



Canadian Nursing Students' Association
Association des étudiant(e)s infirmier(ère)s du Canada

Position Statement #1

Incorporating 2SLGBTIQQA+¹ Education into Nursing Curriculum in Canada

Approved: January 2013

Approved by: CNSA National Assembly

Submitted By: Nicholas Alves, Centennial College; Emilie Hay, McMaster

University **Edited By:** Courtney Blake, North Island College;

Introduction and Background Information

2SLGBTIQQA+¹ (Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, Questioning, Asexual, Pansexual, and many more)² consists of a wide range of genders, sexes, races, ethnic groups and individuals. There are specific vocabulary, terms, facts and training related to 2SLGBTQ+³ people that are not taught in the nursing curriculum and therefore make it difficult for nursing students to provide compassionate, holistic, patient-centered care to members of this population.

While the 2SLGBTQ+³ population has been identified as an equity seeking⁴ population, minimal measures are being taken to specifically address their vulnerability (Daley & MacDonnell, 2011). The stigmatization, oppression, and discrimination experienced by this population contribute to a higher rate of substance use and abuse and other health issues (McKay, 2011). 2SLGBTQ+³ people may seem to represent a relatively low percentage of the population (5-10%), however, in Ontario alone it is estimated that up to 1.25 million people anticipate or face barriers to access health services (Daley & MacDonnell, 2011). 2SLGBTQ+³ youth are four times more likely to attempt suicide, and three times more likely to have experienced domestic and/or sexual violence⁵ than heterosexual youth (Pies, 2011).

Additionally, it is estimated that approximately 57% of transgender people are rejected by their families, 41% have attempted suicide, and 19% reported experiencing homelessness as a result of their gender identity (Pies, 2011)

Canadian Nursing Students' Association's Current Position on the Issue As the Canadian Nursing Students' Association (CNSA) is the national voice of student nurses in Canada, and one of its underlying principles is to influence and advance innovation in the nursing curriculum, the CNSA believes it is vital for education pertaining to the 2SLGBTQ+³ population be integrated into nursing curriculum across the nation. Nursing students are responsible for providing appropriate nursing care to all clients, so it is imperative that the specific needs of this population be met (CNSA, 2005). As future professionals in the healthcare setting, advocating for the nursing profession and ensuring quality healthcare for all Canadians is a fundamental part of caring for different minority groups seen within this country.



Although there are currently low numbers of homophobia among nursing students, there are a larger number of students who show ambivalent and heterosexist attitudes towards 2SLGBTQ+³ people (Lim & Bernstein, 2012). Through proper education and training specific to this population, nursing students can be better equipped to create an environment in which clients feel safe to release any personal information pertaining to their healthcare needs, without feeling judged. Proper education and training will promote sexual orientation and gender identity awareness and allow nursing students to provide culturally competent care by showing openness, using inclusive language, and normalizing disclosure of sexual orientation and gender identity. Due to large numbers of nurses present in healthcare, and by virtue of their scope of practice, nurses are in a position to bridge the gaps found in health inequities and provide culturally sensitive care specific to the 2SLGBTQ+³ community (McKay, 2011). Educating nursing students of inclusive language and knowledge of the unique issues experienced by the 2SLGBTQ+³ population will help correct the insensitive and uninformed care 2SLGBTQ+³ people are currently experiencing (Lim & Bernstein, 2012).

Canadian Stakeholder Involvement

The CNSA believes in actively engaging stakeholders, including nursing schools and nursing organizations, in developing new areas of nursing curriculum and practice opportunities to prepare nursing students to provide safe, competent, ethical care for the 2SLGBTQ+³ community.

Relation to Canadian Nursing School Curriculums

As nursing students are required to learn and care for minority groups, CNSA accept this as their formal position on incorporating 2SLGBTQ+¹ education into nursing curriculum throughout Canada. Regional Directors will support nursing students in promoting this change in their nursing curriculum, and/or program. CNSA will suggest and coordinate educational activities to help promote awareness and bridge this gap in healthcare inequality.

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Edits

1. Changed from LGBTTIIPQQ2SAA+ to 2SLGBTIQQA+ for clarity. The new abbreviation is more widely known within the queer community. Throughout the statement, 2SLGBTQ+ is used as a short form for 2SLGBTIQQA+.
2. Changed acronym and examples;
 - a. Removed Transsexual. While this term is still used by some in the 2SLGBTQ+ community, it is an older term that many in the transgender community do not use, as it is often confused with transgender. Transsexual places emphasis on genitalia, specifically in terms of surgical alteration, while transgender instead focuses on the gender identity of the individual, specifically that it differs from the gender assigned at birth. This means that the term transsexual refers to a single group of people, whereas the term transgender is an umbrella term that includes a wide variety of individuals, including those that identify as transsexual. There is significant push within the trans community to move away from conversations surrounding genitalia, as these conversations are highly sensitive and not reflective of the holistic needs of transgender individuals. Additionally, many individuals who identify as transgender find the term transsexual offensive.
 - b. Removed Ally. The 2SLGBTQ+ acronym is representative of the various identities found within the queer community, but allyship is an action, not an identity. Being an ally is not something that someone decides for themselves, it is decided by members of equity seeking groups, based on the individuals' actions, and whether they have the trust of the community or not. When people use allyship as an identity, the emphasis on behaviours and actions are diminished, and motives are called into question. Additionally, it is well known there is an "A" in the 2SLGBTQ+ acronym, and when people believe that belongs to allies, it erases the identity of Asexual and Aromantic individuals. Allies are also not oppressed in the same manner as 2SLGBTQ+ individuals by means of their heterosexual privilege; including them in discussions of stigma, oppression, and discrimination demeans the experiences of 2SLGBTQ+ people.
 - c. Added additional identities: Asexual, Pansexual



