris, 2008).

For more information, see Resources and Appendix E.

Learning circles. Learning circles promote verbal reflection in an interactive manner and involve group discussion that allows participants to critically reflect on practices, promote growth and change, provide a safe, encouraging and empowering space where students can voice concerns, reflect on their practice, and collaborate with colleagues to learn and grow (RNAO, 2016e).

Peer sharing. Peer sharing is the use of partnership dyads to allow for sharing of clinical experiences, strengthening of confidence and clinical reasoning, providing student support and socialization and increased autonomy, accountability, responsibility and self-confidence (RNAO, 2016e).

Technology to support self-reflection. Communications via text message, online journaling, and listening to health-care stories via podcasts to generate reflections can be used as innovative strategies to promote dialogue and reflection.

Nursing educational programs should ensure that adequate time, resources and opportunities (i.e., time, safe space, secure and confidential online forums) are provided to allow students to share and practice self reflection (RNAO, 2016e).

For more information, see Resources in this section.

TEACHING AND LEARNING ACTIVITIES

The following are teaching and learning activities that can be employed in the classroom to further support nurses in the integration of theory, principles and best practices related to reflective practice.

- Student critical reflections on practice
- Student role play and class discussion
- Interaction process recording and analysis (see Appendix B, C, D)
- Simulation (standardized patients) (see Section 7.2)
- Lived client experience/family experience (see Appendix H)
- Reflective writing and journaling (see Appendix E). Reflective practice through written journals, discussion groups or other means may also be used to acknowledge and address

the emotional work of nurses and the moral distress that nurses and nursing students encounter in their clinical practice

- Response to video/film scenario or clinical scenarios:

  What are you seeing and hearing? How would you describe the person/family? What are their strengths? Formulate your assessment using strengths-based, person-first language. What do you know? What don't you know? What do you need to know in order to nurse effectively in this situation? What can you do? What can't you do? What mental health/mental issues can you identify? What interventions might you offer? What critical questions does this scenario raise?

? LEARNER ENGAGEMENT QUESTIONS

The following are thought-provoking and engaging learner questions that can be used to further discussions with nursing students regarding self-reflective practice. These questions can be used either to stimulate discussion, engage students in critical thinking or be tied to class assignments and/or reflection exercises.

- What is your understanding of recovery oriented mental health care? Strengths-based care? Person/family-centred care? What are your beliefs, ideas and experiences regarding mental health? Mental illness?
- What aspect of mental health/mental illness are you most interested in and why?
- What are your concerns/preoccupations?
- What specific challenges are you facing in your nursing studies and practice?
- What are your strengths?
- What areas of practice do you feel most confident in? Least confident?
- What are your learning needs and goals?
- What would be most helpful to you at this time/in this situation?

EVALUATION AND SELF-REFLECTION

The following tools can be used to evaluate students in their understanding and application of self-reflective practice.

- Promote self regulation and critical reflection by including a student self-evaluation component.
- Ensure a reflective practice component in summative coursework and evaluations; i.e., address application to practice versus testing rote (memorization based on repetition) knowledge/content with process recording assignment, responses to clinical scenarios and essay questions.

SELF-REFLECTION

Reflection question: Are you critically examining your actions and experiences inorder to acquire a new understanding of the situation, and developing one's practice and clinical knowledge?

RESOURCES

RNAO BPGS

Registered Nurses' Association of Ontario (RNAO). (2016). Practice Education in Nursing. Toronto, ON: Registered Nurses' Association of Ontario.

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WEB LINKS

- Resiliency Initiatives (2016).
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- Health Experiences. This website has documented video and audio clips of client testimonials and perspectives of illness and health care experiences.

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4.2 Occupational Stress and Self-Care

Occupational stress is a major health problem that can lead to burnout, illness, turnover, absenteeism, poor morale and performance (Coetzee, & Klopper, 2010; Nowrouzi et al., 2015). Providing opportunities for nursing students to explicitly explore and discuss occupational stress reactions and explore and practice self-care in curricula increases visibility and awareness of this important issue. It also provides a means to explore professional well-being and strategies to enhance career longevity in specialty nursing areas (i.e., mental health and psychiatric mental health practice) documented to increase the risk of experiencing greater levels of occupational stress as a result of the therapeutic interpersonal modalities used during interactions with patients over an extended period of time (Edwards & Bernard, 2003; Nowrouzi et al., 2015).

For more information, see Resources in this section.

TEACHING AND LEARNING ACTIVITIES

The following are teaching and learning activities that can be employed in the classroom to further support nurses in the integration of theory, principles and best practices related to occupational stress and self-care.

For Students:

- Lectures on occupational stress and self-care
- Small group work
- Focused discussions
- Exploration of self-care modalities
- Reflective journaling—Appendix E
- Evaluation of mind/body/spirit approaches to health

Strategies to promote self-care in collaboration with students:

- Consider open-book exams; allow study notes
- Offer flexible due dates/self-scheduling for assignments
- Keep summative evaluations to a minimum
- Offer formative feedback on assignments/exams; provide encouraging comment

? LEARNER ENGAGEMENT QUESTIONS

The following are thought-provoking and engaging learner questions that can be used to further discussions with nursing students regarding occupational stress and self-care. These questions can be used either to stimulate discussion, engage students in critical thinking or be tied to class exercises.

- What are occupational stress reactions?
- Identify the individual and organizational factors that may contribute to the experience of burn out and secondary trauma.
- What does self-care mean to you in the context of your professional identity?
- How does the literature define self-care?

- Why is it important for health-care professionals to understand and engage in self-care practices?
- What are the advantages for health-care professionals and organizations who address occupational stress and workplace mental health practices? Are there any disadvantages?
- Identify personal care strategies documented in the literature to support personal and professional resilience.
- What is your coping style?
- What self-care strategies and techniques do you currently practice?
- Identify some ways to enhance or improve your current self-care practices.

EVALUATION

The following is a tool that can be used to evaluate students in their understanding and application of occupational stress and self-care:

Completion of self-care plan and reflective activities (i.e., see Self-Care Starter Kit in Resources).

RESOURCES

WEBSITES

- Self-Care for Professionals
- Self-Care Starter Kit
- Stress at work

APPS

- Measure workplace stress app
- CALM in the storm app

RNAO TOOLS

- RNAO (2011) Preventing and Mitigating Nurse Fatigue in Health Care Care. Toronto, ON. Registered Nurses' Association of Ontario.
- RNAO (2014) Managing and Mitigating Fatigue: Tips and Tools for Nurses Nurses. Toronto, ON. Registered Nurses' Association of Ontario.

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SECTION FIVE

Foundational Concepts in Mental Health and Addiction Learning Advancement

The Entry-to Practice Mental Health and Addiction Competencies (2015) developed by CASN/CFMHN supports the development of knowledge and skill in mental health, illness and addiction nursing including four core nursing foundational concepts and four areas for mental health skill development. This section provides useful information about each foundational concept and skill, focusing on teaching tools and learning advancement that integrate the corresponding mental health and addiction competencies in curricula.

Four Foundational Concepts

5.1 Therapeutic Relationships
5.2 Recovery Oriented Approach
5.3 Trauma-Informed Care
5.4 Harm Reduction

Four Mental Health Skills

5.5 Mental Health and Illness
5.6 Mental Status Examination (MSE)
5.7 Suicide Risk Assessment and Self-Harm
5.8 Crisis Intervention

5.1 Therapeutic Relationships

OUTCOMES

PURPOSE

This section supports educators with the knowledge and skills required to incorporate the foundational concept of therapeutic relationships into mental health and addiction entry-level nursing curricula.

OUTCOMES

At the end of this section, the educator will ensure students achieve the following:

- Identify the definition, purpose and theories which inform the nurse-client therapeutic relationship.
- Recognize and understand different phases of the therapeutic and non-therapeutic relationship.
- Recognize professional boundaries, counter transference, transference, and power dynamics of the nurse-client therapeutic relationship.
- Understand concepts of therapeutic use of self in providing care (i.e., health promotion, prevention, supportive care).
- Understand and implement effective therapeutic communication skills (i.e., listening, respect, empathy) in assessment and care planning.
- Promote cultural competency and safety (i.e., creating inclusive, safe space) in therapeutic relationships.

CASN/CFMHN COMPETENCIES: 2.8, 3.1, 3.2

Therapeutic Relationships

A "therapeutic relationship" is a relationship that occurs between a client and the nurse that is goal-directed and works towards advancing the best interest and outcomes for the client (RNAO, 2006b). Establishing therapeutic relationships recognizes that effective nursing care is dependent on the nurse coming to know his or her client and engaging in a relationship that supports recovery. Key qualities of a therapeutic relationship include active listening, trust, respect, genuineness, empathy, and responding to client concerns (RNAO, 2006b).

The phases of a therapeutic relationship (Forchuk, 2000) include orientation, working and resolution. Nurses must also be prepared to experience a series of non-therapeutic phases, which include orientation, grappling and struggling and mutual withdrawal. Respecting boundaries that define the limits of the professional role is also important in a therapeutic relationships (RNAO, 2006b). Establishing and maintaining a sense of self-awareness allows a nurse to assess when counter transference and transference—inappropriate meanings and feelings are assigned to the client or vice versa—has taken place, and to assess his or her own ability to address client dynamics (RNAO, 2006b).

Therapeutic relationships are of critical importance to nursing practice and help promote awareness and growth to work through difficulties (RNAO, 2010b). Therapeutic relationships were originally highlighted in psychiatric nursing literature (RNAO, 2010b) before being recognized as fundamental to all nursing (Orlando, 1961; Peplau, 1952; Sundeen, Stuart, Rankin, & Cohen, 1989) and focus on the value associated of developing therapeutic relationships (Brown, 2012).

Establishing therapeutic relationships works in tandem with person-centred-care principles that reflect the belief of getting to know the whole person. Caring for the 'whole person' entails coming to know the person with respect to all components—biological, psychological, emotional, physical, personal, social, environmental, and spiritual—and treating the person holistically rather than treating only their illness or disease (Lovering, 2012; Morgan & Yoder, 2012). According to RNAO's Best Practice Guideline Person- and Family- Centred Care (2015):

> "When optimized, health-care partnerships can improve the autonomy of individuals to make decisions related to their health care and can increase their satisfaction with care." (RNAO, 2015, p. 21).

Recent health-care restructuring resulted in removal of organizational policies and supports that encourage the manifestation of therapeutic relationships (RNAO, 2010b). It is therefore even more important for nursing to place an emphasis on the importance of this best practice in mental health and addiction curricula. The RNAO Nursing Best Practice Guideline Establishing Therapeutic Relationships (2006) developed a Framework for Therapeutic Relationships that organizes learnings around requisite knowledge and capacities for establishing therapeutic relationships, as well as the phases of therapeutic relationships.

For more information about therapeutic practice, see Resources in this section.

TEACHING AND LEARNING ACTIVITIES

The following are teaching and learning activities that can be employed in the classroom to further support nurses in the integration of theory, principles and best practices related to therapeutic relationships.

- Process recordings (Appendix B, C, and D)
- Case studies (Section 9.3)
- Communication labs
- Simulation (standardized patients; lived client experience/family experience, peer support)
- Reflective assignments (pre- and post-clinical practice; portfolios; logs; diaries; journals– Appendix E).
- Group role play: Learning exercise for the application to practice of relational care interventions. Applicable for mental health promotion of and well-being in clients from birth to death across all health-care settings and situations.
- Clinical supervision/peer supervision
- Peer learning
- Handouts (reflective questions)
- Lived client experience/family experience— Appendix H
- Arts-based approaches
  - Theatre
  - Photography
- Narratives/stories

LEARNER ENGAGEMENT QUESTIONS

The following are thought-provoking and engaging learner questions that can be used to further discussions with nursing students regarding establishing therapeutic relationships. These questions can be used either to stimulate discussion, engage students in critical thinking or be tied to class assignments and/or reflection exercises.

- How would you know that you have established a therapeutic relationship?
- Can we have therapeutic relationships with anybody?
- What do therapeutic boundaries look like in different settings/situations? Which boundaries never change?

- When is it okay to touch? When is it okay to use humour?
- How do you terminate the therapeutic relationship? How do you say "Goodbye"?
- How would you determine if it's your needs and/or the client's needs that are being met?
- How do you address observed boundary violations between other clinicians and clients?
- How long can you sit without saying anything? Describe the importance of silence.
- What would it be like to be a patient in this setting?

EVALUATION AND SELF-REFLECTION

The following tools can be used to evaluate students in their understanding and application of therapeutic relationships:

- Process recordings (Appendix B, C, and D)
- Assignments, such as analysis of a video to determine understanding of concepts related to therapeutic/non-therapeutic relationships
- Questions on exams regarding theoretical concepts

SELF-REFLECTION

- Journaling (Appendix E)
- Portfolios
- Pre- and post-clinical placement reflections
- Process recordings (Peplau, 1952; 1988; 1989) (Appendix B, C, and D)

RESOURCES

WEBSITES

- Positive Spaces
- RNAO Rainbow Nursing Interest Group
- Nova Scotia Rainbow action project
- Link to Pride health (Capital health)
- Transgender Archives and Studies (University of Victoria)

VIDEOS AND FILMS

- Movie clips of therapeutic and non-therapeutic relationships. Reel Psychiatry: http://www.amazon.com/Reel-Psychiatry-Portrayals-Psychiatric-Conditions/dp/1894328078
- One Flew over the Cuckoo's Nest
- RNAO videos on therapeutic relationship
- Hey Doc, some boys are born girls: Decker Moss at TEDxColumbus
- Ivan Coyote Why we need gender-neutral bathrooms
- Unconditional love -- journey with our transgender child : Christy Hegarty at TEDxBloomington Love Life, A Recovery Story

RNAO RESOURCES\

- Registered Nurses Association of Ontario. (RNAO). (2006). Establishing Therapeutic Relationships. Toronto: ON, Registered Nurses' Association of Ontario.
- Registered Nurses Association of Ontario. (RNAO). (2015). Person- and Family-Centred Care. Toronto: ON, Registered Nurses' Association of Ontario.
- Registered Nurses Association of Ontario. (ND) Establishing Therapeutic Relationships Video.
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5.2 Recovery Perspective

OUTCOMES

PURPOSE

This section supports educators with the knowledge and skills required to incorporate the foundational concept of a recovery-oriented perspective into mental health and addiction entry-level nursing curricula.

OUTCOMES

At the end of this section, the educator will ensure students achieve the following:

- Identify definitions, relevant theories and principles of recovery.
- Understand concepts related to dignity, hope, empowerment and resilience.
- Identify differences between medical model versus recovery models.
- Identify barriers and facilitators to recovery. Acknowledge the importance of experiential knowledge (i.e., lived client experience/family experience).
- Understand the nurse's role in adopting a recovery perspective, including identify strategies to promote recovery.

CASF/CFMHN COMPETENCIES: 2.2, 2.3, 2.10, 3.2, 3.3, 3.4, 3.7, 4.1, 4.2, 4.3

Recovery perspectives

The concept of "recovery" in mental health refers to living a satisfying, hopeful, and contributing life, even when mental health problems and mental illnesses cause ongoing limitations. Recovery — a process in which people living with mental health issues and mental illnesses are actively engaged in their own journey of well-being — is possible for everyone. Recovery journeys build on individual, family, cultural, and community strengths and can be supported by many types of services, supports, and treatments. Recovery includes a process of refining oneself, learning to accept one's vulnerabilities, overcoming stigma, discrimination, looking beyond what is lacking in one's life, regaining responsibility, control and hope in one's life and becoming involved in meaningful social activities and community citizenship (Snow, 2010). The process for recovery requires genuine interest, and open and transparent therapeutic relationships where the client and health-care provider work in partnership to establish mutual goals (Snow, 2010). Specifically, a recovery model for mental health expands on clinical dialogues to include valued life goals, facilitates hope through education about realistic possibilities and probability of recovering to the point of having a good quality of life, is holistic and treats the person as a person, is sensitive to labeling and stigma and understands the importance of theraputic relations.

Implementing recovery-oriented practices that will enhance health outcomes and quality of life for people with lived experience and their families is at the heart of the Mental Health Commission of Canada's Mental Health Strategy for Canada, and stands on two pillars:

1. Recovery approaches recognize that each person is unique and has a right to determine their recovery journey. Using a recovery-orientated approach, clients take an active role in determining their own treatment paths (Cirpili & Shoemaker, 2014; Mental Health Commission of Canada, 2015).

2. Recovery approaches provide recognition that individuals live in complex societies where there are many intersecting factors (biological, psychological, social, economic, cultural, and spiritual) which have an impact on health and well-being.

The nurses' role in recovery

Future nurses must understand how the recovery perspective guides nurses' engagement with clients along the spectrum of care. Nurses can support recovery with the client by understanding the recovery perspective's overarching guiding principles of dignity, hope, resilience, relationships, creating meaning of one's life, and self-efficacy in each person's unique and evolving journey (Deegan, 1988; Forchuk, 2003; Jacobson, 2012; Jacobson & Curtis, 2000). Nurses can also provide support by:

- Understanding recovery is personal and unique to each individual.
- Understanding each individual has a right to their own path and journey towards wellness.
- Honouring diversity.
- Being culturally responsive and safe.
- Facilitating interconnections between community and health-related resources for their care.
- Fostering and building positive environments that address clients' true needs and fostering a culture and language of hope (Cirpili & Shoemaker, 2014 & Mental Health Commission of Canada, 2015).

Moreover, the perspective acknowledges that recovery is:

- A long-term process of internal change, and that these internal changes are processed through various stages (Substance Abuse and Mental Health Service Administration [SAMHSA], 2005).
- An ongoing process of refining oneself and learning to accept one's vulnerabilities, overcoming stigma and discrimination, regaining hope, control, and responsibility in one's life.
- Involves becoming engaged in meaningful social activities and community citizenship (Snow, 2010).

There is a concern expressed by mental health stakeholders that principles associated with the recovery approach, such as autonomy and peer accountability, will be used to limit or avoid providing services (MHCC, 2015), or, that by being assimilated into mainstream, there is a potential to turn recovery into a task which professionals 'do' or 'facilitate', rather than recovery being a

process (Barker & Buchanan-Barker, 2005, p 238-239). In order to combat these obstacles to recovery, it's important for nurses to develop and promote individualized care planning.

The Philip Barker's Tidal Model, which emphasizes empowering interactions rooted in the lived experience of the client (Pagé, 2010), can be used to guide such strategies. Rather than conducting an assessment, the interaction is a nurse-client collaboration, where the nurses seek to understand who clients are by listening to their stories and perspectives (Barker, 2005). There are 10 commitments of the model and they include: value the voice; respect the language; develop genuine curiosity; become the apprentice; reveal personal wisdom; be transparent; use the available toolkit; craft the step beyond; give the gift of time; and, know that change is constant. Indeed, at the core of this model is change, so the nurse needs to be responding and adapting the focus to the changing needs of the client across the continuum of care (Pagé, 2010).

For more information, see Resources in this section.

TEACHING AND LEARNING ACTIVITIES

The following are teaching and learning activities that can be employed in the classroom to further support nurses in the integration of theory, principles and best practices related to recovery oriented approaches.

