WORDS, VALUES, AND CANADIANS:

A REPORT ON THE DIALOGUE AT THE NATIONAL SYMPOSIUM ON LANGUAGE

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The National Symposium on Language was held at the Morris J. Wosk Centre for Dialogue at Simon Fraser University in Vancouver on January 31, 2006. The symposium was funded and hosted by the Centre for Addictions Research of BC, the BC Provincial Health Services Authority, BC Ministry of Health, and Health Canada. The symposium involved individuals from across Canada in a day of dialogue on issues of language related to substance use. The dialogue was recorded, and later transcribed. The transcription was then analysed and used in the preparation of a first draft of this paper. The authors wish to thank all the participants and the funding partners for their contribution in helping to shape the *National Framework for Action*.

This document has benefited from the feedback of multiple participants in the National Symposium on Language, whose comments have come to reshape its various components. We have made every effort to reflect the diversity of the input provided. We acknowledge, however, that we were unable to accommodate all points, and thus this paper remains the work of the authors. We are also conscious of concerns expressed (at the Symposium itself and in its follow-up) about the lack of participation by people who use substances. The Symposium aimed for inclusivity by engaging members of the law enforcement, education, health, social service, user group, and research communities, as well as all levels of government. While each of these populations had some presence at this event, it is clear that involvement of other individuals (especially those who have traditionally gone unrepresented) would have been meaningful. Dedicated funding and support to include all voices in the future development of the *National Framework for Action* is imperative.

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Words like abuse, misuse, problematic use, user, addict, addiction, dependence, risk, tolerance, and harm reduction have different meanings to different people. The use of these terms may lend power to some persons while stigmatising others; they may facilitate certain forms of public response to drug issues while hindering others; and they may enable particular individuals to communicate intelligibly together while leaving others uninvolved and arguably excluded. Such a predicament tends to cause many of us to feel that we are talking at cross-purposes in a field that already has enough controversy and contradictory debate. The logical reaction to this predicament has been to call for the establishment of a common language that would allow everybody to speak clearly and productively with one another. The implicit assumption is that if we can set down our language in such a way that lets all stakeholders begin to use the same words to describe the same issues, then we might be better able to achieve our goals. A lexicon of terminology would thus help to fix problems with mutual intelligibility and therein allow us to progress, as a coordinated unit, toward meeting the priorities of our *National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada.*

However, as several participants in, and contributors to, the January 31, 2006 National Symposium on Language pointed out, the concept of a lexicon of substance use terms might be comfortable—but it is empty. Language is cultural; it shifts as our values shift, and folds back on itself as new concerns present themselves or as old concerns emerge anew. This means that we cannot set a word in stone today and expect it to be current tomorrow. Moreover, defining words in a dictionary is an act of power; it suggests that we know what is right, and that others are in agreement about the rightness of our words. Realistically, however, a dictionary does not ensure that everyone's voices are heard; it does not guarantee that anybody will use it; and, in the end, it does not allow for much nuance. We could update our dictionary every second day to accommodate the constant evolution of words, but even this would do little to attend to the value-laden nature of our verbiage, and it would still not recognize the fact that some people will never conform to our terms. Indeed, as Canadians *we have the right* to speak in different dialects, and this does not (nor should it) necessarily make us incomprehensible to one another. As one contributor suggested, perhaps we should be thinking about creating a *thesaurus* of terms—as opposed to a dictionary—because a thesaurus, by associating rather than defining words, can absorb the differences and nuances of dialects without invariably excluding people or attempting to control the intent of their words.

Even the nature of "words" is debatable, as was made clear by several participants in the National Symposium. Words can be understood as meaningless containers that await injection by our socio-cultural mores. Alternatively, they can be understood as structures that are inherently meaningful and have varying power depending on their status as nouns, verbs, adjectives, or adverbs. Often our words are used strategically to realize objectives, or to mask social prejudices, or to find ways to accept or avoid accountability for various circumstances. As multiple contributors noted, words are symptoms of our attitudes and values. We should not be surprised, then, to hear some individuals say that they have been shut out of the discourse on substance use, since terms like "addict" and "abuse" seem fundamentally aimed at segregating and circumscribing certain peoples and activities.

