MOMS STOP THE HARM

Moms Stop The Harm

Advocates Handbook

2nd Edition, 2017

MSTH

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Welcome to Moms Stop The Harm (MSTH)

Dear New Member of Ally,

Thank you for joining Moms Stop the Harm (MSTH) and for making this your cause.

Moms Stop the Harm (MSTH) is a network of Canadian mothers and families whose loved ones have died due to substance use or hope for recovery. We call for an end to the failed war on drugs, which is a war on the people we love. We envision a new approach based on reducing harm, where people who use drugs are treated with respect, compassion and support.

We realize that you, too, may have a loved one involved in substance use or in recovery, or you may have lost a child. We're glad you want to work with us, and realize that there are times when it will be hard.

This handbook offers a few suggestions to help you get involved with us, from informing yourself and sharing our message to becoming a more active advocate.

Remember we each can only do so much and grief takes a lot of energy. There is no pressure to get involved in any of these activities. These are just ideas. If you have points to add, please let us know.

Thank you again for ending the stigma and the silence by adding your voice to MSTH.

Yours sincerely,

Moms Stop The Harm

Connect with us

Public Facebook page

Like and follow our public page: **www.facebook.com/MomsStopTheHarm**.

Read about MSTH beliefs, see photos of our loved ones and find resources on our **website: www.momsstoptheharm.com.**

Closed M S T H Facebook group for those with lived experience

If you've lost someone, or love someone who uses/used substances, or if you yourself use(d) you'll be invited to join the closed Facebook group, MSTH or you can go to this link and asked to join https://www.facebook.com/groups/MSTHclosedgroup/

We use this closed group for mutual support, to share information, and sometimes to cry or to vent. We reserve this group for those with lived experience, as much of what is shared is deeply personal and the group is an important tool in helping people deal with grief and trauma. If you have questions about joining, please contact your regional leader. Once you join the closed group you will see the other members and can private message them. Also see section on Emotional Support.

After you have joined, please review the pinned post at the top about the guidelines for using the group. Please read and "like" the post to acknowledge that you agree.

Closed Facebook Affinity Group for those who have loved ones using, seeking or in recovery

The MSTH Affinity group is for people whose loved one is currently using substances or is in recovery. It is a safe place for these members to share their personal experiences and gain support in tough times. Affinity meaning that you have similar concerns and interests. It is a smaller group and a place where you can share and seek support, just like in the larger closed M S T H group described above. If you were not invited to this group when you joined, you can contact Tyla Savard, who moderates this group.

Twitter

Follow **@momsstoptheharm, @leslie_mcbain** and other members on twitter.

Newsletter

MSTH publishes a monthly e-newsletter to keep members up to date on local and organizational initiatives, events, and other information. The newsletter will be sent to all members. If you have a local event or any other information you want to contribute send it to the editor.

Slack

Slack is a productivity website a lot of companies use to share information, work on documents, or discuss topics. If you want to join our Slack channel, email petraschulz100@gmail.com.

Members in your region

We'll let you know if there are other members close to you. We hope that you'll be able to meet, support one another, and find out what you can do locally. Our full list of members is on our website. If there's someone you'd like to get in touch with, let us know and we'll make an e-mail introduction.

You can also contact your regional leader for advice, support and to discuss your advocacy activities.

If you are interested in organizing an informal meet-up of local moms or a grief support group, please let your nearest regional leader know.

Regional Leaders

Note: Contact information is provided for members only. **Do not share it without consent.**

Province	Name & Location	E-mail
National and BC	Leslie McBain, Pender Island	momsstopharm@shaw.ca
BC – Islands	Jennifer Howard, Victoria	jenhoward@shaw.ca
BC – Lower Mainland	Debra Hale Bailey, Vancouver	dhbailey@telus.net
BC – Lower Mainland	Michelle Jansen, Vancouver	jansenclaimsgroup@gmail.com
BC- Interior	Helen Jennens, Kelowna	
BC – Interior	Sandra Tully, Kamloops	
National and AB	Lorna Thomas, Edmonton	lornathomas@me.com
National and AB	Petra Schulz, Edmonton	Petraschulz100@gmail.com
AB – North	Niki Brooks-Lukas, Grande Prairie	nikil@telus.net
AB – North	Tyla Savard, , Grande Prairie	tycartay@msn.com
AB - Calgary	Working with Changing the Face of Addiction Rosalind Davis & Jessica Holtsbaum	Ask for contact info
Saskatchewan	Marie Agioritis, Saskatoon	Magioritis@live.ca
Saskatchewan	Wendy Gore-Hickman, Saskaton	wendygh@shaw.ca
Manitoba	Chris Dobbs, Winnipeg	cdobbs@shaw.ca
Manitoba	Arlene Kolb, Winnipeg	ommm@shaw.ca
Ontario – Niagara region	Working with NAMES (Niagara Area Moms Ending Stigma) Jennifer Johnston-Nesbitt & Sandi Walker Tarantini	Ask for contact info
Atlantic Canada	Working with GPDOTS (Get Prescription Drugs off the Street Society) Amy Graves	Ask for contact info

Help us share our message

The Do Something Prime Minister (DSPM) photo campaign

We have all been feeling the pain of the rising death toll in the opioid crisis, as numbers of families in mourning grow. The actions of all levels of government are inadequate considering the magnitude of the problem. We need to see leadership at the top, starting with our prime minister, Justin Trudeau. Over the past months he has spoken on a number of issues, but has been relatively silent regarding this crisis and did not cover this topic at all at town halls this summer, that some MSTH members had a chance to attend.

To help him recognize how this impacts Canadian families we propose the following initiative, which we call the Do Something Prime Minister Photo Campaign starting on November 13, 2017 – on-going after that. To learn more about the campaign and how to send a message on behalf of your loved one, go to our website http://www.momsstoptheharm.com/personal-blog/2017/11/4/do-something-prime-minister-photo-campaign

Share on social media

Share information from our public social media pages. Like, share, and retweet as often as you like. This is very important, as you are a megaphone for our voice.

The more people share from and to our Facebook and Twitter accounts, the further and louder our message will be heard.

Add your loved one's photo

Photos of our loved ones are the most powerful tool we have in reducing the stigma of substance use. If you have lost a loved one, consider submitting their photo to our gallery. By submitting this photo, you agree that we can share it through our website, public social media pages, and events and presentations.

Please note that the photo may be shared or retweeted by members of the public. As well, media might take photos of our displays or presentations. But we won't share your photo with any third party, including media, government, or other organizations, without your specific permission.

We know this is a big decision. If you don't feel comfortable sharing your photo now, or you need to speak to family members about it first, take your time. If you have questions regarding photo use, please contact your regional leader.

See our loved ones' photos at **www.momsstoptheharm.com/our-children**.

Share your own story

Sharing the story of your child, who he/she was and the struggles he/she faced is powerful. You can do this in a variety of ways. Choose what feels comfortable for you.

- **Friends and strangers**: Depending on how you feel, if people ask about your child, or children, this is on opportunity to speak openly about your loos or your child's struggle. Every conversation you are able to have is an opportunity for engagement and may help to reduce stigma.