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3. 2SLGBT to 2SLGBTQ+

4. Vulnerable to equity seeking. “[The term “vulnerable”] is criticized because it under emphasizes the multi-dimensional processes that cause unequal distributions of material, cultural, social and political resources. Furthermore, characterization of susceptibility and vulnerability can be disempowering”

http://nccdh.ca/images/uploads/Population_EN_web2.pdf

5. Change “dating violence and rape” to “domestic and/or sexual violence”



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Position Statement #2

**Condemning Conversion Therapy: Supporting 2SLGBTQ+ Health Through
Evidence-Based Care**

Approved: January 2020

Approved by: CNSA National Assembly

Submitted to: Board of Directors, 2019-2020

Submitted by: Courtney Blake, North Island College

Introduction and Background Information

Conversion therapy, also known as reparative therapy or sexual orientation change efforts, is the practice of using therapeutic interventions in an attempt to change an individual's sexual orientation to heterosexual (Drescher et al., 2016). It can include religious meditation, aversion therapy, talk therapy, or group therapy (CPA, 2015; Drescher et al., 2016). Conversion therapy has been widely reported to include harmful and abusive methods, such as separating individuals from their social support networks and families, shame, blame, sleep deprivation, verbal abuse, physical abuse, sexual abuse, and emotional abuse. It is primarily funded and supported by religious bodies that reject the validity of non-heterosexual sexual identities. While many organizations that offer conversion therapy deny allegations of abuse, there is no regulatory body to ensure this is true, and many survivors of conversion therapy still report experiencing abusive methods (Stroh, 2019).

Historically, psychoanalysts believed that the cause of homosexuality was poor parenting, an immature or childish personality, or a phobia of heterosexuality, and that there was "no such thing as normal bisexuality" (Drescher et al., 2016). This belief was adopted by many professionals, including psychiatrists, despite contradictory research showing how homosexuality is a natural human variance (Drescher et al., 2016). In the 1970s, mass protests forced the American Psychological Association to re-evaluate the evidence, leading to homosexuality being removed from the DSM -II in 1973 (Drescher et al., 2016). This helped change societal attitudes regarding homosexuality, but it still took almost another 20 years for the World Health Organization to remove homosexuality from their International Classification of Diseases (ICD-10) (Drescher et al., 2016). Despite the lack of evidence or support, old psychoanalytic theories are still used to this day by social and religious conservatives to support the use of conversion therapy (Drescher et al., 2016).

While 2SLGBTQ+ individuals and organizations have always opposed interventions meant to "cure" them of their sexual orientation, the recent influx of professional organizations and health authorities support has given validity to the concerns raised around conversion therapy.

Currently, conversion therapy is opposed by many professional organizations worldwide, including; the World Health Organization, American Academy of Pediatrics,



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American Psychoanalytic Association, American Medical Association, American Counseling Association, American College of Physicians, American Psychological Association, Canadian Psychiatric Association, Canadian Psychological Association, and the Canadian Association of Social Workers (Human Rights Campaign, n.d.; CPA, 2015).

There is no peer-reviewed evidence to support the theory that an individual can change their sexuality after undergoing conversion therapy (Drescher et al., 2016). Many organizations that offer conversion therapy services instead use anecdotal testimonials as their primary source of evidence. However, there is a wealth of peer-reviewed evidence that shows that conversion therapy can lead to depression, anxiety, distress, suicidal ideation, negative self-image, spiritual distress, impaired ability to maintain relationships, and sexual dysfunction (CPA, 2015; Drescher et al., 2016).

In Canada, there is no federal law regarding conversion therapy, despite a petition submitted to the federal government in March 2019 (Stroh, 2019). However, there are some regulations at the provincial and municipal levels throughout Canada that restrict access to conversion therapy. Ontario is the only province with an outright ban, while Manitoba and Nova Scotia have regulations surrounding who can offer and who can receive conversion therapy (Stroh, 2019). Vancouver is currently the only municipality that has enacted regulations preventing businesses from offering conversion therapy services (Stroh, 2019). While these regulations are better than nothing, anything less than an outright ban leaves room for harm to come to 2SLGBTQ+ individuals.

Canadian Nursing Students' Association's Current Position on the Issue In 2013, CNSA passed the position statement "Incorporating 2SLGBTQQA+ Education into Nursing Curriculum in Canada", which recognized the need for nurses to advocate for 2SLGBTQ+ health concepts to be integrated into nursing curriculum and to practice culturally safe care when working with 2SLGBTQ+ populations (CNSA, 2013). Then, in 2017, CNSA passed an additional resolution statement further emphasizing the need to incorporate 2SLGBTQ+ needs into nursing curriculum in addition to working with local 2SLGBTQ+ organizations (CNSA, 2017).

While these previous statements are strongly linked in concept to this current statement, they differ in that they focus on the ability of nurses to provide culturally safe care to 2SLGBTQ+ individuals, whereas this statement opposes interventions that negatively affect 2SLGBTQ+ individuals. Nursing students must continue to advocate for the integration of culturally safe care into nursing curriculum and nursing practice, but it is just as vital that nurses understand the context and implementation of why and how 2SLGBTQ+ individuals have experienced trauma in the name of health care.

Relation to Canadian Nursing School Curriculums

According to the 2016-2021 strategic plan, one of the priorities of CNSA is to



"influence and advance innovation and social justice in the nursing curriculum and the nursing profession" (CNSA, 2016). CNSA has been working diligently with CASN throughout the last six years to stress the importance of integrating 2SLGBTQ+ specific health concepts into nursing curriculum. Understanding the impact of conversion therapy needs to be part of this understanding. Nursing students must recognize the traumatic effects that can occur when an individual undergoes conversion therapy so that they may advocate for their patient if it is presented as a valid therapeutic option. It is also vital that nurses understand the potential harms associated with conversion therapy so that they may provide trauma-informed care when working with individuals who are experiencing adverse outcomes related to these experiences.

