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One Country, Two Education Models: Exploring the Pedagogical Approaches to Training Undergraduate Nurses for Mental Health Care in Canada

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Abstract

The training and registration of psychiatric/mental health nurses has a contested past in Canada. One of the consequences of the professional jostling between psychiatry and nursing for control over this area is the unusual circumstances of Canada having two education systems for this specialty. To understand why the schism has taken place and the impact it has had on psychiatric/mental health nursing, the authors have undertaken a critical review of the ontological and epistemological assumptions of these two pedagogical approaches. This review reveals that while the approaches share much in common, groups from both the East and the West receive different levels of mental health-related curriculum within their training. While it could be argued that psychiatric/mental health nursing practice is different enough to warrant its own framework for the preparation of specialist practitioners, there is no clear answer as to whether one of the current models should be implemented over the other. In this context, this paper argues that it is important that psychiatric nurses advocate for a future for the speciality in Canada.

Keywords: Psychiatric nursing, education, regulation, history, critical

Psychiatric mental health nursing (PMHN) is a specialized field of practice in which nursing care is provided to people experiencing mental health issues to promote recovery. The undergraduate education and subsequent registration of psychiatric mental health nurses (PMHNs) have been contentious issues in a number of countries (Molloy et al., 2016). This has seen tension arise over the use of specialist models of undergraduate nursing education versus *comprehensive* generalist approaches to undergraduate education (Happel & Gaskin, 2013). In Canada, education for nurses who would work in mental health settings had a contested past, with both psychiatry and nursing having jostled for control over training and registration (Tipliski, 2004). This history has resulted in a *one country, two education systems* model, with eastern provinces using a comprehensive general registered nursing model and western provinces utilizing a specialist/psychiatric approach.

The purpose of this paper is to provide an overview of issues related to the training and

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regulation of PMHNs in Canada in this context and the onto-epistemological assumptions that appear to underpin these matters. To understand why this schism has taken place in nurse education in Canada, an understanding of the ontological and epistemological assumptions of these two pedagogical approaches is important. In seeking to examine this area of nursing, the authors are guided by the ideas of critical theory (Kincheloe & McLaren, 2011). The application of critical theories to explore issues relevant to nursing arose out of a consensus that traditional research approaches were not capable of addressing issues such as societal or structural power imbalances, or matters of oppression (Browne, 2000). An ontological stance in critical theory is one in which elaborate social structures influence our thinking, and epistemological considerations can occur through examinations of history in constructed social powers (Paradis et al., 2020). A critical exploration of the reasons behind the existence of two different approaches to undergraduate mental health education nursing in Canada allows for unpacking of such issues as power in ways which an empirical, or strictly interpretative way may not.

Brief History of Psychiatric Mental Health Nursing Education in Canada

In Canada, psychiatric nursing is a distinct regulated nursing profession in British Columbia, Alberta, Saskatchewan, and Manitoba (Jackson & Morrissette, 2014), and practitioners use the title of registered psychiatric nurse (RPN). From the province of Ontario, and in all provinces east to Newfoundland and Labrador, nurses who work with patients in mental health care settings are registered nurses (RNs). As RNs gain more experience, they may pursue a Canadian Nurses Association (CNA) certification in psychiatric mental health nursing (CMHN ©) (Canadian Nurses Association, 2020). This *one country, two education systems* model is unique among countries that regulate PMHN positions and is the result of a past that has mostly all but dropped out of the history books (Tipliski, 2004).

Like many other countries which followed institutional models of care in the 19th century, it was primarily attendants who took care of the physical and safety needs of individuals in asylums in Canada (Walk, 1961). With the medicalization of this care under psychiatry, it was determined that nursing services were the most suitable approach for helping people in asylums, thus, psychiatric nursing was established (Walk, 1961). In Canada, the training and subsequent regulation of these nurses became an issue of contention between nursing associations and psychiatrists or medical superintendents. The nursing associations of the east of the country were against what they viewed as the psychiatric indoctrination of nursing services in institutions. Ultimately, the profession of nursing claimed the management of nursing education in the East, and psychiatry, by way of psychiatric nursing, in the West (Tipliski, 2004).

