# CANADIAN STANDARDS OF PRACTICE FOR PSYCHIATRIC-MENTAL HEALTH NURSING

5th Edition — September 2023

Canadian Federation of Mental Health Nurses

# Canadian Standards of Practice for Psychiatric-Mental Health Nursing – 5th edition


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**Land Acknowledgement**
In Canada, from coast to coast to coast, we acknowledge the ancestral unceded territories and treaty lands of the First Nation, Inuit, and Métis peoples who have been displaced with colonization.


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# Contents

# Introduction

In Canada, psychiatric-mental health nurses are a broad group of practitioners who are licensed in their respective provinces and territories.

They include registered nurses (RNs), registered psychiatric nurses (RPNs), nurse practitioners (NPs) and licensed practical nurses / registered practical nurses (L/RPNs). They provide specialized care for mental health as well as substance-related and addictive disorders to individuals, families, groups, communities, and populations in a wide array of settings. Psychiatric-mental health nursing (PMHN) is provided in-person and virtually across the mental health continuum of care for all ages. The settings include but are not limited to inpatient and outpatient, acute and continuing care, addictions, community, forensics, and public health. PMHN continues to evolve in response to both the acute and complex changes in population needs and the alternative-care delivery technologies. Psychiatric-mental health nurses adapt to change by expanding their specialty nursing knowledge and their understanding of mental health and mental disorders while delivering competent; evidenced-informed; and safe, ethical care to Canadians.

The mental health of Canadians has been impacted by several unprecedented national and global events. The pandemic world that began in 2020 created changes beyond anyone's imagination through stay-at-home isolation; physical distancing; dependency on virtual and social media technologies; mask wearing; stressors at point of care settings; and repeated lockdowns of businesses, schools, and places of worship. The distressing circumstances related to COVID-19 (2019-nCoV acute respiratory disease) made more visible for Canadians the issues of domestic/intimate partner violence and the opioid crisis.

In Canada, the retraumatizing discovery of unmarked gravesites of hundreds of Indigenous children at former sites of residential schools has heightened national attention to the impact of colonialism. Canadians must confront highly publicized events of systemic, targeted community and individual sexual abuse, racism, hate crimes, mass murders, and other forms of trauma and violence. There are widespread calls for grassroots changes to structural and systemic racism that impacts the mental health and wellness of Black, Indigenous, and people of colour; gender; and LGBTQQIP2SSAA+ (lesbian, gay, bisexual, transgender, queer, questioning, intersex, pansexual, 2-spirited, asexual and allies) to ensure diversity, equity, and inclusivity (DE&I) for all.

Rapid global political, social, and economic unrest and military conflict continue. All these issues, including resultant migration and immigration, place pressure on society's mental health resources. In addition, the existential threats from climate change and the traumatic impacts of environmental catastrophes in Canada (e.g., drought, forest fires, floods,

hurricanes) have increased eco-anxiety and other mental health concerns in our population.

Mental health care in Canada occurs under the provisions of federal/provincial/territorial mental health acts and respective legislation. Canadian psychiatric-mental health nurses have long advocated for changes to the country's evolving mental health care system and policies. They continue to support and respond to Canada's mental health strategy (Mental Health Commission of Canada [MHCC], 2012) entitled *Changing Directions Changing Lives: The Mental Health Strategy for Canada* and the T*ruth and Reconciliation Commission of Canada: Calls to Action* (Truth and Reconciliation Commission of Canada [TRC], 2015). The practice of PMHN is also informed by the *Social Determinants of Health* (World Health Organization [WHO], n.d.), and the seventeen sustainable development goals (Department of Economic and Social Affairs, n.d.).

The Canadian Federation of Mental Health Nurses' (CFMHN's) *Canadian Standards of Practice for Psychiatric-Mental Health Nursing* (referred to as "the *Standards*" in this document) are nursing specialty standards to guide practice. Revision of the *Standards* ensures that PMHN practice remains evidence informed, contemporary, relevant, and responsive to the needs of individuals, families, communities, and the health care system. The myriad social issues, global events, and mental health policy changes impacting Canadian society, and described above, have provided the context for revisions to the 5th edition of the *Standards*.

This 5th edition of the *Standards* includes a brief discussion on the evolution of the previous editions of the CFMHN standards of practice and highlights the revised 5th edition of the practice standards. This historical overview of the *Standards*'s development offers insights into the changing Canadian practice contexts shaping our specialty nursing values and care priorities over time. Included in the 5th edition are the purpose of the *Standards* for specialty practice, current issues, values and beliefs, glossary (with terms defined and a list of abbreviation), two appendices and references.

# Evolution of the CFMHN's Standards of Practice

Throughout the past three decades, developing and revising the *Standards* (Canadian Nurses Association [CNA], 2002; Fritzsche, 2008; Kane, 2015; Martin et al., 2013) have been a mandate for the CFMHN. As societal and health care issues and trends, along with empirical evidence, have evolved, so too the *Standards* have responded with timely and substantive revisions. Table 1 is a timeline synopsis of the title and highlights of each edition of the *Standards*. Furthermore, see Appendix A for reflection on the title of the 5th edition.

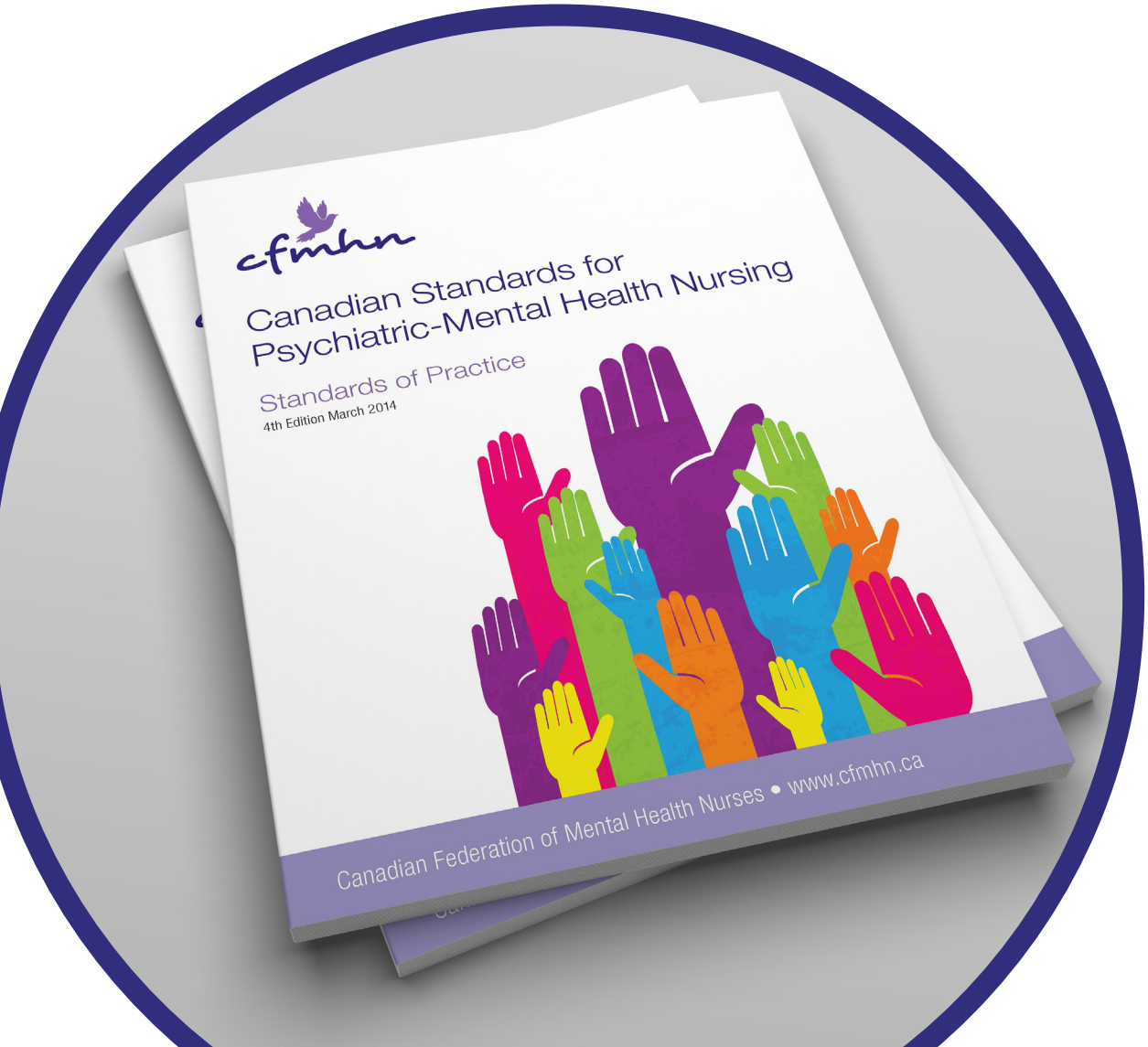

**Table 1**
*Record of Changes*

| *Standards* Edition | Highlights |
|---|---|
| **5th edition (2023)**<br><br>*Canadian Standards of Practice for Psychiatric-Mental Health Nursing* | Recognizes the unprecedented social, political, economic, and environmental / climate change issues that impact the mental health of Canadians by;<br>• updating the literature review on Indigenous mental health, social determinants of health (SDoH), violence, antiracism, intersectionality, substance-related and addictive disorders, COVID-19 pandemic and mental health, and medical assistance in dying (MAiD) and mental health;<br>• incorporating the feedback of two surveys of CFMHN members (pre- and post-COVID-19 pandemic onset) in Fall of 2019 and of 2020 described in Appendix B;<br>• supporting the TRC (2015) and its recommendations;<br>• including advances in technology and virtual care;<br>• acknowledging that the *Standards* are relevant to a broader range of regulated nurses providing specialized mental health care, e.g., RNs, RPNs, L/RPNs, and NPs;<br>• acknowledging the national inquiry into the violence against Indigenous women (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019a, 2019b);<br>• making reference to evolving legislations and policies, including the Cannabis Act (2018), British Columbia's exemption to decriminalization some illegal drugs for personal use (Government of British Columbia, 2022); MAiD and mental illness (Health Canada, 2022);<br>• increasing awareness of discrimination and systemic racism in Canada (Turpel-LaFond, 2020); and<br>• organizing the *Standards* to flow from the micro (individuals) to the macro (organizations and systems). |
| **4th edition (2014)**<br><br>*Canadian Standards for Psychiatric-Mental Health Nursing: Standards of Practice* | • Emphasis placed on primary health care principles, the recovery model, ethics, the therapeutic relationship, reduction of stigma, and embracing and appreciating diversity.<br>• Supported *Changing Direction, Changing Lives: The Mental Health Strategy for Canada* (MHCC, 2012).<br>• Literature was updated to support the *Standards*'s indicators.<br>• Raised a call for more nursing research that is specifically focused on indicators that lacked strong empirical evidence.<br>• Responded to survey requests to make the *Standards* more accessible to different groups of expert psychiatric-mental health nurses, who practice across all sectors from academia to clinical to research (McInnis-Perry et al., 2015). |

