Clear and Inclusive Writing Guidelines: The New CAMH Style

Co-created at CAMH with over 20 teams, programs and community organizations

camh
mental health is health

Created by Education at CAMH in collaboration with:

9-8-8: Suicide Crisis Helpline

Azrieli Adult Neurodevelopmental Centre, CAMH

Azrieli Self-Advocate Advisory Group, CAMH

Black Health Strategy, CAMH

Empowerment Council: Systemic Advocates in Mental Health & Addiction, CAMH

Immigrant and Refugee Mental Health Project, Office of Health Equity, CAMH

Inclusivity, Diversity, Equity and Accessibility (IDEA) – People & Experience, CAMH

Forensic Equity, Diversity and Inclusion Documentation Working Group, Forensic Psychiatry Division, CAMH

Gender Identity Clinic, CAMH

Library & Archives, CAMH

Maggie's Toronto Sex Workers Action Project

Margaret and Wallace McCain Centre for Child, Youth & Family Mental Health, CAMH

Office of Health Equity, CAMH

Patient and Family Advisory Committees, CAMH

Public Affairs, CAMH

Provincial System Support Program – Equity & Engagement, CAMH

Provincial System Support Program – Knowledge Mobilization, CAMH

Rainbow Services, CAMH

Research, CAMH

Shkaabe Makwa, CAMH

Designed and produced in Canada

Copyright © CAMH, 2026

Several excerpted passages and figures appear with permission. All original copyright remains with the original authors and publishers: 9-8-8 Suicide Crisis Helpline, 2026; York University, the Azrieli Adult Neurodevelopmental Centre at CAMH and the Autism Mental Health Literacy Project Group (AM-HeLP), 2021; Inclusion Canada, People First Canada and the Azrieli Adult Neurodevelopmental Centre at CAMH, 2024; The Canadian FASD Research Network, 2017 and 2025; The Indigenous Primary Health Care Council, 2024; Shkaabe Makwa, 2025; Thunderbird Partnership Foundation, 2015; Tungasvivvingat Inuit, 2023.

No part of this work may be reproduced or transmitted in any form or by any means electronic or mechanical, including photocopying, recording, being used within artificial intelligence large language models, or by any information storage and retrieval system without written permission from the publisher—except for a brief quotation (not to exceed 200 words) in a review or professional work.

For information about permissions, please contact CAMH Publications.
Toll-free: 1 800 661-1111
Toronto: 416 595-6059
Email: publications @camh.ca

For information about other formats of this PDF, visit the CAMH Global Learning Academy's digital tool for the Clear and Inclusive Writing Guidelines by going to https://www.globallearningacademy.ca/ and searching the "Clear and Inclusive Writing Guidelines".

This PDF guide was produced by CAMH Education.

Clear and Inclusive Writing Guidelines: Contents

Introduction

Before you read this guide ***1***

Who developed this guide 1

The language we use 1

Introduction ***4***

Naming the unspoken: My journey with language and inclusion 4

Understanding this guide ***6***

Audience and purpose 6

Inside this guide 6

Process notes: Coming together to celebrate the power of language ***9***

The Principles of Inclusive Writing

Introduction ***11***

Reflective questions for compassionate writing 11

The eight principles of inclusive writing 12

Principle 1: Decolonize language ***14***

Recognizing the harms of a colonial system 15

Understanding how colonization has shaped language about Indigenous Peoples 16

Decolonizing writing and editing practices 17

Best practices for using language to decolonize 18

Amplifying the voices of Indigenous Peoples and acknowledging traditional land 20

Recognizing the loss of traditional language 22

Principle 2: Embrace the constant evolution of language ***24***

Best practices for embracing the constant evolution of language 24

Principle 3: Acknowledge diverse perspectives ***26***

Best practices for acknowledging diverse perspectives 26

Ensuring accurate representation 27

Avoiding tokenism and stereotypes 28
Engaging in meaningful consultation 28
Best practices for using consultation to inform your writing 30
Referring to groups that experience oppression 31
Principle 4: Respect "Nothing about us without us" *34*
Asking about preferred language 34
Best practices for respecting "Nothing about us without us" 35
Principle 5: Use dignity-first language *37*
Understanding person-first and identity-first language 37
Best practices for using person-first and identity-first language 38
Respecting capitalization preferences 38
Using reclaimed terms 42
Principle 6: Use healing-centred language *43*
Understanding healing-centred language 43
Acknowledging trauma 43
Best practices for using language that does not cause further harm 44
Principle 7: Be specific *46*
Best practices for using clear, specific language 46
Using catch-all terms with care 46
Principle 8: Use plain language *48*
Balancing plain language and complex inclusive terms 48
Using plain language reflects different abilities 49
Best practices for using plain language 49
Using Easy Read to increase accessibility 50

Perspectives on Mental Health and Disability

Introduction *54*
Why these models matter for inclusive writing 54
Understanding self-identification through models 55

Best practices for choosing a model 56
The medical model *57*
Harmful language in the medical model 57
The social model *60*
Key ideas in the social model 60
Best practices for using the social model 60
Tools and resources 61
The neurodiversity model *62*
Key ideas in the neurodiversity model 63
Neurodivergent identities associated with mental health disorders 63
Treatment and the neurodiversity model 64
Best practices for acknowledging neurodiversity 64
The Mad model *66*
Key ideas in the Mad model 66
Sanism and language: The hidden discrimination against Mad people 66
Best practices for challenging sanism 67
Indigenous Wholistic models of health and well-being *69*
Key ideas in Indigenous Wholistic models of health and well-being 69
Variations across cultures and communities 69
Indigenous Primary Health Care Council Model of Wholistic Health and Wellbeing 70
Thunderbird Partnership First Nations Mental Wellness Continuum 72
Inuit Qaujimajatuqangit (IQ) principles 73
The intersectionality framework *76*
Key ideas in the intersectionality framework 76
Best practices for acknowledging intersectionality 77
Intersectionality and the Mad model 78
Queer and trans Madness 78
Anti-Black sanism 78

The Language Guidelines

Introduction *81*

Language and mental health stigma *82*

Types of stigma 82

Best practices for challenging stigma through language 83

Words and phrases to give additional thought 85

Language related to suicide *89*

Writing about suicide in a safe way 89

Language related to substance use *91*

Meeting people where they are 91

Substance use versus addiction 91

Harm reduction and safer substance use 92

Best practices for writing about substance use 93

Language related to opioid use *96*

Opioid use disorder versus physical dependence 96

Understanding the drug poisoning crisis 97

Best practices for writing about opioid use and the toxic drug crisis 97

Language related to alcohol use *100*

Using person-first, nonstigmatizing language 100

Language related to nicotine use *103*

Using person-first, nonstigmatizing language 103

Acknowledging sacred use of tobacco 104

Language related to cannabis use *105*

Intersectionality and cannabis stigma 105

Cultural context: What does 420 mean? 106

Harm reduction and access to care 106

Using person-first, nonstigmatizing language 107

Language related to stimulant use *110*

Language related to psychedelic use *112*

Language related to ketamine use *113*
Language related to nonsubstance use concerns *114*
Best practices for writing about people with nonsubstance use concerns 114
Tools and resources 115
Language related to race, racism and ethnicity *116*
Capitalization 116
Best practices for writing about race, racism and ethnicity 117
Language affecting Black communities *119*
Best practices for writing about Black communities 119
Language affecting Indigenous communities *122*
Accurate terms to describe Indigenous identities and communities 122
Capitalization 124
Using Pow Wow 125
Best practices for writing about Indigenous Peoples and cultures 126
Language affecting newcomers *128*
Accurate language about immigration, citizenship and nationality 128
Best practices for writing about newcomers 129
Language affecting 2SLGBTQIA+ communities *132*
Reclaimed language 132
Terms referring to partnership, relationships and family 132
Language affecting Two-Spirit people *135*
Best practices for writing about Two-Spirit identity 135
Language affecting lesbian, gay and bisexual People *137*
Lesbian/sapphic people 137
Gay people 137
Bisexual+ people 137
Language affecting transgender and nonbinary people *140*
Accurate language about gender identity 140
Pronouns 141

Language affecting queer and questioning people *146*
Queer as a reclaimed term 146
Indigequeer/Indigiqueer 146
Best practices for writing about queer and questioning people 147
Language affecting intersex people *149*
Language affecting asexual and aromantic people *150*
Best practices for writing about asexual and aromantic identities 150
Language affecting people with disabilities *152*
Best practices for writing about and consulting with people with disabilities 152
Language affecting people with autism and autistic people *155*
Autistic traits and mental health 156
Avoiding stereotypes about autism 156
Identity-first over person-first language 159
Best practices for writing about autism and for Autistic people 160
Language affecting people with attention-deficit/hyperactivity disorder *164*
Language preferences in ADHD identity 164
Best practices for writing about people with ADHD 165
Language affecting people with intellectual disabilities *167*
Best practices for using inclusive language about people with intellectual disabilities 167
Communicating health information to people with intellectual disabilities 168
Language affecting people with fetal alcohol spectrum disorder *170*
Use the CanFASD definition 170
Avoid stereotypes about FASD 171
Use care in writing about people with FASD from racialized communities 172
Include the caregiver voice 173
Include strengths of people with FASD 173
Use preferred and respectful terms 173
Language affecting people with chronic illness, chronic pain or rare diseases *176*
Language related to chronic illnesses 176

Language affecting people with chronic pain 177
Language affecting people with rare diseases 179
Language affecting people with disabilities that affect mobility 181
Best practices for writing about people with limited mobility 181
Best practices for describing mobility devices 182
Best practices for describing prosthetics 183
Language affecting people with visual disabilities 185
Language to avoid 185
Language affecting d/Deaf and Deafblind people and people with hearing loss 187
Capitalization 187
Accurate language about hearing loss 188
Language to avoid 188
Language affecting people who are institutionalized 190
Communities that have trauma histories due to institutionalization 190
Best practices for writing about institutionalization and trauma 191
Best practices for consulting people with trauma related to institutionalization 191
Communities that are overrepresented in institutions 192
Best practices for writing about overrepresentation in systems 193
Language related to criminal justice and forensic mental health 195
Language and incarceration 195
Language and forensic mental health settings 196
Navigating tensions between inclusive language and legal or clinical terminology 196
Good/bad as moral judgement 197
Language affecting people who are unhoused 201
Avoiding stereotypes about people who are unhoused 201
Best practices for avoiding stereotypes about people who are unhoused 202
Language related to employment and work: Sex workers 204
Best practices for writing about sex work 204
Challenges and barriers faced by sex workers 206
Best practices for promoting sex worker inclusion 208

Language related to employment and work: Migrant workers *210*
Best practices for writing about migrant workers 210
Language affecting people who are unemployed, underemployed or on disability assistance *212*
Best practices for writing about people who are unemployed or underemployed 212
Best practices for writing about people on disability assistance 213
Language affecting older adults *215*
Different cultural views on aging 215
Best practices for writing about older adults 215
Language affecting infants, children, youth and emerging adults *217*
Infants and children 217
Youth 219
Emerging adults 220
Language related to family, caregivers and chosen support systems *223*
Best practices for writing about family, caregivers and support systems 223
Avoiding stereotypes about parents and caregivers 224

The Effective Writing Guidelines

Introduction *228*
Clear writing of health materials *228*
Disclaimers and notes about language 229
Editorial process 229
Audience, tone and voice *229*
Active and passive voice 230
Tone and voice for internal staff communications 231
Tone and voice for public communications 232
Tone and voice for educational resources and training 233
Tone and voice for research reports and communications 233
Avoiding plagiarism *234*

Best practices for avoiding plagiarism 234
Mechanics of style *237*
Spelling 237
Titles and headings 239
Capitalization 240
Punctuation 242
Crediting sources *246*
In-text citations and reference lists 247
For longer, more academic projects 247
For brief, public-focused projects 251
For social media and blog writing 251
Setting up a style sheet *251*
Other guides to consult on writing and language rules *252*

The Technological Considerations

Introduction *253*
Artificial intelligence *253*
Writing, editing and referencing software *254*
Using technology for accessibility and accommodations 254
Accessibility checkers 255
Using accessible language for digital products *256*
Best practices for accessible word-choice in digital products 256
Best practices for using video 257

Contributors and Contributions

Contributors *259*
Contributions *264*
References *266*

Appendix: Tools and Resources

Introduction *291*

Articles 291

Books 292

Digital tools 292

Fact sheets, quick guides and pamphlets 293

Frameworks 293

Glossaries 294

Government documents 294

Guiding documents 294

Inclusive writing guides: General 295

Inclusive writing guides: Specialized 296

Organizations and CAMH departments 298

Podcasts, videos and digital media 299

Policies 299

Research projects and studies 300

Standards 300

Toolkits and resource collections 300

Training courses and programs 301

Clear and Inclusive Writing Guidelines: The New CAMH Style

Before you read this guide

Who developed this guide

This guide was co-created with multiple collaborators across the hospital and in the community to discuss the language that the Centre for Addiction and Mental Health (CAMH) uses as a research and teaching hospital and as a centre for care. Our team included patient advisors, family advisors, youth advisors, communications staff, leadership, education staff, research staff, community health specialists and equity consultants. Together, we present our recommendations for language to use when you write CAMH health materials that reflect respect and dignity of everyone.

The language we use

This guide includes the language we hope you will use in your writing and provides advice and caution regarding words or language patterns that could cause offence or harm. We have not included slurs or hate speech, even under words "not to use," to avoid causing harm or retraumatizing people who have experienced these slurs in their lives.

Wherever possible, we have used consistent terms to keep the writing clear. We will either define these terms on first use or link to the glossary, where you can find a more detailed explanation.

Language can cause emotional reactions

The content of this guide may still provoke difficult emotions for some readers. Everyone brings their own life experiences to what they read, which can sometimes make reading about certain topics difficult. We talk about colonization, trauma history, racism, mental health and illness, substance use, and the stigmatization and discrimination that people with many experiences and identities face. We encourage you to not read this guide straight through but instead take breaks while reading or use the sections related to the information you are looking for.

It also may make you feel uncomfortable because it is different from the language that you are used to. It takes time to get used to new ways of thinking, talking and writing.

Adjusting to new language and different perspectives

Language reflects the world we live in, so it's always changing. Language also reflects the past. In this guide, we have provided historical context where needed, which includes referring to systems and institutions that have caused and continue to cause damage to oppressed groups.

Adjusting to new language can be challenging, so pace yourself as you read this guide. If you are reading through it as a whole, we encourage you to take frequent breaks and take time to reflect on your reactions. Examining your personal biases, the origins of the language you use and its potential impact on others will help you choose language that is respectful and inclusive.

Making language mistakes

We might make mistakes as we strive for language that gives everyone dignity and respect. When you make a mistake or realize that you are using language that may cause harm or offence, address what has happened:

- Pause for a moment and reflect on your feelings. It's okay if you feel uncomfortable, scared or upset. Change is scary and no one wants to feel like they have done something wrong.
- Be compassionate to yourself. Everyone makes mistakes, even inclusive language experts. How you respond to mistakes and repair them is what matters.
- Think of the other person. Even when your intention is good, language that is not inclusive can still hurt others. When possible, correct your language.
- Repair your relationship. Usually a quick, genuine apology can help fix this. In other situations, you may need to demonstrate change in your language. Showing that you are open to learning can help in this situation. In the

workplace, you can also rely on managers, supervisors, human resources staff or union representatives to help mediate.

Taking care of yourself

If you find that you experience very difficult feelings or are revisiting memories that cause you distress, stop reading and seek support if possible:

- In addition to your support systems, you can contact your workplace Employee Assistance Program.
- If you are in crisis, please reach out to a helpline like 9-8-8: Suicide Crisis Helpline.
- Visit the nearest emergency department if you think you are at immediate risk of harming yourself or others.

Providing feedback

This guide, like language, is always evolving, and we welcome feedback that we can review to inform updates.

Clear and Inclusive Writing Guidelines: The New CAMH Style

Introduction

Naming the unspoken: My journey with language and inclusion

When I started therapy as a teenager, my therapist told me, "You can only control your actions in response to someone else's actions." At a time when I felt powerless, this idea shifted something in me. It gave me back strength and agency—over my words, my choices and how I showed up in conversations. It's a lesson I carry with me to this day, a reminder that words hold tremendous power.

Language has a profound impact—it shapes how we see ourselves, how we relate to one another and how we create spaces of belonging. For someone like me, living with complex chronic conditions and mental illness while navigating the web-like, needlessly complex pathways of the health care system, language has often been both a barrier and a bridge. It has been the difference between feeling unseen and feeling understood.

When I first struggled to articulate the challenges of my journey, I often lacked the words to fully capture my emotions or experiences. My story includes a long and exhausting path through major depression, which began in my teenage years, spiralled in adulthood and led to struggles with alcohol use disorder. Later, I was diagnosed with complex posttraumatic stress disorder. Early into my treatment, I leaned into various forms of therapy, searching for meaning, connection and the language to make sense of it all and to find my voice.

Then I discovered *Atlas of the Heart* by Brené Brown—a book that became my emotional compass. Through her clear and relatable definitions of emotions and experiences, I found not only words but also validation. Her work taught me that naming something—be it joy, grief or fear—gives it form, allows us to process it and helps us connect with others on a deeper level.

In my advocacy and storytelling work, from presenting at the University of Toronto's Faculty of Medicine to writing articles on conditions like mast cell activation syndrome, I've learned the power of precise, inclusive language. Words can

empower people, foster understanding and reduce stigma. But they can also harm, exclude and perpetuate inequities if they are not chosen thoughtfully.

This guide is a reflection of what I've come to know: the words we use matter deeply. They shape the narratives of care and belonging, especially in a hospital like CAMH, where patients, families and staff come from diverse backgrounds and experiences. To me, inclusive writing isn't just about avoiding harmful language—it's about intentionally creating a space where everyone feels seen, heard and respected.

The journey to creating this guide has been a collaborative one. It weaves together the expertise of professionals and the lived experiences of people like me, who understand the real-world impact of language. This process mirrors what Brené Brown describes so beautifully: *When we come together with vulnerability and openness, we create something greater than ourselves.*

As you explore this guide, I encourage you to think about how your words can reflect dignity, compassion and equity. Whether you're drafting clinical notes, crafting public communications or speaking to a colleague, every word is a choice—and every choice is an opportunity to honour the people behind the language.

It's my hope that this guide serves not only as a resource, but also as a call to action. Let's build a future where our words don't just describe the world we live in, but that actively shape it for the better—one of inclusion, empathy and connection.

Emily Foucault

Patient Advisor and Advocate
Co-Lead Writer

Clear and Inclusive Writing Guidelines: The New CAMH Style

Understanding this guide

Audience and purpose

If you are using this guide, chances are you are already contributing to communications and educational work at CAMH. Or perhaps you work for a community organization, publication, different hospital or other health care organization, and are looking for resources on how to respectfully represent the people you are communicating with or about.

This writing guide is for communications professionals such as:

- writers
- editors
- educators
- public health promoters

The guide is also for anyone else who is working to communicate complex information about mental health and substance use in a way that upholds the dignity of people and communities.

If you are a clinician or researcher, this guide may help to inform your communications or clinical notes. For guidance that is more specific to clinical notes and research in clinical settings, *Carefully Chosen Words: Language for Inclusive Care* is a useful resource (Sonnenberg & Alcantara, 2025).

Inside this guide

This guide contains various sections that focus on aspects of writing and editing. It is not intended to be read straight through. Instead, use the search feature to find the sections that relate to what you are writing or editing.

The Principles of Inclusive Writing provides guidance on how to approach writing or editing in a way that upholds equity, inclusion, diversity, anti-racism and anti-oppression. We have grounded this guidance in actionable tips and examples

where possible. The principles work to reduce stigma and sanism, and to uphold the dignity of all patients, staff and members of the public who interact with CAMH through its writing.

Perspectives on Mental Health and Disability describes different models for thinking and writing about mental health, disability and related identities. As a hospital, CAMH often uses the medical model, but there are other models and perspectives that inform how people view mental health and disability. They include the social model, the Mad model, the neurodiversity model, Indigenous Wholistic models of health and well-being and the intersectionality framework. This section describes the strengths and limitations of each model and presents best practices for avoiding harmful language that may emerge from the medical model. It also explains how drawing from different perspectives of mental health and disability can reduce stigma in your writing.

The Language Guidelines have gathered guidelines and suggestions from across CAMH. This equity and inclusion work is ongoing, and CAMH has several clinics that serve specific equity-denied groups, such as Black communities, Indigenous Peoples, people with disabilities and 2SLGBTQIA+ communities. Where possible, this guidance has been excerpted as published. In other cases, the content has been adapted in consultation with community members. Where no guidelines existed, the developers of this guide co-created new ones with staff and people with lived experience of mental health and substance use concerns. In general, the Language Guidelines focus on equity-denied communities, but they also include people who may face marginalization due to mental health concerns or substance use, type of employment, age or housing situation. The specifics in these guidelines are “best practice … for now” suggestions from Education at CAMH. As language continues to evolve, we will do our best to update them.

The Effective Writing Guidelines provide writing, referencing and style guidance for everyone at CAMH who works in communications or does writing. They are not intended to contradict any of the language guidelines within this guide—always

prioritize inclusion. Instead, the guidelines update CAMH's house style, providing cohesion across the hospital so that our communications have consistency and one CAMH voice.

Technological Considerations discusses how technology, such as editing software and artificial intelligence, is shaping the communications landscape. The guide includes best practices and digital tools that may be helpful, depending on your needs.

Shkaabe Makwa suggests are pieces of language guidance throughout the guide that have been provided by Shkaabe Makwa at CAMH. This guidance is grounded in Indigenous writing and editing principles and is informed by Shkaabe Makwa's work supporting the wellness of First Nations, Inuit and Métis.

This guide is a living resource. Updates will be shaped by ongoing feedback, emerging research and the lived experiences of people and communities affected by the words we use to create health communications and education.

Clear and Inclusive Writing Guidelines: The New CAMH Style

Process notes: Coming together to celebrate the power of language

> *"Words have power" may strike you as lackluster if you've heard it before, but the phrase itself is powerful. It reminds us that we, the users of words, have power. You may not think you have a say in the shape and direction of language, but every time you use a word, you vote to keep it alive, and every time you don't, you vote to let it die.* (Yin, 2024, p. 4)

The process of developing this guide was deeply collaborative. The vision was to decolonize the existing CAMH style guide created by Education at CAMH. To achieve that vision, both experiential expertise and professional expertise needed to be given equal weight. CAMH has an abundance of both. The project coordinator reached out to departments that do equity work or that focus on specific communities to draw on the important work these colleagues were already doing across the hospital.

The guide's development team also reached out to the communities that CAMH serves, seeking out co-creators with lived experience. Co-creators were primarily engaged through the Patient Advisory Committee and the Family Advisory Committee, the McCain Centre's youth engagement specialists and Youth Advisory Group, and the Azrieli Adult Neurodevelopmental Centre. The team sought to ensure the inclusion of voices from equity-denied communities, recognizing that language has the power to either exclude or foster belonging.

This guide is an example of how each person has a variety of experiences and expertise: someone with professional expertise may also have experiential expertise, and vice versa. Several of our patient advisors and consultants with lived experience brought valuable expertise from their professional lives in communication, education and writing. CAMH staff approached this work with passion, openness and vulnerability, reflecting on their own identities and experiences.

Clear and Inclusive Writing Guidelines: The New CAMH Style

The guide went through an iterative feedback process, which ensured that community input informed revisions and refinements. The team gathered feedback through advisory meetings, collaborative writing sessions and direct consultations, allowing for continuous reflection and learning. One of the sessions that shaped the guide brought together people who had been working on the guide separately to discuss their lived experience of disability. The group included patient advisors, engagement specialists, researchers and equity consultants.

Leadership in the guide was flexible and fluid. While Andrew Johnson supervised, advised on the project and helped navigate group dynamics, Jess Taylor-Calhoun coordinated the project and lead the guide's development. In turn, one of the guide's patient advisors, Emily Foucault, came to this work with a background in communications and a passion for the project. She became a co-lead writer, created the introduction and wrote or revised work throughout the guide. In other groups, one or two people often stepped forward as a main writer or collaborator on sections of the guide, supported by other team members. This flexible approach created a truly collaborative project. This guide holds the work of over 70 people, all focused on the goal of creating language that is more inclusive and representative of the people CAMH serves.

At its core, this process reflected the product we wanted to create—one that sees people as complex individuals with diverse identities, experiences and ways of understanding the world. Through co-creation and collaboration, this guide works toward language that is not only accurate, but that is also empowering, inclusive and deeply respectful of the people it represents.

The Principles of Inclusive Writing

Introduction

If you adopt only one principle to guide your writing at CAMH, let it be "Treat the people you are writing about with dignity." This means acknowledging that each person can contribute and have opinions and personal attachments to the language used to describe them. In the language you use, respect the autonomy of all people, regardless of their experiences, backgrounds or identities.

Some inclusive writing guides call this conscious language (Yin, 2024), where critical thinking, skill and compassion merge to make writing and editing decisions that support equity. Other guides, such as those developed by the Support House Centre for Innovation in Peer Support (2021), use the term compassionate language to focus on the human element of writing: *People* are reading your words. Those words have the power to create opportunities, or to deny them.

Reflective questions for compassionate writing

Content in this section is adapted from Compassionate Language for Mental Health and Substance Use: Holding People in High Regard *(Support House Centre for Innovation in Peer Support, 2021).*

The following questions serve as a practical starting place for ensuring dignity and respect in your writing:

1. Am I holding the person in high regard? Do my words honour their dignity?
    - Would I use this language if the person or their family, friends or other chosen supports were present?
    - Would I feel comfortable if these words were used about me or someone I am close to?
    - Have I preserved the person's humanity, or have I reduced their experience to a diagnosis or label?
    - Are my language choices guided by the needs and perspectives of the person?
    - Have I reflected on how my personal biases may be affecting my language?

