3rd Position Paper 2016:

Mental Health and Addiction Curriculum in Undergraduate Nursing Education in Canada

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Fédération canadienne des infirmières et infirmiers en santé mentale du Canada. (2016). *CFMHN's 3rd position statement 2016: Mental health and addiction curriculum in undergraduate nursing education in Canada [CFMHN-FCIISM 3e énoncé de position 2016: L'enseignment de la santé mentale et des toxicomanies dans les programmes de sciences infimières de premier cycle au Canada]*. Préparé par les membres du comité de l'éducation du CFMHN-FCIISM: A. Kent Wilkinson, L. Blaney, M. Groening, E. Santa Mina, C. Rodrigue, & C. Hust. Toronto, ON: Auteur. Document accessible au http://www.cfmhn.ca/positionpapers

- French translation by Louise Racine RN, PhD

CASN/CFMHN 2015 Competencies:

Canadian Association of Schools of Nursing & Canadian Federation of Mental Health Nurses. (2015). *Entry-to-practice mental health and addiction competencies for undergraduate nursing education.* Ottawa, ON: Author. Retrieved from http://www.casn.ca/wp-content/uploads/2015/11/Mental-health-Competencies_EN_FINAL-3-Oct-26-2015.pdf

CFMHN 2014 Standards:

Canadian Federation of Mental Health Nurses. (2014). *Canadian standards for psychiatric-mental health nursing* (4th ed.). Toronto, ON: Author. Retrieved from http://cfmhn.ca/professionalPractices?f=7458545122100118.pdf&n=212922-CFMHN-standards-rv-3a.pdf&inline=yes

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CFMHN 3rd Position Paper 2016: Mental Health and Addiction Curriculum In Undergraduate Nursing Education in Canada

PREFACE

About CFMHN's 2016 Position Paper

This Canadian Federation of Mental Health Nurses (CFMHN) *Position Paper 2016: Mental Health and Addictions Curriculum in Undergraduate Nursing Education in Canada* is the third position paper by the CFMHN Education Committee. Previous position papers in 1998 and 2009 also addressed the need for mental health and addiction content in undergraduate nursing programs.

In 2015, the competencies identified by the CFMNH in 2009 were jointly revised by a task force of the Canadian Association of Schools of Nursing (CASN) and the Canadian Federation of Mental Health Nursing (CFMHN). This 2016 CFMHN position paper supports the *CFMHN 3rd Position Statement 2016: Mental Health and Addiction Curriculum in Undergraduate Nursing Education in Canada* (CFMHN, 2016); accompanies the 2015 CASN/CFMHN *Entry-to-Practice Mental Health and Addiction Competencies for Undergraduate Nursing Education* (CASN/CFMHN, 2015); and aligns with the 2014 CFMHN *Canadian Standards for Psychiatric-Mental Health Nursing* (CFMHN, 2014).

The timelines below of CFMHN publications provide a review of changes made as the psychiatric and mental health (PMH) nursing specialty evolved.

CFMHN PUBLICATIONS

CFMHN'S Position Papers/Statements/Competencies

1998 CFMHN's First Position Paper/Statement

Chan, A., Buchanan, J., Forchuk, C., Moore, S., & Wessell, F. (1998). *Position statement on essential psychiatric mental health nursing education for entry-level nursing programs in Canada.* Toronto, ON: Canadian Federation of Mental Health Nurses.

- authored by Chan, Buchanan, Forchuk, Moore, and Wessell (1998);
- developed as the first position paper/statement by the CFMHN Education Committee;
- addressed the need for mental health content in all undergraduate nursing programs by responding to major curriculum concerns in undergraduate registered nursing programs across Canada; and
- reported that some baccalaureate nursing programs did not offer a theory course or clinical experience in PMH nursing.

2009 CFMHN's Second Position Paper/Statement/Competencies

Tognazzini, P., Davis, C., Kean, A., Osborne, M., & Wong, K. (2009). *Core competencies in psychiatric mental health nursing for undergraduate nursing education: Position paper.* Toronto, ON: Canadian Federation of Mental Health Nurses (CFMHN) Education Committee.

- authored by Tognazzini, Davis, Kean, Osborne, and Wong (2009);
- developed as the second position paper/statement by the CFMHN Education Committee;
- addressed the need for mental health content in all undergraduate nursing programs;
- presented findings of the 2006 environmental scan of undergraduate nursing programs in Canada conducted by the Alberta Mental Health Nursing Interest Group (AMHNIG) members; and
- renamed *Core Competencies in Psychiatric Mental Health Nursing for Undergraduate Nursing Education: Position Paper* (Tognazzini et al., 2009).

2015 CASN/CFMHN's Competencies

Canadian Association of Schools of Nursing & Canadian Federation of Mental Health Nurses. (2015). *Entry-to-practice mental health and addiction competencies for undergraduate nursing education.* Ottawa, ON: Author.

- authored by Canadian Association of Schools of Nursing (CASN) and the Canadian Federation of Mental Health Nurses (CFMHN).

CASN partnered with CFMHN in 2014 to revise the 2009 competencies to

- develop a national, consensus-based framework of essential discipline-specific, entry-to-practice mental health and addiction competencies and indicators;
- delineate the essential knowledge, attitudes, and skills all new nurses should possess related to mental health and addictions regardless of where they are employed following graduation; and
- align with the standards for psychiatric-mental health nurses in Canada (CFMHN, 2014) for generalist, entry-level nurses who may or may not enter this professional specialization following graduation (CASN/CFMHN, 2015).

2016 CFMHN Third Position Statement

Canadian Federation of Mental Health Nurses. (2016). *CFMHN's 3rd position statement 2016: Mental health and addiction curriculum in undergraduate nursing education in Canada.* Prepared by members of the CFMHN Education Committee: A. Kent-Wilkinson, L. Blaney, M. Groening, E. Santa Mina, C. Rodrigue, & C. Hust. Toronto, ON: Author.

- authored by the Canadian Federation of Mental Health Nurses (CFMHN, 2016);
- approved by the CFMHN board in December 2015; and
- prepared by members of the CFMHN Education Committee (CFMHN, 2016).

2016 CFMHN's Third Position Paper

Kent-Wilkinson, A., Blaney, L., Groening, M., Santa Mina, E., Rodrigue, C., & Hust, C. (2016). *CFMHN's 3rd position paper 2015: 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.

- authored by members of the CFMHN Education committee: Kent-Wilkinson, Blaney, Groening, Santa Mina, Rodrigue, & Hust (2016);
- developed by members of the CFMHN Education Committee;

- continues to address the need for mental health content in all undergraduate nursing programs;
- presents the preliminary findings of a systematic literature review of mental health and addiction education in undergraduate nursing programs in Canada by Vandyk (2015);
- submitted to the CFMHN Board in support of the *CFMHN's 3rd Position Statement 2016: Mental Health and Addiction Curriculum in Undergraduate Nursing Education in Canada* (CFMHN, 2016);
- aligns with the 2014 CFMHN *Canadian Standards for Psychiatric-Mental Health Nursing* (CFMHN, 2014); and
- accompanies the *2015 CASN/CFMHN Entry-to-Practice Mental Health and Addiction Competencies for Undergraduate Nursing Education* (CASN/CFMHN, 2015).

About Changes Made in Language to 2016 CFMHN's Third Position Paper/Statement

- 'mental health and addiction' replaces 'psychiatric and mental health nursing' in the title to indicate the area of content needed in undergraduate nursing education in Canada, rather than the specialized field of psychiatric mental health nursing;
- Including 'addiction' with mental health reflects the wide recognition of the need for both mental health and addiction education due to significant intersecting links;
- 'persons' is used throughout this document to mean clients, consumers, patients, and all recipients of care across the life span; and
- the term 'mental health conditions' is used in most examples throughout this document, as this position paper attempts neither to draw a clear distinction between 'problems', 'disorders', 'issues', 'challenges', or 'illnesses', nor to resolve all the controversies surrounding the choice of terminology.