- Yale Program for Recovery and Community Health, The Recovery Knowledge Inventory (other recovery self-assessments)
- Narratives
- Case studies across lifespan, life transitions, and with different populations/contexts (Section 9.3)
- Review of films portraying mental health/illness and examining use of recovery-oriented perspectives
- Lived client experiences/family experience (Appendix H)
- Arts-based approaches
  - Photography
  - Music
  - Poetry

LEARNER ENGAGEMENT QUESTIONS

The following are thought-provoking and engaging learner questions that can be used to further discussions with nursing students regarding using recovery perspectives. These questions can be used either to stimulate discussion, engage students in critical thinking or be tied to class assignments and/or reflection exercises.

- Who defines recovery?
- Does recovery mean that you no longer have an illness?
- What is the difference between traditional medical care versus recovery care?
- What are the benefits of peer support?
- What is positive risk taking?
- How would you promote informed choice and options to clients in relation to care planning?
- How do you balance autonomy with beneficence?
- How do we promote recovery to a client who is hospitalized against their will (i.e., by court order)?
- How would you engage in a conversation about what brings meaning to someone's life?
- What is relapse prevention?

EVALUATION AND SELF-REFLECTION

The following tools can be used to evaluate students in their understanding and application of recovery perspectives:

- Self reflection of Recovery Knowledge Inventory (e.g., pre- and post-clinical placement)

SELF-REFLECTION

Reflection question: If you had depression/anxiety, what would you want that would be unique to your background/experience/knowledge/strengths?

RESOURCES

WEBSITES

- Mental Health Commission of Canada
- Psychosocial Rehabilitation (PSR) Réadaptation Psychosociale (RPS) Canada PSR Society of Canada
- Recovery Journey (Schizophrenia Society of Canada)

- The Wellness Recovery Action Plan®
- Consumer Survivor Initiative (Ontario Peer Development Initiative)
- Therapeutic Relationships: From Hosptial to Community.
- Alcoholics Anonymous
- Canadian Assembly of Narcotics Anonymous

VIDEOS

- Love Life, A Recovery Story
- Safewards by Len Bowers

GUIDES AND GUIDELINES

- RNAO 2015, Person- and Family- Centred Care. Toronto, ON. Registered Nurses' Association of Ontario.
- RNAO 2002, Strengthening and Supporting Families through Expected and Unexpected Life Events. Toronto, ON. Registered Nurses' Association of Ontario.
- 100 Ways to Promote Recovery (Mike Slade)
- Barker, P.& Buchanan-Barker, P. (2009). The Tidal Model®: A guide for mental health professionals. East Sussex, New York. Routledge.
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5.3 Trauma-Informed Care

OUTCOMES

PURPOSE

This section provides educators with the knowledge and skills required to understand and implement trauma-informed approaches to care in mental health and addiction curricula.

OUTCOMES

At the end of this section, the educator will ensure students achieve the following:

- Understand trauma and the impacts on health.
- Identify the principles of trauma-informed care.
- Understand and implement trauma-informed approaches to care.
- Relate trauma-informed approaches to care to universal precautions, cultural competence and safety, and creating safe space.

CASF/CFMHN COMPETENCIES: 2.11, 2.12, 3.7

Trauma-Informed Care

Trauma is defined as an experience that overwhelms an individual's capacity to cope (CCSA, 2012). Traumatic experiences occur at any age, and may include experiences such as child abuse and neglect to violence and war (CCSA, 2012). Trauma can interfere with a person's sense of safety, self and self-efficacy as well as the ability to regulate emotions and navigate relationships (CCSA, 2012).

For those who have faced multiple traumatic events, repeated experiences of abuse, or prolonged exposure to abuse, trauma is overwhelming and may have a significant impact on living (CCSA, 2012; Klinic Community Health Centre, 2013; National Child Traumatic Stress Network, 2008). Moreover, people who access mental health and substance use treatments report trauma and violence as being common (CCSA, 2012). Specifically, evidence shows individuals who have experienced trauma are at greater risk for developing a substance use disorder (Macy & Goodbourn, 2012). People who have experienced trauma view their use of substances as a coping tool; however this can make them more vulnerable to substance use problems (CCSA, 2012). Trauma also affects a person's mental health and can affect thinking, memory, attention and concentration (CAMH, 2012) .

Trauma-Informed Approaches

Educators in partnership with students need to develop an understanding of trauma-informed approaches to care and emphasize their use when assessing and treating all clients who use substances and/or may have a mental health condition, even when trauma is not suspected in clients (RNAO, 2015d).

Trauma-informed services focus on establishing a safe environment, where clients with trauma have choice and control; however, disclosure of trauma is not required (CCSA, 2012). Moreover, the use of trauma-informed approach in treatment does not require nurses to treat trauma, but rather a trauma-informed perspective results in a particular approach and acknowledges how common trauma is among clients who use substances, and the manifestation of trauma in their lives (RNAO, 2015d).

There are four key principles of trauma-informed approaches as outlined by the Canadian Centre on Substance Abuse. They include:

Trauma awareness	All services taking a trauma-informed approach begin with building awareness among staff and clients of: how common trauma is; how its impact can be central to one's development; the wide range of adaptations people make to cope and survive; and the relationship of trauma with substance use, physical health and mental health concerns. This knowledge is the foundation of an organizational culture of trauma-informed care.
Emphasis on safety and trustworthiness	Physical and emotional safety for clients is key to trauma-informed practice because trauma survivors often feel unsafe, are likely to have experienced boundary violations and abuse of power, and may be in unsafe relationships. Safety and trustworthiness are established through activities such as: welcoming intake procedures; exploring and adapting the physical space; providing clear information about the programming; ensuring informed consent; creating crisis plans; demonstrating predictable expectations; and scheduling appointments consistently. The needs of service providers are also considered within a trauma-informed service approach. Education and support related to vicarious trauma experienced by service providers themselves is a key component.

Opportunity for choice, collaboration and connection	Trauma-informed services create safe environments that foster a client's sense of efficacy, self-determination, dignity and personal control. Service providers try to communicate openly, equalize power imbalances in relationships, allow the expression of feelings without fear of judgment, provide choices as to treatment preferences, and work collaboratively. In addition, having the opportunity to establish safe connections – with treatment providers, peers and the wider community – is reparative for those with early/ongoing experiences of trauma. This experience of choice, collaboration and connection is often extended to client involvement in evaluating the treatment services, and forming consumer representation councils that provide advice on service design, consumer rights and grievances.
Strengths-based and skill building	Clients in trauma-informed services are assisted to identify their strengths and to further develop their resiliency and coping skills. Emphasis is placed on teaching and modelling skills for recognizing triggers, calming, centering and staying present. In her Sanctuary Model of trauma-informed organizational change, Sandra Bloom described this as having an organizational culture characterized by 'emotional intelligence' and 'social learning.' Again, parallel attention to staff competencies and learning these skills and values characterizes trauma-informed services.

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For more information, see Resources.

TEACHING AND LEARNING ACTIVITIES

The following are teaching and learning activities that can be employed in the classroom to further support nurses in the integration of theory, principles and best practices related to trauma-informed approaches to care.

- Trauma-informed safety plan—Appendix F
- Case study suggestions (Section 9.3):
  - A person with a diagnosis of schizophrenia begins heavy alcohol use after a sexual assault: Where do you start?
  - A person who has had a close friend or relative die by suicide.
  - A refugee who has witnessed or experienced violence.
  - A veteran who has recurrent nightmares and substance use after returning from service.
- Simulation
- Lived client experience/family experience—Appendix H
- Planning a physical environment that does not re-traumatize
- Handout with Learner Engagement Questions (below)
- Arts-based approaches
  - Photography
  - Music
  - Poetry

? LEARNER ENGAGEMENT QUESTIONS

The following are thought-provoking and engaging learner questions that can be used to further discussions with nursing students regarding using trauma-informed approaches to care. These questions can be used either to stimulate discussion, engage students in critical thinking or be tied to class assignments and/or reflection exercises.

- What is the impact of different restraints in relation to trauma?
- What is the difference between trauma therapy and trauma-informed care?
- How might someone dull the pain of trauma in ways that could be helpful and not helpful?
- How are residential schools related to trauma for First Nations, Aboriginal, Inuit and Métis people?

- How can trauma be experienced on the intergenerational level and over the individual and family lifespan?
- What is the relationship between trauma and homelessness (and other social determinants of health)?
- When is a good time to discuss trauma? How do you engage in this topic? When might you delay the discussion?
- What is a trigger and how would you recognize that someone is experiencing trauma-related distress?
- How might a person with a history of trauma have behaviour that could be interpreted as "noncompliance" or non-adherence?
- Who is vulnerable to trauma?

EVALUATION AND SELF-REFLECTION

The following tools can be used to evaluate students in their understanding and application of trauma-informed approaches:

- Care plans reflecting trauma-informed approaches to care
- Tests of theoretical concepts
- Applications with case studies

SELF-REFLECTION

- Reflection question: What personal experience do you have of trauma and how might this influence your care?
- Journaling experiences—Appendix E

RESOURCES

WEBSITES

The Sanctuary Model by Dr. Sandra L. Bloom
Government of Nova Scotia - Trauma Informed Practices – Discussion Guides
#1: An Introduction and Discussion Guide For Health and Social Service Providers.
#2: Recognizing and responding to the effects of trauma.
#3: Trauma-informed practice in different settings and with various populations.

#4: Trauma-informed practice at the interagency and leadership levels.
Safewards by Len Bowers
Trauma Informed Care Project

RNAO TOOLS

- Registered Nurses' Association of Ontario. (2012). Promoting safety: Alternative approaches to the use of restraints. Toronto, ON: Registered Nurses' Association of Ontario.
- RNAO, 2015 Engaging Clients Who Use Substances. Toronto, ON: Registered Nurses' Association of Ontario.

GUIDES

- British Columbia Provincial Mental Health and Substance Use Planning Council. (2013). Trauma-informed practice guide. Vancouver, BC: Author.
- Link: http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf
- Substance Abuse and Mental Health Services Administration. (2014). Trauma-informed care in behavioral health services. Part 3: A review of the literature. Treatment Improvement Protocol (TIP) Series 57. Rockville, MD: Author.
- Link: http://store.samhsa.gov/shin/content//SMA14-4884/SMA14-4884.pdf
- The Jean Tweed Centre (2013). Trauma Matters: Guidelines for trauma-informed practices in women's substance use services.

BOOKS

Poole, N. & Greaves, L. (2012). Becoming Trauma Informed. Toronto: ON. Centre for Addiction and Mental Health.

Mate, G. (2009). In the realm of hungry ghosts. Berkely, CA: North Atlantic Books.

5.4 Harm Reduction

PURPOSE

This section supports educators with knowledge and skills to integrate harm reduction philosophy in mental health and addiction curricula.

OUTCOMES

OUTCOMES

At the end of this section, the educator will ensure students achieve the following:

- Define and understand the philosophy and key principles of harm reduction.
- Identify key areas of harm reduction in policies and practice.
- Identify harm reduction approaches in other areas of health and safety.

CASF/CFMHN COMPETENCIES: 2.3, 2.4, 2.5, 2.6, 2.8, 2.9, 3.1, 3.3, 3.4, 3.5, 3.7, 3.8

Harm Reduction

Harm reduction is a pragmatic public health approach to practices, programs, and policies that aim to reduce the adverse health, social, and economic consequences of substance use without requiring individuals to abstain from substance use (CNA, 2011; Rassool, 2010).

The aim of a harm reduction approach is to reduce the negative consequences of risky behaviours, including the harmful effects of substance use (CNA, 2011; Rassool, 2010). As such, a harm reduction response recognizes that substance use is a complex phenomenon that encompasses a continuum of behaviours, ensures a non-judgmental provision of care, and advocates for equal access to resources and services for care, regardless of drug use or engagement in other at-risk practices (CNA, 2011). It also focuses on promoting harm reduction within the communities that clients live in and in the areas and conditions where substances are used, rather than in contexts that are removed from these settings (Rassool, 2010).

The dangers associated with substance use are not minimized in a harm reduction approach, which also recognizes the realities of poverty, racism, social isolation, past trauma, and other social inequalities that affect a person's vulnerability and capacity to deal effectively with substance-related harm (Rassool, 2010). According to RNAO's (2015) Engaging Clients Who Use Substances, harm reduction:

- Is an alternative to the disease causation model of substance use.
- Accepts that at any given time some people are not ready to choose abstinence.
- Accepts that substance use occurs in society and works to minimize its harmful effects.

- Accepts that people who are substance-dependent should have a voice in the creation of programs and policies designed to serve them
- Values patient autonomy.
- Does not exclude abstinence as an option (Beirness, Jesseman, Notarandrea, & Perron, 2008; CNA, 2011).

Nurses should integrate principles of harm reduction when working with clients who use substances and when treating those at risk for or experiencing a substance use disorder, according to RNAO's Engaging Clients Who Use Substances (2015). Harm reduction principles and approaches can also be used to support individuals physical and mental health (e.g., from engaging in unprotected sex to refraining from driving after drinking).

Applying a harm reduction framework allows nurses to tailor their approach in order to meet clients "where they are," establish goals collaboratively with the client, and develop a client-centred plan of care, while building trust and autonomy in the nurse–client relationship (RNAO, 2009). However, before integrating the principles of harm reduction, nurses must be aware of and address their own attitudes and biases (RNAO, 2015d).

For more information, see Resources.

TEACHING AND LEARNING ACTIVITIES

The following are teaching and learning activities that can be employed in the classroom to further support nurses in the integration of theory, principles and best practices related to harm reduction principles and approaches.

- Design a learning activity that includes a variety of program/policy options. Have students in small groups determine which option has a harm reduction approach and present to a group how and why they have come to that conclusion. Debrief using examples.
- Bring together a panel of people who can speak to harm reduction approaches from a personal/community/professional perspective (e.g., AIDS coalitions, condoms programs, methadone maintenance programs, needle exchanges, peer administered Naloxone, Housing First, etc.)
- Group Activity that asks students to identify different types of harm reduction practices.
- Narratives
- Case studies across lifespan, life transitions, and with different populations/contexts—or use the template in Section 9.3
- Videos—see Resources

- Lived client experiences/family experience—Appendix H
- Arts-based approaches
  - Photography
  - Music
  - Poetry

? LEARNER ENGAGEMENT QUESTIONS

The following are thought-provoking and engaging learner questions that can be used to further discussions with nursing students regarding harm reduction theory and approaches. These questions can be used either to stimulate discussion, engage students in critical thinking or be tied to class assignments and/or reflection exercises.

- What are the benefits and barriers of a harm reduction approach?
- What are the ethical implications for nursing practice of not providing care to those in need?
- Supervised injection site in my backyard – thoughts?
- What is the difference, similarity, and relationship between harm reduction and abstinence?
- What is the relationship between housing first strategies and harm reduction strategies?
- What is an example of harm reduction safe sexual practices?
- Does handing out condoms promote sexual activity?
- Do needle exchange programs promote drug use?

EVALUATION AND SELF-REFLECTION

The following tool can be used to evaluate students in their understanding and application of harm reduction theory and approaches:

- Assignment on policy review

SELF-REFLECTION

Reflection questions: Do you choose your illness? What are your values and beliefs regarding harm reduction approaches? Does harm reduction save lives?

RESOURCES

RNAO E-LEARNING MODULES

- Engaging Clients with Substance Use Disorders E-learning module
- Engaging Youth Who Use Substances E-learning module
- Addictions E-Learning Series

VIDEOS

- RNAO's Screening & Brief Intervention
- RNAO's Using Motivational Interviewing Approaches
- Opioids: Best Advice For People On, Or About To Start Taking Opioid Medications, Related To Chronic Non-Cancer Pain is an educational video by Dr. Mike Evans.
- University of Utah's Mouse Party: Take a look inside the brains of mice on drugs
- Bevel up - Drugs, Users and Outreach Nursing - Nettie Wild (2007)

RNAO BEST PRACTICE GUIDELINES

- RNAO 2015, Engaging Clients Who Use Substances . Toronto, ON. Registered Nurses' Association of Ontario.
- RNAO 2009, Supporting Clients on Methadone Maintenance Treatment . Toronto, ON. Registered Nurses' Association of Ontario.

WEBSITES

- Canadian Center on Substance Abuse
- Canadian Harm Reduction Network

REFERENCE MATERIALS

O'Grady, C. P., & Skinner, W. J. W. (2007). *A family guide to concurrent disorders*. Toronto, ON: Centre for Addiction and Mental Health.

5.5 Mental Health, Illness and Addiction

OUTCOMES

PURPOSE

This section supports educators with increased knowledge and skills to integrate mental health and screening, assessment and interventions related to mental illnesses in mental health and addiction curricula.

OUTCOMES

At the end of this section, the educator will ensure students achieve the following:

- Understand the continuum of mental health.
- Understand the concept of resiliency and mental health (i.e., concepts of stress, coping, adaptation, etc.).
- Understand mental health promotion, and prevention of mental illness.

Educators will use the Resource Section to:

- Understand the purpose of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) in nursing, and identify DSM-5 diagnostic categories and criteria for the following conditions.
  - Bipolar disorders
  - Depressive disorders
  - Anxiety disorders
  - Substance-related and addictive disorders
  - Trauma- and stressor-related disorders
  - Personality disorders
  - Delirium and Dementia
  - Schizophrenia and other psychotic disorders
- Understand treatment and management of mental illness.
- Learn about co-morbidities, severity, and levels of disability related to mental disorders.

CASF/CFMHN COMPETENCIES: 2.1, 2.2, 2.3, 2.4, 2.5, 2.6

SEC. 5

Mental Health Continuum

The definition of mental health is much more holistic than it once was. According to the Public Health Agency of Canada it is: "The capacities of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice,

interconnections, and personal dignity" (Public Health Agency of Canada, 2014, para 2). However, mental health and mental illness are not the same thing. Mental illness is "a recognized, medically diagnosable illness that results in the significant impairment of an individual's cognitive, affective or relational abilities. Mental disorders result from biological, developmental and/or psychosocial factors and can be managed using approaches comparable to those applied to physical disease (i.e., prevention, screening, diagnosis, treatment and rehabilitation)" (Epp, J., 2009, p. 82).

The "mental health continuum" best describes the relationship between health and illness where they are not at opposite ends of a single spectrum but on a continuum (Keyes, 2002). Every person can flourish or languish somewhere along the mental health continuum, and this state can vary on a daily basis. Inherent in the mental health continuum is the understanding that mental health is not simply the absence of mental illness. Rather the model adopts the notion that individuals can experience complete mental health even if they have been diagnosed with a mental illness (Keyes, 2002). On the other hand, individuals who are free of a diagnosed mental illness can still experience poor mental health if they have poor coping mechanisms. A useful tool for gaining further insight is the 2015 First Nations Mental Wellness Continuum Framework, which views mental well-being as "a balance of the mental, physical, spiritual, and emotional" that gives everyone—even the most vulnerable or mentally ill—an opportunity to live whole and healthy lives (Health Canada, 2015).

There is a relationship between being resilient and having good mental health. People who are "resilient" are able to recover from difficulties or change and move forward as they were before the disruption (Khanlou & Barankin, 2007). However, people who are resilient can develop a mental illness, which may lower resiliency (Khanlou & Barankin, 2007). Because nurses working in all practice settings along the continuum of health care will care for people with varying degrees of mental health and illnesses, they should be aware of and understand ways to improve resiliency in their interactions. Furthermore, faculty should impart not only the importance of using mental and illness knowledge to care for and impact populations, but to take leadership roles in advancing mental health promotion and driving improvements in mental health care delivery (CFMHN, 2016). Promoting mental health in fact encourages the development of resilience by implementing strategies that build on community-based strengths, provide opportunities, create safe places and encourage supportive resiliency (Khanlou & Barankin, 2007, p. 10).