- **Our website and Facebook**: Write and submit your story for our website. Submissions of stories and photos should be sent to PetraSchulz100@hotmail.com. The stories are published in our Facebook gallery with a photo and they photos also go on the gallery on our website. See here http://www.momsstoptheharm.com/our-children/. If you want to become an active member, you can submit a profile that tells your child's story and a bit about you as an advocate. See others' stories at: **www.momsstoptheharm.com/network-members.**
  If you would like to make changes to your story, photo or if there are corrections needed, please contact Petra at petraschulz100@gmail.com.

Local media: The media is very interested in the overdose crisis and is very supportive of featuring local stories of how this has impacted families and loved ones. It provides an opportunity to highlight the gaps that are still missing in terms of harm reduction, medical supports, and treatment options. Don't be afraid if you cry on camera. It is not a sign of weakness but one of love. See below for our media toolkit.

Inform yourself

Website

Visit our website www.momsstoptheharm.com to learn about our organization and drug safety, and to find additional resources. Read our disclaimer about information on our website in Appendix II.

Recommended books

Chasing the Scream: The First and Last Days of the War on Drugs by Johan Hari

This book documents the reasons behind the war on drugs, the devastating effects and the solutions practiced in other countries. See chasingthescream.com.

Note: Some may find the middle section of the book too graphic

Unbroken Brain: A revolutionary new way of understanding addiction by Maia Szalavitz

Maia has also published several good articles you can find by Googling her name.

Movies and videos

Fentanyl: The Drug Deadlier than Heroin

VICE presents an immersive and personal feature film about the fentanyl crisis in Canada told from the perspective of a community of drug users. www.youtube.com/watch?v=28rJqj-7pEY

Why The War on Drugs Is a Huge Failure

The war against drugs has been a terrible disaster for everybody involved. Why? And can we do something differently? www.youtube.com/watch?v=wJUXLqNHCaI&feature=share

Addiction (Adapted from Johann Hari's book Chasing the Scream: The first and last days of the war on drugs.)

What causes addiction? Easy, right? Drugs cause addiction. But maybe it is not that simple.' www.youtube.com/watch?v=ao8L-0nSYzg&t=15s

Harm Reduction 101

A short introduction to the idea of harm reduction. www.youtube.com/watch?feature=youtu.be&v=W7epsLmN604&app=

What is decriminalisation of drugs?

This short video explains the difference between decriminalization and legalization of drugs. www.youtube.com/watch?v=9NKhpujqOXc

Chasing Heroin

FRONTLINE looks at America's heroin crisis in a fresh and provocative light -- telling the stories of individual addicts, but also illuminating the epidemic's years-in-the-making social context, deeply examining shifts in drug policy, and exploring what happens when addiction is treated like a public health issue, not a crime. www.pbs.org/video/2365674182/

Not Alone

Helen Jennings is a mother from Kelowna and a member of the MSTH leadership group. She is shown here speaking at a private fundraising event about the experience of losing both of her sons. https://www.youtube.com/watch?v=G_klM33N0Ic&feature=youtu.be&app=

SALOME (2015) The Study to Assess Long-term Opioid Medication Effectiveness

(SALOME) is research study designed to test if hydromorphone is effective for the treatment of long-term illicit opioid injection. https://vimeo.com/161191620

Best Advice for People Taking Opioid Medication (2012). https://www.youtube.com/watch?time_continue=1&v=7Na2m7lx-hU

News and Radio

Marc Lewis: The Neuroscientist who believes addiction is not a disease

Lewis, famous for detailing his own years of drug addiction in a book, divides the medical profession by arguing it is a behavioural problem, not a medical affliction. www.theguardian.com/culture/2015/aug/30/marc-lewis-the-neuroscientist-who-believes-addiction-is-not-a-disease

Inside the Fentanyl High. CBC Radio, November 26, 2016

Quirks & Quarks interviewed two men -- one still uses but is trying to quit, and the other is a former addict. You can hear some of their story below, and read Dr. David Juurlink's breakdown of what's happening in the brain and body as they react to the potent drug www.cbc.ca/radio/quirks/you-brain-on-fentanyl-westworld-and-ai-erasing-memory-1.3863600/inside-a-fentanyl-high-withdrawal-and-overdose-1.3863622

Opioid crisis: why aren't we moved to action? CBC Radio. October 22, 2017

Zoe Dodd is an authority on the opioid crisis. Not by academic decree, but by virtue of her presence on the front lines. Dodd works at the South Riverdale Community Health Centre in Toronto, and she's deeply involved in harm reduction and overdose prevention. Dodd is so deeply involved that she has had to pull back at times for her own health and well-being; the crisis has claimed friends and acquaintances. Her message is: human beings are at the heart of this crisis, and our society often fails to recognize that. http://www.cbc.ca/radio/tapestry/zoe-and-eddy-1.4363819/opioid-crisis-why-aren-t-we-moved-to-action-1.4363836

Talks

CADTH Lecture Series — Canada's Opioid Crisis by Dr. Hakique Virani, October 17, 2017

On October 12, 2017, Dr. Hakique Virani, Medical Director, Metro City Medical Clinic; and Assistant Clinical Professor, Department of Medicine, University of Alberta, delivered an in-person and webinar lecture entitled "Canada's Opioid Crisis: The Changing Reality Between Exam Rooms and Ivory Towers." He includes photos of the MSTH gallery of children to make his point about the extend of the opioid overdose crisis https://youtu.be/BlTcBxscbTI

Slack

Our listenreadwatch channel includes information on harm reduction and fighting the war on drugs.

- **Your MLA**: Ask for an opportunity to meet with them to share your child's story. As a constituent, they have to meet with you and a meeting is more effective than a letter. Bring a photo of your child to the meeting. You can request that they introduce you at the legislature. Through this introduction, you have another opportunity to highlight the services and supports that continued to be needed by those struggling with addiction.

- **Other government**: Write letters! Keeping the pressure on those able to make change happen is critical. You can share your story with an emphasis on advocating for funding for Harm Reduction measures that can save lives. You can send letters to your local MLAs, MPs, Provincial Office of the Premier, Provincial Health Minister, Federal Health Minister and the Office of the Prime Minister. If you live locally consider dropping the letter off in person.

- **Middle and high schools**: Offer to share your story with students, Parent Advisory Council, and teachers.

- **Local colleges**: The students in nursing education, and social work cover the topic of addiction. Your story will have an impact on their future work in that field.

- **Service clubs and community organizations**: Offer to share your story at a meeting or event.

- **International Overdose Awareness Day**: August 31st is a day of remembrance around the world. Contact local addiction support services to see how you might get involved and share your story.

- **Planned supervised injection sites**: Give a face to the statistics. It will open doors and hearts.

Become an active advocate

MSTH is a grassroots organization that empowers members to engage in advocacy on their own terms, but based on our organization's goals.

If you start to engage in these activities, please let your regional leader know so we can share your advocacy work. You can also share your activities with our newsletter editor: Kathy@contentstrategyinc.com.

Also let us know if you need support or if you want to work together with another member on a project.

