

CANADIAN PSYCHIATRIC MENTAL HEALTH NURSING: INTERSECTIONS OF  
HISTORY, GENDER, NURSING EDUCATION AND QUALITY OF WORK LIFE IN  
ONTARIO, MANITOBA, ALBERTA AND SASKATCHEWAN

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## Abstract

The need for a society that values mental health and helps people live enjoyable and meaningful lives is a clear aspiration echoed throughout our Canadian health care system. Recently, the Mental Health Commission of Canada has put forth a framework for a mental health strategy with goals that reflect the virtue of optimal mental health for all Canadians (Mental Health Commission, 2009). Canadian nurses have a vital role in achieving these goals. In Canada, two-thirds of those who experience mental health problems do not receive mental health services (Statistics Canada, 2003). In this regard, the provision of mental health services by nurses, the largest group of health care workers, beckons exploration. To understand how nurses impact on the mental health care of Canadians, it is first necessary to appreciate the current issues and intricacies of psychiatric mental health nursing (PMHN). Through a sociological perspective the goal of this paper is to further understand how the past has shaped the present state of PMHN. This integrative literature review offers a depiction of Canadian PMHN in light of the intersections of history, gender issues, education and quality of nursing work life. A total of 14 articles were selected for this review. The review provides a partial reflection of contemporary Canadian PMHN that may assist in prioritizing future actions. Specific findings include the association between gender and professional status, the inconsistencies in psychiatric nursing education between the western provinces and Ontario, and the limitations for Canadian Nurse Practitioners to advance the role of the Psychiatric Mental Health Nurse Practitioner.

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### List of Abbreviations

ACHHR - Advisory Committee on Health Human Resources

CNA - Canadian Nurses Association

CASN – Canadian Association of Schools of Nursing

CNAC- Canadian Nursing Advisory Committee

HPRB - Health Policy Research Bulletin

LPN- Licensed Practical Nurse

MRP – Major Research Project

NP – Nurse Practitioner

NSWHN - National Survey of the Work and Health of Nurses

RN - Registered Nurse

RPN - Registered Psychiatric Nurse

PMHN - Psychiatric Mental Health Nursing

PMHNP – Psychiatric Mental Health Nurse Practitioner

PTSD – Post Traumatic Stress Disorder

## Introduction

The account of the way Canadian psychiatric mental health nursing (PMHN) has emerged into its current state can provide an insightful perspective that fosters a better understanding of its present challenges and opportunities. This major research project (MRP) examines the development of Canadian PMHN in Ontario and the western provinces since the beginning of the 20<sup>th</sup> century.

Following the introduction, the MRP's aims and research question are provided. The sociological perspective applied is next presented followed by the methodology section. The results section is organized into three sub-sections. The first section looks at relevant studies with a sociological perspective. The second sub-section considers the history of PMHN in Ontario and the western provinces. The last sub-section details the quality of nursing work life with implications for PMHN. The MRP's discussion, implications for nursing practice and conclusion then follow.

It is helpful to first consider statistics that reflect some of the pertinent conditions of the Canadian mental health system as related to PMHN. For instance, the size of the Canadian nursing workforce continues to fluctuate, including the number of those employed in PMHN. In Ontario alone, between 1993 and 2003, there has been a 29.4 % drop in the number of nurses working in the psychiatric sector (Alameddine et al., 2006). In 2008, 5.1% of all RNs working in Canada were employed in Psychiatry/Mental Health (Canadian Institute of Health Information, 2010). This is a slight decrease from the previous year where 5.2 % of all RNs in Canada were employed in Psychiatry/Mental Health (Canadian Institute of Health Information, 2010). In Canada, PMHN is provided by three categories of nursing; i.e., Registered Nurses (RNs),

Registered Psychiatric Nurses (RPNs)<sup>1</sup> and Licensed Practical Nurses (LPNs). RPNs are a regulated separate profession in the provinces of Manitoba, Saskatchewan, Alberta and British Columbia. Between 2006 and 2008, the number of RPNs declined to 50 RPNs per 100, 000 population from approximately 54 RPNs per 100, 000 population in 2004 (Canadian Institute of Health Information, 2010). This decline is associated with the rapid growth in population in the four western provinces. The Canadian Community Health Survey conducted in 2003 by Statistics Canada revealed that two-thirds of those who experience mental health problems do not receive mental health services. Furthermore, persons living with mental illness may have difficulty competing for limited health care where this group is disadvantaged by a high rate of poverty and disability (Health Canada, 2002a). The reduction in PMHN workforce may, therefore, impact on the provision of adequate mental health care services for Canadians. Moreover, the deinstitutionalization trend that began in the 1960s resulted in many persons with mental illness being released into the community where a serious lack of mental health services prevailed (Boschma, Yonge & Mychajlunow, 2005). This led to a significant portion of individuals with mental illness to become incarcerated. Additionally, a revolving door phenomenon occurred where previously institutionalized individuals were readmitted into acute psychiatric care settings (Boschma, Yonge & Mychajlunow, 2005).

There are recent major initiatives underway in Canada with regards to mental health reform. In 2005 a national review of the Canadian mental health system took place as outlined in

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<sup>1</sup> For the purposes of this paper RPN refers to Registered Psychiatric Nurses that are only legislated in the four western provinces. In Ontario, Registered Practical Nurses, also abbreviated to RPN, provide care in all settings and are not solely specific to or trained in the area of psychiatric mental health. When RPN is used in this paper, the reference is to Registered Psychiatric Nurses.

the Kirby report (Kirby, 2005). In 2006, the Standing Senate Committee on Social Affairs, Science and Technology completed the final report entitled, *Out of the Shadows at Last – Transforming Mental Health, Mental Illness and Addiction Services in Canada*. As the mental health care system was considered to be fragmented, the final report made recommendations for the reformation of mental health care. The assembly of a Mental Health Commission to enable a national strategy for mental health care was emphasized by Michael Kirby, the chairman of the Standing Senate Committee on Social Affairs. Funding for the commission came in 2007 and in 2009, the Mental Health Commission of Canada released the framework: *Towards Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada*. Seven goals are set in this framework that represent how a transformed system will appear. The goals depict that everyone should have the opportunity for optimum mental health and well being (Mental Health Commission of Canada, 2009). The second phase is currently underway for a comprehensive mental health strategy to meet the seven goals.

The Mental Health Commission has recognized that there is a lack of opportunities for Canadians with mental health disorders to achieve optimum mental health. This calls for key stakeholders, i.e., groups interested in responding to people with mental health concerns, to address ways to further the provision of mental health care. Nurses are the largest group of healthcare providers, and nurses who provide mental health care are an important stakeholder in meeting the mental health care needs of Canadians.

A national strategy is needed and mental health care providers will need to be included in this strategy according to the Kirby report (Kirby, 2005). Kirby (2008) indicates the pivotal position that mental health care providers have and also addresses concerns regarding the stress levels and mental health of health care professionals themselves. Indeed this leads to concerns



regarding the quality of nursing work life for PMHN and how this specialty is responding to the demands of mental health care system. The analysis of the history of Canadian PMHN can enable a better understanding of why PMHN is the way it is today. With this understanding opportunities for further PMHN development and education, and future research may surface.

### Review Aims and Research Question

The purpose of this inquiry is to depict the current state of mental health nursing in Canada as evidenced by the existing research and literature. The research question that guided this paper was: What does the research reveal about contemporary Canadian PMHN in terms of the intersections of history, gender, education and quality of PMHN work life? Specific findings included the association between gender and professional status, the inconsistencies in psychiatric nursing education between the western provinces and Ontario and the limitations for Canadian Nurse Practitioners to advanced mental health education.