Further research required:

There are many different types of mental illnesses. Knowledge of the American Psychiatric Association [APA] (2013) Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)—a classification and diagnostic tool for mental illness—is key for nurse educators to teach students about mental illness pathology in order to understand treatment and interventions related to specific mental illness. It may not be imperative to teach about every mental illness, but rather the educator's role is equally important to have students learn where to find credible, reliable resources.

For more information, see Resources in this section.

TEACHING AND LEARNING ACTIVITIES

The following are teaching and learning activities that can be employed in the classroom to further support nurses in the integration of theory, principles and best practices related to mental health and illness.

- Lived client and family experience—Appendix H
- Case studies—Section 9.3
- Simulation—Section 7.2
- Discussion of each illness conditions, causes, prevalence, and treatment/management
- Broad discussion on:
  - Individual counseling
  - Group therapy
  - Family counseling
  - Pharmacological therapy
  - Complementary therapy
  - Other Psychosocial interventions

? LEARNER ENGAGEMENT QUESTIONS

The following are thought-provoking and engaging learner questions that can be used to further discussions with nursing students regarding mental health and illness. These questions can be used either to stimulate discussion, engage students in critical thinking or be tied to class assignments and/or reflection exercises.

- What causes mental illness (e.g., depression)? Give examples from neuroenzyme, hormonal, medication side effects, sociological, psychological, economic, relationship, social determinants, equity, co-morbidities.
- Can you have good mental health with a mental illness?
- What other conditions/illnesses are you at higher risk of because of a mental illness?
- What mental illness(es) are you at higher risk of because of other conditions/illnesses (e.g., diabetes, cardiac, cancer)?
- What is a concurrent disorder?
- How do the social determinants of health influence mental health and illness?
- What community and hospital-based mental health services/resources are available?

- What is the difference between mental health, mental illness and mental disability?
- What complementary therapies might be employed?
- What is the nurse's role in the acute phase of illness? What is the nurse's role in rehabilitation?
- What is the nurse's role in the hospital and community mental health?
- What assessments are completed to determine changes in the mental status (e.g., Mental Status Examination)?
- What are the benefits and risks of diagnosis to the person?

EVALUATION AND SELF-REFLECTION

The following tools can be used to evaluate students in their understanding and application of mental health and illness.

- Test knowledge (e.g., conditions, signs and symptoms, treatment)
- Paper (e.g., students to write papers on certain mental illness/conditions, mental health, current controversies, etc)
- In-class presentations on different illnesses

SELF-REFLECTION

- Reflection questions: What mental illnesses have touched your life?
- How does this influence your care?

RESOURCES

WEBSITES

- MindYourMind
- Mental Health Commission of Canada. (2013). Changing Directions, Changing Lives: The Mental Health Strategy for Canada
- Ontario Centre of Excellence for Child and Youth Mental Health
- Centre for Addiction and Mental Health—Portico Network
- Children's Hospital of Eastern Ontario (CHEO)'s e-mental health portal
- Government of Ontario's Connexx Ontario Health Services Information

VIDEOS

- Mental Health in Hospitals and Treatment Centers: Video-5 Series

MANUALS

- American Psychiatric Association (APA). (2006). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: Author.

RNAO BEST PRACTICE GUIDELINES

- RNAO 2016, Delirium, Dementia, and Depression in Older Adults: Assessment and Care. Toronto, ON: Registered Nurses' Association of Ontario.
- RNAO 2015, Engaging Clients Who Use Substances. Toronto, ON. Registered Nurses' Association of Ontario.
- RNAO 2015, Person- and Family-Centred Care. Toronto, ON. Registered Nurses' Association of Ontario.
- RNAO 2015, Supporting and Strengthening Families Through Expected and Unexpected Life Events. Toronto, ON. Registered Nurses' Association of Ontario.
- RNAO 2009, Supporting Clients on Methadone Maintenance Treatment. Toronto, ON. Registered Nurses' Association of Ontario.
- RNAO 2009, Assessment and Care of Adults at Risk for Suicidal Ideation and Behaviour. Toronto, ON. Registered Nurses' Association of Ontario.
- RNAO 2005, Interventions for Postpartum Depression. Toronto, ON. Registered Nurses' Association of Ontario.

RESOURCE MATERIALS

American Psychological Association (APA). (2013). Cultural Formulation and Cultural Formulation Interviews. In American Psychiatric Association (APA). (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: Author.

Keyes, C. (2002). The mental health continuum: From languishing to flourishing in life. *Journal of Health and Social Research*, 43(June): 207-222.

Peplau, H.E. (1999). On semantics. *Perspectives in Psychiatric Care*. 35(3), 13.

Frances, Allen. (2013). Saving Normal. New York, NY: Harper Collins.

5.6 Mental Status Examination (MSE)

OUTCOMES

PURPOSE

This section provides educators with increased understanding regarding the purpose and implementation of the Mental Status Examination (MSE) across the lifespan and in different types of populations/contexts.

OUTCOMES

At the end of this section, the educator will ensure students achieve the following:

- Understand the purpose of the MSE.
- Understand the MSE in relation to health assessment and care planning.
- Identify the different components and terminology of the MSE.
- Be able to perform and document a MSE.

CASF/CFMHN COMPETENCY: 2.7

The Mental Status Examination (MSE)

The Mental Status Examination (MSE)—a structured assessment of client's behavioural and cognitive functioning—is a vital component of nursing care that assists with evaluation of mental health conditions. The MSE is analogous to the physical examination and is used to evaluate an individual's current cogitative, affective and behavioural functioning (Varcarolis, 2014). Specifically, the MSE assesses a client's current state including general appearance, mood and affect, speech, thought process and content, perceptual disturbances, impulse control, cognition, knowledge, judgment and insight (Lasiuk, 2015). The MSE can be used across clinical settings, not just in a psychiatric context, takes only a few minutes to administer and can generate information that is crucial for creating a plan of care (Robinson, 2008).

MSE Elements

The acronym BEST PICK can assist with learning the main elements of an MSE (Carniaux-Moran, 2008). A brief description of the elements that are assessed includes:

- **B**ehaviour and general appearance - age, sex, gender, cultural background, posture, dress/grooming, manner, alertness, as well as agitation, hyperactivity, psychomotor retardation, unusual movements, catatonia, etc.
- **E**motions: mood and state, emotional state and visible expression (state) including description and variability.

- **S**peech—rate, amount, style and tone of speech.
- **T**hought content and processes—abnormalities, obsessions, delusions and suicidal and homicidal thoughts and thought process as well as loose associations, tangential thinking, word salad, and neologisms, circumstantial thought, and concrete versus abstract thought.
- **P**erceptual disturbances—illusions and hallucinations.
- **I**mpulse control—ability to delay, modulate or inhibit expressions or behaviours.
- **C**ognition—consciousness, orientation, concentration and memory.
- **K**nowledge, insights and judgment—the capacity to identify possible courses of action, anticipate consequences, and choose appropriate behaviour, and extent of awareness of illness and maladaptive behaviours.

Source: Carniaux-Moran, C. (2008). The Psychiatric Nursing Assessement. In O'Brien, P.G., Kennedy, W.Z., Ballard, K.A. Psychiatric mental health nursing: an introduction to theory and practice.,Sudbury, MA: Jones & Bartlett.

Based primarily on observational data gathered by nurses and interview questions, the MSE can be used to establish a baseline, evaluate changes over time, facilitate diagnosis, plan effective care, and evaluate response to treatment in clients with mental health and addiction.

For more information, see Appendix I: Components of a Mental Status Assessment, pg. 96 in RNAO's BPG Assessment and Care of Adults at Risk for Suicide Ideation and Behaviour.

TEACHING AND LEARNING ACTIVITIES

The following are teaching and learning activities that can be employed in the classroom to further support nurses in the integration of the MSE.

- Video demonstration
- Simulation—Section 7.2
- Case studies (across lifespan; different populations)—Section 9.3
- Group discussion
- Assignments related to MSE
- Quick reference cards with questions
- Practice application

? LEARNER ENGAGEMENT QUESTIONS

The following are thought-provoking and engaging learner questions that can be used to further discussions with nursing students regarding MSE. These questions can be used either to stimulate discussion, engage students in critical thinking or be tied to class assignments and/or reflection exercises.

- What are the benefits and challenges of conducting a MSE?
- When should the MSE be conducted?
- Discuss how the MSE contributes to the health assessment.
- What elements of the MSE relate to risk?
- Why are some components of the MSE observed and other components inquired?

EVALUATION AND SELF-REFLECTION

The following tools can be used to evaluate students in their understanding and application of MSE

- Return demonstration
- Documentation

SELF-REFLECTION

Self-reflection questions: How did you feel when conducting MSE? How did you feel in the client role?

RESOURCES

TOOLS

Mental Status Exam

VIDEO

Voice Hearing – Eleanor Longden TED TALK

REFERENCE MATERIALS

Butler, K. (2015). On the Frontline with voices - A grassroots handbook for voice-hearers, carers and clinicians. London, UK: Speechmark Publishing Limited.

Erwin, E. H., & Colson, C. W. (2014). Disorders of children and adolescents. Adapted by R. J. Meadus. In M. J. Halter, *Varcarolis's Canadian psychiatric mental health nursing: A clinical approach.* C. L. Pollard, S. L. Ray, & M. Haase (Eds.), (First Canadian ed., chapter 29, pp. 586–612). Toronto, ON: Elsevier Canada. Mental Status Exam (chapter 29, p. 592–593).

Halter (2014). Mental Status Exam. In M. J. Halter, Varcaroli (Eds.). *Canadian psychiatric mental health nursing: A clinical approach* (1st ed.) (pp. pp. 138 & pp. 592 – 593). Toronto, ON: Elsevier Canada.

Jarvis, C. (2014). *Physical examination & health assessment*. Toronto: Elsevier Canada.

Lasiuk, G. (2015). The assessment process. In W. Austin & M. A. Boyd (Eds.), *Psychiatric & mental health nursing for Canadian practice* (3rd ed., Chapter 10, pp. 148–164). Philadelphia, PA: Wolters Kluwer.

Robinson, D. (2008). The Mental Status Exam Explained, 2nd Edition. London, ON: Rapid Psychler Press. ISBN (13) 978-1-894328-25-8 (2015).

5.7 Suicide Risk and Self-Harm Assessment

PURPOSE

This section supports educators with knowledge and skills to integrate suicide risk, self-harm assessment and developing a safety plan in mental health and addiction curricula.

OUTCOMES

OUTCOMES

At the end of this section, the educator will ensure students achieve the following:

- Understand the prevalence, risk factors, and language of suicide and self-harm.
- Understand the purpose of and differences between suicidal ideation/behaviours and self-harm behaviours.
- Identify the components of the suicide risk/self-harm assessment.
- Perform and document a suicide risk assessment/self-harm assessment.
- Understand suicide risk in the context of Mental Health Act and other legislation.
- Develop a safety plan in collaboration with the client (Appendix F).

CASN/CFMHN COMPETENCY: 2.9

Self-harm

Self-harm is the expression of inner pain, hopelessness and helplessness experienced by people. Self-harm can be due to suicidal thoughts, a coping mechanism to gain control over one's body and to simply feel better and get relief from pain (Moore & Melrose, 2014 & CMHA, 2016). Acts of self-harm can include cutting skin, burning skin, hitting oneself to the point of injury and preventing wounds from healing (CMHA, 2016). Self-harm can affect anyone, and is experienced more frequently by adolescents and females (CMHA, 2016). Self-harm is also more likely to affect those who have experienced trauma, have issues with coping and among those with low self-esteem (CMHA, 2016). It is important for health-care professionals to recognize that self-harm behaviours pose a high risk for completed suicide. Health-care professionals must also recognize the stigma associated with self-harm and understand counter transference and trauma associated with it.

Suicide

Suicide is an abrupt ending to life and is the most extreme way in which individuals respond to overwhelming situations and stress (RNAO, 2009c). Some literature indicates that suicide can be elevated among youth, elderly, indigenous peoples, LGBTQ populations and those who are incarcerated (RNAO, 2009c). Mood disorders, which includes depression, are the most common psychiatric condition associated with suicide (Jamison, 2000). According to the Centre for Addiction and Mental Health (2016), between 20 percent and 60 percent of death by suicide occurs in this community. Other high risk groups include:

- People with bipolar depression—suicide risk is 15 times that of the general population.
- People with schizophrenia—the lifetime risk of suicide is 4 to 7 percent (and a 40 percent risk of suicide attempts).
- People with concurrent addiction—experience higher suicide rates.
- Persons who use and misuse substances—they often have several other risk factors for suicide such as being depressed or having issues pertaining to social health determinants such as social or financial difficulties.

Source: Centre for Addiction and Mental Health, 2016

Suicide is a complex phenomena influenced by biological (i.e., genetics), physical, psychological, spiritual, social, economic, historical, political, cultural and environmental factors (RNAO, 2009c). Many individuals are affected by suicide in Canada. Given the pervasiveness of suicide among these communities, health-care practitioners' ability to recognize and address suicidality can be a life-saving skill (CAMH, 2016). Specifically, nurses have a significant role in intervening when individuals express suicidal ideation and behaviour (RNAO, 2009). Understanding risk factors and warning signs may help nurses identifying clients at risk of suicide.

Assessment of risk

RNAO's Best Practice Guideline Assessment and Care of Adults at Risk for Suicide Ideation and Behaviour states, "A comprehensive assessment of risk involves interviewing the client, reviewing the medical records and/or gathering information from family or significant others" (RNAO, 2009, p. 31). In addition to a mental status examination (MSE), a comprehensive assessment regarding suicidal ideation and plan, a clinical interview and use of valid and reliable assessment tools may be used to gather information specific to:

- Presence of risk factors.
- Lack or presence of protective factors (e.g., spirituality, hope, future orientation, cultural and/or spiritual factors).
- Suicidal intent.
- Plan.

- Lethality.
- Access to means.
- Time frame.
- Hope.
- Previous suicide attempts.

Source: RNAO, 2009

When the risk of suicide is identified, nurses should also work to develop a therapeutic relationship with the client and their family, as appropriate (RNAO, 2009c). Furthermore, nurses need to develop safety plans in collaboration with clients.

A safety plan indicates how clients should respond to their suicidal urge by outlining coping and problem-solving skills and abilities (Centre for Applied Research in Mental Health and Addiction [CARMHA], 1996). For a template of a safety plan see Appendix F.

For more information, see Resources in this section.

TEACHING AND LEARNING ACTIVITIES

The following are teaching and learning activities that can be employed in the classroom to further support nurses in the integration of theory, principles and best practices related to suicide risk/assessment and self-harm.

- Safety Plan Template—Appendix F
- Case study examples:
  - Physical exam where you find different layers of scarring on arms/legs.
  - Person who on leaving states, "You may not see me again."
- Simulation—Section 7.2
- Lived client experience/family experience—Appendix H
- Handout with reflective questions.
- Students might work independently first, and then in small groups, and/or come back to larger class.
- Narratives
- Arts-based approaches

- Photography
- Music
- Vision boards
- Poetry

? LEARNER ENGAGEMENT QUESTIONS

The following are thought-provoking and engaging learner questions that can be used to further discussions with nursing students regarding suicide risk/assessment and self-harm. These questions can be used either to stimulate discussion, engage students in critical thinking or be tied to class assignments and/or reflection exercises.

- How would you explore the client's spiritual and beliefs about death?
- Do people have the right to kill themselves when it is related to mental illness (including addiction)?
- Does age, gender, or additional health concerns make a difference in terms of attitude regarding suicide?
- How might our beliefs about the individual's right to suicide play out in our interactions with patients/clients?
- How do our professional standards help to guide us in working with individuals presenting with suicidal ideation/behaviour?
- How do our professional standards fit with the current move to legalize assisted death/suicide?
- Do some people deserve to die?
- Can talking about suicide cause suicide?
- What's the difference between suicidal ideation/behaviour and self-harm behaviour?
- What might it mean if a person is engaging in "cutting behaviours" to deal with stress?

EVALUATION AND SELF-REFLECTION

The following tools can be used to evaluate students in their understanding and application of suicide and self-harm risk/assessment:

- Return demonstration
- Documentation

SELF-REFLECTION

Self-reflection question: What are my own beliefs about suicide, death and choice? Also, reflect on lived client experience of someone who has lost a friend/family/colleague to suicide.

RESOURCES

WEBSITES

- jack.org
- Suicide Prevention (MHCC)
- Applied Suicide Intervention Skills Training (ASIST) Suicide Prevention Courses—including Safe Talk
- Suicide Prevention Courses – including Safe Talk and ASSIST (https://www.livingworks.net/)

VIDEO

- Gros, G. (2015). Caring for youth at risk of suicide www.youtube.com/watch?v=ex2CBDYvSJA

GUIDES AND HANDBOOKS

- Centre for Addiction and Mental Health (CAMH). (2011). *CAMH suicide prevention and assessment handbook*. Toronto, ON: Centre for Addiction and Mental Health.
- Canadian Coalition for Senior's Mental Health. (2010). Suicide assessment and prevention for older adults. Retrieved from: http://ccsmh.ca/suicide-assessment-prevention-older-adults/
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Montreuil, M., Butler, K., Stachura, M., & Gros, C. (2015). Exploring helpful nursing care in pediatric mental health settings: The perceptions of children with suicide risk factors and their parents. *Issues in Mental Health Nursing*, 36(11), 849-859.

Murray, B. L., & Austin, W. (2015). Self-harm and suicidal behaviour. In W. Austin & M. A. Boyd (Eds.), *Psychiatric & mental health nursing for Canadian practice* (3rd ed., Chapter 19, pp. 340–363). Philadelphia, PA: Wolters Kluwer.

Patrick L. Kerr, PhD, Jennifer J. Muehlenkamp, PhD, and James M. Turner, DO (2010). Nonsuicidal Self-Injury: A Review of Current Research for Family Medicine and Primary Care Physicians. *Journal of American Board of Family Medicine*, 23 (2), 240-259.

Perlman, C. M., Neufeld, E., Martin, L., Goy, M., & Hirdes, J. P. (2011). *Suicide Risk Assessment Inventory: A Resource Guide for Canadian Health Care Organizations*. Toronto: Ontario Hospital Association and Canadian Patient Safety Institute.

Randy A. Sansone, MD, and Lori A. Sansone, MD (2010). Measuring Self-Harm Behavior with the Self-Harm Inventory. Psychiatry (Edgemont), 7(4):16–20.

Registered Nurses' Association of Ontario. (2009). Assessment and Care of Adults at Risk for Suicidal Ideation and Behaviour. Toronto: ON, Registered Nurses' Association of Ontario.

Sakinofsky, I. (2005). Suicide and suicidality. In D. S. Goldbloom (Ed.), *Psychiatric Clinical Skills* (pp. 167–185). Philadelphia, PA: Elsevier Mosby.

Wright, D., & Gros, C.P. (2012). Theory inspired practice for end-of-life cancer care: an exploration of the McGill Model of Nursing. *Canadian Oncology Nursing Journal*. 182-189. Summer 2012.