- A brief timeline of CFMHN's Position Papers/Statements/Competencies is included here.
- See Table 1, Timeline: CFMHN's Position Papers/Statements/Competencies.

TABLE 1. TIMELINE: CFMHN'S POSITION PAPERS/STATEMENTS/COMPETENCIES

1998 - CFMHN's 1st Position Paper/Statement (Chan et al., 1998)
- *Position statement on essential psychiatric mental health nursing education for entry-level nursing programs in Canada.*

2009 - CFMHN's 2nd Position Paper/Statement/Competencies (Tognazzini et al., 2009)
- *Core competencies in psychiatric mental health nursing for undergraduate nursing education: Position paper.*

2015 - CASN/CFMHN's Competencies (CASN/CFMHN, 2015)
- *Entry-to-practice mental health and addiction competencies for undergraduate nursing education.*

2016 - CFMHN 3rd Position Statement (CFMHN, 2016)
- *CFMHN's 3rd position statement 2016: Mental health and addiction curriculum in undergraduate nursing education in Canada.*

2016 - CFMHN's 3rd Position Paper (Kent-Wilkinson et al., 2016)
- *CFMHN's 3rd position paper 2015: Mental health and addiction curriculum in undergraduate nursing education in Canada.*

CFMHN Standards

1995 CFMHN's *Canadian Standards of Psychiatric-Mental Health Nursing* (1st edition)

Austin, W., Gallop, R., Harris, D., & Spencer, E. (1996). A 'domains of practice' approach to the standards of psychiatric and mental health nursing. *Journal of Psychiatric and Mental Health Nursing, 3,* 111–115.

First edition of CFMHN's standards in 1995:

- authored by Austin, Gallop, Harris, and Spencer (1996); and
- reflected issues in psychiatric-mental health nursing practice in 1995 (Austin et al., 1996).

1998 CFMHN's *Canadian Standards of Psychiatric-Mental Health Nursing* (2nd edition)

Buchanan, J., Harris, D., Greene, A., Newton, L., & Austin, W. (1998). *The Canadian standards of psychiatric and mental health nursing practice* (2nd ed.). Canadian Federation of Mental Health Nurses. Toronto, ON: CFMHN.

Second edition of CFMHN's standards in 1998:

- authored by Buchanan, Harris, Greene, Newton, and Austin (1998);
- reflected the evolution of practice in 1998; and
- focused on a community mental health and community development model (Buchanan et al., 1998).

2006 CFMHN's *Canadian Standards of Psychiatric-Mental Health Nursing* (3rd edition)

Canadian Federation of Mental Health Nurses. (2006). *Canadian standards for mental health nursing* (3rd ed.). Toronto, ON: Author.

Third edition of CFMHN's standards in 2006:

- authored by Canadian Federation of Mental Health Nurses (2006); and
- addressed issues important to psychiatric-mental health nursing in 2006 (CFMHN, 2006).

2014 CFMHN's *Canadian Standards of Psychiatric-Mental Health Nursing* (4th edition)

Canadian Federation of Mental Health Nurses. (2014). *Canadian standards for psychiatric-mental health nursing* (4th ed.). Toronto, ON: Author.

Fourth edition of CFMHN's standards in 2014:

- authored by Canadian Federation of Mental Health Nurses (2014);
- built upon previous revisions; and,
- included survey feedback from psychiatric-mental health nurses across Canada (CFMHN, 2014).

- A brief timeline of CFMHN's *Canadian Standards of Psychiatric-Mental Health Nursing* is included here.
- See Table 2, Timeline: CFMHN'S Standards.

TABLE 2. TIMELINE: CFMHN's STANDARDS
Canadian Standards of Psychiatric-Mental Health Nursing
1995 - 1st edition (Austin et al., 1996).
1998 - 2nd edition (Buchanan et al., 1998)
2006 - 3rd edition (CFMHN, 2006)
2014 - 4th edition (CFMHN, 2014)

Glossary

- Definitions of key terms relating to mental health and addiction are included in Section 8.0 GLOSSARY and ACRONYMS
- Most terms or definitions selected for inclusion are from the major mental health associations and organizations in Canada.
- See Glossary on page 18.

Acronyms

- A list of acronyms of mental health and addiction organizations and terms used in this position paper is included in Section 8.0 GLOSSARY and ACRONYMS.
- See Acronyms on page 21.

1.0 INTRODUCTION

About Mental Health Conditions and Addictions in 2016

- In 2015, mental health conditions and addictions persist as serious health concerns that affect the lives of thousands of Canadians and their families every day. The two conditions share many features and are often closely tied to stigma, discrimination, and social determinants of health such as homelessness and poverty, which deeply affect mental health (Canadian Alliance on Mental Illness and Mental Health [CAMIMH], 2006, 2015).
- In 2015, more than 20% of Canadians, or an estimated 1 in 5, live with a mental health condition and/or an addiction (Mental Health Commission of Canada [MHCC], 2013b; Smetanin et al., 2011).
- In 2015, societal stigma towards persons with mental health conditions and/or addictions remains an overwhelming barrier to safe, comprehensive mental health assessment and care. Despite their high prevalence, mental illness and addictions continue to be met with widespread stigma in hospitals, workplaces, and schools, and in both rural and urban communities (CFMHN, 2014; Registered Nurses Association of Ontario [RNAO], 2015).
- In 2015, mental illness and addictions are (as in the past) not problems of moral weakness or personal failings; they are as 'real' as heart disease, cancer, and AIDS (Canadian Centre on Substance Abuse [CCSA], 2009).

Nurses, as the largest group of health care providers, are significant stakeholders in meeting the mental health care needs of Canadians (Smith & Khanlou, 2013). This position paper emphasizes the importance of mental health and addiction content in the curricula of all undergraduate nursing programs in Canada, by exploring the background, definitions, and prevalence of mental health conditions, addiction, and related issues; reviewing several major mental health reports, policies, and strategies; examining recent research on mental health and addiction content in undergraduate nursing curricula; and addressing the need for research on nursing education and the need for entry-to-practice competencies in mental health. The position paper concludes with the CFMHN's recommendations and position statement *Mental Health and Addiction Curriculum in Undergraduate Nursing Education in Canada* (CFMHN, 2016).

2.0 BACKGROUND

About the Canadian Federation of Mental Health Nurses (CFMHN, 2015)

- CFMHN is a national voice for psychiatric and mental health (PMH) nursing in Canada;
- CFMHN is an associate group of the Canadian Nurses' Association (CNA);
- CFMHN provides expertise for the specialty in matters relating to psychiatric and mental health nursing;
- CFMHN's major focus is the quality and quantity of undergraduate PMH nursing theory and practice in Canadian schools of nursing;
- CFMHN members are registered nurses (RNs), although other designations of nurses are also welcome as members including, for example, registered psychiatric nurses (RPNs), registered practical nurses (RPNs), or licensed practical nurses (LPNs); and
- CFMHN advocates for core competencies in undergraduate programs that promote mental health and addiction education in basic nursing education (CFMHN, 2015).

About the Canadian Association of Schools of Nursing (CASN, 2015)

- CASN is the national voice for nursing education, research, and scholarship for baccalaureate and graduate nursing education programs in Canada;
- CASN is the official accrediting agency for university nursing programs in Canada; and,
- CASN has recently partnered with various nursing specialties to publish *Entry-to-Practice Competencies for Undergraduate Nursing Education* (CASN, 2015).