| *Standards* Edition | Highlights |
|---|---|
| **3rd edition (2006)**<br><br>*Canadian Standards for Psychiatric-Mental Health Nursing* | • Title was changed to *Canadian Standards for Psychiatric-Mental Health Nursing*.<br>• Addressed input from 31 consumers of mental health services across Canada, who participated in focus groups. They identified the themes that required indicator enhancement/development: therapeutic relationships, education, work environment, teaching, nurses' stigma, safety and risk management, patient-centred care, consumer experience, and biological/psychological aetiology of mental illness. |
| **2nd edition (1998)**<br><br>*Canadian Standards of Psychiatric and Mental Health Nursing Practice* | • Title was changed to *Canadian Standards of Psychiatric and Mental Health Nursing Practice*.<br>• Mental health nursing specialty expanded beyond acute and long-term care in hospital settings to community care models.<br>• Included input from practitioners across the country. |
| **1st edition (1996)**<br><br>*Standards of Psychiatric and Mental Health Nursing* | • Mental health nursing leaders across Canada created an inaugural standards document that recognized the mental health nursing specialty. It was the forerunner to specialty certification: Certification in Psychiatric-Mental Health Nursing (Canada).<br>• Benner's (1984) domains of practice framework were used to acknowledge the transition from novice to expert, typified by nurses with two- or three-years' experience within the mental health specialty. |

# Development of CFMHN's 5th Edition Standards of Practice

This CFMHN Standards Committee is a subcommittee of CFMHN's Education Committee, with representation from across the country, various mental health sectors, and different regulated nursing professionals who provide mental health care.

The *Standards* continue to use Benner's (1984) "domains of practice" as the conceptual framework and recognize the nurse as evolving from a novice to expert within the mental health nursing specialty practice. The competencies are classified under seven domains: (1) therapeutic relationship, (2) systematic assessment and decision making, (3) administering and monitoring therapeutic interventions, (4) effective management of rapidly changing situations, (5) teaching/coaching function, (6) monitoring and ensuring the quality of health care practices, and (7) organizational and work-role competencies.

With each update to the *Standards*, the CFMHN membership has been surveyed to identify current issues and concerns. For this present 5th edition, surveys were conducted in 2019 prior to the COVID-19 pandemic and again in October 2020 at the emergence of subsequent waves of COVID-19. Presentations on the process of revising the *Standards* were made to the membership during CFMHN's conference workshops in 2019 and 2021 and included interactive input from the participants.

# Transformation in Canadian Nursing: Impact on Standards Development

Previous editions of the *Standards* were developed for RNs working in the specialty area of PMHN. More recently, the CNA has positioned itself to represent all nursing professionals, inclusive of the full range of nursing licensure across Canada. For this reason, the CFMHN has followed suit with a need to broaden the relevance of the *Standards* to regulated nurses beyond RNs.

### CNA's Professional Family of Regulated Nurses

The history of professional nursing in Canada was transformed at the CNA convention on June 18, 2018. RNs voted overwhelmingly (135 to 10) to open the CNA membership to invite all regulated nursing professionals in Canada (CNA, 2019). This change to CNA (2019) governance structure now welcomes a family of regulated nursing professionals: RNs, RPNs, and L/RPNs. Psychiatric-mental health nurses may also hold advanced practice positions such as NP or clinical nurse specialist (CNS) roles. Prior to 2018, the CNA was the national voice of RNs in Canada. Now, CNA provides the national professional voice of all Canadian nurses. This governance change was important, as some of the CNA nursing specialties had already made those changes to their membership (i.e., added L/RPNs/NPs) or were in the process of making this change. As of 2020, CNA's certification process for Certified in Psychiatric and Mental Health Nursing (Canada) [CPMHN(C)] has been opened to RPNs.

As regulated health professionals (Almost, 2021; Canadian Institute for Health Information, 2021), nurses are given the authority to practice under provincial/territorial laws that set out governance, registration, and discipline requirements as a means of protecting the public. These laws require provincial/territorial nursing regulatory bodies to set, monitor, and enforce standards of practice that along with the code of ethics articulate a profession's values, knowledge, and skills. Such standards facilitate a professional self-governance because they make explicate the profession's expectations of its member's competence and performance (Austin, 2019).

The CFMHN specialty standards of practice are intended for nurses specializing in psychiatric-mental health in Canada. In addition, these standards of practice will be made available to and may be helpful for nurses in various regulatory designations.

# Purpose of Specialty Practice Standards

"The primary purpose of having Standards is to provide direction for professional practice in order to promote competent, safe, and ethical service for clients" (CNA, 2017, p. 9).

Standards enable nurses to articulate and be accountable to the desired and achievable level of performance in this specialty area (McInnis-Perry et al., 2015). The *Standards* guide the evaluation of PMHN practice within a professional and ethical framework. The *Standards* informed the *Entry-to-Practice Mental Health and Addiction Competencies for Undergraduate Nursing Education*, which provided guidance for baccalaureate nursing curricula in Canada (Canadian Association of Schools of Nursing [CASN] & CFMHN, 2015) and the CNA CPMH(C) (Austin et al., 1996).

# Current Issues Shaping the Practice Context

When the CFMHN Standards Committee undertook the work of developing this 5th edition, the world was amid the COVID-19 pandemic which was declared by WHO on March 11, 2020 (WHO, 2020). Additional interrelated issues emerged due to the confluence of evolving political, economic, cultural, and social contexts at the time of writing of this document. The main issues are listed below, in no particular order of priority:

### 1. Impact of COVID-19 Pandemic on Well-Being

- Rising mental health stress due to COVID-19 pandemic sequelae, such as the disease's physical impact, social isolation, and interpersonal relationship disruptions (Arevian et al., 2020; Bedore, 2020; Centre for Addiction and Mental Health [CAMH], n.d.-a; Gruber et al., 2021; Zelyck, 2020).
- Distressing circumstances related to COVID-19 increased the prevalence of domestic / intimate partner violence (DeJong et al., 2020; Nelson et al., 2022).
- Need for integrated care for comorbid acute/chronic physical and mental conditions (Pan et al., 2021).
- Response to increased COVID-19–related mortality rates (COVID-19 Excess Mortality Collaborators, 2022).
- COVID-19–related illness and stressors in health care workers (Buselli et al., 2020; Elia & Vallelonga, 2020; Horesh & Brown, 2020).
- Differential impact of the pandemic on vulnerable populations (Cénat et al., 2021; Doan et al., 2021; Friesen et al., 2021; Statistics Canada, 2020).
- Heightened opioid crisis epidemic within the context of the COVID-19 pandemic (Government of British Columbia, 2022).
- Systemic impact of pandemic public health restrictions and interventions (Horesh & Brown, 2020; Moreno et al., 2020).

### 2. Indigenous Wellness and Mental Health

- Indigenous lens / world views of wellness and mental health differ from Eurocentric models (Douglas, 2020; Graham & Stamler, 2010; Kent-Wilkinson & Austin, 2023).
- Emotional triggers by highly publicized events of systemic, community, and individual racism (Mezey et al., 2016; Turpel-LaFond, 2020), including the disturbing and traumatic discovery of unmarked gravesites of Indigenous children at sites of former residential schools (Phillips-Beck et al., 2020; Quon & Issa, 2022).

- Lack of knowledge and education of history of Indigenous people in Canada (Schmalz et al., 2022); need for cultural safety and antiracism principles to be embedded in practice standards and nursing curricula (CASN, 2020; Kent-Wilkinson & Austin, 2023).
- Inadequate, inequitable gaps in mental health care and resources: Indigenous mental health, substance-related and addictive disorders, concurrent disorders, medical comorbidities, and dual diagnoses (Kunyk, 2023a; Pathways Indigenous Health Collaboration, 2021; Perdacher et al., 2019).
- Culture as a SDoH (WHO & Calouste Gulbenkian Foundation, 2014; WHO, n.d.).
- Intergenerational trauma (Franco, 2021; Graham & Austin, 2023).
- Ongoing colonizing processes as factors impacting mental health (Douglas, 2020).
- Indigenous overincarceration in the criminal justice system and overrepresentation in the foster care system (Cesaroni et al., 2019; Clark, 2019; Office of the Correctional Investigator [OCI], 2020).
- Need for the *Standards* to acknowledge that the *Truth and Reconciliation Commission of Canada: Calls to Action* (specifically #19, #23iii, #24, and #40–48) directly relate to mental health (i.e., suicide, addictions, fetal alcohol syndrome disorder, and chronic illness), overincarceration of Indigenous people in the criminal justice system, nursing curricula, and the need for cultural-competence training for all health care professionals (TRC, 2015).

### 3. Impact of Stigma, Discrimination, and Racism on Mental Health

- Ongoing impact of stigma, racism, and colonizing processes on mental health today (CNA, 2020b; MHCC, 2018; Turpel-LaFond, 2020).
- Need for nurses to examine own beliefs and practices, which may be sources of stigma and racism (MHCC, 2013b).
- Importance of ongoing destigmatization interventions (Government of British Columbia, 2021; Turpel-LaFond, 2020).
- Structural stigma; systemic and individual racism (Beaulne-Stuebing, 2021).
- Increased awareness and reporting of hate crimes (CBC News, 2021; McElroy, 2017; Zine, 2021).
- Ongoing exposure to stigma and racism through social media (Lowrie & Malone, 2020).
- Mental health issues further contributing to compounding stigma and discrimination (Mezey et al., 2016).
- Increased awareness of discrimination toward vulnerable populations (e.g., ableism, homeless, LGBTQQIP2SAA+, and cultural minority groups; Adam & Jiang, 2023).

### 4. Abuse, Violence, and Trauma

- Trauma (CAMH, n.d.-c), historical (Aguiar & Halseth, 2015; Graham & Austin, 2023), intergenerational (Aguiar & Halseth, 2015; Brave Heart, 2003; Fossion et al., 2003; Franco, 2021), and intersectional (Ezell et al., 2021).
- Need for trauma-informed care (TIC; Browne & Baker, 2016; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014) and/or trauma- and violence-informed approaches (Hirani & Varcoe, 2023; Ponic et al., 2016; Public Health Agency of Canada [PHAC], 2018).

