

A MENTAL HEALTH STRATEGY FOR MANITOBA

Comments from the College of Registered Psychiatric Nurses of Manitoba April 2009

Background

The College of Registered Psychiatric Nurses of Manitoba (CRPNM) represents the largest single group of mental health professionals in Manitoba: Registered Psychiatric Nurses. There are approximately 970 Registered Psychiatric Nurses (RPNs) practising in Manitoba. Some of these registrants also practise in other parts of Canada, especially in Nunavut. The practice settings for RPNs are very diverse and have changed significantly over the last 30 years.

The history of Registered Psychiatric Nurses began in the psychiatric hospital system and continued as part of the first wave of community mental health services when community psychiatric nurses began providing follow-up services to persons who had been discharged from the psychiatric hospital in the late 1960's. When the community psychiatric nursing positions were changed to that of community mental health worker in the mid-1970's, it was still RPNs who staffed the majority of those positions. Today, RPNs in areas outside Winnipeg have walk-in clinics for persons with mental health issues and get referrals from family physicians, school teachers and the police.

The first psychiatric nursing education programs in Canada were established in Manitoba in 1921. Other such programs followed but were extinguished in Eastern Canada while they flourished in the four Western Provinces.

The education of Registered Psychiatric Nurses evolved from an apprenticeship model to an educational model forty years ago; and from a diploma program that prepared persons for specific agencies to a university program that prepares persons for the delivery of mental health and psychiatric nursing services in diverse settings. The undergraduate Bachelor of Science in Psychiatric Nursing was first established in 1995 at Brandon University and since 2000, is offered completely on site in both Brandon and Winnipeg.

The context of practice

We can not talk about the profession of psychiatric nursing or the practice of Registered Psychiatric Nurses without talking about the mental health needs of the people of Manitoba and the systems within which those needs are met.

One of the problems that all jurisdictions have in addressing mental health issues is that these issues are not limited to any "mental health system" or even "health system". Problems with mental health affect people where they live, work and play.

The concept of mental health can not be restricted to the defined borders that we have traditionally used. For this reason, the practice of Registered Psychiatric Nurses must be fluid enough to meet the needs of the client at any point in time; whether it is doing a physical assessment to ensure that the symptoms being exhibited are not due to a physical health problem; doing an assessment of the effects of any medication; teaching the client to manage his/her symptoms and/or treatment regime; doing a risk assessment for danger to self or others; or assisting a client to prepare a job resume or to find a safe place to live.

As practice has changed, so has the system within which services are provided and vice-versa. Registered Psychiatric Nurses often see people with mental health problems at the peak of their ill health. They also often see the results of the lack of prevention or the lack of early intervention programs.

What we know

The Manitoba Centre for Health Policy published a document in the fall of 2004 titled *Patterns of Regional Mental Illness Disorder Diagnosis and Service Use in Manitoba – A Population Based Study* (Martens, Fransoo, McKeen). The study provided the following data:

- Between 1997 and 2002, more than 1 in 4 Manitobans had at least one mental illness diagnosis. During that time, nearly half of all inpatient days in Winnipeg hospitals were used by people with a mental illness diagnosis and/or addiction.
- Of all Manitobans aged 10 and older, 24% were diagnosed with one or more mental illness and 13% had other emotional disorders.
- People with mental illness and/or addiction are roughly twice as likely to be hospitalized for physical complaints.
- People with mental illness visit physicians, are hospitalized and use home care more than twice as often as people with no mental illness but only about 20% of their physician visits and 10% of their hospitalizations are for mental illness. The large majority of their admissions are for physical health issues.
- While only 19% of males have a mental illness diagnosis, they account for 37% of all hospitalizations for males. They use 41% of all short-stay days and 52% of all long-stay days. Women with a mental illness also use about 52% of long-stay days in hospitals.
- In both Winnipeg and Brandon there is a strong tie between mental illness and income levels with poorer areas having the highest treatment prevalence.
- People with diagnosed mental illness(es) from the highest income areas, both urban and rural, have the highest psychiatrist visit rate.
- People with diagnosed mental illness(es) from the lowest income areas, both urban and rural, have the highest all-cause (for mental and physical illness) hospitalization rate.
- About 83% of nursing home residents have at least one mental illness diagnosis and about 75% of those admitted in 2002/03 were diagnosed with a mental illness in the previous five years.
- The most frequent users of psychiatrists are people aged 35-55. Rates for young adults are low, and extremely low for people 60 or older.
- Male Manitobans commit suicide at three times the rate that females do. But female Manitobans attempt suicide twice as often as males. The highest rates for attempted suicide are in the north. Across all RHAs, the rate of attempted suicide is highest among the young, those 15-25 years old.

