



Annual Meeting of Members
June 21, 2017
Resolutions

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BE IT RESOLVED THAT the Canadian Nurses Association (CNA) support greater collaboration and inclusivity among all nursing designations including registered nurses, licensed practical nurses (registered practical nurses in Ontario), registered psychiatric nurses and nurse practitioners through policy and advocacy initiatives to advance the nursing profession and influence health and nursing policy.

Name of submitter:

Association of Registered Nurses of British Columbia (ARNBC)

Rationale:

The nursing profession in Canada is comprised of a diverse group of clinicians, educators, policy-makers, administrators and researchers. Substantial differences exist within the nursing profession itself, which is made up of four designations including registered nurses (RNs), licensed practical nurses (LPNs), registered psychiatric nurses (RPNs) and nurse practitioners (NPs). While there are differences in relation to the level of educational preparation, training and scope of practice, the core values of nursing remain the same, regardless of nursing designation.

These values include

- providing safe, compassionate, competent and ethical care;
- promoting health and well-being;
- promoting and respecting informed decision-making;
- preserving dignity;
- maintaining privacy and confidentiality;
- promoting justice; and
- being accountable (Canadian Council of Practical Nurse Educators, 2013; Canadian Nurses Association, 2008).

One of the biggest issues facing nursing is the hierarchal culture and historical power structures that have been entrenched over many decades. This has resulted in significant challenges for nurses of different designations to come together under the common title of “nurse” to advance nursing and influence healthy public policy. A lack of unity and collaboration within nursing has shown to have significant implications at the practice, organizational and systems levels (Registered Nurses’ Association of Ontario, 2016). In order to work toward interprofessional collaboration, intraprofessional collaboration within nursing must be discussed and addressed across the country.

As a member of the B.C. Coalition of Nursing Associations (BCCNA), ARNBC has seen the positive impacts of nursing collaboration at the provincial/territorial level. All four nursing designations in B.C. have been working collaboratively to advance the image of nursing, respond to timely health-care issues and influence provincial/territorial health policy. Notably, for the first time, nurses of all designations in B.C. were able to provide a nursing response, as a collective, to the B.C. Ministry of Health policy papers released in 2015. In 2016, the coalition was successful in bringing together a wide range of stakeholders to respond to the opioid crisis in B.C., resulting in a framework to guide nursing’s work in this area. The coalition’s progress to date illustrates the positive impacts of relationship building and collaboration, as it has become a well-respected

organization where government, regulators, health authorities and other key stakeholders can engage in solutions-focused discussion with the entire nursing profession.

Intraprofessional collaboration is strongly needed across Canada, and CNA is well positioned to provide national leadership to advance this policy direction.

Relevance to CNA's mission and goals:

Advancing this resolution will further support components of CNA's mission which aims to:

- Unify the voices of RNs
- Strengthen nursing leadership
- Promote nursing excellence and a vibrant profession
- Advocate for healthy public policy and a quality health system
- Serve the public interest

Key stakeholders:

- CNA's jurisdictional members and interest groups
- BCCNA
- Professional Canadian nursing associations currently not affiliated with CNA

Estimated resources required or expected outcomes:

The expected outcome is the demonstration of national nursing leadership through collaborative advocacy and policy initiatives that advance nursing and influence nursing and health policy. Resources may include financial and human resources to support dialogue, research and the development of policy and advocacy initiatives.

References:

B.C. Coalition of Nursing Associations. (2017). Materials. Retrieved from <http://www.bccna.com/materials.php>

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Registered Nurses' Association of Ontario. (2016). *Intra-professional collaborative practice among nurses*. Retrieved from <http://rnao.ca/bpg/guidelines/intra-professional-collaborative-practice-among-nurses>

WHEREIN the Canadian Nurses Association (CNA) code of ethics (2008) expresses nursing values and commitments of promoting the health, well-being and dignity of vulnerable populations within an ever-evolving society and health-care system;

AND WHEREIN the CNA code of ethics expresses that nurses work to prevent and minimize all forms of violence — collaborating with others to establish preventive interventions, including advocating for social justice to change laws or policies that compromise the delivery of informed, compassionate, and a safe, people-centred, rights-based approach to health-care;