- Bullying of vulnerable populations (e.g., cyber bullying; Jones-Bonofiglio, 2023; Kunyk, 2023b).
- LGBTQQIP2SSAA+ abuse issues (Adam & Jiang, 2023; Hirani & Varcoe, 2023).
- Intimate partner abuse affecting mental health (Nelson et al., 2022).
- Immigrant and refugee mental health issues (O'Mahony & Clark, 2018; Salmani et al., n.d.).
- Impact of mass violence in a community (CBC News, 2022; Graham & Austin, 2023; Lopez-Martinez, 2022).
- Adverse childhood experiences as well as age-related abuse and trauma vulnerabilities across the lifespan (i.e., children, youth, adults, and elders; Centers for Disease Control and Prevention, 2021; Graham & Austin, 2023; Hall et al., 2021; Peternelj-Taylor, 2018).
- Occupation-related posttraumatic stress and mental health vulnerabilities (e.g., health care personnel, military personnel, and first responders; Kunyk, 2023b; MHCC, 2013a).
- Intersectional discrimination (Adam & Jiang, 2023; Ezell et al., 2021).

### 5. Substance-Related, Addictive, and Concurrent Disorders

- Increased prevalence of substance-related, addictive, and concurrent disorders requiring support for an extensive integrated continuum of care (CAMH, n.d.-a; Canadian Centre on Substance Abuse and Addiction, n.d.; CNA, 2020a; Registered Nurses' Association of Ontario [RNAO], 2015a).
- Escalated opioid overdose crisis in Canada and ongoing predominance of harmful effects of alcohol and tobacco use across the country (Government of British Columbia, 2022).
- Evolving social and political climate impacting delivery of care (e.g., legalization of cannabis, discussions of decriminalizing possession of a small amount of substance, and harm reduction strategies; Cannabis Act, 2018; Government of British Columbia, 2022; Health Canada & PHAC, 2019).
- Rising importance of specialized knowledge and skills for withdrawal management, harm reduction, and pharmacological interventions (Kunyk, 2023a).
- Increased need for relevant resources and services to respond to increased acuity and complexity of comorbidities related to substance-use issues (Kunyk, 2023a).
- Current trend toward policy and program planning to integrate substance-related and addictive disorders with mental health care (CAMH, n.d.-b; Correctional Service Canada, 2012; Correctional Service Canada, 2019).

### 6. Comorbid Medical Conditions With Mental Disorders

- Medical and mental health care historically siloed in mental health care settings due to institutional and systemic barriers (Douglas, 2020).
- Unprecedented demand on operational and human resources in the health care system, creating an increased need to care for individuals with mental health conditions holistically and in-situ in a mental health and/or nonmental health setting (Canadian Mental Health Association Ontario, n.d.).
- Increased susceptibility of individuals with serious mental disorders to have chronic physical illnesses and disabilities associated with metabolic side effects of pharma-therapeutics, lifestyle, and the SDoH.

- Persons with mental disorders at risk for significantly shortened life spans and poorer health due to stigma, discrimination, and other barriers to appropriate and respectful health care (Correctional Service Canada, 2019; Douglas, 2020).

### 7. Influences on Professional Roles and Responsibilities

- Increasing awareness of and demand for mental health services; exacerbated systemic inequity in financial allocation for essential resources.
- Changing technologies to include e-mental health and clinical informatics (Li et al., 2022; Steidtmann et al., 2020).
- Increasing need for role clarity due to evolving scopes of practice within the nursing profession and across health professionals working collaboratively within mental health settings.
- Expanding view of the health care team and circle of care to include partnership and collaboration with clients and their natural support systems.
- Experiences of vicarious stigma working in the mental health field impact practice and collegial collaboration.
- Ensuring continuing education to update mental health nursing knowledge, skills, and competences (e.g., legislative changes, diagnostic criteria, pharmacological interventions, physical care for complex comorbid conditions, delivering virtual care, and behavioural support in long-term care).
- Evolving paradigm shift to holistic care to focus on SDoH (WHO, n.d.).
- Challenges of providing mental health care in nonmental health care settings; ongoing debates and inconsistencies in undergraduate nursing education vis-à-vis mental health nursing theory and clinical practice as separate courses versus integrated curricula.
- Barriers to securing adequate student clinical placements in mental health; inadequate time and content.
- Growing demand for faculty, clinical instructors, and preceptors with mental and physical health expertise.
- Continuing need for mental health nursing research as well as evidence-informed and/or best practices in mental health care.
- Increased responsibility to lead in current political and professional issues.

### 8. Social Determinants of Health

- Within the broader determinants of health, a heightened awareness of the impact of SDoH on mental health (WHO; n.d.; WHO & Calouste Gulbenkian Foundation, 2014).
- Impact of unprecedented social, political, economic, and environmental / climate change issues on SDoH (Adam & Jiang, 2023; Kent-Wilkinson & Austin, 2023).
- Need to address systemic inequities in the SDoH and access to mental health services and resources (Graham & Martin, 2016; Graham & Stamler, 2010; PHAC, 2022).
- Fracture of mental health care services by lack of attention to population demographics and cultural diversities (Graham & Stamler, 2010).
- Emphasis on healing, recovery, and well-being (Canadian Mental Health Association [CMHA], 2021; MHCC, 2015).

### 9. Suicide and Self-Harm

- Mounting suicide risk and self-harm behaviours relating to societal stressors associated with the pandemic and increased substance use (CMHA, 2021).
- Increasing demand for mental health services for people at risk for suicide and self-harm (Jones-Bonofiglio, 2023).

### 10. Legislative Changes

- Recent legislative changes impacting individuals living with a mental disorder.
- Responsibility of psychiatric-mental health nurses to stay current with legislative changes that impact the delivery of mental health services, including the following:
    - 2016 MAiD legislation and the 2023 target for including mental illness in MAiD (Health Canada, 2022);
    - 2018 Cannabis Act to legalize recreational cannabis use in Canada (Cannabis Act, 2018);
    - 2019 Updates to Privacy Acts and Access to Information Act (Canada Council for the Arts, 2019);
    - 2022 exemption decriminalizing possession of some illegal drugs for personal use in British Columbia (Government of British Columbia, 2022); and
    - ongoing amendments and revisions to provincial/territorial mental health acts, health care consent acts, and substitute decisions acts (Mental Health Act, 2023; Mental Health Services Act, 2020).

# Values and Beliefs

The *Standards* are grounded in the seven primary nursing values stated in the CNA (2017) *Code of Ethics for Registered Nurses*:

1. providing safe, compassionate, competent, and ethical care;
2. promoting health and well-being;
3. promoting and respecting informed decision making;
4. honouring dignity;
5. maintaining privacy and confidentiality;
6. promoting justice; and
7. being accountable.

In addition to these values, psychiatric-mental health nurses have beliefs specific to our practice with assumptions we hold to be true. Our beliefs are relevant for individual-, family-, and community-centred care. They are important in the context of our practice that is shaped by the social, cultural, legal, economic, environmental/climate and political factors impacting mental health care in Canada.

**Psychiatric-mental health nurses believe:**

- that therapeutic nurse-client relationships are based on trust and mutual respect and are central to practice (Forchuk, 2023);
- in alleviating stigma and discrimination (Mezey et al., 2016; MHCC, 2018);
- in implementing antiracism strategies (Kent-Wilkinson & Austin, 2023);
- that human rights must be protected in care decisions (Austin & Kent-Wilkinson, 2023);
- that determinants of health must inform a holistic caring approach that acknowledges the unique and intersectional experiences of clients (Adam & Jiang, 2023);
- in the importance of strengthening collaborative relationships and allyship with others (e.g., individuals, families, vulnerable groups, communities, social agencies, and colleagues; Bishop, 2015; Dickenson, 2021; Swiftwolfe, 2019);
- that culturally competent care, cultural humility, and cultural safety are fundamental to mental health care (Canadian Medical Protective Association [CMPA], 2021; CNA, n.d.-b, 2018; Curtis et al., 2019; de Peralta et al., 2019; First Nations Health Authority [FNHA], n.d.-b; Foronda, 2020; Greene-Moton & Minkler, 2020; Luznar-Purdy & Kent-Wilkinson, 2021; MacKenzie & Hatala, 2019; Schmalz et al., 2022; Stubbe, 2020; TRC, 2015);
- in the recovery and well-being of people of all ages living with mental health conditions (Hust & Peternelj-Taylor, 2023; Marci et al., 2020; MHCC, 2015);
- in the importance of teaching and coaching to assist in informed decision making (Snow, 2023a);
- in practices and approaches that promote the DE&I of our clients and of each other;
- in continuous learning to advance knowledge, clinical skills, and best practices to respond to emerging clinical needs (e.g., addictions, end of life care, and comorbid nursing skills; Kunyk et al, 2023; Pollard & Jakubec, 2022);

- in improvement initiatives for patient safety (Snow, 2023a);
- in initiating, conducting, and utilizing research to improve care (Kunyk et al., 2023);
- in mentoring the next PMHN generation (CNA, n.d.-a);
- in collaborative inter/intra-professional practice (Lasiuk, 2023);
- in fostering moral and visionary PMHN leaders and researchers;
- in promoting excellence in PMHN accreditation, competencies, and standards (CMPA, 2021; CASN, n.d.; College of Registered Psychiatric Nurses of Alberta et al., 2019);
- in ensuring positive, moral, and healthy work environments (Kunyk, 2023a); and
- in the importance of monitoring and responding to current issues that impact the mental health of Canadians (CNA, 2017; Kunyk et al., 2023; Pollard & Jakubec, 2022).

# Standards

Some of the key terms used throughout the *Standards* document and in the Standards I–VII are defined in the Glossary. Common abbreviations of professional organizations and mental health and addiction terms are also listed in the Glossary.

# Standard I

## Provides Competent Professional Care Through the Development of a Therapeutic Relationship

The therapeutic relationship is central to PMHN practice and is the primary intervention to promote awareness and growth, mental health and well-being, and to prevent or diminish mental disorders (RNAO, 2002).

The therapeutic relationship is the foundation from which psychiatric-mental health nurses enter into partnerships with clients. It is through the use of the human sciences and the art of caring that psychiatric-mental health nurses develop helping relationships (RNAO, 2002, 2006).

Psychiatric-mental health nurses adhere to all ethical, legal, and professional therapeutic relationship standards outlined by their provincial/territorial colleges and in accordance with relevant jurisdictional mental health acts and legislation. There are limits to confidentiality within the therapeutic relationship specific to legislative reporting requirements related to high-risk situations. Confidentiality adheres to respective jurisdictional privacy of information acts.

PMHN care is client-centred, throughout the lifespan. Psychiatric-mental health nurses play a leading role in providing safe, reliable, and consistent therapeutic relationships for clients who may be experiencing long-term chronic illness, prolonged exposure to environmental and societal crises, or the impact of a disaster.