National studies demonstrate the following:

- 1 in 5 persons in Canada will experience a mental health problem this year
- About 1/3 of these persons will actually be able to get some help
- Of those people who do get help, up to 50% do not get what they need
- Jacobs, Bland and colleagues (2008) report that Canada has the lowest rate of mental health spending in the OECD
- Billions of dollars are lost in productivity each year due to mental health problems
- Access to services and supports is a problem for persons with a mental illness and especially so if they are from First nations, Inuit and Metis communities; if they are from a racialised community; if they are children and youth; and if they are seniors

- People living with mental illness report experiencing stigma and discrimination in health care and the broader community
- Too many people with mental health problems end up in the criminal justice system, with sometimes tragic consequences
- There is a 40% prevalence of mental health problems in primary care settings
- 40% of people with mental illness only receive care from a GP
- 72% of people with a psychiatric disorder receive no treatment in the course of a year (81% of these individuals will visit a family physician)

The Schizophrenia Society of Canada recently published a national report on schizophrenia in Canada. The supplement to that report states that even though Manitoba has comparatively good resources in relation to Canada as a whole, there can still be a four month wait time, in Manitoba, to obtain treatment from a mental health specialist after referral from a general practitioner. Although data is not easily available, this probably results in more use of crisis services and especially emergency department services.

We have quite a bit of information. Yet our current “system” appears to mostly ensure the existence of the status quo.

Keeping the system means developing a new paradigm

The CRPNM is fully supportive of the Canada Health Act and the principles included therein. We are also aware of the economic challenges that are posed by the way these principles are currently put into practice. The system has been structured along the lines of where funds can be obtained as opposed to how the needs of a population can best be met.

Mental health problems have a significant impact on the quality of life of people. These problems also have significant economic impact on overall health services.

It is our position that prevention and promotion will ease the burden on health care by reducing the demand for hospital beds and some physician services. This is especially true if mental health services were to be targeted toward the most marginalized and least likely to get care: the poor. Mental health care might also keep some people out of prison, thereby reducing some of those costs as well.

We know that a transition from one type of system to another can be made. This was proven by the processes used in Brandon when the Brandon Mental Health Centre was closed. Much of the resources stayed in Brandon and an exemplary continuum of mental health services was established and maintained in that area.

What can be done – the continuum

There are already examples of effective programs; programs that provide support, teaching and respite for people (mostly women) who may be new to Canada and its culture and norms. There is a school division in Brandon where there is a Registered Psychiatric Nurse on staff to assist students manage their medication and to assist teachers and parents around issues of mental health, emotional distress and mental illness.

What could be done

- primary health care clinics for persons with mental health issues and their families that include psychiatric nurse practitioners, nurse practitioners, consultant physicians, dietitians/nutritionists, and physiotherapists.
- increase the number of Programs of Assertive Community Treatment teams to meet the higher needs of all persons who have a long-term, persistent mental illness where all the determinants of health are addressed – such as housing, employment/education, leisure activities, transportation, income, and nutrition.
- mental health literacy programs in all elementary and high schools as well as for all health care workers.

