Entry-to-Practice Mental Health and Addiction Competencies for Undergraduate Nursing Education in Canada

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Table of Contents

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Introduction

In 2014 the Canadian Association of Schools of Nursing (CASN) partnered with the Canadian Federation of Mental Health Nurses (CFMHN) to develop a national, consensus-based framework of essential discipline-specific, entry-to-practice mental health and addiction competencies and indicators. The purpose of the framework is to promote the integration of core content related to mental health and addictions in undergraduate nursing education in Canada.

Nurses provide care to people experiencing issues related to mental health and addictions in all service sectors. The competencies and indicators, therefore, delineate the essential knowledge, attitudes, and skills all new nurses should possess related to mental health and addictions regardless of where they are employed following graduation. The ensuing CASN/CFMHN competencies reflect the regulatory bodies' entry-to-practice competencies relevant to mental health and addictions that schools of nursing are required to integrate into curricula. However, they are more detailed and specific in order to offer greater guidance to educators. The competencies also reflect the standards for Psychiatric/Mental Health Nurses in Canada (CFMHN, 2014) for entry-level nurses, with a generalist nurse in view, who may or may not enter this specialty field of the profession following graduation.

Preamble

It is estimated that one in five Canadians will develop at least one psychiatric or behavioural disorder in their lifetime, with depression the most prevalent across age groups, social class, and cultures (Mental Health Commission of Canada [MHCC], 2013a). According to the MHCC, over 6.7 million people in Canada are currently experiencing a mental health condition (to put this into perspective, 2.2 million are living with type 2 diabetes) (MHCC, 2013a). Alongside a devastating human toll, the economic costs are estimated to be at least $50 billion. This includes an approximate $6 billion in lost productivity, largely due to the widespread mental health conditions affecting people of working age. The largest cost included in the $50 billion comes from health care, social services, and income support (Lim, Jacobs, Ohinmaa, Schopflocher, & Dewa, 2008).

Mental health conditions take many forms and are truly universal. They affect all ages, genders, geographical locations, ethnic backgrounds, and societies. They are not uncommon among people presenting in emergency departments or among those being treated for health problems across other care settings. Indeed, nurses in almost any area of service are likely to care for patients who are experiencing, or have experienced, varying degrees of mental health conditions (Nadler-Moodie, 2010). It is essential that nursing education equip future nurses to provide quality care to these clients.

There has been a shift to combine what were previously separate systems for mental health and addictions. In 2009, the Canadian Center on Substance Abuse (CCSA) released a report entitled *Substance abuse in Canada: Concurrent disorders.* CCSA (2009) identified a pressing need to integrate mental health and addiction services, pointing out that more than half of those being treated for an addiction also have a mental health condition, and about 20% of those being treated for a mental health condition are living with an addiction. CCSA concluded that "the integration of training, services and programs for substance use and mental health disorders within health care, mental health, education, social service, and criminal justice systems would result in improved care" (CCSA, 2009, p. 9). In light of this shift, CASN and the CFMHN, along with the task force, made the decision for the competencies to clearly refer to mental health conditions and to addiction.

Terminology

An extensive debate currently exists over what terms to use when discussing mental health issues. Members of the task force and stakeholders who attended the in-person forum examined this question at length. While some prefer mental illness, mental health disorder, or mental health problem, for the purpose of this framework, the task force decided to use the term mental health condition which is consistent with terminology used by the World Health Organization (2010).

Further discussions were also held around the terminology of addiction and substance abuse. Substance abuse often refers to a drug or alcohol addiction. However, to be inclusive of process addictions, the term addiction was chosen. In this document, therefore, addiction refers to substance abuse and process addictions.

Key Perspectives

A number of perspectives related to mental health and addiction underpin the competency framework and are reflected in the competencies and indicators.

Mental health promotion

Mental health promotion was an approach to care that continued to be discussed both among the task force and at the stakeholder forum. In 1996 the University of Toronto's Centre for Health Promotion, in collaboration with the Mental Health Promotion Unit of Health Canada, defined mental health promotion as:

> the process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health. Mental health promotion uses strategies that foster supportive environmental and individual resilience, while showing respect for culture, equity, social justice, interconnections, and personal dignity. (Centre for Addictions and Mental Health [CAMH], 2010, p. 16)

Similarly, the Canadian Mental Health Association (CMHA) (2008) views mental health promotion as the actions taken to strengthen mental health that includes enhancing capacity to take control of life and health, promoting resiliency, being reliant on intersectoral linkages, and having a positive perspective. Mental health promotion is, therefore, an asset-focused approach to care rather than a deficit-based one.