Attend or co-organize an event

Regular annual events include:

- Support Don't Punish Global Day of Action in June **supportdontpunish.org/take-action/**
- National day of action organized by Canadian Association of People Who Use Drugs in February
- International Overdose Awareness Day in August
- Recovery Day in September http://www.recoverydaycanada.com/

Support local harm reduction activities

Get involved with a needle exchange or program giving out Naloxone in your area.

Add resources and articles to our Facebook page

Become an editor on our social media pages and contribute. If you're interested, contact petraschulz100@gmail.com

Write letters to the editor

Follow media stories and write letters to the editor if there is something you disagree with or where you can offer your perspective. Keep it short and keep the message clear.

Contribute to our blog

If you want to share information or your opinions, write a blog post and send it to us through Slack. We'll put it up on our website.

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Media tool kit

Prepare to talk to media

- Find out in advance what the press wants to ask you.
- Stay focused on your child's story. Talk about your loved one's life, the qualities you loved about him or her, and his or her achievements. Create an image of our loved one as a person.
- Transform your wounds into wisdom. What have you learned from your experience? What would have contributed to a different outcome?
- Speak about our main asks: stigma, treatment, awareness. See below.
- Give your opinion on the topic and have a few statistics ready.
- Use non-stigmatized language. People first. See section on language below.
- Use a modulated (not monotone) voice.
- Pick just one or two photos to use with media.
- If possible, fact check written articles before they're published.
- Keep notes handy.
- Ask to have a story changed if there's an error.
- The most important part is to tell your loved one's story so people know who the real victims are. You'll do great.

Moms Stop The Harm Asks

What are our asks?

You'll never be able to touch on all these points in one interview, but consider the following questions to determine what you'll focus on:

"What would have given my child a better chance?"

"What is most urgently needed in my region/province?"

"What would make the biggest difference regionally and nationally?"

MSTH asks:

To reduce stigma

- People are people first. Not addicts or junkies.
- Substance use can happen to anyone and there are usually underlying reasons, such as mental health issues and/or trauma.
- Overdose does not discriminate.
- Substance use is a health issue and not a moral failing.

To increase access to evidence based treatment and reduce barriers

- "We can't arrest our way out of the problem."
- Opioid dependency treatment where people live and when they need it (without wait times or prerequisites), with staff that treat people with dignity and respect.

- Focus on treatment that is proven to work, such as opioid agonist treatment (OAT) with methadone and suboxone.
- Prescription heroin for long-term users.
- Rapid access options for people who come to emergency after and overdose. See St. Paul's hospital.
- Psychological counselling with treatment so people can work on underlying issues.

To set standards and ensure accurate reporting

- Implement standards for treatment facilities. See Brandon Jansen report on our personal blog.
- Provide accurate data on overdose death, and emergency service utilization due to substance use in all provinces, territories and nationally.
- Implement drug testing for festivals, events and in clubs

To increase education and public awareness

- Risks, signs and symptoms, overdose response, Naloxone
- Honest and real drug information for families of loved ones who use
- Honest and real drug information in schools
- Strategies for youth to deal with peer pressure and risky situations

To provide timely and accurate information and support to families of people living with addiction

- Risks and how the mitigate them, including the high likelihood of relapse in recovery
- Harm reduction measures, including Naloxone and supervised consumption sites
- Available treatment options and how to support loved ones in accessing treatment
- Getting emotional and psychological support

To provide help for families who have lost loved ones

- Grief recovery groups
- Trauma counselling

The **key beliefs** on our website summarize our key asks. See **www.momsstoptheharm.com/our-goals**.

Regulation & Opioid Prescribing Talking Points

MSTH calls for:

- More cautious, evidence-based prescribing of opioids.
- Better regulating the separation between pharmaceutical company influence and physician education.

- Increase transparency of financial relationships between health care providers and pharmaceutical manufacturers through new legislation (similar to the US Sunshine Act.)
- Offer a naloxone kit with opioid prescriptions
- Impartial oversight and accountability over prescription monitoring programs.

An excellent document outlining key goals MSTH supports is the Vancouver Police Department's (2017, May) *The Opioid Crisis - The Need for Treatment On Demand. Review and Recommendations*. Retrieved from the City of Vancouver website http://vancouver.ca/police/assets/pdf/reports-policies/opioid-crisis.pdf

1) **Expand and provide more funding for evidence-based addiction treatment, including opioid-assisted therapy programs.** Opioid assisted therapy programs that provide people with substance use disorder with a range of effective opioid medications should be made immediately available in therapeutic and supported settings. The goal of this recommendation is to give addicted persons a "clean" opioid (with known contents) for their addiction and prevent them from contributing to the organized and disorganized crime fuelled drug market through the purchase and use of contaminated street drugs.

2) **Create a system for immediate evidence-based addiction treatment and concurrent mental health crisis intervention and support.** This should involve the opening/re-opening of in-patient beds for severe cases and the creation of sufficient community addiction and mental health services to support out-patients upon discharge from in-patient environments. This must include a system to enable first responders or addicted persons to immediately gain access to assessment and evidence-based treatment. This should include withdrawal management and acute addiction treatment intake centres where first responders could transport those seeking treatment, or where addicted persons themselves could go for immediate treatment.

3) **Increase public awareness to support prevention through education.** It is necessary to increase awareness about overdose symptoms with more messaging in high visibility areas where drug consumption is likely. There also needs to be more education for students – elementary through post-secondary – about the dangers of opioid use, overdose prevention, and responses to overdoses. The development and delivery of this information should be coordinated across the province to ensure students in all areas of B.C. are receiving this information.

Where do we stand on cannabis legalization?

The current unregulated illegal market contributes to increased harm for users and especially young people than a government regulated market will be. We support measures that reduce the likelihood of youths and young people using Cannabis and we ask that tax dollars generated from cannabis sales are invested in preventing and treating substance abuse through education, research, harm reduction, and effective treatment options.

Many individuals also seem to benefit from medical use of cannabis and some have been able to reduce or replace opioid pain medication use with cannabis and cannabinoid oils. Much more research needs to be done in this area, which will be easier in a legal environment.

Can it be a gateway? Perhaps. So, can sugar, alcohol, cigarettes and other substances that are currently legal. In an illegal market it is often the dealer that is the gateway, not the drug itself.

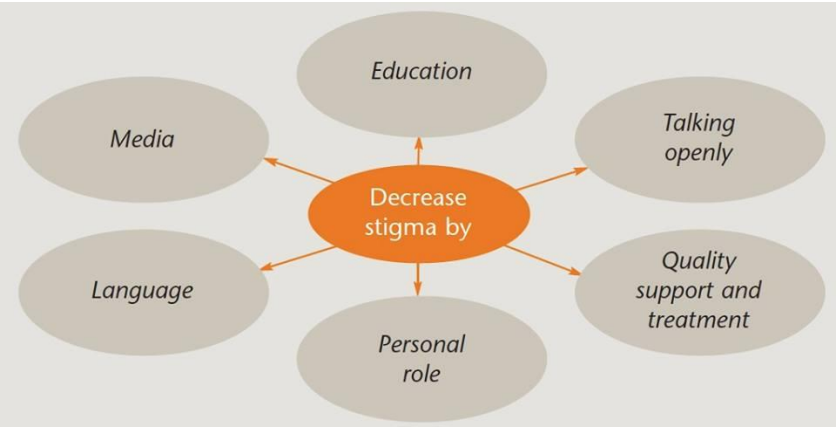
The substance that ignites the addiction is in most cases irrelevant. More often the underlying mental health is the smouldering ember that fuels the substance abuse.