- peer support workers in all formal systems and as adjuncts to all programs – with appropriate remuneration for their services.
- parenting classes and supports

Some basic principles

We have had the opportunity to review the document “A Framework for a Mental Health Strategy for Canada” that has been developed by the Mental Health Commission of Canada. The Framework identifies seven principles that are appropriate for any mental health strategy in any jurisdiction, be it national, provincial, regional or local.

We have used those principles here as a potential framework for a provincial strategy. The MHCC document is specific to mental health systems. We have broadened the concepts somewhat to better reflect a population health approach.

1. The hope of recovery is available to all.

If we apply this in a broad context, we see that adults and children suffering from domestic violence have the opportunity of healing from that experience; that children who develop a mental illness are identified quickly and treated as soon as possible; that persons with an emotional problem can access assistance to go through the experience; that persons with a severe mental illness are taught that there is hope for recovery from their illness; that communities who are suffering from addiction issues, youth suicides, and other despairing behaviours can develop the capacity to heal together.

The concept of recovery requires that systems do not exist to self-perpetuate but rather, to meet the needs of individuals, groups, families and communities. The concept includes the element of choice, partnership and engagement in processes.

2. Action is taken to promote mental health and well-being and to prevent mental health problems and illnesses.

This is where an investment is needed, not just in the systems and programs that fall under the Ministry of “Health” or under “health” portfolios. The determinants of health (and of mental health) are not found in silos. All people need safety, shelter, food, and meaning in their lives. This applies to individuals, families, groups and our communities. Mental health in the workplace is recently receiving some attention; actuaries have known for some time that mental health issues were costing more in productivity than were physical health issues alone. This is a social policy issue and must be applied across the board in all our human services, including child care and education programs. The critical part of mental health promotion is the development of capacity in individuals, families, groups and communities.

We spend millions and even billions of dollars on dealing with the outcomes of poor physical and mental health yet relatively little in prevention. We know that persons with a mental illness diagnosis and/or addiction use general hospital facilities almost twice as much as those without such diagnoses yet we are not making special efforts to assist persons with such issues to manage their physical as well as mental health issues.

3. The mental health system is culturally safe, and responds to the diverse needs of people in Manitoba.

Stigma and discrimination can be felt by people based on their age, language, gender, race, migration, sexual orientation and geographic location. The services that we provide are often structured to best meet the needs of a system rather than the needs of the individuals, families, groups and communities we purport to serve. Stigma and discrimination in the workplace or in schools can lead to depression; to anger and violence and to suicide.

First Nations and Metis peoples of Manitoba are coming into their own and they are celebrating their achievements. Yet there is still much stigma and discrimination against them. We can learn from them so that the majority does not stigmatize the many new immigrants who are arriving in our Province. Just as we have a tendency to want people to meet the needs of a system, we tend to want people from other cultures to meet our own values and processes.

4. The importance of families in promoting recovery and well-being is recognized and their needs are supported.

Natural support systems, irrespective of the structure of those systems, is important to everyone. In our current society, families have broad definitions and can include a very extended network that the service provider needs to understand is fluid and ever changing. This should be seen as positive. In some cultures, the community provides the supports needed by individuals and families. That should be respected and honoured.

Professionals need to be receptive to the concept that communication with families about illnesses, symptoms and processes do not necessarily compromise professional or legislative standards of confidentiality. The goal is to see the individual as part of his or her own natural support system; one that will be critical to a successful life. Policies and procedures should ensure that this is possible and even that there is facilitation of this concept.

5. People of all ages have equitable access to a system of appropriate and effective programs, services and supports that is seamlessly integrated around their needs.

Any “system” that wants to meet the mental health needs of a population should be conceptualized as a multi-dimensional matrix; one that looks at the continuum of needs and services; that also looks at the differing needs of various age groups; at the special needs of marginalized persons; at the target groups for special efforts or prevention activities.