However, simply shedding one set of words in favour of another will not solve the problem. It will not stop all of the stereotypes and moral judgements behind previous words from transferring wholesale over to new terms, especially if the stereotypes and moral judgements themselves are not challenged. Creating

new strings of words such as "problematic substance use" in an attempt to be more inclusive and value-neutral in our approach is not necessarily the best response either. If a majority of individuals do not understand what the new expressions mean, or precisely how they differ from our old words, there is a strong possibility that our neologisms will do nothing more than further isolate and stigmatise our peers.

Reflecting the comments of one participant in the Symposium, it is no wonder that people are confused: doctors are speaking at one level while social workers are speaking at another; policy-makers, researchers, and people who use drugs are often situated somewhere else, and so, in the process, everyone is missing each other. Although it might be easy to turn to a lexicon for support and coordination under such circumstances, the lexicon would overlook the principle commonality that links these parties: ultimately, everyone is using language to serve interests and establish some form of advantage. For example, certain people who use substances might call themselves "junkies" in an effort to empower themselves, while the media might do the same in an effort to disempower. The medical community might understand DSM terminology as the best means to communicate about individuals in treatment, while some social scientists might understand DSM terminology as a discriminating and oppressive construct. This playing with words is complicated because it, like substance use itself, involves a balancing of costs and benefits. There is not necessarily a clear "right" or "wrong" way to use language. There are, however, some risks and some advantages that will need to be negotiated every time we enter a discourse. To call oneself a "junkie" may be a liberating experience, but it also has the potential to be an act of self-deprecation that internalises the very stereotypes and inequities that we seek to dismantle. Similarly, to use DSM terminology in a treatment setting can streamline communication between health care workers, but it also has the potential to close our eyes to other factors (e.g. beliefs or social conditions) that might be an equal part of the problem, and that need to be addressed in any solution. *Every* time we pick a word we navigate a sea of choices involving benefits and risks. This is unavoidable, but it calls us to recognise the need to analyse our language more closely each time we enter into dialogue about drugs.

Ultimately, the goal of the *National Framework for Action* should be to bridge the gap between languages so that it is not as easy for us to misunderstand or talk past (or down to) each other. While power relations will always be present in our discourses, we need mechanisms that create common frames within which to situate our various dialects. Moreover, we need mechanisms that work to moderate these power relations such that they do not manifest themselves in abusive words or behaviour, or serve to stigmatise others.[1] Specialised terminology *could* very well prove the best language for dealing with certain substance use issues in certain contexts. In a similar vein, exaggerated or hyperbolic language *could* very well prove valuable for individuals (including advocacy groups, political delegates or others) in their pursuit of funding or support for their interests. Every language may have a useful place. Yet if we continue to wield our words in such a way as to foster distance and opposition between us, there is little hope for concerted action across fields.

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[1] The issue of stigma was itself the focus of a two-day workshop intended to further the development of the *National Framework*. The workshop, entitled "Raising Public Awareness About Addictions: Creating Momentum for Action," was hosted by the Addictions Foundation of Manitoba in Winnipeg between March 2 and 3, 2006.

Participants in the National Symposium were generally of one mind in saying that unity among Canadians about substance issues will not be achieved by settling, one-by-one, on the best words to describe drugs and drug use (in fact, such a strategy might actually be impossible).[2] Different people need to express themselves in different ways. Rather than seek to deny or eliminate these dialects, we need to encourage awareness of our linguistic diversity. Some people might only have proficiency in one type of language, while others will be skilled in several. Encouraging access to a wide range of expressions to articulate our range of experiences will help to avoid exclusion while locating common ground between us. As one participant put it, we actually do not have *enough* linguistic diversity around some of our substance-related issues (e.g. how we talk about people who use *illegal* drugs). This has contributed to a very limited and uninformed discourse. Our languages, then, need to allow for a multiplicity of ideologies for no reason other than to reflect the diversity of ideologies apparent across the country. Canadians tend not to respect a single value system—generally, they are allowed the right to believe in whatever they choose to believe in, and say what they want to say. This means that a single message or term or dictionary is probably not going to be representative of the population—nor should it be. What is needed, instead, is a commitment to recognising the worth of different languages and encouraging the development of multi-lingual skills. Furthermore, articulating a series of common ideas or themes around substance-related discourse will allow us to moderate our language. *Such themes should reinforce our right to speak in whatever dialect we choose providing that, in so doing, we are not depriving our neighbours of* other *rights* (e.g. the right to safety, respect, humanity, freedom from coercion). Put simply, these themes should help us build understanding that will bridge the gaps between our languages so that, despite using different words, we are mutually intelligible and aligned in purpose.