AND WHEREIN CNA upholds principles of social justice (CNA, 2010) by safeguarding or addressing violations of human rights as identified in the CNA position statement on registered nurses, health and human rights (2011) which refers to the United Nations *Universal Declaration of Human Rights* (1948);

BE IT RESOLVED THAT CNA develop a position statement on non-state actor torture that distinctly reflects:

- Article 5 of the United Nations *Universal Declaration of Human Rights*, which states that no one shall be subjected to torture;
- the importance of promoting social inclusion of vulnerable groups as an essential determinant of health (CNA, 2009); and
- incorporating the United Nations sustainable development goals (SDGs), specifically SDG No. 5.1 and 5.2, which centre on ending all forms of discrimination against women and girls everywhere and on the elimination of all forms of violence against all women and girls in public and private spheres (United Nations General Assembly, 2015).

BE IT RESOLVED THAT CNA submit a written statement to the government of Canada requesting that the government:

- acknowledge and identify that torture by non-state actors is a distinct human rights violation; and
- amend the Criminal Code of Canada to include torture by non-state actors, upholding Canada's due diligence to promote non-discriminatory human rights, social inclusion and social justice for all persons so tortured.

Name of submitters:

Jeanne Sarson, M.Ed., BScN, RN (NS)

Linda MacDonald, M.Ed., BN, RN (NS)

Rationale:

CNA connects with the International Council of Nurses (ICN), which has a position statement on nurses and human rights (2011) endorsing the United Nations *Universal Declaration of Human Rights*, a person's right to dignity and "to be free from . . . torture" (ICN, p. 1). It acknowledges that "individuals' health and wellbeing can be harmed when their human rights in any category are violated" (ICN, p. 1). It also promotes the responsibility of nursing associations to participate in developing health, social and legislative policies that relate to patients' rights, responsibilities that

the CNA equally describes as belonging to its nurses in various documents such as its code of ethics (2008). Similar to CNA, the ICN code of ethics states that respecting human rights is inherent to nursing (2012).

Nurses have, for decades, been involved in and written about the care of persons who have suffered torture inflicted by state actors (Anasarias, Molino, Hernandez, & Briola, 2012; Cowgill & Doupe, 1985; Glittenberg, 2003; Jacobsen, 1998; Laurence, 1992a, 1992b; McCullough-Zander & Larson, 2004; Pabilonia, Combs, & Cook, 2010). However, torture by non-state actors — e.g., private individuals such as parents, spouses, other family members or their friends; human traffickers; and strangers — perpetrated in the domestic or private sphere, has lagged behind in its specific identification and criminalization in national law (Coomaraswamy, 1996; Sarson & MacDonald, 2016a), including in Canada (United Nations Committee Against Torture, 2012). Evidence has been accumulating for decades, e.g., in Canadian governmental and police reports, that women have been subjected to dehumanizing acts of non-state torture (Sarson & MacDonald, 2015). As well, there is now factual criminal evidence that children as young as newborns are also subjected to torture, including acts of sexualized torture (Sarson & MacDonald, 2016b). A lack of specific identification and criminalization “invisibilizes” to nurses the individuals we care for — from infants to adults — who have or are being made grievously vulnerable as a consequence of suffering severe physical and mental torture and pain inflicted by non-state actors in the domestic or private sphere.

Gender-based human rights discrimination and inequality, especially in reference to upholding the United Nations *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, and Article 5 of the *Universal Declaration of Human Rights*, began being challenged by several United Nations Human Rights Council resolutions (2008, 2009). These resolutions recommended that the UN Committee Against Torture (UNCAT) and the special rapporteur on torture incorporate into their work a gendered perspective that addressed manifestations of violence against women and girls or children that amounted to torture by non-state actors. UNCAT incorporated a gendered perspective into General Comment No. 2 (2008), thus operationalizing the *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* by enacting the human rights principle of non-discrimination for the first time, i.e., decades after its coming into force on June 26, 1987 (United Nations Office of Legal Affairs, 2017). Torture being one of the worst human rights violations human beings can inflict on another, Manfred Nowak, the prior United Nations special rapporteur on torture, wrote that countries “bear the primary responsibility for implementing international human rights standards . . . by protecting human rights against interference by . . . private actors” (United Nations Committee Against Torture, 2010, para. 2).