We have tended to ignore the mental health needs of older persons, especially those persons who are in personal care homes; this in spite of the fact that the Manitoba Centre for Health Policy found that between 75% and 83% of the persons in those facilities have at least one mental illness diagnosis.

We like to think that people have choices about who provides services and where they are provided. That requires an open “system” that provides a continuum of services (prevention activities; self-help groups and peer support; crisis services in the community; and various other options prior to, and including, hospitalization). It also requires a continuum of support systems and service providers.

The CRPNM has for many years advocated the position that persons with mental health problems have the same right to quality of services as do persons with physical health problems. Yet, little attention appears to be paid to planning for mental health human resources. As a matter of fact, mental health services often do not have specific staffing standards. Human resource personnel often do not know the different knowledge and skills required to provide safe and ethical services to persons with mental health needs.

6. Actions are based on appropriate evidence, outcomes are measured and research is advanced.

There has been a dearth of research in mental health and about mental illness. One of the reasons is that most of the funding appears to be biased towards quantitative research and most of the research that is pertinent to persons with mental health issues is qualitative research.

There has been some quality of life research done but it is scant and usually as part of obtaining academic qualifications. Very often such rich research is not reviewed in the context of services at the provincial or regional levels.

The issue of how to best meet the crisis as well as ongoing needs of persons with mental health problems and/or persons with severe and persistent mental illness offers many opportunities for research that would result in better, and probably more efficient, services that meet people’s needs as opposed to meeting the ‘system’s’ needs.

7. Discrimination against people living with mental health problems and illnesses is eliminated, and stigma is not tolerated.

Many of the issues we have identified above (the lack of qualified mental health professionals; the lack of research, etc...) demonstrates the stigma against mental illness and the discrimination against people who have a mental health problem. The attitude is the stigma. The behaviour is the discrimination. Many people with a mental illness live in poverty. Safe, affordable housing is critical to successful recovery; to living without daily fear; to having dignity and feeling pride in one’s self. That is difficult to accomplish on \$295.00 per month for rent. It is true that people have to make choices between shelter and food. This is not a choice that promotes good mental health, especially for persons who are already feeling the effects of a mental illness.

Summary

The College of Registered Psychiatric Nurses of Manitoba (CRPNM) has long advocated for quality mental health services, believing that persons needing such services have the right to quality as well as quantity of appropriate services.

The development of a five-year strategic plan for mental health in Manitoba offers an opportunity to look at processes that address the long-term needs of people of Manitoba.

Changes are needed to this system that we have. The continuum of services that is offered to its constituents who have mental health problems by the City of Brandon has been cited nationally and even internationally. Even though it is not perfect, it has established services to meet the needs of those members of their community. Yet not one of the other health regions of this province has been able to establish that continuum of services. We know that the main reason that the Brandon Regional Health Authority has been able to establish those services is because of the resources that remained in Brandon upon the closure of the Brandon Mental Health Centre.

Research must be done to see what impact the system in Brandon has on individuals, groups, families and communities. If it can be demonstrated that this is an effective and efficient way of delivering services and of helping people stay out of expensive hospital beds, why not replicate the processes and procedures in other regions?

The CRPNM wishes to emphasize its belief that any strategies developed for mental health services in Manitoba must address the social determinants of health; must include strong mental health promotion components; must include primary, secondary and tertiary prevention programs; must address stigma and discrimination against people with a mental illness and must ensure adherence to the principles of the Canada Health Act for all persons in Manitoba, including those persons with a mental health problem. It is the CRPNM's position that persons with mental health problems have the right to services provided by qualified human resources, just as much as do persons with physical health problems. The strategies must therefore include provision for a multidisciplinary team of qualified service providers.