Conclusion and Restatement of the CNSA Position

CNSA does not support the use of conversion therapy as a therapeutic intervention, does not support the belief that sexual orientation can be changed, and supports increased legislation aimed towards banning the use of conversion therapy. Conversion therapy can result in serious harm done to the recipient and has no peer-reviewed evidence of any benefit. It is the responsibility of nurses to advocate for the health and safety of their clients, which includes opposing interventions where the benefits do not outweigh the risks. In the case of conversion therapy, the non-existent benefits are vastly outweighed by the negative health outcomes

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Position Statement #3

In Support of Maximizing Autonomy in End of Life (EoL): MAiD as EoL Care

Approved: January 2020

Approved by: CNSA National Assembly

Submitted: Dec 6, 2019

Submitted to: CNSA Board of Directors

Submitted by: Jessica Guthier, Thompson Rivers University

Introduction/Background Information

Legislation. Medical Assistance in Dying (MAiD) has been legal in Canada since 2016 following the passing of *Bill C-14*, An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts (Medical Assistance in Dying). As well, the unprecedented 2015 decision of the Supreme Court of Canada in *Carter v. Canada (Attorney General)* has contributed to the context of policies and culture surrounding MAiD (Canadian Nurses Association, 2017). The term “Medical Assistance in Dying” refers to either administration by a Nurse Practitioner (NP) or Medical Practitioner (MP) of a substance to a voluntary client that causes their death or their prescription or provision of a substance to a voluntary client so that they may later self-administer and cause their death (Government of Ontario, 2018). The *Charter of Rights and Freedoms* (henceforth the Charter) has been central in the process of passing *Bill C-14*. If a law is found to infringe on the Charter rights and freedoms, it will be considered “no force and effect.” In this way individuals have challenged regulations surrounding MAiD (Farmanara, 2017).

Regulations. While in Canada MAiD is a new legal service, other countries (such as the Netherlands) have been providing this service to their dying citizens for years. Eligibility requirements for Canadians receiving MAiD are stringent:

- at least 18;
- considered competent to make healthcare decisions;
- make the request voluntarily;
- be fully informed on the MAiD procedure and all other options available to alleviate their suffering, including palliative care;
- have a *grievous* and *irremediable* condition, comprised of,
 - an incurable illness, disease, or disability;
 - irreversibly declining in function and condition;
 - unbearable mental or physical suffering caused by their condition or their functional decline;



- a natural death is anticipatable (Government of Ontario, 2018);

While an NP or MP may provide or prescribe the treatment, a Registered Nurse (RN) or Licensed Practical Nurse (LPN) may also take part in the MAiD process. According to CNA, RNs and LPNs role in this process is to “Directly engage with people and their human condition, assessing suffering and survival while supporting them as they progress through death and dying.” (Canadian Nurses Association, 2017). Furthermore, nurses of all designations are the professionals to whom clients talk and question most often; and nurses may be questioned about EoL care, including MAiD (Canadian Nurses Association, 2017). The scope of practice of LPNs and RNs may differ between province and territory, and thus it is imperative nurses understand the regulations of their governing body. Despite a nurse’s ability to participate in MAiD, a nurse may also conscientiously object if they wish not to participate (Canadian Nurses Association, 2017).

Ethics. Respecting the autonomy of a capable client means respecting for wishes for death, and that this request does not indicate incapacity (Incardona, Bean, Reel, & Wagner, 2016). This can be difficult when considering the ethical responsibility of nonmaleficence (“to do no harm”). This fiduciary responsibility is brought into conflict because MAiD asks nurses to participate in the death of a client. Moreover, MAiD challenges the notion that death is harmful in all circumstances (Incardona et al., 2016). MAiD reveals that ongoing life may be seen as the more harmful option by the client, given a grievous and irremediable state (Incardona et al., 2016).

Mitigating risk for harm must not result in unnecessary barriers to accessibility; the criteria for MAiD are not *terminal illness* but rather *grievous and irremediable* conditions (Incardona et al., 2016). Barring clients on the basis of their condition, such as chronic or mental illness, infringes upon Sec. 7 and *Bill C-14*. Nonetheless, Conscientious Objection (CO) is an ethical dimension of MAiD that must be considered as well. Allowing for CO is in alignment with the provider’s rights under the Charter, in that it protects their autonomy, respects diversity in opinion, and “protects the [provider’s] moral integrity” (Incardona et al., 2016).

The Position of the Canadian Nursing Students’ Association (CNSA)

The CNSA aims to support students in the journey to becoming licensed nurses by facilitating opportunities for professional development, advocating for quality nursing education and inclusion of students’ voices, and promoting nursing research and quality patient care. One manner in which the CNSA achieves this is through the production and adoption of position and resolution statements. As such, current CNSA literature covers a wide range of topics, but perhaps one of the most unaddressed issues in current CNSA publications surrounds End of Life (EoL) care and treatments. According to the author’s research, CNSA currently supports two resolution statement on EoL care: *Quality End of Life Care in Nursing Education* and



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Mandatory End of Life Education for Nursing Students (Chafe, Dawe, McGrath, Stapleton, & Trahey, 2015; Soer & Bloomberg, 2013).

In this document, CNSA support CNA's statement that to provide quality EoL nurses must meet the needs and respect the wishes of families and individuals (Chafe et al., 2015). As well, CNSA adopts several resolutions including developing a formalized and purposeful position statement supporting quality EoL care education and that CNSA delegates will advocate for the adoption of EoL content in their chapters (Chafe et al., 2015). Given CNSA's resolutions advocating for EoL content in nursing curriculum, it is fitting that CNSA address the largely overlooked topic of MAiD. Providing quality EoL care is encompassing of the family and, most importantly, the client's wishes. Every dying client deserves the right to a dignified death. This may include palliative care, hospice care, do not resuscitate orders, or receiving MAiD. While all these services and treatments are important, and clients' autonomy should be encouraged when deciding on the EoL care they would like to receive, the scope of this position statement is to support MAiD as a valuable treatment option in EoL care. Thus, the proposed position statement follows: the CNSA supports those clients, deemed competent, to request, receive information on, and have access to MAiD without undue barriers or hardship.