CNA nurses are volunteers and or are members in non-governmental organizations (NGO) with mandates to promote human rights and gender equality. Examples include membership in the Canadian Federation of University Women (CFUW) and Graduate Women International (GWI), which have position statements on non-state actor torture (CFUW, 2012; GWI, n.d.). The NGO committee on the status of women, Geneva, wrote in their *NGO Declaration and Recommendations*, for states to “Ensure national laws criminalize non-State torture perpetrated by non-State actors and hold perpetrators accountable for gender-based non-State torture crimes” (2014, p. 5).

Nurse activists who are members of NGOs have brought attention to non-state torture as a human rights violation that occurs in Canada (Huron, 2016a; Huron 2016b). CNA past-president Karima Velji wrote in support of the private member’s bill, C-242, An Act to Amend the Criminal Code (Inflicting Torture), referencing the CNA code of ethics and its values of “preserving dignity” “promoting justice” and the principle that “nurses provide safe, compassionate, competent and

ethical care.” These values, she wrote, includes the responsibility to “work to prevent and minimize all forms of violence,” identifying that CNA also works to promote equity and advocates for vulnerable populations. When writing her letter, Velji offered to provide any support that might help bring the legislation to fruition (written correspondence, March 14, 2016). Although the legislation passed through second reading in the House of Commons, it was defeated at the standing committee on justice and human rights level with the decision that torture by non-state actors can be addressed as forms of aggravated assault (Sarson & MacDonald, 2017). This position ignores that UNCAT had recommended that Canada incorporate fully the *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* into national law (2012). Nowak wrote that it is a state’s duty to prevent torture in the private sphere, and when some manifestations of woman’s victimization are compared to state torture, this would expose that similar atrocities are inflicted by non-state actors in the domestic or private sphere (United Nations Committee Against Torture, 2008). Torture is torture — it is not an assault.

Therefore, the development of a position statement and writing to the government of Canada on the need to acknowledge, identify and criminalize the human rights violation of non-state torture perpetrated in the domestic or private sphere will meet the professional and ethical practice responsibilities nursing has for advocating and promoting human rights equality in the provision of informed health care. The development of a position statement will also serve as an educational awareness tool that advances the nursing profession’s responsibilities to seek social justice and social inclusion for this specific vulnerable population of persons — from infants to adults.

Additionally, increased knowledge can impact positively on the nurse-patient relationship by promoting a people-centred, rights-based approach to nursing practice.

Relevance to CNA’s mission and goals:

In respect to this resolution, CNA can be a voice of advocacy for the vulnerable populations who have been subjected to serious physical and mental pain and suffering as a consequence of non-state torture victimization.

CNA can offer and strengthen nursing leadership to registered nurses, the ethic and practice of the nursing profession and the delivery of care within the health-care system to become informed about caring for persons who have suffered non-state torture victimization, thereby initiating excellence in addressing specific inequalities and inequities and the lack of professional knowledge this vulnerable population is presently challenged by.

CNA’s support of this resolution will help to facilitate public knowledge and healthy public policy on how best to serve this specific vulnerable population. It will promote the ability for non-state-torture-informed nursing care to develop as well as work to help prevent and minimize this specific form of violence, thereby increasing the potential to develop nursing and health-care interventions in collaborations with other stakeholders, both nationally and internationally, as non-state torture victimization is an international reality (Sarson & MacDonald, 2016a).