The fluid nature of the National Symposium was such that as participants shared their feelings about words, language, and substance issues, a series of themes presented themselves which were later identified as containing common "values" we could use to structure our discourses about drugs. Participants did not spend time explicitly defining these values or agreeing on terms to describe them (again, because this would have tended to circumscribe our conversations, rather than leave them open and malleable). However, repeated mention of certain key words and phrases at the Symposium hinted at the overarching principles that participants wished to see infused into our speech. The following themes thus offer a baseline from which we can begin to situate ourselves in our conversations about substances. They attend both to *who* must be involved in our dialogues on substance use, and *how* substance use might be discussed.

PEOPLE-CENTRED APPROACH

Respect for and involvement of all Canadian citizens in our discourses is essential, with the understanding that it is human beings—not abstract entities, nor stereotypes—that are affected by drugs and drug use. As Canadians we have gifts and responsibilities, especially as they pertain to participating in discussions

[2] It is important to note, however, that several participants were concerned about the lack of attempt at the Symposium to define a lexicon of substance use terms. While these individuals' preferred objective was perhaps not realized, they were integral contributors to the Symposium's ensuing dialogue, and their voices are represented elsewhere in this paper.

that might impact on us, our families, friends, and neighbours. Every Canadian should have a say in these conversations, and no single voice should be considered more worthwhile than another. Creating hierarchies of "valued voices" can only perpetuate our existing forms of discrimination and exclusion. We each have direct or indirect experience with substance use issues, therefore we each require a place in the discussion. A people-centred approach necessitates that human beings be at the forefront of our actions concerning drug issues, but not so much that we forget the external circumstances that make substances and substance use possible and potentially harmful. A people-centred stance also demands clear displays of respect for one another.

MULTI-DIMENSIONAL CONTINUUMS

Recognition of the complex continuums of drugs and drug use is needed, with a commitment to addressing the full extent of each continuum without privileging one end over the other. Tobacco, alcohol, cannabis, medications, and other drugs each have a place on the continuum—and, indeed, each substance has its own individual continuum of use. More often than not it is socio-economic or political circumstance that compels us to deal with these drugs as separate and incompatible issues. Choosing to break apart our conversations into substance-specific components has arguably helped to keep Canadians speaking at cross-purposes about best practices in the substance use field. Moreover, it has also likely kept us over-focussed on individual drugs themselves and on some of the people who use them, rather than on the contexts in which that use is associated with harm. This principle involves extending our language of harm to address larger matters behind the substance use continua, including housing, nutrition, literacy, equity, justice, education, and income security. As one Symposium participant noted, substance-specific discussion has a clear place within a larger system of communication that also attends to the social determinants of health. We should therefore be prepared to *truly* extend our language about drugs—not just shift focus from one extreme to the next.

LOCATING OUR IDEOLOGIES

Given that every word we use is influenced by our interests and value systems, no Canadian can claim access to a completely neutral language. It is our responsibility to "own" our position—that is, to identify, up front, our point of view and how this point of view shapes or justifies the opinions/facts/narratives/agendas that we put forth. This process of locating our ideologies allows us to admit that in certain circumstances different languages are going to prove more effective in communicating different (or, in some cases, similar) messages. Medical terminology might indeed offer a perfectly adequate language for addressing drug use, if we recognise that our values are informed by particular treatment models. If, instead, our goal is community protection or social cohesion, then use of a language influenced by criminal justice concerns or social theory might be more appropriate. Either way, our ideologies should be made explicit, thereby giving others an opportunity to respond knowledgeably to their implications.