5.8 Crisis Intervention

PURPOSE

This section provides educators with the knowledge and skills required to understand and identify crisis states and support people through crises.

OUTCOMES

OUTCOMES

At the end of this section, the educator will ensure students achieve the following:

- Identify the definition of a psychiatric/mental health/addiction crisis and relevant theories, and frameworks regarding crisis intervention.
- Identify mental distress.
- Have a basic understanding of mental health first aid.
- Have the ability to intervene to support a client experiencing a crisis.
- Identify individualized triggers, strengths, resources, resilience, and preventative strategies.
- Understand care planning strategies to prevent and support people through crises.

CASF/CFMHN COMPETENCIES: 2.3, 2.9, 2.11, 2.12, 3.1

Crisis Intervention

A crisis is defined as: "An emotional upset, arising from situational, developmental, biological, psychological, socio-cultural, and/or spiritual factors. This state of emotional distress results in a temporary inability to cope by means of one's usual resources and coping mechanisms. Unless the stressors that precipitated the crisis are alleviated and/or the coping mechanisms are bolstered, major disorganization may result. It is recognized that a crisis state is subjective and as such may be defined by the client, the family or other members of the community" (Hoff, 1995; Ontario Ministry of Health and Long-Term Care, 1999ab; RNAO, 2006).

Nurses have an important role to play in delivering effective crisis intervention to meet the needs of clients experiencing a crisis (RNAO, 2006). Evidence demonstrates that crisis care should be incorporated into all areas and units of health care and used when working with clients (RNAO, 2006). It is important for nurses to recognize that crisis intervention is integral for all environments and contexts where care is provided, including hospital and community settings (RNAO, 2006).

Models of crisis intervention

A crisis intervention is defined as: "A process that focuses on resolution of the immediate problem through the use of personal, social and environmental resources (Hoff, 1995). The goals of crisis intervention are rapid resolution of the crisis to prevent further deterioration, to achieve at least a pre-crisis level of functioning, to promote growth and effective problem solving, and to recognize danger signs to prevent negative outcomes [Hoff, 1995]" (RNAO, 2006, p. 16).

Crisis theorists postulate that there are three core components to any crisis.

1. A precipitating event that produces an experience of stress;
2. Perception of the event that leads to feelings and emotions that are overwhelming or confusing.
3. Compromised coping mechanism that does not allow the individual to function emotionally, occupationally and interpersonally.

Source: RNAO, 2006.

While there are many models of crisis intervention, in any crisis intervention the focus is always on increasing the client's level of social, occupational, cognitive and behavioural functioning (RNAO, 2006). Crisis intervention uses a client-centred approach that takes into consideration the client's unique rights, feelings, values, perceptions and wishes (RNAO, 2006). While tools (e.g., interview guides, mental status, risk assessment etc.) may aid in assessment by providing a structured approach to the process, they are not a substitute for empathy, knowledge, clinical judgment and expertise.

It is worth noting that experienced and trained nurses usually apply all phases of the crisis framework and move beyond assessment and referral to include creative problem-solving strategies—which encompass social determinants of health (RNAO, 2006). Too often nurses assume that some clients are incapable of problem-solving and never proceed beyond risk assessment and referral. "Moving out of one's comfort zone and making changes to one's clinical practice involves education, risk taking and an openness to change. Nurses need to assume initiative and responsibility for lifelong learning to maintain currency and competence within their multi-faceted crisis intervention roles" (RNAO, 2006, p 31).

For more information, see Resources in this section.

TEACHING AND LEARNING ACTIVITIES

The following are teaching and learning activities that can be employed in the classroom to further support nurses in the integration of theory, principles and best practices related to crisis intervention.

- Self-reflection on personal past crises and coping strategies
- Develop a safety and comfort plan—Appendix F
- Case study—Section 9.3
- Simulation—Section 7.2
- Lived client experience/family experience—Appendix H
- Class assignment that explores local community crisis intervention resources
- Review of films portraying crisis and examining use of crisis interventions
- Lived client experiences/family experiences
- Narratives
- Arts-based approaches
  - Photography
  - Music
  - Poetry

? LEARNER ENGAGEMENT QUESTIONS

The following are thought-provoking and engaging learner questions that can be used to further discussions with nursing students regarding crisis intervention. These questions can be used either to stimulate discussion, engage students in critical thinking or be tied to class assignments and/or reflection exercises.

- What makes a crisis? Who defines it?
- What is the relationship between crisis and transition points? Provide examples.
- At what point does a crisis become an emergency? What is the relationship to the Mental Health Act and Legislation?
- What is the relationship between the social determinants of health and crises? See RNAO Social Determinants of Health.
- What would be the issues with developing standardized crisis plans?
- How would you engage in a conversation about crisis prevention and management?
- What happens to your attention span when you are in crisis?
- What are the implications for client care?

- What community resources and options can you offer a client in crisis?
- Should you drive a person who is in crisis?
- What risk assessments might you perform on a client in crisis?
- What opportunities might unfold as a result of a crisis?

EVALUATION AND SELF-REFLECTION

The following tools can be used to evaluate students in their understanding and application of crisis intervention.

- Completed safety and comfort plan—Appendix F
- Test questions
- Ability to perform risk assessments and strengths assessments
- Group assignment to resolve a crisis
- Paper that looks at different theories to crisis
- Completed client debrief post-crisis

SELF-REFLECTION

- Reflect on your own crisis and strategies to prevent/resolve crisis
- Written/in-person debrief after a client has experienced crisis

RESOURCES

- Mental Health Commission of Canada's Mental Health First Aid
- The Wellness Recovery Action Plan®
- Mental Health First Aid (MHCC)
  National Psychological Safety Standards
- Crisis Prevention Institute (and training)
- Prevention and Management of Aggressive Behaviour (PMAB)
- RNAO 2015, Person- and Family- Centred Care. Toronto, ON: Registered Nurses' Association of Ontario.
- RNAO 2006, Crisis Intervention. Toronto, ON. Registered Nurses' Association of Ontario.
- RNAO 2002, Strengthening and Supporting Families through Expected and Unexpected Life Events. Toronto, ON. Registered Nurses' Association of Ontario.

SECTION SIX

Legislation, Ethics and Advocacy in Mental Health and Addiction

Upholding the rights and autonomy of persons with mental health condition and/or addiction is a critical nursing responsibility. This responsibility is integrally tied with ethical nursing practice and advocacy. For this reason, Section six addresses three correlating themes in the CASN/CFMHN (2015) Entry-to-Practice Mental Health and Addiction Competencies.

This section is divided into:

6.1 Legislation and Professional Accountability
6.2 Ethical Practice
6.3 Service to the Public

6.1 Legislation and Professional Accountability

OUTCOMES

PURPOSE

This section supports educators and nurses with the key concepts of mental health and addiction legislation in Canada and how they relate to professional accountability of nurses caring for persons with mental health and addiction across the continuum of care.

OUTCOMES

At the end of this section, the educator will enable the student to achieve the following:

- Understand the importance of mental health and addiction legislation at the provincial/territorial, federal and international level.
- Understand how legislation assists in the assessment, treatment, rehabilitation and recovery of mental illness and addiction in the jurisdiction in which they practice.
- Understand that progressive legislation can be an effective tool to promote access to mental health care.
- Understand the role of advocacy in the care of persons with mental health and addiction.
- Have increased knowledge of the criteria for voluntary and involuntary admission as outlined in their provincial or territorial mental health act.
- Understand stigmatizing and discriminating attitudes regarding mental health conditions and addiction among individuals and health-care professionals and the impact they have.
- Understand the influence of socioeconomic factors (poverty, geographic) on the mental health of Canadians.

CASF/CFMHN COMPETENCIES: 1.1, 1.3, 1.5, 1.6

Legislation and Professional Accountability

Mental health and illness in Canada is greatly influenced by legal factors, among other factors including cultural, environmental, historical, physiological, psychological, spiritual and socioeconomic factors (Kent-Wilkinson, 2015). The impact of the law on individuals can be complex. For example, legislation can have effects related to access to health-care services and treatment for those experiencing mental health and/or addiction issues. Therefore it is imperative that nursing students and nurses understand legislation and their professional accountability when working with clients with mental health, illness and addiction issues.

The fundamental aim of mental health legislation is to protect, promote and improve the lives and mental well-being of citizens (World Health Organization, 2005). In other words, mental health legislation is a human right, and it plays an important role in:

- **Codifying and consolidating mental health human rights;**
- **Protecting the rights of people with mental health conditions; and**
- **Providing a mechanism to ensure adequate and appropriate care.**

Canada, in comparison to many other countries, has comprehensive mental health policy, programs and legislation (Austin & Boyd, 2015). In regards to policy, in 2009, the Mental Health Commission of Canada developed an initial framework for a national mental health strategy, Toward Recovery and Wellbeing (MHCC, 2009). It contends that while appropriate legislation must be in place to protect anyone at risk from people living with mental health problems and illnesses, such legislation also represents power imbalances by providing the ability for care providers to impose safety measures on them, which is the "ultimate in loss of control" (MHCC, 2009, p 30). Therefore, it states a principle of recovery-oriented mental health policy and legislation must be employed.

Across Canada, each province and territory has its own Mental Health Act (see Resources) which greatly impacts the provision of care including treatment decisions and involuntary hospitalizations for individual experiencing mental illness and/or addiction (Gray & O'Reilly, 2001). Mental Health Acts rule over decisions made regarding competence—and the evaluation of competence—and what actions can be taken in cases where a person is ruled not competent. There are differing basic criteria for involuntary admission between provinces. As well, legislation impacts access to care through mechanisms such as consent from substitute decision makers, mandatory outpatient treatment (MOT), court-ordered outpatient treatment for clients who are unlikely to be compliant without a court order, and community treatment orders (CTO), an order issued by a physician and agreed to by the client that allows them to receive care and treatment in their community (Kent-Wilkinison, 2015).

Without an understanding of provincial legislation that governs treatment decisions and involuntary hospitalization, nurses will be unable to adequately care for, or advocate on behalf, of clients with mental illness and addiction. The CFMHN's Canadian Standards for Psychiatric-Mental Health Nursing, 4th edition, (March 2014), establishes the maintenance of quality care and provides

direction for safe, competent, ethical professional practice, which includes standards that nurses have knowledge about relevant legislation and strive towards client and system level advocacy, to improve quality of care and mental health services. These standards also call for the reduction of stigma, and to promote social inclusion and community integration for clients.

For more information, see Resources in this section.

TEACHING AND LEARNING ACTIVITIES

The following are teaching and learning activities that can be employed in the classroom to further support nurses in the integration of theory, principles and best practices related to legislation and professional accountability.

Topics for review in curriculum:

- The purpose of mental health legislation in Canada.
- International Agreements and Canadian Legislation related to addiction and mental disorders.
- The principles for the protection of persons with mental illness and the improvement of mental health care in accordance to legislation.
- The provincial/territorial Mental Health Acts/Mental Health Service Acts in Canada.
- The sections of the Criminal Code of Canada that apply for mental health assessment.
- The Principles of Protections of Persons with a Mental Illness (adopted by the United Nations in 1991).
- The Convention on the Rights of Persons with Disabilities (CRPD).
- The criteria for involuntary care in applicable jurisdiction.

Define and distinguish between the concepts of:

- Examples of stigmatizing, discrimination, and stereotyping attitudes, behaviour and actions.
- Competence evaluation.
- Fitness to stand trial (FST).
- Not criminally responsible due to a mental disorder (NCRMD).
- Mandatory Outpatient Treatment (MOT).
- Community Treatment Orders (CTO).

Discussion topics:

- The right to refuse treatment.
- Human rights, patient/client rights, offender rights, in relation to mental disorders.
- The process of commitment for voluntary and involuntary admission in respective jurisdiction.
- The role of the nurse with respect to advocacy, rights and professional responsibility.
- Nursing orders for the provision of care regarding Nursing Close, Nursing Constant for mental disorders (i.e., Q5, Q15 for suicide or eating disorders).

LEARNER ENGAGEMENT QUESTIONS

The following are thought-provoking and engaging learner questions that can be used to further discussions with nursing students regarding legislation and professional accountability. These questions can be used either to stimulate discussion, engage students in critical thinking or be tied to class assignments and/or reflection exercises.

- How is being unable to access treatment and care an infringement of a person's rights?
- Do all Canadians have access to the same levels of health care (i.e., rural areas, northern communities, isolated communities)?
- When does a person have the right to refuse treatment?
- When can a person be held against his/her will?
- When can the nurse legally hold a patient for mental health assessment?
- How can stigma be a barrier to all aspects of life? Can you think of any stigmatizing behaviours that create barriers to care?
- How would you respond to a patient with an opioid use disorder requesting pain medication post-surgery?

? EVALUATION AND SELF-REFLECTION

The following evaluation methods can be used to evaluate students in their understanding and application of legislation and professional accountability.

- Multiple choice exam questions
- Clinical evaluation
- Self-assessment through reflective writing
- Guided discussion

SELF-REFLECTION

Self-reflection questions: What are your personal attitudes about mental illness and addiction?Have you stereotyped a person in your care? How would you know this and how could you change your behaviour in the future?

RESOURCES

ADVOCACY GROUPS

- Advocacy Groups for Mental Health in Canada—Appendix G

WEBSITES

- Canadian Federation of Mental Health Nurses (2014). Canadian Standards of Psychiatric-Mental Health Nursing
- Government of Canada - Criminal Code of Canada
- United Nations – Convention on the Rights of Persons with Disabilities
- PovNet: Building an online anti-poverty community

MENTAL HEALTH ACTS

- Alberta: Mental Health Act
- British Columbia: Mental Health Act
- Manitoba: Mental Health Act
- New Brunswick: Mental Health Act
- Newfoundland and Labrador: Mental Health Care and Treatment Act
- Northwest Territories: Mental Health Act
- Nova Scotia: Mental Health Act
- Nunavut: Mental Health Act
- Ontario: Mental Health Ac
- Prince Edward Island: Mental Health Act
- Quebec: Mental Patients Protection Act
- Saskatchewan: Mental Health Services Act
- Yukon: Mental Health Act

PROVINCIAL COMMUNITY TREATMENT ORDERS

- British Columbia: Community Treatment Orders
- Alberta: Community Treatment Orders
- Saskatchewan: Community Treatment Order
- Manitoba: Community Treatment Orders
- Ontario: Community Treatment Orders
- New Brunswick: Community Treatment Orders
- Newfoundland and Labrador: Community Treatment Orders
- Nova Scotia: Community Treatment Orders

CANADIAN TEXTBOOKS

Kent-Wilkinson, A. (2015). The context of mental health care: Cultural, socioeconomic, and legal. In W. Austin & M. A. Boyd (Eds.), *Psychiatric & mental health nursing for Canadian practice* (3rd ed., Chapter 3, pp. 25–41). Philadelphia, PA: Wolters Kluwer.

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Rynor, B. (2010). Value of community treatment orders remains at issue. *Canadian Medical Association Journal,* 182(8), E337–E338.

Stanyon, W. (2014). Forensic psychiatric nursing. In M. J. Halter, Varcarolis's *Canadian psychiatric mental health nursing: A clinical approach*. C. L. Pollard, S. L. Ray, & M. Haase (Eds.), (First Canadian ed., chapter 34, pp. 676–685). Toronto, ON: Elsevier Canada.

Srivastava, R. (Ed.) (2007). The healthcare professional's guide to clinical cultural competence. Toronto, ON: Mosby Elsevier.

6.2 Ethical Practice

OUTCOMES

PURPOSE

This section provides educators with knowledge and skills required to support nurses to assist persons with a mental health illness and addiction in making informed decisions about their care and symptom management in an ethical and culturally competent manner.

OUTCOME

At the end of this section, the educator will enable students to achieve the following:

- Have increased knowledge of nursing ethics, including the CNA (2008) Code of Ethics for Registered Nurses.
- Have increased knowledge of cultural competency and cultural safety, and relate the concepts to the role of the nurse.
- Recognize that nurses have a professional ethical responsibility to advocate for persons with mental health and addiction disorders.
- In a clinical setting for students—establish a safe and respectful environment for voluntary and involuntary patients seeking or receiving treatment for a mental illness and addiction; and demonstrate cultural competency and cultural safety.

CASF/CFMHN COMPETENCIES: 4.1, 4.2, 4.3

SEC. 6

Ethical Practice

Every nurse is responsible for upholding ethical practice standards. In Canada, the Canadian Nursing Association's (2008) Code of Ethics for Registered Nurses provides guidance regarding ethical values for nurses and their client's health-care needs. This resource is intended for all context and domains of nursing practice, and is also an excellent resource for nurses working with clients who have mental health or illness conditions and addiction.

Because "the expression of mental illness is heavily determined by culture" (Kent-Wilkinson, 2010, p. 31), it is imperative that nursing students understand and demonstrate cultural competency and cultural safety when caring for individuals with mental illness and addiction. Cultural competency is "the application of knowledge, skills, attitudes and personal attributes required by nurses to provide appropriate care and services in relation to the cultural characteristics of their client" (CNA, 2010, p. 1). Nurses first develop an awareness of one's self and understand that cultural differences exist. It is also important to be aware that one's own culture is not superior to that of others. Nurses caring for people with mental illness with a whole-person and recovery-oriented view must also be willing to learn about other people's cultures, and respect the differences in culture and be willing to incorporate that knowledge into practice and educational curricula (Kent-Wilkinson, 2015).

Due to the complex nature of mental illness, nurses may face ethical dilemmas when working with this population, such as issues relating to client autonomy and restraint. Nursing students need to be well-prepared for a variety of ethical dilemmas, including voluntary and involuntary care, that will arise when working with people with mental illness and addiction. They should be taught the skills and knowledge to proactively and reactively manage the unpredictable.

For more information, see Resources in this section.

TEACHING AND LEARNING ACTIVITIES

The following are teaching and learning activities that can be employed in the classroom to further support nurses in the integration of theory, principles and best practices related to ethical practice.

- Review the CNA Code of Ethics (2008) and local College of Nurses documents pertaining to ethics
- Define culture competency and cultural safety
- Facilitate group discussion using questions such as:
  - What does the nurse do and at what point does the nurse have an obligation to do regarding (insert particular situation)?
  - Bathing/hygiene: what is the importance of bathing and the patients' rights to make choice and decision regarding bathing?
  - Eating: what's the importance of eating disorders and refusing right to eat?
- Guest lecturer—person with lived experience (Appendix H), and Rights Advisors
- Case studies—Section 9.3
- Practice application
- Review Safewards by Len Bowers

? LEARNER ENGAGEMENT QUESTIONS

The following are thought-provoking and engaging learner questions that can be used to further discussions with nursing students regarding ethical practice. These questions can be used either to stimulate discussion, engage students in critical thinking or be tied to class assignments and/or reflection exercises.

- How can nurses become more culturally competent?
- How would you balance off rights and laws/legal obligation?

- Does addiction cause mental illness?
- What is the relationship between mental health and addiction?
- When is the use of coercion ever okay (e.g., medication, hunger strikes passes, bathing, eating, etc.)?
- What does the nurse do when patients refuse to bath, eat, or take their medication?
- How can the nurse engage clients therapeutically?
- How does this link back to assessments (i.e., risk and strengths and health head to toe)?

EVALUATION AND SELF-REFLECTION

The following tools can be used to evaluate students in their understanding and application of therapeutic relationships.