APPENDIX A

HISTORICAL PERSPECTIVE ON PRACTICE SETTINGS FOR REGISTERED PSYCHIATRIC NURSES IN MANITOBA

Practice Setting	1980	1990	2000	2005	2007
Community-based services	6%	11%	24%	24%	26%
Developmental/Residential	18%	15%	17%	11%	10%
General Hospitals	15%	17%	22%	23%	23%
Mental Health Centres	45%	35%	15%	15%	14%
Personal Care Homes	7%	12%	17%	16%	15%
Other/Unknown	6%	11%	5%	3%	2%
Association/Government				2%	2%
Private Agency				2%	2%
Educational Institution				2%	2%
Corrections				1%	2%
Self-employed				1%	1%

A small number of RPNs live and work in Nunavut and maintain registration in Manitoba. Recently, Nunavut has been recruiting for mental health professionals and would prefer to hire RPNs. Manitoba has a higher number of RPNs providing mental health services in Nunavut than any of the other Western provinces primarily because there are two agencies based in Manitoba that have contracts with the Government of Nunavut.

APPENDIX B

Examples of the ROLES of Registered Psychiatric Nurses In Manitoba

We are all concerned with the large systemic issues, with ensuring that policies reflect the best possible programs and approaches. It is the people in the “front lines” who implement those policies and who ensure that the programs are implemented and that there are positive outcomes for the clients. Here are some examples of how Registered Psychiatric Nurses attend or contribute, on a daily basis, to the mental health of people in Manitoba.

School Counsellor- Glenda RPN, MEd - Glenda works for the Brandon School Division, and, working out of Crocus Plains High School, is involved in the counseling of teens who are in grades 9-12. This counseling covers the wide range of topics affecting today’s adolescents. In addition to counseling, she advocates for students, helps connect them to the appropriate community agencies and acts as a liaison between the school and the numerous agencies that they work with in assisting the adolescents. Glenda provides assessment for any referral of an adolescent who may be at risk or in need of further mental health counseling/assessment. She also works with families.

Medication Follow-up Program – Elaine, RPN -. Elaine provides assessment, education, and follow-up for those students with the Brandon School Division requiring the use of stimulant medications. Elaine offers support to the students, families, and teachers as needed. She also assists the school to initiate the assessment process of those students exhibiting symptoms related to ADHD.

Mental Health Clinician - Centralized Intake C&A Mental Health Program- Gord, RPN - Gord is responsible for telephone and/or in-person triaging, assessing and consultation for youth and families experiencing mental health/behavioral difficulties. This includes liaising with the WRHA's C&A Mental Health Program Services and the community regarding disposition of referrals. Gord is also the In-Patient Program Liaison between the Health Sciences Centre and the Manitoba Adolescent Treatment Centre, which includes monitoring the admission of patients to the HSC's C&A in-patient beds in order to determine whether any patients require consideration for transfer to MATC for longer term in-patient assessment/treatment and to coordinate same when required. As well, Gord assists the HSC in-patient units with discharge planning and facilitates referrals to program and non-program services.

Residential Coordinator - Melanie, RPN - Melanie works at the Manitoba Developmental Centre where she has practiced in both the Habilitation Program (persons who exhibit behaviours which present a risk to themselves or to others) and the Extended Care Program (persons who are more medically fragile and have complex care needs). Melanie has developed programs for persons with a developmental disability and dual diagnosis of Axis I or II pathology and been responsible for monitoring the implementation of these programs. She has been responsible for the interdisciplinary team delivery of integrated services to meet the needs of residents of a specific residential area; providing leadership and direction to a staff complement of up to 40 persons who together work for the quality of the lives of up to 40 residents. Her leadership responsibilities also include operational and budgetary planning; human and materials resource management; policy/procedural development and review; and, decision-making relevant to the area of responsibility.

Psychiatric Consult Liaison Nurse –Kris RPN, BScMH – Debbie held this position at the Health Sciences Centre. In this position consults are received from the general medical-surgical units (including ICU and dialysis) for medically ill patients and/or their family who are experiencing mental health issues. Consults are written by any member of the patient’s treatment team (i.e. physician, nurse, etc). The patient may already have a mental health diagnosis or may be reacting emotionally to the current hospitalization. The Psychiatric Consult Liaison Nurse will assess and provide intervention and/or recommendations to the treatment team. (Debbie is currently the Mental Health Program Manager at Seven Oaks General Hospital.)