### Background

During the last ten years, I have worked in a large Canadian psychiatric hospital and in a First Nation community as both an RN and as a Nurse Practitioner (NP). This experience has contributed to a firsthand view of PMHN and the mental health care needs of Canadians. The daily interaction with fellow nurses has also sensitized me to the quality of nursing work life. In the in-patient psychiatry setting, I frequently hear complaints from nurses concerning their heavy work load and how tired and stressed they are. Often nurses request assistance with certain mental health care situations that are outside of the scope of NP practice and not within the organization's medical directives. The physician must be contacted in such situations but may be unfamiliar with the specific circumstances of the client. Today, NPs often provide much of the care and may know their clients at the depth required to make complex

decisions concerning their clients. Unfortunately the preparation for primary health care NPs in mental health is limited and this creates difficulties when proximity to physician support is lacking.

While practicing in the community, the lack of mental health services within the provision of primary care was a common concern. The inability to provide psychiatric treatments as a result of the limitations of scope of practice for NPs and the co-existing lack of physicians, psychiatrists and mental health care services in rural areas contributed to fragmented care that was not conducive to effective mental health care delivery. It would seem logical that the benefits of the NP would be appreciated in terms of increasing access and minimizing delays for persons with mental health disorders, especially in remote areas where psychiatric care is often lacking. Yet despite changes to legislation for the NP in other specialties, the Mental Health Act has not been changed in this regard (Forchuk & Kohr, 2009).

Continued education and life long learning is a high priority for all nurses. The educational programs for nurses vary in each province in terms of content and the prerequisites. As an NP working in mental health care, the options for pursuing advanced mental health nursing education in Canada are limited. PMHN education varies across Canada and unlike the United States there is no legislated PMHNP role. With the variety of different educational approaches to PMHN in Canada, the career path to advance nursing practice in PMHN is complicated. For instance, an RPN in the western provinces has had different preparation than an RN working in mental health care in Ontario. This paper will assist further understanding of how these different educational approaches have come to be and the implications for Canadian PMHN in general.

#### Theoretical Perspective

A sociological perspective allows for a critical assessment of common assumptions, and fosters recognition of opportunities and constraints that shape our circumstances, the interplay between societal forces and personal lives, and of human diversity (Macionis & Gerber, 2005). In addition, the concept of gender stratification is comprehensively analyzed within sociology and is applicable to the topic of this paper. Gender stratification concerns the imbalanced division of privilege and power between females and males (Macionis & Gerber, 2005). As PMHN has a high proportion of females to male nurses, and nurses are employed within hierarchal structures that interact and are influenced by the larger political agendas, it fits that a sociological perspective is appropriate for this inquiry.

Feminist theories, emerging from a sociological perspective, address patriarchy, power structures and gender inequality. They are concerned with the societal organization and interactions that maintain male authority and female subordination (Brym, 2001). A feminist perspective enables the depiction of the social structures leading to the devaluation of women. Social order then becomes the problem rather than women themselves (Brown, 2000). The intent in this MRP is not to devalue women or nurses but, rather, to illuminate the social structures that have persevered throughout history and that have influenced PMHN education and quality of work life. The sociological perspective applied will encompass feminist concepts.

A sociological perspective also bridges the connection between history and how things are today. Mills (1959) calls this way of thinking the sociological imagination that grasps the connection between history and the way we are and the way we are becoming. The history of PMHN seen through a sociological perspective can promote an understanding of its current state.

## Methodology

*The Integrative Review:*

An integrative methodology was determined to be most suitable for this review in order to capture findings from existing empirical and theoretical literature. Whittlemore and Knafl (2005) explain that the integrative review is particularly suited to inquiries with limited existing empirical research. Historical events in PMHN are relevant to how this field has come to be. Yet few research studies exist on Canadian PMHN and the studies are in the form of social historical analyses that reflect on the events of the past. In the integrative review, according to Whittlemore and Knafl (2005), diverse methodologies may be incorporated to further a comprehensive grasp of issues suited to the complexities of health care. Both quantitative and qualitative research may contribute to the perspective concerning a phenomenon. Rigor is maintained through evaluating primary sources for methodological quality. The methodology of the studies utilized in this paper are depicted in the appendices. The integrative review includes the stages of problem identification, literature search, data evaluation, data analysis and presentation. In this integrative review, primary sources were grouped into themes and presented in a table format (see Appendices 1, 2, and 3) to organize author and date, purpose, methodology, country, sample size and findings.

*Search Strategies:*

The primary literature search involved databases, the internet and published on-line journals. The databases included CINAHL, PsychINFO, Evidence-Based Mental Health, Cochrane, Pubmed and Proquest. Published on-line journals were accessed through Blackwell Synergy and Sage. Primary search results were then analyzed to search their references for secondary sources of interest. The databases were accessed through the York University Library and texts were borrowed through the assistance of the librarian at the Mental Health Centre Penetanguishene.

Search terms used included psychiatric nurses in Canada, Canadian psychiatric nursing history, Canadian psychiatric nursing education, Canadian mental health nursing, Canadian psychiatric mental health nursing, Canadian nurses and gender, quality of life for Canadian psychiatric mental health nurses, stress experienced by psychiatric nurses in Canada, Registered psychiatric nurses in Canada, work stress of nurses working in mental health, literature review on psychiatric mental health nursing in Canada, sociological perspective of psychiatric nursing, and sociology of nursing stress.

The searches included English language reports, studies, reviews, editorials and narratives and was limited to Canadian sources and Canadian PMHN. The intent was to discover the Canadian context of PMHN from a sociological perspective and to avoid international comparisons that were beyond the scope of this undertaking. With regards to the unique Canadian historical influences shaping PMHN, PMHN history, related gender issues, education and quality of PMHN work life, 14 studies were selected as suitable. There was a lack of studies that focus solely on the Canadian PMHN experience. Evidence on quality of Canadian PMHN work life often occurred together with that of all Canadian nurses. This made it difficult to discern the unique state of Canadian PMHN from that of all Canadian nurses.

The inclusion of research from 1996 and onwards was an attempt to better understand current conditions of PMHN and recognition of the intersections of history, gender, education and quality of work life. Furthermore, works before 1996 lacked the sociological perspective that incorporates feminist views in nursing specific to PMHN. Therefore, a contemporary reflection was sought through the emphasis of utilizing the most recent research available.

## Results

The results from the literature review are divided into three sections. The first section, reviews literature from 3 sources that ties in the sociological perspective. The next section considers the interrelation of history, gender and education for Canadian PMHN through review of 5 studies. The final section focuses on the quality of Canadian mental health psychiatric nurses work life from 6 studies.

*Studies with a sociological perspective relevant to PMHN:*

To further understand the sociological perspective as related to the current state of PMHN, it was necessary to look for similar research. Although not specific to PMHN, three studies were found that utilized a sociological perspective. These studies were helpful at discovering the way a sociological perspective unveils issues concerning patriarchy, power, subordination and gender in nursing that may be relevant to PMHN and the underlying perspective of this inquiry.

Davis (2006), Wall (2010) and McGibbon et al. (2010) demonstrate how a sociological perspective can further awareness of the intricacies of nursing. First, Wall (2010) utilized a sociological outlook to critique nursing practice settings and nursing research as a way to offer a different paradigm for potential research. The experiences of nurses can be further understood through a lens that encompasses professionalization and organizational influences. In addition, gender is ingrained in all of nursing where a patriarchal culture manifests. According to Wall (2010), the domination of medicine over nursing is evident in nursing's utilization of quantitative approaches in research that fosters the illusion of legitimacy but in fact represents gender induced subservience. Health care, being a largely institutionalized entity, has its own way of socializing nursing and continues to place medicine at the pinnacle of health care despite health care reformation. A critical sociological paradigm is emphasized as necessary to unveiling the

heart of issues in nursing related to nursing knowledge, gender, professionalization and organizations (Wall, 2010). This view magnifies sensitive areas related to the specialty of PMHN.