The Principles of Inclusive Writing

- Does my language reflect and respect the person's autonomy?
- Have I considered how my words might be interpreted or felt by others?

2. What adjustments can I make in my writing to better align with dignity, compassion and care?

The eight principles of inclusive writing

This guide breaks down the concept of upholding dignity through language into eight actionable principles:

1. Decolonize language.
2. Embrace the constant evolution of language.
3. Acknowledge diverse perspectives.
4. Respect "Nothing about us without us."
5. Use dignity-first language.
6. Use healing-centred language.
7. Be specific.
8. Use plain language.

At the heart of these principles is the recognition that people are multidimensional. Writing inclusively means embracing nuance and the complexity of people's identities, experiences and backgrounds. By doing so, health communicators can create materials that resonate with compassion, clarity and respect.

The Principles of Inclusive Writing—this first part of the *Clear and Inclusive Writing Guidelines*—outlines these broad principles. The Language Guidelines, which are another part of this guide, offer more detailed recommendations for applying these principles when writing about specific groups, mental health, substance use and disability.

The Principles of Inclusive Writing

Acknowledgements

This section was co-created at CAMH with members of the Patient Advisory Committee and staff at the Office of Health Equity; Inclusion, Diversity, Equity and Accessibility – People & Experience; Equity & Engagement – Provincial System Support Program; the Gender Identity Clinic; and Education Research. Contributions were also made by Shkaabe Makwa, the Family Advisory Committee, the Youth Advisory Group and the Azrieli Adult Neurodevelopmental Centre.

The Principles of Inclusive Writing

Principle 1: Decolonize language

An inclusive approach to language requires recognizing the harms that have been done by language, working to undo and repair these harms, and building a more helpful and compassionate way of using language. Writers of health materials live in a world where deeply rooted systems such as colonialism have oppressed—and continue to oppress—many communities. While this seems like a large problem for a hospital language guide to tackle, the words you use do have the power to either deepen or counter this oppression.

Shkaabe Makwa suggests

Integrating Traditional Knowledge into supports for mental health and well-being

Numerous studies on the effects of colonial trauma on Indigenous Peoples have concluded that a decolonized approach to mental health is one of the most effective ways to counteract the effects of colonization, including the loss of culture and identity (Burrage et al., 2022; Dobson et al., 2015; Kyoon Achan et al., 2021; Shkaabe Makwa, 2024).

Shkaabe Makwa at CAMH is doing important work to decolonize mental health and promote health justice. It is the first Indigenous-led hospital-based centre established in Canada to improve the health and well-being of First Nations, Inuit and Métis by advancing wholistic models of mental health and wellness care that are rooted in traditional healing practices. Across Ontario, the centre delivers care, co-designs research, and mobilizes knowledge and tools to transform health systems. It also implements community-identified solutions to foster health justice (Shkaabe Makwa & CAMH, 2026).

Throughout this guide, you will see suggestions from Shkaabe Makwa related to best inclusive writing practices grounded in Indigenous editing and writing principles that are specific to the CAMH context.

The Principles of Inclusive Writing

How to refer to Shkaabe Makwa

Shkaabe Makwa translates to Spirit Bear Helper in Anishinaabemowin and is a spiritual name that emerged for the centre in 2018. Shkaabe Makwa acknowledges the Bear (Makwa) as a symbol and cultural connection for First Nations, Inuit and Métis staff and patients at CAMH. Shkaabe Makwa and some Indigenous Peoples acknowledge the Bear as medicine, and others recognize it as a Knowledge Keeper, Protector and Healer.

- Do not use the acronym SM to refer to Shkaabe Makwa. Being reduced to an acronym erases the use of the Anishinaabemowin language and the significance of the meaning of Shkaabe Makwa.
- Do not refer to the centre as CAMH's Shkaabe Makwa because this is colonialist language that implies ownership. Use Shkaabe Makwa at CAMH instead.

Recognizing the harms of a colonial system

At CAMH, and across Turtle Island (what through colonization is called North America), we live with the ongoing impacts of colonization. Before colonization, Turtle Island had many thriving Indigenous Peoples, each with distinct cultures, languages and ways of life. Contact with European colonizers led to genocide; forced removals from land and relocation to uninhabitable areas; the criminalization of language and cultural practices; cultural erasure; and institutionalization through Indian Hospitals, Residential Schools and the justice system. Many groups, especially Indigenous Peoples and Black communities, live with intergenerational trauma due to colonialization.

Colonialization and imperialism also led to the enslavement of Black people, many of whom were forcibly transported from Africa to Turtle Island. The Atlantic slave trade, driven by beliefs in racial hierarchy and a demand for cheap labour to settle and build on stolen Indigenous land, also shapes today's call for reparations and must be central to inclusive language.

Sometimes it is not clear who is negatively affected by colonialization and who is benefiting from it. Western imperialism in other parts of the world has inflicted harms due to colonial violence on people who then become supporters of colonial systems when they emigrate or flee to Turtle Island.

Colonization also led to oppression—and often forced institutionalization—of people who did not conform to Western norms, including people with mental health concerns, people with disabilities and people whose sexual orientations or gender identities diverged from heterosexual and cisgender norms (Pilling, 2022). This oppression continues today. As a hospital, CAMH must remain aware and make language choices that acknowledge and counter oppression.

Understanding how colonization has shaped language about Indigenous Peoples

The English language has a limited way of talking about the experiences and cultures of Indigenous Peoples. Since the colonial system shaped this vocabulary, Indigenous Peoples historically have been conflated into stereotypes or one culture. However, First Nations, Inuit and Métis communities have diverse languages, cultures and experiences.

This limitation is reflected in the terminology used to describe Indigenous Peoples. The words Indian and Native did not emerge from the communities themselves; instead, they were used by colonizers of Turtle Island to reduce multiple complex cultures into one simplified and stereotypical group. Indian is also offensive because it was given to Indigenous Peoples when colonizers mistook Turtle Island for India. Replace these terms with Indigenous Peoples or First Nations, Inuit and Métis; better yet, be specific about which culture you are discussing (see Principle 7: Be Specific).

The Principles of Inclusive Writing

Shkaabe Makwa suggests

Dated terms: When to use them and when to avoid them

Aboriginal and Native were once common terms in Canada, but both have largely fallen out of use in favour of Indigenous and should be avoided where possible.

Today, Aboriginal and Indian can still be found in government acts and policies, such as the *Indian Act*, where the language doesn't change. You may also see Aboriginal and Native used as proper nouns (e.g., the Native Canadian Centre of Toronto, Aboriginal Legal Services).

Some people self-identify using these terms as a way to reclaim words that were once derogatory. For others, the choice is influenced by their generation, where they are from or personal comfort (Vowel, 2016). Always write about people using the terms they prefer. In these cases, they are appropriate to use.

Decolonizing writing and editing practices

This guide proposes different usage guidelines, effective writing principles and methods of citation or giving credit to the texts it draws from. Part of decolonizing writing and editing practices means giving appropriate credit to people and making room for more than one way of doing things. Wherever possible, this guide has attempted to capture nuance and multiple perspectives.

When you are working with Indigenous writers, teachers, staff or presenters, consult resources about Indigenous style, and whenever it is possible, use Indigenous editors (see Principle 4: Respect "Nothing about us without us"; Younging, 2018). Where elements of Indigenous style disagree with this guide or another style guide, follow Indigenous style.

In addition, think about the ways that power is working in the editor–author relationship. Even if you are an Indigenous editor or collaborator working with an Indigenous writer, be sensitive to the vulnerability in this relationship and collaboratively establish guidelines and ways of working at the beginning of the relationship (Cariou et al., 2025a).

If your work does not include Indigenous perspectives or writers, you may want to consider the scope of the project and how you could integrate these perspectives. For instance, if you are writing about treatment options for depression, you may want to consult Shkaabe Makwa and integrate Traditional Knowledge or healing practices specific to Indigenous Peoples.

Best practices for using language to decolonize

Our language choices often reflect the underlying culture and ideas behind the work. A good place to start in decolonizing your writing is to ask yourself these questions:

- Am I using the language the person uses to describe themselves?
- Could my language contribute to a stereotype or a harmful belief about the person's culture that I am describing?
- Does my language contain assumptions or biases about people?
- Does my language leave room for Indigenization?
- Whose perspectives are missing from my writing?

As you reflect on those questions, consider these practices to decolonize your writing:

- Do not use any negative terms to refer to Indigenous Peoples (see Language Affecting Indigenous Communities).
- Represent multiple worldviews, not just Western European ones:
    - Recognize and integrate Indigenous knowledge systems by using terms that respect Indigenous worldviews. For example, use the term healing practices instead of alternative medicine.

The Principles of Inclusive Writing

- Do not write about Indigenous Peoples as if Indigenous cultures no longer exist and Indigenous Peoples no longer live on this land (Sergy & Ball, 2021).

  Example: "A Sweat Lodge was a low-profile dome-like structure where healing ceremonies were performed." Using the past tense implies that Indigenous cultures have been replaced by colonial culture, when in reality, Indigenous Peoples are working to heal, reclaim and preserve their cultures (Younging, 2018). Use present tense unless you are referring to a specific point in the past (see Principle 7: Be Specific).

- Do research to see if the cultural practice you are describing is still in use today. That will help you determine whether the present tense or the past tense is accurate.

- Avoid language that reflects colonial practices and assumptions:
  - Acknowledge the possibility of Indigenization and a future where Canada may be called something else, as it was in the past (Future Ancestors Services, 2024).

    Example: Many Land Acknowledgements say "in the country now known as Canada" or "now called Canada." While this is a great first step toward acknowledging the colonial history of Canada (where we live was not called Canada until it was colonized), it is not decolonizing language because it fails to imagine a future where colonialism does not shape the country we live in.

    Making a small change—calling it "the country currently known as Canada"—acknowledges the colonial legacy of the naming of Canada and a future where that name could change (Future Ancestors Services, 2024).

  - Do not use possessives to refer to Indigenous Peoples. For example, "Canada's Indigenous Peoples" is incorrect because it is colonizing language that implies ownership. If you need to be specific, write "Indigenous Peoples in what is currently known as Canada."

  - Avoid terms such as slave that could be triggering for people with intergenerational trauma. Instead, use enslaved person or person who was enslaved. This shows that it was something done to the person, rather than the core of who they were (see Language Affecting Black Communities).

— Avoid the term stakeholder, which has colonial associations and may be considered disrespectful to Indigenous Peoples. Historically, it referred to a person who marked land by driving a stake into the ground to claim territory that was taken from Indigenous Peoples (Akl et al., 2024). Instead, be specific about who these people are (e.g., service users, patients, funders) or use interest-holders as an umbrella term.

Shkaabe Makwa suggests

Terms and phrases to avoid

Think carefully about the meaning of common terms, phrases and euphemisms because some of them are offensive to Indigenous Peoples.

Here is an incomplete list of words and phrases that you should never use:

- bottom of the totem pole (meaning that somebody or something is unimportant)
- pow wow (when referring to a meeting)
  - Try: meeting, brainstorm session, chat, conversation
- spirit animal (when referring to a person, animal or object that matches your personality)
  - Try: soulmate or kindred spirit
- tribe (when talking about a group of like-minded people)
  - Try: team, friends, group, squad

Amplifying the voices of Indigenous Peoples and acknowledging traditional land

In your written work, you can include a Land Acknowledgement. This is especially appropriate for reports, public-facing documents, long documents and formal publications. Acknowledge not only the land where the material was written and

published, but also potentially where it may be read. Here is an example of a written Land Acknowledgement for CAMH:

> CAMH is situated on lands that have been occupied by First Nations for millennia; lands rich in civilizations with knowledge of medicine, architecture, technology and extensive trade routes throughout the Americas. The site of CAMH appears in colonial records as the council grounds of the Mississaugas of the New Credit (as their name in 1860), today known as the Mississaugas of the Credit. (CAMH Reconciliation Working Group Land Acknowledgement Subcommittee, 2022, p. 7)

This is only one example. In your own Land Acknowledgements, include something about your specific location and context and the steps you are taking toward reconciliation.

Shkaabe Makwa suggests

How to use the names First Nations, Inuit and Métis

When writing about First Nations, Inuit and Métis in Canada, it is important to use a distinctions-based approach. This means recognizing each as a distinct Indigenous People with its own cultures, histories, communities, governance systems and relationships with the Crown, rather than treating Indigenous as a single, homogeneous category.

Federal legislation describes First Nations, Inuit and Métis as distinct, rights-bearing communities. Under Section 35 of the *Constitution Act, 1982*, First Nations, Inuit and Métis are recognized as "Aboriginal peoples of Canada," and the existing Aboriginal and treaty rights are constitutionally affirmed.

Historically, most Crown–Indigenous treaties (such as the numbered treaties) were concluded with specific First Nations, but Inuit and Métis communities were largely excluded from those particular agreements. Today, Inuit and Métis rights are increasingly recognized through modern treaties and land claims agreements, as well as Supreme Court decisions

and contemporary self-government and treaty-making processes that clarify and affirm their constitutionally protected rights.

Follow these practices when writing about First Nations, Inuit and Métis:

- Using the term First Nations, Inuit and Métis is preferred over the more general term Indigenous Peoples. Even better is referring to a specific Nation or group of people.
- When using the term First Nations, Inuit and Métis, it is not necessary to include the word Peoples afterward because it is redundant; Inuit, when translated from Inuktitut, means "the people."
- Use terms such as Indigenous health, Indigenous engagement or Indigenous approaches to signal the work that CAMH does with multiple communities, partners and service providers.
- When writing is based on one Indigenous community, culture or perspective, acknowledge this.

The CAMH Land Acknowledgement uses distinction-based language. It states: "Toronto is now home to a vast diversity of First Nations, Inuit and Métis who enrich this city." This wording is more specific and accurate than "Toronto is now home to a vast diversity of First Nations, Inuit and Métis Peoples who enrich this city," or "Toronto is now home to a vast diversity of Indigenous Peoples who enrich this city."

Recognizing the loss of traditional language

Many Indigenous Peoples were punished for using their own languages in the Residential School and Indian Day School systems. Some generations lost their fluency, but many Indigenous cultures are focusing on cultural and linguistic revitalization. All over the world, Indigenous Peoples have faced similar harms due to colonization, and they continue to resist, and to preserve and rebuild cultures (Duvasic, 2022).

The Principles of Inclusive Writing

Over the past few decades, mainstream language and culture have begun to acknowledge the cultural preservation work being done by Indigenous communities around the globe. They use the terms decolonization or Indigenization to describe these efforts (Sergy & Ball, 2021).

One way you can acknowledge this work is to use the same term and in the same language that an Indigenous person chooses to describe themselves, rather than using a term that has been assigned to them by an outside community. For instance, someone from the same nation may identify as either Kanyen'kehá:ka or Mohawk. Kanyen'kehá:ka is the proper term in Kanyen'kéha, the language of the Mohawk people. Mohawk is the Algonquin term adopted by colonizers and neighbouring First Nations (Abler, 2019; Kanyen'keha:ka Nation, n.d.).

Tools and resources

Elements of Indigenous Style (Brush Education)

Guidance for Honouring the Land and Ancestors Through Land Acknowledgements (CAMH Reconciliation Working Group Land Acknowledgement Subcommittee)

Indigenous Editors Association

Acknowledgements

Thank you to Shkaabe Makwa for contributing excerpts from *Literature Review Summary: First Nations, Inuit, and Métis Models of Healing and Wellness* (Shkaabe Makwa, 2024).

This section was co-created at CAMH with members of the Patient Advisory Committee and staff at the Office of Health Equity; Inclusion, Diversity, Equity and Accessibility – People & Experience; Equity & Engagement – Provincial System Support Program; the Gender Identity Clinic; and Education Research. Contributions were also made by Shkaabe Makwa, the Family Advisory Committee, the Youth Advisory Group, the Azrieli Adult Neurodevelopmental Centre and the Azrieli Self-Advocate Advisory Group.

The Principles of Inclusive Writing

Principle 2: Embrace the constant evolution of language

Language is always changing. Words that at one time may have been slang or nonsensical grow in usage over time and end up recorded in the dictionary.

This guide embraces constant evolution by being a living document. There will never be a perfect inclusive language guide because language will always change faster than we are able to record it. This guide's development team recognizes this challenge by remaining flexible and open to feedback. Surveys, focus groups and our feedback form will help us to collect feedback to inform future versions of this guide.

Embracing the evolution of language means that sometimes there is not one right word to use. There may be times when the correct or most inclusive language may seem evasive. In these cases, ask the people you are trying to represent for the most appropriate term. There are other ways you can address this challenge:

- Acknowledge that there is no established appropriate term.
- List the options that different groups prefer.

Best practices for embracing the constant evolution of language

- Be open to writing and editing practices that align with changing cultural and clinical understanding.
- Include acknowledgements that language in your materials may become outdated, along with a justification for the words you have decided to use.
- Don't take language change personally. Language changes faster than attitudes and sometimes it takes a while to adjust. That's okay. Ultimately, language should be the most equitable, diverse, inclusive and antiracist it can be. At times, this means adjusting to language you aren't used to.
- Be open to feedback and integrate it in your project.

    Example: An online course lists an email address where people can send feedback. The course developers review the language feedback quarterly

and either update the language in the current course or work it into the next course revision.

Example: A clinic's webpage includes a feedback form. The form goes directly to the communications team, which changes language where needed.

Example: A drop-in centre holds frequent meetings with its advisory committee and keeps language and terminology as a running item on the agenda, even if members don't have changes to suggest at every meeting.

Acknowledgements

Thank you to Shkaabe Makwa for contributing excerpts from *Literature Review Summary: First Nations, Inuit, and Métis Models of Healing and Wellness* (Shkaabe Makwa, 2024).

This section was co-created at CAMH with members of the Patient Advisory Committee and staff at the Office of Health Equity; Inclusion, Diversity, Equity and Accessibility – People & Experience; Equity & Engagement – Provincial System Support Program; the Gender Identity Clinic; and Education Research. Contributions were also made by Shkaabe Makwa, the Family Advisory Committee, the Youth Advisory Group, the Azrieli Adult Neurodevelopmental Centre and the Azrieli Self-Advocate Advisory Group.

The Principles of Inclusive Writing

Principle 3: Acknowledge diverse perspectives

CAMH has staff, patients and volunteers from all over the province, with different backgrounds, abilities, experiences and identities. As we strive for a *Connected CAMH*, we need to acknowledge the many perspectives that contribute to the work here. Writing and editing practices must recognize this diversity and ensure that language reflects a range of cultures, genders, abilities and lived experiences.

In *The Inclusive Language Field Guide*, Suzanne Wertheim (2023) describes language as needing to "reflect reality." Inclusive language reflects reality by recognizing the wide variety of people, identities, experiences and backgrounds in the world. In contrast, writing as if only one perspective exists represents an untrue version of the world. As a hospital, CAMH must accurately and respectfully reflect the reality it is working in—one with a diversity of perspectives.

Best practices for acknowledging diverse perspectives

- Incorporate input from various groups to reflect a more complete understanding of the topic you are writing about (see Principle 4: Respect "Nothing about us without us").
- Cite diverse sources such as Black writers, Indigenous writers, writers from various other cultures and ethnicities, and writers with lived experience of the disability you are writing about.
- Use language that is ungendered and open to difference:

  Example: Using they as a singular pronoun when a person's gender is unknown, instead of he/she, has been accepted by most style guides (American Medical Association, 2020; American Psychological Association, 2020; University of Chicago Press, 2024). The pronoun they is more open to a variety of genders, including people who are nonbinary.

  Example: The word normal implies there is only one way to be normal. But there are many ways to live, and not one way to be. For example, if you are writing about a person who is neurotypical, then normal for them is neurotypical. If you are writing about someone who does not experience

anxiety, their normal is to not feel anxiety. This guide suggests removing normal from your vocabulary.

- Be aware that language isn't neutral. What may seem inoffensive to one group may be offensive or exclusionary for others.
- Communicate your limitations. Nothing you write can be completely relatable to everyone, but you can acknowledge where perspectives may be missing and highlight plans to increase the diversity of perspectives, sources or language.

Ensuring accurate representation

When writing about different equity-denied groups and communities or organizations that represent them, double-check the spelling, capitalization and conventions they use. This shows respect and ensures that your work is accurate.

Shkaabe Makwa suggests

Métis—remember the accent!

Always include the accent when writing the word Métis.

- In Word and Outlook (using desktop applications on a Windows computer):
  - Press Ctrl + '.
  - Type lowercase e.
- In Excel and PowerPoint (using desktop applications on a Windows computer):
  - Select the insert tab and then select the symbol option.
  - Select é and click Insert.
- On an Apple computer, phone or iPad:
  - Press and hold down e to bring up the accent menu.
  - Select é using the cursor.

The Principles of Inclusive Writing

Avoiding tokenism and stereotypes

It is important to represent diverse perspectives in your writing, but make sure you do it in a way that is meaningful and that avoids stereotypes (Agic et al., 2023).

> *Example:* You are writing content for a course and are developing a case scenario activity about substance use treatment. You finish writing the scenario and then decide to mention that the patient is Black. You receive negative feedback from your supervisor about the representation of race and are confused because you were trying to add more diversity in your courses.
>
> The issue is not that the patient in the case scenario was Black, but how race and the patient's Black identity were not a part of this specific activity.

- Representation is important, but it must be meaningful to the content to not be tokenistic. Ask yourself, "Why is this being included?" Reflect on your rationale.
- Without meaningful reflection or integration, representation could perpetuate stereotypes (e.g., in the case scenario example, someone may infer a racial stereotype between being Black and using substances).
- Engaging with Black people and their communities is essential in developing training material and other resources that refer to specific communities.
- The following strategies can help you to move forward:
  - Mention structural factors that are contributing to the mental health and substance use concerns of racialized patients.
  - If race is essential to the example, engage with Black patients and their communities to ensure accurate representation.
  - Integrate equity concerns into the material and the questions asked.
  - Have learners reflect on their bias.
  - Remove the racial identity if race is unrelated to the question and the learning outcome.

Engaging in meaningful consultation

Consultation is an effective tool to help you include different perspectives in your writing. Make sure that it allows people to contribute in a meaningful way.

The Principles of Inclusive Writing

Otherwise, you risk engaging in a consultation process that could further harm people or be tokenizing. Consultation that is not thoughtful can make people feel disempowered and less likely to share their experiences. Consider using an existing co-production or patient-engagement framework (Greenhalgh et al., 2019).

A group of advisors that this guide's development team met with described the following tokenistic consultation practices:

- engaging a group too late in the process, even if this is due to logistical reasons or structural barriers
- dismissing discussion points that do not align with the project's or consultation session's focus
- shaping discussions in a way that doesn't feel natural to advisors

These advisors—who were engaged later than the lead advisory group—provided feedback on the development team's consultation process, which was guided by specific questions.

- One advisor mentioned that starting the consultation with specific questions made them feel like an object of study rather than a full person. They explained that having an engaging, open conversation that established trust and invited advisors to shape the process was more fulfilling.
- Other advisors appreciated having a more structured consultation meeting.
- In response to this feedback, the team loosened the meeting structure by extending the time and following the lead of advisors in determining what to discuss. The planned topic was preferred language related to disability and identity, but it shifted to structural issues related to disability language, which advisors wanted to focus on.
- This negotiation led to a stimulating conversation, which balanced flexibility in engagement with a predictable structure, allowing more people to contribute. The experience ended up shaping and informing this section on meaningful consultation.

The Principles of Inclusive Writing

Best practices for using consultation to inform your writing

- Do research to become familiar with the scholarship and other work that has been created by the communities you are consulting.
- Work with staff members who are experienced in engagement:
  - Some organizations have coordinators or board members who can arrange advisors.
  - Some advisors have expertise in best practices for engagement.
  - CAMH has specific roles that focus on creating positive engagement experiences and relationships, such as engagement specialists, equity consultants, health equity specialists and engagement coordinators. They can inform the process and share preferences from the group you will be engaging with. They may also arrange meetings with advisors, especially if they are patients.
- Make sure that you are not seeking consultation to confirm ideas you already have, but rather to demonstrate your openness to different perspectives.
- Consider the role that power will play in your consultation sessions and how you will commit to centring the experience and expertise of the people and communities you will be consulting.
- Engage consultants as early in the process as possible to ensure that their thoughts, opinions and perspectives can be incorporated effectively (Parri, 2024).
- Make sure that the people you are consulting are truly representative of the project (e.g., a project about autism and mental health concerns would engage people with lived experience of both, not a patient advocate who does not have that experience).
- Consider all information that advisors contribute:
  - Information that is not relevant to your project can be passed along to relevant projects or departments with the advisors' permission.
  - Information that is "off topic" to your consultation session may still be relevant to the project and can inform new insights on your work.

The Principles of Inclusive Writing

- Communicate clearly and transparently throughout the process about how the consultation will be used.
- Provide credit, acknowledgement and authorship to the people you consulted with:
  - Ask advisors if they would like to include their name, use a pseudonym or remain anonymous.

Referring to groups that experience oppression

You may see different collective terms, such as equity-denied or equity-deserving, which refer to communities that experience oppression or that are underrepresented in certain fields. Members of these communities may include:

- people who are Black, Indigenous or racialized
- immigrants, migrants, refugees and other newcomers
- people with disabilities
- women
- people who are transgender, nonbinary or agender
- people who are Two-Spirit, lesbian, gay, bisexual, queer or asexual
- intersex people

People within these groups may use different words to self-identify, and many people belong to more than one group (see The Intersectionality Framework). No overarching, collective term "fully capture[s] the harms, barriers and violence experienced by members of these communities" (Canada Research Coordinating Committee, 2025).