Recent Mental Health Reports, Policies, Strategies, and Initiatives

The CFMHN, in revising the position paper and statement, reviewed major reports on mental health and addiction in Canada commissioned to provide direction in policy, practice, research, and education. CFMHN applauds recent policy initiatives on mental health and addiction and recognizes barriers that continue to exist.

2006 *The Human Face of Mental Health and Mental Illness in Canada*

- authored by the Government of Canada (2006);
- helped to increase public awareness of mental illness and mental health; and
- acknowledged the Canadian Government's commitment to mental health (Government of Canada, 2006).

2006 *National Action Plan on Mental Illness and Mental Health*

- authored by the Canadian Alliance on Mental Illness and Mental Health (CAMIMH, 2006);
- presented the bold statement *'There is no health without mental health'*;
- launched a framework for action (CAMIMH, 2006).

2006 *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*

- authored by the Standing Senate Committee on Social Affairs, Science and Technology (2006b);
- played a major role in increasing awareness about mental health and addiction issues;
- noted that stigma of mental illness pervades all levels of Canadian society today;
- led to the creation of the MHCC in 2007 to serve as a catalyst for change; and
- prompted governments to address stigma in their reports (Standing Senate Committee on Social Affairs, Science and Technology, 2006a).

2009 *Opening Minds Initiative: 10-Year Anti-Stigma and Discrimination Reduction Campaign*

- established by the Mental Health Commission of Canada in 2009 (MHCC, 2013d, 2013e);
- became the largest systematic effort in Canadian history focused on reducing stigma related to mental illness;
- targeted groups of youth, health care providers, workforce, and the news media through a contact-based educational program;
- sought to change Canadians' behaviours and attitudes toward people living with mental illness to ensure they are treated fairly and as full citizens with opportunities to contribute to society;

- set multiple goals, ranging from improving health care providers' understanding of the needs of people with mental health conditions to encouraging youth to talk openly and positively about mental illness; and
- set an ultimate goal to cultivate an environment in which those living with mental illness feel comfortable seeking help, treatment, and support on their journey toward recovery (MHCC, 2012a, 2013d, 2013e, 2014).

2012 ***Changing Directions, Changing Lives: The Mental Health Strategy for Canada***

- authored by the Mental Health Commission of Canada (MHCC, 2012a);
- established Canada's first national mental health strategy;
- developed in consultation with consumers, families, and health professionals; and
- provided a framework for change of the mental health system through six key strategic directions: 1) promotion and prevention; 2) recovery and rights; 3) access to services; 4) disparities and diversity; 5) First Nations, Inuit, and Métis; and 6) leadership and collaboration (MHCC, 2012a).

2012 ***The Canadian Community Health Survey (CCHS): Mental Health***

- authored by Statistics Canada (2013a);
- collected information about mental health status, access to and perceived need for formal and informal services and supports, functioning and disability, and covariates;
- surveyed the population 15 years of age and over living in the ten provinces;
- did not survey the institutionalized population, full-time members of the Canadian Forces, and persons living on reserves and in other Aboriginal settlements, which altogether represented about 3% of the target population (Statistics Canada, 2013a).

2012 ***Mental Health Strategy for Corrections in Canada***

- authored by a Federal-Provincial-Territorial (FPT) Partnership (2012);
- designed to reflect the experience and collective thinking of thousands of staff, stakeholders, and offenders from across Canada;
- intended to assist the vulnerable men and women who come into conflict with the law;
- intended also to address the overrepresentation of mental illness and addiction in offender populations (FPT Partnership, 2012).

2013 ***Mental Health Action Plan 2013–2020***

- authored by the World Health Association (WHO) as a comprehensive action plan (WHO, 2013);
- asserted that 'mental health matters' but recognized that this ideal cannot be recognized until many unfortunate trends are reversed, particularly neglect of mental health services and care, abuses of human rights, and discrimination against people with mental health conditions and psychosocial disabilities;
- used a life-course approach;
- recognized the essential role of mental health in achieving general health for all people;
- aimed to achieve equity through universal health coverage;
- stressed the importance of prevention;
- presented four major objectives:
  1) more effective leadership and governance for mental health;

2) comprehensive, integrated mental health and social care services in community-based settings; 3) implementation of strategies for promotion and prevention; and 4) strengthened evidence, research, and information systems (WHO, 2013).

Timeline: Key Mental Health Reports, Strategies, and Initiatives

- A brief timeline of key mental health reports, strategies and initiatives is included here.
- See Table 3, Timeline: Key Mental Health Reports, Strategies, and Initiatives.

TABLE 3. TIMELINE: KEY MENTAL HEALTH REPORTS, STRATEGIES and INITIATIVES

2006 - *The Human Face of Mental Health and Mental Illness in Canada*
(Government of Canada, 2006)

2006 - *National Action Plan on Mental Illness and Mental Health*
(Canadian Alliance on Mental Illness and Mental Health [CAMIMH], 2006)

2006 - *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*
(Standing Senate Committee on Social Affairs, Science and Technology, 2006b)

2009 - *Opening Minds Initiative: 10-Year Anti-Stigma and Discrimination Reduction Campaign*
(Mental Health Commission of Canada [MHCC], 2009)

2012 - *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*
(MHCC, 2012a)

2012 - *The Canadian Community Health Survey (CCHS): Mental Health*
(Statistics Canada, 2013a)

2012 - *Mental Health Strategy for Corrections in Canada*
(Federal-Provincial-Territorial Partnership, 2012)

2013 - *Mental Health Action Plan 2013–2020*
(World Health Association [WHO], 2013)

Additional Reports and Initiatives

2014 *Working Together for Change: A 10 year Mental Health and Addictions Action Plan for Saskatchewan* by Stockwell Winder (2014)

- authored by Dr. Fern Stockdale Winder and endorsed by the Government of Saskatchewan in 2014;
- reviewed services in Saskatchewan and implemented mental health and addiction strategies and action plans relevant to the province;
- committed to improving responses to mental health and addiction issues in Saskatchewan;
- responded to the 2012 *Mental Health Strategy for Canada* (MHCC, 2012a), as did action plans by other provinces, territories, and government sectors (Stockdale Winder, 2014).

2015 *Informing the Future: Mental Health Indicators for Canada*

- authored by the Mental Health Commission of Canada (MHCC, 2015);
- presented Canada's first national-level set of indicators;
- identified and reported on the mental health of Canadians;
- covered a broad range of topics related to mental health, including access to care and treatment, caregiving, diversity, economic prosperity, housing and homelessness, population wellbeing, recovery, stigma and discrimination, and suicide; and

- provided indicators for children and youth, adults, and seniors, as well as for particular populations including immigrants, residents of northern communities, and lesbian, gay, or bisexual individuals (MHCC, 2015).

2015 *Economic Burden of Illness in Canada (EBIC) online tool*

- authored by the Government of Canada (2015a);
- allows users to access the Canadian cost of illness estimates for all major diseases and injuries including, for example, 15 neuropsychiatric conditions and self-intentional injuries (Government of Canada, 2015a).

2015 *Report from the Canadian Chronic Disease Surveillance System: Mental Illness in Canada*

- authored by the Government of Canada (2015b);
- includes administrative health data to monitor mental illness nationally (a 'first' for a Canadian publication);
- features the most recent data available from the Canadian Chronic Disease Surveillance System (fiscal year 2009/10), as well as trend data spanning over a decade (1996/97 to 2009/10); and
- includes children and adolescents under the age of 15 years (another 'first' for a national report) (Government of Canada, 2015b).