**The psychiatric-mental health nurse:**

1.1. assesses the influences of mental health stigma on own personal beliefs, values, and life experience on therapeutic relationships; uses self-examination to reflect on own personal biases and potential impact on providing care;

1.2. establishes professional boundaries between social and therapeutic relationships, including physical space, under-involvement, and over-involvement;

1.3. identifies transference and countertransference issues; engages in reflective practice and seeks supervision to ensure healthy outcomes of the therapeutic relationship;

1.4. uses expert therapeutic communication techniques (both verbal and nonverbal) across all phases of the therapeutic relationship to ensure safety, trust, and engagement of the client, including clients who may be hesitant and/or are involuntary in care;

1.5. works in partnership with clients to determine goal-directed needs and to establish environments that are conducive to goal achievement;

1.6. recognizes intersectionality (i.e., the confluence of diverse client attributes and their respective biopsychosocial impact on the therapeutic relationship and process) and negotiates and delivers relevant, culturally competent nursing care that is sensitive to unique client responses and behaviours triggered by complex personal life experiences;

1.7. understands the impact of trauma on the client's mental health and physical health with chronic or acute illnesses, communication, and behaviour (i.e., human reactions to distress, environmental/climate change, and societal crises as well as loss of control that may be expressed as anger, anxiety, fear, grief, helplessness, hopelessness, and humour); recognizes the impact of trauma on the therapeutic relationship and process; negotiates and delivers relevant, trauma-informed nursing care;

1.8. identifies client's stage of readiness for change; adjusts therapeutic nursing role depending on client's readiness to change (e.g., substance use and addictions, medication adherence, wellness/illness management, housing); acknowledges and supports the client's participation, responsibility, and choices in care;

1.9. respects the client's lived expertise and unique knowledge in fostering mental health, promoting healing, and informing the recovery process; and

1.10. fosters cultural humility and safety by reflectively critiquing therapeutic effectiveness through client responses and feedback, clinical supervision, and self-evaluation.

# Standard II

## Performs/Refines Client Assessments Through the Diagnostic and Monitoring Function

Effective assessment, diagnosis, formulation of care plans, and clinical monitoring are central to the psychiatric-mental health nurse's role and depend upon expert PMHN knowledge and understanding the meaning of the health or illness experience from the client's perspective.

The nursing process provides a framework for gathering client data and for developing client-centred plans of care. Psychiatric-mental health nurses make professional judgments based upon evidence and recognize and include the client as a valued partner. Nurses explain the assessment process to the client and provide feedback.

The client-centred plan of care includes evidence-based interventions that encompass the biological, psychological, social, cultural, and spiritual needs identified in collaboration with the client. The care plan may also include environmental interventions to support the client's needs.

**The psychiatric-mental health nurse:**

2.1. collaborates with the client and their circle of care to gather holistic, client-centred assessments with a specialized focus on mental health and substance-related/addictive disorders through observation, engagement, examination, interview (using respectful, recovery-focused language), and consultation; recognizes variability in client's ability to participate in the process;

2.2. actively elicits the client's expert knowledge of their life experiences and their experiences of care received in the assessment process;

2.3. documents the assessment data and analyses data to evaluate safety and risk to self and others, mental status, biopsychosocial-spiritual health status, best possible medication history; life experiences (including history of trauma and/or abuse); history and impact of substance use and addictions; inequities within the determinants of health, strengths, and potential for wellness; and client goals and readiness for change;

2.4. formulates and selects the most relevant evidence-based safety responses and therapeutic modalities across the mental health continuum (i.e., mental health maintenance, early interventions, psychosocial rehabilitation for severe mental illnesses, addictions and functional disorders that promote wellness, treatment, recovery, and reintegration / social inclusion); documents the plan of care in collaboration with the client and mental health team, community partners, and case managers that support access to necessary resources;

2.5. engages in ongoing reassessment and compares new client data with baseline to anticipate potential emerging mental health and other holistic needs and risks as well as new client goals and stage of readiness; revises and documents updated plan of care; and

2.6. plans for safe and effective care transitions across mental health and other care continuum settings (e.g., inpatient to outpatient to home and community care, according to evidence-informed practice guidelines).

# Standard III

## Administers and Monitors Therapeutic Interventions

The nature and complexity of mental health disorders and comorbid medical conditions raise specific practice issues in administering and evaluating the effectiveness of psychotherapeutic and other therapeutic interventions. This includes monitoring client outcomes and responding in a timely manner to adverse reactions and changing mental and physical health conditions. Psychiatric-mental health nurses take the lead and/or collaborate with others in implementing interventions that centre on biological, psychological, social, cultural, and spiritual domains. Psychiatric-mental health nurses also focus interventions on the therapeutic milieu which include managing a safe environment such as infection control, trauma, violence, risk prevention, fall prevention, and other vulnerabilities.

Evidence-based therapeutic interventions used or supported by psychiatric-mental health nurses may include interventions that are:

- biological (e.g., electroconvulsive therapy, pharmacology, light therapy, harm reduction, and nutrition);
- psychological (e.g., cognitive behavioural therapy, dialectical behaviour therapy, motivational interviewing, acceptance and commitment therapy, and group therapies);
- social (e.g., social skills, stress management, person- and family-centred care, strength-based approach, TIC, stages of change, harm reduction, recovery, and critical social theory);
- spiritual (e.g., relationship with self and others, hope, and faith); and
- environmental (e.g., milieu therapy, infection prevention and control, physical safety interventions, and close monitoring; Austin et al., 2019).

Psychiatric-mental health nurses may have knowledge and training to take the lead, and/or they may collaborate with others to implement the interventions. Evidence-based therapeutic interventions provide culturally competent, culturally humble, culturally safe, diversity-relevant, ethical, holistic, effective, and efficient PMHN care consistent with the needs of the client.

Some clients may be at risk for suicide, others for self-harm or harm to others, either directly or through neglect (including self-neglect) and in some cases may be deemed unable to care for self. Although every effort is made to include the client in all aspects of decision making, PMHN interventions must prioritize the safety of the client and those in the client's environment when the client is deemed unable to make safe decisions or is unable to care for self. (See Standard IV Effectively Manages Rapidly Changing Situations.)

Psychiatric-mental health nurses recognize that mental health legislation should protect and promote the well-being of Canadians. Therapeutic interventions must consider all relevant legislation that may impact client care and require client education, consultation, and informed consent (e.g., provincial/territorial mental health acts, privacy legislation, MAiD legislation, and health care consent legislations).

**The psychiatric-mental health nurse:**

3.1. implements and continually evaluates the evidence-based interventions to provide ethical, culturally competent, safe, effective, and efficient nursing care;

3.2. is informed on current legislation and educates and empowers clients and/or substitute decision makers in the intervention's implementation of plan of care (see Standard V Intervenes Through the Teaching-Coaching Function);

3.3. supports clients to apply their strengths for self-care (e.g., daily living activities, resource mobilization, and mental health promotion);

3.4. uses e-mental health and technologies to perform safe and efficient PMHN interventions in all aspects of holistic care (e.g., technologies supporting client observation/monitoring, closed-loop medication administration, point-of-care testing, physical health monitoring, falls prevention, and virtual on-line therapies);

3.5. applies knowledge and understands the effects of pharmacological interventions on diverse client groups with psychiatric, addiction, and comorbid conditions;

3.6. administers psychotropic and other medications accurately and safely by monitoring therapeutic responses, reactions, untoward effects, toxicity, and potential incompatibilities with other medications or substances; provides medication education with relevant content for diverse client groups;

3.7. utilizes therapeutic elements of group process to facilitate therapeutic group-oriented interventions within the therapeutic inpatient milieu or in outpatient/community settings;

3.8. incorporates knowledge of and engages in family nursing interventions to manage mental health, substance-related and addictive disorders, and comorbid conditions;

3.9. collaborates with client, health care providers, and community members to access and coordinate resources for client recovery (e.g., social support networks, employment, housing, education, and volunteering); and

3.10. gathers client's responses and perceptions to evaluate nursing and other therapeutic interventions; incorporates feedback into practice for continual improvement of the care plan.

# Standard IV

## Effectively Manages Rapidly Changing Situations

The effective management of rapidly changing situations is essential in critical circumstances that may be termed psychiatric, medical, environmental, pandemic, catastrophic, or other emergencies. Rapidly changing situations require wide-ranging mental health care that responds to escalating risk factors for suicide, self-harm, aggressive behaviours, acute decompensations in mental and physical health states, opioid or other substance-related medical crises, infection outbreak risks, social crises, etc. Psychiatric-mental health nurses are experts at anticipating unpredictable and rapidly changing situations and respond accordingly to resulting risk factors. Psychiatric-mental health nurses provide TIC, applying least restrictive interventions.

**The psychiatric-mental health nurse:**

4.1. utilizes the therapeutic relationship and safe physical boundaries throughout the management of rapidly changing situations (see Standard I Provides Competent Professional Care Through the Development of a Therapeutic Relationship);

4.2. promptly and efficiently assesses the client and client's environment, in person or virtually, using a comprehensive holistic social justice and determinants of health approach in anticipating rapidly changing situations;

4.3. applies safety training principles and mobilizes resources required to manage any potential/actual rapidly changing situation;

4.4. coordinates rapid communication and intervention response to keep the client safe;

4.5. initiates life-saving emergency responses during rapidly changing situations in accordance with organizational clinical protocols;

4.6. monitors client and milieu risk factors for safety; utilizes continual assessment to detect early changes in client's mental, physical, or psychosocial status; intervenes accordingly;

4.7. implements and documents timely, age-appropriate, and client-specific interventions to rapidly changing situations at the individual, family, community, or societal levels;

4.8. uses TIC to acknowledge triggers and manage rapidly changing situations to support ongoing trust, healing, and recovery objectives;

4.9. commences evidence-based critical event protocols (i.e., based on current organization policies and procedures, and relevant provincial legislation) in rapidly changing situations;

4.10. advocates for a least restraint approach to care; utilizes best practices in use of environmental/chemical/physical restraints when they are necessary; engages in client and team debriefing post restraint event;

4.11. collaborates with client to identify the precipitants of the rapidly changing situation; develops and documents a crisis and safety plan to minimize risk of recurrence;

4.12. evaluates the effectiveness of the rapid responses with the client and modifies interventions as necessary;

4.13. participates in debriefing and incident process reviews with the client, family, clinical leadership, health care team, and other service provider team as needed; and

4.14. participates in and implements quality improvement activities that improve client and health care team safety in the practice setting (see Standard VI Monitors and Ensures the Quality of Health Care Practices).

# Standard V

## Intervenes Through the Teaching-Coaching Function

All interactions are potentially teaching/learning situations for both clients and nurses. Psychiatric-mental health nurses recognize that the client is the expert in their own life experiences. Psychiatric-mental health nurses assess the actual/potential strengths and needs within the client's lived experiences and use the assessment to support and promote learning related to health and personal development. Psychiatric-mental health nurses provide health promotion, illness treatment, and recovery information to diverse clients. Teaching and learning with clients provide opportunities for advocacy and allyship by psychiatric-mental health nurses to partner with marginalized clients and to help mitigate any challenges they may have within the system.