Intensive Case Manager – Grant, RPN, BA – As an Intensive Case Manager Grant utilizes a client centered rehabilitation oriented case management approach in identifying the goals and needs of the clients. This predicates the response and service provided. A client- centered, recovery-based philosophy is endorsed and a strong, positive, therapeutic/interpersonal relationship between client and case manager assists the client to become satisfied and successful in living, learning, working, or in a social environment of choice, with the least amount of professional help. A focus on personal strengths is used in the teaching of necessary skills and/or accessing resources to overcome deficits which create barriers to achievement of client goals.

Community Mental Health Nurse - Tracy RPN, BScPN, BSc.- Tracy works for Community Mental Health Services in Brandon, out of the Mental Health Promotion Clinic. This role includes daily psychosocial and psychiatric rehabilitation support for a number of individuals living in the community of Brandon. She assists with medication management for both oral and injectable (long acting medications), clozapine protocols - monitoring of vital signs, minor medical assessments (ex. blood sugar monitoring, wound & skin care), self management instruction, life skills support and education, as well as individual case management. In addition, Tracy is heavily involved in community education and support around Mental Health Literacy for the Brandon region. She works with a variety of local committees and agencies to support the increased knowledge, understanding and acceptance of Mental Health and Mental Illness.

Mental Health Clinician - Community Child and Adolescent Treatment Services (MATC) – Sharon, RPN -This program offers community-based mental health services to children, adolescents and their families. Sharon is responsible for the delivery of direct client service including the following: screening/assessment, implementation and evaluation of clinical services to clients/families; acute treatment and consultation; clinical case management; critical incident intervention; systems consultation and community education.

Mental Health Clinician - Early Psychosis Prevention and Intervention Service (MATC) – Tamara, RPN – Tamara is responsible for the delivery of direct client care (the planning, implementation, and evaluation of clinical services) to the client and families including: individual support and psycho-educational groups; assertive case management, including the screening, assessment, treatment and working through client recovery from a first episode of psychosis; liaison and the establishment of professional working relationships with the client/family, multidisciplinary team and community; and, community resource identification and utilization.

Coordinator of Patient Services- Lynn, RPN – Lynn coordinates interdisciplinary patient treatment teams at the Selkirk Mental Health Centre to provide assessment, treatment, planning and implementation of patient outcomes and effectiveness of treatment through patient progress notes, Kardex, patient/family conferences and informal patient centered discussions using a patient-directed approach that is characterized by hope for recovery.

Manager of Patient Care (MPC) – Dawn, RPN, BScMH - Dawn is the MPC for the Forensic Inpatient Unit and the Psychiatric Intensive Care Unit at the Health Sciences Centre. The Forensic Inpatient Unit is part of the provincial program providing assessment and treatment for persons with mental illnesses who are involved in the justice system in any way. The Psychiatric Intensive Care Unit provides secure acute mental health care to persons who are in the WRHA system. The MPC position includes responsibility for the day to day operations of each inpatient unit, and includes all issues related to patients, staffing, safety, operational and budgetary needs/demands, materials resource management, program development and all other responsibilities related to the Adult Mental Health program. Dawn is the leader of two multidisciplinary teams made up of RPNs, RNs, Unit Assistants, Nursing Assistants, Unit Clerks, Social Workers, Occupational Therapists and Mental Health Rehabilitation Worker. Dawn also is responsible for the Mental Health Unit Assistant/Nursing Assistant (UA/NA) Casual Support Staff and the UA/NA Relief Team.

APPENDIX C

Some Examples of Settings and Types of Practice of Registered Psychiatric Nurses (RPNs) in Manitoba (as of December 31, 2006 – n=976)

Setting %age of Registrants

COMMUNITY –BASED PRACTICE

RPNs who have roles in the community that focus on the stabilization, restoration and optimization of mental health of individuals, families, groups and communities.