Relation to Canadian Nursing School Curriculums

Invariably, nurses will work with clients at the end of their life, no matter in what area of nursing they work. MAiD is a legislatively new treatment option for nurses, each health authority, provincial/ territorial, and municipal governing body will have its own regulations. As the primary resource for nursing students across Canada, and MAiD being such a new treatment option, CNSA must advocate for this to be included in curriculum in all our chapter schools. Nursing students must be prepared to be competent practitioners, and understand their own morals regarding MAiD— including Conscientious Objection—to allow clients dignified deaths.

Conclusion and Restatement of CNSA Position

The Canadian Nursing Students' Association believes all nursing students have the right and the responsibility to understand EoL options. As our population ages and the incidences of chronic and comorbid conditions increases, this issue will become ever more important. The CNSA will continue to support, advocate for, and provide resources about quality EoL treatment options.



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Position Statement #4

Supporting Harm Reduction Strategies in Response to the Opioid Crisis

Approved: January 2018

Approved by: 2018 National Assembly, Canadian Nursing Students' Association

Submitted by: Mary Jane Butler, Western Regional School of Nursing; Josh Duncan, North Island College; Caitlyn Patrick, Sault College; Logan Tullett, Ryerson; Kyle Warkentin, University of the Fraser Valley

Edited by: Jessica Guthier, Thompson Rivers University

Updated: January 2020

Introduction/Background Information

Canada is facing an overdose epidemic; the solution, supervised consumption. These sites employ harm reduction strategies as well as connecting individuals with addiction services (PHAC, 2008). Supports available are grounded in evidence, best-practice guidelines, and harm reduction philosophy: needle exchange programs; supervised injection sites; HIV, HSV, and other testing; safe injection and harm-reduction education; and street outreach (Fast et al., 2008). Fentanyl is a cost effective and powerful synthetic opioid that is commonly used as a cheap 'cutting' agent to increase supply for illicit drug suppliers. Fentanyl has been found in cocaine, counterfeit oxycodone tablets, and heroin, among others (Frank & Pollack, 2017; London Free Press, 2017). *Carfentanil*—which is 100x stronger than fentanyl and 10,000x more potent than morphine—has been found in two separate drug investigations completed by the Public Health Agency of Canada in Ontario. *Carfentanil* found to be disguised as other, less potent substances. Potent opioids can easily suppress the respiratory system and result in fatal overdoses – especially in opiate naïve persons (London Free Press, 2017). Additionally, dangers associated with injected substances not only stem from the risk of developing HSV, but also bacterial infections (e.g. *necrotizing fasciitis*), skin lesions, movement disorders, gastrointestinal complications, and psychological conditions (Potier, Laprevote, Dubois-Arber, Cottencin, & Rolland, 2014). Opioid and substance-related morbidity and mortality serve as foundations for the supervised consumption movement. The point of intervention focuses on reducing the harms associated with substance use without further stigmatizing an already marginalized population (Small, 2012).

Education and sample-testing at supervised consumption sites (SCS) recognizes that many who are dying from fentanyl overdoses are consuming these substances unwittingly (Frank & Pollack, 2017). Moreover, access to trained professionals and Naloxone (Narcan) at consumption sites allows for the reverse of potentially fatal overdoses; meanwhile, providing Naloxone education and supply for individuals empowers them to step in during overdoses when a professional is not present (Frank & Pollack, 2017; London Free Press, 2017).



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SCS are places where individuals can use their personally sourced illicit substances while under professional supervision, while also having access to health professionals (often advance-practice nurses) and referrals as needed for social services, health services, and addiction services. The goals of such programs are designed to increase access to healthcare and addiction services, reduce the incidence of overdose mortality, and reduce the spread of blood-borne infections (PHAC, 2008). Nonetheless, one underlying issue with supervised consumption sites is that if individuals are unable to receive services in a timely fashion, they are more likely to avoid using these facilities in the future (Bell & Globerman, 2014).

The Position of the Canadian Nursing Students' Association (CNSA)

The CNSA strongly supports the need for more supervised consumption sites across Canada as a public health measure and will promote this intervention in nursing venues across the country. In addition, the CNSA commits to supporting community groups who are working towards opening supervised injection sites. While explicit mention to supervised consumption sites has not been made in past CNSA documents, the CNSA strongly supports harm reduction measures. An exemplar position statement was approved in 2019 regarding affordable PrEP access for all (CNSA). Previously, the CNSA has supported a harm-reduction approach through a position entitled *Promote Harm Reduction and Primary Health Care Access through Supervised Injection Sites* (2013). Acceptance of this updated statement, which builds on that passed in 2013, addresses the current public health issues surrounding opioid use in particular.

In addition, CNSA stands with other national organizations and aims to support this evolving public health issue. The Coalition of Nurses and Nursing Students for Supervised Injection Services and the Community Health Nurses of Canada have laid foundations through past documents and resources, and the CNSA supports this position.

Relation to Canadian Nursing School Curriculums

Community nursing practice offers students the opportunity to use their assessment skills to work in community settings that may or may not involve clients who use drugs. The inclusion of this topic within the nursing curriculum would provide nursing students the opportunity to expand their knowledge base on how to effectively market health promotion initiatives in public and political spectrums. Thus, nursing students can increase public awareness and the scope of care. Additionally, students will learn how to network with community organizations and build their ethical and professional identity.

In addition to the health-related benefits to this curriculum proposal, students can also develop a better understanding of economics and public spending which could reinforce their stance that public health initiatives have a positive return on capital investment. More specifically, the *Economic Burden of Illness in Canada* report stated that the cost of harm reduction by means of prevention would save Canada millions over the long run. This results



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from a divergence of money and resources used to treat chronic conditions, such as hepatitis, later (PHAC, 2014).