**The psychiatric-mental health nurse:**

5.1. collaborates with the client to assess learning needs inclusive of education for prevention and early intervention, emphasizing and supporting the client's potential for healing and recovery;

5.2. plans and implements health promotion and illness treatment education with the client while considering the context of the client's determinants of health, in particular: client's readiness, culture, literacy, intellectual capacity, language, preferred learning style, and available in-person/virtual/on-line resources;

5.3. incorporates knowledge of diverse learning models and principles (including social justice and determinants of health, principles of TIC, strength-based care, person-centred care, stages of change and motivational interviewing, harm reduction, and recovery) when creating learning opportunities for clients;

5.4. explores options and resources with the client and client's support persons to build knowledge for making informed choices related to health needs and for accessing the system as needed;

5.5. documents the teaching/learning process (assessment, implementation, client involvement, and evaluation);

5.6. evaluates with the client the effectiveness of the educational process and collaboratively develops or adapts it to meet learning needs; and

5.7. advocates for and engages in teaching/learning opportunities at a systemic level to ensure a culture of inclusion and equity for clients.

# Standard VI

## Monitors and Ensures the Quality of Health Care Practices

Psychiatric-mental health nurses ensure quality health care through evidence-informed and best practices that promote safety, effectiveness, client centredness, timeliness, efficiency, and equity.

Psychiatric-mental health nurses promote scientific knowledge and multiple ways of knowing to improve the design of the health care system and quality of PMHN care. Psychiatric-mental health nurse's philosophies, attitudes, and beliefs value a quality and safety culture in the workplace. (See Standard VII Practices Within Organizational and Work-Role Structure.)

Psychiatric-mental health nurses have a responsibility to advocate for clients' rights to receive the least restrictive form of care and to respect and affirm clients' rights to self-determination in a safe and equitable manner. Psychiatric-mental health nurses must keep themselves informed about relevant legislation, its interpretation, and its implications for nursing practice.

Psychiatric-mental health nurses recognize the importance of research in mental health care to improve our understanding of the causes and risk factors for mental health problems. In addition, research supports promotion and prevention initiatives helping people to stay well, underpins the development and evaluation of new forms of support, and provides evidence on implementing innovative approaches in practice in the health care system and in wider settings.

**The psychiatric-mental health nurse:**

6.1. recognizes and responds to potential and actual safety risks associated with psychotropic medications, suicide risks, aggression risk, falls, elopement risk, staff injury, effects of substance use and withdrawal, mental status change, and cognition impairment;

6.2. ensures quality outcomes by providing the right care at the right time (e.g., early intervention, access to services and resources, timing of medication administration, rapid code responses, and proactive care transition planning);

6.3. follows code of conduct and organizational policies, legislation, nationally accredited required organizational practices, infection prevention and control standards, and health and environment safety protocols to protect clients, self, and colleagues;

6.4. expands and incorporates quality practice innovations, inclusive of technology, to ensure safe, confidential, and effective PMHN care;

6.5. is accountable for manual and electronic documentation of near misses and incidents for ongoing review and evaluation of quality PMHN care;

6.6. participates in incident process reviews with the client, family, clinical leadership, health care team, and other service providers to ensure safety and quality in the overall plan of care;

6.7. participates in and implements quality improvement activities that improve client and health care team safety in the practice setting;

6.8. ensures efficient quality mental health care (e.g., efficient verbal and written communication and reporting strategies, relevant technology use, integrated client record, streamlined work processes, and assigning and delegating to appropriate nursing and interdisciplinary team members);

6.9. understands relevant legislation for specialized mental health clinical populations and its implications for practice (e.g., forensic populations and individuals requiring substitute decision makers [children, elderly, and cognitively impaired]);

6.10. advocates for quality of care for each unique client through the lens of social justice and the determinants of health;

6.11. understands the potential impacts of stigma, discrimination, and racism as well as the impact of the determinants of health on the quality of client care;

6.12. participates in timely quality care measures to deal with national or global changes that impact mental health care at the local level (e.g., mental health care responses to epidemics, pandemics, and global conflicts); and

6.13. understands the importance of, may participate in, or lead the research process to improve mental health care.

# Standard VII

## Practices Within Organizational and Work-Role Structure

PHMN care occurs in home/community as well as out-patient and in-patient settings. Psychiatric-mental health nurses can occupy different work roles within these clinical settings and their organizational structures. They serve as direct care clinicians, NPs, CNSs, mentors/preceptors, educators, researchers/scientists, administrators, policy/decision makers, quality, and risk management leaders, etc. As a collective group, they help design an effective health care system. They promote the highest standards of PMHN care as well as healthy and safe workplace environments. They also promote and foster the advancement of the specialty of PMHN.

**The psychiatric-mental health nurse (regardless of work role or organizational setting):**

7.1. stays current with advances in technology and its application in psychiatric-mental health care and the workplace;

7.2. advocates for continuous improvement to the organizational/systemic structures consistent with ethical principles and concepts of cultural competence, cultural humility, and cultural safety;

7.3. collaborates with clients, colleagues and other stakeholders to facilitate a mutually respectful, psychologically safe, and supportive workplace climate for all persons;

7.4. advocates for support and resources for health care providers experiencing moral injury, distress, and burn-out in the workplace (e.g., health care worker shortage, pandemic challenges, workplace trauma, MAiD legislation, racism, and stigma);

7.5. participates in opportunities to promote trauma-informed self-care for health care provider peers;

7.6. promotes a just culture to ensure accountability for quality outcome indicators (e.g., ensuring appropriate accountability for human errors versus at risk behaviour versus reckless behaviour);

7.7. seeks to utilize constructive and collaborative approaches to resolve differences among members of the health care team which may impact care;

7.8. participates in developing, implementing, and critiquing mental health care policies;

7.9. advocates for and supports various leadership opportunities in PMHN work-roles and organizational settings;

7.10. supports, mentors, and precepts nursing students, newly graduated nurses, internationally educated nurses, and students for advanced practice roles;

7.11. engages in continuing education (both teaching and learning) related to PMHN specialty practice, leadership, and research; seeks additional education and supervision in high-risk clinical situations and settings;

7.12. pursues opportunities to reduce stigma, discrimination, and racism and to promote social justice, equity, social inclusion, and community integration for all clients (Adam & Jiang, 2023; MHCC, 2013b); responds to the TRC's (2015) calls for action as they apply to mental health care; and

7.13. engages through allyship in social action (Atcheson, 2018; Thorne, 2022); proactively advocates for and mobilizes equitable care, services, and resources in partnership with various consumer and advocacy groups.

# Glossary

# Terms and definitions

### ableism

Ableism is a term to "identify discrimination in favour of able-bodied people. An example of ableism occurs when people with disabilities experience exclusion in schools (e.g., segregation in the classroom), workplaces (e.g., stigma in finding employment; higher unemployment rates) and in social settings (e.g., inaccessible places)" (Oliver, 2009, Prince 2009, as cited in Adam & Jiang, 2023, p. 34). "Income, education, and employment are key social determinants of health (SDoH) and people with disabilities often have limited access to them" (Adam & Jiang, 2023, p. 34).

### aging population and older adults in Canada

The definition of older adults in Canada is 65 years. An aging population defined as one where the proportion of older people is increasing (Statistics Canada, 2022b). As of July 1, 2022, the percentage of persons aged 65 years and older in Canada is 19%, or 7,329,910 of Canada's total population of 38,454,327; this percentage expected to increase to 50% by 2051 (Statistics Canada, 2022b). While women still outnumber men, the ratio of women to men among people aged 85 and older is decreasing (Statistic Canada, 2022a).

### allyship

Allyship is "when a person of privilege works in solidarity and partnership with a marginalized group of people to help take down the systems that challenge that group's basic rights, equal access, and ability to thrive in our society" (Nfonoyim-Hara, as cited in Dickenson, 2021, para 2). Being an ally is about disrupting oppressive spaces by educating others on the realities and histories of marginalized people (Swiftwolfe, 2019). Psychiatric-mental health nurses recognize their privilege and undertake to move toward a more just world by helping to break the cycle of oppression in the health care system are acting as allies (Bishop, 2015).

### best possible medication history (BPMH)

A BPMH is a history created using 1) a systematic process of interviewing the patient/family; and 2) a review of at least one other reliable source of information to obtain and verify all patient's medication use (prescribed and nonprescribed). Complete documentation includes drug name, dosage, route, and frequency. The BPMH is more comprehensive than a routine primary medication history, which is often a quick preliminary medication history that may not include multiple sources of information (Institute for Safe Medication Practices Canada, n.d.).

### best practice guidelines

"Best practice guidelines …, also termed clinical practice guidelines …, are broad or specific recommendations for health care based on the best current evidence" (Snow et al., 2019, p. 195).

### bio/psycho/social/spiritual model

"The bio/psycho/social/spiritual model consists of separate but interacting domains that can be understood independently but that are mutually interdependent with the other domains" (Austin, 2019, p. 58).

### boundaries

Boundaries are used to describe the limits of relationships. The term implies clear borders that should not be crossed, where in actual practice it is more complicated. The most serious type of boundary violation is sexual harassment and abuse of patients. Transgressions of boundaries are most often discussed as *over-involvement*. *Under-involvement* can also be an ethical issue (Austin & Kent-Wilkinson, 2023).

### care transitions

Care transitions are defined as a set of actions designed to ensure the safe and effective coordination and continuity of care as clients experience a change in health status, care needs, health care providers, or location (within, between, or across settings; Coleman & Boult, 2003). Accreditation Canada (2013, 2014) identifies care transitions as (but not limited to) any of the following: "visits to primary care providers, referral to a specialists or health services or providers, handovers at shift change, transfers or discharges, or relocations to another health-care setting" (as cited in RNAO, 2014, p. 66). (See transitions of care.)

### circle of care

Includes all those directly involved in providing health care to an individual client, (e.g., family, support persons/network, health care, and all other providers of care).

### client

Individual (person, patient, resident, or consumer), substitute decision maker, service user, family, community, and population groups that access mental health services.

### countertransference

Countertransference is the "direction of all the nurse/therapist's feelings and attitudes toward the client/patient. Feelings and perceptions caused by countertransference may interfere with the nurse/ therapist's ability to understand the patient" (Austin, 2023, p. 161). "It can significantly interfere with the nurse-patient (client) relationship" (Austin et al., 2019, p. 948).

### culture

Culture is the "learned values, beliefs, norms and way of life that influence an individual's thinking, decisions and actions in certain ways" (CNA, 2017, p. 21). "Culture reflects the basic values and biases through which we interpret the world around us and make decisions about our own behaviour and our relationships with others" (Kent-Wilkinson & Austin, 2023, p. 42).