Recovery oriented

Another key perspective guiding the competency development is the belief that identified mental health and addiction services and care must be recovery oriented.

> Recovery is not the same as being cured. For many affected individuals, recovery constitutes living a satisfying, hopeful, and productive life even with the limitations caused by mental illness; for others, recovery means the reduction or complete remission of symptoms related to mental illness. (Standing Senate Committee of Social Affairs, Science, And Technology, 2006, p. 5)

What constitutes recovery is unique to each individual, and varies depending on the client's needs and wants, as well as their lived experience. A recovery perspective leads to collaboration and shared decision making between the health care provider and the client. MHCC has urged all health service providers to ensure their care is recovery oriented, and many provincial governments have embraced this movement (Cavanaugh, 2014).

Trauma-informed approach

Understanding root causes of a mental health condition or an addiction is an integral part of the recovery process. In order to sensitively and effectively care for clients with substance abuse problems, the CCSA advocates for a trauma-informed approach. Past trauma, either single-incident or long-term sustained trauma, is commonly associated with substance abuse and mental health conditions. Encompassing past trauma into the current plan of care in a "treatment culture of non-violence, learning and collaboration" (CCSA, 2014) can create an empowering environment for the client (British Columbia Centre for Excellence in Women's Health [BCCEWH], 2013). Given the prevalence of trauma among individuals experiencing mental health conditions and addictions, it is important that nursing graduates possess foundational knowledge related to trauma and trauma-informed approaches when caring for clients.

Stigma as a Barrier
Stigma is defined by the MHCC as "a complex social process that marginalizes and disenfranchises people who have a mental illness and their family members" (MHCC, 2013b, p. 2). According to the MHCC (2013b), up to 60% of people with mental health conditions will not seek the help they need, and stigma is often a major factor for this. Many who have received treatment for a mental health condition have found the stigma they face as difficult to live with as the condition itself (Corrigan, Druss, & Perlick, 2014).

Health care providers may not be aware that their words and behaviour perpetuate mental health stigma in health care settings (Langille, 2014). MHCC (2013b) has identified past incidents of diagnostic overshadowing, prognostic negativity, and marginalization in health care settings resulting from negative beliefs or opinions held by health care professionals. This type of stigma can be greatly reduced through the education of pre-licensure health professionals.