Lastly, a harm reduction curriculum within nursing education has the potential to build off the 2013 resolution statement regarding the inclusion of 2SLGBTBQ+ education. As many nursing students may already know, gender and ethnic minorities face systems of oppression and marginalization that results in these minorities being disproportionately represented in the substance using community. In this vein, such curriculum inclusion builds upon past work of the CNSA to advocate for marginalized and equity seeking populations.

Rationale

WHEREAS, Canada is facing a crisis of opioid overdoses.

WHEREAS, the CNSA supports harm reduction as a valid public health and safety measure.

WHEREAS, a resolution statement has not yet come forward to address the 2013 CNSA Position Statement entitled *Promote Harm Reduction and Primary Health Care Access through Supervised Injection Sites* (2013).

Be it Resolved, That the CNSA, as the voice of the new generation of nurses, promote safe injection services within their chapter schools through collective partnerships with professors, nurses, school faculty and nursing students in order to prioritize public health measures.

Be It Further Resolved, That the CNSA support the efforts of Canadian nursing students to advocate for increasing the number of safe injection sites across Canada that follow and adhere to institutional protocols and nursing CNO standards of practice.

Be it Further Resolved, That the CNSA advocate for the inclusion of safe injection practices as a legitimate harm reduction approach in nursing education within community and public health curriculum.

Conclusion

The lack of accessibility for minority and substance-using communities within primary health care settings often results in them being disproportionately represented in overdose incidences. As morbidity and mortality related to opioid overdoses continue at epidemic rates, healthcare professionals must adapt their practices to be inclusive, non-judgmental, and employee harm-reduction philosophy. This position statement builds upon other documents passed by the CNSA regarding ethnic and cultural minorities, accessible healthcare and primary health care, and other supervised consumption positions.



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Edits

1. Canada is facing an overdose epidemic; the solution, supervised consumption. These sites employ harm reduction strategies as well as connecting individuals with addiction services (PHAC, 2008). Supports available are grounded in evidence, best-practice guidelines, and harm reduction philosophy: needle exchange programs; supervised injection sites; HIV, HSV, and other testing; safe injection and harm-reduction education; and street outreach (Fast et al., 2008).
2. Fentanyl is a cost effective and powerful synthetic opioid that is commonly used as a cheap 'cutting' agent to increase supply for illicit drug suppliers. Fentanyl has been found



in cocaine, counterfeit oxycodone tablets, and heroin, among others (Frank & Pollack, 2017; London Free Press, 2017). *Carfentanil*—which is 100x stronger than fentanyl and 10,000x more potent than morphine—has been found in two separate drug investigations completed by the Public Health Agency of Canada in Ontario. *Carfentanil* found to be disguised as other, less potent substances. Potent opioids can easily suppress the respiratory system and result in fatal overdoses – especially in opiate naïve persons (London Free Press, 2017). Additionally, dangers associated with injected substances not only stem from the risk of developing HSV, but also bacterial infections (e.g. *necrotizing fasciitis*), skin lesions, movement disorders, gastrointestinal complications, and psychological conditions (Potier, Laprevote, Dubois-Arber, Cottencin, & Rolland, 2014). Opioid and substance-related morbidity and mortality serve as foundations for the supervised consumption movement. The point of intervention focuses on reducing the harms associated with substance use without further stigmatizing an already marginalized population (Small, 2012).

3. Education and sample-testing at supervised consumption sites recognizes that many who are dying from fentanyl overdoses are consuming these substances unwittingly. 4. Moreover, access to trained professionals and Naloxone (Narcan) at consumption sites allows for the reverse of potentially fatal overdoses; meanwhile, providing Naloxone education and supply for individuals empowers them to step in during overdoses when a professional is not present (Frank & Pollack, 2017; London Free Press, 2017). 5. The CNSA strongly supports the need for more supervised consumption sites across Canada as a public health measure and will promote this intervention in nursing venues across the country. In addition, the CNSA commits to supporting community groups who are working towards opening supervised injection sites. While explicit mention to supervised consumption sites has not been made in past CNSA documents, the CNSA strongly supports harm reduction measures. An exemplar position statement was approved in 2019 regarding affordable PrEP access for all (CNSA). Previously, the CNSA has supported a harm-reduction approach through a position entitled *Promote Harm Reduction and Primary Health Care Access through Supervised Injection Sites* (2013). Acceptance of this updated statement, which builds on that passed in 2013, addresses the current public health issues surrounding opioid use in particular. 6. In addition, CNSA stands with other national organizations and aims to support this evolving public health issue. The Coalition of Nurses and Nursing Students for supervised Injection Services and the Community Health Nurses of Canada have laid foundations through past documents and resources, and the CNSA supports this position.
4. The inclusion of this topic within the nursing curriculum would provide nursing students the opportunity to expand their knowledge base on how to effectively market health promotion initiatives in public and political spectrums. Thus, nursing students can



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increase public awareness and the scope of care. Additionally, students will learn how to network with community organizations and build their ethical and professional identity.

5. The lack of accessibility for minority and substance-using communities within primary health care settings often results in them being disproportionately represented in overdose incidences. As morbidity and mortality related to opioid overdoses continue at epidemic rates, healthcare professionals must adapt their practices to be inclusive, non-judgmental, and employee harm-reduction philosophy. This position statement builds upon other documents passed by the CNSA regarding ethnic and cultural minorities, accessible healthcare and primary health care, and other supervised consumption positions.



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Position Statement #5

Advocating for Sexual and Reproductive Education in Nursing Curricula: Supporting Reproductive Autonomy

Approved: January 2020

Approved by: CNSA National Assembly

Submitted: November 27, 2019

Submitted to: Board of Directors, 2019-2020

Submitted by: Jessica Guthier, Thompson River University; Courtney Blake, North Island College; Latitia Pelley-George, BScN, RN; Victoria Marchand, University of Ottawa

Introduction and Background Information

Induced abortions have been legal in Canada since 1988 and are currently governed by the Canada Health Act (Government of Canada, 2019). Furthermore, in section 7 of the Canadian Charter of Rights and Freedoms states every Canadian has the right to “life, liberty, and security of the person and the right not to be deprived thereof” (Government of Canada, 2019). In 1988, when induced abortions were legalized in Canada, the highest courts of our country also ruled that nobody but the pregnant person themselves could decide for or against an induced abortion. To attempt to control a person’s reproductive capacity would be to violate that person’s right to *life, liberty, and security of the person* (Government of Canada, 2019; LawforAlbertaWomen.ca, 2015).