Next, McGibbon, Peter and Gallop (2010) also echo the need to connect with critical sociological viewpoints. McGibbon et al. (2010) utilize the works of Dorothy Smith's (1987) sociological frame of institutional ethnography to reconsider the stress in nursing through interviews, focus groups and observation of pediatric intensive care nurses. Findings suggest that stress is framed within the social structure of organizations, hierarchical and power based relations and articulating patient matters within the system. Studies concerning nursing stress or vicarious trauma often neglect how gender influences the life of nurses. Theories that are utilized in nursing research may avoid gender analysis with findings that lack solutions for occupational stress. Gender, race and class are aspects of nurses' identities but may not be within the range of the theory utilized for the research. This then leads to research that fails to identify the real issues for nurses and contributes to the lack of progress in this area (McGibbon, Peter & Gallop, 2010).

Another angle of PMHN that is linked with a sociological perspective concerns the competitiveness between stakeholders in mental health care. Davis (2006) discusses professional imperialism where the self interests of stakeholders are elucidated. Professions that have achieved high status are those that declare ownership of skill and knowledge, power to control the substance of their work and are self-regulated (Davis, 2006). Within the perspective of self interest psychiatry has triumphed in this regard, yet nursing as a lower status profession has struggled throughout time to develop nursing knowledge and to achieve self regulation. A sociological perspective allows the critical questioning if self regulation is a way to protect the profession's self interest in dominating an area. Indeed this is an area of high tension between

professions. As Wall (2010) depicts, nursing has a culture that fosters medicine's power and domination. As nursing is a work force that is predominately female and as women have collectively emerged to call for equality, the tension between nursing and medicine grows. This tension may manifest as stress in the workplace. McGibbon et al. (2010) connects stress directly to the power struggles occurring in the workplace where nurses must provide more medical care blurring the turf of physicians. The sociological angle critically examines the motives behind historical events and the current work life of PMHN.

*Intersections of history. gender and education for Canadian PMHN.*

Tipliski (2004) contributes to the understanding of Canadian PMHN history in the study entitled, *Parting at the crossroads: The emergence of education for psychiatric nursing in three Canadian provinces, 1909-1955*. The significance of gender stands out as a force that permitted psychiatry to maintain control of psychiatric nursing education in the western provinces. Unlike Ontario, where nurses were able to assume control over PMHN, thereby allowing PMHN incorporation into general nursing education, the provinces of Manitoba and Saskatchewan permitted psychiatry to prevent the merging of PMHN with general nursing. In this way, two different models for Canadian PMHN education developed leading to the class of the RPN that only exists in the western provinces. This creates a division in the PMHN nursing force in Canada, as the RPN is not educated in the same way as an RN.

Tipliski (2004) describes how the nursing leaders of Saskatchewan and Manitoba failed to assert control over nursing education. In 1955, the Canadian Nurses Association recognized how the separate training that was occurring in the western provinces was not conducive to the efforts to professionalize nursing for all of Canada. Unfortunately, a progressive movement by the nursing leaders of that time to bring psychiatric nursing under the umbrella of general



nursing in the 1950's dissolved. This left the western provinces with a split nursing educational approach where psychiatric nurse training remained separate from general nursing education and in the hands of psychiatrists (Tipliski, 2004). Although psychiatric nursing is no longer controlled by the psychiatrists in the western provinces, there still remains the separate training for RPNs. From this perspective it can be appreciated how nursing leaders in Ontario were successful despite being mostly female. The Ontario nurse leaders were able to gain control over their own nursing education and practice.

From a client centered approach, one must ponder if the RPNs provision of client centered care is lacking the full range of knowledge that is fostered through a comprehensive general nursing education that aims to incorporate a holistic perspective. Furthermore, the implications for those suffering from mental illness warrants consideration in terms of how the quality of care provided by the RPN or RN differ. From this angle, it can be argued that the differing educational model to those providing PMHN in Canada may impact on the quality of care for mentally ill individuals. This may be then a social injustice, when an individual may not receive the same standard of PMHN within the western provinces as result of the differing models of psychiatric nursing education that have arisen and have been influenced by the intersections of gender with professional dominance. There are no studies that have focused on the difference in the quality of care provided by either RPNs or RNs.

Despite the context that led to the separate training in the western provinces, Ontario took a different course. Tipliski (2004) explains how the Ontario male medical superintendants attempted to keep mental nursing separate from general nursing thus hindering the professionalization of nursing. The contributions from Nettie Fidler in 1933, a nurse graduate from the Toronto General Hospital, together with a report by Professor George Weir that

recommended the merging of general with mental nursing, stimulated the progression by the Registered Nurses Association of Ontario (RNAO) to advocate for closure of the separate schools that provided training in mental health to nurses that were not trained in general nursing. The Ontario nurse leaders persevered and were aided by government authority over mental health care that led to the eventual successful merging of general with psychiatric nursing (Tipliski, 2004, p. 258-259).

Of interest is Tipliski's (2004) reference to gender in terms of the psychiatric monopoly that led to the RPN designation of the western provinces. This relates to the feminist concepts of patriarchy. Brown (2000) defines patriarchy as a social system that holds several assumptions. One assumption portrays women as being assigned a social function. In nursing as Tipliski (2004) depicts, nurses were assumed to be fitting to provide for the patients as a result of their female gender with their inherent ability to nurture. The notion of nurses as nurturers, due to their female gender, was a patriarchal belief held by the male medical superintendents. Another patriarchal assumption is that women are thought of as weaker and less strong. Tipliski (2004) also considers the patriarchal context of PMHN, where the nurse leaders of the western provinces struggled unsuccessfully against the dominance of the medical profession.

It can be seen that the success of the Ontario nurse leaders is an extraordinary event in that it signifies a movement away from the dominating authority of the medical superintendents. Without the control over nursing education by the medical superintendents, nursing was able to elevate nursing status to a higher level. It may be helpful to imagine how nursing would look like today if mental health education was excluded from our general nursing education, and psychiatry leaders of mental health institutions would continue to control the way nurses were to be educated in the field of mental health. The Ontario nursing leaders were victorious and this

was during a time in history in which women faced significant structural barriers for professional progress.

Dooley (2004) argues that the separate class of psychiatric nurses from general nurses that developed in Manitoba evolved their own unique craft that is specialized for the mentally ill population. In this study, the account from Manitoba mental health nurses of the 1930's supports the view that the nurses were not resistant to the agenda of the governing physicians and the development of their nursing is the outcome of the cooperation that existed between the nurses and the physicians. Interestingly, the female Manitoba mental health nurses in this time era considered themselves skilled and at a higher level than the male attendants. The female nurses were often in supervisory positions directing the personal care given by the male attendants. This contrasts with Tipliski's (2004) view on the separate division of psychiatric nursing being related to paternalistic structures and in which female mental nurses could not overcome male physicians and psychiatrists domination that sought control and power. Yet the Manitoba mental health nurses that would become RPNs asserted their distinct class and this has enabled the continuation of the separate training for mental health nursing that continues to manifest inside the western provinces. The significance this has for the culture of Canadian psychiatric nursing and the implications for a national strategy for education of PMHN raises many concerns that cannot be ignored. Without a unified approach to PMHN education, PMHN cannot evolve to fully develop in a way that most effectively enables quality client centered care. The separate divisions of psychiatric nursing education in Canada may contribute to the fragmentation of health care that is not conducive to the mental health care reform efforts that are occurring. This impacts on the effectiveness of mental health care and may present as an inequality for those with mental health disorders. One must acknowledge the circumstances that influenced Canadian

women as nursing leaders in the past. For instance Dooley (2004) describes the social context of the interwar years where women were looking for ways to support themselves and mental health nursing provided a way to live that would provide regular meals and housing for mental health nurses.