Current Initiatives: Anti-Stigma Campaigns

Anti-stigma campaigns are gaining momentum. In addition to the many initiates of the Mental Health Commission of Canada (2012a), there are a number of on-going anti-stigma campaigns by mental health societies in Canada:

Partnership Program

- established by the Schizophrenia Society of Canada in Vancouver, British Columbia in mid 1990s, and eventually spread across Canada;
- the Partnership Program is a public awareness program designed to inform people about schizophrenia and related psychosis (Schizophrenia Society of Canada, 2015).

Elephant in the Room Campaign

- established by the Mood Disorders Society of Canada (MDSC, 2015);
- addresses mental illness as the 'elephant in the room' no one discusses;
- aims to eradicate stigma of mental illness by raising public awareness and sparking conversation (MDSC, 2015).

Bell Let's Talk

- founded by the Ottawa Senators Foundation (2015);
- organized around the slogan 'let's talk about mental health and end the stigma around mental illness';
- established *Bell Let's Talk Day* on January 28, in 2010, and every year since on either January 27 or January 28;
- generates funds for mental health programs: on *Bell Let's Talk Day* each year, Bell Canada donates 5 cents for every text message or long distance call made by Bell and Bell Aliant customers, every

tweet using *#BellLetsTalk*, and every Facebook share of the *Bell Let's Talk* image (regular long distance and text charges apply) (Ottawa Senators Foundation, 2015).

Stigma continues to exist as a barrier to the mental health of Canadians. Nursing students are participating in many anti-stigma campaigns across the country. Vital to implementing mental health and addiction policy initiatives in Canada is the education of nurses, who are the largest and often the most directly involved providers of mental health and addiction care.

3.0 PREVALENCE and RATIONALE

Mental Health Conditions and Addiction

- One in five Canadians, or approximately 7 million people, live with a mental disorder (Canadian Mental Health Association [CMHA], 2014a) or a mental health or an addiction problem (Centre for Addiction and Mental Health [CAMH], 2012).
- Mental health conditions and addictions are found in all areas of health care: primary, secondary and tertiary, as well as in acute care psychiatry and community mental health.
- Young people aged 15 to 24 are more likely to experience mental illness and/or substance use disorders than any other age group (Statistics Canada, 2013a).
- Men have higher rates of addiction than women, while women have higher rates of mood and anxiety disorders (Statistics Canada, 2013a).
- Canadians in the lowest income group are 3 to 4 times more likely than those in the highest income group to report poor to fair mental health (Statistics Canada, 2013a).
- Studies in various Canadian cities indicate that between 23% and 67% of homeless people report having a mental illness (Canadian Institute for Health Information, 2007; MDSC, 2009).
- The cost of mental illness in Canada is an estimated $51 billion per year and of that, $20 billion is attributed to lost productivity in the workplace (MDSC, 2014; MHCC, 2013c).
- Canadians in their prime working years are the most affected by mental health problems and illnesses (Great-West Life Centre for Mental Health in the Workplace, 2015).
- Mental health challenges occur across the lifespan and will extend into the next generation of Canadians.

The general population seldom understands the complex scope of mental health conditions and addiction. All nurses need education in mental health and addiction across the lifespan to complement primary health care and provide mental health care in general hospitals and community settings (Smith & Khanlou, 2013).

Substance Use Disorders

- Substance use disorder occurs in approximately 4.4% of Canadians aged 15 and older who met the diagnostic criteria in 2012 (Statistics Canada, 2013a).
- Alcohol abuse or dependence is the most common substance abuse disorder among Canadians at 3.2% of the total population (Statistics Canada, 2013a). Twenty percent (20%) of individuals with alcohol abuse and dependence were responsible for 72% of the total alcohol consumption in the country (Statistics Canada, 2013a, 2013b; Thomas, 2012).

- Cannabis abuse and dependence occurs in 1.3% of Canadians aged 15 and older, almost double the proportion of those with other drug abuse or dependence (0.7%) (Statistics Canada, 2013a).
- Substance abuse is related to risky behaviours, poorer health, and premature mortality, not to mention the loss of the *essence of the person* while they are engaging in substance abuse (Tjepkema, Wilkins, Senécal, Guimond, & Penney, 2010).
- The prevalence of substance abuse is difficult to measure, as is the level of damage it causes individuals and families. However, motor vehicle deaths, suicide, injury deaths, criminal activity leading to imprisonment, and violence against others are thought to be closely related to substance abuse (Allard, Wilkins, & Berthelot, 2004).

The recent best practice guideline by the RNAO (2015) *Engaging Clients who use Substances* recommends nurses in every health care setting ask their clients if they use drugs, such as cannabis and opioids, or consume alcohol. Knowledge about substance abuse and addiction disorders, on their own or concurrently with mental health conditions and related consequences, is needed in all undergraduate nursing education curricula.

Concurrent Disorders

- Concurrent conditions are common and profoundly affect the daily lives of all Canadians. In Canada, people with both a mental illness and a substance abuse problem are said to have a concurrent disorder. In the United States, the combination of these problems is called a dual diagnosis (MDSC, 2009).
- More than half of those seeking help for an addiction are experiencing a mental illness, and 15% to 20% of those seeking help from mental health services are living with an addiction (CCSA, 2009).
- For persons with schizophrenia, the number who have a concurrent substance use problem may be as high as 50% (Buckley, Miller, Lehrer, & Castle, 2009).
- Concurrent disorders do not discriminate between young people, old people, those in early phases of mental illness, or those with long-term illnesses (Els & Kunyk, 2015).
- "Persons with concurrent substance-related/addictive disorders and other mental disorders are more likely to be stigmatized, are socially marginalized, experience high degrees of relational problems, and are more likely to become involved in the criminal justice system" (Els & Kunyk, 2015, p. 823).

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. Nurses must be attentive to the possibility that persons presenting with either a substance-related or addictive disorder or a mental illness may have a concurrent disorder. Any person presenting with either condition should be screened for a concurrent mental illness or a substance-related or an addictive disorder (Els & Kunyk, 2015). Due to the significant overlap of mental health and substance abuse conditions, nurses entering the health care system should understand that the most effective treatments recognize this interplay (CCSA, 2009) and adopt an integrated approach.

Depression and Suicide

- Depression is the leading cause of disability worldwide (WHO, 2012).
- Mood disorders are one of the most common mental illnesses in the general population (Public Health Agency of Canada [PHAC], 2014).

- Of the Canadian population aged 15 years and over, 5.4% reported symptoms that met the criteria for a mood disorder in the previous 12 months, including 4.7% for major depression and 1.5% for bipolar disorder (PHAC, 2014; Statistics Canada, 2013a).
- The global estimate of suicide prevalence is 1 suicide every 40 seconds (WHO, 2014b).
- In Canada, approximately 11 people a day will end their lives by suicide (Canadian Association for Suicide Prevention [CASP], 2014).
- More than 90% of Canadians who die by suicide have a diagnosable mental illness (MHCC, 2012a; 2013a).
- Suicide claimed the lives of more than 3,500 Canadians in 2012 (MHCC, 2013a).
- Suicide is one of the top ten causes of death in Canada (MHCC, 2012b).
- Suicide is the second leading cause of death, next to accidents, among those aged 15 to 24 (MHCC, 2012b; 2013a).
- Compared with the general Canadian population, suicide is 3 times higher for Aboriginal peoples, 5–6 times more prevalent for Aboriginal youth, and 11 times the national average for Inuit youth, among the highest in the world (Douglas, 2013; Health Canada, 2015).