Access to an induced abortion is both a reproductive and human right, however, there are many people in Canada who do not have reliable access to abortion nor other reproductive services. This is due to the inconsistencies in funding throughout the country, geographical constraints, anti-choice politicians, as well as the ideological alignment of many influential non-profit groups. Many provinces regulate which facilities can provide induced abortions, unnecessarily requiring services to be performed in hospitals and refusing to allow these services to be performed in smaller clinics with equally trained professionals (CBC, 2019). This constraint creates a barrier for people living in rural and remote communities, who would then be required to commute long distances to receive services at a hospital. Huge financial barriers are created for clients when they must travel long distances, additional to possibly having to pay for some or all of the service - as coverage is province dependent. When there are barriers to accessing reproductive services - including legislative barriers, social stigmatization, and bureaucratic processes - people who require or depend on these services cannot access them. Thus, their reproductive options and bodily autonomy can be limited (Reeves et al, 2018).

There are many fake abortion clinics, often called “Pregnancy Crisis Centers”, which cater to vulnerable pregnant populations but refuse to refer their clients to abortion services (ARCC, 2019). These fake clinics provide misinformation about abortion or



withhold information in an attempt to exaggerate the dangers of abortions (ARCC, 2019). These clinics are funded primarily by religious organizations and private donors, are not medical clinics, and do not willingly disclose their religious ties (ARCC, 2019). People who are seeking abortion services also face long wait times to receive the services they require, which compromises their eligibility to receive said services (CBC, 2019). For example, many hospitals put early upper limits on how far along in the pregnancy the client can be; cut-offs such as 12 or 18 weeks result in clients learning about their pregnancies and then only having a short amount of time to decide whether or not to access abortion services.

Nurses have a moral, ethical, and professional obligation to advocate for increased access to health care services, regardless of their personal opinions about those services. Nurses know that inadequate access to reproductive services does not lead to less abortions, it leads to less safe abortions. At home remedies become enticing and may seem like viable options, but these can have devastating, and sometimes fatal, effects. Creating barriers to proper reproductive health will only assure that many unwanted pregnancies end in physical illness or pain, psychological and emotional stress, financial challenges, or death of the pregnant person.

Canadian Nursing Students' Association's Current Position on the Issue As of 2019, the CNSA harbours no definitive position on this issue. While referring to the 1984 to 2006 position and resolution statements, not one mention towards reproductive autonomy was made. Furthermore, recent position and resolution statements also fail to make any mentions to reproductive health, and especially not to induced abortions. Whether this is due to the lack of need historically for CNSA to take a stance, or whether this has been a conscious choice due to the politically heated nature of this topic, is unknown. In January of 2013, CNSA passed a resolution statement encouraging educational institutions to include political education in curriculum, encouraging nursing students to become involved in political activism, and attempting to involve nursing students in their communities at an advocacy level (Gielarowiec, Hardy-Moffat, Telegdi, & Bloomberg, 2013). While resolution statements such as these have inspired students to become involved within the CNSA, it is unclear how involved CNSA students have become in the external political climate.

Indirectly related to this issue is a position statement passed in 2018 regarding rural and remote health equity. Although this position statement speaks more closely to the health discrepancies faced by Indigenous populations and other populations living remotely and rurally, it indirectly speaks in support of reproductive autonomy (Norris, Pelley-George, Gustafson, 2018). This is because remote and rural communities often lack the infrastructure necessary to provide clients with choices and educational supports surrounding their reproductive health. Furthermore, creating a position on this issue falls within CNSA's strategic plan Objective B, Outcome 1: members "[b]e involved in curriculum decisions, planning and review", and Objective B, Outcome #4: "Members of CNSA incorporate research and



evidence-based decision making into their current and future practice to positively influence patient outcome” (CNSA, 2016).

Relation to Canadian Nursing School Curriculums

A clear objective of CNSA is to influence and make advancements in innovation and social justice within the nursing curriculum and the nursing profession (CNSA, 2016). A clear objective of nursing schools' curricula is to provide graduate nurses with at least the minimal requirements to allow graduates to perform at a generic level. Curricula and the culture permeating healthcare would have one believe that sexual and reproductive healthcare are niche topics--ones requiring extra certification to be able to address. While it may be true that to provide sound advice and perform thorough assessments regarding sexual and reproductive health, it is in no way true that a graduate nurse should not have the competencies to discuss sexual and reproductive health with their clients. In every healthcare setting, a person's sexual orientation and gender are present. Despite not being the focus of their visit, a client will always carry their sexuality and gender with them and it will influence every decision they make and every experience they have. To provide holistic care, a nurse *must* be willing to address a client's sexual and reproductive needs and, where their own expertise fails, refer them to an appropriate professional.

Moreover, impartiality to all patients to provide excellent care despite personal beliefs is a fundamental belief in the nursing discipline. Whatever a nurses' personal beliefs on sexual and reproductive topics, they must not let it influence the information they provide their patients, the options they present, or the care they provide. Such an important concept is currently being left up to individual universities to decide whether or not to discuss, and that is unacceptable. The CNSA must be a strong advocate that *every* nursing curriculum include education on how to address sexual and reproductive health topics.