- Clinical evaluation
- Guided discussion
- Presentation

SELF-REFLECTION

Self-reflection questions include:

- What are your thoughts regarding self-disclosure of addiction or mental illness in clinical practice? In school?
- When is it appropriate to self-disclose? When is it inappropriate?
- What are your personal beliefs about addiction, substance use and how it affects mental wellness or mental illness?
- How do you apply the Code of Ethics in your practice?
- Do you think you are culturally aware?
- How much of your cultural awareness is based on stereotyping, influence from media or personal experience?

RESOURCES

WEBSITES

- Canadian Nursing Association's (2008) Code of Ethics
- College of Nurses of Ontario Ethics (2009)
- Aboriginal Nurses Association of Canada, Canadian Association of Schools of Nursing, & Canadian Nurses Association. (2009). Cultural competence and cultural safety in nursing education. Ottawa, ON: ANAC.
- Canadian Nurses Association. (2010). *Cultural Competence Position Statement*. Retrieved from: https://www.cna-aiic.ca/en/advocacy/policy-support-tools/cna-position-statements
- Canadian Nurses Association. (2004). *Promoting Continuing Competence for Registered Nurses*. Retrieved from: https://www.cna-aiic.ca/en/advocacy/policy-support-tools/cna-position-statements reference
- Kent-Wilkinson, A., Blaney, L., Groening, M., Santa Mina, E., Rodrigue, C., & Hust, C. (2016). CFMHN's 3rd position paper 2016: *Mental health and addiction curriculum in undergraduate nursing education in Canada*. Prepared by members of the Canadian Federation of Mental Health Nurses' Education Committee. Toronto, ON: CFMHN.

FILM

The following films demonstrate ethical dilemmas that can be used to educate nursing students regarding ethics. Consider using the self-reflection questions to highlight themes that can be found in the films listed below.

- *Blue Jasmine (2013).* Cate Blanchett plays Jasmine, a rich socialite who's life falls apart when her husband Hal dies and she is left destitute.
- *Fisher King (1991)* Robin Williams plays Parry, a teacher who becomes mentally ill after he witnesses his wife being killed in a restaurant massacre. Unable to recuperate from the tragic incident, Perry becomes a deluded homeless man. He believes that he is a knight sent by God on a sacred quest.
- *28 Days (2000)* Sandra Bullock plays Gwen Cummings, a newspaper columnist obliged to enter rehabilitation for alcoholism.

CANADIAN TEXTBOOKS

Austin & Boyd (Eds) (2015) Psychiatric & Mental Health Nursing for Canadian Practice (Third Canadian Edition).

- Chapter 3: Kent-Wilkinson (2015) The Context of Mental Health Care: Cultural, Socio-economical and Legal.
- Chapter 7: Austin (2015). Ethical Psychiatric and Mental Health Nursing Practice.

Halter (2014) Varcaroli's Canadian Psychiatric Mental Health Nursing: A Clinical Approach (First Canadian Edition).

- Chapter 7: Mordoch. (2014)Cultural implications for psychiatric mental health nursing.
- Chapter 8: Pollard (2014)Ethical Responsibilities and Legal Obligations for psychiatric mental Health Nursing Practice.

REFERENCE MATERIALS

Baba, L. (2013). *Cultural safety in First Nations, Inuit and Métis public health: Environmental scan of cultural competency and safety in education, training and health services.* Prince George, BC: National Collaborating Centre for Aboriginal Health.

Browne, A. J., Varcoe, C., Smye, V., Reimer-Kirkham, S., Lynam, M. J., & Wong, S. (2009). Cultural safety and the challenges of translating critically oriented knowledge in practice. *Nursing Philosophy*, 10(3), 167–179.

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6.3 Service to the Public

OUTCOMES

PURPOSE

This section provides educators with the knowledge and skills about educating and supporting nurses to be able to work collaboratively with government, organizations, and other public community stakeholders to promote mental illness and addiction advocate for improvements in health services for persons experiencing a mental health condition and/or addiction.

OUTCOME

At the end of this section, the educator will enable students to achieve the following:

- Apply knowledge of the health-care system in order to contribute to the improvement of mental health and addiction services.
- Recognize the impact of the organizational culture on the provision of mental health care to persons experiencing mental health conditions and addiction, and act to ensure appropriate services are delivered safely.
- Define the terms: collaborative, inter- and intra-professional, and inter-sectoral practice.
- Engage in collaborative, inter and intra-professional, and intersectoral practice when providing care for persons with mental health conditions and addiction.

CASF/CFMHN COMPETENCIES: 5.1, 5.2, 5.3

Service to the public

According to the WHO, "Advocacy is an important means of raising awareness on mental health issues and ensuring that mental health is on the national agenda of governments. Advocacy can lead to improvements in policy, legislation and service development" (WHO, 2003, p. 1). Every nurse has the opportunity—and professional ethical responsibility—to advocate for improvements and advancements in health care for persons with mental health, illness and addiction.

Ensuring future nurses have knowledge of mental health legislation, and the health-care system, is vital to identifying improvements and strengthening mental health and addiction services. However, in order to advocate for change, it is also necessary to understand political and organizational culture, and its impact on the provisions of care. Establishing and maintaining collaborative processes within inter- and intra-professional practice teams, understanding person-centred care and leadership is important when caring for clients with complex mental health and addiction conditions (RNAO, 2006a). For more information, see Resources in this section.

TEACHING AND LEARNING ACTIVITIES

The following are teaching and learning activities that can be employed in the classroom to further support nurses in the integration of theory, principles and best practices related to service to the public.

- Define the terms: collaborative, inter and intra-professional, and inter-sectoral practice
- Identify local systems (child welfare, criminal justice system, mental health system, social service, housing programs, methadone clinics, community treatment providers, and addiction treatment centres, police services, mental health courts, diversion services etc.)
- Reflect on organizational culture through guided discussion
- Discuss the following:
  - Legal implication of persons with mental disorders charged under the Criminal Code of Canada;
  - The role and responsibility of the Substitute Decision Maker;
  - Collaboration and communication between the person with a mental health condition and addiction condition, their family, the health care system and the nurse; and
  - The role of Mental Health Advocate.
- Schedule tours of psychiatric facilities, addiction treatment centres, community clinics and local street level centres such as shelters, correctional facilities
- Mapping local systems such as services, facilities and treatment centres

? LEARNER ENGAGEMENT QUESTIONS

The following are thought-provoking and engaging learner questions that can be used to further discussions with nursing students regarding service to the public. These questions can be used either to stimulate discussion, engage students in critical thinking or be tied to class assignments and reflection exercises.

- Where are the mental health and addiction services in your city/province?
- Can you identify a local advocacy group for mental health/illness awareness?
- How can nurses advocate for persons with mental illness outside of the psychiatric ward?

EVALUATION

The following tools can be used to evaluate students in their understanding and application of service to the public.

- Guided discussion
- Presentation (about an advocacy group)

RESOURCES

CANADIAN TEXTBOOKS

Austin & Boyd (Eds) (2015) Psychiatric & Mental Health Nursing for Canadian Practice (Third Canadian Edition).

- Chapter 3: Kent-Wilkinson (2015)The Context of Mental Health Care: Cultural, Socio-economical and Legal.

Halter (2014) Varcaroli's Canadian Psychiatric Mental Health Nursing: A Clinical Approach (First Canadian Edition).

- Chapter 8: Pollard (2014) Ethical Responsibilities and Legal Obligations for psychiatric mental Health Nursing Practice.

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SECTION SEVEN

Clinical Placements and Simulations in Mental Health and Addiction Nursing Education

7.1 Clinical Placements

PURPOSE

To provide educators with information about best practice related to mental health and addiction clinical and simulation learning modalities.

OUTCOMES

OUTCOMES

At the end of this section, educators will:

- Understand the importance of clinical placements and simulation in undergraduate mental health education and how to most effectively use them.
- Understand how to consolidate classroom learning through clinical placements and simulation.
- Ensure the practice experience supports the learning objectives.
- Develop collaborative partnerships between health-care organizations and colleges/universities.
- Consider and explore the use of co-creating learning objectives where possible.

CASF/CFMHN COMPETENCIES

This sections supports the integration of the competencies and indicators through the use of clinical placements and simulation but does not teach specifically to a particular competency or indicator. Specific competencies which may be developed include:

1.1, 1.2, 1.3, 1.4, 1.6, 2.7, 2.8, 2.9, 2.10, 2.11, 2.12, 3.1, 3.2, 3.3, 3.5, 3.6, 3.7, 3.8, 4.1, 4.2, 4.3, 5.3, 6.1, 6.2, 6.3, 6.4, 6.5

SEC. 7

Clinical learning experience in nursing education provides students the opportunity to consolidate theory and practice together. It is through clinical placements that nursing students develop and refine their skills in therapeutic relationship, person and family-centred nursing care, among other foundations learned in nursing school.

Mental health and psychiatric nursing clinical placements among undergraduate nursing students have been successful in generating interest in this area (O'Brien, Buxton & Gillies, 2008). Studies regarding clinical learning have demonstrated that student satisfaction with mental health content is positively correlated to performance, as well as to a correlation between clinical placement in

mental health and interest post graduation in working in mental health (Spence, 2012 & Happell, Moxham & Platania-Phung, 2009). However the current challenge with securing clinical mental health and addiction placements presents a gap in placement opportunities in acute care inpatient psychiatric settings, according to the 3rd position paper 2016: Mental health and addiction curriculum in undergraduate nursing education in Canada (CFMHN, 2016).

Educators must recognize the diversity of placement opportunities, and understand that other placement settings can provide mental health and addiction experiences. Diverse placement settings to consider include mental health outpatient clinics, schools, addiction centres, senior centres, forensic psychiatry, corrections, shelters, primary care, public health units among others (CFMHN, 2016). If selecting non-traditional placement settings, it is imperative that educators consider the compatibility of the placement site with the learning objectives.

Planning for clinical placements

There are a number of factors to consider when planning a clinical placement for students. CASN, with the input of nursing educators from across Canada, has developed recommendations for clinical placements and simulation. The framework for these recommendations is applied here.

Many of the concepts in the content below can be demonstrated in the placements such as community, med surgical, acute care etc.

Timing and length of mental health and/or addiction practice experience

The following themes were identified in the literature with regards to timing and length of mental health and addiction clinical practice.

1. **Theory preparation prior to placement.**
   Prior to clinic placement, it is important for nursing students to have some theoretical preparation to support implementation of evidence-based practice. For example, nursing students should receive some theory related to medication administration and be knowledgeable of the concepts of compliance and adherence, and be comfortable with the pharmacokinetics of psychiatric medications before administering medications in a clinical setting.

2. **Length of placement.**
   The length of the placement should be sufficient to meet the learning objectives, e.g., traditional length placement (Fiedler, Breitenstein & Delaney, 2012); and short, intensive placement (Tratnack, O'Neil, & Graham, 2011). The CFMHN recommends a stand-alone course in psychiatric/mental health and a dedicated clinical placement in a psychiatric setting (CFMHN, 2016; Happell, Gaskin, Byrne & Welch, 2015).

Selection of the placement (psychiatric placements versus mental health)

The literature demonstrates positive outcomes related to reduction in stigma and fear when students are provided opportunities to interact with clients who experience mental illness and/or addiction, across all settings including psychiatric settings. Students who interact with these clients report less fear and stigma towards their patients. Outcomes related to placements in mental health and addiction placements include the following:

- Improved attitudes towards patients with mental illness;
- Increased confidence in caring for people with mental illness/mental health concerns;
- Increased understanding of psychiatric nursing;
- Safe medication administration;
- Improved therapeutic communication;
- Improved assessment skills; and
- Increased use of holistic approaches to care.

While the literature does stipulate that placements in psychiatric settings are ideal in reducing stigma and fear, educators must be cognizant of the challenges and gaps associated with securing such placements. In such, educators must recognize the diversity of placement opportunities, and understand that other placement settings can provide mental health and addiction experiences (CFMHN, 2016).

Source: Chadwick & Porter, 2014; Tratnack, O'Neill, & Graham, 2011; Henderson, Happell, & Martin, 2007, Happell & Platania-Phung, 2012; Happell, Gaskin, Byrne & Welch, 2015

Quality of instruction

Collaboration between clinical instructors, simulation coordinators and faculty members who teach mental health theory courses improves consolidation of learning. As clinical instructors and preceptors play an important role in changing students' attitudes towards mental health psychiatric nursing, clinical instructors and preceptors should have experience in psychiatric mental health nursing where possible.

Furthermore, preceptors should:

- Encourage diverse learning experiences;
- Help identify transferable skills;
- Foster a positive image of mental health nursing;
- Have regular contact with students; and
- Give consistent and regular feedback.

Student and preceptor difficulties arise when preceptors:

- Don't understand their role;
- Have unrealistic expectations of the student;
- Have heavy work loads that limit their ability/time to interact with students; and
- Have negative attitudes to mental health/psychiatric nursing.

Source: O'Brien et al., Oudshoorn & Sinclair, 2015; Charleston & Happell2 005, 2006; Cleary, Horsfall, & De Carlo, 2006.

Such obstacles provide challenges to student placements and can also create negative perceptions, attitudes and stigma among nursing students.

Pedagogical Process

When engaging students in mental health and/or addiction placements, it is important that the placement includes an orientation, daily pre-conferences, daily-conferences and critical reflection/reflective practice. The following describes the processes.

Orientation

A well thought out orientation promotes a positive student placement.

- Include orientation of the unit or site prior to the placement.
- Include a review of learning objectives.

Daily pre-conferences

- Ensure that students are prepared for their patient/client assignments.
- Highlight potential learning experiences that students may be able to engage in that day.
- Address student concerns.

Daily post-conference

- Reflect on clinical experiences.
- Engage in further learning.
- Share experiences among students.

Critical incidents

- Students should be debriefed according to workplace policy.

Reflective practice

- See Section Four: Student Reflective practice and Self-Care in Mental Health Nursing Education

Source: Woodley, 2015; Ganzer & Zauderer, 2013; O'Brien, 2008; Oudshoorn & Sinclair, 2015

Other important clinical placement considerations include:

- Ensuring the practice experience supports the learning objectives (Medley & Horne, 2005; Seropian et al., 2004);
- Facilitators play an integral role in student learning; and
- Efforts should be made to develop collaborative partnerships between health-care organizations and colleges/universities; consider the use of co-creating learning objectives where possible.

For more information, see Resources in this section.

7.2 Simulation

According to the CASN's *Practice Domain for Baccalaureate Nursing Education: Guidelines for Clinical Placements and Simulations* (2015), the challenge of securing clinical placements for students has driven a search for alternative strategies for practice experiences. Placements have become wide-ranging (Smith, Corso & Cobb, 2010), and simulation is being increasingly used to prepare students for practice. Some educators see simulation as valuable learning opportunities that are complementary to clinical placements, others have introduced it as a substitute.

"While both clinical placements and simulation provide opportunities for students to develop practice outcome expectations, there are some important differences in the practice experiences they offer. As a result, there are also some differences in the nature of the learning they foster" (CASN, 2015, p. 9). Students in clinical placements can experience unplanned, unpredicted and uncontrolled events that can provide teachable moments. This is helpful for experiencing real-life scenarios; whereas in a controlled simulation nurses can make mistakes without real-life consequences and learn from them. The expert panel recommends that simulation should be used to augment clinical placement opportunities and not replace them.

A useful tool that shows how the differences between the experiences offered by simulation and by clinical placements affect the nature of the learning they foster can be found in the CASN's Guidelines for Clinical Placements and Simulations (2015), Table 3.

Simulations in Mental Health, Illness and Addiction Practice

Students should have some foundational theory based concepts prior to engaging in a simulation experience. The length of the simulation is directly related to the type of simulation and the learning objectives. The following demonstrates the type of simulations, factors to be considered and proficiency of instructors in simulation and pedagogy approaches that can be used.

Selection of the simulation

There are three major levels of simulation fidelity: low, medium and high.

- Low fidelity—used to practice psychomotor skills, e.g., a foam pad simulator used to practice intramuscular injections.
- Medium fidelity—more closely resembles reality and can be used to provide more in-depth learning opportunities, e.g., perfecting an understanding of heart sounds.
- High fidelity—sophisticated and mimics real life, e.g., computer or instructor controlled mannequins.

When using simulation, the following factors should be considered:

- Live actors should be used when possible in place of mannequins;
- Caution against student role-playing that can reinforce pre-existing stigma;
- Consider the use of multiple simulations that increase in complexity; and
- Simulation doesn't have to be expensive to be effective.

Simulation experiences are valuable learning opportunities for students that can help to consolidate their learning. It is important for educators to remember that simulation is not a replacement to clinical practice, however provides a resource to augment theory into the practice environment (RNAO, 2016e). Educators should determine compatibility and select the level of simulation in accordance with the learning objectives for nursing students. Educators may also consider the use of co-creating learning objectives, wherever possible to provide students the opportunity to identify their learning needs. It is also imperative that students are taught the fundamental basics/concepts prior to engagement in a simulation experience.

Quality of instruction

Collaboration between clinical instructors, simulation coordinators and faculty members who teach mental health theory courses improves consolidation of learning. Instructors should be comfortable and proficient with the types of simulation or technology being used. In addition to having knowledge of the learning outcomes, they should have the mental health knowledge and skills needed to integrate theory and practice and debrief with students.

Source: Happell, Gaskin, Byrne & Welch, 2015; Oudshoorn & Sinclair, 2015; RNAO, 2016

Pedagogical Process

When engaging students in clinical mental health and/or addiction simulations, it is important that the placement includes a pre-briefing, the simulation and debriefing opportunities (Jeffries, 2005). The following describes the elements included in each of the stages of pre-briefing, simulation and debriefing.

Pre-briefing

- Familiarize students with the technology and equipment.
- Discuss the learning objectives, participant roles, and details surrounding the simulation scenario.

Actual simulation scenario

- Students work together in teams and actively participate in the decision-making processes related to the nursing care in the simulated clinical situation.

Debriefing

- Time is dedicated toward group discussion, feedback and integrated learning.
- Debriefing is an activity that aims to strengthen the positive aspects of the experience and promotes reflective student learning.

For more information, see Resources in this section.

TEACHING AND LEARNING ACTIVITIES

Refer to respective sections throughout this guide for teaching and learning activities that can be employed in simulation to further support nurses in mental health and addiction knowledge and skill development.

RESOURCES

TOOLS

Forchuk, C.& Vingilis, E. (2008). Health Canada's Inter-Professional Education for Collaborative Patient-Centred: Practice Strategy Creating Interprofessional Collaborative Teams for Comprehensive Mental Health Services. Retrieved from: http://www.hc-sc.gc.ca/hcs-sss/pubs/hhrhs/2006-iecps-fipccp-workatel/index-eng.php

CASE STUDIES USEFUL FOR SIMULATION:

St Johns of God Health Care (2010). Mental Health Clinical Education Toolkit case studies. Retrieved from: http://www.sjog.org.au/careers/mental_health_simulation/case_studies.aspx

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WEBSITES WITH RESOURCES

Clinical Teaching in Mental Health
https://lyonpaul.wordpress.com/about/

SIM ONE: provides simulation training and certification
http://www.sim-one.ca/

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SECTION EIGHT

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8.2 Bibliography

The expert panel has compiled a list of resources and websites that may be helpful related to mental health, illness and addiction. This list is not exhaustive.