Some collective terms used to describe these groups position oppression and marginalization as something that is done to these groups, without specifying who the actor is (Black, 2023). This can prevent a realistic discussion of the racist and oppressive systems at the root of these experiences. These terms are also often used by governments and institutions, and then become part of common vocabulary (Washington, 2025).

The Principles of Inclusive Writing

Rather than using collective terms, try to be specific about who you are discussing, the type of marginalization or oppression they experience and the systems at the root of these experiences. If you need to use a collective term, consider the strengths and limitations of the following terms you may come across:

- **Equity-seeking groups:** This term is no longer used because it implies that equity must be earned or requested and places the obligation on people in the group to advocate for themselves, which ignores the structural reasons these groups have been oppressed.
- **Equity-deserving groups:** This term has replaced the term equity-seeking groups in many settings. Instead of implying that equity must be earned or requested, it recognizes equity as a fundamental right and shifts responsibility for achieving equity from the person or group to the system. This term works well in "educational, community and organizational change efforts where the goal is to inspire reflection, empathy and action" (Edwards, personal communication, 2025). However, this term has been criticized for implying that some groups deserve equity and others do not (Harris et al., 2024; Washington, 2025). It could be misinterpreted by people who do not work in equity-related fields, making it less plain-language than some of the alternatives.
- **Equity-denied groups:** This more recent term reflects the underlying systemic discrimination that bars some groups from accessing resources (Harris et al., 2024; Interdepartmental Terminology Committee on Equity, Diversity and Inclusion, 2024). It is relatively easy to interpret, even by people who are not involved in equity work, making it a good term to use for a general audience. It may not be the best term for mobilizing groups to action because it focuses on the barriers to equity rather than the potential to achieve it.
- **Structurally marginalized groups:** Like equity-denied, this term reflects the structural aspect of the oppression and barriers that some groups face. It is an appropriate choice in research settings and in writing for an academic audience (Agic, personal correspondence, 2025; Edwards, personal correspondence, 2025).
- **Underrepresented groups in [x] or groups underrepresented in [x]:** These terms recognize that some groups have been excluded from certain areas and fields. Rather than simply using the term underrepresented groups, be clear

what that area or field is, and define the term earlier in your writing. For instance, you could write something like groups underrepresented in medicine (Agic, personal correspondence, 2025) or underrepresented groups in academic leadership. These terms are useful when you are writing about a particular field or area and are addressing specific barriers or forms of exclusion.

Ultimately, which collective term you should use will depend on your purpose, context and audience (Agic, personal correspondence, 2025; Edwards, personal correspondence, 2025).

Tools and resources

Empowerment Council (CAMH)

Health Equity and Inclusion Framework for Training and Education (CAMH)

Making Your Events More Accessible and Inclusive: A Toolkit for the Mental Health and Addictions Sector (EENet)

Patient and Family Engagement (CAMH)

Patient and Family Partners Program (CAMH)

Acknowledgements

This section was co-created at CAMH with members of the Patient Advisory Committee and staff at the Office of Health Equity; Inclusion, Diversity, Equity and Accessibility – People & Experience; Equity & Engagement – Provincial System Support Program; the Gender Identity Clinic; and Education Research. Contributions were also made by Shkaabe Makwa, the Family Advisory Committee, the Youth Advisory Group, the Azrieli Adult Neurodevelopmental Centre and the Azrieli Self-Advocate Advisory Group.

The Principles of Inclusive Writing

Principle 4: Respect "Nothing about us without us"

The concept of "Nothing about us without us" dates back hundreds of years when it became a slogan in Central Europe to demand representation in political decisions (Bath & Willson, 2025). In the 1990s, disability rights movements popularized the concept, using it to advocate full participation of people with disabilities in all decisions that affect them (Bath & Willson, 2025; Charlton, 2000). Ideally, it involves meaningful collaboration and engagement, and empowering leadership of people from equity-denied groups to break down barriers to inclusion. This participation prevents misrepresentation, stereotypes and stigma, and the exploitation of people from equity-denied groups. It can also work against tokenism. (See Avoiding tokenism and stereotypes.)

At CAMH, there are several avenues for involving people with lived experience of mental health and substance use concerns in your writing and projects, such as the Patient Advisory Committee, the Family Advisory Committee, the Azrieli Self-Advocate Advisory Group, the McCain Centre's Youth Advisory Group and the Empowerment Council. You can also engage community partners. Consider co-developing resources with grassroots organizations run by people with lived experience of the community you are writing about.

Asking about preferred language

There is often debate about which terms are the most precise or the truest to people's experiences. In response to this, a clinician from the Gender Identity Clinic at CAMH suggested, "Just ask." People often feel nervous asking someone about their preferred language, whether this be which pronouns to use, how the person describes their identity or how they view their diagnoses or experiences.

There are different ways you can ask people about their preferred language:

- Include questions about language choice when you meet with consultants or advisors who are people with lived experience.
- On forms for staff or patients, include space for people to put their identities into their own words.

- Provide contact information or another way people can update you on their preferred terminology.

Best practices for respecting "Nothing about us without us"

- Involve people with lived experience in the creation of policies, research or communications that affect them directly.
- Explicitly acknowledge contributors from specific communities to reinforce shared ownership of language and decisions.
- If you are writing about a particular group or community, consult them directly or refer to guidelines they have developed to inform your writing. If you do not have a plan for this, stop and ask yourself why you are the one best suited to do this work. If possible, make a plan for meaningful consultation.

Tools and resources

Clearing a Path: A Psychiatric Survivor Anti-Violence Framework (Empowerment Council, CAMH)

Hear Us, See Us, Respect Us: Respecting the Expertise of People Who Use Drugs (Canadian Drug Policy Coalition & Canadian Association of People Who Use Drugs)

Key Practices for Community Engagement in Research on Mental Health or Substance Use (Re:searching for 2SLGBTQIA+ Health)

Learning Together: Evaluation Framework for Patient and Public Engagement (PPE) in Research (Centre of Excellence on Partnership with Patients and the Public)

More Than Paint Colours (Empowerment Council, CAMH)

Patient Engagement Framework (Canadian Institutes of Health Research)

Peers Examining Experiences in Research (PEERS) Study (Re:searching for 2SLGBTQIA+ Health)

The Principles of Inclusive Writing

Acknowledgements

This section was co-created at CAMH with members of the Patient Advisory Committee and staff at the Office of Health Equity; Inclusion, Diversity, Equity and Accessibility – People & Experience; Equity & Engagement – Provincial System Support Program; the Gender Identity Clinic; and Education Research. Contributions were also made by Shkaabe Makwa, the Family Advisory Committee, the Youth Advisory Group, the Azrieli Adult Neurodevelopmental Centre and the Azrieli Self-Advocate Advisory Group.

The Principles of Inclusive Writing

Principle 5: Use dignity-first language

Dignity-first language means asking a person or people what language they prefer to describe their identity and experiences. It includes honouring the phrasing, identity terms and capitalization of each person from an equity-denied group. We co-created this term through working groups with patient advisors to provide an alternative to language discussions that often pit terms against one another. In reality, even within specific community groups, preferred language varies from person to person, and individual choice is respected.

Understanding person-first and identity-first language

There are two widely used approaches to describe identity related to disability: person-first language and identity-first language (see Table 1 and Table 2).

- Person-first language:
  - emerged in a reaction to language such as bipolar patient or schizophrenic, which reduced a person to their diagnosis
  - emphasizes the person rather than their disorder, concerns, experiences or identity (e.g., person with bipolar disorder)
  - is considered more sensitive because it puts the person before their disorder or disability
- Identity-first language:
  - emphasizes what the person considers to be a core part of their identity (e.g., autistic person instead of person with autism)
  - is often used by communities that have a strong presence in disability advocacy and rights discussions, such as Autistic people and Deaf people. (See Language Affecting People with Autism/Autistic People, Language Affecting Deaf and Deafblind People and People with Hearing Loss.)

Person-first language is preferred at CAMH (Agic et al., 2023; CAMH, 2026) and by Health Canada (2022). Identity-first language is often preferred by disabled people and disability advocates, people within the Mad movement (see The Mad Model)

and some other patients and health care professionals. Although many discussions of person-first language and identity-first language pit the two against each other, both exist within many communities and both are respectful choices, depending on the preference of the person you are writing about.

Identity-first language may be preferred by advocates and many people in a particular community, but each group contains diverse opinions and perspectives. Many people still prefer person-first language. These choices are often personal and related to the person's views about their identity, their disorder or disability, and their experiences. Do not make assumptions about why someone prefers or avoids a certain term.

Best practices for using person-first and identity-first language

- Do research on the groups you are writing about and consult resources and guides developed with or by those groups.
- Consult the communities you are writing about to determine their language preferences.
- Indicate whether you are using person-first or identity-first language and explain why you made that choice.
- Provide feedback forms or contact information so people can raise concerns about language.
- Unless a community has a stated preference (e.g., Deaf community), do not assume one form of language. For mental health and substance use concerns, opt for person-first language unless the person describes themselves using identity-first language.

Respecting capitalization preferences

Dignity-first language also means using the capitalization preferences of the person or community. CAMH uses a down style, which means that, in general, only proper nouns are capitalized. This style does not make capitalization choices based on importance like some styles do. When it comes to identity, writing inclusively

includes using capitalization for national, ethnic and cultural identities, such as Canadian, Asian or Black.

In disability communities, identity terms are also often capitalized to represent a distinct culture of people who have a disability (e.g., Autistic, as a proud Autistic person). This symbolizes dedication to and involvement in the related community and often goes beyond connecting their identity to their disability (see Table 1). To reflect dignity-first language, respect these identities and use the capital when you are describing communities associated with activism and advocacy.

Capitalization in this context has a specific cultural meaning and does not imply that one person's experience of a disability, neurotype or condition is more or less worthy than that of any other person. If someone prefers to use the capital to describe their identity, be sure to use it.

Unlike language that reflects personal or community identity, terms that refer to a diagnosis or condition are not capitalized (e.g., autism versus Autistic).

This approach to capitalization does not apply to race—always capitalize Indigenous and Black. When used as a racial descriptor, white should use lowercase. Always capitalize specific ethnicities and nationalities. (See Capitalization.)

Table 1
Capitalization guidance for identity terms

Without capital	With capital	What these differences mean
autistic person person with autism person who has autism	Autistic person Autistic community	Using Autistic (with a capital A) indicates a pride in the identity and may also be connected to political advocacy and community involvement.[a] Someone who identifies as an autistic person (lowercase a) may see their autism as central to who they are but not have the same political or community-minded aspect to their identity.

The Principles of Inclusive Writing

		Someone who identifies as a person with autism may not see their autism as part of who they are but as a condition they have.
deaf person	Deaf person Deaf community	Someone who uses Deaf person (with a capital D) has a distinct cultural, political and community identity:[b,c] They often use Sign as a first language, have attended Deaf school and are embedded in the Deaf community. Someone who prefers deaf person (lowercase d) may not have the cultural, political and community identity that someone Deaf has.[b] Respect each person's preference. Person-first language is not recommended for this community.[b]
N/A	Mad person Mad community	Do not use mad person (lowercase m) because it is offensive and outdated. Using Mad person (capital M) indicates that the person belongs to the Mad movement and is reclaiming the offensive term mad.[d]
disabled person person with a disability	Disabled person Disability community	The term disabled person (lowercase d) is used by some people who identify strongly with their experiences of disability. Disabled person (capital D) is preferred by people who are politically active in the Disability community or who frame their disability in line with the social model of disability (see The Social Model). When describing a community, use Disability community to reflect the social model. The term Disability community is more common than Disabled community. When discussing disability in general or as something someone has, use lowercase d.

[a] Canucks Autism Network (2024); [b] Canadian Association of the Deaf (2015); [c] Khalifa (2018); [d] Archibald (2021).

The Principles of Inclusive Writing

Table 2

Person-first language, identity-first language and stigmatizing language

Person-first language	Identity-first language	Stigmatizing language
person who uses substances person who uses drugs person with a substance use disorder	addict drug user (Never use these terms unless a person uses them to self-identify. See Using reclaimed terms.)	drug user druggie addict other slurs or language that doesn't respect self-identification
person with bipolar disorder person with a diagnosis of bipolar disorder person with experiences often associated with bipolar disorder	bipolar person[a] Mad person (if part of the Mad community)	crazy unstable
person experiencing psychosis person with experiences often associated with psychosis person who hears voices / sees visions	Mad person (if part of the Mad community[a] voice hearer[b]	psychotic/psycho delusional lunatic insane schizo
person with autism	autistic/Autistic person (capitalization depends on community identification) Autist	differently abled handicapped special needs any ableist term or language that does not respect self-identification
person who has hearing loss	deaf/Deaf person (capitalization depends on community identification)	hearing-impaired person who is hearing-impaired

	the Deaf community	avoid person-first language for deaf/Deaf people (e.g., someone who is deaf)

[a] Archibald (2021); [b] Hearing Voices Network (n.d.).

Using reclaimed terms

Many communities reclaim words that were once discriminatory, offensive or stigmatizing to show that there is no shame related to that identity. Examples are crip for someone from the Disabled community, addict for someone who uses substances, queer for someone who has a 2SLGBTQIA+ identity or Mad for someone with experience in the mental health system. Never change these terms if you are quoting someone or if people use these words to describe themselves.

Who is using the term is as important as what the term is. When you are writing about people and communities, be careful with how you use reclaimed terms. They can still cause offence if they are used by someone from outside of the community. If you are unsure how to phrase someone's identity or how they would like to be referred to, ask them (see Asking about preferred language).

Acknowledgements

This section was co-created with members of the Patient Advisory Committee and staff at the Office of Health Equity; Inclusion, Diversity, Equity and Accessibility – People & Experience; Equity & Engagement – Provincial System Support Program; the Gender Identity Clinic; and Education Research. Contributions were also made by Shkaabe Makwa, the Family Advisory Committee, the Youth Advisory Group, the Azrieli Adult Neurodevelopmental Centre and the Azrieli Self-Advocate Advisory Group.

Principle 6: Use healing-centred language

During the process of developing this guide, advisors and staff sought a more expansive way to describe language that is sensitive to people's experiences and that focuses on avoiding harm through the words we use. The group created the term healing-centred language to describe this approach.

Understanding healing-centred language

Healing-centred language is:

- sensitive to the vulnerability that people bring into health care settings
- mindful of all trauma, whether or not it is recognized by *the Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR; American Psychiatric Association, 2022)
- compassionate to the experiences of infants, children and youth, especially in terms of adverse childhood events
- trauma-informed

A trauma-informed approach to writing means acknowledging that many of your readers have experienced some form of trauma. In a health care setting like CAMH, where people are receiving care, it is especially important to choose language that is safe and respectful and that avoids retraumatization.

Acknowledging trauma

While the North American medical model, reflected in the DSM-5-TR, recognizes only certain events as trauma, this guide acknowledges a broader range of experiences that can be traumatic. These include:

- minority stress (i.e., emotional, psychological and physical stress related to being a member of an equity-denied group)
- discrimination
- microaggressions

- adverse childhood experiences (i.e., stressful or traumatic events during childhood)

What is and isn't considered trauma has consequences: it affects diagnosis, qualification for disability supports and access to services for people who live with the lasting effects of trauma. When you are writing about trauma, be specific about the context and explain what definition of trauma you are using. (See Disclaimers and notes about language.)

Best practices for using language that does not cause further harm

- Avoid words or phrases that could retraumatize, such as victim or abuse survivor, without considering the context and individual preferences (Mental Health Coordinating Council, 2023).
  - Instead, use terms such as "person affected by trauma" to create a safer, more empowering space.
  - If content requires more graphic descriptions or words that could be associated with trauma, include a content warning and clear indications about what is to come.
- Ensure that the content and tone are nonstigmatizing, which is especially critical for a mental health organization. Person-first language helps to reduce stigma.

  Example: Instead of referring to someone as a victim of mental illness, use "person living with mental illness."
- Be as transparent and clear as possible about recommendations or next steps so that the person feels a sense of control (Mental Health Coordinating Council, 2023).
- Avoid language that people may perceive as commanding. Instead, use invitational language to create a feeling of choice and control (Health and Wellness Equity Research Group Carleton, 2023).

  Example: Instead of "Tell us what you think about the care you are receiving at CAMH," you could write "We invite you to tell us what you think about the care you are receiving at CAMH." Or "If you feel comfortable, please tell us about …"

The Principles of Inclusive Writing

- Try to keep language free from words that convey judgement.

  Example: Instead of "The patient is resistant to therapy and refuses to engage," reframe this using trauma-informed, neutral language. You could say, "The patient has expressed hesitation about engaging in therapy at this time."

- Take a strengths-based approach instead of focusing on a person's weaknesses.

  Example: You are writing a case study about an Autistic person who is receiving treatment for depression. The research you've seen frames autistic traits as a lack of positive qualities—for example, people with autism are less social, less able to adjust to change, and often struggle with communicating their emotions—so in your case study you indicate that the person's depression was triggered by their recent move. You explain that the person was brought to the family doctor by their parents but was noncommunicative with the doctor. You think this is a well-developed character for the case study.

  The advisory group that reviews your case study points out that the person isn't described as having any strengths or interests, and that they aren't shown to be interested in their care. The group feels that this reinforces the stereotype that non-speaking autistic people cannot communicate, when the reality is that they can communicate in various ways (e.g., by writing, with a tablet, through gestures or sounds). By writing only about the person's weaknesses rather than representing them as a whole person, you have reinforced stereotypes about both autistic people and people with depression.

Acknowledgements

This section was co-created at CAMH with members of the Patient Advisory Committee and staff at the Office of Health Equity; Inclusion, Diversity, Equity and Accessibility – People & Experience; Equity & Engagement – Provincial System Support Program; the Gender Identity Clinic; and Education Research. Contributions were also made by Shkaabe Makwa, the Family Advisory Committee, the Youth Advisory Group, the Azrieli Adult Neurodevelopmental Centre and the Azrieli Self-Advocate Advisory Group.

The Principles of Inclusive Writing

Principle 7: Be specific

For language to be clear, professional and inclusive, it is important to make it as specific and focused as possible.

Best practices for using clear, specific language

- Be clear early in the document:
  - Clarify the meaning of important terms.
  - Specify who you are discussing.
  - Indicate who you are writing for.
- Be clear throughout the document:
  - Do not use group terms if you can use the more specific term.
  - Define terms precisely but concisely.
  - Provide examples or additional context for complex concepts.

Using catch-all terms with care

Over the years, there has been a trend to create catch-all terms for certain identity groups. These terms include:

- BIPOC (Black, Indigenous, people of colour)
- racialized
- Indigenous Peoples (First Nations, Inuit and Métis; can also refer to Indigenous Peoples around the globe)
- 2SLGBTQIA+ (Two-Spirit, lesbian, gay, bisexual, transgender, queer and questioning, intersex, and asexual and aromantic, with the plus sign representing additional sexual and gender identities)

These terms are meant to identify common characteristics (e.g., similar experiences of structural marginalization). They can be useful, but don't use them as a stand-in when you are only talking about one or two communities. Be as specific as possible to the group you are discussing (American Medical Association, 2020).

Example: You are writing only about bisexual women. Avoid using the term 2SLGBTQIA+ to describe them because it overgeneralizes their experiences.

Example: You are writing about a study that focused on women from India. Use the term Indian women, not BIPOC women. If you know what region the women came from, be even more specific and provide that detail.

Example: You are writing about an Inuk throat-singer. Explaining that throat-singing is an Indigenous musical form is not incorrect, but it is preferable to be specific and use the word Inuit.

Example: It is Transgender Day of Remembrance. In a public announcement, you describe a memorial event being held as "a moment to remember all the 2SLGBTQIA+ community members we have lost." The event is poorly attended, and you hear there was a complaint about the announcement. This is because Transgender Day of Remembrance is meant to honour transgender people who were murdered through acts of transphobic violence. There is overlap and intersectional identities between others in the 2SLGBTQIA+ term, but transgender people reading the announcement felt their identity and the importance of the day were erased and misunderstood.

Acknowledgements

This section was co-created at CAMH with members of the Patient Advisory Committee and staff at the Office of Health Equity; Inclusion, Diversity, Equity and Accessibility – People & Experience; Equity & Engagement – Provincial System Support Program; the Gender Identity Clinic; and Education Research. Contributions were also made by Shkaabe Makwa, the Family Advisory Committee, the Youth Advisory Group, the Azrieli Adult Neurodevelopmental Centre and the Azrieli Self-Advocate Advisory Group.

The Principles of Inclusive Writing

Principle 8: Use plain language

You may hear plain language mentioned as a best practice when writing for the public and broad audiences. At CAMH, we do write for the public, but plain language is important even in our internal and research communications, and when writing for any audience. The hospital is made up of people in many different roles. They do not all share the same understanding of subject-specific words, or jargon.

Plain language also avoids figurative language such as metaphors or similes, and it avoids slang. Figurative language and slang are often specific to a particular location or community and can lead to misunderstandings (e.g., slang differs between the United Kingdom and North America). Figurative language can also be difficult for neurodivergent people, many of whom tend to prefer straightforward, clear language (Autism Mental Health Literacy Project, 2021). Many idioms also include language that may have a racist or discriminatory history. (See Language Related to Race, Racism and Ethnicity.)

We do not suggest aiming for a specific reading level because tools that measure reading levels are often flawed and don't consider context (e.g., CAMH is a medical context and some medical terminology has long names that might skew results).

Balancing plain language and complex inclusive terms

When using inclusive language, some of the terms listed in this guide may seem too complex or new to meet the standards of plain language. This is not true. Plain language and complex terms can coexist. You will need to break down the term into its important parts and define the term in plain language. This can be done by inserting a note about the terminology or language you use if defining it when it first appears does not fit the flow of your document. (See Disclaimers and notes about language.)

The Principles of Inclusive Writing

Using plain language reflects different abilities

When you are putting something into plain language, be aware of your audience. For instance, people with an intellectual disability, learning disability or processing disorder may find it difficult to understand a text-heavy document. This type of document isn't a useful way to communicate your ideas.

Ask yourself these questions to help you focus on your audience: What information do they already have? What are their concentration needs? If you are writing for a general audience, consider making materials available in other formats, such as audio, video or Easy Read.

Best practices for using plain language

- Avoid jargon, which is language that has a specific meaning within a profession or group. For people outside of those groups, these words might have different meanings or be unfamiliar. Examples include the terms siloed, deliverable, system-oriented, bandwidth and game changer.
    - Ask yourself these questions: Is it too vague? Do you need to be part of a certain group or context to understand? If so, revise the language.
    - Replace jargon with clear, accessible terms to ensure that communication is understood by a broad audience, including patients and non-experts.
- Use technical words or language if it is relevant to the audience and define it briefly in plain language. Do not oversimplify concepts, and do not avoid depth on a topic of relevance.
- Avoid casual or figurative language (i.e., slang, idioms, metaphors, similes such as on the other hand, see eye to eye, low-hanging fruit).
- Use relatively short words and sentences.
- Define acronyms and abbreviations the first time you use them.

The Principles of Inclusive Writing

Using Easy Read to increase accessibility

This section is adapted from Advancing Accessible Communication for People with an Intellectual Disability*, which was developed by Inclusion Canada, People First of Canada and the CAMH Azrieli Adult Neurodevelopmental Centre Easy Reads Project.*

Inclusion Canada and People First of Canada partnered with CAMH to develop guidance and resources on how to make communication more accessible to people with intellectual disabilities. One of these formats, which is used all over the world, is Easy Read. It includes guidelines and example documents that show how to use plain language for people with intellectual disabilities.

These suggestions are developed with a specific audience in mind, but they may be beneficial for many people. Some patients or staff may also find that their concentration and energy vary from day to day, meaning something that is easier for them to understand one day may be harder to understand another day.

What is Easy Read?

Easy Read is a way of writing that uses plain language, short sentences and images to make information easier to understand. It is designed to be accessible to a wider audience, including people with intellectual disabilities or low literacy. It uses a simple structure with large fonts, clear headings, a lot of white space and bullet points to present information. Easy Read uses photos, graphics or other visual aids that are placed next to the text to support the message.

Is Easy Read the same as plain language?

No, plain language is different from Easy Read. Plain language is for a general audience and focuses on clear, straightforward writing. Easy Read is for a specific audience and uses a more simplified style that combines simple writing and visual aids. Plain language can be presented in many formats and doesn't require visual aids.

The Principles of Inclusive Writing

What do Easy Read and plain language have in common?

Both use similar ways to make information easy to understand. And both take the following approaches:

- Use simple, everyday words.
- Keep sentences and paragraphs short.
- Explain unfamiliar or technical words.
- Use titles and headings.
- Use bulleted lists.
- Provide a lot of white space.
- Include a table of contents or glossary, or both.
- Test the material with the intended audience at every stage of the writing process.

What is the best way to structure an Easy Read?

There are no strict rules about how to create an Easy Read document, but here are important guidelines.

Length

- Keep it short. The document should be short enough to read in 15 minutes.
  - Make documents 16 pages long or less.
  - Don’t write more than 1,600 words.
  - Keep each page to 100 words or less.
  - Number each page.

Tone and approach

- Use an approachable, friendly tone.
- Start with an introduction.
- Make it clear what the document is about.
- Be clear about who the document is for.

The Principles of Inclusive Writing

- Put the most important information first in each section.
- Use short paragraphs, about three sentences long.