### cultural competence

In every domain of practice, nurses have a professional and ethical responsibility to be mindful of, respect, and value each person's individual culture in every encounter. Nurses have an obligation to consider how culture may impact an individual's experience with health care and the health care system. Cultural competence should be an entry to practice competency, with ongoing professional development for all nurses. Support for cultural competence is a shared commitment among individual nurses, Indigenous leaders and organizations, employers, educators, professional associations, regulatory bodies, unions, accreditation organizations, government, and the public. The client participating in the professional encounter with the nurse decides if it is culturally appropriate or not (CNA, 2018, para 1).

### cultural humility

Cultural humility is a process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. "Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience" (FNHA, n.d.-a., slide 7; FNHA, n.d.-b, Framework for Cultural Safety and Humility).

### cultural safety

Cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. Cultural safety "results in an environment free of racism and discrimination, where people feel safe when receiving health care" (FNHA, n.d.-a., slide 5; FNHA, n.d.-b, Framework for Cultural Safety and Humility).

### determinants of health (DOH)

"Determinants of health are the broad range of personal, social, economic, and environmental factors that determine individual and population health" (PHAC, 2022, para, 2). Determinants of health have twelve main factors: (1) income and social status, (2) employment and working conditions, (3) education and literacy, (4) childhood experiences, (5) physical environments, (6) social supports and coping skills, (7) health behaviours, (8) access to health services, (9) biology and genetic services, (10) gender, (11) culture, and (12) race/racism (PHAC, 2022). (See social determinants of health.)

### diversity

Diversity is "the variation between people in terms of a range of factors such as ethnicity, national origin, race, gender, gender identity, gender expression, ability, age, physical characteristics, religion, values and beliefs, sexual orientation, socio-economic class or life experiences" (CNA, 2017, p. 21; RNAO, 2006) and is "considered an asset to our society by Canadians" (Kent-Wilkinson & Austin, 2023, p. 43). In this *Standards* document, diversity refers to age (children, youth, adults, and seniors), culture, ethnicity, race, Indigenous experience, immigration experience, high-stress occupational roles/experiences, incarceration, class, education, sexual orientation, gender identity (LGBTQQIP2SAA+), language, ability and capacity, stigma, and social exclusion.

**equality**
Equality means each individual or group of people is given the same resources or opportunities (Milken Institute School of Public Health, 2020). (See equity and inequality.)

**equity**
Equity means fairness and justice. Equity recognizes that each person has different circumstances and allocates the exact resources and opportunities needed to reach an equal outcome (Milken Institute School of Public Health, 2020). (See equality and inequity.)

**e-mental health**
"E-mental health is the offering of mental health services via electronic means" (Snow, 2023b). Christensen et al. (2002) defined e-mental health "as mental health services and information delivered or enhanced through the Internet and related technologies" (p. 3). The MHCC (2014) developed a briefing document to guide the incorporation of technology into mental health service delivery.

**family**
Family is whoever the client says are "family." "A family is a group of people committed to each other and involved relationally in a complex process where economics, emotion, context, and experiences are interwoven and multi-layered" (Peternelj-Taylor & King, 2023, p. 322).

**family nursing**
Family nursing is a part of the primary care provided to patients of all ages, ranging from infant to geriatric health. Nurses assess the health of the entire family to identify health problems and risk factors, to help develop interventions to address health concerns, and to implement the interventions to improve the health of the individual and family. Family nurses often work with patients through their whole life cycle. This helps foster a strong relationship between the health care provider and the patient. Family nursing is not so much patient-centred care as it is centred on the care of the family unit. It also takes a team approach to health care (Nursing Theory, 2020, para 1).

**harm reduction**
"Harm reduction is an essential evidence-based approach for reducing the adverse health, social and economic consequences of substance abuse without requiring abstinence" (CNA, 2018, para. 1). "The principles of harm reduction are consistent with the primary values in the CNA *Code of Ethics for Registered Nurses*, *2017*, particularly nurses' responsibility to provide safe, compassionate, competent, and ethical care. Nurses should help advance organizational and governmental harm reduction polices" (CNA, 2018, para. 1). Harm reduction is most commonly used in relation to public health programming with people who use psychoactive substances, but it can also be applied to programs that address alcohol use, sexual practices, cycling, driving, gaming, and others (Canadian Nurses Association & Canadian Association of Nurses in HIV/AIDS Care, 2018; Harm Reduction Nursing Association, 2019).

### homelessness
Homelessness describes the situation of an individual, family, or community without stable, safe, permanent, appropriate housing or without the immediate prospect, means, and ability of acquiring it (Canadian Observatory on Homelessness, 2017; Gaetz et al., 2012).

### Indigenous (Aboriginal) Peoples in Canada
The term "Indigenous Peoples," also known as "Aboriginal Peoples," encompasses those who are native to the land of North America and their descendants (Crown-Indigenous Relations and Northern Affairs Canada, 2021). Indigenous Peoples refers to three groups in Canada: First Nations, Métis, and Inuit people who are recognized in the Constitution Act (Statistics Canada, 2022d). In 2021, the Census of Population counted more than 1.8 million (1,807,250) Indigenous Peoples in Canada, making up 5% of the total population. The Indigenous population grew by 9.4% from 2016 to 2021, making it the fastest and youngest growing population (Statistics Canada, 2022c).

### Indigenous overincarceration
While only 5% of the adult population in Canada, Indigenous Peoples continue to be vastly overrepresented in the federal correctional system, accounting for 28% of all federally sentenced individuals and 32% of all individuals in custody (OCI, 2020; Zinger, 2022). This overrepresentation is largely the result of systemic bias and racism, including discriminatory risk assessment tools, ineffective case management, and bureaucratic delay and inertia (Zinger, 2022).

### inequality
Inequality refers to an imbalance or lack of equality. Inequality does not necessarily refer to injustice (Writing Explained, n.d.). (See equality)

### inequity
Inequity is defined as a lack of fairness or justice. Inequity is a noun and is defined as injustice, unfairness, or an instance of injustice or unfairness (Writing Explained, n.d.). (See equity)

### intersectionality
"Intersectionality is a framework that reveals the way in which social categories (e.g., race, gender) applied to an individual or group intersect, creating systems of discrimination or privilege" (Adam & Jiang, 2023, p. 30).

### just culture
A just culture is defined as "the importance of fairly balancing an understanding system failure with professional accountability" (Health Care Excellence Canada, n.d.). Just culture is an atmosphere of trust in which health care workers are supported and treated fairly when something goes wrong with patient care. Just culture is important to patient safety, as it creates an environment in which people (health care workers and patients) feel safe to report errors and concerns about things that could lead to patient-adverse events.

Reports of errors and patient safety hazards are important sources of information about weaknesses in the system that need to be addressed by a learning culture to improve patient safety (Health Quality Council of Alberta, n.d., para 1).

### least-restrictive care/environment

Least restrictive means treatment and conditions of treatment that, separately and in combination, are no more intrusive or restrictive of freedom than reasonably necessary to achieve a substantial therapeutic benefit or to protect the client from injury (Law Insider, n.d.). Least restrictive refers to the process whereby physical, relational, and procedural restrictions are kept to a minimum and only implemented when necessary (Sustere & Tarpey, 2019). "The least restrictive environment is the setting that puts the fewest restraints on the patients' rights while still ensuring their safety" (Jones-Bonofiglio, 2023, p. 434). (See restraint.)

### medical assistance in dying (MAiD)

MAiD is an umbrella term that includes clinician-administered assistance in dying and self-administered assistance in dying. These practices include what is called euthanasia (clinician-administered) and assisted suicide (self-administered) in other jurisdictions (Health Canada, 2022).

### mental disorder

The DSM-5-TR states that a "mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or development processes underlying mental functioning" (American Psychiatric Association, 2022). Mental disorder is the term used in many provincial mental health acts and in both major diagnostic classification schemes relied upon in Canadian psychiatric practice: the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and WHO's *International Classification of Diseases* (ICD; Health Canada, 2022).

### mental health

"Mental health is the state of your psychological and emotional well-being. Mental health is a necessary resource for living a healthy life and a main factor in overall health. This does not mean the same thing as mental illness. However, poor mental health can lead to mental and physical illness" (PHAC, 2020a). One in five (approximately 6.7 million) Canadians experiences mental illness at any given time (CAMH, n.d.-a). (See mental illness.)

### mental health nursing

(See psychiatric-mental health nursing.)

### mental illness

"Mental illnesses are characterized by alterations in thinking, mood or behaviour associated with significant distress and impaired functioning" (PHAC, 2020b). (See mental health.)

### mental status examination (MSE)

The MSE is a systematic assessment of an individual's appearance, affect, behaviour, and cognitive processes. "The MSE provides 'a snapshot' of the client's subjective report and experiences and the examiner's observations and impressions at the time of the interview" (Lasiuk, 2023, p. 219).

### milieu therapy (therapeutic environment)

Milieu therapy provides a stable and coherent social organization to facilitate an individual's treatment. (The terms milieu therapy and therapeutic environment are often used interchangeably.) In milieu therapy, the design of the physical surroundings, structure of the client activities, and promotion of a stable social structure and cultural setting enhance the setting's therapeutic potential (Snow, 2023a, p. 241).

### nursing care plan

The nursing care plan is a carefully prepared outline of nursing care showing all the patient's needs and the ways of meeting them. The nursing care plan is a dynamic document initiated at admission and is subject to continuous reassessment and change by the nursing staff caring for the patient. It typically includes nursing diagnosis, nursing interventions, and outcomes; ensures consistency of care; and may be standardized or preprinted (Mosby, 2022). (See plan of care.)

### nurse-client relationship

"The nurse-client relationship is a dynamic process that changes with time. It can be viewed in steps of phases with characteristic behaviours for both the client and the nurse" (Forchuk, 2023, p. 115).

### nursing diagnosis

"A nursing diagnosis is a clinical judgement about individual, family, or community responses to actual or potential problems/life processes" and involves selecting nursing interventions to achieve desired outcomes (Carpenito, 2017, as cited in Snow et al., 2019, p. 196). "Nursing diagnosis, nursing interventions, and individual outcomes are initially derived from the assessment data" (Snow et al., 2019, p. 210).

### nursing interventions

"Nursing interventions are treatments or activities based on clinical judgement and knowledge that are used by nurses to enhance an individual's achievement of care goals" (Butcher et al., 2018 as cited in Snow, 2023a, p. 234).

### outcomes

"Outcomes are the individual's response to nursing care at a given point in time. An outcome is concise, stated in a few words, and in neutral terms. Outcomes describe an individual's state, behaviour or perception that is variable and can be measured" (Snow et al., 2019, p. 193).