Mental health continuum
To craft a full picture of mental health, Epp (1988) put forward the notion that mental illness cannot be separated from mental health; but rather that mental illness can act as a contributing factor, or an obstacle to mental health. Epp visualized mental health and mental illness as belonging to two separate continuums that when considered together, would encompass "a range of different situations in which symptoms of mental disorder would be present to varying degree[s]" (Epp, 1988, p. 334). Further, Keyes (2002) described adults with complete mental health as flourishing in life with high levels of well-being, and adults with incomplete mental health as languishing in life with low well-being. Figure 1 (Together to Live, 2014) depicts the notion that mental health is not simply the absence of mental health, but rather looks at mental illness in relation to mental well-being. Keyes finds that "mental health is best operationalized as a syndrome that combines symptoms of emotional well-being with symptoms of psychological and social well-being" (Keyes, 2002, p. 608).
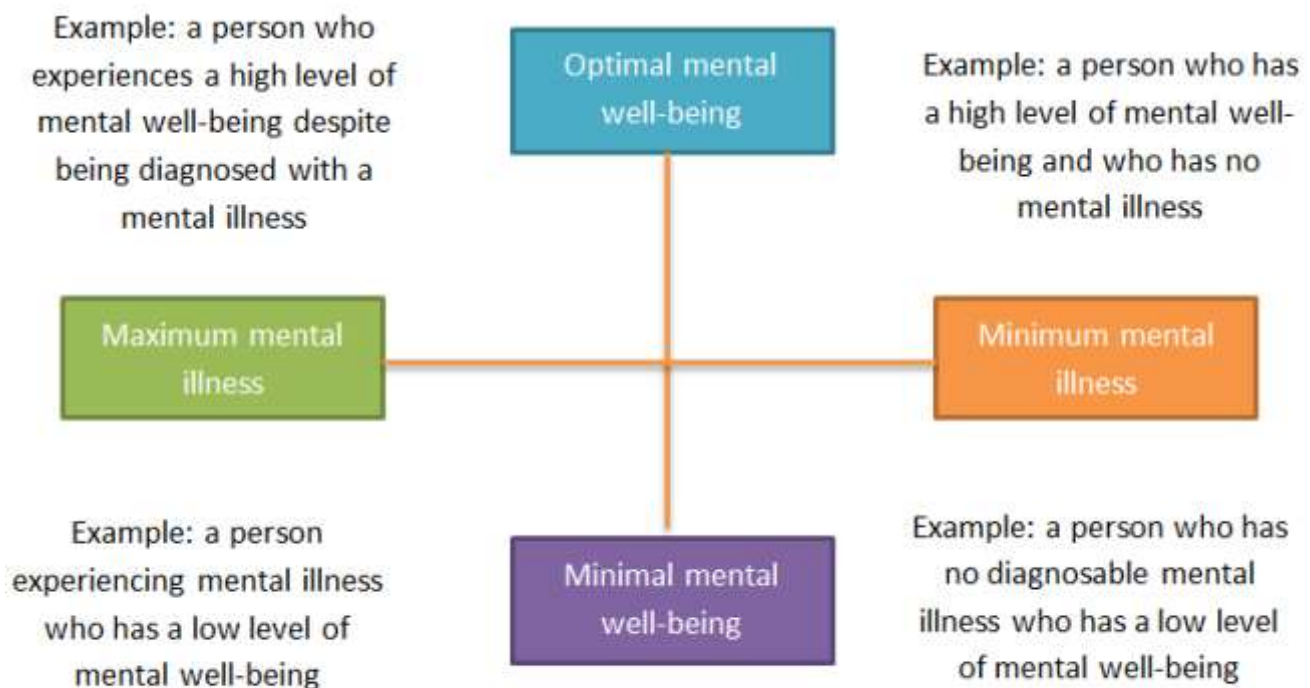

Figure 1: Mental Health Continuum (Source: Together to Live, 2014)

Methods

A task force of experts from across Canada was struck to guide the development of the competencies. The task force included regional representation, as well as representation from various specializations within mental health nursing, including those working with youth, adults, and older adults living with addictions and other mental health concerns such as dementia, depression, and schizophrenia.

A review of the literature and identification of existing competencies on mental health and addiction for health professionals was carried out to support an initial draft of competency statements and their accompanying set of indicators. This draft was revised multiple times by the task force who continued to seek out relevant literature, and meet regularly via teleconference and go-to-meetings to discuss key issues and continuously modify the competencies and indicators.

Once a final draft of the competencies was adopted by the task force, CASN and CFMHN, in collaboration with the Registered Nurses Association of Ontario (RNAO), held a one and a half day Stakeholder Forum in Toronto on March 4 and 5, 2015, for wider consultation. The competencies and indicators were reviewed and in-depth feedback was given from experts in mental health and addiction, nursing education, representatives from across the continuum of care (i.e., primary care, public health and acute care), practice and policy, and individuals with lived experience from across Canada. Following the forum, the feedback was collated and integrated into another draft of the competencies. The revised version of the competencies and indicators was sent out nationally to obtain feedback, using Fluid Surveys, an online program, and a snowball sampling method. All heads of schools of nursing across Canada, the stakeholder forum attendees, the CASN education committee, the CASN mental health interest group, and the CFMHN education committee received the survey. Each recipient was also invited to distribute the online survey to their networks.

There were 90 responses to the survey, with a 64% completion rate. Respondents were asked to rate each competency and indicator as one of the following; "essential", "important", "somewhat important", "not important to entry-level mental health and addiction nursing practice", or to indicate if they did not know. To determine consensus, it was established that if less than 50% of the responses indicated "essential", the competency or indicator was reviewed. The survey received responses from educators, health authorities, and mental health centres from across Canada. The survey largely validated the work of the task force and the outcomes from the in-person stakeholder forum.

Competency Framework

The ensuing mental health and addiction competencies are one of a number of competency documents developed by CASN. CASN entry-level competencies for a specific area of nursing are developed for one of two reasons. The first is to provide schools of nursing with guidance regarding the integration of an emerging and growing content area such as nursing informatics into curricula. The second reason is to determine from a national, consensus-based perspective, what the core entry-level competencies should be in a given, longstanding specialty area of nursing education. These are intended to be consistent with a generalist education and reflect required regulatory body entry-to-practice competencies but provide greater specificity and detail. The mental health and addiction competencies fall into the second category. The purpose in developing these competencies and indicators is to enhance mental health and addiction content in curricula by clarifying the essential expectations for all undergraduate nursing graduates.