Key stakeholders:

- RN associations
- Educational resource for other health-care providers with whom RNs work, both within institutions and in the community
- Educators and the students they teach
- Canadian Nursing Students’ Association
- Nursing researchers

- Canadian Network of Nursing Specialties, especially for nurses in public health involved in the Community Health Nurses of Canada, members of the Canadian Forensic Nurses Association, the Association of Women's Health, Obstetrics and Neonatal Nurses, and the Canadian Federation of Mental Health Nurses, as well similar international nursing associations
- Resource knowledge when negotiating with Health Canada for the promotion of inclusive and informed public health policies
- Knowledge to share with ICN
- NGOs working in the area of eliminating all forms of violence and discrimination against women and girls
- School-based nurses who may be utilizing the UN *Declaration on Human Rights Education and Training* (2011)

Estimated resources required or expected outcomes:

- Staffing time and paper on which to write a submission statement to the government of Canada (if mailed, no postage is required).
- Staffing time to develop a position statement on the human right violation of non-state torture.
- In-kind hours by the submitters of this resolution to assist CNA, if required.

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BE IT RESOLVED THAT the Canadian Nurses Association (CNA) and its provincial and territorial members study the personal and professional impact and implications to nursing practice around medical assistance in dying (MAID), including anticipation and implications of further addendums to the current legislation that would include individuals with written and notarized advance care directives, mature minors and individuals suffering solely from mental illness.

BE IT FURTHER RESOLVED THAT CNA additionally anticipate and study the implications around a legally designated substitute decision-maker whose legislated responsibility and accountability is to speak on behalf of the person when they are not able to speak or follow the process by themselves.

BE IT FURTHER RESOLVED THAT CNA work with jurisdictional representatives and stakeholders to develop tools to guide nurses in managing discussions around MAID and implementing MAID into their practice.

Name of submitter:

Association of Registered Nurses of British Columbia (ARNBC)

Rationale:

It has been almost one year since Bill C-14 received royal assent, making medical assistance in dying (MAID) law throughout Canada. Today, nursing regulators, professional associations, educators, employers and nurses continue to work toward addressing its multi-faceted implications to nursing practice. After the passing of Bill C-14, the federal government committed to further studying MAID among three groups that were identified to be particularly complex. These include mature minors, individuals with advance requests and requests from individuals suffering solely from mental illness. The Council of Canadian Academies has been tasked to study the possible expansion of Bill C-14's eligibility criteria as requested by the minister of health and the minister of justice and attorney general of Canada (Council of Canadian Academies, 2017). Findings are to be tabled in Parliament before the end of 2018.

Many nurses across Canada who provide care to patients requesting MAID have been faced with multiple professional and personal ethical questions. If Bill C-14's eligibility criteria expands to include these three populations, nursing must be ready to respond to the unique and unprecedented situations that Canadian nurses will face. Supporting nursing practice within the context of MAID has proven to be complex, requiring significant clarity and practice support.

While CNA's *National Nursing Framework on Medical Assistance in Dying in Canada* offers an important foundation for nurses engaging in MAID in today's context, there has been no concrete discussion around the implications to nursing practice when and if MAID shifts to these three specific populations. In anticipation of changes to the eligibility criteria in Bill C-14, further CNA leadership is required to chart a course for Canadian nurses.

Relevance to CNA's mission and goals:

As per CNA's national framework around MAID, "Canada's nurses will continue to have a significant role in providing high-quality, person-centred end-of-life care that includes palliative care and natural death or MAID" (p. 3). Advancing this resolution will ensure that nurses across the country will be ready and supported to continue to provide high-quality, person-centred care if the

eligibility criteria in Bill-C14 expands to include mature minors, those suffering solely from mental illness and individuals with advance requests.

Advancing this resolution will further support components of CNA's mission, which aims to:

- promote nursing excellence and a vibrant profession;
- advocate for healthy public policy and a quality health system; and
- serve the public interest.

Key stakeholders:

- CNA's jurisdictional members and interest groups
- Council of Canadian Academies
- Registered Psychiatric Nurse professional associations
- Nursing regulators
- Health-care employers
- Patients
- Other jurisdictions who have explored these three unique groups
- Non-nursing professional associations and regulatory bodies

Estimated resources required or expected outcomes:

The expected outcome is the development of resources to support Canadian nurses in anticipating MAID for mature minors, those solely suffering from mental illness and individuals with advance requests. Resources will include financial and human resources to support dialogue, research and the development of policy and advocacy initiatives.

References:

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BE IT RESOLVED THAT... All First Nations, Métis and Inuit persons and communities across Canada have access to safe drinking water.