Layout and structure

- Put images in a column on the left.
- Put the text that goes with the image in a column on the right.
- Use one image next to each paragraph.
  - Provide images that are five to six centimetres in size.
  - Place four or five images on each page.
- Align text on the left.
- Use size 30 pt font for headings.
- Use at least size 16 pt font for the main text. Larger font sizes such as 18 pt or 21 pt are even better.
- Use a consistent format. For example, highlight unfamiliar words in the same way. That can mean using a glossary, putting words in bold or defining the word in a text box close by.

Tools and resources

Grammarly accessibility tools

Hemingway Editor app

One Idea Per Line: A Guide to Making Easy Read Resources (Autistic Self Advocacy Network)

Plain Language (Accessibility Standards Canada)

The Easy Read Standard: Evidence-Based Framework for Accessible Information (Photosymbols)

The Principles of Inclusive Writing

Acknowledgements

Thank you to Inclusion Canada, People First of Canada and the CAMH Azrieli Adult Neurodevelopmental Centre Easy Reads Project for the contribution of Advancing Accessible Communication for People with an Intellectual Disability.

This section was co-created at CAMH with members of the Patient Advisory Committee and staff at the Office of Health Equity; Inclusion, Diversity, Equity and Accessibility – People & Experience; Equity & Engagement – Provincial System Support Program; the Gender Identity Clinic; and Education Research.

Contributions were also made by Shkaabe Makwa, the Family Advisory Committee, the Youth Advisory Group, the Azrieli Adult Neurodevelopmental Centre and the Azrieli Self-Advocate Advisory Group.

Perspectives on Mental Health and Disability

Introduction

When we write about health, disability and identity, the way we frame our language matters. Different models influence how we think about these topics and, in turn, the language we use. But these models do not exist in a vacuum, and they are not static or mutually exclusive. Instead, they exist in dialogue with one another to help us think more expansively about mental health, disability and identity.

This means that in our writing we can apply different aspects of different models, rather than strictly adhering to one model or another. For instance, CAMH is a hospital, but we often combine language from the medical model with the social model to centre the voices of patients. Whichever model or combination we use, we should always choose words that empower rather than stigmatize, helping to build a more inclusive and respectful health care system.

The next sections of this guide describe some models of mental health, disability and identity, and how each one shapes inclusive language differently. We discuss the medical model, the social model, the Mad model, the neurodiversity model, Indigenous Wholistic models of health and well-being and the intersectionality framework. For each model, we offer best practices for writing compassionately and accurately and for maintaining the dignity of those you are writing about. When in doubt, refer to The Principles of Inclusive Writing.

Why these models matter for inclusive writing

- The **medical model** is important in diagnosis and treatment. By using language from this model, we ensure that mental health receives the same level of recognition in terms of research, funding and clinical care as other medical concerns.
- The **social model** shifts the focus from the person to the barriers created by society. It recognizes that mental health challenges and disability are often caused or exacerbated by stigma, lack of accessibility and systemic inequities rather than by the condition itself. This model promotes structural changes to create more inclusive environments.

- The **neurodiversity model** recognizes brain differences as natural and encourages accommodation. It promotes a wider acceptance of diverse ways of thinking, learning and processing the world, rather than viewing neurodivergence as something that needs to be fixed.
- The **Mad model** empowers people with lived experience of the mental health system to define themselves on their own terms. It supports them in resisting ideas, policies or decisions that cause harm, don't serve them or don't align with their values.
- **The Wholistic model** is rooted in Indigenous views of well-being, which consider all aspects of a person—culture, language and spiritual practices. These aspects are vital to the healing and wellness of Indigenous Peoples. In this model, the focus is on reestablishing balance rather than addressing a particular symptom.
- **The intersectionality framework** acknowledges that each person comes with multiple identities, cultures and life experiences. These different aspects build on one another to create a person's experience, which can contain both privileges and disadvantages, depending on the person's experiences and power.

Terms and perspectives arising from the social, Mad and neurodivergent models are usually about how to improve systems and treatment of people with mental health concerns, people who are neurodivergent and people with disabilities. These approaches also focus on empowering the voices of these groups in treatment and care, and on promoting acceptance while advocating social change.

There are other ways of framing language around mental health. Some may be culturally specific, while others may be informed by political beliefs or certain social justice causes. When writing about a specific community, research the models that are most relevant to it and use them to inform your language.

Understanding self-identification through models

From each model, we can learn how different people view their mental health and how this shapes the language they prefer. A person may find that elements of several models resonate with them. For example, someone may describe

themselves as Mad, neurodivergent and Disabled. Someone else may be Inuit and follow a Wholistic model of health and well-being, and also identify as Mad.

Best practices for choosing a model

- Consider whose perspective you are centring:
  - Are you prioritizing the voice of the hospital or the voices of patients?
  - Is that perspective the best choice for that material?
  - Is there room to incorporate other perspectives and models?
- Respect the autonomy of the people you are representing:
  - Does your language honour self-identification even if the person has a different perspective than yours?
  - Does your language emphasize empowerment over pathology? (See Principle 5: Use Dignity-First Language.)
- Pay attention to your context and audience:
  - Who are you writing for?
  - What perspectives will the audience hold?
  - Do you need to explain your model and language choices? (See Disclaimers and notes about language.)
- Consider the benefits and limitations of each model:
  - Can you draw on elements from other models to address limitations of the primary model you are using?

Acknowledgements

This section was co-created at CAMH with members of the Patient Advisory Committee and staff in the Office of Health Equity; Equity & Engagement – Provincial System Support Program; Education Research; and the Azrieli Adult Neurodevelopmental Centre.

The medical model

In hospital settings, the medical model is often the dominant framework for understanding health, disability and mental health. At CAMH and much of the Western world, this model is the foundation for diagnosis, treatment and research, ensuring that conditions are recognized, studied and addressed through medical interventions. This approach allows health care professionals to develop treatment plans and allocate resources based on clinical needs.

However, the medical model focuses on what is "wrong" with a person rather than on external factors that may make their life more difficult. It sees disability, illness and mental health conditions as problems that need to be diagnosed, treated or cured, rather than considering broader social, environmental and systemic factors that affect individual and community well-being. Although this model plays an essential role in health care, relying on it too heavily when writing about mental health and disability can contribute to stigma, disempowerment and exclusion.

At CAMH, even when we use the medical model, we try to avoid harmful language by drawing from other perspectives, especially the social model. This model promotes language that avoids judgement and acknowledges differences, rather than reinforcing deficits, abnormality or impairment.

Harmful language in the medical model

When using the medical model, harmful language often arises from unnecessary labelling, which reinforces ideas of a normal or ideal body or brain, and framing aspects of a person as needing to be fixed, rather than emphasizing acceptance and support. Table 3 highlights language to avoid and more supportive alternatives.

Table 3
Harmful language that can arise from the medical model

Language to avoid	Language to consider	Why?
Don't label people as their disorder (e.g.	Use person-first language (e.g., person living with	Labels reduce a person to their diagnosis.

schizophrenic, diabetic, epileptic)	schizophrenia, person who has diabetes) Indicate what symptoms the person has or what items they endorsed on a screener.	People view their experiences differently—not everyone agrees with their diagnosis or even the concept of diagnosis. Some people who know their diagnosis is not accurate are seeking a better understanding of their health and experiences.
Don't label differences as defects, impairments or abnormalities	Use neutral words such as condition, differences or variations (e.g., has a genetic condition or has a variation in …)	Labels assume that disability, differences or neurodivergence are inherently negative rather than part of natural human diversity.
Don't frame behaviour outside of expectations as wrong or bad: • Avoid compliance-based language (e.g., This patient is not complying with treatment). • Don't describe a patient as difficult. Don't describe a patient as unreliable, flaky or inconsistent. Don't describe behaviour as acting out or attention seeking. Don't describe a person's understanding of their condition as poor insight.	Use "patient experiencing difficulty with treatment" or "patient experiences challenges adhering to treatment." Draw from the social model and acknowledge barriers the person may face[a] (e.g., The patient has challenges with treatment because they have difficulty accessing medication). Describe the behaviour or emotion (e.g., When overwhelmed, the patient may yell or leave the room). When describing a person's understanding, indicate what they report or note that they view their condition differently.	Labelling deepens stigma and reduces compassion, which can stop people from getting care. Referring to compliance reduces people to their diagnosis and frames them as a problem. It often overlooks personal choice, autonomy, social barriers or problems with the treatment. "Difficult patient" is used more with certain mental health conditions, such as borderline personality disorder. Describing someone as difficult ignores the possible roots of the behaviour. All behaviour is communication, whether it is a product of trauma, a symptom of a mental health concern or a response to the environment.

Don't describe a person as low-functioning or high-functioning.	Describe the person's needs rather than categorizing the person.	This distinction is outdated and doesn't represent experiences with spectrum disorders.
Don't make unnecessary comments about a patient's appearance or size[b] (e.g., funny-looking kid/FLK[c]).	Use neutral and descriptive language if you do need to comment on appearance or size.	Language that associates appearance with values (e.g., normal/abnormal) stigmatizes people with physical differences.

[a] Sonnenberg & Alcantara (2025); [b] Bednarek et al. (2024); [c] Feingold (1969).

Acknowledgements

This section was co-created at CAMH with members of the Patient Advisory Committee and staff in the Office of Health Equity; Equity & Engagement – Provincial System Support Program; Education Research; and the Azrieli Adult Neurodevelopmental Centre.

The social model

The social model, often called the social model of disability, was originally created by disability activists in the 1970s and has been adopted by mainstream health care. At CAMH, we often use a mix of the medical and social models. The social model shifts the focus away from the person and onto the barriers created by society. It argues that disability is not just about a person's body or diagnosis—it's also about how the world is designed. Inaccessible buildings, rigid workplace policies or lack of mental health support can create more challenges than the person's disability itself does.

Key ideas in the social model

- People do not have disabilities; instead, they are *disabled by* environments and the barriers in them (Linton, 1998).
- The social model views structures of employment, education, treatment access and stigma as aspects that are disabling for someone with mental health concerns.
- The social model promotes solutions such as universal design, flexible work environments and inclusive health care.
- People who describe themselves as Disabled (with a capital D) are part of the Disability community and their perspectives often align with the social model. This is a political and cultural identity that grew out of the ways society and environments fail to meet the needs of all people.
- Traditionally, the social model, especially in the United Kingdom, uses the term impairments instead of disabilities to describe specific conditions that might need treatment or that cause pain or physical distress.

Best practices for using the social model

- Although the social model uses the term impairment, be careful when using this term to describe specific conditions. For example, never use it to describe someone with a loss of sight or hearing. (See Language Affecting People with Visual Disabilities and Language Affecting Deaf and Deafblind People and People with Hearing Loss.)

- Use language that focuses on barriers not disabilities. For example, instead of "She has behavioural issues," write "She is experiencing distress in an environment that does not meet her needs."
- Use language that focuses on supports, not limitations. For example, instead of "He is wheelchair-bound," write "He uses a wheelchair for mobility."

For more language examples of the social model, see Language Affecting People with Disabilities.

Tools and resources

Against Technoableism: Rethinking Who Needs Improvement (W.W. Norton & Company)

Disability Politics: Understanding Our Past, Changing Our Future (Routledge)

What Is the Social Model of Disability? (Scope Video)

Acknowledgements

This section was co-created at CAMH with members of the Patient Advisory Committee and staff in the Office of Health Equity; Equity & Engagement – Provincial System Support Program; Education Research; Black Health Strategy, and the Azrieli Adult Neurodevelopmental Centre.

The neurodiversity model

The neurodiversity model, which was developed with Autistic civil rights activists and within Autistic online communities, builds on the social model by viewing neurological differences as natural variations of how people think, process information and experience the world (Archie, 2025; Botha et al., 2024; Shew, 2023). Neurodiversity refers to those natural variations, called neurotypes. Neurotypical is a neurotype that is the assumed typical. Neurodivergent is a neurotype for people who are different than neurotypical. The neurodiversity model challenges the medical model, which often describes this neurodivergence in terms of disorders, deficits or impairments that need to be fixed or cured (Sinclair, 1993).

These differences occur in people with an autism diagnosis, attention-deficit/hyperactivity disorder (ADHD), dyslexia and other neurodevelopmental disabilities; mental health diagnoses; and acquired neurological disabilities, such as traumatic brain injury. Neurodivergence is not limited to people with a formal diagnosis because many people with these neurological differences do not seek a diagnosis.

Some people with neurodivergent minds consider themselves to have a disability, whereas others see their minds as working differently from neurotypical minds. Medical and service-based definitions of disability do not always reflect people's experience of their neurodivergence. For example, some people feel that their neurodivergence is debilitating, but do not meet criteria for disability services or programming. Other people don't feel that their neurodivergence interferes with their life; they simply see it as part of who they are.

These varied perspectives shape how people understand themselves and influence the language they use to describe their neurodivergence (Natri et al., 2023). Language that embraces the neurodiversity model and supports neurodivergent people is called neuro-affirming language (Segers et al., 2024).

Key ideas in the neurodiversity model

- Neurodivergence is not an illness. Autism, ADHD and other neurotypes are natural variations in how people think and experience the world, rather than problems to be fixed, cured or mourned (Sinclair, 1993). Writing from this perspective tends to avoid deficit-based language, such as the word disorder, opting for the word autism or the descriptive term autistic rather than autism spectrum disorder (Segers et al., 2024).
- There is no "normal brain." There are various kinds of brains, with the majority being neurotypical, and others being neurodivergent in many ways. Do not use the word normal.
- All neurotypes are equal and valuable (Segers et al., 2024).
- Describe aspects of neurodivergent brains using words such as characteristics or traits instead of the medical term symptoms (Segers et al., 2024).
- This model focuses on strengths, not just challenges. Many neurodivergent people thrive in creative, analytical and non-traditional thinking.
- This model focuses on support, not conformity. Instead of forcing neurodivergent people to display neurotypical behaviours, which can cause distress and mental health concerns, the model emphasizes accommodations, acceptance and accessibility.

Neurodivergent identities associated with mental health disorders

The neurodiversity model views neurodivergence on a spectrum, with strengths and difficulties in different domains, including motor skills, perception, sensation, energy, attention, regulation and communication. These differences could include altered states, hearing voices and different perceptions of time (Jane, n.d.). According to this model, people diagnosed with mental health disorders could identify as neurodivergent.

Activist Katherine Asasumasu, one of the original contributors to the term neurodivergent, has stated that the concept was intended from the start to include a wide range of brain differences (Archie, 2025). This includes differences

associated with mental health diagnoses, such as bipolar disorder, as well as brain differences acquired through illness or injury.

Treatment and the neurodiversity model

Identifying as neurodivergent does not necessarily mean that a person will be uninterested in treatment. Although they may consider their brain type as a strength, they may still want to manage mental health symptoms that cause them distress or work on developing skills that they find more difficult.

For example, Autistic people who are proud of their Autistic identity may engage in therapy, such as speech therapy, occupational therapy or social skills training, to improve aspects of their lives. Likewise, some people who identify as Mad participate in treatment programs that feel safe and support their identity.

Best practices for acknowledging neurodiversity

- Define the terms you are using in the text or in a note about language. (See Disclaimers and notes about language.)
- Know the difference between the terms neurodiverse and neurodivergent. People often use them interchangeably, which is incorrect. One of our advisory groups warned that some neurodivergent people will not engage with researchers or writers who make this mistake because it shows that they have not engaged with current research or neurodivergent communities. Become familiar with these terms before you engage in consultation.
- Review literature and resources about neurodivergent communities or explore online communities, where a great deal of neurodivergent community-building and debate take place. This information is widely available, and the burden should not be on neurodivergent people to explain these terms when you are working with them.
- When writing about mental health, consider adding perspectives on neurodiversity:
    - Ask whoever you are consulting with or quoting about their relationship to their mental health.

- Include information about neurodivergence where possible.
- Include different perspectives on mental health conditions.

  Example: You are writing a pamphlet for the public about schizophrenia. Include the perspectives—informed by consultation, a guide or research—of different people with schizophrenia. Some people may prefer to be referred to as "a person with schizophrenia." Others may consider themselves neurodivergent, and still others may identify with the Mad movement or with both models (see The Mad Model).

Tools and resources

Embracing Neurodiversity in Mental Health: A New Paradigm (NeuroLaunch)

Language Guide for Neurodiversity-Research (developed for R2D2-Mental Health Consortium)

Mental Illness and Neurodivergence: Intersections and Distinctions (NeuroLaunch)

Neurodiversity educational resources (Sonny Jane: Lived Experience Educator website)

Acknowledgements

This section was co-created at CAMH with members of the Patient Advisory Committee and staff in the Office of Health Equity; Equity & Engagement – Provincial System Support Program; Education Research; and the Azrieli Adult Neurodevelopmental Centre.

The Mad model

The Mad model is rooted in a long history of social movements, such as Mad Pride and Hearing Voices support groups, that challenge traditional psychiatric labels and offer different paradigms for understanding people's experiences. This model recognizes madness as a valid and diverse way of experiencing the world. It pushes back against the medical model, which often frames mental health conditions as individual problems or illnesses to be treated or cured.

Key ideas in the Mad model

- Many people with psychiatric histories have reclaimed Mad as a form of identity, much like other equity-denied groups have reclaimed words used against them (Archibald, 2021). This word is always spelled with the capital M. Some people also reclaim terms related to the diagnosis they were given in the mental health system and use identity-first language, much like many Autistic and Deaf people do.
- While the word Mad has been reclaimed by the Mad movement, some people who are part of the movement do not use Mad or a reclaimed diagnostic term to self-identify. Some people who are unfamiliar with this movement may also find the term offensive. Always use the language people self-identify with. (See Principle 5: Use Dignity-First Language.)
- Instead of viewing mental distress as purely a medical issue, the Mad model sees it as a response to personal, social and systemic factors, including trauma and oppression.
- The Mad model promotes patient choice, alternatives to forced treatment, and the idea that experiences of mental distress or mental difference should not be automatically labelled as disorders.

Sanism and language: The hidden discrimination against Mad people

Sanism is a form of systemic discrimination against people who are perceived as mentally ill, Mad or neurodivergent (LeBlanc et al., 2004). It influences laws, health care and everyday language, reinforcing the idea that some minds are normal,

whereas others are broken, dangerous or untrustworthy. Regardless of the model you are writing in, avoid sanist language because it does not respect people with mental health concerns, Mad people or neurodivergent people.

Best practices for challenging sanism

- Avoid words that dehumanize or dismiss, such as crazy, insane, lunatic, psycho or schizo. Instead, use specific, nonstigmatizing language (e.g., a person in distress rather than acting crazy).
- Be intentional. Avoid casual or metaphorical use of mental health terms. For example, don't say "She's so OCD about cleaning" or "That meeting gave me PTSD." This language minimizes real experiences and turns them into jokes or exaggerations.
- Avoid framing people as dangerous, incompetent or unreliable. Instead of writing "She is unstable," recognize that distress doesn't mean someone is less credible. Use judgement-free language when describing behaviours and moods.
- Use strengths-based language. Instead of writing that someone struggles with or suffers from a condition, simply write "a person with" that condition or that they "live with" or "manage" the condition.
- Consider using language that acknowledges that not everyone agrees with diagnostic systems or their own diagnosis. For example, instead of writing "suffers from bipolar disorder," write "was given a diagnosis of bipolar disorder" or "experiences changes in mood often associated with bipolar disorder."
- Acknowledge self-identification. If someone identifies as Mad, respect that choice. Some people reject psychiatric labels altogether, and it's best to ask how they identify. The language they prefer may also overlap with the social model, the neurodivergent model or both. Instead of "mentally ill person," write "Mad person" (if self-identified) or "person who has experienced the mental health system."

Acknowledgements

This section was co-created at CAMH with members of the Patient Advisory Committee and staff in the Office of Health Equity, Equity & Engagement –

Provincial System Support Program, Education Research, Black Health Strategy, and the Azrieli Adult Neurodevelopmental Centre.

Indigenous Wholistic models of health and well-being

First Nations, Inuit and Métis communities conceptualize health and wellness in many ways depending on their culture and experience. Although there are some differences among First Nations, Inuit and Métis concepts of healing and wellness, they all agree that healing and wellness occur when a person's physical, mental, spiritual and emotional states are in balance, and that well-being does not exist independently of physical, cultural, social, economic and political factors.

Given the growing body of evidence indicating the importance of cultural practices and traditional Indigenous healing methods in mental health care, many Indigenous communities and organizations have developed new models of care that are Wholistic and rooted in Traditional Knowledge, knowledge systems and cultural practices.

Key ideas in Indigenous Wholistic models of health and well-being

- There is not one Wholistic model of care that applies to all First Nations, Inuit and Métis as they have many different cultures and worldviews.
- The term Wholistic differs from the term holistic in that it is grounded in Indigenous culture and ways of knowing and being, and incorporates Traditional Knowledge of Indigenous Peoples. Wholistic should always be capitalized. (See Language Affecting Indigenous Communities.)
- What these models have in common are frameworks for delivering mental health interventions with Indigenous Healing Practices or culture at their core.
- Interventions delivered under an Indigenous Wholistic wellness model include Traditional Plant-Based Medicines, Smudging, Sweat Lodges and Ceremonies that promote mental, emotional and spiritual healing.
- Knowledge Keepers and Elders play a central role in guiding these practices.

Variations across cultures and communities

This section is adapted from Literature Review: First Nations, Inuit, and Métis Healthcare Models, *an unpublished manuscript prepared by Shkaabe Makwa at CAMH.*

Although there are notable distinctions among First Nations, Inuit and Métis concepts of healing and wellness, these communities share a similar Wholistic framework in which healing and wellness occur when the physical, mental, spiritual and emotional aspects of life are in balance. Not every Nation or community uses these exact categories, but the underlying framework remains consistent.

- A Fort Albany First Nation Elder describes health and well-being as a balance between physical well-being (e.g., health); mental well-being (e.g., Indigenous identity); spiritual well-being (e.g., balance of body, mind, spirit, emotions and harmonious relationships); and cultural well-being (e.g., going out on the land) (Tsuji et al., 2023).
- Factors that support Inuit health and well-being include community, family, identity, food, land, knowledge, economy, sense of belonging, housing, connection, caring and somewhere to go (Pawlowski et al., 2024).
- Métis conceptualize health in the physical sense, whereas well-being is seen as interconnected, encompassing several dimensions: spiritual (e.g., being supportive); emotional (e.g., practising traditional activities); mental (e.g., respecting others' views); and physical (e.g., nutrition and physical activity) (Tsuji et al., 2023).

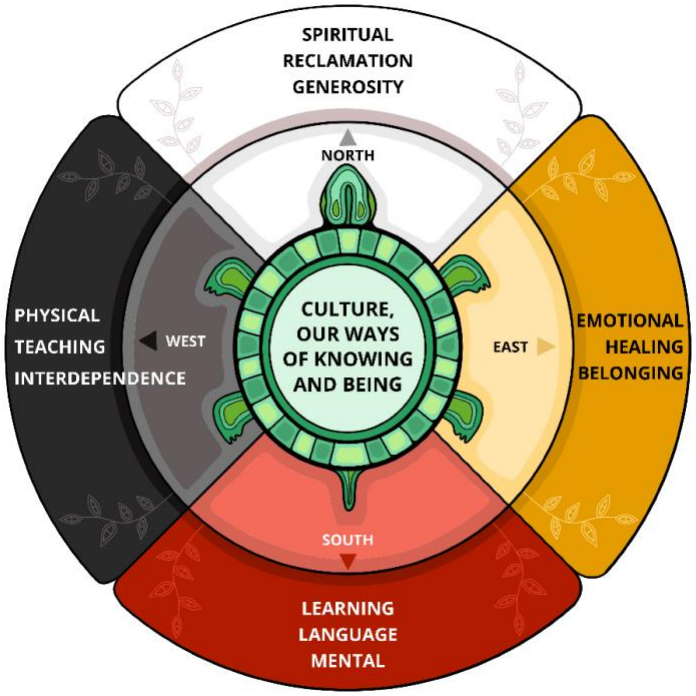
The next section describes three Indigenous Wholistic models. It introduces two First Nations–based models—the Indigenous Primary Health Care Council Model of Wholistic Health and Wellbeing and the Thunderbird Partnership First Nations Mental Wellness Continuum—both of which are grounded in the Medicine Wheel. It also presents an Inuit model. Inuit approaches do not typically use the Medicine Wheel. Instead, Inuit Qaujimajatuqangit (IQ) principles articulate Inuit-specific values that guide community, health and wellness.

Indigenous Primary Health Care Council Model of Wholistic Health and Wellbeing

The Indigenous Primary Health Care Council (2024), an Indigenous-governed organization focused on improving Indigenous health outcomes across Ontario, has developed the Model of Wholistic Health and Wellbeing. This model is grounded in Traditional Knowledge and views physical, spiritual, emotional and mental well-

being as interconnected (see Figure 1). Rather than only treating health issues as they arise, the focus is on wellness and prevention. This model is a good introduction to Wholistic wellness models.

Figure 1
Indigenous Primary Health Care Council Model of Wholistic Health and Wellbeing



Note. Reprinted with permission from the Indigenous Primary Health Care Council. https://iphcc.ca

A mental health clinic that uses this model would offer cultural and spiritual practices and integrate them into a person's care. At Shkaabe Makwa, Cultural Care Practitioners are part of the person's support team, alongside social workers. These practitioners include Elders, Healers and Knowledge Sharers. Shkaabe Makwa also offers ceremonies and cultural events, a Sweat Lodge, spiritual services and family support as part of treatment for substance use or mental health concerns.

Watch this video developed by the Indigenous Primary Health Care Council to learn more about the Model of Wholistic Health and Wellbeing.