Canada's mental health strategy *Changing Directions, Changing Lives* includes a comprehensive suicide prevention strategy that covers all six of the identified strategic directions (MHCC, 2012b). As future frontline health care professionals, nurses must be aware of the assessment and prevention strategies and guidelines for suicide prevention available at the local, national, and global level (CAMH, 2011; WHO, 2014b).

Nurses play a key role caring for individuals with depression or who are suicidal, as health care providers can enhance their interventions to help persons achieve optimal health and recovery by recognizing and naming adaptive and/or maladaptive responses to stressors. The extent and negative impact of depression (mood) disorders and suicide nationally and internationally highlights the urgency for well-educated, competent, registered nurses (RNs) to assess, plan, implement, and evaluate safe, competent, and holistic client care.

Physical and Mental Health Links

- Mental health and physical health are strongly linked. People living with a serious mental illness are at higher risk of experiencing a wide range of chronic physical ailments. Conversely, people living with chronic physical health conditions experience depression and anxiety at twice the rate of the general population (CMHA, 2008; Cavanaugh, 2014).
- Co-existing mental and physical conditions can diminish quality of life and lead to longer illness duration and worse health outcomes (Patten, 1999).
- Decades of research have indicated that diabetes mellitus, cardiac disease, and metabolic disorders are more common among people with psychiatric disorders than among the general population (De Hert et al., 2011).
- Depression is both an outcome and a predictor of physical illness. For example, people with depression are 2.6 times more likely to have a stroke and 1.35 to 1.88 times more likely to develop cancer. Conversely, 17%–27% of people with heart disease and 22%–29% of people with cancer develop depression (MDSC, 2013).

Nurses are commonly called upon to provide basic health education and to promote health for physical illnesses such as respiratory disease, but may be underprepared to promote mental health (MHCC,

2013c). The undergraduate education of all registered nurses (RNs) must provide them with the ability to recognize co-existing physical and mental health conditions and the interconnections between them.

Mental Health in the Workplace

- Almost 25% of Canadian workers are affected by mental health problems or disorders that will lead to absence from work, a significant drop in productivity, or job turnover. The economic loss is estimated at $20 billion (Shain, Arnold, & GermAnn, 2013).
- Workplace absenteeism related to psychological conditions can average 65 days per year, as compared to 11 days for respiratory illness, while the costs associated with psychological episodes average $17,734, compared with $2,907 for respiratory illness (Dewa, Chau, & Dermer, 2010).
- Despite growing awareness and action, mental health conditions continue to be the most common reason for disability claims in Canada. Survey respondents identified the top three drivers of their short-term disability claims. "Fully 83% cited mental health conditions, followed by muskuloskeletal/back issues at 76% and accidents at 37%. Similarly, mental health conditions are cited by 85% of respondents as a top driver of their long-term disability claims, followed by muskuloskeletal/back issues at 76% and cancer at 63%" (Towers Watson, 2011, para 3).

Workplace mental health is one of the strategic directions and priorities of *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* (MHCC, 2012a). "Nurses need to understand the psychosocial factors that contribute to a healthy and inclusive workplace, and the need for flexibility in sustaining a healthy workplace and for accommodating employees at risk for stress and/or mental health problems" (Austin, 2015, p. 285). Future graduates entering nursing, the largest component of the health care workforce, need education in mental health and addiction to provide many workplace settings with health promotion education, access to preventive health services (Canadian Standards Association, 2013), and links to primary, secondary, and tertiary health care.

Economic Burden or Investment in Mental Health

- The economic burden of mental health and addiction in Canada is estimated at $51 billion per year. This cost to the Canadian economy includes health care dollars spent, lost productivity, and reductions in health-related quality of life (Jacobs et al., 2010; Lim, Jacobs, Ohinmaa, Schopflocher, & Dewa, 2008; MDSC, 2014; MHCC, 2013c, 2013f; Smetanin et al., 2011).

If one in five Canadians lives with a mental health or an addiction problem, then 20% of the health care budget should be allocated to address this reality. Nurses must be prepared to provide preventative mental health education to reduce the increasing costs associated with mental health conditions as well as to promote quality of life.

A growing body of international evidence demonstrates that mental health promotion, mental condition prevention, and early intervention initiatives show positive returns on investment (MHCC, 2013c, 2013f; Roberts & Grimes, 2011). The strongest evidence for the value of interventions comes from work with children and youth in such areas as conduct disorders, depression, parenting, and suicide awareness and prevention (Roberts & Grimes, 2011). Nurses prepared in mental health assessment of children and youth can thus serve as an investment in the mental health of all Canadians.

Access to Services

- A significant number of Canadians do not receive the treatment and care they need for mental health conditions and addiction disorders (MHCC, 2009, 2012a).
- According to the CCSA, only 0.4% of Canadians who abuse drugs or alcohol are able to access publicly funded substance-use treatment services, suggesting a need for identification and treatment services (Zych, 2015).

Access to mental health and addiction services is an ongoing concern as the health care system continually struggles with limited resources. The health care system must be able to provide physical and mental health access for all people in Canada (CAMIMH, 2006, 2015). Many provincial and territorial governments have made it a priority to improve access to mental health services, including promotion, prevention, early intervention, and community support and treatment programs.

The Canadian Nurses Association, in its recent *Position Statement on Mental Health Services* (CNA, 2012), expects that nurses will "demonstrate strong clinical expertise and leadership in providing mental health services to Canadians, including health promotion, illness prevention, early detection, diagnosis, intervention, crisis management, rehabilitation and recovery" (p. 1). Without curricula specifically focused on mental health and addiction, nurses graduating from Canadian schools of nursing may not have even basic competence in mental health and thus be unable to meet the CNA's position on mental health services, nor the priorities of provincial and territorial governments.

Stigma

- "Stigma occurs around the world, unconfined by demographics or national boundaries" (MHCC, 2013b, para. 2).
- In Canada, 60% of people with a mental health condition or illness do not seek help for fear of being labeled (MHCC, 2013d).
- In Canada, 4 out of 10 people who had unmet mental health treatment needs preferred to manage their condition on their own, according to the *Mental Health Stigma and Discrimination Report* of the larger CCHS mental health survey conducted in 2012 (Statistics Canada, 2013a). Reasons for this may lie in the stigma still associated with mental health conditions.
- Negative beliefs and attitudes still exist among health care providers (including nurses) towards persons with mental health challenges and mental illnesses (MHCC, 2012a; Standing Senate Committee on Social Affairs Science and Technology, 2006a, 2006b).

Nursing students, like all members of society, are not immune to societal perceptions and discrimination towards people with mental health and addiction challenges. Despite the recognition that stigma exists among health care providers, Canadian undergraduate nursing curricula contains limited mental health content (Moxham, McCann, Usher, Farrell, & Crookes, 2011; Tognazzini et al., 2009).

Tragically, persons who seek help for mental health conditions report that they "often experience some of the most deeply felt stigma from front-line health care personnel" (MHCC, 2013e, p. 4). For this reason, health care providers remain one of the target groups of the MHCC's (2013d) *Opening Minds* anti-stigma initiative.

There is a clear need in health care for more mental health promotion, including mental health and addiction assessment, yet a chasm between need and practice remains (Shattell & Apostolopoulos,

2010); undergraduate nursing education provides an obvious start-point for addressing the gaps and stigmas.

Reducing stigma in society requires a change in behaviour and attitudes so that people living with mental illnesses can be assured of acceptance, respect, and equitable treatment. Because nursing professionals constitute a strong and influential stakeholder group that can change both mental health care and social attitudes, nurses would benefit from pre-practice educational programs that provide a uniform stance throughout Canada (Smith & Khanlou, 2013).