### patient safety culture

Culture refers to shared values (what is important) and beliefs (what is held to be true) that interact with a system's structures and control mechanisms to produce behavioural norms. Culture influences patient safety directly by determining accepted practices and indirectly by acting as a barrier or enabler to the adoption of behaviours that promote patient safety. Understanding the components and influencers of culture and assessing the safety culture is essential to developing strategies that create a culture committed to providing the safest possible care for patients (Health Care Excellence Canada, n.d.).

### person-centred care

Person-centred care (client/patient) uses person empowerment to move away from the paternalistic model of health care to a model of shared power and responsibility (CNA, 2018). Person-centred care means the nurse establishes therapeutic relationships and advocates for health care that encompasses spirituality and beliefs relevant to the cultural views of the individual and group. Person-centred care is in collaboration with the worldviews, values, and needs of the client and client groups and as expressed and identified by them.

### person/family-centred approach

"A person and family centred approach to care places the person and their family members at the centre of health care, its practice and services, in such a way that individuals are genuine partners with health care providers for their health" (RNAO, 2015b; Snow, 2023a, p. 230).

### plan of care

The plan of care is the outline of nursing care showing all of the patient's needs and the ways of meeting them (Mosby, 2022). (See nursing care plan.)

### psychiatric-mental health nursing (PMHN)

PMHN is a specialized area of nursing that has as its focus the promotion of *mental health*, the prevention of mental illness, and the care of *clients* experiencing *mental health problems and mental disorders* (Austin & Kent-Wilkinson, 2023). The psychiatric-mental health nurse works with clients in a variety of settings, including institutional, agency, and community settings. Clients may be unique in their vulnerability as, in this area of nursing practice, they can be involved involuntarily and can be committed to care under the law. Further, clients may receive treatment against their will. This fact affects the nature of the nurse-client relationship and can raise complex ethical dilemmas (Austin & Kent-Wilkinson, 2023). May be referred to as mental health nursing.

### racism

Racism is the belief that certain races of people are by birth and nature superior to others. Racism has for years been defined as a "form of discrimination" or hatred based on race (Merriam-Webster, n.d.). More recently, racism is described as different from racial prejudice, hatred, or discrimination. "Racism involves one group having the power to carry out systemic discrimination through the institutional policies and practices of the

society and by shaping the cultural beliefs and values that support those racist policies and practices" (Calgary Anti-Racism Education Collective, n.d., para 1). An effective brief definition of racism first proposed by Patricia Bidol-Padva in 1972 is Racism = Racial Prejudice + Institutional Power (R=P+P; Bidol, 1972).

### rapidly changing situations

Rapidly changing situations may be termed psychiatric, medical, environmental, pandemic, catastrophic, or other emergencies. Rapidly changing situations require wide-ranging mental health care that responds to escalating risk factors for suicide, self-harm, aggressive behaviours, acute decompensations in mental and physical health states, opioid or other substance-related medical crises, infection outbreak risks, social crises, etc. Psychiatric-mental health nurses are aware of risk factors and anticipate unpredictable and rapidly changing situations.

### recovery

Recovery is the personal process that people with mental illness go through 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. The goal of many mental health services and treatments is now recovery (CMHA Toronto, n.d., para 1).

Recovery approaches stand on two pillars. The first pillar is the recognition that each person is a unique individual with the right to determine their own path towards mental health and well-being. The second pillar the understanding that we all live our lives in complex societies where many intersecting factors (biological, psychological, social, economic, cultural, and spiritual) have an impact on mental health and well-being (MHCC, 2015, p. 4).

### registered psychiatric nurses (RPNs)

In Western Canada (Manitoba, Saskatchewan, Alberta, and British Columbia) and the Yukon, the distinct profession of RPNs is regulated by separate provincial/territorial associations and regulatory bodies (Austin, 2019; Hust & Peternelj-Taylor, 2023). In 2019, the Standards of Psychiatric Nursing Practice were published collaboratively by the College of Registered Psychiatric Nurses of Alberta, the British Columbia College of Nursing Professionals, the College of Registered Psychiatric Nurses of Manitoba, and the Registered Psychiatric Nurses of Saskatchewan (Hust & Peternelj-Taylor, 2023, p. 96).

### restraint

Restraint is the most restrictive safety intervention and is only used in the most extreme circumstances as a measure of last resort. Chemical restraint is the use of medication to manage or control a client's behaviour. This is distinct from medication used to treat their psychiatric illness. "A physical restraint is any human or mechanical method that restricts the freedom of movement or normal access to ones' body, material or equipment and cannot be easily removed" (Snow, 2023a, p. 244). (See least-restrictive care.)

### social determinants of health (SDoH)

The SDoH are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age as well as the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems (WHO, n.d.). The SDoH have an important influence on health inequities—the unfair and avoidable differences in health status seen within and between countries. In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health (WHO, n.d.). The following are examples of SDoH that can influence health equity in positive and negative ways:

- income and social protection;
- education;
- unemployment and job insecurity;
- working life conditions;
- food insecurity;
- housing, basic amenities and the environment;
- early childhood development;
- social inclusion and non-discrimination;
- structural conflict; and
- access to affordable health services of decent quality (WHO, n.d.).

(See determinants of health.)

### standards of practice

The standards of practice are "the explicit responsibilities and competencies of a profession" (Austin et al., 2019, p. 959).

### stigma (self, public, and structural)

The stigma of mental illness is evident across history and still exists as a significant and problematic issue. Stigma is negative and discriminatory; it rejects attitudes and behaviour of a characteristic or element exhibited by an individual or group. It can occur at three levels: self, public, and structural (Austin et al., 2019).

> **"Self-stigma** occurs when a person with a mental health illness internalizes the negative views of others and feels ashamed about their illness. This not only seriously diminishes their sense of self-worth but can prevent them from seeking help" (Austin et al., 2019, Stereotyping, Prejudice, Discrimination, and Stigma).
>
> **"Public stigma** is influenced by cultural misbeliefs about those with mental illness: they will never recover; they are dangerous, unpredictable, and violent; they should not be around other people; they are flawed as human beings. Such stigma is oppressive and alienating. It can act as a barrier in all aspects [including access to, prevention of, and outcomes] of life: housing, education, employment, and health care" (Austin et al., 2019, Stereotyping, Prejudice, Discrimination, and Stigma). Many clients report this stigma to be worse than the symptoms of the mental disorder itself (MHCC, 2013b). "The stigma of mental illness can affect families of persons

with mental illness, as well. Their status in their community can be affected; they may be assigned blame for the illness of their family member" (Austin et al., 2019, Stereotyping, Prejudice, Discrimination, and Stigma). Stigma can affect health professionals who choose to practice in psychiatric and mental health settings (Harrison et al., 2017). "Such a career choice can be silently queried: Lack of "real" skills? Personal psychological problems? It is evident in its effects upon recruitment and retention to this clinical area" (Austin et al., 2019, Stereotyping, Prejudice, Discrimination, and Stigma).

**"Structural stigma** occurring at the institutional level is evident when persons with mental illness are denied their basic rights. Bias against mental illness can also affect funding for health services and research" (Kent-Wilkinson & Austin, 2023, p. 52).

### strength-based approach

A strength-based approach "focuses services on individuals' strengths in terms of resources, abilities, skills, and capacities" (Manitoba Trauma Information and Education Centre, 2018, p. 1). "A strength-based approach to nursing care, unlike a deficit approach that focuses on an individual's problems and health barriers, concentrates on an individual's assets such as personal qualities (e.g., flexibility, experience, humour), interpersonal assets (e.g., family, support group membership) and external resources (local health care institute, visiting nurse services, accommodating employer)" (Hirani & Varcoe, 2023, p. 924).

### systemic racism

Systemic racism, also known as institutional racism, refers to "established laws, customs, or practices that are systematically reflected in and that produce racial inequities in society" (Phillips-Beck et al., 2020, p. 3). Both systemic racism and colonialism contribute to a myriad of consequences, including health and economic disparities, hazards, toxic environments, and unfair perceptions (Phillips-Beck et al., 2020).

### therapeutic (communication, environment, relationship)

Therapeutic relates to the treatment of disease or disorders by remedial agents or methods: a curative, medicinal, or healing effect.

**Therapeutic communication** is "the ongoing process of interaction through which meaning emerges" (Forchuk, 2023, p. 107). The nurse-client relationship is built on therapeutic communication including verbal and nonverbal interactions between the nurse and the client. Some therapeutic communication skills include "active listening, positive body language, appropriate verbal responses and the ability of the nurse to interpret appropriately and analyse the client's verbal and nonverbal behaviours" (Forchuk, 2019, pp. 94–95; 2023, p. 106).

**Therapeutic environment** (See milieu therapy.)

**Therapeutic relationship** development is the foundation from which psychiatric-mental health nurses enter into partnerships with clients. It is by using human sciences and the art of caring that helping relationships are developed (RNAO, 2002, 2006).

### transference
"The unconscious assignments to others of feelings and attitudes that were originally associated with important figures such as parents or siblings" (Forchuk, 2023, p. 117).

### transitions of care (TOC)
"Transitions of care refers to the various points where a patient moves to, or returns from, a particular physical location, or contacts a health care professional for the purposes of receiving health care" (WHO, 2016, p. 3). This includes transitions between home, hospital, residential care settings, and consultations with different health care providers in out-patient facilities. (See care transitions.)

### Transtheoretical Model (TTM) / Stages of Change Model
The TTM (also called the Stages of Change Model), developed by Prochaska and DiClemente in the late 1970s, evolved through studies examining the experiences of smokers who quit on their own with those requiring further treatment to understand why some people were capable of quitting on their own. It was determined that people quit smoking if they were ready to do so. Thus, the TTM focuses on the decision making of the individual and is a model of intentional change. The TTM operates on the assumption that people do not change behaviours quickly and decisively. Rather, change in behaviour, especially habitual behaviour, occurs continuously through a cyclical process. The TTM is not a theory but a model; different behavioural theories and constructs can be applied to various stages of the model where they may be most effective (Boston University School of Public Health, 2022).

The TTM posits that individuals move through six stages of change: precontemplation, contemplation, preparation, action, maintenance, and termination. Termination was not part of the original model and is less often used in applying the stages of change for health-related behaviours. For each stage of change, different intervention strategies are most effective at moving the person to the next stage of change and subsequently through the model to maintenance, the ideal stage of behaviour (Boston University School of Public Health, 2022; Prochaska & DiClemente, 1983).

### trauma (historical, intergenerational, intersectional)
Trauma is the lasting emotional response that often results from living through a distressing event. Experiencing a traumatic event can harm a person's sense of safety, sense of self, ability to regulate emotions, and the ability to navigate relationships. Long after the traumatic event occurs, people who experience trauma can often feel shame, helplessness, powerlessness, and intense fear (CAMH, n.d.-b, para 1).