Domains are the organizing categories of competencies. To ensure consistency with provincial/territorial regulatory entry-to practice competencies, the core mental health competencies for RN graduates have been organized into the five domains developed by the regulatory bodies in Canada. Each domain includes a competency followed by a set of indicators.

The domains:

Professional Responsibility and Accountability: refers to professional conduct, adherence to the provincial/territorial regulatory bodies' standards, and safe, ethical, and competent nursing care (College of Nurses of Ontario [CNO], 2014; College of Registered Nurses of British Columbia [CRNBC], 2015).

Knowledge-Based Practice: refers to a specialized body of knowledge from nursing and other sciences, humanities, research, ethics, spirituality, relational practice, critical inquiry, and principles of primary health care (Association of Registered Nurses of Newfoundland and Labrador [ARNNL], 2013; Saskatchewan Registered Nurses Association [SRNA], 2013). Also refers to the ability to apply knowledge in the four components of RN care (assessment, health care planning, providing care, and evaluation) (SRNA, 2013).

Ethical Practice: refers to exercising competent, professional judgement and practice decisions that are guided by the code of ethics for registered nurses. Critical inquiry informs the nurse's decision-making, and the nurse develops relationships with clients and other health care team members that are therapeutic, caring, and culturally safe (College and Association of Registered Nurses of Alberta [CARNA], 2013; College of Registered Nurses of Manitoba [CRNM], 2013).
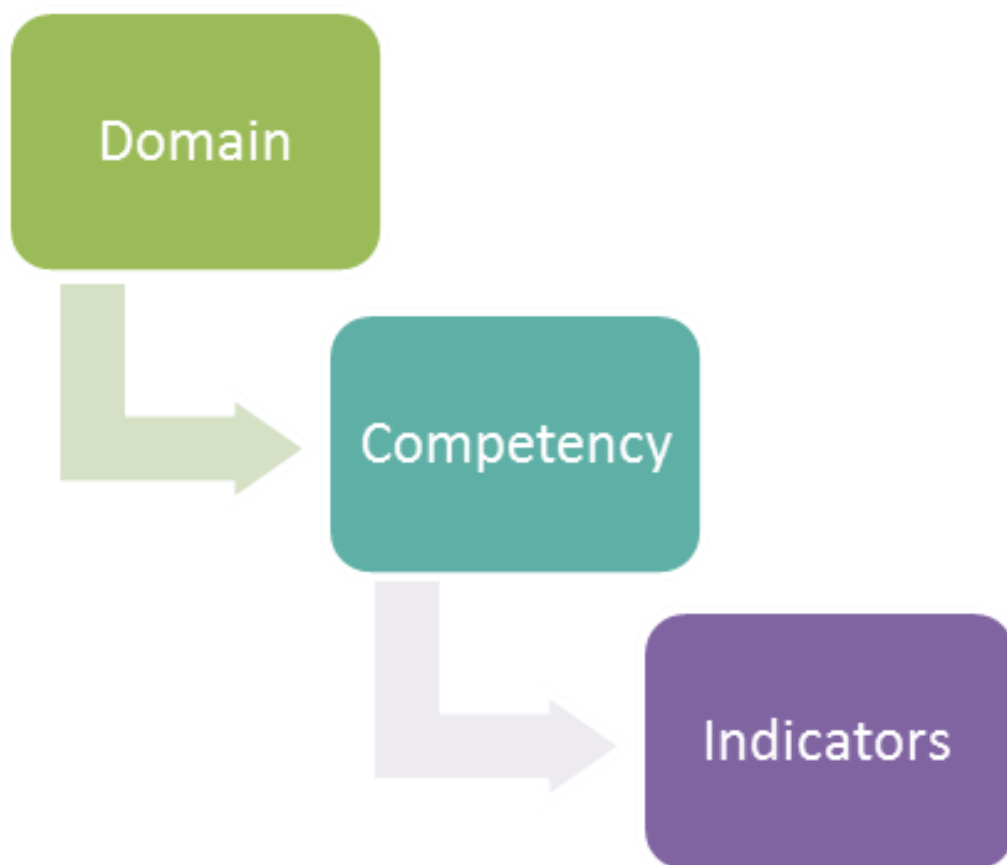
Service to the Public: refers to the nurses' ability to show their understanding of the notion of public protection, and their responsibility to provide care in the public's best interest (Nurses Association of New Brunswick [NANB], 2013; College of Registered Nurses of Nova Scotia [CRNNS], 2013).