We support decriminalization of the possession of small amounts of substances for personal use, and will continue to advocate for safe drugs. Safe needles in supportive environments. and greater access to resources that will stabilize the substance abuser while minimizing the effect - both emotionally and financially on our communities.

How do we reduce stigma?

This blog post from one of our BC leaders illustrates the issue of dealing with stigma:

Today while driving I happened to be listening to CBC Radio Vancouver. They were hosting a call in show to talk about the announcement by our new Minister of Mental Health & Addiction, where individuals can now access Naloxone kits at their local pharmacy. Overall, people were supportive and welcoming, but one caller set me back. His basic message was that addicts just needed to stop taking drugs and perhaps they should leave those that die on the streets to have the "crows pick at their eyeballs" so that it would help show others not to do drugs. The absolute ignorance of this caller enraged me. I pulled over and repeat dialled until I got through. Thankfully, I was the last call on the show and shared my thoughts on losing a child to Fentanyl. That Robby died in the privacy of his home and that if I had known he was struggling and Naloxone was readily available I would have been down to my local pharmacy in a second. This is needed. For every family member and friend who worries about their loved one....easy access is needed! However, I went on to say that at the end of the day, reducing stigma and focussing on public education will be one piece in solving this crisis. The ignorant and uneducated comments that I heard call in, will not improve the lives of those struggling. The conversation about the challenges of substance use must be LOUD, CLEAR AND PERSISTENT to change the mindset of the public! The above attitudes are what prevent people from getting treatment and only serve to reinforce a sense of morality and shame. Hearing these words are hurtful when you have lost a child. However, it only strengthens my resolve to educate others and make sure change happens.



Suggestions for engaging media

Note: This section is copied and adapted from: Alberta Hate Crimes Committee (2012). Beyond Hate. A Resource Toolkit. Linked from this website http://www.albertahatecrimes.org/resources

Letters to the Editor: Newspapers and magazines have a "letters page" that gives readers the opportunity to express their view or correct previously published information they feel to be inaccurate or misleading. Letters are widely read and provide a good opportunity to promote your cause. Letters should be short and concise. Those over 500 words are unlikely to be published. Well-written letters of no more than 100 words can be very effective. A letter should aim to make one main point and to end on a challenging note, with a call to action. Letters can also be signed by a number of signatories, representing various organizations or interests, which may increase their impact. If a letter is responding to an article carried in a daily newspaper, it is important to email, fax or deliver it to the paper within a couple of days.

To summarize:

- **Be timely:** Your letter will be irrelevant very quickly. You need to get into the very next edition. Send your letter before 1PM and send it be e-mail.
- **Be concise:** Nothing beats a short letter. Sentences should be short. Staying brief will help you bring your point across more clearly.
- **Be bold:** If you are taking the time to write a letter, you have an opinion. State it directly rights upfront.
- **Be funny:** Funny letters get published. Humour is one of the most effective ways of communicating. If you can include it, do. [For our cause being satirical or even cynical may be more applicable than being funny.]
- **Be easy:** Editors don't have time to waste. Make it easy for them to publish you. There are many ways you can help them. Follow their rules regarding letters (check the paper's website). Spell everything correctly. Include your name, full address, and phone number.

Editorial: An editorial statement from your leading local newspaper, addressing the responsibilities of your elected officials, is perhaps the most powerful form of media advocacy. You should approach the editorial board members of your local paper and offer to provide them an editorial briefing on the issue. If you can arrange an editorial board meeting, this will provide you with an excellent opportunity to gain the editorial support of a newspaper which, in turn, can be very influential in shaping political decisions. Begin by doing your homework prior to the meeting. Profile the kinds of editorials that appear in the paper and the position they tend to take, particularly in relation to international issues. Arrive armed with facts and figures that are relevant to the newspaper's audience. Make a persuasive argument that their readers should be concerned about the issue. Make clear why specific elected officials from your area have influence on these matters. Be ready to answer any questions the editor might have. After the meeting, research and provide any further information requested.

Opinion pieces: Most newspapers print opinion editorials (op-eds) or guest columns. An op-ed is an expression of opinion rather than a release of news. Although style varies according to different countries, an op-ed tends to be lively, provocative and sometimes controversial. They provide a very

effective way to register concern about your issue to policy-makers and to inform communities about why they should care about addressing it. Op-eds are usually around 600 to 1,000 words. It is best to call the newspaper first and request their guidelines for submitting an op-ed. If possible, speak to the appropriate editor to alert them that you intend to submit an op-ed, briefly explain the importance of the issue.

New advisories: Advisories are used -- along with phone calls -- to alert journalists to a media event or news conference. An advisory should give all of the basic information on the purpose, date, time, location, and speakers at an event, often in a Who, What, When, Where, and Why format. A good advisory should also build some anticipation concerning the news that will be announced. A strong headline helps.

Press releases: Some journalists receive hundreds of news releases each week. For your release to get noticed, the headline and first paragraph must catch their attention. You should devote most of your time to getting this right compared to preparing the rest of the news release. You can either issue the release in advance and embargoed until the date of publication, or you can issue it on the day of a news event/conference.

Calling journalists: Once you have sent an advisory or news release it is imperative to call journalists to make sure they have received it or that the right journalist has it. Sometimes, you will be asked to resend the release. Sometimes it will be to another journalist or bureau. When you call a busy journalist in a large city, you may have only 30 seconds to gain his or her interest in the story. To be successful, you must be direct and to the point concerning the importance of your story or event. Keep it simple and do not overwhelm them with too much information. Consider practicing your “pitch” with a colleague or friend before making your first call. Try to avoid calling when journalists are facing deadlines. It will also be useful to know something about the publication or program that you are calling. An editor can sense immediately if you have never read their publication or watched their program and may not see you as a credible source of news.

Feature story: Feature stories are usually longer than news stories. They go into greater depth on how an issue affects people. In magazines, they can span several pages and be accompanied by pictures. On television, they can become five minute segments or programs up to a half-hour in length. The best way to obtain a feature story is to describe your idea in a two or three-page story proposal. Be prepared to do a substantial amount of research on this before handing the story over to the journalist to follow up. Your proposal should provide an outline of the story and list interesting people who could be interviewed. The newer, more unusual, significant or dramatic the story, the better. For example, a journalist may be more interested in an unreported story about a hate incident in a school than just a general story about hate activity.

Press briefing: If journalists -- who cover hundreds of different stories and may know next to nothing about this topic -- are to produce informative and accurate stories, they need to be properly briefed. Consider organizing an informal press briefing that also serves to build good relations with journalists. For example, invite half a dozen select journalists to attend a briefing in advance of your event. Brief them on key developments and issues relating to it and your group's relevant work on the issue. You may want to conduct this as a breakfast meeting and provide refreshments. It is a good idea to have clear briefing materials to distribute, such as fact sheets or advocacy publications. If you attend an

important national or international conference, you may wish to brief journalists in your community about important developments upon your return.