Hicks (2008) provides further details concerning Manitoba's adoption of the RPN model. Through a genealogical analysis, the study considers the historical events and circumstances that led to the RPN model instead of having psychiatric nursing as a component of general nursing. Gender stands out as a main influence in this movement where the male leaders of the psychiatric nursing associations of the adjacent western provinces were influential in drawing Manitoba to call for the distinct nursing class. The male nurses of the RPN psychiatric nursing associations in the western provinces developed a collegial relationship with the male attendants of Manitoba who sought RPN status. In addition, the separate psychiatric RPN distinction was favored by the male medical superintendents. Furthermore, there was a lack of interest by the general nurses to work in psychiatry. Hicks (2008), depicts the large number of male attendants and the significance of gender in the creation of the RPN designation. This represents an interesting finding in terms of gender analysis, where one may construe RPN profession's origins in Canada may be more associated with the rising of the psychiatric male attendants. The male attendants provided custodial care and sought to provide nursing care that would elevate the status of the male attendants. Unlike Dooley (2004) and Tipliski (2004) who focus on the female gender of nursing, Hicks (2008) depicts the collegiality and support of male RPN leaders of the western provinces. The Canadian Council of Psychiatric Nursing provided support to the Manitoba attendants who sought RPN status (Hicks, 2008). The RPN emergence may be seen as a way for the male gender to enter into nursing in a time where nursing was culturally enshrined

as a female role and the attendants of psychiatric institution sought status and class through the RPN profession. In this way, Hicks' study demonstrates how male gender has influenced the history of Canadian PMHN. The RPN profession and PMHN in western Canada had developed in a unique way, shaped by the politics of the times.

Boschma, Yonge and Mychajlunow (2005) examined nurses' stories that further the understanding of the development PMHN in Alberta. The accounts from nurses reveal their involvement in the development of the educational system for PMHN. RN status was recognized as being desirable for PMHN and could be achieved by mental health nurses by taking an extra 18 months of training in a general hospital after completing 2 years in a psychiatric hospital. Women were sought as nurses by the governing psychiatrists for their caring and compassionate nature. The male attendants were excluded from nursing because of their gender and became increasingly resentful. The male attendants sought recognition and professional status. Like Saskatchewan, the separate status from RNs was lobbied for by the male attendants and in 1963 registration was given to psychiatric nurses. In this sense, the development of the separate RPN status stems from the gender division that favoured RN status to females leaving male mental health attendants to seek professional status by becoming RPNs. Similar to the discourse by Hicks (2008) concerning the way the RPN profession was promoted by the male attendants, Boschma et al., also indicate the influence of male attendants. This differs from the view held by Tipliski (2004) that mainly denotes the oppression of the largely female nurses by the medical superintendants and the perspective by Dooley (2004), where the female psychiatric nurses saw the RPN category as separate and offering more to the mental health care of patients than the general nurse education could extend. Despite the development of the RPN class, mental health care in Alberta continued to suffer and the need for further

education fostered continued pressure to achieve RN status (Boschma et al., 2005). From this depiction, it can be appreciated how gender is linked to the professional status and the shaping of PMHN education within Canada.

McPherson (1996) acknowledges that RPNs are separate from RNs and excludes them in her description of nursing history. However, as Tipliski (2004) explains, the RPN class only exists in the Western provinces. East of the Manitoba border PMHN is delivered by RNs, Registered Nursing Assistants and Licensed Practical Nurses (LPNs). Furthermore, the issues that McPherson describes mirror the circumstances for PMHN. The subordination of nurses is linked with gender, class and patriarchy. As previously discussed, the female gender of nurses brought the connotation of kind and caring women who were subservient to males or doctors. Like fathers in the 20<sup>th</sup> century, doctors were often the head of the family and the main decision makers. Women at one time did not work for pay and being paid less than males has also typified history. Nurses for many generations were underpaid. In terms of class, nurses were required to cater to the medical requests made by doctors but, as they were also skilled, this meant that they were often considered to be at a higher class than less skilled workers. Similar to a factory, hospitals had many levels of production where doctors were at the top controlling medical practice. Unlike production line work, nurses were reluctant to take job action, join unions or strikes because their products were their patients who could possibly die without their care (McPherson, 1996).

Despite the persistence of subordination, professionalization offered a way for nurse leaders to improve education for nurses that would make them more skilled and place nursing at a higher level within society. Nurses were able to organize into provincial nursing associations and in 1924 the Canadian Nurses Association formed to guide Canadian nurses at a national

level (McPherson, 1996). The professionalization of nursing influenced the PMHN to achieve higher educational levels. This in turn contributed to the improved working circumstances and pay for PMHN. With improved working conditions, adequate remuneration and higher education, PMHN nursing has grown to further client centered care. In addition, professionalization has fostered a move towards equality for nurses and this is significant within the perspective that women had for the most part been economically oppressed and confined as poorly paid caregivers.

*Quality of Canadian Mental Health Psychiatric Nurses Work Life*

In 2001 the Canadian Nursing Advisory Committee (CNAC) was formed as a result of the recommendations by the Advisory Committee on Health Human Resources (ACHHR). The ACHHR's first recommendation of the *National Strategy Nursing Strategy* was to create the CNAC. The CNAC included nursing representatives from the three nursing professions of RNs, RPNs and LPNs. The CNAC's main goal concerned the quality of nursing work life and the identification of provincial and territorial strategies to enhance nursing work life. With the shrinking workforce this was deemed a high priority. The CNAC's recommendations concern all nursing workplaces including settings that provide PMHN. In this regard, the recommendations are relevant to all nurses.

In order to explore current issues, the CNAC commissioned 6 projects. The projects looked at strategies to improve workplaces, costs related to absenteeism and overtime, workload issues, satisfaction of nurses in the workplace, workplace respect and autonomy and health care organizational structures (Health Canada, 2002). The lack of data concerning RPNs is considered a drawback to the depth of the projects. From the projects and research as set forth by the CNAC, 51 recommendations were made to the ACHHR. The recommendations can be summarized into

three categories. The first category concerns management issues and resources. There is a need to reduce nursing's pace and intensity, to increase full time work, decrease sick time and overtime and enable full scope of practice. The second recommendation speaks to professional work settings that foster a thriving and dedicated workforce. Respect for nurses is key to this recommendation, as well as education at the masters and doctoral levels. Education for nurses should be accessible in remote and rural areas. Violence and abuse in the workplace must be addressed. In the third recommendation, monitoring of the health of nurses and workplaces and disseminating information to keep nurse abreast of initiatives and education is considered. Accreditation, awards to promote quality of nursing work life, continued research on the nursing workforce, implementation of regional nursing committee recommendations, national nursing retention and recruitment campaigns with a heightened emphasis for diverse and Aboriginal groups are a few activities mentioned within this recommendation (Health Canada, 2002).

The recommendations strive to rectify the main issues that concern the shortage of nurses, the lack of educational opportunities, the limited scope of nursing practice and the unfavourable working conditions. The main issues described here are also applicable to the RPNs and RNs who provide PMHN. However, the CNAC recommendations previously discussed lack consideration of gender and its intersection with professionalization and workplace culture that culminate in the heart of issues that impact on nursing work lives (Wall, 2010). As a stakeholder in mental health, PMHN needs to organize as a united front, so that its voice is heard. This is challenging when other stakeholders, like physicians, hold more power in the health care system and the representation of PMHN as a stakeholder may not be given the same status. For instance, with regards to limited scope of practice, Davis (2006) describes prescription privileges that are granted to pharmacists and psychologists. Psychiatry and



medicine have opposed the right of any other professional group to prescribe. As exemplified by Davis (2006), psychologists in New Mexico who have been granted prescribing privileges have been criticized that they may frequently misdiagnose and are not suited to identification of physical complications. This critique also applies to pharmacists who have met opposition with medical associations claiming concerns with regards to patient safety when given the right to provide emergency birth control pills (Davis, 2006).

Given the history of nursing, in terms of their subordination to medicine, one can see why PMHN has developed with regards to scope of practice and prescriptive authority. This is like the invisible elephant within the room, where many Canadians, especially in rural areas, lack mental health care and nurses have become increasingly skilled, and where NPs are often providing a high proportion of primary care to communities yet they are unable to prescribe psychotropic medications and face challenges in making referrals to mental health specialists. Furthermore, in Ontario, NP prescribing is confined to lists of medications. The process in Ontario for making changes to the NP drug and lab list is a lengthy process. Open prescribing would eliminate lists and is fundamental to best practices as NPs provide care to many different age groups within a variety of settings for diverse populations. From this angle one may question if the voice of PMHN as a stakeholder is being heard over the more historically prominent stakeholders.