FULL DISCLOSURE AND OPEN DIALOGUE

Clear and solid information delivered frankly to Canadian citizens is critical to reducing the confusion and hysteria that tend to envelop substance-related conversations. Silence and fear of speaking forthrightly about drugs (including about their positive effects) inhibit the exploration of new and alternative

responses to substance use issues. Moreover, they allow us to nurture unsafe environments in which many Canadians—youth especially—simply opt out of the conversation, feeling it lacks integrity and has become meaningless. Our poverty of language, as one participant in the Symposium put it, is killing us. Successful relationships (e.g. between parents and children, counsellors and clients) tend to depend upon open dialogue, so relationships that encourage silence and lack of clarity about "the facts" cannot expect to be supportive or multi-sided.

CONTEXTUALIZATION

Drugs are tools—not cancers or social evils—that many human beings, across time and space, have turned to for support, release, spiritual connection or insight. Understanding that substances have an adaptive value allows us to rethink our responses to drug use issues. Aiming to eradicate certain substances from society without offering Canadians alternative means to fulfill those same adaptive values is perhaps less practical (and less respectful) than recognising that drugs are tools which we might substitute or scaffold with less harmful (or harm minimizing) tools. Contextualization means appreciating that substances meet certain human needs. Thus when we respond to harms associated with drug use, we should be ready to give people access to other tools that might achieve the same ends. We should also be prepared to offer individuals very structured environments for handling these tools.

HUMAN RIGHTS AND CITIZENSHIP

As Canadians, each of us has a right to open, healthy, safe environments, and to a social system that works to make these environments accessible to us. Attitudes and approaches that are bigoted, sexist, ageist, or otherwise prejudicial, or that infringe upon our rights in any other way, do not have a place within Canadian society. Responses to drug concerns must be reflective of our rights as citizens, balanced alongside the rights of the community. Moreover, they should work to minimise discriminatory or stigmatising behaviour while encouraging responsibility and full participation by all.

The National Symposium on Language made clear that as we move forward on realising the priorities of the *National Framework for Action*, special attention to Canadian rights and values can be drawn on to align (but not erase) our differing languages. Canadian interests in diversity and multiculturalism need to be built into the *Framework* in order to respect individual freedoms, while at the same time acknowledging that commonalities (e.g. the valuing of diversity itself) still unite us. The *Framework* should provide an organising structure around which Canadians can coordinate a multi-system, multi-cultural approach to substance use harms. It should not aim to suppress certain languages or make our words identical, but to provide us with a meta-language that helps to situate our speech. The *Framework*'s own language, far from trying to be all things to all people, can thus offer *basic building blocks* for Canadians to use in structuring their local conversations about drug issues. In all cases, as citizens and stakeholders, we would still be obliged to monitor and moderate our choice in words. The *Framework*'s structural principles, however, would give us reference points from which to do so.

Having argued against the development of an authoritative lexicon, the National Symposium on Language nonetheless provided a foundation for making a few pragmatic recommendations relative to the language

used in the *National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada* and related documents.

RECOMMENDATION 1: USE SIMPLE, GENERAL LANGUAGE WHENEVER POSSIBLE.

The *Framework* documents should use the broadest possible language (e.g. *substance use* and *substance-related harm*) to refer to the field of interest and use narrowing language (e.g. *substance use disorders*) only when clearly required in the context. Effort should be made to use common language and avoid the creation or use of technical terms or jargon that tend to be owned by particular interest groups. One obvious application of this recommendation might be to seek a simple title for the *Framework* that does not try to say everything at once (e.g. *National Framework for Action on Substance Use*).

RECOMMENDATION 2: INCLUDE A "GLOSSARY" IN ALL WRITTEN DOCUMENTS INTENDED FOR BROAD DISTRIBUTION.

While recognizing that simple, general language should be used whenever possible, glossaries of terms should be added to printed documents to ensure clarity of meaning around specific or technical terminology, and to thereby facilitate understanding. Inevitably, terms that have multiple meanings, or that might be specialized and esoteric, will need to be used. Inclusion of a glossary will encourage authors to be explicit about their language. It will also make clear that our terminology is not always consistent, for the same term may appear with different definitions in our different glossaries. Furthermore, it might help to expose the poverty of language that impinges upon the substance use field, therein promoting the development of more substantial, nuanced, and precise discourse.