Exposure to formal PMH treatment settings can also motivate nursing students to seek both preceptorships and further preparation for employment in this specialized area of practice. At a minimum, such exposure begins to address the health care stigma surrounding people who have, or appear to have, mental health challenges, mental illness, or addiction disorders (MHCC, 2013d, 2013e; Neville & Goetz, 2013).

The most effective response to increase knowledge and decrease stigma is to ensure evidence-informed education of future nurses through a significant increase of psychiatric mental health and addictions theory and practice in undergraduate nursing curricula, as advocated by Tognazzini and colleagues (2008, 2009), and by CASN and CFMHN's joint publication: *Entry-to-Practice Mental Health and Addiction Competencies for Undergraduate Nursing Education* (CASN/CFMHN, 2015).

4.0 LITERATURE/RESEARCH/RESOURCES

Literature from Other Countries

- Studies in Australia and New Zealand exploring nursing students' attitudes and beliefs prior to clinical experiences in PMH nursing suggest that they hold negative attitudes and beliefs about people living with mental illness, including fear that persons with a mental illness are dangerous (Happell, 1999; Happell, Robins, & Gough, 2008; Reed & Fitzgerald, 2005).
- Clinical experience was identified as the most important way to address these fears and foster a more favourable view of PMH nursing (Happell et al., 2008; Happell, 2010; Rushworth & Happell, 2000).
- Research conducted in urban areas of New Zealand reports that many nurses are unprepared to respond to the mental health needs of persons with mental illnesses and addictions (Brinn, 2000). Nurses who graduate without any clinical experience in mental health and addiction state that they have insufficient knowledge, skills, and confidence to intervene with persons who have mental health and addiction challenges (Brinn, 2000; Happell, 2008).
- Happell (2010) from Australia notes that stigma remains high among nurses and PMH nursing content remains low in the majority of undergraduate nursing programs and that "real change is not likely to occur unless specific minimum standards for the mental health content of undergraduate nursing programs are set" (p. 643), a perspective that is supported by the Australian Mental Health Nurse Education Task Force (Department of Health, 2009).

Conclusions drawn from the psychiatric and mental health nursing literature in other countries emphasize clinical experience as highly influential in providing nursing students with the knowledge,

skills, and attitudes to care for persons with mental health and addiction challenges (Martin & Happell, 2001; Mullen & Murray, 2002). Weaving mental health topics into a generic curriculum was found to be ineffective from a pedagogical perspective and ineffective in increasing awareness about stigma (McCann, Moxham, Usher, Crookes, & Farrell, 2009; Moxham et al., 2011).

Research Regarding Mental Health Content in Undergraduate Nursing Programs in Canada

In preparation for the third revision of the CFMHN position paper, members of the CFMHN Education Committee compared the results of a 2006 national environmental scan of undergraduate nursing programs in Canada conducted by members of the Alberta Mental Health Nursing Interest Group (Tognazzini et al., 2008, 2009), and a 2015 systematic literature review of mental health and addiction education in undergraduate nursing programs in Canada by Dr. Amanda Vandyk, University of Ottawa (Vandyk, 2015).

2006 Environmental Scan of Undergraduate Nursing Programs (by the Alberta Mental Health Nurses Interest Group [AMHNIG])

- In 2006, 30 schools of nursing in Canada responded to a questionnaire that asked whether a stand-alone theory course in PMH nursing and a mandatory clinical experience were included in the school's curriculum. Responses indicated that 20% of participating schools of nursing did not offer a dedicated, core course or clinical experience in PMH nursing. Some schools of nursing in Canada stated that PMH nursing theory was 'threaded' or 'woven' throughout the curriculum (Tognazzini et al., 2008, 2009).
- Participating schools were also asked about the number of hours of clinical practice and the number of hours of theory in PMH nursing in their programs (Tognazzini et al., 2008, 2009). Of the 80% of schools of nursing in Canada in 2006 that did offer a mental health theory course, the number of hours of PMH nursing theory and clinical practice varied greatly. The hours of theory ranged from 1.5 to 7.5 hours per week for 12 weeks with a mean of 3 hours per week. The number of hours of clinical experience in a PMH setting varied from 25 to 330 hours over 12 weeks, with a mean of 9 hours per week. The clinical settings included inpatient psychiatric units in general hospitals and psychiatric hospitals as well as outpatient and day programs. Some schools also offered community experience with mental health clinics and with assertive case management teams (Tognazzini et al., 2008, 2009).

Although the results of the environmental scan conducted in 2006 by members of AMHNIG were not published, some of the key findings were cited in a paper by Tognazzini and colleagues (2008) '*Reducing the Stigma of Mental illness'* published in the *Canadian Nurse,* and also cited in the CFMHN's (2009) *Core Competencies in Psychiatric-Mental Health Nursing for Undergraduate Nursing Education: Position paper* (Tognazzini et al., 2009).

2015 Systematic Literature Review of Mental Health and Addiction Education in Undergraduate Nursing Programs (by Vandyk, 2015)

- In 2015, Vandyk conducted a systematic literature review of mental health and addiction education in undergraduate nursing programs in Canada. The purpose was to examine all literature available and information posted on nursing program websites that described the pedagogy for mental health and addiction nursing education (inclusive of theory, clinical practice, and simulation) in undergraduate nursing programs for registered nurses (Vandyk, 2015).

- Vandyk's (2015) preliminary results identified 46 undergraduate nursing degree programs across Canada through a website survey method, and found that 36 (78.26%) of the 46 programs offered a designated (stand-alone) mental health theory course. Of the 36 designated mental health theory courses delivered, 29 were mandatory and 7 were elective. In addition, 1 program had a mandatory combined mental health and cultural crisis course; 8 programs threaded mental health theory throughout their curriculum; and 1 program did not identify mental health content.
- Vandyk (2015) found that only 30 (65.2%) of the 46 nursing programs offered both mental health theory and mental health clinical courses. Of the 30 programs offering a mental health clinical placement, 27 were mandatory; 2 (4.3%) reported having a 50% of the programs had a mandatory clinical experience; 1 (2.2%) had an embedded clinical experience; and 13 (28.3%) of the 46 programs appeared to offer no clinical mental health experience.

Although there may be some limitations to Vandyk's (2015) study, the early results from 46 nursing programs are nonetheless concerning when compared to the results of the environmental scan of 30 nursing programs conducted approximately 10 years earlier. While AMHNIG members in 2006 found that 20% of nursing programs did not have a designated mental health course in the curriculum (Tognazzini et al., 2008, 2009), Vandyk's (2015) scan demonstrated that a higher percentage of undergraduate nursing programs (21.74%) lacked a designated mental health theory course in their curriculum and 28.3% of the nursing programs did not offer a clinical placement in mental health. The finding that mental health theory and clinical experience in undergraduate curricula decreased between the two studies is troubling, given the research in mental health education in other countries and the importance of clinical placements and integration of content (Brinn, 2000; Happell, 2008; McCann et al., 2009; Moxham, 2011). However, partnering with CASN to recommend and deliver mental health and addiction competencies may reverse this trend.

Need for Educational Research in Mental Health and Addiction

Continued research into mental health and addictions education is needed, including

- periodic environmental scans of all nursing programs in Canada to determine the number of nursing programs delivering mental health and addiction concepts; and
- collection of specific information about the number of curriculum hours dedicated to mental health and addictions theory, simulation, and clinical practice, and whether they indicate stand-alone courses or content that is integrated throughout the curriculum.

Given the limited research in mental health education in nursing curricula, CFMHN argues that research is critical in two key areas of undergraduate education:

- the relationship between knowledge and competencies accrued through dedicated mental health courses compared with integrated mental health theory; and
- the association between the number of hours of mental health theory, clinical practice, and simulation in undergraduate programs and the knowledge and skills at graduation and entry-to-practice.