Conclusion and Restatement of the CNSA Position

A person's sexuality and gender are their own, and options such as contraception and induced abortions are an important aspect of comprehensive healthcare. No matter a nurses' personal beliefs, they must always be willing to provide all possible information with the best interpretation for their client, and treat their clients with autonomy, justice, maleficence, and beneficence. Fostering this mind-set must happen at the undergraduate nurse level, and be declared as a core-competency no-matter where a nurse works. It is far better for a graduate nurse to be prepared to address a client's sexual and reproductive needs and never be asked, than for them to be ignorant of these topics when a client is in need.

Currently, the CNSA has no positions or resolutions specifically targeting this issue--or any reproductive health issues. Some position statements indirectly support adoption of a strong position in favour of reproductive autonomy, as do the CNSA's objectives and outcomes. Lastly,



it is written within our very constitution that every person living in Canada has the right to *life, liberty, and security of the person* (Government of Canada, 2019). That means they have an inalienable right to do with their body what they wish. The CNSA must make a stance on this topic and be staunch advocates for patient-centered and holistic care.

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Position Statement #6

Incorporating Education Surrounding Populations with Diversabilities into Nursing Curriculum

Approved: January 2020

Approved by: CNSA National Conference

Submitted on: Dec 1st, 2019

Submitted By: Courtney Blake, North Island College; Emma Hill, Vancouver Island University

Introduction and Background Information

According to the World Health Organization, over one billion individuals, 15% of the global population, live with diversabilities (2018). The term diversability refers to diversity in an individuals' level of ability, whether it be neurologic, cognitive, intellectual, physical or developmental (Disabled World, 2019). Compared to the general neurotypical and able-bodied population, individuals with diversabilities who seek healthcare go with their needs unmet and pursue healthcare more often (WHO, 2018). The health of individuals with diversabilities is rarely addressed by health promotion and primary prevention services, increasing their vulnerability to experiencing significant health disparities (WHO, 2018).

Barriers to accessing healthcare services include cost of services, limited accessibility, physical barriers, and the lack of knowledge of healthcare workers (WHO, 2018). Due to a lack of knowledge of healthcare provides, patients may have traumatic healthcare experiences and may encounter negative attitudes from staff (Ali, Scior, Ratti, Strydom & King, 2013). Other significant barriers to accessing healthcare services include difficulty in communicating with healthcare practitioners, miscommunication between healthcare staff and carers of the individual with a disability, and the lack of support for carers in the healthcare system (Ali et al., 2013). According to Connell (1998), patients with disabilities "want someone who seeks to understand not only their disease, but their experience of illness – the composite of the patient's views, feelings, and responses to disease, and its effects on the patient's life and the lives of those with whom they relate" (p. 83). Due to the lack of education of health care provides surrounding individuals with diversabilities, this population faces stigmatization and judgement from their care providers. This cultivates an unsafe space where individuals are treated poorly and are denied care, which can result in premature and potentially avoidable deaths (WHO, 2018). According to article 25 of the United Nations Convention on the Rights of People with Disabilities (CRPD) (2006);

“[P]ersons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. [This includes providing] persons with disabilities with the same range, quality and standard of free or affordable



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health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes... [Health professionals are] require[d] to provide care of the same quality to persons with disabilities as to others, including

on the basis of free and informed consent by raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care... Discrimination against persons with disabilities in the provision of health insurance, or denial of health care or health services or food and fluids on the basis of disability, shall [be] prevent[ed] and prohibit[ed]". Canada is a signatory member of the CRPD, ratifying their commitment in 2010.

Canadian Nursing Students' Association's Current Position on the Issue

In 2016, CNSA passed the position statement "Accommodation within Clinical Placements for Students with Temporary, Transient, or Sporadic Disability or Injury" (Payette & Delage, 2015). This position statement mainly focused on the rights of students with disabilities who experience barriers to meeting their educational institution's clinical requirements; however, it also outlined CNSA's support of increased awareness of accessibility, disability, and accommodation within the nursing curriculum (Payette & Delage, 2015). This statement is the only current literature within CNSA that supports the inalienable rights of persons with disabilities.

This current position supports CNSA's strategic objective B: "Influence and advance innovation and social justice in the nursing curriculum and the nursing profession". By advocating for positive, evidence-based curriculum change, CNSA is being involved in curriculum decisions, planning and review, and incorporating research and evidence-based decision making into their current and future practice to positively influence patient outcomes (CNSA, 2016). Education regarding the numerous diversabilities and the nursing considerations for these populations is vital for the growth of the nursing profession.

Due to the negative impact that uneducated health professionals can have on the health and mortality of people with diversabilities, CNSA believes that nursing curriculum must include education on how to support the needs of this population.

CNSA recognizes that it is the duty of the nurse to advocate for the unique needs of every patient they support, including patients with a wide variety of abilities and disabilities. However, nurses cannot hope to adequately support people with diversabilities if they are not equipped with the knowledge and tools to do so.

Relation to Canadian Nursing School Curriculums

The current nursing curriculum does not adequately address the unique needs of individuals with diversabilities, and it does not prepare nurses with the knowledge, skill and relational practice to safely care for these individuals. According to Troller et al., "if nurses



develop skills and knowledge to modify their assessment and treatment practices, and to manage challenging behaviour, post-registration they will be more likely to detect physical and mental health conditions in this population, deliver more effective treatments, and provide more positive healthcare experiences. In short, they will be in a better position to help address these inequalities” (2017).

A study reviewing nursing textbooks for disability-related content found that the textbooks lacked adequate information on the health needs and nursing considerations when caring for an individual with diversabilities (Smeltzer, Robinson-Smith, Dolen, Duffin & Al-Maqbali., 2010). While some textbooks included more education than others, the consensus of the study was that the available information was not reflective of the population size (Smeltzer et al., 2010).

Health care programs rarely include how to address the needs of people with intellectual disabilities in their curriculum, which leaves graduates unequipped to meet the unique challenges that people with intellectual disabilities face, especially in acute care settings (Trollor et al., 2016), a relevant barrier to all individuals with diversabilities. As the largest profession within health care, nurses are pivotal in ensuring that people with disabilities receive appropriate health care services, including health promotion, disease detection, and treatment (Trollor et al., 2016). However, nurses are among the many health professionals not getting the education required to fulfill this role.