RECOMMENDATION 3: ARTICULATE THE COST-BENEFIT NATURE OF BOTH SUBSTANCE USE AND OUR LANGUAGE CHOICES.

By expressing awareness of how our substance use and our related discourse are inherently connected to beliefs and decisions about benefits or harms, the *Framework* documents could help set a context in which meaningful dialogue can take place. This will help focus attention on the very nature of language and discourse rather than on the individual words lifted out of their context. It will also avoid exclusive attention to the negative that has in the past contributed to a lack of robustness in our language. There are many places in the current *Framework* where reference to "problematic substance use" constrains the dialogue and forces attention exclusively toward the negative when a more balanced language would be far more useful. For example, it is not only "problematic" substance use by adults that influences the future choices of children and youth. Appropriate patterns of use are also influential.

RECOMMENDATION 4: USE LANGUAGE THAT IS CONSISTENT WITH THE COMMON THEMES IDENTIFIED AT THE NATIONAL SYMPOSIUM ON LANGUAGE.

To a large extent this is already true within the *Framework* itself. But greater emphasis needs to be placed on articulating these common themes and linking them, within public discourse, to issues related to substance use. By framing the issues broadly, as suggested by the themes that emerged at the Symposium, artificial distinctions can be eroded and more helpful and inclusive constructs pursued. Yet

the Canadian appreciation for diversity and multiculturalism suggests an inclusivity that is not uniformity. Careful attention should be given to draw out, rather than paper over, some of the distinct perspectives that co-exist in our current systems and to engage them in meaningful dialogue based on common principles. The importance of this process was underscored at the Symposium itself when one participant suggested that there was actually *too much uniformity of opinion* at the event, and thus it probably did not reflect reality in terms of the variety of viewpoints that exist in the general public. Indeed, the argument was made that it was unfortunate that our prevention programs had failed us to the point that we were now forced to convene at these sorts of conferences to debate issues like discourse, harm reduction, and best practices. Clearly there *are* a diversity of perspectives existent in the community. We need to create safe spaces to enable these voices to interact and truly be heard.

The *National Framework for Action* offers an unprecedented opportunity to create a genuinely Canadian response to the complex issues related to substance use. Strategic discussions are already moving forward in several areas. The use of language that encourages dialogue and respects diversity while creating a sense of collective experience will benefit all Canadians.

Ultimately, the *National Framework for Action* speaks of shared ownership and the ability for various agencies and sectors to shape national processes, programs, and policies. Such inclusivity is consistent with the opinions raised at the National Symposium on Language. But inclusivity and shared ownership are also part of the challenge. Despite the activity within various mechanisms of consultation, the *Framework for Action* lacks a clearly defined formula for amendment or change. This needs to be addressed if future dialogue is to be meaningful. In the end, the participants at the Symposium on Language envision a *Framework* that is ever-evolving in a reflective and deliberate way.

APPENDIX A: TOWARD A META-LANGUAGE FOR SUBSTANCE-RELATED DIALOGUE IN CANADA

The following pages offer examples of the type of dialogue that should accompany terms used in the *Framework for Action*, as well as in other substance-related documents. Some of the entries offer definitions that could be included in document glossaries, while others provide a discussion of related issues and may suggest more appropriate alternative language. The terminology reviewed herein is not comprehensive, meaning that other words should be subject to assessment and clear definition as well.

Please note that reference to the *Framework* in the discussion below should be understood to include all those documents that are designed to provide guidance in the development of a national substance use strategy.

ABUSE

Formal definitions of the term "abuse" are diverse. However, because of its varying meanings in popular discourse, WHO (via its International Classification of Diseases) discourages its use and the *Framework* should avoid the term wherever possible. Harmful use, hazardous use and problematic use are equivalent terms. Simply using the word "use" without a qualifier is often preferable when speaking generally of the issues.