News conference: A news conference can be a very effective way to announce a newsworthy story to journalists. Speakers take the platform in a venue and make presentations after which journalists can ask questions. This is a tried and tested formula which can make life easy for journalists and for yourself. Be sure that your story warrants holding one, as news conferences can take a lot of time to organize and it can be disheartening if only a few reporters attend. In some cases, you may find you can achieve the same results by handling the story from your office. For this, you need to send journalists your news release and briefing materials under embargo until the date of publication, highlighting who is available for interview, and talking them through the story in person or on the phone.

Photo opportunities: Television news and magazines need good pictures or visuals in order to report on a story. When you plan a media strategy, think about what images you need and how you will supply these. You may want to pay for a photographer to take pictures and then distribute them to selected publications. You may also want to prepare a video news release (VNR) for broadcasters to use. Or, arrange a photo opportunity for photographers and television news people to take pictures themselves. To announce the photo opportunity, send an advisory that gives the who, what, when, where and why of the event to media.

Please post any media reports to our Facebook page and email a link to PetraSchulz100@gmail.com to have it added to the media blog on our website.

A word on language

By choosing to rethink and reshape our language, we will allow people with a substance use disorder [an addiction] to regain their self-esteem more easily and more comfortably seek treatment, allow lawmakers to appropriate funding, allow doctors to deliver better treatment, allow health professional to provide evidence-based treatment and help the public understand this is a health condition and should be treated as such.

The Associated Press took an important step to stop using stigmatizing language toward people struggling with a substance use disorder, recognizing that words have power. We invite you to do the same.

Here is a list of words and phrases to avoid and words to use in their place. Together, with a unified language, we can help reshape the landscape and end the negative stereotypes and stigma of addiction. And by doing so, we can remove barriers that continue to hold back too many people from the lifesaving treatment they need.

AVOID SAYING: Abuse / Abuser

EXAMPLE: He's a drug abuser.

WHY? Linked with violence, anger, or a lack of control. Not positioned as a health issue and places blame on the person with an addiction.

INSTEAD SAY: Misuse, risky use, harmful use, inappropriate use, unhealthy use, hazardous use, problem use, unhealthy use, non-medical use; individual struggling with misuse, individual suffering with substance use disorder, individual struggling with chemical dependency.

AVOID SAYING: Addict

EXAMPLE: She's an addict.

RELATED: alcoholic, crackhead, druggie, dopehead, doper, drunk, drunkard, junkie, pothead

WHY? The word addict is stigmatizing, reducing a person's identity down to their struggle with substance use and denies their dignity and humanity. In addition, these labels imply a permanency to the condition, leaving no room for change. It's better to use words that reinforce the medical nature of the condition.

INSTEAD SAY: A person with a substance use disorder (SUD), with addiction, in active addiction, experiencing an alcohol/drug problem, with an addictive disorder, with the disease of addiction, with an addictive disease; person who suffers/suffered with addiction; patient (if receiving treatment services).

AVOID SAYING: Clean/Sober/Staying Clean/Clean Test

EXAMPLE: She smoked pot for many years but now she's clean; His test was clean.

WHY? It associates illness symptoms with filth and implies a person struggling with a dependence on drugs or alcohol is inherently "dirty" or socially unacceptable. Same goes when referring to a drug test as a "clean test" (i.e. a negative result/no evidence of use) or "dirty test" (i.e. to a positive result/evidence of use). These terms regarding tests should also be avoided.

INSTEAD SAY: In recovery, addiction-free, addiction survivor, in remission, maintaining recovery, wellness, quality of life, substance-free; positive test or negative test.

AVOID SAYING: Habit

EXAMPLE: She has a bad drug habit.

WHY? A habit is something that can easily be broken through persistence or willpower. Addiction is more complicated. As a health condition affecting the brain, it requires medical treatment for physiological needs, cravings, and/or physical pain, in addition to a psychological commitment to treatment and recovery. Calling addictive disorders a habit denies the medical nature of the condition and implies that resolution of the problem is simply a matter of willpower.

INSTEAD SAY: Substance use disorder (SUD), alcohol and drug disorder, active addiction, inappropriate use, hazardous use, problem use, non-medical use, unhealthy use, misuse, risky use, harmful use; person struggling with misuse, person suffering with substance use disorder, person struggling with chemical dependency, person who suffers/suffered from/with addiction.

AVOID SAYING: Replacements/Substitution Therapy

EXAMPLE: He takes Suboxone, a replacement therapy for his opioid addiction.

WHY? The use of this term applies to discussions surrounding treatments for opioid dependence like Methadone, Suboxone and Vivitrol. By describing them as "replacements," it minimizes the validity of these treatments and implies that the individual is still actively using drugs. Methadone, Suboxone and Vivitrol are medications prescribed to a person suffering from an illness, the disease of opioid addiction. Addiction is an uncontrollable compulsive behavior.... With medication-assisted treatment as part of a comprehensive treatment plan with behavioral counseling, the dangerous addictive behavior is stopped, not replaced – and life can be extended.

Note: Public education underlining the need for good medicine is needed. Measures such as the nicotine patch, insulin for diabetes, anti-depressants for low serotonin or dopamine, are widely accepted and the way we describe opioid dependency treatments needs to become part of our positive everyday language.

INSTEAD SAY: Medication-assisted treatment, Opioid Antagonist Treatment (OAT), anti-craving medication, medication, treatment.

Source: Julie (2017, June 21). Why You Shouldn't Use the Word "Addict". *Partnership for Drug Free Kids.* Retrieved from https://drugfree.org/parent-blog/shouldnt-use-word-addict/#.WVhE45_MK7w.facebook

Emotional support

Regardless if you are mourning the loss of a loved on due to substance use or if you are working to support someone in or towards recovery, you will benefit from the emotional support of peers. In the Connect with Us section at the front of this handbook you are introduced to our closed Facebook Group. If you've lost someone, or love someone who uses/used substances, or if you yourself use(d) you'll be invited to join the closed Facebook group, MSTH. Hopefully this group will help you navigate your difficult journey and provide emotional support.

It is important to remember that everyone in the group is a peer and a volunteer. We can only speak from our own experience and not as professionals.

If you feel you are unable to cope or if you have thoughts of ending your life, contact emergency services, such as help lines or health services for your region. Have those numbers available. If you or someone else is imminently at risk, call 911.

If you notice another member posting messages that might indicate that they are at risk, encourage them to call for help. Try to reach out to someone in the same region or community if possible. If a private message from someone gives you cause for concern, ask for a phone number and try to call the person, if possible. In an emergency, call 911.

Ultimately there are limits to how we can help and reach out to each other over social media. We can only do what we think is best with the information and resources available at the time. Most importantly we show we care, understand, and walk with each other.

Living with Grief

Thankfully many members of MSTH have loved ones seeking or in recovery, however, the great majority of mothers, fathers, siblings, spouses, grandparents, and friends who have joined this group are living with grief. Sadly, there is little available in terms of grief support specifically for those who have lost a loved one due to substance use related causes. There are, however, clear linkages between the kind of complicated grief that develops after a substance use loss and the grief felt by those who lost someone to suicide. In both cases the grief is complex and prolonged, due to feelings of guilt and shame, as well as societal stigma.