Many countries around the world offer specialized training for nurses who wish to work exclusively with people with diversabilities. Research has shown that a lack of exposure to nursing specialities during undergraduate education leads to a lack of graduate nurses seeking to practice in those areas (Happell, 2010). In Canada, several nursing organizations provide post-baccalaureate education and certification, such as the Canadian Nurses Association (CNA) and the Canadian Association of Schools of Nursing (CASN). CNA is the largest organization that offers certification, yet they do not currently provide any resources for nurses seeking to further their knowledge surrounding people with diversabilities. CASN also offers certifications for nurses in addition to outlining the accreditation framework required of nursing schools, but they offer no material specifically for nurses who support people with diversabilities. There are some private institutions in Canada, for example St. Francis Xavier University, that offer additional education regarding how to best support people with intellectual disabilities through their health care journey, however, many are phasing out their programs due to declining enrollment.

Conclusion and Restatement of the CNSA Position

The CNSA recognizes that adequately preparing nursing students to care for people with diversabilities is not currently a part of the nursing curriculum, which contributes significantly to the inequitable health outcomes experienced by this population. It is crucial for nurses to have



the education that ensures patients with diversabilities are receiving safe, compassionate and ethical care that are meeting their specific and complex needs to achieve a positive health outcome.

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Position Statement #7

Equitable Healthcare and Education for Deaf and Hard of Hearing Populations

Approved: January 2020

Approved by: CNSA National Assembly

Submitted: December 5, 2019

Submitted to: CNSA Board of Directors

Submitted by: Amy Rowe, Queen's University

Introduction and Background Information

It is estimated that 350, 000 Canadians are profoundly deaf and 3.2 million are Hard of Hearing (Canadian Association of the Deaf, 2015). There is no universal sign language, but there are hundreds of sign languages around the world, just as there are spoken languages (Olson & Swabey, 2017). The main sign languages in Canada are American Sign Language (ASL), French Sign Language (Langue des Signes Francaise) and Indigenous Sign Language (Gessner, Herbert, & Parker, 2017). While some Deaf and Hard of Hearing Canadians receive speech therapy or undergo surgery for cochlear implants, their primary language is ASL (American Psychological Association, 2013).

To provide accessible healthcare, understanding Deaf culture is critical. Direct translation from English is not enough to properly communicate. There is a lack of culturally competent sign language interpreters that understand both medical terminology and Deaf culture (Canadian Hearing Society, 2019). Deaf culture encompasses the rules, traditions and behaviours of Deaf people (Rosen, 2007). Their rich culture impacts the understanding, values and beliefs of Deaf people in healthcare settings (Gallaudet University, 2015). Inaccessible healthcare leads to poor health assessment, limited prevention services, culturally inappropriate treatment, and poor health outcomes (Olson & Swabey, 2017).

According to the United Nations (2018), access to education and health care services is a human right. Yet Deaf and Hard of Hearing populations do not receive equitable healthcare or education in Canada. Deaf and Hard of Hearing Canadians face educational barriers in post secondary education. Systemic barriers and discrimination prevent nursing and medical students from becoming health care providers and accessing post-secondary education. This population experiences marginalization, poor employment conditions and inadequate mental health resources (Olson & Swabey, 2017).



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The Position

The Canadian Nursing Students Association (CNSA) supports and advocates for equitable healthcare for all Canadians (CNSA, 2016). This extends to Deaf and Hard of Hearing Canadians who face healthcare inequalities. The lack of culturally competent medical interpreters is only one problem contributing to disparities in this population. The lack of preventative medicine, poor communication and misdiagnoses contribute to poor health outcomes. These issues are relevant for future nurses to understand.

The CNSA strives to strengthen relationships and create new partnerships (CNSA, 2016). The Canadian Hearing Society and the Canadian Association of the Deaf are key resources for the CNSA to collaborate with. In order to break down barriers this population faces, we all must work together. It is not the responsibility of the Deaf or Hard of Hearing students alone to advocate for inclusion and integration.

The CNSA advocates for cultural safety and accessibility (CNSA, 2016). Providing basic education on Deaf culture and sign language is essential to bridging the gap between hearing nurses and Deaf patients. Nursing students should learn basic, medical signs. Communication barriers pose safety risks to patients when health care professionals cannot sign basic words. Currently, there is no requirement for nursing schools to provide this type of education. A basic education should be added to nursing curriculum immediately to advance nursing students for their practice. This education will increase nursing students' awareness and promote inclusion for all patients. Deaf and Hard of Hearing individuals should lead the development of culturally appropriate curriculum. By advocating for this curriculum, the CNSA follows its objective of advancing and influencing nursing education (CNSA, 2016).

The CNSA is the national voice of all nursing students, and supports the education of Deaf and Hard of Hearing nursing students. Regardless of hearing function, all students can become nurses and should be encouraged to pursue post-secondary education and qualifications. Providing equal opportunity to nursing students who require interpretation is necessary. Integration of all nursing students who sign is encouraged by the CNSA. It is the responsibility of hearing people to work with Deaf and Hard of Hearing populations to make nursing school accessible. One barrier to nursing is using a stethoscope. However, Deaf doctors in Canada are already using electronic stethoscopes with visual displays (Kozicka, 2014). While there are still many barriers, the CNSA advocates for innovation and research (CNSA, 2016). Finding creative solutions for every barrier is possible and necessary.

Conclusion and Restatement of CNSA Position

In order to address the healthcare inequalities in this population, nursing students need to



learn about Deaf culture, inequalities this population faces, and basic sign language. Deaf and Hard of Hearing nursing students should be able to attend nursing school and become healthcare providers. Nurses who are Deaf or Hard of Hearing will improve health outcomes of these populations. To achieve healthcare equity in this population, it is critical to improve nursing curriculum and advocate for future Deaf and Hard of Hearing nursing students.

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