ADDICTION

The usefulness of the word "addiction" is unclear. Technically, it is equivalent to dependence (see below), but popularly it may refer to any prevailing behaviour. It is often used in the context of the phrase "the addictions field," but this usage runs the risk of restricting the range of factors that contribute to substance-related harm. The *Framework* should avoid the term wherever possible. Reference to substance use professionals or substance use services and the substance use field may be more useful descriptors.

BINGE DRINKING

This term is given special definition in the research literature (often five or more drinks in a row on a single occasion for a man or four or more drinks for a woman) in a way that is quite different from how it is understood by the general population. It thus has the potential to cause confusion and misinterpretation. When referring to drinking patterns that present risks for short-term harm, the *Framework* should seek to use general descriptors like "excessive drinking." Where reference to a specific level of consumption is required, this level should be plainly identified in common language.

CONCURRENT DISORDER

"Concurrent disorder" describes a condition in which a person has both a mental illness and a substance use problem. This term is a general one, referring to a wide range of mental illnesses and substance use issues.

DEPENDENCE

As related to substance use, "dependence" refers to a need for repeated doses of a substance to feel good or to avoid feeling bad. In diagnostic contexts it has a technical definition referring to a cluster of cognitive, behavioural and physiologic symptoms that indicate a person has impaired control of psychoactive substance use and continues use of the substance despite adverse consequences. The term is preferable to the word "addiction" both because of its more general nature and its less connotative (and potentially less stigmatizing) implications. Attention should be given to context to ensure clarity.

DETERMINANTS OF HEALTH

The determinants of health include social and economic conditions that have an impact on the health of individuals, communities, and jurisdictions as a whole (e.g., income, social status, social support networks, education/literacy, employment, working conditions, social environments, housing, physical environments, personal health practices, childhood development, biology genetics, gender and culture).

DETERMINANTS OF PROBLEMATIC SUBSTANCE USE

This expression is sometimes used to draw attention to the determinants of health as they relate to substance use patterns. In the substance use context, however, it is more accurate to speak of risk factors (see below) than of determinants.

EVIDENCE-INFORMED [EVIDENCE-BASED]

"Evidence-informed" means that decision-making processes related to policy or practice have included a conscientious review and judicious integration of the best available research evidence, professional expertise, and practical wisdom. When the term "evidence-informed" or "evidence-based" is used, it should always be accompanied by a clear description of the nature of the evidence it speaks to.

HARM REDUCTION

Various definitions of "harm reduction" have been proposed by leading organizations. The International Harm Reduction Association (IHRA) and the World Health Organization (WHO) use the term to refer to policies or programs that focus directly on reducing the harm resulting from substances without necessarily affecting the underlying substance use.[3] The *Framework* should apply the term only as defined

[3] International Harm Reduction Association. (2002). Available online at: http://www.ihra.net/; World Health Organization. (2006). Lexicon of alcohol and drug terms published by the World Health Organization. Available online at: http://www.who.int/substance_abuse/terminology/who_lexicon/en/.

above by the IHRA and WHO (and ensure that it is clearly identified/described in its context or in a document glossary), but recognize that others may use the term more generically to refer to any policy or program that can demonstrate its effectiveness in preventing or reducing harm.

HARMFUL SUBSTANCE USE

Also: Hazardous use
Harms associated with alcohol and other drugs and substances
Problematic substance use
Problematic use of alcohol, other drugs and substances
Problematic use of pharmaceuticals

There are many ways to refer to substance using behaviours which harmfully impact on the people using drugs, their family and friends, and society as a whole. As no single or formal definition of the concept of substance-related harms is available, the *Framework* should aim to use adjectives like "harmful", "hazardous", or "problematic" only in reference to patterns of use that cause *specific* physical, mental or social harms. Where general use of substances is the topic of interest, the *Framework* should employ more balanced and basic terms like "substance use" or "drug use", while avoiding qualifiers like "harmful" and "problematic". It should be noted that adjectives which focus attention exclusively on the negative can constrain dialogue and overlook the fact that different patterns of use can prove functional in different contexts for various individuals, groups, and societies.