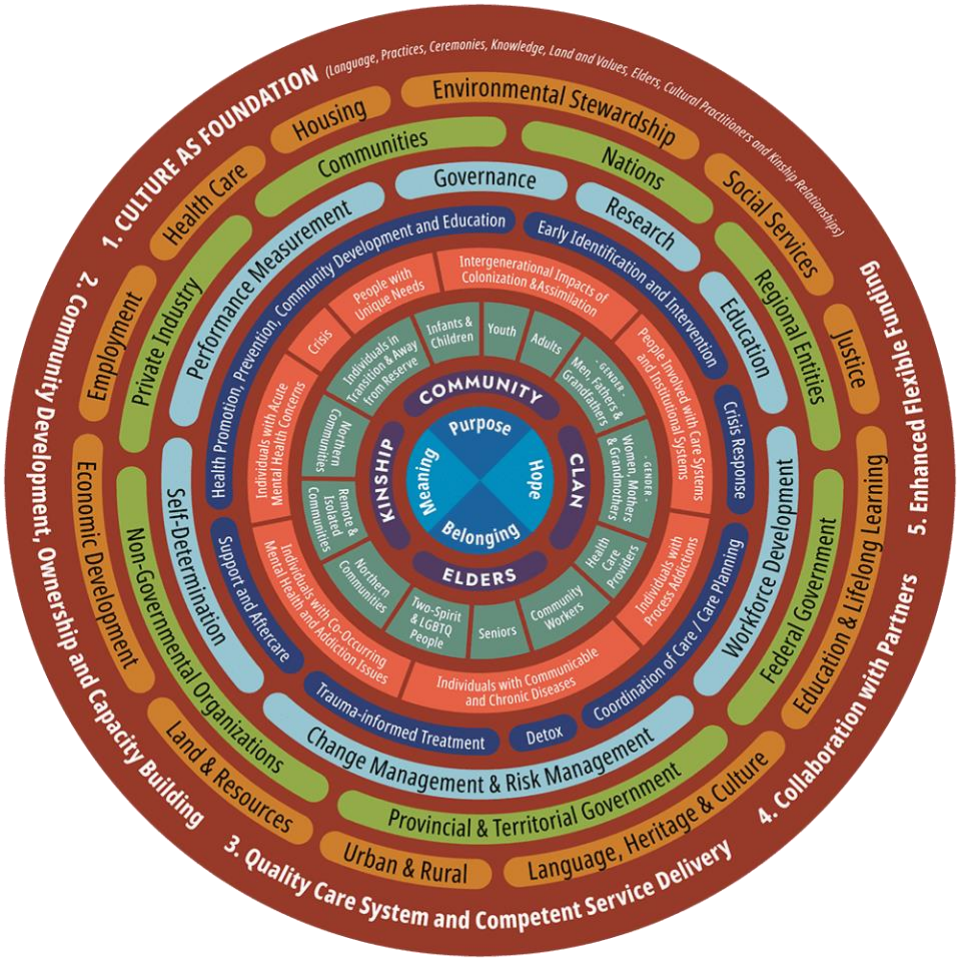
Note. Used with permission from the Indigenous Primary Health Care Council. https://iphcc.ca

Thunderbird Partnership First Nations Mental Wellness Continuum

Thunderbird Partnership Foundation, a division of the National Native Addictions Partnership Foundation, is a leading culturally centred voice advocating collaborative, integrated and wholistic approaches to healing and wellness. Together with focus group members, the Thunderbird Partnership Foundation (2015) developed the First Nations Mental Wellness Continuum, a complex model that breaks down various systems (see Figure 2).

This model is often used by Shkaabe Makwa because it is specific to the mental health work at CAMH while focusing on purpose, hope, belonging and meaning. It is also a practical framework grounded in how to best care for First Nations people as they seek mental health and wellness services. This model shows that all systems connect and that an integrated approach to care is the most effective.

Figure 2
Thunderbird Partnership First Nations Mental Wellness Continuum



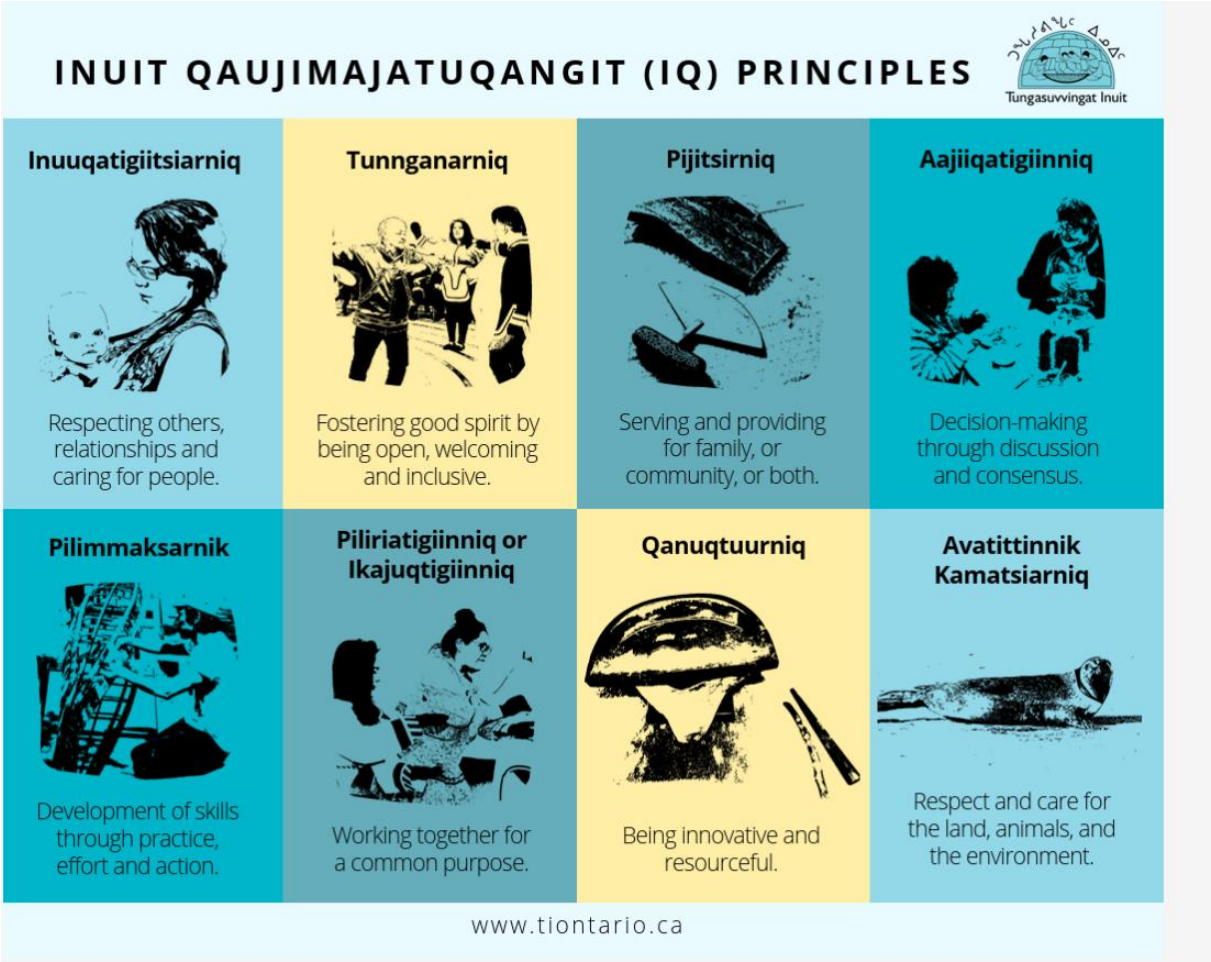
Note. First Nations Mental Wellness Continuum Framework, by Thunderbird Partnership Foundation, 2015. Copyright 2015 by Thunderbird Partnership Foundation, National Native Addictions Partnership Foundation. Reprinted with permission. https://thunderbirdpf.org/about-the-iwf

Inuit Qaujimajatuqangit (IQ) principles

Tungasvivvingat Inuit is an Inuit-specific service provider in Ontario that offers social support, cultural activities, employment and education assistance, youth programs, counselling and crisis intervention for Inuit living in urban areas. It also provides day counselling and residential programs.

Tungasvivvingat Inuit (2023) has created a graphic (see Figure 3) representing Inuit Qaujimajatuqangit (IQ) principles that were developed by Inuit Elders and knowledge holders over thousands of years as a living system of knowledge, philosophy and societal values (E. Partridge, personal correspondence, May 8, 2026). These principles govern community, health and well-being. Each one uses its Inuktitut name, which ties to the importance of language for Inuit communities.

Figure 3
Inuit Qaujimajatuqangit (IQ) principles



Note. Reprinted with permission from Tungasvivvingat Inuit. https://tiontario.ca

Tools and resources

First Nations Mental Wellness Continuum Framework (Thunderbird Partnership Foundation)

Indigenous Primary Health Care Council

Shkaabe Makwa webinars and training (CAMH)

Tungasuvvingat Inuit

Acknowledgements

This section was co-created at CAMH with members of the Patient Advisory Committee and staff from Shkaabe Makwa; the Office of Health Equity; Equity & Engagement – Provincial System Support Program; Education Research; and the Azrieli Adult Neurodevelopmental Centre.

The intersectionality framework

Intersectionality, a term coined by legal scholar Kimberlé Crenshaw, is more than an academic framework—it is a practical and necessary approach to inclusive writing. It reminds us that no one lives a single-issue life (Crenshaw, 1991). Intersectionality is a framework that should be applied no matter what audience we are writing for.

Inclusive writing demands that we move beyond one-dimensional portrayals. It asks us to consider how systems of oppression overlap and how those intersections affect the ways people are seen, described or written into policies, programs, research and public discourse. As communicators, we must use inclusive, stereotype-free language that reflects people's multiple, intersecting identities, not just the single group we aim to represent. Language that doesn't reflect these complexities risks flattening identities and erasing realities.

Key ideas in the intersectionality framework

- All people have multiple identities, experiences and cultures. For example, when we write about Black communities, it's not enough to focus on race alone. Gender, class, disability, sexual orientation, immigration status and other factors intersect to shape lived experiences.
- Some people who face discrimination due to one part of their identity also face it due to another part, resulting in a compounding effect that can lead to increased harms (Crenshaw, 1991; Otmar, 2023).
- Some people experience oppression due to one part of their identity but are privileged due to another (e.g., one contributor to this guide has experienced discrimination due to being queer and neurodivergent, but experiences privilege due to being white and having post-secondary education). Patients at CAMH may face stigma, bias or stereotyping due to their experiences with mental health concerns or substance use, as well as to identity factors related to race, culture, ethnicity, sexual orientation, gender, age or ability.

Example of intersectionality

The following example illustrates how key ideas from the intersectionality framework can be applied to writing about mental health and substance use services:

> You are writing about a caregiver support group for the AMANI Mental Health & Substance Use Program at CAMH, which provides services for Black youth. Your focus is on people who support youth in the program. You use the term caregiver instead of parent to acknowledge that caregivers can hold multiple, overlapping identities, including adoptive or guardian roles, different racial backgrounds, same-sex relationships, non-traditional family structures and accessibility needs.

The AMANI Mental Health & Substance Use Program uses this type of inclusive language on its website and specifies that the group is for "caregivers of Black youth," which does not assign a specific identity factor, race or culture to the caregiver. (See Language Related to Family, Caregivers and Chosen Support Systems.)

Best practices for acknowledging intersectionality

- Consider the intersectionality of identities and represent people as whole people who contain complexity (Cariou et al., 2025a, 2025b).
- Do not make assumptions. Remember that all people are different and that there are multiple communities within every race, culture, sexual orientation, gender and other identity.
- Consider stereotypes and stigma across multiple identities as you write.
- Do not make assumptions about how someone might identify based on the identity you know of. For example, just because someone identifies as neurodivergent does not mean that they will not also identify as Mad. Instead, you can gently ask what ways they identify.
- Consider multiple perspectives and models as you are writing. What is missing? Whose voices and perspectives are being left out? Does the content change if you approach the work from another model? How?

Intersectionality and the Mad model

The Mad model considers intersectionality in its depiction of mental health. Work done in Mad studies often looks at how other oppressed groups have been subjected to sanism. This model makes room for many kinds of identities because it "frames psychiatric experiences as diverse forms of human emotional and spiritual expression" (Dwornik, 2021, p. 25).

Sanism is connected to racism, homophobia and transphobia, and people who are neurodivergent, disabled, queer, transgender or racialized have experienced increased harms through the mental health system. Throughout history, many of these identities were seen as diseased or abnormal, which led to forced confinement of people who did not fit what was considered normal, often in institutions and hospitals.

Queer and trans Madness

The Mad movement empowers queer and transgender voices, especially as their very identities were often considered a form of mental illness. Homosexuality was included as an illness in the *Diagnostic and Statistical Manual of Disorders* until the 1970s (Pilling, 2022). The Mad model imagines a different way of looking at queerness, transness and mental distress, with the hope of building responses that centre queer, trans and Mad experiences.

Anti-Black sanism

Black people who access mental health and substance use services often experience two types of stigma: anti-Black racism and sanism (Feng et al., 2023; Gary, 2005). Anti-Black sanism has been described as a "crisis of misdiagnosis, over-diagnosis, incarceration, confinement, silencing, shooting, and physical violence" (Meerai et al., 2016, p. 19). For example, Black people in North America are overrepresented in diagnoses of serious mental illness, such as schizophrenia, and are more likely to be forcibly held in hospital (Fernando, 2012; Knight et al., 2021).

Best practices for acknowledging intersectionality in writing about Black communities

- Don't assume that all groups are the same:
  - "The Black community" is often written about like it is one uniform group, which erases the richness, complexity and diversity within it. If you are speaking generally, use the word communities instead.
  - Wherever possible, be specific. For example, are you referring to Afro-Caribbean Canadians? Black Muslim youth? Black people with disabilities? The more precise your language, the more respectful and accurate your message will be. (See Principle 7: Be Specific.)
- Name systems, not just symptoms. When you focus only on individual struggles without naming the systems behind them, you risk blaming the people who are most affected.

  Example: Don't just write "Black people affected by poverty." Instead, write "Black communities navigating poverty due to systemic racism." Whenever possible, point to the root causes, not just the outcomes.
- Don't tag on intersections as an afterthought. Black people live at the intersection of many identities—gender, sexuality, ability, immigration status—and those identities shape how people experience racism.

  Example: A Black queer woman or a Black transgender man with a disability is not experiencing only one identity at a time. Make sure your writing reflects that reality from the start, not as a side note.
- Use language that uplifts, not flattens. The words we choose can either reduce people to their challenges or reflect their strengths, agency and humanity.

  Example: Instead of writing "Black people affected by trauma," try "Black people healing from the effects of systemic trauma." Centre resilience, not victimhood. Show people as whole, not broken. (See Principle 6: Use Healing-Centred Language.)

Tools and resources

An Introduction to Anti-Black Sanism (*Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice*)

Intersectionality and Mental Health: Identity's Impact on Wellbeing (NeuroLaunch)

Intersectionality Resource Guide and Toolkit (UN Women)

The intersectionality toolbox: A resource for teaching and applying an intersectional lens in public health (*Frontiers in Public Health*)

Acknowledgements

This section was co-created at CAMH with members of the Patient Advisory Committee and staff in the Office of Health Equity; Equity & Engagement – Provincial System Support Program; Education Research; the Azrieli Adult Neurodevelopmental Centre; and Black Health Strategy.

The Language Guidelines

Introduction

The Language Guidelines incorporate guidance from various guidelines used at CAMH, as well as suggestions from across the organization. We are fortunate to work at an organization where this equity and inclusion work is ongoing and where we have several clinics serving specific communities, such as Black adults and youth, Indigenous Peoples, people with disabilities and 2SLGBTQIA+ people. Where possible, we have included guides in full. In other cases, we have excerpted pieces of guidance or co-created guidelines with staff, patient advisors and people with lived experience.

We have tried to include multiple perspectives on mental health, substance use and wellness. The specifics are “best practice … for now” suggestions. As language continues to evolve, we will do our best to update this guidance.

In this guide, we group identities and communities to discuss language preferences and common stereotypes to avoid. We use these categories for ease of communication, but we recognize that people’s identities and experiences are complex and often intersect across multiple communities. The order in which communities are presented does not reflect their importance. (For more information on intersectionality, see The Intersectionality Framework.)

The Language Guidelines

Language and mental health stigma

Stigma refers to negative attitudes, beliefs and behaviours—including the language people use—that are directed at a person or group based on a perceived difference. It is often experienced by people who have a mental illness or disability or who use substances. Members of other equity-denied groups also experience stigma.

Stigma has many harmful effects. It prevents people from accessing services or being honest about their needs, reinforces shame and self-blame and increases social isolation. It also worsens health outcomes, erodes trust in health care professionals and institutions, and perpetuates systemic inequalities in how care is delivered. In health care settings, stigma also affects how people are treated by health care professionals. When people feel judged, dismissed or excluded, they may disengage from care.

As communicators at CAMH, we want people to talk about mental health often, openly and compassionately. The more awareness we create, the greater the opportunity to support people who experience challenges related to mental health. The words we choose can either break down stigma or reinforce it. By using language that respects people's experiences, avoids stereotypes and encourages open dialogue, we foster a culture of understanding, compassion and dignity in how we discuss mental health.

Types of stigma

- **Social/public stigma:** Negative attitudes held by society or communities.
- **Self-stigma:** Internalized negative messages a person has about themselves.
- **Structural stigma:** Discriminatory policies, practices or systems that reinforce exclusion or inequity (e.g., criminalization of substance use, lack of culturally safe care, underfunded mental health services, inadequate disability accommodations, systemic barriers in education, employment or justice systems).
- **Sanism:** Discrimination against people with mental health concerns. It is a root cause of structural stigma and appears in systems such as health care,

education and the legal system. Sanism dismisses the lived experiences and expertise of people with mental health concerns, which reinforces structural stigma in areas such as academia, research and policy. (See The Mad Model.)

- **Intersectional stigma:** The combined experience of multiple forms of stigma based on aspects of identity such as race, gender, sexual orientation, disability, income or immigration status. These overlapping stigmas can increase barriers to care. (See The Intersectionality Framework.)

Best practices for challenging stigma through language

Choosing our words intentionally means avoiding language that reinforces stereotypes, prejudice or discrimination. But it is about more than avoiding stigmatizing terms. The language we use can also have a positive, empowering effect, which makes choosing the right words just as important as avoiding harmful ones. Table 4 provides examples.

- Avoid metaphors that exaggerate or dramatize.
- Choose neutral, accurate and respectful terms.
- Avoid language that refers to or defines people by their diagnosis:
  - In general, use person-first language unless the person prefers otherwise (e.g., person with bipolar disorder; person living with bipolar disorder; person diagnosed with bipolar disorder).
  - Ask people how they want to be described.
- Use strengths-based language that centres the person, not the condition.
  - Use language that supports recovery, autonomy and dignity.
- Avoid language that implies that mental illness makes people more creative, fragile or violent. These are stereotypes and reinforce a view of people with mental illness as “other.”
- Avoid language that minimizes or invalidates experiences. People with mental health concerns or mental illness are experts on their experience. Never discount the experiences of another person.
- Acknowledge that mental health exists on a spectrum of severity and varies for everyone.

The Language Guidelines

Table 4
Respectful language for writing about mental health

Language to avoid	Language to consider	Why?
suffering from a mental illness, struggling with a mental illness	living with a mental illness, experiencing a mental illness, with a mental illness	People with mental illness should not be portrayed as victims. Many people prefer language that acknowledges their experiences without implying helplessness. It's important not to assume someone's experience when writing about it.
[Name] is mentally ill. [Name] is schizophrenic.	[Name] is living with a mental illness, is experiencing a mental illness. [Name] has schizophrenia, is living with schizophrenia.	Labelling someone as mentally ill or defining them by their diagnosis reduces them to their condition, while person-first language acknowledges the person's full identity beyond their condition.
non-compliant patient	person who prefers a different approach to care, person who has concerns about treatment	Compliance language places blame on the person rather than acknowledging systemic barriers, personal autonomy or the need for individualized care.
high-functioning or low-functioning high or low support needs	Avoid terms that indicate a value system associated with productivity. Describe the person's specific strengths and the difficulties they experience.	Functioning and support labels oversimplify and dismiss individual abilities, strengths and challenges. These labels imply that some people are better or worse contributors to society or have an easier or harder time navigating concerns or disabilities. For many people, their experiences and symptoms are not static: • Stress, circumstances or an unknown factor can cause acute reactions in a person who

		would otherwise be thought of as needing few supports. • With proper supports, someone who is labelled low-functioning may have periods of stability and wellness.
emotionally disturbed	person experiencing emotional distress, person in crisis	The word disturbed is stigmatizing and vague. Describing someone's experience more accurately reduces stigma and increases understanding.
That's crazy, nuts, insane.	That's unbelievable, wild, surprising, unexpected	Casual language reinforces stigma around mental illness. Being mindful of word choices promotes a stigma-free environment where people feel comfortable discussing mental health without fear of judgement.

Words and phrases to give additional thought

Patient, client, service user

CAMH tends to use the word patient in different contexts across the hospital. When using the word client or patient, consider your audience and the project's purpose.

- patient: someone who is interacting with hospital services, either inpatient or outpatient
- client: used by some organizations, clinics or programs in health care to mean someone who is accessing services
- service user: someone who uses any health program, clinic or service

There are benefits and drawbacks to each term. The word patient, especially in a mental health context, uses the same language for all people accessing the hospital. However, some people feel that this word enforces the power imbalance

between health care professionals and people receiving care. The term is also considered very clinical. Client, in comparison, implies a service relationship.

Some people prefer the term service user, but others think it is too removed from the human experience, and, like the word client, treats people accessing mental health supports like customers. It is also less specific, so consider context and specificity in what you are writing.

Some people dislike being referred to using some or all of these terms, so always respect their preferences (Self-Advocate Leadership Network British Columbia, 2020).

Mental health concerns, mental health challenges, mental illness, mental health disorder

CAMH tends to use the term mental health concerns or mental health challenges more often than the term mental illness. When talking broadly about areas affecting mental wellness, the term mental health is preferred over the term mental illness (e.g., mental health research, mental health education). This language focuses on well-being and reinforces the message that mental health is health. (See Principle 6: Use Healing-Centred Language.)

The terms mental illness and mental health disorder may be appropriate when writing about diagnosed mental health conditions, particularly for a clinical audience. Mental health disorder is the preferred term.

When describing mental health symptoms that may cause someone to seek services, the terms mental health concerns or mental health challenges are appropriate. However, both terms have drawbacks: mental health concerns implies that the person is concerned and the term challenges has a negative connotation. Choose one term to use throughout your writing if needed, but remember that being specific and descriptive is always best. (See Principle 7: Be Specific.)

We recommend avoiding the terms mental health problems or mental health issues unless you are directly quoting a patient.

Person with lived experience

CAMH often uses the term “person with lived experience” to refer to someone who has or has had mental health and/or substance use concerns. Another option is “person with living experience” or “person with lived/living experience.” These terms can refer to both people who have received services and those who haven’t. Sometimes you may need to group people with various types of experience under the term people with lived experience, but the preference is to be as specific as possible about the lived experience without disclosing sensitive information. (See Principle 7: Be Specific.)

Be mindful of using the acronym PWLE because acronyms can reduce people to labels. Although spelling out the full term is lengthy, the acronym can be used sparingly by reserving it for use as an adjective (e.g., “PWLE research”) rather than as a noun (e.g., “Our research participants were PWLE”).

Recovery

Recovery can be a loaded term because people with mental health and substance use concerns often do not experience recovery as the linear process it is typically depicted as. Language around recovery also focuses on returning to a state of health, wellness or so-called normalcy, which many people may not have experienced. For many people, going through treatment involves highs, lows and setbacks.

Some people prefer terms such as remission instead of recovery, especially for mental health or substance use concerns that may be lifelong.

For people who see their experiences in the mental health system or their brain differences as part of their identity, phrasing treatment around recovery may feel dismissive of their perspective. Be mindful when using this word and consult with your audience to see how they view this process.

Provider, health care provider, service provider

The word provider can be problematic for several reasons. Some people feel it is paternalistic, and others think it frames the patient–health care professional

relationship as transactional, rather than emphasizing compassionate, person-centred care (Hodges, 2020). Historically, similar terminology was used during the Nazi era in Germany to relabel Jewish doctors (using the term *Behandler*), which may make the word provider triggering or devaluing for some professionals (Scarff, 2021). Instead, consider using terms such as health care professional or mental health professional and be as specific as possible when referring to individuals or roles.

Tools and resources

Dismantling Structural Stigma in Health Care (Mental Health Commission of Canada)

Mental Health 101 course (CAMH)

Structural stigma (Mental Health Commission of Canada)

Understanding Stigma course (CAMH)

Acknowledgements

This section was co-created at CAMH with members of the Patient Advisory Committee and with contributions and review from Inclusion, Diversity, Equity and Accessibility – People & Experience; the Office of Health Equity; and Equity and Inclusion – Provincial System Support Program.

Language related to suicide

Responsible portrayals and reporting on suicide make a difference and reduce harm. This section outlines ways to write about suicide in a safe way, as described by 9-8-8 Suicide Crisis Helpline. This national 24/7 service provides support for anyone in Canada who is thinking about suicide or is worried about someone else. 9-8-8 is available by phone and text, in English and French.

Writing about suicide in a safe way

Sometimes the words we use can be stigmatizing, even if we don't mean them to be. By choosing words carefully and using suicide-safe language, we can lessen the shame and stigma associated with suicide and encourage people to get help when they need it. We can also reduce stigma by using person-first language, which respects people's identities and experiences, rather than putting labels on people. Table 5 provides examples.