Self-Regulation: refers to the understanding of the importance of professional self-regulation, demonstrated by continual development of own competence, safe practice, and maintenance of personal fitness to practice (Association of Registered Nurses of Prince Edward Island [ARNPEI], 2011).

A competency is defined as "a complex *know-act* that is based on combining and mobilizing knowledge, skills, attitudes, and external resources and then applying them appropriately to specific types of situations" (Tardif, 2006).

Indicators are defined as "assessable and observable manifestations of the critical learnings needed to develop the competency" (Tardif, 2006).

For the purpose of this document, the term **persons** refers to clients, individuals, families, groups, communities, or populations.

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        │  Indicators │
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Entry-to-Practice Mental Health and Addiction Competencies for Undergraduate Nursing Education in Canada

Domain 1	Professional Responsibility and Accountability

Competency 1

The nurse provides care in accordance with professional and regulatory standards when promoting mental health and preventing or managing mental health conditions and/or addiction.

Indicators

1.1 Understands and applies mental health related legislation, and upholds the rights and autonomy of persons with a mental health condition and/or addiction.

1.2 Therapeutically engages with persons experiencing a mental health condition and/or addiction, with dignity and respect.

1.3 Recognizes stigmatizing and discriminating attitudes regarding mental health conditions and addiction in health care professionals and/or self, as well as the detrimental impact of such attitudes on health care outcomes and responds therapeutically.

1.4 Applies policies related to principles of health promotion and prevention of injury (i.e. least restraint) in caring for persons with a mental health condition and/or addiction.

1.5 Demonstrates knowledge related to the process of voluntary and involuntary care.

1.6 Protects clients, self and others from harm in situations where a person with a mental health condition and/or addiction poses a safety risk, while maintaining the client's dignity and human rights.

<table>
<tr><td>**Domain**

2</td><td>Knowledge-Based Practice</td></tr>
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Competency 2 — The nurse uses relational practice to conduct a person-focused mental health assessment, and develops a plan of care in collaboration with the person, family, and health team to promote recovery.

Indicators

Knowledge

2.1 Demonstrates an understanding of the concepts of mental health, developmental, and situational transitions, and the spectrum of mental health conditions and addictions as they are manifested in individuals across the lifespan.

2.2 Demonstrates an understanding of how mental health comorbidities increase severity, levels of disability, and use of mental health services.

2.3 Describes key elements of relevant theories, including but not limited to stress, coping, adaptation, development, harm reduction, crisis intervention, recovery, loss, and grief, and articulates their implications for clinical practice.

2.4 Demonstrates knowledge of the possible effects of complementary therapies on mental health conditions and addiction.

2.5 Understands the complex interrelationship of physiology, pathophysiology, and mental health (e.g., neuroleptic malignant syndrome, delirium, hypertension, etc.).

2.6 Demonstrates knowledge of medications used to treat addiction and withdrawal, including opiate replacement medications.

Assessment

2.7 Conducts a mental status exam.

2.8 Uses a range of relational and therapeutic skills including listening, respect, empathy, reaffirmation, mutuality, and sensitivity in assessments and care planning for persons experiencing a mental health condition and/or addiction.

2.9 Demonstrates the ability to identify clients' emotional, cognitive and behavioural states, as well as level of anxiety, crisis states, indices of aggression, self-harm, suicide, risk to others, competency to care for self, and signs of substance abuse, addiction, and withdrawal.

Planning Care

2.10 Plans care in partnership with clients to promote mental health, prevent a mental health condition and addiction, minimize negative effects on physical health, manage or reduce symptoms of mental health conditions, and foster recovery and resilience.

2.11 Recognizes the role of social determinants of health on mental health outcomes and incorporates this when planning care of persons experiencing a mental health condition and/or addiction.

2.12 Uses a trauma-informed approach to plan care and recognizes the negative effects of violence, abuse, racism, discrimination, colonialization, poverty, homelessness, and early childhood maltreatment (such as neglect) on mental health.