> **Historical trauma** is the process by which a social group is affected by the consequences of multiple, collectively experienced adversities across time that outweigh group resiliency factors; become cumulative; and are carried forward to subsequent generations, such that the trauma may become part of a single trajectory (Graham & Austin, 2023, p. 370).

**Intergenerational trauma** (sometimes referred to as trans- or multigenerational trauma) is defined as trauma that gets passed down from those who directly experience an incident to subsequent generations. Intergenerational trauma may begin with a traumatic event affecting an individual; traumatic events affecting multiple family members; or collective trauma affecting larger community, cultural, racial, ethnic, or other groups/populations (historical trauma; Franco, 2021). Intergenerational trauma was first identified among the children of Holocaust survivors (Fossion et al., 2003), but recent research has identified intergenerational trauma among other groups such as Indigenous populations in North America and Australia (Aguiar & Halseth, 2015; Brave Heart, 2003).

**Intersectional trauma** refers to "the psychosocial marginalization of individuals across multiple axes of identity, including race, ethnicity, gender, nativity status, religion, sexual orientation, mental health status, and so forth" (Di-Capua, 2015, as cited in Ezell et al., 2021, p. 79). A broader concept of intersectional trauma is inclusive of how other fundamentally social phenomenon, such as public health disasters, formatively influence one's well-being, place, and identity and effectively reshape one's cultural health capital (Ezell et al., 2021).

### trauma-informed care (TIC)

Four principles provide structure for TIC: trauma awareness; emphasis on safety and trustworthiness; opportunity for choice; and collaboration, and connection (SAMHSA, 2014).

Trauma-informed organizational approach to care is grounded in four assumptions:

- realization of the widespread impact of trauma on individuals, groups, families, and individuals;
- recognize the signs of trauma;
- respond by integrating knowledge about trauma on all areas of functioning (e.g., policies, procedures, and practices); and
- resist retraumatization of clients and of staff and prevent triggering painful memories (SAMHSA, 2014, pp. 9–10).

Traumatic events experienced across the lifespan can have lasting adverse effects on a person's bio/psycho/social/spiritual functioning. "It is important that treatment and care of any individual be carried out with awareness that a person may have a traumatic history, in what is known as trauma-informed care" (Hust & Peternelj-Taylor, 2023, p. 97).

TIC has evolved in Canadian health services as a means of establishing a safe environment for all patients impacted by historical violence, such as residential schooling (Browne & Baker, 2016). (See trauma- and violence-informed approaches.)

### trauma- and violence-informed approaches/care

Trauma- and violence-informed approaches to care are policies and practices that recognize the connections between violence, trauma, negative health outcomes, and

behaviours. These approaches increase safety, control, and resilience for people who are seeking services in relation to experiences of violence and/or have a history of experiencing violence (PHAC, 2018).

**Trauma- and violence-informed approaches** require fundamental changes in how systems are designed, organizations function, and practitioners engage with people based on the following key policy and practice principles:

1. Understand trauma and violence as well as their impacts on peoples' lives and behaviours.
2. Create emotionally and physically safe environments.
3. Foster opportunities for choice, collaboration, and connection.
4. Provide a strengths-based and capacity-building approach to support client coping and resilience (PHAC, 2018).

**Trauma- and violence-informed care** is "an approach to care that is grounded in an understanding of the impact of trauma and violence on individuals' lives and behaviours, situated in physically and emotionally safe environments, and offers strength-based, capacity-building support that fosters coping and resilience" (Hirani & Varcoe, 2023, p. 922).
(See trauma-informed care.)

### values and beliefs

"The main difference between values and beliefs is that values are principles, ideals, or standards of behaviour while beliefs are convictions that we generally accept to be true. It is these ingrained beliefs that influence our values, attitudes, and behaviour" (Hasa, 2016, para 1).

# List of abbreviations

| Abbreviation | Term |
|---|---|
| BPMH | best possible medication history |
| CAMH | Centre for Addiction and Mental Health |
| CASN | Canadian Association of Schools of Nursing |
| CFMHN | Canadian Federation of Mental Health Nurses |
| CMHA | Canadian Mental Health Association |
| CMPA | Canadian Medical Protective Association |
| CNA | Canadian Nurses Association |
| CNS | clinical nurse specialist |
| COVID-19 | 2019-nCoV acute respiratory disease |
| CPMHN(C) | Certified in Psychiatric and Mental Health Nursing (Canada) |
| DE&I | diversity, equity, and inclusivity |
| FNHA | First Nations Health Authority |
| LGBTQQIP2SSAA+ | lesbian, gay, bisexual, transgender, queer, questioning, intersex, pansexual, 2-spirited, asexual and allies |
| L/RPN | licensed practical nurse / registered practical nurse |
| MAiD | medical assistance in dying |
| MHCC | Mental Health Commission of Canada |
| MSE | mental status examination |
| NP | nurse practitioner |
| OCI | Office of the Correctional Investigator |
| PHAC | Public Health Agency of Canada |

| Abbreviation | Term |
|---|---|
| PMHN | psychiatric-mental health nursing |
| RN | registered nurse |
| RNAO | Registered Nurses' Association of Ontario |
| RPN | registered psychiatric nurse |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SDoH | social determinants of health |
| TIC | trauma-informed care |
| TRC | Truth and Reconciliation Commission of Canada |
| TTM | Transtheoretical Model |
| UN | United Nations |
| WHO | World Health Organization |

# Appendix A

## Reflection on the Title of Canadian Standards of Practice for Psychiatric-Mental Health Nursing, 5th edition

At this time, the CFMHN Standards Committee for the 5th edition reflected on the representativeness of the title of the *Standards* document for nurses across Canada who practice with individuals, families, and communities with mental health challenges. The previous, 4th edition is entitled *The Canadian Standards for Psychiatric-Mental Health Nursing*.

The term "psychiatric" refers to "psychiatry" defined as a branch of medicine that deals with mental, emotional, or behavioural disorder (American Psychiatric Association) and speaks specifically to the medical model of care. Mental health nursing practice, inclusive of the medical model, is broader. These Standards are an adjunct to the competencies in the practice of nursing and articulate the level of practice in the specialty area of mental health nursing.

Our 5th edition CFMHN Standards Committee questioned and debated whether to revise the title of this document to be the *Canadian Standards for Mental Health Nursing* (5th ed.). This change would be congruent with the name of the federation: Canadian Federation of Mental Health Nurses. However, the CFMHN specialty certification is Certified in Psychiatric and Mental Health Nursing (C)anada, so this also is a matter for discussion as to whether either the Standards or specialty certification and abbreviation should change, or not, to be consistent with the name of the federation. Further, it is often questioned whether 1) there should be a "hyphen," an "and," or "&" between Psychiatric and Mental, or nothing at all, and 2) whether it is: "Standards of" or "Standards for" Psychiatric-Mental Health Nursing. We felt this discussion and debate needs to go to the CFMHN Board and current membership. Perhaps it is a decision to think about in the next few years as we move forward.

# Appendix B

## Context and Considerations for Standards of Practice Revisions

In November of 2021, the Standards Committee held a virtual presentation and group discussion for the CFMHN members to explore general areas of context for the Standards document. The committee sought member input regarding opportunities and challenges specific to each of the context areas. A synopsis of member perspectives and ideas are listed.

| | November 2021 CFMHN Virtual Membership Discussion: Standards Contexts, Opportunities, and Challenges |
|---|---|
| 1 | **Questions:**<br>• Is this a national document? Of Standards? Domains? Reference? High level politics?<br>• Are these standards or domains of practice?<br>**Opportunities:**<br>• YES, would bring unity in understanding of PMHN practice<br>• Give voice coming from Canada<br>• Positions CFMHN as a national voice<br>• Would search for it internationally as our national doc<br>• CNA has positioned itself as the voice so the CFMHN aligned with CNA<br>• National certification based on standards<br>• Nursing landscape~ foster inclusivity<br>• Gives client and public a consistent understanding of PMHN practice<br>**Challenges:**<br>• Regional differences<br>• Does this represent a national voice?<br>• Different nursing professional designations across the country and region with different regulatory requirements<br>• Provincial authority<br>• Document would have to be rewritten as an adaptation to describe the national scene to explain regional and jurisdictional interpretation<br>• Would have to respect professional nursing practice provincial/territorial diversity and complexity<br>• Different licenses for practice<br>**Implications:**<br>• Must be mentioned in the introduction |

| | November 2021 CFMHN Virtual Membership Discussion: Standards Contexts, Opportunities, and Challenges |
|---|---|
| 2 | **Questions:**<br>• Is this document inclusive for registered nurses, registered psychiatric nurses, licensed practical nurses, and registered practical nurses practicing in a mental health setting?<br>• Are these standards or domains of practice?<br>• Jurisdictional level?<br>**Opportunities:**<br>• Already are multiple practice documents<br>• Opportunity to package and articulate it all to create a national profile of PMHN practice<br>• Feeds into or informs licensure requirements<br>• Educators use in curriculum for accreditation<br>**Challenges:**<br>• Would have to respect intra professional nursing practice provincial and territorial diversity and complexity<br>• A disconnect between four types of licensure requirements and overall national standards<br>• Confusing to colleges of nursing and frontline nurses<br>**Implications:**<br>• n/a |
| 3 | **Questions:**<br>• Who are the stakeholders for this document?<br>**Opportunities:**<br>• Educators: academic and clinical<br>• Evidence-based practice education in clinical settings<br>• CASN chief nursing officer<br>• Health care organization leadership<br>• Federal Minister of Mental Health and Addictions<br>**Challenges:**<br>• Nurses as part of the solution<br>**Implications:**<br>• n/a |

| | November 2021 CFMHN Virtual Membership Discussion: Standards Contexts, Opportunities, and Challenges |
|---|---|
| 4 | Questions:<br>• In relation to provincial practice standards, what is the correct terminology for this document (including definitions for standards, domains of practice, competencies)?<br>Opportunities:<br>• More clearly defined<br>• Glossary that outlines the scope<br>Challenges:<br>• There is a conflict in standards territory with provincial/territorial regulatory standards<br>• Do people understand domains of practice<br>• Historically practice domains with competencies (now use indicators)<br>Implications:<br>• Complex term and our understanding of standards |
| 5 | Questions:<br>• At what level is this document to be written?<br>• Concept:<br>• Important that all these items fit with relevant language/terminology<br>Opportunities:<br>• n/a<br>Challenges:<br>• At a political level as an advocacy document for psychiatric-mental health nurses to deliver in settings: (in the background~ as way of introduction)<br>Implications:<br>• Clarify in the introduction for PMHNs |

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Provide a national forum for nurses with a commitment to mental health to learn, grow, unite, and influence health policy and participate as decision makers to make sustainable positive changes in the mental health for all.

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