Maslove and Fooks (2004) conducted a study to determine the degree of implementation of the 51 CNAC recommendations made in 2002 as requested by the Office of Nursing Policy at Health Canada. Policies of the stakeholder organizations were assessed to determine their impact on facilitating the implementation of the recommendations. The methodology to determine the implementation of the recommendations included the scanning of websites,

sending letters to 94 stakeholders to determine their progress and interviewing 14 informants to identify barriers and supports. The 94 stakeholders included employer organizations, the federal government, provincial/territorial governments, unions, professional associations/ regulators, educators, research community and national organizations. There was a 50% response rate from stakeholders. Findings were then shared with nursing stakeholders at a roundtable to enable feedback.

The recommendation to increase the number of education seats occurred in a uniform manner. However, other recommendations occurred in some areas but not all and there was difficulty in determining what had occurred nation-wide. Recommendations including workload measurement systems, increased full time positions, analyzing sick time, increasing nurse mentors and flexible scheduling were not consistently taking place throughout Canada. Key informants favoured regulation at the provincial versus the national level. Stable funding was depicted as a barrier to implementation of the recommendation to develop secure jobs. Assigning recommendations to the differing nursing organizations is not straight forward, as each province has a different way of operating their professional associations and regulatory colleges. Respondents addressed lack of interest from government regarding nursing issues. Accountability is seen as critical to implementation of the recommendations made by the CNAC. Determining what organizations should be responsible for is a priority concern and employers need support to enable improvements that will impact on nursing quality of work life (Maslove & Fooks, 2004). Organizations require the support often through government funding to implement the recommendations that will enhance nursing work environments.

Together the CNAC's recommendations and the study by Maslove and Fooks (2004) are applicable to PMHN in that they reveal the current issues that are affecting nursing and the

degree of change that is occurring to improve nursing work life. It can be appreciated that nurses require adequate education, adequate staffing levels and professional work environments to provide client centered care. One can argue that the poor working conditions may negatively impact on quality care, and the lack of action and accountability by organizational and provincial territorial leaders may indeed represent a form of social injustice that manifests in poor mental health for both nurses and the Canadian population which they serve.

The 2005 National Survey of the Work and Health of Nurses (NSWHN) examined the health of Canadian regulated nurses as related to their work environment. Nineteen thousand nurses inclusive of RNs, RPNs and LPNs were surveyed with a response rate of 80% (Statistics Canada 2006). All findings were statistically significant. More than one-quarter reported being physically assaulted. Of note is that 44% males reported assault compared to 28% of female nurses. The reasons for this finding are not elaborated upon in 2005 NSWHN. It is not known if this points to male nurses being more likely to be assaulted or more likely to report assault. Forty four percent of nurses reported emotional abuse. High physical demands were reported by 75% of LPNs, 60% of RNs and 45% of RPNs. Gender difference was not specified for physical demands, i.e., if male or female nurses reported higher physical demands. The mental health of nurses was adversely associated with evening shifts and employment in long-term care facilities. Lack of respect and low support from co-workers and superiors was linked with poorer mental health. In addition, the mental health of nurses was also affected by elevated job strain, low autonomy and control and poor physician relations. One in ten nurses reported having depression and needing to take time off in relation to their mental health. In comparison to the overall employed population, depression is highest amongst nurses. One-fifth reported their mental health difficulties interfering with their jobs. Also, quality of care was negatively affected by

inadequate staffing. Thirty eight percent of nurses felt that staffing was inadequate.

Improvements in quality care were related to improved management and more staffing (Statistics Canada 2006). The results of the survey are a red flag for the Canadian health care system. It appears that the nursing workforce in general is suffering in many ways. This is relevant to the current state of PMHN and the recognition that the mental health of nurses is cause for concern given the present working conditions.

The Health Policy Research Bulletin (HPRB) is published usually twice yearly by Health Canada with the purpose of reinforcing the evidence that supports decision making in health policy. In 2007, the HPRB's issue, titled *The Working Conditions of Nurses: Confronting the Challenge*, focused on the Canadian nurses' working conditions and implications for the country's health care system. In relation to PMHN there appears to be more male nurses in comparison to the entire Canadian nursing workforce, where 94.6% of all Canadian nurses were female in 2005. In the specialty of mental health for this same year, the percentage of female RNs was 85.4% and 14.6% for males. For RPNs, 77.4 % were female and 22.6% were male. For LPNs, 76.6% were female and 23.4% were male (Health Canada, 2007). In PMHN there is still a predominance of female nurses but there is less of a difference in the number of female to male nurses as compared to non mental health nursing sectors.

In relation to the CNAC's recommendation to increase full time employment for nurses as a way to reduce the effects of the nursing shortage, the HPRB indicates that 64.6% of the nursing work force including RNs, RPNs and LPNs employed in mental health held full time positions in 2005. This compares to 53.2% full time RN positions for all areas excluding mental health (Health Canada, 2007). Between 1997 and 2005 overtime by RPNs, LPNs and RNS increased in all areas where nurses work by 58%. In light of the high overtime rates it is

questionable if the current level of full time nursing positions in mental health care in Canada is sufficient to adequately care for those with mental illness. All areas in nursing face similar pressures concerning increased overtime and a need for more full time work, however, mental health settings entail frequent interactions with challenging and difficult behaviours. This may intensify the stress on nurses working in mental health care where there is shortage of full time nurses.

Robinson, Clements, and Land (2003) conducted a study with a cross sectional design. A survey of 1015 RPNs in Manitoba was conducted to determine the predictors, prevalence, correlates and distribution of vicarious trauma and burnout. The survey included the Maslach Burnout Inventory, the Traumatic Stress Institute Belief Scale and a section on post traumatic stress disorder (PTSD) symptoms. Seventy nine percent of the respondents were female and 20.2% were male. Emotional exhaustion was highest in RPNs working in community services and acute care hospitals. Constant interruptions, burdensome responsibility, increased trauma work, depersonalization and elevated vicarious trauma scores were linked with higher emotional exhaustion levels. With regards to vicarious trauma, 21% had persistent thoughts in relation to client trauma and 30% experienced a heightened level of arousal. Client trauma is the exposure to a stressful experience that overwhelms a person's coping mechanism. Fifty five percent of those involved in client trauma met one criteria of PTSD and 48% responded that symptoms were troublesome to some degree. Lack of peer support and skills to deal with trauma could be rectified by increased education and team-building. The RPNs in this study also reported a high level of personal accomplishment which is associated with low burnout (Robinson et al., 2003). Personal accomplishment includes the perception that clients are improving and have the skills necessary to help individuals with mental health disorders. The study is significant in that it

mirrors the results of the studies in the preceding discussion concerning nursing quality of work life. Stress is evident in nurses working in mental health care and unfortunately it stress negatively impacts on the mental health of the caregivers. How this impacts on client care requires further study.

Nicholls (2004) studied the repercussions of health reform in RPNs. Seven focus groups with RPNs from a diversity of health care settings took place in Manitoba over a nine month period. The themes that emerged from the focus groups consisted of changes from institutional care to the community, variations in professional position, primary and secondary care and prevention, lack of provincial communication and consistency amongst policies. Deinstitutionalization was considered to have largely impacted on the practice setting of RPNs. This change led to an extension of their roles in many different settings including emergency departments, treatment centres and acute psychiatry. RPN professional status has required a move to more autonomous roles within the primary care setting where professional competence is emphasized. Emphasis on health promotion and prevention is in contrast to the traditional approaches that focused on treating illnesses in the institutionalized settings. The lack of consistency within the region concerning standards of mental health and policies was attributed adversely to the provision of mental health services.