Domain 2	Knowledge-Based Practice

Competency 3

Provides and evaluates person-centered nursing care in partnership with persons experiencing a mental health condition and/or addiction, along the continuum of care and across the lifespan.

Indicators

3.1 Communicates therapeutically with persons and families who are experiencing a range of mental health conditions and/or addiction, abuse, bereavement, or crisis.

3.2 Uses self therapeutically in providing health-promoting, preventive and supportive care for persons experiencing a mental health condition and/or addiction.

3.3 Engages clients in strengths-based care that promotes resilience.

3.4 Advocates for persons experiencing a mental health condition and/or addiction.

3.5 Demonstrates basic knowledge of psychobiology in relation to psychopharmacology, and the therapeutic dose range, side effects, interactions, and adverse effects of psychotropic medications across the lifespan.

3.6 Engages individuals and families in learning about a mental health condition and/or addiction and its management.

3.7 Provides care to persons experiencing a mental health condition and/or addiction that is recovery oriented, trauma-informed and uses principles of harm reduction and addresses social determinants of health.

3.8 Administers medication used to treat a mental health condition and/or addiction safely, monitors clients for therapeutic effects, side effects, and adverse reactions to medications, and intervenes effectively when side effects and adverse effects of medications occur.

Domain **3**	Ethical Practice

Competency 4	Acts in accordance with the CNA Code of Ethics when working with persons experiencing a mental health condition and/or addiction.

Indicators

4.1 Provides a safe and respectful environment to voluntary and involuntary clients seeking or receiving treatment for a mental health condition and/or addiction.

4.2 Assists persons with a mental health condition and/or addiction in making informed decisions about their health care and symptom management.

4.3 Demonstrates cultural competency and cultural safety when caring for diverse persons with a mental health condition and/or addiction.

Domain 4	Service to the Public

Competency 5 — The nurse works collaboratively with partners to promote mental health and advocate for improvements in health services for persons experiencing a mental health condition and/or addiction.

Indicators

5.1 Demonstrates knowledge of the health care system in order to contribute to the improvement of mental health and addiction services.

5.2 Recognizes the impact of the organizational culture on the provision of mental health care to persons experiencing mental health conditions and addiction, and acts to ensure appropriate services are delivered safely.

5.3 Facilitates and engages in collaborative, inter- and intra-professional, and intersectoral practice when providing care for persons with a mental health condition and/or addiction.

Domain 5	Self-Regulation

Competency 6

Develops and maintains competencies through self-reflection and new opportunities working with persons experiencing a mental health condition and/or addiction.

Indicators

6.1 Evaluates one's individual practice and knowledge when providing care to persons with a mental health condition and/or addiction, and seeks help as required.

6.2 Identifies one's own morals, values, attitudes, beliefs, and experiences related to mental health conditions and/or addiction and the effect these may have on care.

6.3 Identifies learning needs related mental health conditions and addiction.

6.4 Seeks new knowledge, skills, and supports related to mental health conditions and addiction.

6.5 Evaluates self-learning related to mental health conditions and addiction.

Glossary

Term	Definition
Addiction	"Used as an umbrella term inclusive of substance misuse, substance abuse, substance dependence, and process addictions such as gambling" (Kent-Wilkinson et al., 2015, p. 21).
Advocate	"To speak or act on behalf of self or others by respecting decisions and enhancing autonomy" (Canadian Council for Practical Nurse Regulators [CCPNR] 2013, p. 11).
Collaborative practice	"In healthcare, occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings. Practice includes both clinical and nonclinical health-related work, such as diagnosis, treatment, surveillance, health communications and management" (World Health Organization, 2010, as cited in Registered Psychiatric Nurse Regulators of Canada [RPNRC], 2014, p. 24).
Competencies	"Competencies are complex know-acts based on combining and mobilizing internal resources (knowledge, skills, attitudes) and external resources and applying them appropriately to specific types of situations" (Tardif, 2006).
Culture	"The shared beliefs, values and practices of a group that shape a member's thinking and behaviour in patterned ways. Culture can also be viewed as a blueprint for guiding actions that impact care, health and well-being" (Halter, 2014, as cited in RPNRC, 2014, p. 24).
Cultural safety and cultural competence	"A set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals, and enables… [them] to work effectively in cross-cultural situations" (Canadian Nurses Association [CNA], 2010, p. 1).
Determinants of Health	"The health of individuals is determined by a person's social and economic factors, the physical environment and the person's individual characteristics and behaviour. The determinants include income and social status; social support networks; education and literacy; employment/working conditions; social environments; physical environments; personal health practices and coping skills; healthy child development; biology and genetic endowment; health services; gender; and culture" (Public Health Agency of Canada [PHAC], 2013, as cited in RPNRC, 2014, p. 24).