Alberta Health has a resource on dealing with suicide grief that includes helpful information that would in most cases also apply to a substance use loss. This guide is written with a focus on an indigenous audience. The recourse from the British Columbia Ministry of Health contains similar information, written for a general audience. Either booklet can help you navigate some of the difficult decisions you will have to make.

Resources on coping with grief.

Alberta Health Services (2017). *Healing Your Spirit. Surviving the Suicide of a Loved One*. Retrieved from the Alberta Health Services website http://www.albertahealthservices.ca/assets/healthinfo/ipc/hi-ip-pipt-chc-healing-your-spirit-2017.pdf

British Columbia Ministry of Health. (n.d.) Hope and Healing. A Practical Guide for Survivors of Suicide. Retrieved from the Government of BC website http://comh.ca/publications/resources/pub_hh/HopeandHealing.pdf

B.C. Bereavement Hotline - Helpline and referral for people who are bereaved. 1-877-779-2223 www.bcbereavementhelpline.com

Grief support groups

In response to the lack of grief support several of our members have started peer support groups, either under the umbrella of the US organization GRASP or as a local group. Currently Canadian GRASP groups exist in Victoria, Kelowna, Edmonton, Calgary, Toronto, and Waterloo. The Vancouver group is currently inactive and a group is Saskatoon is in discussions. If you want to get involved in starting a group, please let a leader know. To contact the active groups and find out when they meet, go to the GRASP website http://grasphelp.org/meetings/

Some of our members started grief support groups without the GRASP banner.

A local group is operational in Fort MacMurray. For information on this group call Mari-Lee Paulszak at 780-370-3816 or through the Dragonfly's Wings Support Group's closed group Facebook page. The group meets at the Wood Buffalo Regional Library.

Most hospices will offer grief support groups for any type of loss, and several MSTH members have found these groups to be helpful. Check local resources.

Private grief counselling resources

With the lack of public or peer lead resources for grief counselling, some of you may seek out private services. We can share contact information for services members have used. If there are others that you have used and can recommend, please let us know. We are looking to add resources that are specific to substance use related loss or trauma.

Grief is unique

Grief is unique to each of us, but for me this helped understand some of my process.

As for grief, you'll find it comes in waves. When the ship is first wrecked, you're drowning, with wreckage all around you. Everything floating around you reminds you of the beauty and the magnificence of the ship that was, and is no more. And all you can do is float. You find some piece of the wreckage and you hang on for a while. Maybe it's some physical thing. Maybe it's a happy memory or a photograph. Maybe it's a person who is also floating. For a while, all you can do is float. Stay alive.

In the beginning, the waves are 100 feet tall and crash over you without mercy. They come 10 seconds apart and don't even give you time to catch your breath. All you can do is hang on and float. After a while, maybe weeks, maybe months, you'll find the waves are still 100 feet tall, but they come further apart. When they come, they still crash all over you and wipe you out. But in between, you can breathe, you can function. You never know what's going to trigger the grief. It might be a song, a picture, a street intersection, the smell of a cup of coffee. It can be just about anything...and the wave comes crashing. But in between waves, there is life.

Somewhere down the line, and it's different for everybody, you find that the waves are only 80 feet tall. Or 50 feet tall. And while they still come, they come further apart. You can see them coming. An anniversary, a birthday, or Christmas, or landing at O'Hare. You can see it coming, for the most part, and prepare yourself. And when it washes over you, you know that somehow you will, again, come out the other side. Soaking wet, sputtering, still hanging on to some tiny piece of the wreckage, but you'll come out.

Take it from an old guy. The waves never stop coming, and somehow you don't really want them to. But you learn that you'll survive them. And other waves will come. And you'll survive them too.

If you're lucky, you'll have lots of scars from lots of loves. And lots of shipwrecks.

("Old Man's Advice To Grieving Woman", author and date unknown)

Appendix I: Opioid prevention and response glossary

Source: Government of British (n.d.) Retrieved from the Government of British Columbia website www2.gov.bc.ca/assets/gov/overdose-awareness/overdose_prevention_glossary.pdf

The Government of British Columbia created this glossary to clarify words and phrases used about opioid overdose prevention and response. Language changes and evolves over time and the definitions in this document may be updated in the future to reflect current research and understanding of substance use.

Addiction: Behaviour characterized by a loss of control and a continued craving for the behaviour despite negative consequences. Current medical terminology identifies drug addiction as "substance use disorder." Addiction is a complex issue which has many causes, including biological, psychological, social, economic, and spiritual factors.

Adulterant: Chemical or compound that may be added to illegal drugs typically without the knowledge of the consumer to increase profitability.

Analogue: Chemical compound that is structurally similar to another but differs slightly in composition. For example: Carfentanil is a fentanyl analogue.

Analgesic: Medicines that relieve pain.

Buprenorphine: Analgesic that may be prescribed to control or moderate severe pain or to treat opioid use disorder as an opioid substitution medication. It can be administered under the tongue by tablet, by injection, or by a transdermal skin patch. In Canada, buprenorphine is most often provided in combination with naloxone a formulation which reduces the risk of diversion and non-medical use. It helps with withdrawal symptoms and cravings for opioids. Also known as Suboxone.

Carfentanil: Synthetic opioid which can be up to 100 times more toxic than fentanyl. Use of this toxic drug, even in very small amounts, could result in overdose. It is used as a tranquilizer for large animals such as elephants.

Carries (in the context of Opioid Substitution Therapy): Measured daily doses of opioid substitution treatment medications (e.g., buprenorphine/naloxone or methadone) that patients are allowed to take home with them for self-administration outside of a pharmacy. Carries are only prescribed by a health provider once a patient has become stable through success in their treatment. The number of doses they are allowed to take home can vary, but is usually enough for a few days or up to one week.

Club drugs: Psychoactive (mind-altering) substances often used at all-night dances or raves. Some examples of club drugs are ecstasy (MDMA), methamphetamine, gamma-hydroxybutyrate (GHB), flunitrazepam (Rohypnol), and ketamine. The term "club drug" is not a scientific one, and substances are varied and have different pharmacological properties.

Cognitive Behavioural Therapy (CBT): A form of psychosocial treatment that helps people understand their patterns of thinking and behaviour to learn healthier skills, habits and coping techniques. CBT is flexible, easily customized, supports self-efficacy and can help with self-management of mental health issues, including substance use problems.

Concurrent disorder: Condition in which a person experiences two medical problems, such as having a mental illness and a substance use disorder. Concurrent disorder can refer to a wide range of co-occuring mental illnesses and substance use issues.

Consumption: Taking a substance into the body by ingestion, inhalation, injection, or absorption via mucous membranes (including in the nose, through snorting) or through the skin.

Crystal meth: A smokable chemical variation of methamphetamine (also called jib, ice, crystal, speed or crank). Methamphetamine is a potent, long-acting synthetic stimulant drug. Use of crystal meth can lead to adverse health effects, including psychotic episodes.

Dependence: A need for repeated doses of a substance to feel good or avoid feeling bad, despite potential bad effects or consequences.