The RPNs recognized the move to client centered care where mental health consumers are involved in the decision making process. The transition from the medical model has left some RPNs feeling unprepared and concerned that the client may not choose what is best for them (Nicholls, 2004). The importance of engaging the family has become more apparent and this contrasts to the way care was provided in the past where family involvement was limited in the institutional setting (Nicholls, 2004). This leads one to conclude that the education of RPNs and

RNs is essential to meet the changing ways of caring for those with mental illness. Client centered care requires advocacy and involvement with family and community beyond the confines of institutional care.

According to Nicholls (2004), the shortage of RPNs is a concern held by the existing RPNs. Previously it was believed that deinstitutionalization would perhaps leave RPNs without jobs. Now there are not enough RPNs to fill the vacant positions. In addition, participants in the focus groups discussed concern about the 2 year diploma program changing into the 4 year baccalaureate degree for RPNs, graduating only 15 students per year as compared to 60 students per year from the diploma program (Nicholls, 2004). Therefore the issues for RPNs parallel the issues of the broader nursing workforce, where the shift to higher education has impacted on the size of the nursing workforce but at the same time the nursing graduates of today have increased knowledge to meet the current challenges of health care.

### Discussion

This review points to the state of PMHN today being intricately connected to the events of the past, and intersections of gender, professionalization, and the predominating organizational culture. Overall PMHN in Canada is fragmented, nurses are stressed and there is a need to enhance a coordinated national approach for advanced degrees in PMHN. The lack of a uniform approach to PMHN education in Canada has consequences for the further development of PMHN and may be linked to the quality of care for mental health consumers. The implementation of standards by the Canadian Federation of Mental Health Nursing is a way to address the need for an overarching educational approach for PMHN that enables quality PMHN practice. In 2006, the third edition of the *Canadian Standards for Psychiatric-Mental Health Nursing* was released in an effort to prompt nurses to adopt the standards into daily practice and

further nursing reflection of their work (Canadian Federation of Mental Health Nurses, 2006). The latest standards were developed after consultation with Canadian consumers of mental health across Canada. Beal et al. (2007) acknowledge that systemic issues, i.e., labeling, stigma, caregiver and treatment role, affect PMHN but emphasize the need for nurses to know their clientele to foster therapeutic relationships. The concern here is the way systemic factors, including workforce size, workload and nursing scope of practice factor into the ability of PMHN to incorporate the standards into their daily practice. The systemic aspects and quality of work life of PMHN today are linked to the historical gender influences where, as Tipliski (2004) explains, medical superintendants had power and control over the psychiatric attendants, nurses and education leading to the RPN role only in the western provinces. This has resulted in the varying PMHN practice throughout Canada that is linked to the fragmented care identified by as Michael Kirby (2005). The impact that this has had on PMHN as a stakeholder in mental health care is the difficulty to come together of PMHN at a national level because it is divided through different credentials, namely the RPN and RN designation. As an influential and strong stakeholder that can effect change in mental health care, PMHN would benefit from a uniform educational process throughout Canada.

Also of great concern is the mental health of nurses who experience high stress. As nurses are mostly women and nurses form the largest group of health care providers, the ramifications for the health and productivity of Canadian society are especially disconcerting if the majority of nurses are experiencing reduced quality of work life. As Wall (2010) and McGibbon et al. (2010) point out, a sociological paradigm enables the discussion of sensitive issues that have not been fully addressed in the past. The labour division in organizations where



nurses practice are entrenched in hierarchal power struggles that undermine nursing knowledge and autonomy and contribute to poor quality of work life and stress.

#### *Limitations of review*

There were limitations encountered in this review. Although several studies were found in relation to the history of PMHN for the western provinces and Ontario, no studies were located that convey the full PMHN history of eastern Canada. Works subsequent to 1996 were excluded to maintain a contemporary approach, however, this may have eliminated pertinent perspectives concerning PMHN. While there were government documents concerning the quality of work life for all nurses, it was difficult to abstract information specific to PMHN from these documents. For instance, although the NSWHN found a high incidence of depression amongst nurses, the percentage of nurses in PMHN experiencing depression was not given. It is acknowledged that the whole puzzle of what PMHN is like in Canada is not complete. Despite this, the findings reported here depict important points regarding the issues that concern PMHN and how they impact on the provision of mental health care for Canadians.

#### Implications for Nursing Practice

The fragmentation of PMHN in Canada has bearing on the advancement of PMHN education. Gallop (2007) considers how the education system in Canada lacks opportunities for nurses working in mental health to obtain advanced degrees in PMHN. Certification for RNs is available only at a basic level and there is no organization to provide advanced certification. With so few nurses having advanced degrees the ability for nurses to champion advanced education is limited and those who do are often classified as elitist by other nurses (Gallop, 2007). There is however a recent increase in the number of nurses who have achieved graduate degrees. The report entitled, *Nursing Education in Canada Statistics, 2008 – 2009*, conducted by

the Canadian Nurses Association (CNA) and the Canadian Association of Schools of Nursing (CASN), reveals an increase of 15.7% in one year for nurses entering masters and doctoral in 2007 – 2008. With this trend it is likely that mental health education for nurses and nursing research pertaining to mental health and PMHN will flourish.

While NPs have made significant progress in achieving prescriptive authority in the area of primary care, minimal movement has occurred regarding the feasibility of NPs specializing in mental health. In Canada there are no educational programs or legislated provisions for NPs who wish to specialize as a psychiatric NP or who already have extensive experience providing mental health care (Forchuk & Kohr, 2009). The existing situation for NPs practicing within mental health care settings is hampered by the absence of recognition for the Psychiatric Mental Health Nurse Practitioner (PMHNP) in Canada. Prescriptive authority can only be obtained in Ontario through registration in the extended class in the designated specialties, NP-Paediatrics, NP-Primary Health Care, NP-Adult and NP-Anesthesia. The educational programs that prepare NPs for these specialties focus on the medical and physiological aspects of the specialties with limited content on mental health (Forchuk & Kohr, 2009). This becomes a matter of social injustice for communities with insufficient mental health care resources who could be better served by nurses with an expanded scope of practice that is grounded in mental health. In addition, although there have been proposed changes to legislation that would give admitting and discharging privileges to NPs, changes to the mental health act have not been made and regulated forms enabling admission to a hospital for psychiatric assessment cannot be completed by Canadian NPs. When the NP is the person's main care provider it would seem prudent that the NP should be involved in decisions concerning psychiatric admission and discharge. Furthermore with the variance in career pathways for RPNs and RNs in Canada, the matter of

advanced education is further complicated. The CNA motioned a resolution in 2005 to include RPNs as it was recognized that a separate national level for RPNs would hinder professional nursing practice and the power for Canadian nurses to advocate for change (CNA Resolutions, 2005). The need to amend the division between RPN and RNs and to enable certification and eligibility of CNA membership for both groups may strengthen the Canadian PMHN workforce. However, the necessity to fully understand the physical health of those with mental illnesses is afforded by the RN designation and this is essential to further advanced education in mental health nursing. Therefore, advanced education in PMHN is best enabled by a comprehensive general RN training that precedes mental health specialization. As mental health care is no longer confined to institutional settings and mental health training is pertinent to all areas of health care, the necessity of advanced mental health education is relevant to all health care settings where nurses practice. Nursing needs to facilitate advanced education in mental health so that people within the primary care setting also benefit from the knowledge and expertise of nurses who have additional mental health education. Enhanced education for PMHN will likely lead to increased research that will further benefit the working circumstances for nurses and the people they serve.

### Conclusion

PMHN in Canada must take action to meet the goals as set out by the Mental Health Commission of Canada. Advanced education for PMHN will further the accessibility of quality care for Canadians in need of mental health care. Efforts to unite the varying groups providing PMHN at a national level are necessary to reduce fragmented care and to empower PMHN as a stakeholder to impact on mental health care reform. Also, the mental health of nurses in light of their quality of work life is a red flag for all leaders in the Canadian health care system. There is

a need to understand the circumstances of nurses with regards to occupational stress and barriers to advanced education in mental health nursing. Although the full picture of what Canadian mental health nursing looks like today cannot be fully realized by this synthesis, important issues facing PMHN have been identified through a critical sociological perspective. Another chapter on the evolution of Canadian PMHN has yet to be written; hopefully it will entail how PMHN works together with all stakeholders equally to provide the best care possible.