In the 1990s, Canadian provinces ramped up the closure of traditional mental health institutions (Sealy & Whitehead, 2004), meaning that acute psychiatric services were integrated into general hospital settings. This subsumption of mental health services into the regular health care system was referred to as mainstreaming (Hurley & Ramsay, 2008). Grant (2006) described the attitude of Canadian academics such as Carpenter, who argued that with the closure of institutions, specialist psychiatric nursing education would no longer be required; however, PMHN education and regulation continued to operate from the two systems approach after deinstitutionalization.

Generalist Model of Education in Eastern Canada Today

It is pertinent to touch upon the amount of mental health curriculum that students receive in eastern baccalaureate nursing programs to help understand what type of ontological and epistemological positions are adopted in their education. Adam (2017) conducted an ethnographic study of an undergraduate nursing program in Ontario to assess their mental health curriculum, revealing that only two subjects

within the program focused on mental health: health assessment and pathotherapeutics, with other mental health content appearing intermittently throughout other courses. In an unpublished doctoral dissertation, Boyko (2011) described the content of the mental health curriculum as varying significantly in Ontario undergraduate nursing programs, with some programs describing content as being threaded throughout their studies.

In thinking of the reality of nurses with a generalist preparation working in mental health, with issues of global workforce shortages in mental health nursing and a lack of interested students pursuing nursing in mental health, the use of fewer nurses who have a broader level of skills may be viewed as an effective response (Hurley & Ramsay, 2008). Paul and MacDonald (2014) discuss cross-training nurses or having nurses who have competencies in a variety of fields as a method to not only save expenses but also address nursing shortages. One argument in support of generalist prepared nurses, then, is that they possess a broader range of skills for application in mental health settings and that it is more effective to support their use than it is to train, recruit, and retain nurses with specialist psychiatric education.

Specialist Model of Education

There is no doubt that a long and interweaving history in which psychiatric nurses learned directly from psychiatrists has created an impression that psychiatric nurses are the established counterpart of psychiatrists (Hurley & Ramsay, 2008). This resulted in historical psychiatric nursing being rooted in a medical epistemology, in which the patient has a problem with their mind as a result of a physical disease process (Horsfall, 1997). The ontological and epistemological positions of psychiatric nursing practice have shifted from a strict grounding in a materialist model to a blend that incorporates both this history and an interpretive constructivist standing. The turning point for this change in Canada (and throughout the world) appeared to be deinstitutionalization when the practice settings for psychiatric nurses changed from institutions to mainstreaming wards within general hospitals and the use of community teams (Ryan-Nicholls, 2004). Although deinstitutionalization happened over time, the impact on psychiatric nursing identity may be considered a crisis event for those who hold that psychiatric nursing should be a special discipline, separate from general nursing (Lakeman & Hurley, 2021).

It is important to ask, then, what is the current state of epistemological groundings in western Canadian psychiatric nursing? There is a growing body of literature on psychiatric nursing education in those provinces available, especially in Manitoba. A 2020 study conducted in Manitoba asked RPNs about their unique contributions to the health care team. One sub-theme that arose was that of a recovery orientation in psychiatric nursing practice, with the authors describing “psychiatric rehabilitation and recovery” as “traditional psychiatric nursing knowledge” (Graham et al., 2020, p. 1). Whether “traditional” or not, it is clear that recovery-oriented practices are now a major component of curriculum in psychiatric nursing programs across Canada (Kidd et al., 2014).

The *Tidal model*, perhaps one of the best-known recovery-oriented theoretical approaches in PMHN care, was created in England in the late 1990s and has been applied both in practice and in applied research throughout the world (Barker, 2001). Barker described the theory as “a radical, catholic model of psychiatric nursing practice, focused on the care processes that are fundamental (radical) to nursing practice in mental health and appropriate for any care setting and any mental health population (catholic)” (p. 235). The theory uses a narrative approach (Barker, 2003). This narrative approach is evident in the *Tidal model* in the emphasis on metaphor, with examples such as life being akin to a journey on an ocean in a boat, subject to crises such as piracy (trauma), and the need for safe harbor (psychiatric hospitalization) (Barker, 2001). From a philosophical lens, Barker’s theory would be described as belonging to an interpretive, or constructivist perspective.