Table 5
Respectful language for writing about suicide

Language to avoid	Language to consider	Why?
commit suicide	died by suicide	The term commit suicide comes from a time when suicide was a crime.
failed attempt, failed suicide unsuccessful attempt, unsuccessful suicide incomplete suicide, completed attempt, completed suicide	attempted suicide, survived a suicide attempt died by suicide, death by suicide	Referring to failure, success or completion suggests that dying by suicide is an achievement. In fact, every death by suicide is a tragedy.
at-risk people/communities high-risk people/communities	communities with a potentially high risk of suicide, communities with higher rates of suicide,	Cultural background or race does not inherently put people at risk of suicide, but how they are treated can be a factor.

	factors that may increase someone's risk of suicide	
suicide victim	he/she/they died by suicide	Calling people victims reduces their identity to their cause of death. A person's identity is not defined by suicide.
He/she/they are suicidal.	having/experiencing suicidal thoughts/feelings thinking about suicide experiencing suicidal ideation [in a clinical context]	Describing someone as suicidal reduces them to their thoughts of suicide. It is more helpful to be specific about the thoughts, feelings or plans related to suicide.

Tools and resources

9-8-8: Suicide Crisis Helpline

Language Matters: Safe Communication for Suicide Prevention (Government of Canada)

Acknowledgements

Thank you to 9-8-8: Suicide Crisis Helpline for contributing this section from its Suicide-Safe Language guidance.

Language related to substance use

Substance use is a part of many people's lives, and people use substances for a wide range of reasons, for example, to cope, seek pleasure, connect socially, control pain or manage the effects of trauma. It can affect anyone, regardless of background, profession or identity.

We can't discuss substance use without first addressing the stigma that surrounds it. Stigma discourages people from asking for help, sharing their experiences or feeling safe in clinical and community spaces. It can lead to isolation, shame and serious harm.

Many terms we hear in everyday language, such as addict or clean, are so common that we may not realize how stigmatizing they are. These words can cause real harm and reinforce stereotypes, even if that isn't our intention. The language we use to write about substance use should reflect compassion, nonjudgement and respect. This approach helps people feel seen and supported, rather than silenced and shamed.

Meeting people where they are

People's relationships with substances are complex and personal. Mental health and substance use journeys are rarely linear. Instead of assuming what's best for someone, ask, listen and collaborate (Support House Centre for Innovation in Peer Support). Support should reflect where a person is in their journey—not where we think they should be.

This means moving away from language that implies blame, failure or moral judgement, and toward language that centres the person, respects autonomy and promotes dignity (Public Health Agency of Canada, 2020).

Substance use versus addiction

Understanding the difference between substance use and addiction (i.e., substance use disorder) helps to avoid harmful generalizations.

- Substance use refers to consuming alcohol or other drugs. This may include experimental, occasional, recreational or regular use for recreational or medicinal purposes (Public Health Agency of Canada, 2020).
- Addiction, or substance use disorder, describes a pattern of use that causes distress, health problems or difficulty functioning in everyday life. At CAMH, we tend to use the term substance use disorder or substance use concerns more frequently than the word addiction.
- Some people may seek treatment for difficulty with behaviours, such as gambling, gaming, internet use, shopping or sex. Without a diagnosis, these are called nonsubstance use concerns. With a diagnosis, they are referred to as nonsubstance use disorders or addictions. (See Language Related to Nonsubstance Use Concerns.)

Not everyone who uses substances has a substance use disorder or wants to stop using them. Language that conflates use and addiction can lead to stigma, misrepresentation and missed opportunities to give people the right kind of support (Support House Centre for Innovation in Peer Support).

Harm reduction and safer substance use

Harm reduction is a person-centred approach that supports health and safety, regardless of whether or not a person stops—or wants to stop—using substances. It recognizes that people use substances for complex and valid reasons and that abstinence is not a prerequisite for care.

Common harm reduction strategies include:

- overdose prevention sites
- safe/supervised consumption sites
- needle and syringe programs
- street outreach and peer-led support
- safer smoking kits
- naloxone distribution programs
- safer opioid supply programs

There are many types of harm reduction services, but people sometimes use terms for them interchangeably, which isn't accurate because these are different services that address different community needs (Atira, 2025; Morais, personal communication, 2025). However, what all of these services have in common is that they reduce the risk of poisoning, infection and death, and are often led or informed by people with lived experience.

Here are descriptions of two types of harm reduction services:

- **Overdose prevention sites** are community-run services that offer harm reduction supports. They usually provide peer support, but not nursing care. These sites are not government funded and are either privately funded or operate as non-profits. They are often temporary and are able to be set up quickly to address an immediate community need.
- **Safe/supervised consumption site** is an umbrella term that may include safe injection sites, safe inhalant sites or sites that support another form of substance use. These services may be more general and able to accommodate many kinds of substance use. They are government-funded and have dedicated health care staff that includes nurses. Because these sites must meet more requirements before they can operate, they may take longer to open and typically remain open long-term (Atira, 2025).

Best practices for writing about substance use

- Ask people how they would describe their experience with substance use.
- Use person-first, nonstigmatizing language (see Table 6; CAMH, 2026a).
- Avoid implying moral failure, shame or blame.
- Don't make assumptions about someone's relationship with substances or their readiness for treatment.
- Avoid dramatizing language that criminalizes or sensationalizes substance use (Support House Centre for Innovation in Peer Support, 2021).
- Be guided by harm reduction, dignity and trust.

Table 6
Respectful language for writing about substance use

Language to avoid	Language to consider	Why?
addict, junkie, drug abuser	person who uses substances, person with a substance use disorder, person who uses drugs	Labels such as addict are dehumanizing. Person-first language centres the person, not the condition.
clean/dirty clean/dirty urine drug test results	in recovery, currently using substances clear results, results that suggest substance use or that indicate substance use	The word clean implies moral purity. Neutral terms are less judgemental and more respectful.
substance abuse, substance misuse	substance use, substance use disorder, non-medical substance use	The words abuse and misuse are outdated and stigmatizing. The word use is more neutral and nonjudgemental.
relapsed	returned to use	The word relapse can imply failure or moral weakness. The term returned to use, acknowledges the reality of non-linear recovery.
valid/legal substance use illicit/illegal substance use	prescribed substance use non-prescribed substance use	More neutral terms avoid stigmatizing or criminalizing language.

Tools and resources

Communicating About Substance Use in Compassionate, Safe and Non-Stigmatizing Ways (Public Health Agency of Canada)

Compassionate Language for Mental Health and Substance Use (Support House Centre for Innovation in Peer Support)

Overcoming Stigma Through Language: A Primer (Canadian Centre for Substance Use and Addiction)

Acknowledgements

This section was co-created at CAMH with patient advisors from the Patient Advisory Committee. Contributions were also made by staff from Community and Continuing Education, Education at CAMH; Patient & Family Education and Mental Health Literary, Education at CAMH; and Shkaabe Makwa. Consultation was provided by CAMH Pharmacy Services.

Language related to opioid use

People use and access opioids in different ways and clear, descriptive language reflects those differences. Opioid use can include:

- using opioids with a prescription, as directed (e.g., medical or therapeutic use)
- using opioids with a prescription, but not as directed (e.g., taking more than prescribed or obtaining prescriptions from multiple providers)
- using prescription opioids without a prescription (e.g., diverted use, sharing medication, accessing from the street)
- using non-pharmaceutical opioids such as heroin, street fentanyl or other illegally produced opioids for a medical reason (e.g., to manage pain or mental health symptoms, will experience physical symptoms if not using them)
- using non-pharmaceutical opioids for a non-medical reason (e.g., to socialize, experience pleasurable effects, pass the time)

Understanding the full context of opioid use—including pain, trauma, access to care and systemic inequities—is essential to writing about opioid use in a way that is compassionate, trauma-informed, medically accurate and rooted in harm reduction. Respectful language also reflects a range of lived experiences and avoids criminalizing people. Rather than using terms such as illicit or illegal, use prescribed and non-prescribed, or pharmaceutical and non-pharmaceutical, which are more neutral and respectful.

Opioid use disorder versus physical dependence

It's important to distinguish between opioid use disorder and physical dependence. A person may develop physical dependence from long-term therapeutic use without meeting criteria for opioid use disorder. Misunderstanding this difference can lead to stigma or inappropriate treatment decisions. Terms such as abuse or misuse suggest intentional harm or wrongdoing, when in fact someone may be navigating legitimate pain management challenges or tapering strategies.

Understanding the drug poisoning crisis

Content in this section was contributed by the Needle Syringe Program Community of Practice, EENET – Provincial System Support Program, CAMH.

Since 2016, Canada has been facing a public health emergency related to opioid-related poisoning deaths. This crisis has shifted over time from one associated with prescription opioids to a broader toxic drug supply crisis that includes fentanyl, benzodiazepines and other substances. Most deaths are unintentional and involve multiple substances.

Terms such as drug poisoning crisis and drug toxicity deaths are replacing the term opioid overdose to reflect the changing nature of the crisis (First Nations Health Authority, 2023; Vancouver Coastal Health, 2023). The unregulated drug supply has become increasingly unpredictable and contaminated with fentanyl and other substances, contributing to a growing number of drug toxicity deaths (Government of Canada, 2023; Kingston et al., 2023; Pappas, 2023). Most of these deaths are accidental and involve multiple substances, with fentanyl present in the majority of cases (Mack et al., 2023; Pawson, 2023).

Best practices for writing about opioid use and the toxic drug crisis

The language we use affects how people are treated, how policies are written and whether people feel safe accessing care. It can also influence public support for harm reduction services (Barry et al., 2018; see Harm reduction and safer substance use). The toxic drug crisis is not a crisis of character—it is a crisis of contaminated supply, structural barriers and social inequity. The words we choose can either reinforce stigma or build trust (see Table 7).

With this in mind, avoid the term opioid overdose because it can be stigmatizing by implying personal blame or wrongdoing; however, some people who access services use this language, in which case it is appropriate. Generally, terminology such as drug poisoning and drug toxicity is more medically accurate and less stigmatizing.

- The word overdose may imply that a person knowingly took too much of a substance.
- The word poisoning more accurately describes what occurs in the body when someone unknowingly consumes a toxic or contaminated substance.
- While the word overdose remains common in clinical and community settings, terms such as drug poisoning, toxic drug crisis or unregulated drug supply are generally preferred for their accuracy and lower stigma.

Table 7
Respectful and accurate language for writing about opioid use and the toxic drug crisis

Language to avoid	Language to consider	Why?
opioid addict, junkie	person who uses opioids, person with opioid use disorder	Person-first language centres the person, not their condition.
opioid abuser, opioid misuser, opioid user	person using opioids outside of prescription guidelines person using opioids without a prescription person who uses non-prescribed opioids person using opioids in a non-prescribed way	More descriptive language avoids blame and reflects context.
opioid abuse, opioid misuse	opioid use, non-medical use of opioids, use outside of prescribed guidelines	
drug-seeking	person requesting opioids, discussing pain management	More descriptive language reduces judgement in clinical settings.
aberrant behaviours	describe the specific behaviour (e.g., seeking an early refill)	The word aberrant implies moral failure.
overdosed	experienced a poisoning, had an opioid-related incident	This language is more accurate and less judgemental.

illicit opioids, illicit drug market	illegally obtained opioids, non-prescribed opioids, unregulated or illegal drug supply	The word illicit has moral connotations.
opioid crisis	toxic drug crisis, drug poisoning crisis	The issue is not increased opioid use but increased toxicity.

Tools and resources

Guide for Communicating About Overdose Prevention (Berkeley Media Studies Group)

Reducing Stigma and Promoting Recovery for Opioid Use course (CAMH Global Learning Academy)

Why we use the term "overdose" (International Overdose Awareness Day)

Acknowledgements

Thank you to the Needle Syringe Program Community of Practice (EENet – Provincial System Support Program) for contributing *Briefing Note on Terminology*, which became the "Understanding the overdose crisis" section.

This section was co-created at CAMH with patient advisors from the Inclusive Writing Patient Advisory Group. Contributions were also made by staff from Community and Continuing Education, Education at CAMH; Patient & Family Education and Mental Health Literary, Education at CAMH; and Shkaabe Makwa. Consultation was provided by CAMH Pharmacy Services.

Language related to alcohol use

Alcohol is one of the most widely used and socially accepted substances in many cultures. It is often associated with celebration, relaxation or tradition. For other people, alcohol use may serve as a coping mechanism or become part of a broader pattern of substance use.

These diverse relationships with alcohol can create challenges in how we write about it. Cultural norms and social pressures can sometimes normalize high-risk alcohol use—or, conversely, label low-risk or culturally rooted alcohol use as problematic. Understanding this context helps us avoid assumptions and write with clarity and respect.

Like other forms of substance use, alcohol use exists on a spectrum. For some people, it never becomes an issue. For others, it may lead to alcohol use disorder, which can be shaped by genetics, trauma, social environment or co-occurring mental health conditions.

Alcohol use disorder is a medical condition characterized by a pattern of alcohol use that causes distress or interferes with daily life (CAMH, 2026b). It may involve physical dependence, loss of control over drinking, cravings or continued use despite harm. Not everyone who uses alcohol has alcohol use disorder—and not everyone with the disorder identifies with that label. It's important not to conflate alcohol use with addiction because it can reinforce stigma, create barriers to care and overlook the full range of experiences people have with alcohol.

Using person-first, nonstigmatizing language

Stigma around alcohol use is common and can lead to shame, secrecy or silence within families and communities (Morris et al., 2025). The language we use to describe alcohol use and addiction can affect how people understand and respond to it. Stigmatizing terms can reinforce stereotypes, while person-first, nonjudgemental language promotes empathy, understanding and support (Table 8; Support House Centre for Innovation in Peer Support, 2021).

The Language Guidelines

People who drink during pregnancy often face significant stigma and judgement, which can discourage them from seeking prenatal care or substance use treatment. Shaming language discourages pregnant people from seeking services, while nonjudgemental language creates a supportive environment where people feel safe discussing alcohol use and receiving care (Canada FASD Research Network [CanFASD], 2017). Table 9 provides examples of nonstigmatizing language related to alcohol use and pregnancy.

This respectful approach also extends to how we write about parents and caregivers in general and about people with fetal alcohol spectrum disorder (CanFASD, 2023). For more guidance, see Language Related to Family, Caregivers and Chosen Support Systems and Language Affecting People with Fetal Alcohol Spectrum Disorder.

Table 8
Respectful language for writing about people who use alcohol

Language to avoid	Language to consider	Why?
drinker	person who drinks	Person-first language avoids reducing a person to their behaviour.
alcoholic, drunk	person with alcohol use disorder, person experiencing challenges with alcohol use	Person-first language reduces stigma and centres the person, not their condition.
problem drinker	person experiencing challenges with alcohol use	Describing the behaviour avoids labelling or moral judgement.
dry, sober (as labels)	in recovery, not drinking at this time	Neutral terms focus on the experience, not on a fixed identity.

Table 9
Respectful language for writing about people who drink during pregnancy

Language to avoid	Language to consider	Why?
admitted to alcohol use	confirmed alcohol use	The word admitted suggests a confession of wrongdoing and carries a moral judgement, whereas the word confirmed is neutral.
alcoholic/addict person who chooses to drink	person who uses alcohol	Pregnant people do not seek to harm their unborn children. Some may be unaware they are pregnant when drinking heavily, while others find it difficult to stop drinking due to substance use or mental health concerns. Others have abusive partners who pressure them to drink.
don't care about their children bad parent	parent or caregiver	

Note. From *Language Guide: Promoting Dignity for Those Impacted by FASD* (p. 1), by Canada FASD Research Network, 2017. Copyright 2017 by Canada FASD Research Network. Adapted with permission.

Tools and resources

Alcohol (CAMH)

Managing Alcohol Use Problems course (CAMH Global Learning Academy)

Reporting on Alcohol Use, Alcohol Use During Pregnancy, and Fetal Alcohol Spectrum Disorder (CanFASD, 2023)

Acknowledgements

Thank you to the Canadian FASD Research Network for contributing excerpted material from *Language Guide: Promoting Dignity for Those Impacted by FASD*.

This section was co-created at CAMH with patient advisors from the Patient Advisory Committee. Contributions were also made by Patient & Family Education and Mental Health Literary, Education at CAMH; and Shkaabe Makwa.

Language related to nicotine use

Nicotine products are some of the most widely used substances in the world. Long-term tobacco use is linked to many serious health problems, including cancer, heart disease, stroke, respiratory illness and early death. Commercial nicotine products are highly addictive and often marketed in ways that target vulnerable communities, such as people with low income, people experiencing stress or trauma, and youth (U.S. Centers for Disease Control and Prevention, 2024; Watts et al., 2024).

Despite extensive public health campaigns, nicotine use continues, often influenced by social, economic and psychological factors. When writing about nicotine and tobacco use, it's important to reflect the full context of use, including systemic factors that may contribute to addiction or continued use.

Using person-first, nonstigmatizing language

People who use nicotine products often face stigma that can make it harder to seek support, access care or discuss quitting. Shaming or blaming language reinforces stereotypes and may reduce the likelihood of meaningful engagement or behavioural change, whereas nonjudgemental, person-first language creates a supportive environment (see Table 10).

Table 10
Respectful language for writing about people who use tobacco or nicotine

Language to avoid	Language to consider	Why?
smoker, chain smoker	person who uses nicotine, person who smokes	Person-first language focuses on the person, not their behaviour.
dirty habit	commercial nicotine use, nicotine use	Words such as dirty have moral connotations and promote shame.
quitter, ex-smoker	person who has stopped using nicotine, person who used to smoke	Person-first descriptive language avoids identity-based framing.

Acknowledging sacred use of tobacco

Be mindful of representing all tobacco use as negative, harmful or leading to nicotine addiction. For many First Nations and Métis, as well as some Inuit, tobacco is a sacred medicine used in traditional ceremonies to support physical, social and spiritual well-being (Morris & Etitiq, 2021). Sacred tobacco may be offered to Elders or Knowledge Keepers as a part of traditional protocols or used in practices such as Smudging or Pipe Ceremonies. Avoid collapsing all tobacco use into a single category or pathologizing its use in cultural or spiritual contexts.

Sacred medicines and ceremonial practices vary widely across Indigenous cultures, so avoid over-generalization. Be specific when referring to tobacco's role in particular communities or ceremonies, and consult cultural protocols when appropriate. When in doubt, consult with Indigenous Elders, Knowledge Keepers or community partners to make sure you use respectful and accurate language when referencing sacred practices that involve tobacco.

Tools and resources

New policy of people-first language to replace "smoker," "vaper," "tobacco user" and other behaviour-based labels (*Tobacco Control*)

People-first language policy (*Tobacco Control*)

Two Row Medicine: Smudging in Clinical Care video (Shkaabe Makwa)

Acknowledgements

This section was co-created at CAMH with patient advisors from the Patient Advisory Committee. Contributions were also made by staff from Patient & Family Education and Mental Health Literary, Education at CAMH, and Shkaabe Makwa.

Language related to cannabis use

Cannabis is one of the most used substances in Canada. It is legal for both medical and recreational use, and people use it for a variety of reasons, such as to relax, socialize, manage pain, improve sleep and reduce anxiety (CAMH, 2025). For some people with chronic or rare health conditions, including neurological disorders and immune dysregulation (such as mast cell activation), cannabis offers relief when other treatments fall short. When discussing cannabis use, remember that medical use is not always formally prescribed—and recreational use may still serve a therapeutic purpose.

Despite legalization and growing clinical interest, stigma around cannabis use persists (Rowe et al., 2025). Cultural attitudes toward cannabis often lag behind medical research and public policy. In some contexts, cannabis use is still seen as irresponsible, especially when compared with alcohol, which is widely accepted and normalized, even when it is used in risky ways.

Cannabis use can pose health risks, and some people may experience harms due to their use. This may lead some people to want to either stop using cannabis or change their relationship with cannabis use. The Lower-Risk Cannabis Use Guidelines can help guide these decisions (Fischer et al., 2017).

Intersectionality and cannabis stigma

The way cannabis use is perceived often depends on who is using it. A white professional using cannabis for anxiety may be seen as health-conscious, while a racialized person doing the same may be judged or criminalized (Yafai, 2020). This discrepancy reflects long-standing social and institutional biases.

This double standard is rooted in historical, racialized and class-based narratives about substance use, many of which continue to shape public opinion and health care interactions (Wiese et al., 2022; Yafai, 2020). For decades, cannabis was criminalized in ways that disproportionately harmed racialized and other equity-denied communities, especially Black people and Indigenous Peoples. Legalization

has not erased these harms (Wiese et al., 2022). Language that reinforces stigma or criminality risks compounding that inequity.

Stigma may also show up in gendered ways (Rowe et al., 2025). For example, mothers or women who use cannabis may face harsher judgement than their male counterparts, even when the use is therapeutic. Transgender and nonbinary people also face unique scrutiny, especially when they are accessing medical cannabis or disclosing cannabis use in clinical settings (Levine et al., 2022).

In Canada, stigma about cannabis use affects youth more than people of other age groups (Rowe et al., 2025). Stigmatizing attitudes toward cannabis use are most common among older adults—including self-stigma related to their own use (Dahlke et al., 2024; Rowe et al., 2025). For example, Dahlke et al. identified a "stigma hierarchy" in which older adults distinguished medical use as less shameful than recreational use, even though both are legal (p. 727). This stigma was also reflected in the language older adults used, such as the phrase "put me on dope," when describing being prescribed cannabis (p. 722).

Cultural context: What does 420 mean?

When consulting with people who use cannabis, you may hear the term 420, which is associated with cannabis culture. While 420 is used lightheartedly in some circles, it also represents political and cultural resistance, especially for people advocating racial equity, reparative justice and access to care (Wilder, 2021).

The term reportedly originated in the 1970s in California, where a group of high school students used it as a code for meeting after school to use cannabis. Gradually, 4:20 p.m. became a symbolic time to consume cannabis, and April 20 (4/20) evolved into a Global Day of Recognition—often celebrating cannabis culture, advocating legalization and calling attention to social justice issues related to drug policy (Shum, 2017; Wilder, 2021).

Harm reduction and access to care

Although cannabis is legal in Canada, barriers to access remain, especially for people who use it for medical reasons. Many people must pay for medical cannabis

because it is not universally covered by public or private insurance plans. Others face stigma when they disclose cannabis use to health care professionals, which may prevent them from getting safe, informed care.

Some people use cannabis as a harm reduction strategy, for example, to reduce their use of alcohol or opioids or of psychiatric medications that cause difficult side effects (Mok et al., 2023). Using cannabis in this way is often misunderstood. As with all substance use, meeting people where they are is key.

Cannabis can be addictive and some people develop cannabis use disorder. Other people may experience health harms due to the ways they use cannabis, some of the chemicals in the products they use or the potency of the cannabis products. These people may choose to either stop using cannabis or want to find a way to use cannabis that leads to less harm (CAMH, 2025).

For people who use cannabis, harm reduction strategies include:

- using in a safe and supportive environment
- avoiding contaminated or unknown sources
- using non-combustible methods (e.g., oils, edibles, vaporizers)
- decreasing use slowly
- being mindful of interactions with other medications

Using person-first, nonstigmatizing language

Using nonstigmatizing, accurate language about cannabis use avoids shaming people, reduces barriers to care and promotes health equity. Table 11 provides examples of language that puts people first and reflects different experiences with cannabis use.

Table 11
Respectful language for writing about people who use cannabis

Language to avoid	Language to consider	Why?
pothead, stoner, fiend	person who uses cannabis	Person-first language reduces stigma and avoids stereotypes.
drug user	person using cannabis for pain, sleep, etc.	Descriptive language acknowledges the purpose of cannabis use and avoids moral judgement.
recreational user (as a label)	person who uses cannabis non-medically	Descriptive language avoids labels and respects individual experiences.
high all the time	person who uses cannabis frequently/daily, or be specific about frequency of use	Descriptive language is more accurate and avoids exaggeration or shaming.
dependent, addicted (casually)	person navigating cannabis use challenges	Person-first, neutral language emphasizes compassionate framing.
using weed, using dope, using marijuana, getting lit	using cannabis, consuming cannabis	Neutral language is more respectful and accurate in clinical settings. The word marijuana has racial connotations.
abusing cannabis	using cannabis outside of medical guidance	Terms such as abuse have moral connotations.

Tools and resources

Cannabis: What Educators Need to Know (CAMH)

Cannabis: What Parents/Guardians and Caregivers Need to Know (CAMH)

Do You Know ... Cannabis (CAMH)

The Language Guidelines

Acknowledgements

This section was co-created at CAMH with patient advisors from the Patient Advisory Committee. Contributions were also made by staff from Patient & Family Education and Mental Health Literary, Education at CAMH; and Shkaabe Makwa.

Language related to stimulant use

Stimulants include methamphetamine, cocaine and prescription medications such as Adderall or Ritalin. People may use them therapeutically, recreationally or in ways that differ from prescribed guidelines. Not all non-medical stimulant use is associated with pleasure (Johnson et al., 2025). For example, people may use stimulants to support mental health, cope with trauma or boost the energy, alertness and concentration needed for work, school or daily functioning. As with all substance use, context matters—and so does the language we use to talk about using substances.

Stimulant use is often heavily stigmatized. Language that labels or stereotypes people who use stimulants is dehumanizing and ignores the broader social, medical or psychological factors that can shape substance use (Support House Centre for Innovation in Peer Support, 2021). When writing about stimulant use, use language that is neutral, respectful and person-centred. Table 12 provides examples of harmful language and respectful alternatives.