In addition, nurse educators need to conduct research into

- evidence-informed teaching and learning strategies, the efficacy of various approaches to teaching and learning mental health and addiction content to help students optimize stigma reduction and knowledge and skills acquisition.

Resource Textbooks on Mental Health and Addiction (Canadian Context)

There are now a number of existing and developing curricula that can be applied to the Canadian context (McKie & Naysmith, 2014). Two Canadian nursing textbooks available for undergraduate curriculum are

- *Psychiatric & Mental Health Nursing for Canadian Practice* (3rd ed.) by Austin and Boyd (2015); and
- *Varcarolis's Canadian Psychiatric Mental Health Nursing* (1st ed.) by Halter (2014).

Both textbooks include a broad scope of mental health and addiction behaviours, issues, and disorders, along with theoretical foundations, cognitive-behavioural techniques, historical overview, cultural and legal context, ethical practice, psychopharmacology and other biological treatments, and the assessment of specific populations and appropriate interventions. Mental health and addiction disorders reviewed include anxiety and obsessive compulsive disorders, schizophrenia and psychotic disorders, mood disorders, substance related and additive disorders, concurrent disorders, personality and disruptive disorders, impulse control and conduct disorders, feeding and eating disorders, neurocognitive disorders, sleep-wake disorders, and somatic disorders. The mental health and addiction content also includes care of persons who are abused, medically compromised, children and adolescent, older, or offenders.

NCLEX-RN

- Beginning in 2015, all new nursing baccalaureate graduates in Canada began writing the National Council Licensure Exam-Registered Nursing (NCLEX-RN).
- According to the *NCLEX-RN Basic Test Plan*, 8%–14% of the exam questions focus on 'psychosocial integrity' (National Council of State Boards of Nursing, 2013).

The need for mental health and addiction content in every undergraduate program in Canada is further justified by the knowledge required for writing the national licensing exams.

5.0 CORE COMPETENCIES

Core Competencies to Support the Position Statement

Core competencies are essential in undergraduate curricula to assess, plan, implement, and evaluate holistic nursing care with individuals experiencing mental health challenges and mental illnesses, and with families and communities. Competencies refer to the specific knowledge, skills, and personal attributes required for a registered nurse to practice safely and ethically in a designated role and setting.

- The five competency domains are professional responsibility and accountability, knowledge-based practice, ethical practice, service to the public, and self-regulation.
- Core competencies can be applied to mental health promotion and also to patient care in primary, secondary, and tertiary treatment settings.
- For the specific indicators, see the 2015 CASN/CFMHN *Entry-to-Practice Mental Health and Addictions Competencies for Undergraduate Nursing Education* (CASN/CFMHN, 2015).

Need for Entry-to-Practice Mental Health and Addiction Competencies (in Undergraduate Nursing Curricula)

- Entry-level competencies in mental health and addiction are needed in every practice setting including, but not limited to, psychiatric emergency services, acute care inpatient and outpatient mental health programs, cardiac and surgical units, correction/forensic institutions, long-term and palliative care facilities, addiction centres, and occupational health clinics.
- Although it is common for undergraduate nursing students to feel apprehensive about transitioning into the graduate nursing role in any area of nursing, entry-to-practice core competencies in mental health and addictions are needed in undergraduate nursing programs when 20% of Canadians live with a mental health condition and/or addiction, in addition to the high frequency living with concurrent and co-morbid disorders.
- Nurses encounter persons with mental health conditions and addiction disorders in all health care populations, including persons with depressive symptoms after heart surgery, women with postpartum depression, families with a member exhibiting signs of a medication-induced psychosis, persons suffering from post-traumatic stress symptoms or anxiety disorders, and/or persons with pre-existing disorders who shows signs of mental distress in hospital or community settings.

How will new graduate nurses be able to advocate for persons with mental health conditions and addictions if they have not had theoretical and clinical nursing exposure in their undergraduate nursing program? Quality mental health education throughout nursing programs will benefit the nursing profession as a whole. Nursing graduates will better understand what mental illness entails and how to support those living with it. Mental health education and exposure to persons with mental health conditions may spark students' interest in this often undervalued field and encourage more nursing students to pursue this important and rewarding area of nursing as a career (Boyko, 2011).

Need for Competencies in Mental Health and Addiction by Other Health Care Providers

The need for core competencies in mental health and addiction is also recognized by other health care providers, as noted by recent publications:

2014 *Registered Psychiatric Nurse Entry-Level Competencies,* developed by the Registered Psychiatric Nurses Regulatory Committee (RPNRC, 2014) specifically for the RPN programs in Canada.

2014 *Mental Health Core Competencies for Physicians,* developed by the Royal College of Physicians and Surgeons of Canada (RCPSC, 2014) to enhance care for patients with mental health conditions and addictions who receive treatment for a physical illness from a physician (especially in specialties other than mental health).

A number of the recommendations of the *Mental Health Strategy for Canada* (MHCC, 2012a), emphasized the importance of core competencies in mental health and addictions for all health care professionals.

6.0 CFMHN RECOMMENDATIONS

- CFMHN believes that education (both theoretical knowledge and psychomotor/psychosocial clinical skills) in mental health and addiction for all undergraduate nursing students in Canada is essential.
- CFMHN believes that the quality and quantity of mental health education in undergraduate nursing curricula is critical to de-stigmatization, and to the visibility and advancement of the overall mental health of Canadians.
- CFMHN strongly recommends collaboration between educators and nursing staff when designing and providing clinical experiences for nursing students.
- CFMHN, based on consensus opinion of members, prefers that mental health and addiction nursing concepts be taught via stand-alone theory courses and dedicated clinical practicums. Although it may not be possible to provide all nursing students with a 'clinical' mental health and addiction placement in an acute care inpatient psychiatric setting, many clinical alternatives provide exceptional mental health and addiction experiences: mental health outpatient clinics, schools, addiction centers, senior centers, forensic psych and correctional centers, homeless and domestic violence shelters, and others.
- CFMHN strongly recommends incorporating mental health and addiction core competencies both into theory courses and clinical practice based on the *2015 CASN/CFMHN Entry-to-Practice Mental Health and Addictions Competencies for Undergraduate Nursing Education* (CASN & CFMHN, 2015).

7.0 CONCLUSION

In 2016, the scope and complexity of mental health conditions and addiction issues globally provides a clear justification for including mental health and addiction competencies within all nursing undergraduate programs in Canada.

CFMHN argues that it is reprehensible for schools of nursing to graduate nursing students who have little or no knowledge of caring for the 20% of Canadians living with mental health conditions and/or addiction problems. Furthermore, nurse educators may perpetuate societal stigma if their programs never expose students to persons and families experiencing mental health conditions.

The need for the education of future nurses to have solid knowledge, judgment, and skills in mental health and addiction informs CASN/CFMHN's (2015) recommended competencies, which align with the CFMHN *Canadian Standards for PMH nursing* (CFMHN, 2014) and underpin this position statement:

POSITION STATEMENT

The Canadian Federation of Mental Health Nurses (CFMHN) 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)**

Approved by CFMHN Board December 2015

ÉNONCÉ DE POSITION

La Fédération canadienne des infirmières et infirmiers en santé mentale (FCIISM-CFMHN) recommande l'inclusion de connaissances théoriques et de compétences cliniques en santé mentale et toxicomanies dans l'enseignement des programmes de sciences infirmières de premier cycle menant à l'admission à la pratique au Canada. La FCIISM privilégie la transmission de ces compétences fondamentales par l'offre de cours distincts et d'expériences cliniques portant de façon spécifique sur la santé mentale et toxicomanies. Indépendamment des approches pédagogiques utilisées, l`acquisition de solides connaissances en santé mentale et toxicomanies représente l'objectif obligatoire de la formation infirmière de premier cycle tel que stipulé dans les normes de pratique de la FCIISM (CFMHN).