To further articulate a philosophy of PMHN, in the absence of writings in a Canadian context, it is useful to review literature from other jurisdictions. Cutcliffe and Goward (2000) argued that PMHNs are drawn to qualitative approaches to knowledge production because of an apparent harmony between the ontological and epistemological position of those approaches and the actual practice of psychiatric nursing. This concurrent view was evidenced through such elements of PMHN practice as, "(a) the purposeful use of self; (b) the creation of an interpersonal relationship; and (c) the ability to accept and embrace ambiguity and uncertainty" (Cutcliffe & Goward, 2000, p. 590). Therefore, although psychiatric nursing may have its origins in a materialist, reductionist ontology, literature on psychiatric nursing philosophy appears to indicate that this has shifted with deinstitutionalization to an interpretive, constructivist one.

Two Models, Similar Philosophical Assumptions

Upon initial examination it appears that the current use of a general model of education in eastern Canada and a specialist one in western Canada is not based on documented, evidence-based outcomes for people receiving mental health services. Rather the reality of two education systems echoes the history of a disciplinary competition in which it appears general nursing has not yet realized or accepted the shift in psychiatric nursing paradigms of care. Movements to bring nursing education in mental health under general nursing are still described as innovative in the eastern provinces (Smith & Khanlou, 2013), and although the mental health content revealed in his study was limited, Adam (2017) described it as part of "psychiatry's dominance in mental health nursing" (p. 2). He further described the role of nursing associations in Ontario in propagating a psychiatric discourse through their use of the DSM-5 in generating standards and ethics. This might be reflective of a resurgence in sentiment that mental health nursing in eastern provinces must be devoid of psychiatric influence.

The role of associations and regulators of nursing in the East is not to be overlooked, with the Canadian Nurses Association (CNA) releasing a position statement in 2012 which stated that the "CNA believes that registered nurses demonstrate strong clinical expertise and leadership in providing mental health services to Canadians, including health promotion, illness prevention, early detection, diagnosis, intervention, crisis management, rehabilitation and recovery" (CNA, 2002/2012, p. 1). It should be noted that the CNA is a national representation body for registered nursing, with its origins and headquarters in Ottawa, Ontario. With the position statement in mind, when the role of registered nurses and their future in Canada is articulated, the role of registered nurses in mental health settings is absent. In their 40-page framework for the practice of registered nurses in Canada (CNA, 2015), the term mental health appeared only once, and the term psychiatric nurse is used only in association with referencing professional organizations or staff mixes across Canada. It may be intuited from this document that mental health services are not a priority for registered nurses as a general body. Finally, if a general preparation for nurses to work in mental health settings lacks a significant emphasis on education focused on psychopharmacology, interpersonal relationships, psychiatric disorders, and instead an emphasis on de-medicalizing mental illness (Adam & Juergensen, 2019), with what tools and from what perspective are nurses in the East intended to provide nursing care to people with mental health concerns?

A brief review of ontological and epistemological underpinnings of these two educational preparations reveals that they share much in common; that is, the philosophical and theoretical underpinnings found in general nursing education might be found to fit psychiatric nursing education, but also, that psychiatric nursing practice may be different enough to warrant an articulation of its own framework (Hicks, 2009).

The Role of Other Disciplines

An additional point of discussion for consideration is that if the body of nurses are generically trained, this might enable other disciplines to take an expert role in supervision and advanced clinical approaches in mental health settings. Hurley and Ramsay (2008) explained that, in the UK context, disciplines such as psychology and social work have been advocating for an increased role for their respective disciplines in relation to mental health work through leadership roles and supervision of nurses in mental health settings. In Australia, the number of psychologists has experienced an exponential increase of 120% between 2001 and 2011, whereas nursing services contracted by 7% (Lakeman & Molloy, 2018). In the Canadian context, although the discipline of psychology does not appear to have entered the debate about their role in supervising or working with nurses, in other countries the generic model of education appears to have been associated with it (Molloy et al., 2016).