Table 12
Respectful language for writing about people who use stimulants

Language to avoid	Language to consider	Why?
tweaker, crackhead	person who uses stimulants	Person-first, descriptive language reduces stigma and avoids stereotypes.
abusing Adderall	using Adderall outside of prescribed guidelines	Descriptive language avoids moral judgement.
drug-seeking, manipulative	person asking for medication, seeking support	Descriptive language avoids assuming intent or character traits.

Acknowledgements

This section was co-created at CAMH with patient advisors from the Patient Advisory Committee. Contributions were also made by Patient & Family Education and Mental Health Literary, Education at CAMH; and Shkaabe Makwa.

Language related to psychedelic use

Psychedelic substances such as psilocybin (commonly known as magic mushrooms) are gaining recognition for their potential therapeutic use in mental health care, particularly for treating depression, posttraumatic stress disorder and existential distress (CAMH, 2026c; Goodwin et al., 2022). These substances may also be used recreationally, spiritually or culturally.

Language around psychedelics often swings between sensationalized and dismissive. Terms such as tripping or hallucinogen user can trivialize or stigmatize the experience. Use language that respects the personal, cultural and therapeutic significance of psychedelic use and that reflects the growing body of evidence-based research supporting the clinical potential of these substances.

Tools and resources

Psychedelics – FAQs (CAMH)

Acknowledgements

This section was co-created at CAMH with patient advisors from the Patient Advisory Committee. Contributions were also made by Patient & Family Education and Mental Health Literary, Education at CAMH; and Shkaabe Makwa.

Language related to ketamine use

Ketamine is a dissociative anesthetic used in medical settings for anesthesia and, more recently, for treatment-resistant depression and thoughts of suicide (CAMH, 2026d; Shim et al., 2026). It is also used recreationally and in party or club settings, where it may be referred to as Special K. Stigma is experienced both by people who use ketamine recreationally and by those receiving ketamine-assisted therapy to treat mental health concerns (Can et al., 2025).

As with all substances, the way we write about ketamine should reflect both its clinical relevance and the lived experiences of the people who use it. Avoid slang terms or moralizing language. Instead, use neutral, person-first language, such as "person who uses ketamine" or "person receiving ketamine treatment."

Tools and resources

Ketamine (CAMH)

Ketamine: Frequently Asked Questions (Ketamine Assisted Therapy Association)

Ketamine's History as a Useful Medicine and a Therapeutic Tool for Mental Health Conditions (Ketamine Assisted Therapy Association)

Acknowledgements

This section was co-created at CAMH with patient advisors from the Patient Advisory Committee. Contributions were also made by Patient & Family Education and Mental Health Literary, Education at CAMH; and Shkaabe Makwa.

Language related to nonsubstance use concerns

Nonsubstance use concerns or disorders (i.e., behavioural or process addictions) involve repetitive use of or participation in certain behaviours or processes in ways that cause harm to the person or interfere in their life. People may seek support or treatment when these behaviours become difficult to control or stop. The behaviours should not be assumed to be inherently amoral. Treatment typically focuses on changing the person's relationship to the behaviour. For some people, this involves complete abstinence, while others seek ways of engaging in that behaviour that feel healthier for them.

Inclusive language resources for nonsubstance use concerns are much less common than those for substance use because many difficulties for which people seek treatment are not recognized in *the Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2022; Potenza, 2017).

Best practices for writing about people with nonsubstance use concerns

Language to describe nonsubstance use concerns should avoid stigmatizing or moralizing terms and focus instead on the person's experiences, challenges and goals for change (see Table 13).

Table 13
Respectful language for writing about people with nonsubstance use concerns

Language to avoid	Language to consider	Why?
gambling addiction, pathological gambling, compulsive gambling, disordered gambling	problem gambling, gambling disorder (if referring to DSM-5-TR diagnosis)	Recognizing the behaviour as a medical concern avoids implying that it is a personal or moral failure.
technology addiction, internet addiction, technology overuse, problem internet use	problem technology use	A consistent umbrella term helps to describe concerns related to technology use.

problem gambler, gambling addict	person experiencing problem gambling, person with problem gambling	Person-first, neutral language avoids judgement.
problem gamer, gaming addict	person experiencing problem gaming, person with problem gaming	
shopping addict, shopaholic	person experiencing compulsive buying person seeking support for their spending habits	
sex addict, sexaholic	person experiencing hypersexuality person experiencing sexual compulsion person seeking support for sexual compulsion	

Tools and resources

How to Reduce the Stigma of Gambling Harms Through Language: A Language Guide (GambleAware)

Non-Substance Addiction: Exploring Behavioral Addictions and Their Impact (NeuroLaunch)

The Language We Use Matters: Combatting Stigmatizing Language Around Problem Gambling (National Council on Problem Gambling)

Acknowledgements

This section is based on information from the Gambling, Gaming and Technology Use project with the Provincial System Support Program at CAMH. Staff from the program and from Education at CAMH also gave feedback.

The Language Guidelines

Language related to race, racism and ethnicity

We recognize that antiracism is not a checklist or a final destination, but a continuous, evolving commitment to justice and equity. This work builds on generations of activism and advocacy by Black, Indigenous and other equity-deserving groups, alongside allied communities, that have challenged systemic oppression in all its forms. We honour their efforts, past and present, and commit to carrying this work forward in our language, policies and everyday actions. We recognize this guide is only one small way that CAMH is advancing antiracism.

Capitalization

- Capitalize the word Black and terms for ethnicities and cultures (American Psychological Association, 2020).
- Do not capitalize the word white. Different guides suggest different practices (Yin, 2024). We choose this practice due to the historical implications of capitalizing terms that describe race:
    - While Black people may have different ethnicities, cultures and backgrounds, many Black people have a shared historical and cultural experience of oppression due to anti-Black racism, which creates an identity that should be capitalized.
    - The capitalization of Black is also part of reclamation of identity: "The term has historically connected people of African descent around the world and was revived during the Black Power Movement" (Diversity Style Guide, cited in Laws, 2020).
    - Generally, white people do not have the same history of oppression due to their race or as many unifying cultural factors (Agic et al., 2023).
    - Despite these reasons for capitalizing, there is also a history of white supremacists capitalizing the word, and White has been associated with white power (Language, Please, 2025; Meir, 2020).
    - Using the lowercase white acknowledges the power imbalance that has long been held between Black and white people, and attempts to rectify this.

- Some style guides suggest using White because they want to handle race and ethnicity similarly (American Psychological Association, 2023). Other guides use White because "writing white in the lowercase could give the impression that it is the default, neutral or a standard" (National Association for Black Journalists, 2020; National Institutes of Health, 2025). Similarly, others capitalize White to highlight Whiteness as a socially and politically powerful racial identity, making White people and institutions more visible and accountable in conversations about racism (Diversity Style Guide, 2025).

Best practices for writing about race, racism and ethnicity

- Avoid umbrella terms such as people of colour or BIPOC (Black, Indigenous, and people of colour) when you can use more specific language. Use broader terms only when discussing multiple groups and never use them in situations that involve only one or two distinct groups.
- Acknowledge systemic racism whenever possible particularly when writing about disparities in health, education, employment, criminal justice or other institutional contexts.
- Be aware of racial microaggressions that may appear in your writing:
  - Avoid mentioning the race of a racialized person when it is irrelevant, while leaving white people unidentified by race. For example, in a press release announcing that two doctors have won an award, avoid identifying one recipient as a Black doctor while referring to the white doctor only by name. This would be fine if race is relevant to the story, for example, "This is the first Black person to win this award." Otherwise, adding that detail implies that it is exceptional for Black people to be doctors or win awards.
  - Avoid stereotypes linked to what a person of a specific race can or cannot do. Even going directly against stereotype if you are creating a fictional character may be problematic if it is linked to race in an artificial or tokenistic way (Agic et al., 2023).
- Be aware that the term microaggression is sometimes used to soften descriptions of discriminatory behaviour when it actually constitutes racism. Using clear and direct language—calling this behaviour racism or instances of

racism—validates the experiences of the people you are writing about (Kendi, 2019).

- Do not use the word diverse to mean marginalized or to refer to a race that is not white (Wertheim, 2023). Also avoid using it to describe a person.
- Avoid idioms because it will help you stay away from outdated or offensive language that has worked its way into casual use (see Principle 8: Use Plain Language).
- When comparing demographic data, avoid grouping people in white and racialized categories because this framing implies that there are only two types of people in the world: white and other (American Psychological Association, 2020).
    - Be as specific as possible and report on all relevant demographic factors (see Principle 7: Be Specific). An exception would be for research focusing on white participants versus participants who are not white. It would still be preferred to describe each demographic group. Justification should also be provided for the language and research focus.

Tools and resources

Anti-Racism, Harassment, and Discrimination Policy (CAMH)

Inclusive Language Guide (American Psychological Association)

San'yas Indigenous-Specific Anti-Racism training

Acknowledgements

This section was co-created at CAMH with the Office of Health Equity and with Inclusion, Diversity, Equity and Accessibility – People and Experience, CAMH. Contributions were also made by Black Health Strategy and Shkaabe Makwa.

The Language Guidelines

Language affecting Black communities

The *Foundational Knowledge on Anti-Black Racism* course offered by CAMH (2024) provides this definition of anti-Black racism:

> Anti-Black racism is a systemic form of prejudice, discrimination or antagonism that intentionally or unintentionally harms people of African and Caribbean origin through systems and structures that exclude, silence, devalue and marginalize Black experiences. Anti-Black racism is rooted in the history and legacies of slavery and colonization, and it continues to uphold narratives of white superiority and Black inferiority, thereby creating and reproducing prejudices, stereotypes and disadvantages for Black people (Black Health Alliance, n.d.; City of Toronto, n.d.).

Within health care, anti-Black racism is experienced by Black people accessing care and working across the hospital. By writing respectfully about Black people and communities, we can work against anti-Black racism and toward an environment that is healthy and safe for Black people.

Best practices for writing about Black communities

- Consult Black staff, patients and community members.
- Always use terms that reflect the agency and humanity of people and groups.
- Recognize the diversity within Black communities, such as Afro-Caribbean, Afro-Latine, Afro-Indigenous and African identities.
- Use identity-first language to affirm Black identities, recognizing its roots in historical moments of identity affirmation, such as the Black Power movement and the civil rights movement (see Principle 5: Use Dignity-First Language). In Canada, the word Black is typically used as an adjective (e.g., Black person, Black communities) rather than as a noun, and person-first language is generally not used (i.e., person who is Black). Some people choose to identify by their nationality, citizenship, religion or specific ethnicity. Always respect and use the language people choose to describe themselves.
- Avoid umbrella terms such as people of colour when referring to experiences that are specific to Black communities. Generalized language can obscure the distinct experiences of Black people, which have been erased through racist

systems. Grouping people by race may also be traumatizing and ignores the diversity of cultures, ethnicities and nationalities within racialized communities.

  - Be specific about the group you are referring to (e.g., Black Canadians, African Canadians, Afro-Latinx people).
  - Use the term Black person or Black community member where identity is central to the discussion.

- Avoid the term Black Canadians when describing a diverse group unless you have consulted with that group and confirmed that this is the term they prefer. Some people prefer the term Black people, while others identify as African Canadian or Afro-Caribbean. Respect individual preferences and provide opportunities for self-identification.
- Be aware that some language may evoke historical trauma or cause offence by reinforcing stereotypes. Using respectful, accurate language avoids causing further harm (see Table 14).

Table 14
Respectful language for writing about Black communities

Language to avoid	Language to consider	Why?
slave	enslaved person	The term enslaved person shows that this was an action done to the person and centres personhood.
plantation	If speaking about a historical location, be specific instead of using the word plantation as a shorthand. If writing about an actual plantation with a history of enslavement, plantation may be the most accurate word. Use farm or farm-grown instead of plantation to describe agricultural operations or food.	The word plantation may be triggering for people whose ancestors were enslaved, especially when used outside of the historical context or as a positive descriptor (e.g., some Southern U.S. properties call themselves plantations to appeal to certain buyers and some food uses plantation to mean Southern food).[a, b]

urban culture	Use specific descriptors relevant to the context.	The term urban culture reduces diverse Black communities to a geographic stereotype.[c]
low-income Black families poor Black families Black families living below the poverty line	Black families affected by poverty due to systemic racism.	Implying that poverty is inherent to Black communities is inaccurate and stigmatizing. Writing about poverty should focus on systems, not personal or familial deficits.

[a] CounterPoint News (2025); [b] LeBlanc (2020); [c] Andrews (2018).

Tools and resources

Anti-Racism Learning Series (Canada School of Public Service)

Changing Systems, Transforming Lives: Canada's Anti-Racism Strategy 2024–2028 (Government of Canada)

Foundational Knowledge on Anti-Black Racism online course (CAMH)

Acknowledgements

This section was co-created at CAMH with the Office of Health Equity and with Inclusion, Diversity, Equity and Accessibility – People & Experience, CAMH. Contributions were also made by staff with Black Health Strategy and the Collaborative Learning College.

Language affecting Indigenous communities

This section borrows heavily from Gregory Younging's *Elements of Indigenous Style: A Guide for Writing by and About Indigenous Peoples* (2018). This guide is a living document and is not meant to provide definitive guidelines but rather recommendations. As Younging writes, "The process of decolonizing language surrounding Indigenous Peoples is not finished: terms, names and styles continue to evolve" (p. 50).

Accurate terms to describe Indigenous identities and communities

Terms that refer to Indigenous Peoples cannot be used interchangeably. If you are writing about these communities, make sure you are familiar with the following terms and Indigenous communities.

Indigenous

Indigenous is an umbrella term for First Nations, Inuit and Métis in Canada, but it also can refer to Indigenous Peoples worldwide (e.g., the United Nations Declaration on the Rights of Indigenous Peoples).

Do not use possessives when describing Indigenous Peoples. "Canada's Indigenous Peoples" is incorrect because it implies ownership over these communities. Instead, use "Indigenous Peoples in what is currently known as Canada." (See Best practices for using language to decolonize.)

Indigenous is always an adjective. For example, "an Indigenous person is someone who identifies as First Nations, Inuit or Métis." Where possible, avoid using Indigenous as a blanket term when describing a specific person. Use this opportunity to learn how a person identifies and be mindful of their spelling.

The term Indigenous Peoples refers collectively to communities and identities, whereas the term Indigenous people refers to individuals.

Examples:

"The clinic serves various communities, including Indigenous Peoples."

"Some Indigenous people access the clinic for primary care."

First Nations

First Nations are some of the original Indigenous Nations that occupied North America prior to contact with Europeans. In the 2021 census by Statistics Canada (2023a), 1,048,405 people in Canada identified as First Nations. There are over 630 First Nations communities in Canada (133 communities in Ontario), speaking over 60 languages and having distinct cultures, ceremonial practices and rights protected in the *Constitution Act, 1982*.

When you are writing about some communities and places where some First Nations people live, refer to those places as reserves, not reservations. Reservations are in the United States. Also don't use the words Nation and Tribe interchangeably. Tribe is used by Native Americans in the United States. In the Canadian context, use Nation unless the community specifies another term.

First Nations as an adjective is always plural, but as a noun, it can be singular or plural. For example, in reference to a single First Nation community, write "He is a member of Curve Lake First Nation."

Inuit

Inuit describes Indigenous Peoples who traditionally inhabit Inuit Nunangat. Its four regions consist of the Inuvialuit Settlement Region (northern Northwest Territories); Nunavut; Nunavik (northern Quebec); and Nunatsiavut (northern Labrador). According to the 2021 census by Statistics Canada (2023a), 70,545 Inuit live in Canada, and about 69 per cent reside in Inuit Nunangat. There is a growing southern Inuit population in urban centres such as Ottawa and Edmonton.

The word Inuit can be an adjective, and it is also a collective noun. Do not say Inuit Peoples because Inuit in Inuktitut translates to "the people." Simply using Inuit conveys that you are referring to the people. Inuk is a singular noun for a person who is Inuit. It is incorrect to write "The patient is an Inuk." Instead, write "The patient is Inuk."

Métis

Métis is a distinct Nation of people with its own identity, language, culture, consciousness and practices. The area known as the historic Métis Nation Homeland includes Alberta, Saskatchewan and Manitoba, and extends into Ontario, British Columbia the Northwest Territories and the northern United States.

According to the 2021 census (Statistics Canada, 2023a), there were 624,220 Métis living in Canada. Currently, over 28,000 Métis are registered with the Métis Nation of Ontario. There are also seven historic Métis communities in Ontario (Métis Nation of Ontario, 2025).

Capitalization

According to *Elements of Indigenous Style* (Younging, 2018), "Indigenous style uses capitals where conventional style does not. It is a deliberate decision that redresses mainstream society's history of regarding Indigenous Peoples as having no legitimate national identities; governmental, social, spiritual, or religious institutions; or collective rights" (p. 77).

In general, capitalize terms for Indigenous identities; Indigenous government, social, spiritual and religious institutions; and Indigenous collective rights. Examples include:

- Healer
- Elder
- Knowledge Keeper
- Pow Wow
- Traditional Knowledge / Traditional Teachings
- Sweat Lodge

Some Indigenous languages, such as Cree, do not use capitalization. In that case, language (and dialect) standards take precedent. Example: “The patient is Cree and a nêhiyawêwin speaker.”

The term Indigenous Elder is a specific designation given by a community to someone recognized for their spiritual and cultural knowledge. When using the adjective elder (or elderly) to refer to an Indigenous person who is an older adult, you do not have to capitalize the word. Some communities may have their own practices regarding the use of the capitalized Elder and use it for all older people in their community.

Examples:

“Older children sometimes provide care for their elders.”

“An Elder shares knowledge of cultural protocols in their community.”

Using Pow Wow

Pow Wow can speak more broadly to Pow Wow as a cultural practice, tradition and way of gathering or to one particular event. Depending on which meaning you use, you will phrase things a bit differently.

For Pow Wow as a cultural practice, tradition and way of gathering, use Pow Wow without the article “the” or “a”. For example, “participate in Pow Wow” or “the power of Pow Wow”.

For a specific event, you would use an article. For example, “Each year I enjoy going to the Pow Wow at CAMH,” or “I’ll see you at the Pow Wow on Saturday!”

Use can vary depending on context and community. Remember to default to the language used by First Nations, Inuit and Métis rather than correcting to one set way.

Best practices for writing about Indigenous Peoples and cultures

- Recognize that people have complex relationships with aspects of their identities, which might include preferring terms that are no longer common. If you aren't sure what language to use, ask the person or community you're referring to. (See Principle 5: Use Dignity-First Language.)
- Unless an Indigenous organization uses an acronym in its public communications, do not shorten names or use acronyms, especially if the organization uses Traditional Language. Traditional Language is important for decolonization efforts and preserving the cultures of First Nations, Inuit and Metis. For this reason, never refer to Shkaabe Makwa at CAMH as SM. Reducing Shkaabe Makwa to an acronym erases the use of Anishinaabemowin and the significance of its meaning, which is Spirit Bear Helper.
- For the same reason, do not shorten First Nations, Inuit and Métis into the acronym FNIM. This acronym conflates many distinct Indigenous Peoples into one acronym.
- Avoid outdated, harmful and culturally insensitive language (see Table 15).

Table 15
Respectful language for writing about Indigenous identities, culture and practices

Language to avoid	Language to consider	Why?
Aboriginal Native Indian/NDN	Indigenous Whatever the person's specific designation is: First Nations, Inuit or Métis Whatever community or cultural term a person or community prefers	These terms were not created by Indigenous Peoples but were assigned to them, usually by government. The terms Aboriginal and Indian are still found in legal documentation (e.g., The Indian Act). You may also see Aboriginal or Native as proper nouns (e.g., Native Canadian Centre of Toronto, Aboriginal Legal Services). Only use them in this context. If a person identifies as Native or Aboriginal, use that term to describe them. You can specify that this is how they identify.

		Avoid the term Indian because it was used as a slur. Some Indigenous people still identify as Indian if that is the term they grew up with or if they are reclaiming it. They may use it casually among themselves.[a] NDN is a recent term that reclaims the word Indian.[a, b] It is more common in Indigenous advocacy, internet spaces, the arts and youth culture (e.g., the advocacy organization NDN Collective). It is not appropriate for someone who is not Indigenous to use NDN.
Pow Wow (to refer to a meeting)	meeting, brainstorm session, chat, conversation	Using important Indigenous terms for other meanings is appropriative and disrespects Indigenous cultures.
Spirit Animal (to refer to a person, animal or object that matches your personality)	soul mate, kindred spirit or another appreciative term	
Tribe (to describe a group of like-minded people)	team, friends, group, squad	

[a] Native Americans in Philanthropy (n.d.); [b] Cornum (2017).

Tools and resources

Elements of Indigenous Style (1st and 2nd editions; Brush Education)

Indigenous Peoples Editorial Resource (University of Alberta)

Acknowledgements

Thank you to staff and advisors at Shkaabe Makwa at CAMH for contributing this section.

Language affecting newcomers

When writing about immigrants and refugees, be aware that these are distinct groups and that these terms should not be used interchangeably. An immigrant typically makes a choice to move from one country to another, whereas a refugee is forced to flee for their safety (Canadian Council for Refugees, 2010).

However, this distinction is not always clear-cut because of the different admission categories to Canada and migration exists along a spectrum of choice and necessity. Not all immigrants leave their country purely out of personal choice. Systemic factors such as political instability, economic hardship, discrimination or limited access to basic needs and opportunities can influence the decision to migrate.

Foreign nationals are admitted to Canada through two broad categories:

1. Temporary residents are refugee claimants, visitors, international students, temporary foreign workers or work permit holders.
2. Permanent residents are immigrants who have been granted the right to live permanently in Canada. They are admitted through different immigration classes: economic class, family class or refugee class.

Accurate language about immigration, citizenship and nationality

The following definitions can help ensure that your writing uses accurate terminology:

Citizen: A person who is Canadian by birth, either born in Canada or born outside Canada to a Canadian citizen who was born in Canada or granted citizenship (Government of Canada, 2025).

Immigrant: A person who is a landed immigrant or permanent resident, which means they have been granted the right to live in Canada permanently by immigration authorities. Immigrants who have obtained Canadian citizenship by naturalization are included in this group (Statistics Canada, 2023b).

Naturalization: A formal process by which a person who is not a Canadian citizen applies for and is granted citizenship. The person must be a permanent resident first (Government of Canada, 2025).

Newcomer: An immigrant or refugee who has recently moved to a new country and is beginning to get established in the new country. Newcomer is often considered more welcoming language.

Refugee: A person who has fled their country of origin due to a well-founded fear of persecution based on race, religion, nationality, membership in a particular social group or political opinion (Immigration Partnership Winnipeg, 2024).

Refugee claimant: A person who has applied for refugee protection status while in Canada and is waiting for a decision on their claim from the Immigration and Refugee Board of Canada (Government of Canada, 2025). They are temporary residents while their claim is being considered. You will hear the term asylum seeker, but refugee claimant is the term used in Canadian immigration law.

Resettled refugee: A person who is selected for resettlement while living outside their country of citizenship or the country where they usually live an is granted permanent resident status based on a well-founded fear of returning to that country. They receive permanent residency status upon arrival in Canada (Statistics Canada, 2023c).

Best practices for writing about newcomers

Using the appropriate words when talking about immigrants and refugees is a way to treat newcomers with respect. Some terms can reinforce stereotypes, encourage prejudice and discrimination and shape public perceptions.

- Do not frame immigrants and refugees as criminals or would-be terrorists (Pruysers et al., 2024). Every refugee and immigrant undergoes a process of screening, health checks and security clearances. Immigrants commit fewer crimes than other people and are actually under-represented in prisons. It is more common that refugees are running from crime, not causing it (Refugee Alberta, n.d.).

- Avoid portraying refugees as poor, needy, helpless, voiceless victims who need to be saved (Tyyskä et al., 2017).
- Avoid referring to floods or waves of immigrants and refugees because these expressions dehumanize people as natural disasters. If it is necessary to note numbers, use neutral, people-first language, such as increased arrivals or growing numbers of newcomers.
- Use words that are welcoming and that promote safety for immigrants and refugees. Table 16 provides examples of harmful terms and respectful, accurate alternatives.

Table 16
Respectful language for writing about immigrants and refugees

Language to avoid	Language to consider	Why?
illegals illegal migrant or immigrant	people who are undocumented person without status	The word illegal criminalizes people by transferring illegality from the status to the person.[a] Actions are illegal; people are not. The word illegal is used by people who want harsh immigration policies that are racist and xenophobic.[b]
aliens	people who are undocumented, people without status	Aliens is used in some countries, such as the United States, for people who are not citizens. Many immigrants find this term dehumanizing.[a]
fresh off the boat (FoB)	new immigrant, new refugee, newly arrived immigrant or refugee, newcomer	Fresh off the boat is a derogatory expression that mocks someone's cultural practices, while minimizing the challenges many newcomers face when resettling in a new country.[b]
imposter, non-Canadian, green carder, foreigner, outsider, stranger, squatter, interloper	immigrant, person without Canadian citizenship	Terms such as immigrant and person without Canadian citizenship are factual. Terms such as imposter and foreigner are offensive and imply the person does not belong in the country.

[a] Canadian Council for Refugees (2010); [b] Canadian Cultural Mosaic Foundation (2018).

Tools and resources

Glossary of Terms for Frontline Settlement Workers (Affiliation of Multicultural Societies and Service Agencies of British Columbia)

Immigrant and Refugee Mental Health Project (CAMH)

Immigration Status Fact Sheet (Immigration Partnership Winnipeg)

Inclusive Language Guide (Regional Municipality of York)

Inclusive Language Manual (City of Oshawa)

Talking About Refugees and Immigrants: A Glossary of Terms (Canadian Council for Refugees)

Acknowledgements

Thank you to the Immigrant and Refugee Mental Health Project, delivered out of CAMH's Office of Health Equity for contributing this section. The information was gathered from grey literature produced by governments and by settlement and social service agencies.