INJECTION DRUG USER

The term "injection drug user" or "IDU" is often employed in the research literature to refer to individuals who use a needle and syringe to inject certain drugs (e.g. steroids, cocaine, heroin) into their bodies. While this terminology may be acceptable at a general population level, it privileges the drug and its mode of administration above the thinking, feeling, sensitive and contextualized human who engages in substance use. Such prioritizing of the drug before the human being can have a potentially stigmatising effect, enabling us to forget that real people with varying social, psychological, physical and material circumstances use substances in different ways to meet different needs. In many cases, "people who inject drugs" is a preferable term.

PATTERNS OF USE

The term "patterns of use" refers to trends in the consumption of psychoactive substances (e.g. frequency of consumption, quantity consumed, mode of consumption, etc.) that may or may not be associated with individual, familial or social harms. Among other factors, patterns of use can be informed by socio-cultural and socio-economic circumstances and gender roles.

PHARMACEUTICAL DRUGS

Also: Pharmaceuticals
Prescription drugs
Medications

Reference to "prescription drugs" and other "medications" is complicated, as the definition and regulation of particular pharmaceutical substances has changed over time and differs from one country to another. Value judgements are sometimes applied to this terminology, framing prescription drugs as "better" or "healthier" than other substances. Like every drug, however, pharmaceuticals carry benefits and risks, and thus can prove advantageous or harmful depending on their use. When referring to this terminology, the *Framework* should clearly indicate that pharmaceuticals are substances distributed through the pharmaceutical industry which can have a range of effects on human wellbeing.

POPULATION HEALTH APPROACH

While definitions of "population health" are varied in their scope and underlying values, the concept generally recognises that substance use is linked to a complex system of social, economic and political factors which are best addressed through comprehensive, integrated and contextualised measures. Because of the vagueness of this term, the *Framework* should offer clear indicators wherever it is used.

PREVENTION

Prevention is a term that refers to measures which prepare and support individuals, groups, communities and larger systems in minimizing harms from substance use. Preventative measures include policies, programs and practices which promote wellbeing among families and neighbourhoods, protect healthy childhood and youth development, prevent or delay uptake of substance use among youth, and prevent substance-related harms.[4] Because the term "prevention" is often interpreted as an abstinence-only educational approach to controlling substance use, the *Framework* should aim to clarify that preventative measures are multi-dimensional, focusing on youth and adults, and addressing a range of issues including use reduction, harm reduction, and supply reduction.

PSYCHOACTIVE SUBSTANCES/DRUGS

"Psychoactive substances" refers to those substances that can be consumed to alter mood or consciousness, including caffeine, alcohol, tobacco, certain medications, and currently illegal drugs such as cannabis, heroin and cocaine. As the World Health Organization notes, "psychoactive substances" is a "neutral and descriptive" term for the "whole class of substances...of interest to drug policy." The terminology "does not necessarily imply dependence-producing."[5]

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[4] City of Vancouver. (2005). Preventing Harm From Psychoactive Substance Use. Available online at: http://www.city.vancouver.bc.ca/fourpillars/pdf/DrugPolicyFinalPreventionP.pdf

[5] World Health Organization. (2006). Lexicon of alcohol and drug terms published by the World Health Organization. Available online at: http://www.who.int/substance_abuse/terminology/who_lexicon/en/

RISK FACTORS

"Risk factors" generally refers to characteristics of individuals or environments (whether social, systemic, biological, genetic, or psychological in nature) that increase the chance of developing, prolonging or intensifying harmful patterns of substance use and have the potential to be modified through targeted or large-scale intervention. Since risk factors vary by substance, by person and by community, care should be taken to situate and define them in all *Framework* documents.

SUBSTANCE USE DISORDERS

Reference to the term "substance use disorders" should be clearly contextualized and qualified in all documents. Transparency about the specific system of disease classification to which the term refers (e.g. DSM-IV or ICD-10) is imperative. Because "disorder" can be laden with heavy political or ideological undertones, it should be applied only when necessary, in specialized and precisely-defined contexts. Otherwise, in generalized or high-level documents, the simple term "substance use" is preferred.