Cet énoncé de position a été approuvé par la direction du FCIISM-CFMHN en décembre 2015.

[Traduction française par Louise Racine, RN, PhD, Professor, College of Nursing, University of Saskatchewan]

8.0 GLOSSARY and ACRONYMS

TABLE 4. Glossary

Most definitions selected for inclusion are from the major mental health associations and organizations in Canada.

Addiction

- In this position statement, 'addiction' is an umbrella term that includes substance misuse, substance abuse, substance dependence, and behavioural addictions such as gambling, shopping, eating disorders, internet gaming, sex addictions, etc.
- 'Behavioural addiction' is commonly defined as a state characterized by compulsive engagement in rewarding stimuli despite adverse consequences (Angres & Bettinardi-Angres, 2008).
- The term 'addiction' has been used to recognize all substance-related and addictive disorders included in DSM-5 (American Psychiatric Association [APA], 2013a, 2013b), and to reflect the more prevalent language used in public and legal texts.
- 'Addiction' is recognized by both the major disease classifications, DSM-5 (APA, 2013a) and ICD-10 (WHO, 2007), as a bona fide, chronic, and relapsing medical condition.
- Addiction is defined in two ways: "psychological dependence (the individual believes the substance is necessary for social functioning) and physiological dependence (increased consumption over longer periods of time, increased tolerance, withdrawal symptoms and health problems related to substance intake)" (MDSC, 2009, p. 31).

Concurrent disorders

- 'Concurrent disorders' describes the occurrence of at least one substance-related or addictive disorder co-occurring with one other mental disorder. DSM-5 lists more than 300 psychiatric maladies (APA, 2013a).
- 'Concurrent disorders' also describes a condition in which a person has both a mental illness and a substance use problem. This term is a general one and refers to a wide range of mental illnesses and addictions (CMHA, 2015).

Depression

- Depression or a depressive episode can be defined as "a depressed mood or loss of interest and pleasure in nearly all activities" (Austin & Boyd, 2015, p. 921).
- "Mood is a pervasive and sustained emotion that colours one's perception of the world" (Austin & Boyd, 2015, p. 926) and how one functions in it.

Mental disorder

- A disorder of thought, perception, feelings, or behavior that seriously impairs a person's judgment, capacity to recognize reality, ability to associate with others, or ability to meet the ordinary demands of life in respect of which treatment is advisable (Government of Saskatchewan, 2013, p. 4).
- The introduction in DSM-5 states that "Mental disorders are defined in relation to cultural, social, and familial norms and values. Culture provides interpretive frameworks that shape the experience and expression of the symptoms, signs, and behaviors that are criteria for diagnosis" (APA, 2013a, p. 14).

Mental health

- 'Mental health' is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community (MHCC, 2012a; WHO, 2014a).
- In Canada, according to the CAMIMH (2006) national framework, 'mental health' is a generic term encompassing the continuum of positive mental health, mental illness, disorders, conditions, and addictions.

Mental health and addictions (MHA)

- 'Mental health and addictions' (MHA) describes a range of mental health conditions from mild to more severe mental illnesses, and substance problems ranging from misuse to abuse to dependence (CCSA, 2009).

Mental health condition

- 'Mental health condition' as a term was adopted from the 2010 report by the World Health Organization *Mental Health and Development: Targeting People with Mental Health Conditions as a Vulnerable Group* (WHO, 2010).
- 'Mental health condition' has been used to describe all mental disorders or illnesses that meet generally accepted criteria for clinical diagnosis. They include common conditions such as depression and anxiety disorders, as well as far less common conditions such as schizophrenia or bipolar disorder. Terminology is important; describing these conditions as mental health 'problems' reinforces the false stereotype that individuals who have such conditions are always problematic in the workplace. In fact, many people are able to manage their mental health condition successfully and continue to perform excellently in their jobs (Government of the United Kingdom, 2009, p. 11).

Mental health conditions or mental illness

- 'Mental health conditions' or 'mental illness' is used to encompass the spectrum of diagnosable mental illnesses, disorders, conditions, and addictions (CAMIMH, 2006).

Mental illness and addictions

- 'Mental illness and addictions' as a term refers to a wide range of disorders that affect mood, thinking, and behaviour. Examples include depression, anxiety disorders, schizophrenia, as well as substance use disorders and problem gambling. 'Mental illness and addictions' can be associated with distress and/or impaired functioning. Symptoms vary from mild to severe (CAMH, 2012).

Mental health problems and/or mental illnesses

- 'Mental health problems and/or mental illnesses' are terms to describe "clinically significant patterns of behaviour or emotions that are associated with some level of distress, suffering or impairment in one or more areas such as school, work, social and family interactions or the ability to live independently" (MHCC, 2009, p. 11).

Mental well-being

- Mental well-being is a fundamental component of WHO's definition of health. Good mental health enables people to realize their potential, cope with the normal stresses of life, work productively, and contribute to their communities (WHO, 2013).

Recovery

- 'Recovery' is the personal process that people with mental health conditions experience in gaining control, meaning, and purpose in their lives. Recovery involves different things for different people. For some, recovery means the complete absence of the symptoms of mental illness. For others, recovery means living a full life in the community while learning to live with ongoing symptoms (CMHA, 2014b).
- The concept of 'recovery' in mental health refers to living a satisfying, hopeful, and contributing life, even when there are on-going limitations caused by mental health problems and illnesses (MHCC, 2014).

Stigma

- 'Stigma' refers to negative, unfavourable attitudes and the behaviour they produce. Suicide, for example, spreads fear and misinformation, labels individuals, and perpetuates stereotypes. Stigma against people with mental illnesses is oppressive and alienating; it prevents many from seeking help, denying them access to the support networks and treatment they need to recover (MHCC, 2013e).

Suicide

- Suicide is "the voluntary and intentional act of killing oneself" (Murray & Austin, 2015, p. 340).
- Suicide is a serious public health problem that can have lasting, harmful effects on individuals, families, and communities. Suicide remains surrounded by fear, shame, and silence (MHCC, 2012b).

Workplace health

- "Workplace health is the promotion and maintenance of the health and well-being of workers through policies, programs, and practices that promote safety, minimize risk, and create a positive, responsive, equitable workplace culture and a supportive workplace climate" (Austin, 2015, p. 275).

Workplace violence

- "Workplace violence includes any type of intimidation, harassment, or abuse directed against a person in his or her place of employment as well as encompassing physical assault" (Austin, 2015, p. 280).

TABLE 5.	Acronyms
AMHNIG	Alberta Mental Health Nurses Interest Group
CAMIMH	Canadian Alliance on Mental Illness and Mental Health
CASN	Canadian Association of Schools of Nursing
CASP	Canadian Association for Suicide Prevention
CCSA	Canadian Centre on Substance Abuse
CCHS	Canadian Community Health Survey
CFMHN	Canadian Federation of Mental Health Nurses
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
RN	Registered Nurse
RNAO	Registered Nurses' Association of Ontario
RPN	Registered Practical Nurse
RPN	Registered Psychiatric Nurse
RPNRC	Registered Psychiatric Nurse Regulators of Canada
RCPSC	Royal College of Physicians and Surgeons of Canada
PHAC	Public Health Agency of Canada
PMH	Psychiatric Mental Health Nursing
WHO	World Health Organization

9.0 REFERENCES

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