## References

- Alameddine, M., Laporte, A., Baumann, A., O'Brien, L., Croxford, R., Mildon, B., Wang, S., Milburn, B., & Deber, R. (2006). Where are nurses working? Employment patterns by sub-sector in Ontario, Canada. *Healthcare Policy*, 1(3), 65-86.
- Beal, G., Chan, A., Chapman, S., Edgar, J., Mcinnis-Perry, G., Osborne, M., & Mina, E.S. (2007). Consumer input into standards revision: changing practice. *Journal of Psychiatric and Mental Health Nursing*, 14, 13-20.
- Boschma, G., Yonge, O., & Mychajlunow, L.(2005). Gender and professional identity in psychiatric identity in psychiatric nursing practice in Alberta, Canada, 1930-75. *Nursing Inquiry*, 12(4), 245-255.
- Brown, L.S. (2000). Feminist therapy. In *Handbook of Psychological Change: Psychotherapy Process and Practice for the 21<sup>st</sup> Century*. Snyder, C.R. & Ingram, R.E., (eds) pp.358-380. New York: Wiley.
- Brym, R.J. (2001). *Sociology for the 21<sup>st</sup> Century*. New Society. Harcourt Canada Ltd. Toronto, Ontario.
- Canadian Nurses Association. (2005). *Resolution 2. Inclusion of Psychiatric Nurses*. Available at:  
[http://www.cna-nurses.ca/CNA/about/meetings/resolutions\\_2005/resolutions\\_02\\_e.aspx](http://www.cna-nurses.ca/CNA/about/meetings/resolutions_2005/resolutions_02_e.aspx)  
 (accessed September 20, 2010).

- Canadian Federation of Mental Health Nurses. (2006). *The Canadian Standards for Psychiatric-Mental Health Nursing*, (3<sup>rd</sup> ed.). Available at: <http://cfmhn.ca/index.html> (accessed September 13, 2010).
- Canadian Institute for Health Information. (2010). *Regulated Nurses: Canadian Trends, 2004 to 2008*. Updated February 2010. Available at: [http://secure.cihi.ca/cihiweb/products/regulated\\_nurses\\_2004\\_2008\\_en.pdf](http://secure.cihi.ca/cihiweb/products/regulated_nurses_2004_2008_en.pdf) (accessed September 20, 2010).
- Canadian Nurses Association & Canadian Association of Schools of Nursing. (2010). Nursing Education in Canada Statistics, 2008-2009. Available at: <http://www.casn.ca/vm/newvisual/attachments/856/Media/40605NursingEducationinCanadaStatistics20082009ENGFINAL.pdf> (accessed December 6, 2010).
- Davis, S. (2006). *Community mental health in Canada. Theory policy and practice*. Vancouver, BC:UBC Press.
- Dooley, C. (2004). 'They gave their care, but we gave loving care': Defining and defending boundaries of skill and craft in the nursing service of a Manitoba mental hospital during the Great Depression. *Canadian Bulletin for Medical History*, 21:2, 229–51.
- Forchuk, C. (2001). Evidence-based psychiatric/mental health nursing. *Evidenced Based Mental Health*, 4, 39-40.
- Forchuk, C. & Kohr, R. (2009). Prescriptive authority for nurses: The Canadian perspective. *Perspectives in Psychiatric Care*, 45(1): 3-8.
- Gallop, R. (2007). International society of psychiatric nurses [ISPN]. *Advanced practice psychiatric nursing in Canada*. Available at: [http://www.ispn-  
psych.org/html/what\\_canada.html](http://www.ispn-psych.org/html/what_canada.html).(accessed September 21,2010).

- Health Canada (2002a). *Sharing the Learning. The Health Transition Fund*. Ottawa: Health Canada. Available at: [http://www.hc-sc.gc.ca/hcs-sss/alt\\_formats/hpb-dgps/pdf/pubs/2002-htf-fass-prim/2002-htf-fass-prim-eng.pdf](http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2002-htf-fass-prim/2002-htf-fass-prim-eng.pdf) (accessed October 22, 2010.)
- Health Canada. (2002b). *A Report on Mental Illnesses in Canada*. Ottawa, Canada. Available at: [http://www.phac-aspc.gc.ca/publicat/miic-mmacc/pdf/men\\_ill\\_e.pdf](http://www.phac-aspc.gc.ca/publicat/miic-mmacc/pdf/men_ill_e.pdf) (accessed September 13, 2010).
- Health Canada. (2002c). *Our Health, Our Future: Creating Quality Workplaces for Canadian Nurse, Final Report of the Canadian Nursing Advisory Committee, Advisory Committee on Health Human Resources*. Available at: [http://www.hc-sc.gc.ca/hcs-sss/alt\\_formats/hpb-dgps/pdf/pubs/2002-cnac-ccesi-final/2002-cnac-ccesi-final-eng.pdf](http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2002-cnac-ccesi-final/2002-cnac-ccesi-final-eng.pdf) (accessed September 20, 2010).
- Health Canada. (2007). *The working conditions of nurses: Confronting the Challenges*. Available at: [http://www.hc-sc.gc.ca/sr-sr/alt\\_formats/hpb-dgps/pdf/pubs/hpr-rps/bull/2007-nurses-infirmieres/2007-nurses-infirmieres-eng.pdf](http://www.hc-sc.gc.ca/sr-sr/alt_formats/hpb-dgps/pdf/pubs/hpr-rps/bull/2007-nurses-infirmieres/2007-nurses-infirmieres-eng.pdf) (accessed September 18, 2010).
- Hicks, S.C. (2008). *From barnyards to besides to books and beyond: The evolution and professionalization of registered psychiatric nursing in Manitoba, 1955-1989*. University of Manitoba, Canada.
- Kirby, M.J. (2005). Mental health reform for Canada in the 21<sup>st</sup> century: Getting there from here. *Canadian Public Policy: Analyse de Politique*, 31(s1), 5-12.
- Kirby, M.J. (2008). Mental health in Canada: out of the shadows forever. *Canadian Medical Association Journal*. 178(10), 1320-1322.

- Macionis, J. J., & Gerber, L. M. (2005). *Sociology*. (5<sup>th</sup> Ed.). Pearson Education Canada Inc. Toronto, Ontario.
- Malove, L., & Fooks C. (2004). *Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses: A Progress Report on Implementing the Final Report of Canadian Nursing Advisory Committee*. Canadian Policy Research Networks. Available at: [http://www.cprn.org/documents/30762\\_en.pdf](http://www.cprn.org/documents/30762_en.pdf) (accessed September 20, 2010).
- McPherson, K. (1996). *Bedside matters: The transformation of Canadian nursing, 1900–1990* (pp. 1-25). Toronto: Oxford University Press. Reprinted (2003).
- McGibbon, E., Peter, E., & Gallop R. (2010). An Institutional Ethnography of Nurse's Stress. *Qualitative Health Research*, 20(10), 1353-1378.
- Mental Health Commission Canada. (2009). *Toward recovery and well being-: A framework for a mental health strategy for Canada*. Available at: [http://www.mentalhealthcommission.ca/SiteCollectionDocuments/boarddocs/15507\\_MH CC\\_EN\\_final.pdf](http://www.mentalhealthcommission.ca/SiteCollectionDocuments/boarddocs/15507_MH_CC_EN_final.pdf) (accessed September 18, 2010)
- Mills, C. Wright. (1959). *The Sociological Imagination*. New York: Oxford University Press.
- Registered Nurses Association of Ontario (2002). *Client-centered care*. Toronto, ON: Author. RNAO.pdf
- Registered Nurses Association of Ontario (2006). *Supplement to Client Centred Care*. Available at: [http://www.rnao.org/Storage/15/933\\_BPG\\_CCCare\\_Supplement](http://www.rnao.org/Storage/15/933_BPG_CCCare_Supplement) (accessed September 18, 2010).
- Rioux, M. (2006). The right to health. Human rights approaches to health. In Raphael, D., Bryant, & Rioux, M. (Ed.). *Staying alive: Clinical perspectives on health, illness, and health care*. (p.87- 89). Canadian Scholars' Press Inc. Toronto.