BE IT RESOLVED THAT... Federal and provincial/territorial legislator bodies foster sustainable solutions to drinking water issues through First Nations-, Métis- and Inuit-led water programs. Such sustainable solutions must take into account local contextual factors and a wider understanding of the issues that impact safe drinking water in communities (David Suzuki Foundation, 2017).

BE IT RESOLVED THAT... Federal and provincial/territorial legislator bodies recognize the leadership of First Nations governments and organizations and work collaboratively with these organizations, including the free, prior and informed consent for laws and regulations related to First Nations water (David Suzuki Foundation, 2017).

BE IT RESOLVED THAT... Solutions for safe drinking water in First Nations, Métis and Inuit communities include sufficient infrastructure funding, allocation processes and management capacity (David Suzuki Foundation, 2017).

Name of submitter:

Canadian Nurses for Health and the Environment

Rationale:

The United Nations recognizes that all humans have a right to water and sanitation, as these are essential not only to the realization of all other human rights, but to living a life in human dignity (United Nations, n.d.). The United Nations *Declaration on the Rights of Indigenous Peoples* also affirms that Indigenous individuals have an “equal right to the enjoyment of the highest attainable standard of physical and mental health,” and that “states shall take the necessary steps with a view to achieving progressively the full realization of this right” (United Nations, 2008. Article 24.2).

Despite this, in the fall of 2016, even with the creation of the *Safe Drinking Water for First Nations Act* (2013), there were 151 drinking water advisories in First Nations communities across Canada. One hundred of these advisories are issued on a regular basis, many for as close as 20 years (David Suzuki Foundation, 2017). As per the World Health Organization (2016), lack of access to clean water has deleterious impacts on health: contaminated water and poor sanitation result in elevated risks of disease transmission, and inadequate water and sanitation services expose communities to preventable health risks. There are also multiple economic and social consequences due to the time and efforts needed for collecting and storing safe drinking water.

Relevance to CNA’s mission and goals:

This resolution is consistent with the CNA mission to take an active role in the advancement of high-quality health care for all and to voice concerns on issues related to nursing and the health of all those living in Canada (CNA, 2017). Social justice is an integral component of CNA’s mission, vision and values, such as the promotion of justice, safeguarding human rights, equity and fairness, as well as promoting the public good (CNA, 2010). This resolution is also consistent with the 2016 CNA resolution, Honouring and Respecting Canada’s Obligation to Indigenous Peoples (CNA, 2016).

Key stakeholders:

- CNA's jurisdictional members and stakeholders
- First Nation, Inuit, Métis leadership and communities
- Federal and provincial/territorial regulatory bodies and legislators, federal minister of health

Estimated resources required or expected outcomes:

The expected outcome is safe accessible drinking water for all First Nations, Métis and Inuit communities of Canada with the shortest possible delay.

Estimated resources include expenditures to ensure advocacy and involvement from CNA to follow up with federal, provincial/territorial and local First Nations, Métis and Inuit regulatory bodies, in concert with the Assembly of First Nations and NGOs — including the David Suzuki Foundation, Amnesty International, the Council of Canadians, Human Rights Watch International — as to the progress of the above-named resolutions so as to ensure accountability of these varied levels of Canadian government bodies to meeting these goals. Resources needed also include communiqués and external communication on these issues.

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Canada violates human right to safe water, says report by international watchdog. (2016, June 7). *CBC News*. Retrieved from <http://www.cbc.ca/news/canada/thunder-bay/human-rights-water-first-nations-1.3619218>

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BE IT RESOLVED THAT the Canadian Nurses Association (CNA) make a concerted effort to increase the ecoliteracy of the future and current nursing workforce to address the increasing concerns related to environmental health.