Captured under the broad heading of community mental health services are: Addiction services, community geriatric assessment and treatment, community mental health services, mental health promotion, community development, mental health services for children and adolescents in schools and in child and adolescent treatment centres and crisis services including crisis stabilization and mobile crisis.

For reporting purposes and due to small numbers, family services and home care are collapsed into community mental health/community based practice.

RPNs who have roles in business and industry where the focus is on the health/mental health of workers.

RPNs who have roles in national, provincial or territorial organizations or governments that deal with policy development or the protection of the public 27%

GENERAL HOSPITAL

RPNs in in-patient and out-patient roles that focus on the stabilization and restoration of mental health of individuals during or following acute illness and with individuals who have mental health issues who have had interaction with the justice system.

RPNs in general hospitals assume roles in the emergency room, as psychiatric consultation/liaison, as out-patient therapists, as group counselors, in in-patient services and as mental health managers and mental health educators. 23%

MENTAL HEALTH CENTRE

RPN's provide recovery and rehabilitative services to persons with severe and persistent mental illness. They also work with persons with acquired brain injuries; with elderly persons with serious and long-term cognitive dysfunction and mental illness and with persons who have been deemed to be not criminally responsible for a criminal act.

15%

PERSONAL CARE HOME

RPN's provide services to individuals who require personal care on a continuous basis. RPN's assume additional roles, as psychiatric consultant/liaison or mental health liaison nurses, to assist personal care home staff to meet the mental health, cognitive and behavioral needs of residents. RPN's also assume roles as resident care managers/administrators and CEOs. 16%

RESIDENTIAL CARE

RPN's provide services where the primary focus is on the care, treatment and community preparation of individuals with a developmental disability. RPN's assume additional roles as residential care managers. 11%

CORRECTIONS

RPN's provide recovery and rehabilitative services to individuals with mental health and/or addiction issues who are being detained or are on probation due to a criminal act. 1.4%

SELF EMPLOYED & PRIVATE AGENCIES

RPN's assume roles as counselors/therapists in independent practice settings. RPN's provide mental health services to individuals, families, groups and communities in the North. .03%

EDUCATIONAL INSTITUTION

RPN's have roles as faculty and researchers. 2%

APPENDIX D

Education of Registered Psychiatric Nurses in Manitoba

The Bachelor of Science in Psychiatric Nursing program is a four year undergraduate program offered by Brandon University in both Brandon and Winnipeg. The program consists of a combination of didactic, lab and clinical courses that lead to an understanding of mental illnesses and of mental health. Some of the courses taken in the program are:

Required Health Studies Courses :

- Health Promotion: Developmental Transitions Throughout the Lifespan
- Fundamentals of Psychiatric Nursing Practice
- Introduction to Interpersonal Communication
- Principles of Health Assessment
- Psychopharmacology
- Principles of Individual Counselling
- Medical Nursing for Psychiatric Nurses
- Psychiatric Nursing with Elderly Persons
- Palliative and End of Life Care
- Acute Mental Health Challenges I & II
- Psychiatric Nursing with Children and Adolescents
- Community Health
- Psychopathology
- Therapeutic Groups
- Family Counselling
- Developmental Challenges
- Introduction to Health Research Methods
- Interpersonal Abuse
- Addictions
- Psychiatric Rehabilitation and Recovery
- Leadership in Professional Practice
- Contemporary Perspectives on Professional Health Issues

Required Arts/Science Courses:

- Introduction to Psychology
- Introduction to Sociology
- General Psychology
- Sociology of Medical Systems
- Human Anatomy & Physiology
- Statistics

And one elective (3 Credit Hours):

For more details, go to the School of Health Studies site of Brandon University (www.brandonu.ca) and look for the information for the Bachelor of Science in Psychiatric Nursing (BScPN) program.