Links to websites that are external to RNAO are provided for information purposes only. The RNAO is not responsible for the quality, accuracy, reliability, or currency of the information provided through these sources. Further, the RNAO has not determined the extent to which these resources have been evaluated. Questions related to these resources should be directed to the source.

A

Aboriginal Mental Health

Douglas, V. (2013). Introduction to Aboriginal health and health care in Canada: Bridging health and healing. New York, NY: Springer Publishing Company.

Government of Canada. (1982). Rights of Aboriginal peoples of Canada. Canada's Constitution Act, 1982. Ottawa, ON: Author. Retrieved from http://laws-lois.justice.gc.ca/eng/const/page-16.html

Health Canada. (2015). First Nations and Inuit health: Mental health and wellness. Retrieved from http://www.hc-sc.gc.ca/fniah-spnia/promotion/mental/index-eng.php

Abuse (Interpersonal Violence, Child, Older Adult and Intimate Partner Abuse)

McCay, E.A. (2015). Care of persons with a history of abuse. In W. Austin & M. A. Boyd (Eds.), Psychiatric & mental health nursing for Canadian practice (2nd ed., Chapter 37, pp. 853– 890). Philadelphia, PA: Wolters Kluwer.

Sateren, J. & Carson, V. B. (2014). Interpersonal violence, child, older adult and intimate partner abuse. Adapted by S. L. Ray. In M. J. Halter, *Varcarolis's Canadian psychiatric mental health nursing: A clinical approach*. C. L. Pollard, S. L. Ray, & M. Haase (Eds.), (First Canadian ed., chapter 27, pp. 543–569). Toronto, ON: Elsevier Canada.

Acute Care Settings (see also comorbid)

Cirpili, A., & Swisher, M. (2014). Psychiatric mental health care in acute care settings. Adapted by K. Clements. In M. J. Halter, *Varcarolis's Canadian psychiatric mental health nursing: A clinical approach*. C. L. Pollard, S. L. Ray, & M. Haase (Eds.), (First Canadian ed., Chapter 5, pp. 74–84). Toronto, ON: Elsevier Canada.

Addiction (Substance Use)

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Angres, D. H., & Bettinardi-Angres, K. (2008). The disease of addiction: Origins, treatment, and recovery. Dis Mon, 54(10), 696–721.

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Kunyk, D., & Els, C. (2015). Substance-related and addictive disorders. In W. Austin & M. A. Boyd (Eds.), *Psychiatric & mental health nursing for Canadian practice* (3rd ed., Chapter 26, pp. 572–604). Philadelphia, PA: Wolters Kluwer.

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Adolescents and Children

Erwin, E. H., & Colson, C. W. (2014). Disorders of children and adolescents. Adapted by R. J. Meadus. In M. J. Halter, *Varcarolis's Canadian psychiatric mental health nursing: A clinical approach*. C. L. Pollard, S. L. Ray, & M. Haase (Eds.), (First Canadian ed., chapter 29, pp. 586–612). Toronto, ON: Elsevier Canada.

Faulkner-Gibson, L., & Wong, K. (2015). Mental health promotion with children and adolescents. In W. Austin & M. Boyd (Eds.), *Psychiatric & mental health nursing for Canadian practice* (3rd ed., Chapter 29, pp. 668–690). Philadelphia, PA: Wolters Kluwer.

Faulkner-Gibson, L., & Wong, K. (2015). Mental health assessment of children and adolescents. In W. Austin & M. A. Boyd (Eds.), *Psychiatric & mental health nursing for Canadian practice* (3rd ed., Chapter 30, pp. 691–717). Philadelphia, PA: Wolters Kluwer.

Faulkner-Gibson, L., Wong, K., & Austin, W. (2015). Psychiatric disorders diagnosed in children and adolescents. In W. Austin & M. A. Boyd (Eds.), *Psychiatric & mental health nursing for Canadian practice* (3rd ed., Chapter 31, pp. 718–751). Philadelphia, PA: Wolters Kluwer.

Advocacy

Schizophrenia Society of Canada. (2016). Advocacy. Retrieved from http://www.schizophrenia.ca/advocacy.php

World Health Organization. (2003). Advocacy for mental health, Mental Health Policy and Service Guidance Package. Retrieved from http://www.who.int/mental_health/resources/en/Advocacy.pdf

Advocacy Groups for Mental Health in Canada

Canadian Alliance on Mental Illness and Mental Health (CAMIMH)

The Canadian Alliance on Mental Illness and Mental Health (CAMIMH) is Canada's largest mental health advocacy group. It is an alliance of mental health organizations comprised of health care providers as well as of the mentally ill and their families.

Canadian Mental Health Association (CMHA)

The Canadian Mental Health Association (CMHA) is a national voluntary organization that promotes mental health and serves consumers and others through education, public awareness, research, advocacy, and direct services.

Disability Rights International (DRI)
Disability Rights International (DRI) is an advocacy organization dedicated to the recognition and enforcement of rights of people with mental disabilities.

Mental Health Commission of Canada (MHCC)
The Mental Health Commission of Canada (MHCC) is a non-profit organization created to focus national attention on mental health issues, to work to improve the mental health of Canadians, and to reduce the stigma associated with this disease.

Schizophrenia Society of Canada
This toolkit provides support and basis information regarding core concepts of advocacy and working with the media. It provides practical steps that are required by people living with mental illness, caregivers and supporters to start advocating (SSC, 2007).

World Federation for Mental Health (WFMH)
The World Federation for Mental Health (WFMH) is the only international, multidisciplinary, grassroots advocacy and education mental health organization.

World Health Organization (WHO)
The World Health Organization (WHO) is the United Nations agency for health. The objective set out in its constitution is the attainment, by all peoples, of the highest possible level of health.

Aging

Moore, S. (2015). Mental health promotion with older persons. In W. Austin & M. A. Boyd (Eds.), *Psychiatric & mental health nursing for Canadian practice* (3rd ed., Chapter 32, pp. 752–764). Philadelphia, PA: Wolters Kluwer.

Moore, S. (2015). Mental health assessment of older persons. In W. Austin & M. A. Boyd (Eds.), *Psychiatric & mental health nursing for Canadian practice* (3rd ed., Chapter 33, pp. 765–779). Philadelphia, PA: Wolters Kluwer.

Anger, Aggression and Violence

Hull, M. B. (2014). Anger, aggression and violence. In M. J. Halter, *Varcarolis's Canadian psychiatric mental health nursing: A clinical approach*. C. L. Pollard, S. L. Ray, & M. Haase (Eds.), (First Canadian ed., Chapter 26, pp. 526–542). Toronto, ON: Elsevier Canada.

Savard, Y. (2015). Anger, aggression and violence. In W. Austin & M. A. Boyd (Eds.), *Psychiatric & mental health nursing for Canadian practice* (3rd ed., Chapter 18, pp. 317– 339). Philadelphia, PA: Wolters Kluwer.

Anxiety Disorders and Obsessive-Compulsive Disorders

Halter, M. J., Varcarolis, E. M., & Shoemaker, N. C. (2014). Anxiety, obsessive compulsive, and related disorders. Adapted by M. Haase & S.L. Ray. In M. J. Halter, *Varcarolis's Canadian psychiatric mental health nursing: A clinical approach.* C. L. Pollard, S. L. Ray, & M. Haase (Eds.), (First Canadian ed., Chapter 13, pp. 199–130). Toronto, ON: Elsevier Canada.

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Assessment

Austin, W., & Boyd, M. A. (Eds.). (2015). Abnormal Involuntary Movement Scale (AIMS). In W. Austin & M. A. Boyd (Eds.), *Psychiatric & mental health nursing for Canadian practice* (3rd ed., appendix C, pp. 910–911). Philadelphia, PA: Wolters Kluwer.

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B

Best Practice Guidelines (BPG)

Registered Nurses' Association of Ontario. (2002). *Crisis Intervention*. Toronto, ON: Author.

Registered Nurses' Association of Ontario. (2002). *Supporting and Strengthening Families Through Expected and Unexpected Life Events*. Toronto, ON: Author.

Registered Nurses' Association of Ontario. (2009). *Supporting Clients on Methadone Maintenance Treatment*. Toronto, ON: Author.

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Biologic

Creamer, A. M. (2015). Biologic basic of practice. In W. Austin & M. A. Boyd (Eds.), *Psychiatric & mental health nursing for Canadian practice* (3rd ed., Chapter 9, pp. 114–145). Philadelphia, PA: Wolters Kluwer.

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Bipolar Disorders

See Mood Disorders (Bipolar Disorders)

C

Canadian Textbooks on Mental Health & Addiction

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Medical

See Biologic

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See Education (Mental Health Nursing)

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Nursing Diagnosis

See Diagnostics

Nursing Education (Mental Health)

See Education (Mental Health Nursing)

O

Obsessive-Compulsive Disorders

See Anxiety Disorders (and Obsessive-Compulsive Disorders)

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Stress

See Trauma and Stressor-Related Disorders

Substance Abuse/Use/Dependence

See Addiction(s)

Suicide

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Trauma and Stressor-Related Disorders

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V

Violence

See Anger, Aggression and Violence

W

Workplace Safety /Mental Health

Austin, W. (2015). Psychological health and safety in the workplace. In W. Austin & M. A. Boyd (Eds.), *Psychiatric & mental health nursing for Canadian practice* (3rd ed., Chapter 16, pp. 275–286). Philadelphia, PA: Wolters Kluwer.

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SECTION NINE

Appendices and Case Studies

9.1 Appendices

Appendix A: Alignment between CASN/CFMHN Entry-to-Practice Mental Health and Addiction Competencies and sections in the Nurse Educator Mental Health and Addiction Resource

Appendix B: Process Recording

Appendix C: Criteria for Validation: Process Recording

Appendix D: Criteria for Phase of Relationship: Process Recording

Appendix E: Journaling Activity

Appendix F: Crisis/Safety Plan Template Model

Appendix G: Advocacy Groups for Mental Health in Canada

Appendix H: Engaging Lived Experience Tips

9.2 Glossary of Terms

9.3 Case Studies

Appendix A: Alignment between CASN/CFMHN Entry-to-Practice Mental Health and Addiction Competencies (2015) and sections in the Nurse Educator Mental Health and Addiction Resource

Every effort was made to develop educational content and tools that would support the CASN/CFMHN (2015) competencies in mental health and addiction. The following table shows how each section of the guide aligns with various competencies.

DOMAIN	CASN/ CFMHN (2015) ENTRY-TO-PRACTICE MENTAL HEALTH AND ADDICTION COMPETENCY	ALIGNMENT WITH NURSE EDUCATOR MENTAL HEALTH AND ADDICTION RESOURCE
Professional Responsibility and Accountability	**1.0** The nurse provides care in accordance with professional and regulatory standards when promoting mental health and preventing or managing mental health conditions and/or addiction.	**Section Three:** Faculty Teaching Modalities and Reflective Practice **Section Four:** Student Reflective Practice and Self-Care in Mental Health and Addiction Nursing **Section Six:** Legislation, Ethics and Advocacy in Mental Health and Addiction Nursing **Section Seven:** Clinical Placements and Simulations in Mental Health and Addiction Nursing
Knowledge-based Practice	**2.0** The nurse uses relational practices to conduct a person-focused mental health assessment, and develops a plan of care in collaboration with the person, family, and health team to promote recovery.	**Section Three:** Faculty Teaching Modalities and Reflective Practice **Section Five:** Foundational Concepts in Mental Health and Addiction Learning Advancement **Section Seven:** Clinical Placements and Simulations in Mental Health and Addiction Nursing
Knowledge-based Practice	**3.0** Provides and evaluates person-centred nursing care in partnership with persons experiencing a mental health condition and/or addiction, along the continuum of care and across the lifespan.	**Section Five:** Foundational Concepts in Mental Health and Addiction Learning Advancement **Section Seven:** Clinical Placements and Simulations in Mental Health and Addiction Nursing

Ethical Practice	**4.0** Acts in accordance with the CNA Code of Ethics when working with persons experiencing a mental health condition and/or addiction.	**Section Five:** Foundational Concepts in Mental Health and Addiction Learning Advancement **Section Six:** Legislation, Ethics and Advocacy in Mental Health and Addiction Nursing **Section Seven:** Clinical Placements and Simulations in Mental Health and Addiction Nursing
Service to the Public	**5.0** The nurse works collaboratively with partners to promote mental health and advocate for improvements in health services for persons experiencing a mental health condition and/or addiction.	**Section Six:** Legislation, Ethics and Advocacy in Mental Health and Addiction Nursing **Section Seven:** Clinical Placements and Simulations in Mental Health and Addiction Nursing
Self-regulation	**6.0** Develops and maintains competencies through self-reflection and new opportunities working with persons experiencing a mental health condition and/or addiction.	**Section Three:** Faculty Teaching Modalities and Reflective Practice **Section Four:** Student Reflective Practice and Self-Care in Mental Health and Addiction Nursing **Section Seven:** Clinical Placements and Simulations in Mental Health and Addiction Nursing

APPENDIX B

Process Recording

Process recording. (2016). In C. Forchuk, *Arthur Labatt Family School of Nursing course work*. London, ON: University of Western Ontario. Adapted with permission.

Student name: **Student number:** **Date:**

Context: (Describe what was happening prior to meeting, context, and briefly describe patient.)

PATIENT: VERBAL & (NON-VERBAL)	STUDENT NURSE: VERBAL & (NON-VERBAL)	THOUGHTS AND FEELINGS AT THE TIME	ANALYSIS

NOTE: Make additional copies of this page.

Appendix C

Criteria for Validation: Process Recording

Criteria for validation: Process recording. (2016). In C. *Forchuk, Arthur Labatt Family School of Nursing course work. London*, ON: University of Western Ontario. Adapted with permission

Student name: **Student number:** **Date:**

1) Context clearly and succinctly described.

0 **Information vague and unclear**	1	2	3	4	**5** **Context clearly and succinctly described**

2) Client: Verbal and non-verbal behaviour observed and clearly identified.

0 **Information vague and unclear**	1	2	3	4	**5** **Both verbal and non-verbal behaviour clearly identified**

3) Student Nurse: Verbal and non-verbal behavior observed and clearly identified.

0 **Information vague and unclear**	1	2	3	4	**5** **Both verbal and non-verbal behaviour clearly identified**

4) Awareness of thoughts and feelings demonstrated on form.

0 **Aware of only concrete, obvious thoughts and feelings**	1	2	3	4	**5** **Great insight into own thoughts and feelings**

5) Includes consistent, appropriate use of "I" statements.

0 **Consistently uses second or third person in speech without referring to self**	1	2	3	4	**5** **Clearly and consistently uses "I" statements, identifies own thoughts, feelings to patient as appropriate**

6) Student nurse seeks validation of own observations and conclusions.

0 **Appears to use assumptions rather than validation**	1	2	3	4	**5** **Clear, consistent and appropriate use of validation**

7) i.) Student nurse is able to analyze the interaction.

0 **Patient behaviour not analyzed**	1	2	3	4	**5** **Patient behaviour insightfully analyzed**

7) ii.) Student nurse is able to analyze the interaction.

0 **Own behaviour not analyzed**	1	2	3	4	**5** **Own behaviour insightfully analyzed**

8) Overall, the process recording reflects a sound understanding of Orlando's process of validation.

0 **Appears to have no understanding of process**	1	2	3	4	**5** **Exceptional grasp of process**

Comments:

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APPENDIX D

Criteria for Phase of Relationship: Process Recording

Criteria for phase of relationship: Process recording. (2016). In C. Forchuk, *Arthur Labatt Family School of Nursing course work*. London, ON: University of Western Ontario. Adapted with permission

Student name: **Student number:** **Date:**

1) Context clearly and succinctly described.

0 **Information vague and unclear**	1	2	3	4	**5** **Context clearly and succinctly described**

2) Client: Verbal and non-verbal behaviour observed and clearly identified.

0 **Information vague and unclear**	1	2	3	4	**5** **Both verbal and non-verbal behaviour clearly identified**

3) Student Nurse: Verbal and non-verbal behaviour observed and clearly identified.

0 **Information vague and unclear**	1	2	3	4	**5** **Both verbal and non-verbal behaviour clearly identified**

4) i) Indicators of Phase of Relationship clearly identified.

0 **Indicators re: patient behaviour are consistently missed**	1	2	3	4	5 Indicators re: patient behaviour clearly identified

4) ii) Indicators of Phase of Relationship clearly identified.

0 **Indicators re: patient behaviour are consistently missed**	1	2	3	4	5 Indicators re: patient behaviour clearly identified

5) Student behaviour is consistent with client vis-a-vis current stage of relationship.

0 **Behaviours totally out of sync with patient re: phases of relationship**	1	2	3	4	5 Behaviours completely match patient re: phases of relationship

6) i.) Analysis is comprehensive in identifying current phase.

0 **Consideration of patient is absent**	1	2	3	4	**5** **Consideration of patient is thorough and insightful**

6) ii.) Analysis is comprehensive in identifying current phase.

0 **Consideration of self is absent**	1	2	3	4	**5** **Consideration of self is thorough and insightful**

6) iii.) Analysis is comprehensive in identifying current phase.

0 **Consideration of interactional dimension is absent**	1	2	3	4	**5** **Consideration of interactional dimension is thorough and insightful**

7) Stage of relationship clearly identified.

0 **Stage of relationship not identified**	1	2	3	4	**5** **Stage of relationship clearly identified**

8) Process Recording is clearly written

0 **Vague**	1	2	3	4	**5** **Exceptional, clear and understandable**

9) Overall, a good understanding of Peplau's Phases of Relationship is demonstrated.

0 **Appears to have no understanding of the process**	1	2	3	4	5 Exceptional grasp of process

Comments:

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APPENDIX E

Journaling Activity

Journaling activity. (2016). In C. Forchuk, *Arthur Labatt Family School of Nursing course work*. London, ON: University of Western Ontario. Adapted with permission.

Reflect on a life experience that involved significant joy, sadness, conflict, anger. Situate the experience historically, personally and socially by asking yourself: What were the circumstances? What events preceded the experience? Utilize the life world existential—lived space, lived body, lived time, and lived human relation—as guides to reflection.

Begin to write the story. Try to be as clear and descriptive as you can.

When you feel that you have completed the story, put it down. Walk away from it for awhile. Then return to it and reread it. Does it seem true to life? Do other memories surface as you revisit it? Add them if they do.

Reflect on the following and write a journal to summarize the following:

- **What themes emerged within your story? How do those themes speak to you of your life experience?**
- **What did you become sensitive to within yourself through the process of reflecting upon and writing this story?**
- **Why do you believe that you chose this particular story? Why did these memories emerge? How do they speak to you of your life and of the significance of your experience to whom you are today?**

Come to class prepared to share your process and the critical reflection revealed to you within your journal.

APPENDIX F

Safety and Comfort Plan

Reprinted from "Safety and comfort plan" by the Professional Practice Office, 2016, Centre for Addiction and Mental Health (CAMH). Reprinted with permission.

Form is intended to capture the client's perspective.