Name of submitter:

Canadian Nurses for Health and the Environment

Rationale:

With an increasing amount of evidence demonstrating a relationship between human health and environmental health, it can be inferred that health-care providers, including nurses, will require an expanded body of knowledge to address the related human health concerns (Bentley, 2013; Canadian Nurses Association [CNA], 2013). Analysis of the literature indicates that nurses' lack of environmental health training is a barrier to incorporating environmental health concepts into practice (CNA, 2009; Hewitt, Candek, & Engel, 2006; Hill, Butterfield, & Kuntz, 2010; Tinker, Postma, & Butterfield, 2010; Van Dongen, 2002), inhibiting their ability to address the environment as a determinant of health. This data coincides with literature identifying that environmental health concepts taught in nursing programs at the undergraduate level are lacking (Gerber & McGuire, 2010). Barna, Goodman, and Mortimer (2012) recognize the need for the inclusion of basic concepts connecting the natural environment and human health within undergraduate nursing programs to support literacy amongst our future nurse leaders. The deficiency in environmental health knowledge noted within the nursing profession further validates the need for undergraduate curriculums and continuing education programs to be inclusive of content relating to the environmental determinants of health (CNA, 2009; Anderko & Koepsel, 2009) as well as growing ecological health concerns.

Relevance to CNA's mission and goal:

This resolution is consistent with four CNA position statements: *Climate Change and Health*; *Nurses and Environmental Health*; *Environmentally Responsible Activity in the Health-care Sector*; and *Toward an Environmentally Responsible Canadian Health Sector*. The resolution has a direct relationship to the following CNA mission and goal statements: strengthening nursing leadership while advancing the profession; promoting nursing excellence and, at the same time, enhancing the role of the registered nurse to maintain a vibrant profession; advocating for healthy public policy and a quality health system at various levels; as well seeking to serve the public interest. This resolution sets forth to broadly engage nurses in advancing nursing and health.

Key stakeholders:

- CNA's jurisdictional members and their special interest groups
- Provincial regulatory bodies and associations, where applicable
- Canadian Association of Schools of Nursing (CASN)
- Canadian Nursing Students' Association
- Canadian Coalition for Green Health Care

Estimated resources required or expected outcomes:

Request that CNA, in conjunction with the Canadian Nurses for Health and the Environment, revise and redistribute the previous survey, titled *Nurses and Environmental Health* (2008).

Ongoing dialogue with provincial/territorial regulatory bodies relating to the competencies required of registered nurses regarding environmental health specifically.

Ongoing dialogue with CASN to discuss the potential for an increased infusion of content that would support a higher level of ecoliteracy amongst the future and current nursing workforce.

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BE IT RESOLVED THAT the Canadian Nurses Association (CNA) advocate for increased access to injectable opioid agonist therapy to support greater treatment options for people who use drugs across Canada.

Name of submitter:

Association of Registered Nurses of British Columbia (ARNBC)

Rationale:

The high death toll associated with the current opioid crisis continues to demonstrate the strong need to expand harm reduction strategies across Canada. Research illustrates that there are significant benefits to implementing injectable opioid agonist therapy, specifically, heroin-assisted treatment (HAT) on patient outcomes. Advocates across the world continue to advocate for HAT for long-term opioid users who have not benefited from conventional treatments. In North America, two HAT clinical trials, including the North American Opiate Medication Imitative (NAOMI) study and the Study to Assess Long-Term Opioid Maintenance Effectiveness (SALOME), conducted at Providence Crosstown Clinic in the Downtown Eastside of Vancouver, have shown promising results.

The NAOMI Study was a randomized control trial that tested whether diacetylmorphine (medically prescribed heroin) was more effective than methadone therapy for individuals with chronic heroin addiction who had not responded to conventional treatments. Results indicated that those receiving injectable diacetylmorphine were more likely to reduce their use of drugs, decrease engagement in illegal activities and increase the likelihood of staying in treatment when compared to oral methadone (Oviedo-Joekes et al., 2009). The SALOME study found hydromorphone (HDM) to be as effective as diacetylmorphine for those with chronic heroin addiction who had not responded to conventional treatments. Participants on both medications reported fewer use of street drugs, reduction in illegal activities and increased likelihood of staying in treatment (Oviedo-Joekes, et al., 2016).