- Smith, D. (1987). *The everyday world as problematic: A feminist sociology*. Toronto, ON, Canada: University of Toronto Press.
- Statistics Canada. (2003). *Canadian Community Health Survey: Mental Health and Well Being*. Available at: <http://www.statcan.gc.ca/daily-quotidien/030903/dq030903a-eng.htm> (accessed September 16, 2010).
- Statistics Canada, Special Surveys Division. (2006). *Findings from the 2005 National Survey of the Work and Health of Nurses*. Available at: <http://www.statcan.gc.ca/pub/83-003-x/83-003-x2006001-eng.pdf> (accessed September 20, 2010).
- Tiplisky, V. (2004). Parting at the crossroads: The emergence of education for psychiatric nursing in three Canadian provinces, 1909–1955. *Canadian Bulletin for Medical History*, 21: 2, 253–79.
- The Standing Senate Committee on Social Affairs, Science and Technology. *Out of the shadows at last: transforming mental health, mental illness and addiction services in Canada*. The Committee: 2006. Available: [www.parl.gc.ca/39/1/parlbus/commbus/senate/com-e/soci-e/rep-e/rep02may06-e.htm](http://www.parl.gc.ca/39/1/parlbus/commbus/senate/com-e/soci-e/rep-e/rep02may06-e.htm) (accessed September 20, 2010).
- Wall, S. (2010). Critical perspectives in the study of nursing work. *Journal of Health Organization and Management*. 24(2), 145-166.
- Whittlemore, R., & Knafl, K. (2005). The integrative review: updated methodology. *Journal of Advanced Nursing*. 52(5), 546-533.



Appendix A: *Studies using a sociological perspective relevant to PMHN*

Author & Date	Purpose	Design/Methodology/Approach	Province	Sample size	Findings
Wall (2010)	To critique nursing research on nursing practice environments using critical sociological perspective. To propose a paradigm for future research.	Review of research on nursing practice environments. Sociological concepts are linked to variables in nursing literature.	Refers to nursing in general within the Canadian context.	NA	Nurses' job satisfaction can be linked to gender knowledge, professionalization and organization not just management concerns.
McGibbon, Peter, Gallop (2010)	To reformulate the nature of nursing stress with regards to context.	Interviews, participant observation and focus groups with pediatric ICU nurses. Theoretical perspective uses Smith's critical sociological frame of institutional ethnography..	Study occurs within the province of Ontario.	23 nurses	Six main forms of stress – emotional distress, constancy of presence, burden of responsibility, negotiating hierarchical power, engaging in bodily caring, being mothers, daughters, aunts and sisters.
Davis (2006), Chapter 4. Professional Imperialism, p.77-79	To see group behaviour of practitioners as reflecting self interest	Review of research - sociological perspective, economic analysis	Not specific to one province but to Canadian mental health care. Also describes features of health care in the United States of America in association with Canadian health care.	NA	Self interest of professions, professions act in a competitive manner, medical authority has had high success.

Appendix B: *History. Gender and Educational implications for Canadian Psychiatric Mental Health Nursing*

Author & Date	Purpose	Design/Methodology/Approach	Province	Sample size	Findings
Tipliski (2004)	How Canadian psychiatric nursing developed into two entirely different models?	Historical analysis - Case studies in the provinces of Ontario, Manitoba and Saskatchewan	Ontario, Manitoba, Saskatchewan	Not applicable (NA)	PMHN development can be understood through psychiatry's authority in the context of the gender limitations traditionally imposed upon women and nurse leaders. Ontario nurses leaders took control of psychiatric nursing whereas Manitoba and Saskatchewan did not.
Dooley (2004)	Historical account of Manitoba's distinct mental health nursing.	Labour history - Historical analysis - oral testimony of Manitoba of nursing graduates from the 1930	Manitoba	NA	Manitoba - distinct class of PMHN giving rise to the regional differences where psychiatric nursing education is not integrated into general nursing education
Hicks (2008)	Examination of factors that lead Manitoba to adopt the western style of PMHN and RPN class.	Genealogical analysis from archives, interviews and secondary sources	Manitoba	NA	RPN in Manitoba is a political, contingent development that will evolve.
Boschma, Yonge & Mychajlunow, (2005).	How gender shaped training, work opportunities and professional identity of PMHN?	Social history method of analysis - interviews with questionnaires of PMH nurses who practiced between 1939 – 1990.	Alberta	34 women, 9 men	Alberta PMHN professional identity shaped by gendered care ethic.
McPherson, K. (1996).	To re-examine nursing's past.	Analytical general nursing framework, -oral histories and interviews, archival records	Refers to nursing in general within Canada.	NA	Nurses sought recognition as skilled workers; class and gender are significant to the structure of nursing.

Appendix C: *Canadian Mental Health Psychiatric Quality of Nurses Work Life*

Author & Date	Purpose	Design/Methodology/Approach	Province	Sample size	Findings
Robinson, Clements, Land (2003)	To examine prevalence, distribution, correlates, and predictors of vicarious trauma and burnout among Registered Psychiatric Nurses (RPN) in Manitoba.	Survey contained Maslach Burnout inventory, Traumatic Stress Institute Belief Scale (TSIBS) and section on PTSD	Manitoba	295 surveys returned, response rate of 29%	RPNs experiencing high levels of emotional exhaustion, higher levels of personal accomplishment. No significant difference on TSIBS.
Nicholls (2004)	To address impact of health reform on RPN practice.	Focus groups	Manitoba	33	Increase in independence. Insufficient preparation for new roles, current and future shortage of RPNs.
Statistics Canada (2006) Findings from the 2005 National Survey of the Work and Health of Nurses	To assess work and health of Canadian nurses.	Survey	All provinces	19000 nurses including RNs, licensed practical nurses (LPN) and RPNs	Mental and physical health problems of nurses linked to work stress, low autonomy, shift work, poor physician-nurse relationships, low support and lack of respect.
Health Canada (2002): <i>Our Health, Our Future: Creating</i>	To improve quality of nursing work life	6 research & information projects	All provinces		-Paucity of data on licensed practical nurses and RPNs - 51 recommendations (3 categories): 1)

<i>Quality Workplaces for Canadian Nurse, Final Report of the Canadian Nursing Advisory Committee</i>					implement conditions to resolve work load, overtime, absenteeism, decrease non-nursing tasks; 2) create professional practice environment in leadership , education and prevention of violence and abuse; and 3) monitor workplaces and health of nurses, accreditation, research and disseminate information to keep nurses informed.
Maslove & Fooks (2004)	To learn what actions to implement recommendation by the Canadian Nursing Advisory Committee (CNAC) made in the 2002 <i>Our Health, Our Future: Creating Quality Workplaces for Canadian Nurse report</i>	Scan of web sites, letter to stakeholders to learn what had been done, interviews with key informants, presentation with 14 representatives from nursing stakeholders in Ottawa	All provinces	94 stakeholders, 14 key informants	- increase number of education seats for RNs, LPNs and RPNs, workload measurements systems, increased number of full time positions, nurse mentors and flexible scheduling – progress not uniform but concentrate in acute care rather than community, responsibility to carry out recommendations is unclear, need for CNACs, leadership position, funding, survey, accreditation, research to identify problems
Health Canada. (2007). <i>The working conditions of nurses: Confronting the Challenges.</i>	To examine research on the state of Canada's nurses and implication for larger health care system	Bulletin	All provinces	NA	Workplace and workforce issues require collaboration and government involvement.