Diacetylmorphine: The medical term for the pharmaceutical-grade opioid that is more commonly known as heroin.

Discrimination: Action or a decision that treats a person or a group negatively for reasons such as their race, age, socio-economic status, gender, sexual orientation or ability.

Dope sick: A slang term for withdrawal, or a group of symptoms that happen when a person stops or decreases use of a substance that they are dependent on. Long-acting medications like methadone or buprenorphine/naloxone can help avoid withdrawal symptoms while on opioid substitution treatment (OST).

Fake Oxys: Illegally produced counterfeit pills that are made to look like a pain medication that used to be available in Canada (Oxycontin).

Fentanyl: An opioid pain medication. Fentanyl has medical uses and can be prescribed by a physician to help control severe pain, but in recent years it is also being produced in illegal labs and sold on the streets, often mixed with other drugs (such as heroin, cocaine, and others). Fentanyl is 50 to 100 times more toxic than morphine, which makes the risk of accidental overdose higher.

Harm reduction: Policies, programs and practices that aim to reduce the adverse health, social, and economic consequences of psychoactive substance use for people unable or unwilling to stop using immediately. Harm reduction is a pragmatic response that focuses on keeping people immediately safe and minimizing death, disease, and injury from high-risk behaviour. It involves a range of strategies and services to enhance the knowledge, skills, resources, and supports for individuals, families and communities to be safer and healthier.

Heroin: A slang term for an illegal opioid street drug, originally the trade name for diacetylmorphine. It is usually a white, odorless, bitter crystalline compound that is derived from morphine.

Heroin Assisted Treatment: Treatment that includes the provision of pharmaceutical grade heroin (diacetylmorphine) under medical supervision, along with other interventions that support people who are seeking treatment for opioid use disorder.

Housing: Where a person lives. A person's housing situation can influence the impact substance use has on their health and can also compromise the effectiveness of treatment. People who do not have stable and supportive home environments (such as those living on the streets, in unstable housing or with a substance-dependent or abusive partner) need supports to help them find stable housing.

Hydromorphone (trade name Dilaudid): An opioid medication used to treat severe pain, which has also been studied in Canada as a medication to assist in the treatment of opioid use disorder, for patients who have not responded to other forms of treatment. This drug is available as an oral tablet, a liquid solution and extended-release tablet that is taken orally. It can also be administered as an intravenous (IV) injection from a healthcare provider.

Illicit: A thing or act that is forbidden, disapproved of, or not permitted for moral or ethical reasons by custom, society, laws or rules. It can be something illegal, or may not be specified by law.

Low threshold/low barrier: Services that have very few requirements for people to access them. For example, services may not require clients to be seeking or to achieve abstinence from substance use in order to participate.

Methadone: A long-acting opioid medication that may be prescribed to treat pain or opioid use disorder. It relieves withdrawal symptoms, reduces the physiological cravings and allows body functions to become stable.

Methylenedioxymethamphetamine (MDMA): Psychoactive (mind-altering) substance. Also known as ecstasy or E.

Naloxone: Medication that can reverse the effects of an opioid overdose when injected into an arm, buttocks or thigh muscle or when administered as an intranasal spray. Within two to five minutes, naloxone can reverse slowed breathing. Also known as Narcan.

Opioid Agonist Treatment: See Opioid Substitution Treatment.

Opioid Substitution Treatment: An evidence-based treatment for opioid use disorder, which involves the prescription and daily administration of medications that are substitutes for opioids such as heroin or fentanyl. It relieves withdrawal symptoms, reduces the physiological cravings and allows body functions to become stable. Methadone and buprenorphine/naloxone (also called Suboxone) are the most common medications used for opioid substitution treatment. Also known as Opioid Agonist

Treatment and Opioid Assisted Treatment.

Opioid use disorder: A problematic pattern of opioid use that causes clinically significant impairment or distress. A diagnosis is based on criteria such as unsuccessful efforts to cut down or control use, as well as use resulting in social problems and a failure to fulfill obligations at work, school, or home. Opioid use disorder can also be called opioid dependence or opioid addiction.

Opioids: Opioids are a class of substances that are used to reduce pain in the body. Opioids can be legal and illegal. Examples of opioids include heroin, morphine, fentanyl, methadone and codeine.

Outreach: Community-based services that are designed to improve health and reduce drug-related risk or harm. These services are designed to link people to health or social services by sending staff to places where people who use substances frequently spend time.

Over the counter drugs: Medicines you can buy without a prescription.

Overdose (OD): Use of a substance in excess, resulting in negative health effects on the person who consumed the substance. An overdose may or may not be fatal.

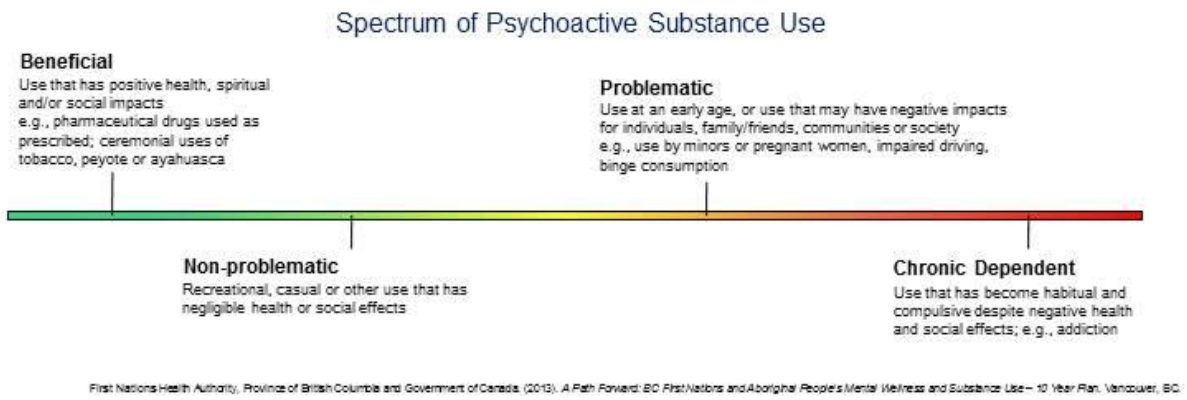
Overdose prevention sites: Services in some parts of British Columbia that were established as a response to the opioid overdose public health emergency, which provide people who use drugs a space where they can be monitored by health professionals, and receive treatment for an overdose if needed.

Oxycodone: An opioid analgesic used to relieve moderate to severe pain.

OxyNeo/OxyContin: A time-released formulation of the opioid pain medication oxycodone. It was developed in 1995 for people needing around-the-clock pain relief, so they don't have to take pills as often. OxyContin is no longer sold in Canada, replaced by a new tamper-resistant formulation, OxyNeo.

Person-first language: A non-stigmatizing way of referring to a person that does not prioritize their behaviour or health condition. Acknowledges that a person's condition, illness or behaviour is not that person's defining or primary characteristic. For example, "A person who uses drugs," or "A person living with HIV."