Despite the feasibility, efficacy, safety and effectiveness of these treatments, the Providence Crosstown Clinic remains the only clinic in North America to provide injectable diacetylmorphine or prescription heroin. To date, there have been no overdose deaths associated with HAT in both Canada and Europe. As leaders in harm reduction, B.C. nurses in practice, policy and research have strongly articulated the need to expand these options across the country. As the national association representing nurses across Canada, CNA is well positioned to take on a leadership role in advocating for the expansion of injectable opioid agonist therapy to ensure that people who use drugs are provided with all possible options.

Relevance to CNA's mission and goals:

CNA has a history of advocating for evidence-informed harm reduction policies within the context of substance use.

This resolution specifically addresses the components of CNA's mission which aim to:

- Advocate for healthy public policy and a quality health system
- Serve the public interest

Key stakeholders:

- CNA's jurisdictional members and networks
- B.C. Coalition of Nursing Associations
- Canadian Association of People Who Use Drugs (CAPUD)
- Canadian Public Health Association (CPHA)
- Harm reduction nursing experts
- Providence Crosstown Clinic (Vancouver, B.C.)
- Canadian Drug Policy Coalition

Estimated resources required or expected outcomes:

The expected outcome is the development of advocacy and policy resources to support the expansion of injectable opioid agonist therapy across Canada. Resources will include financial and human resources to support dialogue, research and the development of policy and advocacy initiatives.

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BE IT RESOLVED THAT the Canadian Nurses Association (CNA) continue to support greater harm reduction approaches within the context of substance use by advocating for the decriminalization of drugs across Canada.

Name of submitter:

Association of Registered Nurses of British Columbia (ARNBC)

Rationale:

Despite the strong evidence that supports harm reduction approaches in improving the health and well-being of individuals who use drugs, significant barriers continue to exist as decision-makers approach drug use as a criminal issue rather than a health issue. In 2016 alone, 914 British Columbians died of a drug overdose. Harm reduction practitioners across the country have begun discussing policy options, including the decriminalization of hard drugs, to combat the current opioid crisis. While policy changes such as the introduction of Bill C-37, currently in committee (Senate), will provide greater access to options such as supervised consumption sites, other solutions are required to address the underlying causes of addiction.

Multiple health care advocacy groups have been vocal around the need to address substance use — not only through prevention, treatment and enforcement, but harm reduction as well. In B.C., top health officials have called for changes to drug policy that support an end to the “war on drugs,” which has invested largely in law enforcement rather than evidence-based harm reduction initiatives. Contrary to the popular belief that criminal prohibition decreases drug use and its associated harms, evidence suggests that criminal prohibition creates a highly lucrative illegal market and in fact increases harms (Canadian Drug Policy Coalition, 2012).

Several jurisdictions across the world have decriminalized drug possession at varying degrees, illustrating both economic and health benefits. Notably, since Portugal decriminalized low-level possession and use of all illicit drugs in 2001 research has shown: (1) no major increases in drug use; (2) problematic and adolescent drug use has been reduced; (3) fewer people have been arrested and incarcerated for drugs; (4) more people have been receiving drug treatment; and (5) there has been a reduction in HIV/AIDS incidence, drug induced deaths and social costs associated with drug misuse (Drug Policy Alliance, 2015).

B.C. nurses understand the need to adopt forward thinking and evidence-based policies to reform Canada’s drug policies. Nurses in direct care, policy and research working within the area of harm reduction are vital in providing leadership to advance this policy direction. As the national voice of nursing in Canada, CNA is well positioned take on a leadership role in advancing this resolution.

Relevance to CNA’s mission and goals:

CNA has a history of advocating for evidence-informed harm reduction policies within the context of substance use. This resolution specifically addresses the components of CNA’s mission which aim to:

- Advocate for healthy public policy and a quality health system
- Serve the public interest

Key stakeholders:

- CNA's jurisdictional members and networks
- B.C. Coalition of Nursing Associations
- Canadian Association of People Who Use Drugs (CAPUD)
- Canadian Association of Nurses in AIDS Care
- Canadian Public Health Association (CPHA)
- Harm reduction nursing experts
- Canadian Drug Policy Coalition

Estimated resources required or expected outcomes:

The expected outcome is the development of advocacy and policy resources to support the decriminalization of drugs across Canada. Resources will include financial and human resources to support dialogue, research and the development of policy and advocacy initiatives.

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