Mental disorder	"A health condition characterized by alterations in several factors that include mood, affect, behaviour, thinking, and cognition. The disorders are associated with various degrees of distress and impaired functioning" (Austin & Boyd, 2009, as cited in CFMHN, 2014, p. 13).
Mental health	"The capacity of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity" (PHAC, 2006).
Mental health promotion/mental illness prevention	"Mental health promotion aims to foster positive mental health for all people, regardless of whether they are living with a mental health problem or illness, while prevention focuses on measures taken to prevent mental health problems and illnesses, to the greatest extent possible. Efforts to promote mental health and well-being can overlap with those directed at preventing mental health problems and illnesses" (MHCC, 2009, p. 122, as cited in CFMHN, 2014, p. 13).
Mental illnesses	"Characterized by alterations in thinking, mood or behaviour—or some combination thereof—associated with significant distress and impaired functioning. The symptoms of mental illness vary from mild to severe, depending on the type of mental illness, the individual, the family and the socio- economic environment. Mental illnesses take many forms, including mood disorders, schizophrenia, anxiety disorders, personality disorders, eating disorders and addictions such as substance dependence and gambling" (PHAC, 2006, para 2).
Persons	"Throughout this document 'persons' is synonymous with clients, consumers, patients, and recipients of care across the life span" (Kent-Wilkinson et al., 2015, p. 4).
Psychopharmacology	"A sub-specialty of pharmacology that studies medications that affect the brain and behaviour and that are used to treat psychiatric and neurodegenerative disorders" (Austin & Boyd, 2010, as cited in RPNRC, 2014, p. 25).
Recipients of healthcare	"The competency set requires the use of consistent language to refer to the recipients of healthcare. The terms used by different professions/ specialties and in different settings vary widely (i.e., patient, client, or consumer) and it is clear that no single term is preferred by, and perhaps even acceptable to, the many groups and individuals involved in the delivery of integrated care" (Hoge, Morris, Laraia, Pomerantz, & Farley, 2014, p. 5).

Recovery	"is the personal process that people with mental health conditions experience in gaining control, meaning and purpose in their lives. Recovery involves different things for different people. For some, recovery means the complete absence of the symptoms of mental illness. For others, recovery means living a full life in the community while learning to live with ongoing symptoms" (CMHA, 2014b, as cited in Kent-Wilkinson et al., 2015, p. 22).
Recovery model	"A model of care which seeks to enable people living with mental health and addictions problems to enjoy a meaningful life in their community, while striving to achieve their full potential. It is built on the principles that each person should determine their own unique path to wellness, accounting for the many factors (social, economic, cultural, spiritual etc.) that have an impact on mental health and well-being" (MHCC, 2014).
Stigma	"Stigma refers to negative, unfavourable attitudes and the behaviour they produce. It is a form of prejudice that spreads fear and misinformation, labels individuals and perpetuates stereotypes" (MHCC, 2015, para 1).
Therapeutic relationship	"A relationship grounded in an interpersonal process that occurs between the nurse and the client(s). The therapeutic relationship is a purposeful, goal-directed relationship intended to advance the best interest and outcome of the client" (RNAO, 2002b, as cited in CFMHN, 2014, p. 13).

Table of Acronyms

ARNNL	Association of Registered Nurses of Newfoundland and Labrador
ARNPEI	Association of Registered Nurses of Prince Edward Island
CAMH	Centre for Addictions and Mental Health
CASN	Canadian Association of Schools of Nursing
CARNA	College and Association of Registered Nurses of Alberta
CCSA	Canadian Centre on Substance Abuse
CFMHN	Canadian Federation of Mental Health Nurses
CNO	College of Nurses of Ontario
CRNBC	College of Registered Nurses of Ontario
CRNM	College of Registered Nurses of Manitoba
CRNNS	College of Registered Nurses of Nova Scotia
MHCC	Mental Health Commission of Canada
NANB	Nurses Association of New Brunswick
RNAO	Registered Nurses Association of Ontario
SRNA	Saskatchewan Registered Nurses Association

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