Student name: **Student number:** **Date:**

1. Who participated in developing this safety plan

☐ Client ☐ Family	☐ Significant Other ☐ SDM	☐ Clinical Staff ☐ Friend	☐ Other

2. What makes me feel safe?

_____

_____

_____

3. What makes me feel safe?
Some things that make me angry, afraid, very upset, or cause me to go into crisis:

_____

_____

_____

4. How do I know when I am becoming, or in, distress/crisis?
My warning signals.

_____

_____

_____

5. What does it look like when I am in distress or losing control?
What would others see?

_____

_____

_____

6. When I'm in distress/crisis, I need:

_____

_____

_____

7. What activities or coping strategies can I try to calm and comfort myself?
Activities that have helped me feel better when I'm having a hard time:

_____

_____

_____

8. What can others do to help?
Identify who can help and how they can help. Are there other resources that can help?

_____

_____

_____

9. What gets in the way of me using my strategy?
Barriers, obstacles, or situations that impact my ability to apply this safety plan:

_____

_____

_____

10. What would others notice about me when I'm coping effectively?

Things others may notice about me when I am no longer in distress/crisis:

_____

_____

_____

APPENDIX G

Advocacy Groups for Mental Health in Canada (Kent-Wilkinson, 2015)

Some national and international advocacy organizations:

Canadian Alliance on Mental Illness and Mental Health (CAMIMH)
The Canadian Alliance on Mental Illness and Mental Health (CAMIMH) is Canada's largest mental health advocacy group. It is an alliance of mental health organizations comprised of health care providers as well as of the mentally ill and their families.

Canadian Mental Health Association (CMHA)
The Canadian Mental Health Association (CMHA) is a national voluntary organization that promotes mental health and serves consumers and others through education, public awareness, research, advocacy, and direct services.

Disability Rights International (DRI)
Disability Rights International (DRI) is an advocacy organization dedicated to the recognition and enforcement of rights of people with mental disabilities.

Mental Health Commission of Canada (MHCC)
The Mental Health Commission of Canada (MHCC) is a non-profit organization created to focus national attention on mental health issues, to work to improve the mental health of Canadians, and to reduce the stigma associated with this disease.

Schizophrenia Society of Canada
This toolkit provides support and basis information regarding core concepts of advocacy and working with the media. It provides practical steps that are required by people living with mental illness, caregivers and supporters to start advocating (SSC, 2007).

World Federation for Mental Health (WFMH)
The World Federation for Mental Health (WFMH) is the only international, multidisciplinary, grassroots advocacy and education mental health organization.

World Health Organization (WHO)
The World Health Organization (WHO) is the United Nations agency for health. The objective set out in its constitution is the attainment, by all peoples, of the highest possible level of health.

APPENDIX H

Engaging Lived Experience

Tips for how educators can work with persons with lived experience, support groups and how to engage with them.

Prepared by Betty-Lou Kristy, Lived Experience/'Family' Advocate- Mental Health, Addiction, Trauma & Bereavement (2016)

Engaging lived or family experience to share journeys of struggle and/or recovery with mental health and addiction issues can be one of the most powerful and humanizing ways to pass on knowledge to nursing students. Personal lived experience journeys (stories) and the journeys of the supporting self-defined family members (caregivers) are great examples of personal experiences and demonstrate the impact of the broader determinants of health. Specifically, lived experience of people and families can speak to the complex reality people living with mental health and substance use issues, and help to break down stigma, misperceptions, fears and myths, while breathing life into knowledge exchange.

Some of the potential outcomes of sharing lived experience include:

- Evidence of qualitative data, such as facts and mitigating emotions, that leads to more fulsome evidence of human tragedy and resilience, what loss of hope and dignity can do to a person and the power of human spirit; and
- Profound teaching moments that express the feelings behind events, enabling learners to experience how a situation feels.

Planning tips

Here are some things that need to be considered if you are inviting lived or family experience to become part of your choices for teaching, according to the Centre for Addiction and Mental Health's *Strengthening Your Voice Speakers Training*.

BEFORE THE EVENT

Ensure you inform speakers of the following items:

- ❑ **The intent of the event;**
- ❑ **The topic you would like them to talk about—this could include specific content you would like them to include or content you prefer they stay away from;**
- ❑ **How much time you are allotting them to speak;**
- ❑ **Who else will be speaking and what their role is (for example, peers with similar experiences, health care workers, parents, youth);**
- ❑ **Who the audience is (for example, general public, health care workers or students at a certain level or in a particular class);**

- ❑ The date and time of the event;
- ❑ The location of the event and detailed directions to get there;
- ❑ Whether you can provide them with and set up any equipment they might need (for example, computer and screen);
- ❑ How you will let them know how much time they have left to speak, or that it is time to stop speaking; and
- ❑ That you appreciate their contribution to making the event a success.

Provide speakers with:

- ❑ A contact name and details of how and when they can reach that person;
- ❑ Practice time with the microphone during the setup; and
- ❑ Encouragement.

DURING THE EVENT

Provide speakers with:

- ❑ Water;
- ❑ Tissues; and
- ❑ Any help they might need (for example, with the microphone or other equipment, with the question-and-answer part of the event).

AFTER THE EVENT

Provide speakers with:

- ❑ An honorarium; and
- ❑ Reimbursement of their travel costs (for example, mileage, parking, public transportation) or any other expenses they may have incurred related to participating in the event. If possible, provide bus fare before the event.

HOW TO DEBRIEF WITH SPEAKERS

- ❑ Ask them, for example, how they're feeling personally and how they're feeling about the event itself.
- ❑ Give speakers feedback about how you think the event went, including feedback about their presentation. Make constructive comments about what worked well and why.
- ❑ If it is not possible to debrief immediately after the event, tell speakers you will call them the following day to debrief.

Don't forget to thank speakers for sharing their story and for helping to make the event a success.

Honorarium and/or expense reimbursement

Consider the follow recommendations regarding honorarium and expense reimbursement.

- ❑ **Ensure ahead of the event that the person's travel, accommodation, event registration costs (if applicable), and meal needs related to the event are covered up front (if needed). Keep in mind that many people with lived experience can not afford to wait 30 to 60 days to be reimbursed.**
- ❑ **Offer support and flexibility in how an honorarium is given. Frequently people with lived experience have money concerns so it is helpful to make it clear that it is up to the person to report the income or not. Cash is best where feasible and safe. If they are really leery to accept money, you can negotiate things like grocery cards instead—as long as gift cards are a fallback tactic and not the default go-to method.**

Reflection considerations

Invited speakers may not been trained in peer support, lived experience speaking, facilitating, sharing their journey, group facilitation. Lived experienced speakers may also not have participated in many different modalities that involve sharing their journey. It is important to encourage them to use technique of reflection to answer the following questions:

- ❑ **Are they ready?**
- ❑ **Have they considered the gains and risks of sharing their story?**
- ❑ **Are they aware of triggers?**
- ❑ **Are they aware of personal wellness?**

Other elements educators may wish to provide guidance in include: preparation, questions to ask, how to know your audience, being neutral and professional, being trauma-informed, developing your story, presentation styles, taking care of yourself, managing audiences etc.

RESOURCES

Centre for Addiction and Mental Health: Strengthening Your Voice Public Speakers Guide

Centre for Addiction and Mental Health. (2013). Strengthening your voice: A public speaking guide for people with lived experience of problems with prescription pain medication. https://www.porticonetwork.ca/learn/videos/strengthening-your-voice

Newfoundland: CHANNAL Consumers Health Awareness Network Newfoundland and Labrador http://www.channal.ca

Nova Scotia Self Help Connection http://selfhelpconnection.ca/

The Ontario Peer Development Initiative (OPDI)
http://www.opdi.org/members.php

Mississauga Halton Enhancing & Sustaining Peer Support, TEACH
http://www.t-e-a-c-h.org/

Manitoba is focused on LGBTQetc Peer Support Groups | Rainbow Resource Centre
http://www.rainbowresourcecentre.org/peersupport/

Support Groups

eMentalHealth.ca
http://www.ementalhealth.ca

Youth Peer-to-Peer Support | Together to live
http://www.togethertolive.ca

Mood Disorders Association of Manitoba
http://www.mooddisordersmanitoba.ca/winnipeg-support-groups/

Saskatchewan: generalized peer support cross-disability
http://www.nsilc.com/#!peer-support/c15k1

Peer Support | North Saskatchewan Living Centre
http://www.nsilc.com

Calgary Peer Support Meetings
https://www.su.ualberta.ca/services/psc/

Peer Support Centre
http://www.su.ualberta.ca

Section 9.2 Glossary of Terms

Aboriginal people

Section 35(2) of Canada's Constitution Act, 1982, defines "Aboriginal people" as Indian (First Nations), Inuit, and Métis people (Government of Canada, 1982).

Acute Stress Reactions

A psychological condition that involves a rapid response to an abrupt, single, easily identified stressor and often responds positively to some form of intervention. For example, a person may experience acute stress in response to a negative situation such as an unexpected bereavement, conflict in the workplace or commencing a new position (Bergerman, Corabian, & Harstall, 2009; Kendall, Murphy, O'Neill & Bursnall, 2000).

Addiction

"Used as an umbrella term inclusive of substance misuse, substance abuse, substance dependence, and process addictions such as gambling" (Kent-Wilkinson et al., 2015, p. 21).

Advocacy

"Advocacy" is defined as verbal support or argument for a cause or policy. Simply put, it is telling your story to a decision maker, through various means, in order to compel that person to do something. Most commonly, advocacy is directed towards government and decision makers. In the area of mental health, individuals and organizations advocate for a wide variety of reasons, including improved access to services and improved benefits and supports for people with mental illness. A successful advocacy effort can take some time to produce results. But each time you speak on behalf of your chosen issue, you raise awareness and build support (Schizophrenia Society of Canada, 2016).

Burnout

Describes a state of being that is characterized by emotional exhaustion, depersonalization, and a reduced feeling of personal accomplishment. Burnout develops as a result of general occupational stress (National Child Traumatic Stress Network, 2016).

Clinical Supervision

The development of clinical learning within a practice setting between an experienced supervisor and a beginner or novice supervisee. "Supervision occurs in conjunction with working with patients and varies according to the supervisor, the workload of the unit and the atmosphere of the setting" (Haggman et al., 2007, p. 382).

Community Treatment Orders (CTO)

A community treatment order (CTO), a form of mandatory outpatient treatment MOT, is an order to provide a comprehensive plan of community-based treatment to someone with a serious mental disorder. CTOs are only issued for persons with severe mental illness and with a history of hospitalization who have been examined by a physician and been deemed in need of continuing treatment and care while residing in the community (Canadian Mental Health Association [CMHA], 2013). See Resources in Section 6.1. CTOs are less restrictive than being detained in a psychiatric facility and serve as an alternative to hospitalization (CMHA, 2013).

Collaborative Practice

"In health care, occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings. Practice includes both clinical and nonclinical health-related work, such as diagnosis, treatment, surveillance, health communications and management" (World Health Organization, 2010, as cited in Registered Psychiatric Nurse Regulators of Canada [RPNRC], 2014, p. 24).

Competencies

"Competencies are complex know-acts based on combining and mobilizing internal resources (knowledge, skills, attitudes) and external resources and applying them appropriately to specific types of situations" (Tardif, 2006).

Crisis

An emotional upset, arising from situational, developmental, biological, psychological, socio-cultural, and/or spiritual factors. This state of emotional distress results in a temporary inability to cope by means of one's usual resources and coping mechanisms. Unless the stressors that precipitated the crisis are alleviated and/or the coping mechanisms are bolstered, major disorganization may result. It is recognized that a crisis state is subjective and as such may be defined by the client, the family or other members of the community (Hoff, 1995; Ontario Ministry of Health and Long-Term Care, 1999ab; RNAO, 2006).

Crisis Intervention

A process that focuses on resolution of the immediate problem through the use of personal, social and environmental resources (Hoff, 1995). The goals of crisis intervention are rapid resolution of the crisis to prevent further deterioration, to achieve at least a pre-crisis level of functioning, to promote growth and effective problem solving, and to recognize danger signs to prevent negative outcomes (Hoff, 1995; RNAO 2006).

Critical Reflection

Critical Reflection involves looking back on experience(s) so as to learn from them and gain new or deeper understanding about practice development and/or develop alternative ways of acting when leading and/or facilitating practice development or related activities. It is also about connecting personal learning and ways of knowing with other types of learning and knowledge knowledge (Foundation of Nursing Studies [FoNS], 2013).

Culture

"Culture is commonly understood as learned traditions and unconscious rules of engagement that people use to interpret experience and to generate social behaviour" (Srivastava, 2007, p. 324). Canada's mental health strategy has emphatically asserted that in service and treatment of mental health, culture counts (Mental Health Commission of Canada [MHCC], 2012).

Cultural Competence

Cultural competence is the application of knowledge, skills, attitudes, and personal attributes required by nurses to maximize respectful relationships with diverse populations of patients (patients may be individuals, families, groups, or populations) and co-workers. "Underlying values

for cultural competence are inclusivity, respect, valuing differences, equity and commitment" (CNA, 2010; RNAO, 2007, p. 19). Cultural competence is considered an entry-to-practice competence that is evident in quality practice environments and improves health outcomes (CNA, 2010). Cultural competence is an ongoing process and requires continuous skill development, self-evaluation, and growing knowledge about different cultural groups (Kersey-Matusiak, 2012, p. 34).

Cultural Safety

Cultural competence and cultural safety are prerequisites for working effectively in global health (CNA, 2010). Cultural safety is both a process and an outcome whose goal is greater equity. It focuses on root causes of "power imbalances and inequitable social relationships in health care" (Aboriginal Nurses Association et al., 2009; Kirkham & Browne, 2006, as cited in Browne et al., 2009, p. 168).

Family

A term used to refer to individuals who are related (biologically, emotionally, or legally) to and/or have close bonds (friendships, commitments, shared households and child rearing responsibilities, and romantic attachments) with the person receiving health care. A person's family includes all those whom the person identifies as significant in his or her life (e.g., parents, caregivers, friends, substitute decision-makers, groups, communities, and populations) (RNAO, 2015). The person receiving care determines the importance and level of involvement of any of these individuals in their care based on his or her capacity (Saskatchewan Ministry of Health, 2011).

Harm Reduction

"'Harm Reduction' refers to policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption. Harm reduction benefits people who use drugs, their families and the community" (International Harm Reduction Association, 2010, p. 1).

Human Rights

In accordance with the objectives of the UN Charter and international agreements, a fundamental basis for mental health legislation is human rights. Key rights and principles include equality and nondiscrimination, the right to privacy and individual autonomy, freedom from inhuman and degrading treatment, the principle of the least restrictive environment, and the rights to information and participation (Kent-Wilkinson, 2015, p. 36; UN, 1991).

Mandatory Outpatient Treatment (MOT)

Mandatory outpatient treatment (MOT) involves legal provisions requiring people with a mental illness to comply with a treatment plan while living in the community (O'Reilly et al., 2003).

Mental Disorder

"A health condition characterized by alterations in several factors that include mood, affect, behaviours, thinking and cognition. The disorders are associated with various degrees of distress and impaired functioning" (Austin & Boyd, 2009, as cited in CFMHN, 2014, p. 13).

Mental Health

A term used to mean all diagnosable mental disorders (Austin and Boyd, 2010).

Mental Illness

"Characterized by alterations in thinking, mood or behaviour—or some combination thereof—associated with significant distress and impaired functioning. The symptoms of mental illness vary from mild to severe, depending on the type of mental illness, the individual, the family and the socio-economic environment. Mental illnesses take many forms, including mood disorders, schizophrenia, anxiety disorders, personality disorders, eating disorders and addictions such as substance dependence and gambling" (PHAC, 2006, para 2).

Mental Health Act

A Mental Health Act is a law that gives certain powers and sets the conditions (including time limits) for those powers, to stipulated health-care professionals and designated institutions regarding the admission and treatment of individuals with a mental disorder. It also provides a framework for mental health delivery of services and establishes rules and procedures that govern the commitment of persons suffering from mental disorders (Government of Saskatchewan, 2013).

Mental Health Legislation

The fundamental aim of mental health legislation is to protect, promote, and improve the lives and mental well-being of citizens (WHO, 2005).

Mentoring

The act of engaging in mentorship. Mentoring is less formal than preceptoring and involves a longer-term professional relationship between a novice nurse or nursing student and a more experienced nurse. Mentoring tends to be less formally instructional and more encouraging of positively influencing those with less experience through role modeling and guidance (CNA, 2004).

Not Criminally Responsible due to a Mental Disorder (NCRMD)

Separate from mental health legislation are the legal provisions that can require people to follow treatment as a condition of probation. The law allows for persons to be found *Not Criminally Responsible due to a Mental Disorder* for an offence if they are suffering from a mental disorder that makes them incapable of appreciating the nature of the act or knowing that what they did was wrong. In these cases, the mentally ill offender needs to comply with treatment monitored by the Criminal Code Review Boards (Kent-Wilkinson, 2015).

Occupational Stress

An individual's physiological and psychosocial response to work stress that can result in harm psychologically, emotionally and physically. Depending on professional, personal and workplace factors, occupational stress often influences an individual's capacity to cope with workplace situations and function at their professional and personal capacities (WHO, 2016; Bergerman, Corabian, & Harstall, 2009).

Post Traumatic Stress Disorder

Develops as a delayed and/or deferred response to an acute stressful event or situation (either short- or long-lasting). This event usually has a particularly threatening or catastrophic nature, with the potential to cause pervasive distress in almost anyone (Nowrouzi et al., 2015).

Preceptor

An experienced nurse who provides individual guidance to a student (Bourbonnais & Kerr, 2007).

A "frequently employed teaching and learning method using nurses as clinical role models. It is a formal, one-to-one relationship of pre-determined length, between an experienced nurse (preceptor) and a novice (student/preceptee) designed to assist the novice in successfully adjusting to and performing a new role" (CNA, 2004, p. 13).

Recovery

"Recovery involves a process of growth and transformation as the person moves beyond the acute distress often associated with a mental health problem or illness and develops new-found strengths and new ways of being" (MHCC, 2009; RNAO, 2015).

Recovery-Oriented Practice

A recovery-oriented approach is "inclusive, participatory, and seek involvement of patients, families, and staff to advance mental health and well-being" (MHCC, 2015). Unlike other models of care, which often involve symptom alleviation and clinical recovery, recovery-oriented health care seeks to understand the unique lived experiences of patients and families, and to personalize the recovery process (Allott & Loganathan, 2002).

Reflective Practice

Reflective practice is the process of examining ones actions and experiences for the purpose of developing one's practice and clinical knowledge with the outcome of acquiring a new understanding and appreciation of the situation (Boud, Keogh, & Walker, 1985; Caldwell, 2013).

Role Modeling

The process of an experienced nurse demonstrating skills and behaviours to beginner or novice nursing students. Role modeling is more than simply imitation of behavior; it requires repetition, reinforcement, and reward in the form of feedback (Donaldson & Carter, 2005).

Self-care

Self-care refers to activities and practices engaged on a regular basis to reduce stress and maintain and enhance short- and longer-term health and well-being. Self-care is necessary for effectiveness and success in honouring professional and personal commitments (University at Buffalo, 2016).

Secondary Trauma

Secondary trauma refers to the emotional duress that results when an individual hears about the first-hand trauma experiences of another. Individuals affected by secondary stress may find themselves re-experiencing personal trauma or notice an increase in arousal and avoidance reactions related to the indirect trauma exposure. They may also experience changes in memory and perception; alterations in their sense of self-efficacy; a depletion of personal resources; and disruption in their perceptions of safety, trust, and independence (NCTSN, 2016).