SYNTHETIC DRUGS

The usefulness of the term "synthetic drugs" is debatable, and formal definitions are generally ambiguous or non-existent. Unless required in specific technical documents, the term should be avoided—and when and where it is used, it should be very clearly defined. In generalized documents and high-level policy materials, common and basic words (e.g. substances, drugs) should be employed.

USE

"Use" is the preferred term for non-technical discourse about substance-related issues given that it is simple, general, and not necessarily linked to the interests of particular individuals or groups. As more specificity and contextualization about substance issues are required, clearly defined adjectives and technical descriptors can be added to qualify the terminology.

APPENDIX B: CONTRIBUTORS TO THE NATIONAL SYMPOSIUM ON LANGUAGE

Registered participants in the National Symposium and individuals who offered input on an earlier draft of this paper as well as on the Symposium's "Language Workbook" are noted below. Many thanks are extended to everyone (including those whose names might not appear in this appendix) who contributed their time, wisdom and voices to the dialogue.

Deirdre Ah Shene, Alberta Alcohol and Drug Abuse Commission
Penny Ballantyne, National Symposium on Language - Facilitator
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Manon Blouin, Canadian Centre on Substance Abuse
Annette Bourque, New Brunswick Department of Health
Anne Bowlby, Ontario Ministry of Health and Long-Term Care
Bruna Brands, Centre for Addiction and Mental Health
Nadine Caplette, Vancouver Coastal Health
Walter Cavalieri, Canadian Harm Reduction Network
Claire Checkland, Canadian AIDS Society
Peter Coleridge, Provincial Health Services Authority
Howard Collins, Brewers Association of Canada
Linda Dabros, Health Canada
Maxine Davis, Dr. Peter Centre
Cameron Duff, Vancouver Coastal Health
Deborrah Dunne, Centre for Addictions Research of BC
Brian Emerson, BC Ministry of Health
Carolyn Franklin, Canadian Centre on Substance Abuse
Fiona Gold, BC Centre for Disease Control
Irene Goldstone, BC Centre for Excellence in HIV/AIDS
Laura Goossen, Addictions Foundation of Manitoba
Brian Grant, Correctional Service of Canada
Lorraine Greaves, BC Centre of Excellence for Women's Health
Gordon Harper, Regional Addictions Advocacy Society
Enid Harrison, Canadian Centre on Substance Abuse
James Jamieson, Department of National Defence
Liz Janzen, Toronto Public Health
Mary Johnston, Health Canada
Doug LePard, Vancouver Police
Bob Lindsay, Canadian Association of Principals
Ann Livingston, Vancouver Area Network of Drug Users (VANDU)
Donald MacPherson, City of Vancouver
Mike Mancinelli, AIDS Vancouver
David Marsh, Vancouver Coastal Health

Gillian Maxwell, Keeping the Door Open
Jane McCall, BC Centre for Excellence in HIV/AIDS
Yehalem Metiku, Centre for Addictions Research of BC
Warren Michelow, University of British Columbia
Rafe Mooney, BC Ministry of Health
Rob Morgan, Western Aboriginal Harm Reduction Society
Zarina Mulla, City of Vancouver
Larry Myette, Healthcare Benefit Trust
Warren O'Briain, BC Ministry of Health
Michael Olotu, Correctional Service of Canada
Darlène Palmer, Centre d'action communautaire auprès des toxicomanes utilisatrices et utilisateurs de seringues (CACTUS)
Sara Perry, Centre for Addictions Research of BC
Nancy Poole, BC Women's Hospital & BC Centre of Excellence for Women's Health
Jannit Rabinovitch, International Centre to Combat Exploitation of Children
Deb Reist, Centre for Addictions Research of BC
Amy Salmon, BC Centre of Excellence for Women's Health
Susan Shepherd, City of Toronto
Wayne Skinner, Centre for Addiction and Mental Health
Michael Smith, Public Health Agency of Canada
Patrick Smith, Provincial Health Services Authority of BC
Brent Taylor, Unified Networkers of Drug Users Nationally (UNDUN)
Diane Tobin, Vancouver Area Network of Drug Users (VANDU)
Kenneth Tupper, BC Ministry of Health
Jan Westcott, Spirits Canada
Ethel Whitty, Carnegie Centre