People who use drugs: People who use psychoactive substances, which can occur along a spectrum of use. Some people choose abstinence and use no substances at all, a decision which should be honoured, respected and supported. Some people who use substances do so in beneficial or non-problematic ways, such as drinking coffee to stay alert, or ceremonial uses of tobacco, peyote or ayahuasca; others drink alcohol moderately in social situations and do not experience problems. Some people engage in problematic substance use-for example, using at an early age, using while pregnant, or driving while impaired-which increase the risk of harms that can and should be prevented. Some people develop chronic dependent substance use, or addiction, which may require treatment or other drug-related health and community supports. Talking about "people who use drugs" is preferable to labelling them as an "addict," or "user," underscoring the humanity of the person first.



First Nations Health Authority, Province of British Columbia and Government of Canada. (2013). *A Path Forward: BC First Nations and Aboriginal People's Mental Wellness and Substance Use – 10 Year Plan*. Vancouver, BC.

Prevention: Measures that prepare and support individuals, groups, communities and larger systems in reducing the onset of problematic substance use or minimizing harms from substance use.

Process addiction: The compulsive and persistent engagement in a behaviour or action (other than drug use) that causes serious negative consequences to a person's physical, mental, social and/or economic well-being. Examples of behaviours that for some individuals may become process addictions are gambling, video gaming, work, sex, shopping and internet use.

Problematic substance use: Instances or patterns of substance use associated with physical, psychological, economic or social problems or use that constitutes a risk to health, security or well-being of individuals, families or communities. Some forms of problematic substance use involve potentially harmful types of use that may not constitute clinical disorders, such as impaired driving, using a substance while pregnant, binge consumption and routes of administration (i.e. ways of taking a substance into one's body) that increase harm. Problematic substance us e also includes "substance use disorders" (defined as dependence or "addiction"). Problematic substance use is not related to the legal status of the substance used, but to the amount used, the pattern of use, the context in which it is used and, ultimately, the potential for harm. See also "Addiction," "Substance Use" and "Substance Use Disorders."

Psychoactive substance: A plant or chemical that affects the brain and associated mental functions, such as sensations of pain and pleasure, moods, views of reality, thinking ability, motivation or being alert. Examples include coffee and tea (caffeine), alcohol, tobacco (nicotine), cannabis, coca (cocaine), amphetamines, LSD, psilocybin mushrooms, opium and derivative opioid medications.

Recovery: A process of change through which individuals work to improve their health and wellness, live self-directed lives, and strive to reach their full potential. Recovery is built on access to evidence-based clinical treatment and recovery support services for all populations.

Resilience: The ability to cope with challenges, process negative feelings, bounce back from bad experiences, and move forward in the face of adversity. It is vital for health and well-being. The four key "protective factors" that lead to resilience and help young people grow into thriving adults are:

connectedness; opportunities for participation, contribution and high self-expectations.

Risk factors: Characteristics of people or environments that increase the chance of developing, prolonging or intensifying substance use problems.

Self-efficacy: Believing in yourself, your abilities and knowing or trusting that you can succeed at setting and achieving a goal.

Stereotypes: An oversimplified, generally over-exaggerated belief that all members of a certain group act and think in the same way. People use negative stereotypes to justify discrimination.

Stigma: Disapproval of a person or group by society, community or larger group, based on perceived characteristics, which significantly discredits the person or group in the eyes of others, particularly when the person or group differs from the larger cultural norms. For example, beliefs and attitudes about people living with mental illness or substance dependence that leads to negative stereotyping and prejudice against them and their families. These beliefs are often based on fear, ignorance, misunderstanding and misinformation.

Suboxone™: The brand name of a medication that contains a four-to-one ratio of buprenorphine and naloxone, and is prescribed for opioid substitution treatment. Buprenorphine activates opioid receptors in the brain and relieves pain up to a certain point. The result is that treatment with Suboxone virtually eliminates cravings for opioids in people with opioid use disorder who use it as directed by a qualified medical professional. It can be taken once per day as a pill or other format.

Substance use: The intentional consumption of a psychoactive substance (legal or illegal) in order to modify or alter consciousness. Psychoactive substances include alcohol, caffeinated beverages, tobacco, certain medications, solvents and glues and a range of controlled (i.e. illegal) substances, such as cannabis, cocaine and heroin. The use of psychoactive substances is an almost universal human cultural behaviour and has been engaged in since the beginning of human history. Substance use can occur for a variety of reasons – including medical, scientific, spiritual or religious, social, pleasurable or habitual – and its effects can range to beneficial to severely problematic, depending on the quantity, frequency, method or context of use.

Substance use disorder: A diagnostic term for an illness in which the use of one or more psychoactive substances leads to clinically significant symptoms - including craving and inability to stop using despite negative consequences - that are detrimental to the individual's physical and mental health, or the welfare of others. The terms substance use disorder is the preferred current medical term for what is more commonly known as drug addiction or dependence.

Supervised Consumption Services (SCS): Health services where people consume drugs (that they have obtained elsewhere) in a hygienic environment, under the supervision of trained staff. The intent is to reduce the number of overdose deaths, connect people who use illegal drugs with healthcare services, including treatment and reduce public drug use and discarded used needles. SCS also provides opportunities to engage in other health and social services.

Tapering: The gradual reduction of a dose of medication such as methadone. This should only be done with the supervision of a health care provider.

Titration (Stabilization): The process of determining the lowest dose of a substance needed to achieve the desired effects. This involves starting out on a low dose and safely working up to the dose that provides a stable feeling of comfort and wellness with minimal side effects.

Transdermal skin patch: A method of administering medication, in a stick-on patch that is applied to skin. Also known as a skin patch.

Trauma: An experience that overwhelms an individual's capacity to cope. Trauma can be devastating, interfere with a person's sense of safety, self and self-efficacy, as well as the ability to regulate emotions and navigate relationships. Traumatized people may feel terror, shame, helplessness, powerlessness, and may engage in problematic substance use or unhealthy behaviours as a way to cope. Trauma can include events experienced in early life, such as child abuse, neglect, disrupted attachment or witnessing violence.
It can also be rooted in events later in life such as violence, accidents, natural disasters, war, sudden unexpected loss and other life events that are out of one's control.

Withdrawal: Symptoms that may occur when a person with a substance use disorder or drug dependence stops or decreases use. These symptoms can typically be managed through appropriate treatment (withdrawal management).

Withdrawal management: Quitting or cutting down on substance use under the care of a health professional. The aim is to alleviate pain and to achieve a temporary state of abstinence from the substance(s) and to treat any physical or psychiatric conditions.

W-18: A lethal fentanyl analogue

Appendix II: Disclaimer

MSTH is a volunteer organization and members are not able to provide professional advice. We speak from our personal perspective only and share what we have learned or experienced.

1. MSTH Facebook page and website are online communities and information resources for individuals and organizations seeking information on drug policy reform and substance use. The content of the website and Facebook page is provided for information purposes only. MSTH has made its best endeavours to ensure that the content of this website is correct and current at the time of publication but makes no warranty, express or implied, that the material is accurate, authentic or complete and takes no responsibility for any error, omission, or defect.
2. MSTH does not accept any liabilities for any loss, damage, cost, or expense you or others might incur as a result of the information, advice (or the use or uptake of such information, advice or volunteering opportunities) provided on our website and Facebook page, or incorporated into it by reference.
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