Social Determinants of Health

The conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at the global, national and local levels. The social determinants of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen within and between countries (WHO, 2014, "What are social determinants of health", para. 1). The social determinants of heath include income and

social status, education, biology and genetics, and health services, among other determinants. Health inequities—the differences in the health of individuals that result largely from the social determinants—are socially produced (and therefore modifiable), systemic in their distribution across the population, and unfair (National Collaborating Centre for Determinants of Health, 2013).

Stigma

Stigma is the negative, unfavourable attitudes and the behaviour they produce associated with a particular trait displayed by or activity engaged in by an individual or group (MHCC, 2013a).

Substitute Decision Maker

"If a person is incapable of making a decision with respect to a treatment, consent may be given or refused on his /her behalf by another person. In order of hierarchy, the substitute decision-maker is: the incapable person's court-appointed guardian; attorney for personal care; a representative appointed by the Consent and Capacity Board; a spouse or partner; a child or parent; a parent of the incapable person who has only a right of access; a brother or sister; or any other relative (Health Care Consent Act, 1996, s. 20[1]). The provincial Public Guardian and Trustee is the substitute decision-maker of last resort if there is no other appropriate person to act for the incapable person (Government of Ontario, 1999).

A substitute decision-maker may give or refuse consent only if he or she (Health Care Consent Act, 1996, s. 20):

1. Is capable of understanding the proposed treatment;
2. Is at least 16 years old, unless he or she is the incapable person's parent;
3. Is not prohibited legally from having access to the incapable person or giving or refusing consent on his or her behalf;
4. Is available; and
5. Is willing to assume the responsibility of giving or refusing consent.

A patient/resident cannot name a health-care practitioner, their health team or anyone else who provides them with health care as their attorney in a power of attorney for personal care, unless that person is a spouse, partner or relative (Substitute Decisions Act, 2992, s. 46[3]). The substitute decision-maker will cease to act on behalf of an incapable person if he/she should regain capacity" (RNAO, 2011, p. 93)

Therapeutic Relationship

"A relationship grounded in an interpersonal process that occurs between the nurse and the client(s). The therapeutic relationship is purposeful, goal-directed relationship intended to advance the best interest and outcome of the client" (RNAO, 2002 b, as cited in CFMHN, 2014, p. 13).

ACRONYMS

AMHNIG	Alberta Mental Health Nurses Interest Group
CAMIMH	Canadian Alliance on Mental Illness and Mental Health
CASN	Canadian Association of Schools of Nursing
CASN	Canadian Association for Suicide Prevention
CCSA	Canadian Centre on Substance Abuse
CCHS	Canadian Community Health Survey
CFMHN	Canadian Federation of Mental Health Nurses
CIHC	Canadian Interprofessional Health Collaborative
CMHA	Canadian Mental Health Association
CNA	Canadian Nurses Association
CAMH	Centre for Addiction and Mental Health
LPN	Licensed Practical Nurse
MHCC	Mental Health Commission of Canada
MDSC	Mood Disorders Society of Canada
NCSBN	National Council of State Boards of Nursing
PHAC	Public Health Agency of Canada
PMH	Psychiatric Mental Health Nursing
RN	Registered Nurse
RPN	Registered Practical Nurse
RPN	Registered Psychiatric Nurse
RPNRC	Registered Psychiatric Nurse Regulators of Canada
RCPSC	Royal College of Physicians and Surgeons of Canada
WHO	World Health Organization

Section 9.3 Case Studies

The case study is an effective teaching strategy that is used to facilitate learning, improve critical thinking, and enhance decision-making Sprang, (2010). Below are nine case studies that educators may employ when working with students on mental illness and addiction. The case studies provided cover major concepts contained in the RNAO Nurse Educator Mental Health and Addiction Resource.

While not exhaustive, the case studies were developed and informed by the expert panel. It is recommended that educators use the case studies and tweak or add questions as necessary to impart essential information to students. Also, educators are encouraged to modify them to suit the learning objective and mirror the region in which the studies are taking place. Potential modifications include:

- Client demographics (age, gender, ethnicity);
- Mental illness and addiction, dual diagnosis or additional co-morbidities such as cardiovascular disease; and
- Environmental setting (clinical, community).

Suggested "Student questions" explore areas of learning, while "Educator elaborations" recommend ways to modify the case study. Discussion topics are a limited list of suggested themes.

When using these case studies, it is essential that this resource is referenced.

See Substance use BPG appendices for examples
www.rnao.ca/substanceuse

CASE STUDY 1. Teresa is a 32-year-old woman in your practice who frequently misses her appointments, and at other times shows up without an appointment, often in crisis. She currently uses alcohol and tobacco, and has started to use street drugs.

As you have developed a therapeutic relationship with Teresa, you learn that she grew up in a household with a violent father who frequently assaulted her mother, her siblings and herself. Although now estranged from her father, the impact of his violence presents itself on a daily basis as Teresa struggles to cope with the trauma she experienced.

Teresa left school early, has few marketable skills and has never been able to hold a job for more than three months. Teresa receives $606 per month from Ontario Works and has no money left for food or other essentials at the end of the month. She is currently in a relationship with a man whom you suspect may be violent.

Student questions:

- What are your next steps with Teresa? How do you go about providing trauma-informed care?
- Is a crisis intervention required?
- What are some other interventions you could take to improve Teresa's health in this situation that include addressing health inequities and structural drivers of the conditions of daily life, such as the inequitable distribution of power, money and resources?

Educator elaborations: Assess Teresa's mental status and history of mental health care; explore her substance use and whether it places her at high risk for self medication and suicide; explore issues of violence in her life, income support and her housing situation.

DISCUSSION TOPICS:

- Cultural competency and mental illness
- Trauma informed care
- Crisis intervention
- Social determinants of health

CASE STUDY 2. Joseph is a 55-year-old First Nations man on Ontario Disability Support Program due to a physical back injury in the factory he worked in. Despite his injury, he still receives work health benefits and is able to perform some amount of activities of daily living. Due to his chronic back pain, his doctor has prescribed Oxycodone which he uses occasionally (prn), as prescribed. However, he also uses marijuana daily because it makes him feel more in control. He is recently divorced, lives alone and is finding it hard to cope with this loss. Joseph presents at the clinic reporting of increasing pain. During your conversation you discover that he is gradually increasing the amount of marijuana he is using to combat his pain and feelings of isolation.

Student questions:

- What are your next steps with Joseph?
- How would you conduct a motiva-tional interview?
- What do you suggest talking about with Joseph at his next appointment?
- What strategies could you provide that would support a recovery oriented approach?
- What strategies could you provide that assist with harm reduction?

Educator elaborations: Change the ethnicity of Joseph and layer in cultural nuances. Pose questions that teach cultural competency.

DISCUSSION TOPICS:

- Culture and diversity as it relates to mental health.
- The relationship between addiction and mental health.
- Grief and loss.

CASE STUDY 3. Thomas, a 16-year-old high school student, visits you during class in distress. He tells you that he's being bullied at school because the kids think he is gay. Thomas tells you he thinks he might be transexual, but that he is scared to tell anyone, and voices suicide ideation. He is not supported at home: his mother and father, both professionals, work long hours and his older sister picks on him. Thomas's best friend since the age of 10 recently told him he didn't want to hang out with him anymore because he was "weird." A few months ago another friend who was picked on more than Thomas went missing. Rumour in the school indicates that he ended his life.

Student questions:

- What are your next steps with Thomas?
- Do you have any immediate con-cerns in terms of Thomas's safety?
- How do you conduct a Mental Status Exam?
- How do you conduct a suicide risk assessment?
- Is a crisis intervention required?
- What kinds of community-based support strategies would you recommend?
- Do you approach Thomas's family? If so, how?
- What's your role in terms of mental health advocacy and promotion?
- How does organizational culture influence the current provision of mental health care for students; how might that culture impact any changes you propose?
- What kinds of strategies can you develop?
- Who might be on an inter and intra-professional team?
- What kinds of stakeholders are available to assist with policy or program development?

Educator elaboration: As school nurse, you want to prevent incidences of bullying and address the systemic issues related to student mental health.

DISCUSSION TOPICS:

- The impact of bullying on youth
- Diversity as it related to mental health
- Sexuality and its impact on mental health, (e.g., sexuality is not an illness)

- Stigma and its impact on mental health
- Developmental psychology/child and youth
- Family centred care

CASE STUDY 4. Gladys, an 84-year-old widow, is close to being discharged from outpatient services after breaking her hip from a fall. She uses alcohol, and tells you that she has been drinking more heavily since her husband passed away more than a year ago to help her cope with grief. She won't tell you how often or how much she drinks, but admits that she's lost over 25 pounds in the past year.

Student questions:

- How do you establish a therapeutic relationship with Gladys?
- What supports can you provide for Gladys?
- What are some key risk considerations?
- When would you consider a harm reduction approach?
- How do you develop a risk assessment?
- What are the suicide considerations in this scenario?
- What are interventions that would tackle the immediate risks in daily live, such as housing situation or ambulation?
- What are the key medication considerations, especially give her age and alcohol use?
- What other considerations may you have to maintain her safety?
- How would you use a harm reduction approach with Gladys?
- What accommodations at home may she need?

Educator elaborations: Give Gladys an acute scenario, for example, she is in withdrawal from alcohol and experiencing delirium.

DISCUSSION TOPICS:

- Aging and mental illness and addiction
- Coping with grief and loss
- Mental health and illness and addiction; plus concurrent health disorders

CASE STUDY 5. Anthony, 29, is under the jurisdiction of your local provincial Mental Health Review Board on your acute care ward. He's in breach of a disposition because of repeated alcohol and marijuana use; Anthony is also diagnosed with bipolar disorder and is currently prescribed olanzapine 10 mg and lithium 800 mg daily. He experiences mania when he uses substances, and the incident that led to his review occurred when he was under the influence (he racked up over $100,000 in property damages). He uses substances and alcohol due to the negative side effects (weight gain) from his prescribed medications. Anthony is divorced and recently obtained regu-lar visits with his kids. He holds down a steady job in construction, but he's worried about losing his employment because he sometimes misses shifts.

Student questions:

- What is the relationship between addiction and mental illness?
- What is the relationship between the drug and alcohol use and Anthony's diagnosis?
- What assessments would be completed?
- What medications and lab work should be done (e.g., Lithium levels)?
- In terms of Anthony's stay on the unit, what are some safety precautions? How is a forensic general/acute unit different than a non-forensic unit?
- How does one balance custody vs. care?
- What is the legislation that pertains to Anthony's rights?
- What is the criteria for involuntary admission in your jurisdiction?
- How do you evaluate Anthony's capacity?
- How do you prepare for the hearing that will decide whether Anthony will continue to be committed/detained?
- What is the role of the nurse in Anthony's case?
- And the role of the community ACT Team?
- Examine your values and beliefs: How do you balance issues of transference and countertransference?
- If you don't support Anthony's release, how will you maintain a therapeutic relationship or respond to him when he expresses a sense of betrayal during your day-to-day care?
- How might self-reflection help you? What are your ethical responsibilities to the Anthony and the public?

DISCUSSION TOPICS:

- Mental health and illness legislation
- Ethics and professional responsibilities
- Personal safety

CASE STUDY 6. You arrive at work to find out that Rajat, a 48-year-old client diagnosed with chronic schizophrenia, abused his roommate because he thought he was making gestures at him. Rajat was admitted overnight involuntarily when a neighbour who he has a relationship with encouraged him to go to emergency. Rajat was extremely confused and not making any sense. The community he lives is purported to have a high amount of IV drug use. Rajat spends the government provided disability support he gets on rent and the rest on drug use and cigarettes (he has been smoking since he was 8, which he informs you is common in India). He is also obese with metabolic syndrome.

Student questions:

- What are your first steps?
- How do you develop a safety plan?
- How do you assess Rajat?
- What are the results of your assessment and how do they impact care?
- What about the link with Schizophrenia and drug use?
- What is the most important aspect you would work on with Rajat?
- How would you prioritize his care?
- How does Rajat's culture impact influence his illness?
- How do you establish a therapeutic relationship with Rajat?
- What kinds of strategies can you put in place for him when he is eventually discharged?

Educator elaboration: Give Rajat a specific ethnicity and explore culture competence as it re-lates to mental illness.

DISCUSSION TOPICS:

- Metabolic syndrome and its impact mental illness and treatment
- Social determinants of health
- Mental health and illness legislation

CASE STUDY 7. You visit Melanie, 58, in her home for a post-hospital discharge visit. She is visibly lethargic and when you ask how she is feeling, she tells you she is grieving for her son who died more than a month ago. Moreover, she worries how her life choices contributed to her son's problems. As the child of alcoholic and violent parents, she felt alone, and constantly frightened. She ran away at the age of 16, and eventually married an abusive alcoholic, who was the father of her son. She and her son escaped with police help, but at the age of 25, childhood traumas flooded her, and she began to drink and use drugs to cope. Her second husband aided her drug use, which included cocaine, prescription barbiturates and marijuana. At that point, Melanie says she had been in and out mental health hospitals for breakdowns and suicide attempts. Not only

was she anorexic, but she also cut herself. Her diagnoses included rapid cycling bipolar disorder, acute anxiety and panic disorders, personality disorders, obsessive compulsive disorders and post-traumatic stress disorders and "the list goes on." She was treated with medications and rounds of bilateral shock treatments that she says she never wanted. "The worst part was being labeled an alcoholic and drug addict," she adds, which diminished her true needs. She tells you that she has been alcohol and drug free for over 10 years thanks to meeting her third husband who is very supportive. And that she has had therapy to assist with her past traumas. But none of it was enough to help her help her son who died of an accidental drug overdose caused by a lethal combination of opioids mixed with the newly prescribed high powered psychiatric drugs.

Student questions:

- What are you next steps with Melanie?
- How do you assess her risk for re-lapse?
- What kinds of support strategies can you provide?

DISCUSSION TOPICS:

- Recurring trauma and its influence pre-existing mental health illness and substance use dis-orders
- Community supports necessary to ensure ongoing mental health and wellness for clients with diagnoses

CASE STUDY 8. John, 23, is checked into emergency with severe gastro-intestinal pain. This is his sixth visit to the same ER with the same symptoms. He is visibly in discomfort, and requires opioid pain medications. John tells you he has been taking opioids for years to deal wth the flare-ups, which include vomiting and diarrhea, and have led to a 40-pound weight loss and five colonoscopies. This latest flare up occurred after he ran out of his pain medication and couldn't get a refill. John gets very angry and defensive when the staff suggest he is addicted to pain killers. He contends that he wouldn't be on the pain killers if the doctors could figure out what is wrong with him. When he calms down, you are able to learn a little more about his past: He tells you he has battled anxiety and panic attacks since he was a kid and diagnosed with learning disabilities. Currently, he feels the only relief for his emotional and physical pain is pain medication and that "he is trapped in this situation." Finally, he adds that lately he's experienced auditory, sensory and visual hallucinations. Schizophrenia runs his family.

Student questions:

- Is John in crisis?
- How do you initiate a crisis intervention?
- How do you implement a harm reduction approach?
- How do you use trauma-informed approaches with John?

DISCUSSION TOPICS:

- Age and linkages with schizophrenia
- Withdrawal symptoms
- Stigma and learning disabilities
- Stigma and substance use and its impact on mental health attitudes and interventions

CASE STUDY 9. Below is an anecdotal scenario that seeks to prepare students for a typical inpatient work day. It is structured into three phases and begins with arrival at work.

You've just arrived at your shift on a mental health unit and are reviewing your client case load.

Student questions:

- How do you prioritize the client case load?
- Provide the rationale for the prioritization.
- What information is missing before you can move forward?

Next, you hone in on one patient, a 61-year-old, Caucasian female, with bipolar disorder who is mildly agitated. You review the night shift vital stats, as well as medications including her lithium levels.

Student questions:

- What are you most worried about?
- What should your immediate action be?
- How do the client assessment results impact care?

Despite your interventions, the patient's agitation is escalating. You would describe her as aggressive.

Student questions:

- How do you intervene in a non-confrontational way?
- What psychosocial interventions should you consider?
- When do you use medications, and what PRN medication do you choose and why?
- Which intramuscular site do you choose, what size syringe do you use and how do you prevent a needle stick injury?
- What assessment do you do after you've administered PRN?

Debriefing: What was students' reaction to this scenario? How did they feel about the experience? What do they understand better and were there any learning gaps identified? How can you apply what you've learned today to the real world clinical practice?

Educator elaborations: Ensure the case load represents an array of patient scenarios from anxiety to bipolar disorder and then nuance those with themes such as a suicide attempt and addiction to pain medication.

DISCUSSION TOPICS:

- Mental health diagnosis and medications
- Therapeutic care and restraints
- Ethics

Endorsement

CASN ACESI

Canadian Association of Schools of Nursing
Association canadienne des écoles de sciences infirmières

March 17, 2017

Valerie Grdisa, RN, MS, PhD
Director, International Affairs and Best Practice Guidelines Centre
Registered Nurses' Association of Ontario (RNAO)
158 Pearl Street
Toronto, ON M5H 1L3
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Subject: *Letter of endorsement for RNAO's "Nurse Educator Mental Health and Addiction Resource: Integrating Mental Health and Addiction into the Undergraduate Nursing Curriculum"*

Dear Dr. Grdisa,

On behalf of the Canadian Association of Schools of Nursing/l'Association canadienne des écoles de sciences infirmières (CASN/ACESI), I appreciate the opportunity to offer a letter of endorsement for RNAO's *Nurse Educator Mental Health and Addiction Resource: Integrating Mental Health and Addiction into the Undergraduate Nursing Curriculum*. This resource is based on the CASN and Canadian Federation of Mental Health Nurses (CFMHN) Entry-to-Practice Mental Health and Addiction Competencies for Undergraduate Nursing Education in Canada (2015), and supporting research. It aims to provide educational institutions and service agencies opportunities to integrate quality and evidence-based competencies, indicators and content related to mental health and addiction in undergraduate nursing education across Canada.

As the national voice for nursing education in Canada, CASN/ACESI establishes and promotes national standards of excellence for nursing education and nursing scholarship in the interest of healthier Canadians. CASN/ACESI facilitates the integration of theory, research and practice to support nursing education, which is closely aligned with the content and tools in this resource. The resource provides direction on how educational institutions can facilitate effective theoretical, clinical and simulation education experiences through integration of core competencies and associated curriculum content for students, preceptors, nursing educators and clinical nursing instructors, and nurses in general.

1145 Hunt Club Rd, Suite 450, Ottawa, ON K1V 0Y3
www.casn.ca

CASN/ACESI is committed to delivering high quality nursing education at all levels and we believe that this document will serve as a valuable resource and tool for nursing education delivery within undergraduate curriculum. We believe the *Nurse Educator Mental Health and Addiction Resource: Integrating Mental Health and Addiction into the Undergraduate Nursing Curriculum* will assist faculty, educators, students and nurses in integrating and promoting the importance of evidence-based nursing curriculum based on core competencies, to promoting the advancement of mental health and addiction nursing knowledge, within the undergraduate curriculum.

Congratulations, and thank you for this important work!

Sincerely,

Cynthia Baker, RN, PhD
Executive Director

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RNAO Nurse Educator

Mental Health and Addiction Resource

Integrating Mental Health and Addiction into the Undergraduate Nursing Curriculum

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