According to Votta-Bleeker and Cohen (2014), over half of Canada's psychologists are in Quebec, which is noteworthy in the light of the *one country, two education systems* model apparent in PMHN pedagogy and regulation. Summarizing the findings of a conference of the Canadian Psychological Association on the need, demand, and supply of psychologists in Canada, Votta-Bleeker and Cohen (2014) described the Canadian mental health service provision landscape as having become homogenized, with professionals who were less qualified and less compensated than psychologists taking the work that psychologists might otherwise do. Will such findings ultimately result in a desire for the discipline of psychology to assert their own professional control over roles traditionally undertaken by PMHNs?

While the benefit to psychologists as a group was not openly explicated, the Quebec Association of Psychologists (Ordre des Psychologues du Québec) welcomed the move of that province to implement funding that expands the ability of the public to obtain psychological counselling, an initiative that was inspired by a similar movement in the UK (Fidelman, 2017). Robinson et al. (2012) comment on the initiative in the UK, describing how mental health workers were taken from related fields such as nursing, and then transitioned into new role as psychotherapists. These authors, in their qualitative study, pointed out the need for such workers to be supervised. It may be suggested that a generalist model, in which nurses possess less expertise in psychiatric or mental health approaches, creates a space for a discipline such as psychology to provide leadership in this field, and thus enjoy increasing economic and disciplinary prestige.

Conclusion

A comparison of the ontological and epistemological positions of pedagogy for generalist and specialist prepared nurses who will work in mental health is not simple. The reality is that there has been a paradigm shift in psychiatric nursing practice, whereby psychiatric nurses are creating an identity and approach to practice independent of a reductionist psychiatric ontology. It appears that nurses prepared both generally and in a specialist model receive a similar philosophical education, although psychiatric nursing programs appear to incorporate an increased focus on theories of non-medical recovery. It may be reasonable to suggest that such shifts in practice are due to the shift in mental health care, generally, rather than as a result of pedagogical initiatives. This means that the dominant ontology of nursing practice for both RPNs and RNs is an interpretive one, and that dominant epistemologies include phenomenology and other interpretive approaches.

Another conclusion of this paper is that there is an opportunity for RPNs (and all nurses) to elaborate on existing theories and philosophies of psychiatric mental health nursing, and to develop new, appropriate philosophical positions. From this paper, it may be apparent that groups from both the East and the West receive different levels of mental health related

curriculum in their training, which itself is an opportunity for further exploration.

A final question (beyond the scope of this paper) remains on whether the *one country, two education systems* model approach to PMHN pedagogy should continue, or whether one of the current models should be implemented over the other. Arguably, this places the respective groups of nurses in a position in which they must defend or justify their approach to providing mental health services, and the writers believe this issue may ultimately become rooted in issues of power, dominance, and political discourses. In this light, the discipline of psychiatric nursing in the West may be viewed as a minority, with less than 6,000 members compared to the over 275,000 registered nurses in Canada (CIHI, 2021).

The findings of this review have highlighted that it is important that nurses advocate for a future for the PMHN speciality within the broader mental health care landscape, rather than let other disciplines or policy makers set the scene (Hurley & Ramsay, 2008). There is a clear need in Canadian society for access to skilled mental health clinicians and cost effective, evidence-based mental health care (Moroz et al., 2020). This has been further reinforced by the mental health impacts of the COVID-19 pandemic and the mental health care needs of Canadians during this difficult time (Jurcik et al., 2021). While it may be the case that the *one country, two education systems* will continue to reflect regional preferences, Canadians must question which of these approaches best prepares nursing students for the mental health practice our society needs in the 21st Century (Happell & Cutcliffe, 2011).

Ethics, Funding, Conflict of Interest

The author declares no conflict of interest associated with the development of this manuscript. This research paper was non-intrusive, and did not involve direct interaction between the author and any individuals. The research paper used online material such as documents, records, and other material freely available through the internet, for which there was no expectation of privacy. Therefore, ethical approval was not sought from an REB for this research paper. Finally, no funding was received in support of this manuscript.

Limitations

The issues of undergraduate nursing education in mental health were explored in a broad way in this paper. The authors have not carried out a thorough comparative review of mental health curriculum in all nursing programs across Canada. This presents a limitation, as it is difficult to make conclusive, definitive statements about differences in mental health curriculum. The paper utilises a critical review of key publications on this area and does not represent a comprehensive or systematic review of literature.

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