The Language Guidelines

Language affecting 2SLGBTQIA+ communities

Language is important to people who are Two-Spirit, lesbian, gay, bisexual+, transgender, queer and/or questioning, intersex and asexual/aromantic (2SLGBTQIA+). It shapes and is shaped by pride, politics, dysphoria, trauma, access in the world and safety.

Within 2SLGBTQIA+ communities, language evolves quickly, especially in spoken language. It may take time for the language we use at CAMH to catch up to all the nuances and terms used in these communities. Using current language creates a sense of community and safety for people with diverse gender and sexual identities.

When writing about someone, never assume a gender identity or sexual orientation. Use open language that is inclusive of gender and orientation and that does not assume heteronormative ways of being.

Reclaimed language

Many 2SLGBTQIA+ communities reclaim terms that were once slurs (Crowley, 2025). If someone identifies using a term you would have considered a slur, only use it to describe them if you are directly quoting them or if they ask you to use that term to describe them. Do not assume that you can use that term to refer to that person unless they explicitly say so, and do not refer to others by that term. Reclaimed language is often allowed only by members of that specific community, and people who do not identify with that term should not use it themselves.

Terms referring to partnership, relationships and family

People in 2SLGBTQIA+ communities use various terms to refer to romantic partners, sexual partners and family.

- **Partner:** An umbrella term that can refer to both a long-term partner and a shorter-term partner. Some people who are married use this term, and allies may use it to refer to a more serious relationship.
- **Significant other:** An alternative to the term partner.

- **Husband, wife, spouse:** Common terms to refer to someone who is married or in a long-term common-law relationship.
- **Boyfriend, girlfriend, lover, date:** Common terms to refer to an often more casual romantic or sexual partner.
- **Date-mate, joyfriend:** Less common terms used by nonbinary people to refer to a romantic or sexual partner.
- **Family of origin:** The family a person was raised in.
- **Chosen family:** People someone chooses to treat as family (e.g., friends, partners, colleagues, community members).

Best practices for writing about families

- Avoid language that makes assumptions about how families are made.
- Don't make assumptions about how trans and queer people build their families (e.g., who carried a child, genetic assumptions, process assumption, birth versus adoption).
- Acknowledge chosen family as equally important as biological family.

Tools and resources

2SLGBTQ Health in Focus podcast (Rainbow Health Ontario)

2SLGBTQ+ Education Guide: Intersectionality (Humber Polytechnic)

Education and Resources (Rainbow Health Ontario)

Glossary of Terms (The 519)

Glossary of Terms: LGBTQ (GLAAD)

Trans Care BC Health Professionals section

Acknowledgements

This section was co-created at CAMH with members of the Patient Advisory Committee and staff at the Office of Health Equity; the Gender Identity Clinic; Rainbow Services; Inclusion, Diversity, Equity and Accessibility – People &

Experience; Equity & Engagement – Provincial System Support Program; and Education Research. Contributions were also made by Shkaabe Makwa, the Family Advisory Committee, the Youth Advisory Group, the Azrieli Adult Neurodevelopmental Centre and the Azrieli Self-Advocate Advisory Group.

The Language Guidelines

Language affecting Two-Spirit people

Two-Spirit is a term that captures the various gender identities that have been present and part of the lives of many Indigenous peoples since before colonization. It typically means that someone's body holds both a feminine and a masculine spirit, but for many cultures, the term is only confined to people who would otherwise identify as nonbinary. In other cultures, Two-Spirit is associated with people who feel a more expansive gender identity beyond what they were assigned at birth (Cariou, 2025b).

Although Two-Spirit refers to an experience of gender and sexuality that has been traditionally present for many Indigenous Peoples, the term came into use in the 1990s. The *Two-Spirit Terminology Guide* (Beauchamp et al., n.d.) explains the history of the term:

> Grandmother, mother, sister, daughter, teacher, counsellor, administrator, mentor and Elder, Dr. Myra Laramee (Cree) brought the term "Two-Spirit" to a sharing circle of 80 Indigenous LGBTTQQIAAP+ people from across North America at the 1990 Gathering, and Two-Spirit was quickly adopted as a descriptive term:
>
> "I would like for our people to understand that Two-Spirit came to us in a dream for our people and community, and I was merely the vessel. I did not coin this term, word, or phrase, it came from the Creator or the Great Mystery.... It is sacred and is more than just words, it is a spirit/heart language, if you know what I mean. When Two-Spirit is used, it invokes our sacredness and reminds us that we have always been here, and we will always be here. As a result, with Two-Spirit comes a great responsibility, to those who use it, as we walk and work in a sacred way with and for our people." — Myra Laramee (p. 1)

Best practices for writing about Two-Spirit identity

- The term Two-Spirit holds a spiritual and cultural significance, so use it only for people who are First Nations, Inuit or Métis.
- Always capitalize Two-Spirit.

- When writing about someone who is Two-Spirit, use the term they identify with. They may identify as Two-Spirit and use another gender identity or sexual orientation term, either in English or in a Traditional Language. Others may only identify as Two-Spirit.
- Put 2S at the beginning of the 2SLGBTQIA+ acronym to acknowledge that Indigenous non-heteronormative views of gender and sexual orientation predate contemporary views. It also is an act of reparations for the colonial harms enacted on Indigenous Peoples.
- Be aware that each Nation and Indigenous group has a different meaning for Two-Spirit that is connected to their own culture and Traditional Knowledge.
- Use the term Two-Spirit with respect because Two-Spirit people traditionally held special positions within their communities, such as Healer or Peacekeeper.
- Do not refer to Two-Spirit as a "traditional" term because it has only been used since 1990 to capture an Indigenous experience of sexual and gender orientation within the English language.

Tools and resources

Two Spirit and Indigiqueer Cultural Safety: Considerations for Relational Practice and Policy webinar (National Indigenous Cultural Safety Learning Series)

Two-Spirit Terminology Guide (Nation Builder)

Acknowledgements

This section was co-created at CAMH with members of the Patient Advisory Committee and staff at Shkaabe Makwa; the Office of Health Equity; the Gender Identity Clinic; Rainbow Services; Inclusion, Diversity, Equity and Accessibility – People & Experience; Equity & Engagement – Provincial System Support Program; Azrieli Adult Neurodevelopmental Centre; and Education Research.

Language affecting lesbian, gay and bisexual People

These sections cover inclusive language practices and writing guidance related to lesbian/sapphic, gay and bisexual people. Many of these categories are umbrella terms and people may identify with more than one 2SLGBTQIA+ term. When people who are attracted to the same gender, avoid the term homosexual, which is an outdated and stigmatizing term (GLAAD, 2026).

Lesbian/sapphic people

- The word lesbian is traditionally used to refer to women who are attracted only to women.
- Sapphic is a term that comes from the Greek poet Sapphos, who wrote love poetry about women. Sapphic has come to describe women who are attracted to other women, especially in a romantic way. It can be used as an adjective or a noun. Current use of sapphic also tends to be more gender-inclusive than lesbian (Hamou, 2022).
- Not all women who date women identify as lesbian. They may identify as bisexual, gay or another preference (GLADD, 2026).
- In recent use, nonbinary people may also identify as lesbian.

Gay people

- The word gay used to refer to men who are attracted only to men, but now many other people in 2SLGBTQIA+ communities use gay as their preferred term (GLADD, 2026).
- Some women or nonbinary people prefer to identify as gay because the term no longer has the gender connotation it once did.

Bisexual+ people

- Bisexual+ is an umbrella term that includes a wide variety of sexual orientations and romantic preferences, including pansexual (i.e., attraction to people regardless of gender) and omnisexual (i.e., attraction to all gender

presentations). The plus sign refers to the broad spectrum of identities included under this umbrella (GLAAD, 2026).

- Casually, bisexual+ is often shortened to bi+ or bi.
- When writing about sexual orientations, include bisexuality because many bisexual+ people are often left out of conversation related to 2SLGBTQIA+ issues and often are invalidated by both 2SLBTQIA+ communities and hetero/cisnormative culture. This is called bisexual erasure.
- Bisexual+ erasure can be considered a form of biphobia. Biphobia contributes to most stereotypes about bisexual+ people.

Avoiding stereotypes about bisexual+ identity

Be aware of stereotypes and myths about bisexual+ people because they invalidate their experiences. Still Bisexual (2022) has developed a list of common myths.

Myth: Bisexual+ people are only attracted to two genders.
Fact: This myth ignores the wide range of sexual orientations included in the bi+ umbrella and assumes that the term bi only refers to two genders. Bisexuality is inclusive of many genders.

Myth: Bisexual+ people are only attracted to cisgender men and women, and only cisgender people are bisexual.
Fact: All bisexual+ people are individuals and have different preferences.

Myth: A person's current partner or relationship/sexual history is a clear indicator of their sexual orientation.
Fact: Bisexual+ sexual and romantic orientations refer to the person's attraction. Who they date, their experience level or their current partner do not make them more or less bisexual. Bisexual+ people who are dating a person with a gender different from their own are still bisexual.

Myth: Identifying as bisexual just means that the person is questioning or confused or that they are going through a phase.

Fact: Identifying as bisexual doesn't mean the person is still trying to figure out who they are "really" attracted to. It is a valid and entirely whole identity. It is also not true that bisexual women are secretly lesbian and bisexual men are secretly gay.

Myth: Bisexual people cheat more often than non-bisexual people.

Fact: Bisexual people are a diverse group with many different preferred relationship models, just like all other people.

Myth: Bisexual people are attention-seeking.

Fact: The vast majority of people have put a lot of thought and energy into understanding their sexual orientation.

Tools and resources

Bisexual+ (Resource Center for Sexual & Gender Diversity)

GLAAD Media Reference Guide (GLAAD)

Still Bisexual

Acknowledgements

This section was co-created at CAMH with members of the Patient Advisory Committee and staff at the Office of Health Equity; the Gender Identity Clinic; Rainbow Services; Inclusion, Diversity, Equity and Accessibility – People & Experience; Equity & Engagement – Provincial System Support Program; and Education Research. Contributions were also made by Shkaabe Makwa, the Family Advisory Committee, the Youth Advisory Group and the Azrieli Adult Neurodevelopmental Centre.

Language affecting transgender and nonbinary people

In general, it is inappropriate to ask or write about a person's sex or gender unless it is directly relevant to the topic or the person chooses to share that information (Smith, 2018). When writing about gender, make sure to use accurate language and identity terms that reflect the people you are writing about.

Accurate language about gender identity

The following definitions can help ensure your writing uses accurate, respectful terminology.

Transgender or trans: An umbrella term that captures the varied and complex ways that people identify as a gender different from the sex they were assigned by a doctor at birth based on observable physical characteristics (i.e., assigned female at birth [AFAB] or assigned male at birth [AMAB]). Transgender includes people whose self-identification, appearance, anatomy or expression challenges society's expectations around gender. Many people can identify as trans, including those with binary and nonbinary gender identities (e.g., trans man, trans woman, trans nonbinary person).

Trans women are women and trans men are men. Trans is a descriptor similar to saying "a tall woman" or "an Italian man." It is better to just use the terms woman or man for binary trans people except when it is relevant to describe someone as trans.

Cisgender/cis: People who identify as the sex they were assigned at birth.

Nonbinary: Encompasses people whose gender does not match the sex they were assigned at birth and does not fit into the binary categories of gender (man or woman). Nonbinary can be a gender itself, and it can also be an umbrella term for other genders. Some nonbinary people also identify as trans, while others do not. Several genders can fall under the category of nonbinary, including but not limited to genderqueer, genderfluid, bigender, pangender, agender, neutrois, trigender, genderflux, demiboy and demigirl.

Transition/transitioning/transitioned: Never use transgender/transgendered as a verb. Someone who is speaking about their own process of aligning their gender socially, medically or legally to their gender identity may refer to this as their transition or may use transitioning/transitioned as a verb. This process will be different for each trans person (Smith, 2018).

Gender dysphoria: The distressing experience of being at odds with one's gender and/or gender expression. The person's gender may feel unaligned with secondary sexual characteristics or the body, but it can also be caused by clothing, conventions, cultural practices and social interactions. Some trans people experience dysphoria as a generalized detachment or dissociation without a conscious link to a specific physical or social trait or experience. For some, gender dysphoria feels like a mild discomfort, but for others, it can trigger a mental health crisis, anxiety, depression, thoughts of suicide or physical discomfort such as nausea.

Gender euphoria: In contrast to gender dysphoria, gender euphoria refers to the satisfaction or joy a person feels when their gendered experience aligns with their gender identity, rather than with the gender they were assigned at birth (The Trevor Project, 2023). Gender euphoria does not require a previous experience of gender dysphoria.

Pronouns

This section is adapted from the Pronoun and Language Guidelines for Trans-Affirming Workplaces in the Mental Health and Addictions Sector*, developed by Laur O'Gorman and Jacob Wolframe in the Provincial System Support Program, CAMH. Clinicians, students and staff at the Gender Identity Clinic also made contributions.*

Pronouns are an important part of how we identify ourselves. It's important not to make assumptions about people's gender based on how they look. The only way to know a person's pronouns is for them to tell you.

Even when the incorrect pronoun is used unintentionally, it can cause gender dysphoria, anxiety, lowered self-esteem and embarrassment (Lowik, 2018).

Repeated misgendering can be a form of harassment under CAMH's Anti-Racism, Harassment and Discrimination Policy and under the Human Rights Code of Ontario (Ontario Human Rights Commission, 2014).

Only they/them/their/theirs pronouns should be used when a person's pronouns are unknown. These pronouns should also be used instead of he/she when referring to people in general because they are inclusive of all genders. They/them pronouns should not be used for transgender people who use she/her or he/him exclusively.

While there was once a contentious debate about using the word they as a singular pronoun, this debate is now over: They is a gender-neutral pronoun that can refer to someone with they/them pronouns or as a general pronoun when a person's gender is not known. This has been accepted by several style guides, including those developed by the American Psychological Association (2020), the American Medical Association (2020) and the University of Chicago (2024). Table 17 presents gender pronouns and how to use them.

Table 17
Gender pronouns and their grammatical forms

Subjective	Objective	Possessive	Reflexive	Example
she	her	hers	herself	She is speaking. I listened to her. The presentation is hers.
he	him	his	himself	He is speaking. I listened to him. The presentation is his.
they	them	theirs	themself/themselves	They are speaking. I listened to them. The presentation is theirs.
ze	hir/zir	hirs/zirs	hirself/zirself	Ze is speaking. I listened to hir. The presentation is zirs.
it[a]	it	Its	itself	It is speaking. I listened to it. The presentation is its.

Name only	Name only	Name's	Name	Priya is speaking. I listened to Priya. The presentation is Priya's.
all pronouns	any pronouns	any possessive pronoun, or Name's	any reflexive pronoun	She is speaking. We need to listen to him. The presentation is theirs.

Note. This table was adapted from the Common Gender Pronouns table developed by Trans Student Educational Resources that appears in *Pronoun and Language Guidelines for Trans-Affirming Workplaces in the Mental Health and Addictions Sector* developed by the Provincial System Support Program (O'Gorman & Wolframe, 2024). It was adapted by the Inclusive Writing Guide project team and the Gender Identity Clinic at CAMH.

[a] Never use the pronoun it unless someone tells you that is their pronoun. Otherwise, it is offensive.

Best practices for using pronouns in writing and consultations

Your writing projects may include consultations with diverse groups of people, so it is important to use pronouns accurately and respectfully in these interactions. Here are recommendations for using and acknowledging pronouns in both your writing and in consultations.

- When facilitating introductions during meetings or introducing new staff members, include name, job title and pronouns.
- If someone uses multiple pronouns (e.g., he/they), you can ask them how they would like their pronouns to be used. Some people might not have a preference, whereas others might want a mix (e.g., "Ben forgot his water bottle in my office. I hope they come back for it later.") or prefer one over the other depending on context. If you do not have an opportunity to ask, consider using gender-neutral pronouns until you do.
- Normalize talking about pronouns, but do not make it mandatory. For example, if you are asking a group of people to introduce themselves and someone does not disclose their pronouns, just move to the next person.
- Use current name and pronouns even when you are talking about the past.
- Use gender-neutral greetings when you are addressing groups of people. Instead of using terms such as ladies and gentlemen, his or her or you guys, use

collective terms such as colleagues, everyone, valued guests, friends, team or folks.

- Include pronouns in written materials such as speaker descriptions for events, public statements and other written communications for both cisgender and transgender people. This shows that you are aware of pronouns, which can make trans people feel safer indicating their pronouns.
- Ensure that work forms, company directories, surveys, HR records and pension/benefits documents refrain from using previous names or forced binary gender options.
- Use gender-inclusive language in training/orientation material, presentations, policy documents, job descriptions and reports. Gendered language is particularly pervasive in restroom and locker room signage, dress codes and medical-related forms.
- If you are writing about an individual in a public announcement, double-check their pronouns. If you are unsure, it's okay to ask them before writing the announcement.
- If you are writing a case scenario, include a variety of genders in your examples. When first mentioning the character, include their pronouns in parentheses, regardless of whether the character is cis or transgender.
- When writing examples of an introduction between people, include pronouns in the scenario, especially as a professional practice.

  Example:

  Dr. Thompson: Hello, Dina. I'm Dr. Thompson. I use he/him pronouns.

  Dina: Oh, I use she/they pronouns.

  Dr. Thompson: Would you prefer I use both in my session notes?

  Dina: Yeah, that would be great.

Tools and resources

Creating Safe and Gender-Affirming Health Care Spaces online course (CAMH)

Glossary of Transgender Terms (Johns Hopkins Medicine)

Pronoun and Language Guidelines for Trans-Affirming Workplaces in the Mental Health and Addictions Sector (CAMH)

Acknowledgements

Thank you to Equity & Engagement – Provincial System Support Program at CAMH for contributing *Pronoun and Language Guidelines for Trans-Affirming Workplaces in the Mental Health and Addictions Sector*, developed by Laur O'Gorman and Jacob Wolframe, which became the "Pronouns" subsection. This section was also co-developed with clinicians, students and staff at the Gender Identity Clinic and members of the Patient Advisory Committee. Contributions were made by Rainbow Services; Inclusion, Diversity, Equity and Accessibility – People & Experience; and Education Research.

Language affecting queer and questioning people

The Q in 2SLBGTQIA+ represents two identity groups: queer and questioning people. There is no universal definition of the term queer, but it is largely used as an umbrella term for 2SLGBTQIA+ identities, especially sexual and gender identities that are fluid (Collins, 2019). Because the adjective queer originally meant odd, strange and unusual, cisgender straight people adopted it as a way to insult and alienate 2SLGBTQIA+ people. The first recorded use of the term as a slur was in 1894 (Cheves & Lopez, 2025).

Questioning, in comparison, is also represented by the Q, which at times is doubled to be 2SLGBTQQIA+. The inclusion of questioning people in the 2SLGBTQIA+ acronym shows support of those who are in the process of discovering their sexual orientation or gender identity.

Queer as a reclaimed term

Queer is thought to have been reclaimed by the community during the 2SLGBTQIA+ rights movement that arose after the 1969 Stonewall Riots and has moved into more mainstream use (Cheves & Lopez, 2025). As with many reclaimed terms, queer has a political and cultural connotation and usually has the added meaning of someone who is connected to the queer community.

Indigequeer/Indigiqueer

This is a newer term coined by Plains Cree trans artist TJ Cuthand. It was created for Indigenous queer people who feel uncomfortable claiming the term Two-Spirit due to its gendered connotations in many cultures (Cariou, 2025b). Indigenous author Joshua Whitehead further popularized this term in his writing. Indigiqueer also has a political meaning rather than only referring to sexual identity: Typically, someone who identifies as Indigiqueer will be involved in or believe in Indigenization (see Amplifying the voices of Indigenous Peoples and acknowledging traditional land).

Best practices for writing about queer and questioning people

- Never use the term queer in a derogatory manner, such as to suggest that a person or group is abnormal, strange, odd, deviant or pathological.
- Do not assume the romantic, sexual or gender identities of someone who identifies as queer. A person who identifies as queer is part of the 2SLGBTQIA+ community in some way. However, the term queer does not signify any one specific romantic, sexual or gender identity within the community.
- Do not use the term queer interchangeably with the term 2SLGBTQIA+.
- When referring to multiple people who self-identify as queer, do not use the plural queers. Queer people or queer folks is appropriate.
- When writing for a general audience, be mindful when using the word queer because even within 2SLGBTQIA+ communities some people still consider the term offensive, depending on their own experiences, generation and culture.
    - While many people in 2SLGBTQIA+ communities self-identify as queer, others do not, whether it is because they feel that the term doesn't represent them, because of discomfort or trauma related to the term's derogatory history, or both.
- Recognize that among people who identify as queer, some may use the word queer interchangeably with or in addition to more specific terms to describe their identity (e.g., nonbinary and queer, bisexual and queer). Others may only use queer.
- If you are concerned about the history of queer being used as a slur, write "they identify as queer" instead of "they are queer" to make it clear that is the identity you are writing about.
- Never use the term questioning interchangeably with queer or to describe people who are not in a questioning process (i.e., they have shared a specific identity).
- Include both queer and questioning when spelling out the acronym in full.

Tools and resources

Editing 2SLGBTQIA+Affirming Terminology (Editors Toronto)

GLAAD Media Reference Guide (GLAAD)

Glossary of Terms: LGBTQ (GLAAD)

What Is Two Spirit, Indigiqueer, & LGBTQPAI+? (Indigenous Pride LA)

Acknowledgements

This section was co-created at CAMH with members of the Patient Advisory Committee and staff at the Office of Health Equity; the Gender Identity Clinic; Rainbow Services; Inclusion, Diversity, Equity and Accessibility – People & Experience; Equity & Engagement – Provincial System Support Program; and Education Research. Contributions were also made by Shkaabe Makwa, the Family Advisory Committee, the Youth Advisory Group and the Azrieli Adult Neurodevelopmental Centre.

Language affecting intersex people

Intersex refers to people whose biological sex does not fit in the male/female binary. This may be due to hormones, chromosomes or other genetic factors or to differences in primary or secondary sexual characteristics.

- People who are intersex face stigma and discrimination. Although intersex identities are included in the 2SLGBTQIA+ term, they tend to be discussed less openly than the other terms.
- When writing about intersex people, try to address the stigma and discrimination they experience.
- Do not assume a person's gender identity or pronouns based on visible traits. People who are intersex may identify as any gender, so also avoid the common assumption that they are nonbinary. If you aren't sure what pronouns to use, ask the person.
- Never use the term hermaphrodite because it is a slur (Interact, 2021). You may come across someone who has reclaimed this term, but in general, avoid it in your writing.

Tools and resources

Intersex Canada

What Is Intersex? (Interact)

Acknowledgements

This section was co-created at CAMH with members of the Patient Advisory Committee and staff at the Office of Health Equity; the Gender Identity Clinic; Rainbow Services; Inclusion, Diversity, Equity and Accessibility – People & Experience; Equity & Engagement – Provincial System Support Program; and Education Research.

Language affecting asexual and aromantic people

People who are asexual are not sexually attracted to other people, while people who are aromantic are not romantically attracted to other people. Someone who is asexual may refer to themselves as ace, while someone who is aromatic may use the term aro.

Asexual and aromantic are often used as umbrella terms for people who experience little or no attraction. Because attraction exists on a spectrum, some people may experience it in very specific circumstances. To capture this range, there are many sexual and romantic identity terms, as well as terms describing people's attitudes toward sex, relationships and companionship. For a detailed list, see the asexual/aromantic glossary developed by the Resource Center for Sexual & Gender Diversity (n.d.).

Like intersex people, asexual and aromantic people are less represented than others in the 2SLGBTQIA+ community. When writing about these identities, taking time to also discuss asexual and aromantic people can help them feel included.

Best practices for writing about asexual and aromantic identities

- Be open-minded and do not make assumptions when writing about this community.
- Acknowledge that each asexual or aromantic person may have different needs when it comes to sex, romance and companionship.
- Do not conflate asexual and aromantic identities because they are distinct.
- Do not assume the sexual or romantic orientation of asexual or aromantic people. Here are two examples:
    - An asexual person who experiences romantic attraction to all genders might refer to themselves as asexual and panromantic.
    - An aromantic woman who experiences sexual attraction to only men might refer to herself as aromantic and heterosexual.
- Do not assume that someone is asexual or aromantic due to a medical problem, trauma, fear or inability to find a partner.

- Do not assume the relationship status of asexual or aromatic people.
- Do not assume that aromantic people do not experience love or do not desire emotionally intimate relationships.
- Do not assume that asexual people are sexually inactive (Lehmiller, 2020).

Tools and resources

Asexual/aromantic glossary (Resource Center for Sexual & Gender Diversity)

Acknowledgements

This section was co-created at CAMH with members of the Patient Advisory Committee and staff at the Office of Health Equity; the Gender Identity Clinic; Rainbow Services; Inclusion, Diversity, Equity and Accessibility – People & Experience; Equity & Engagement – Provincial System Support Program; and Education Research.

Language affecting people with disabilities

Disability is often misunderstood, minimized or erased in both health care and broader society. One of the biggest misconceptions is that disabilities are always visible, when many people live with invisible disabilities—chronic pain, autoimmune conditions, fatigue-related illnesses, neurological conditions and mental health concerns that are not outwardly apparent.

Using inclusive language means acknowledging all types of disabilities—visible and invisible—without diminishing or doubting someone's lived experience. How we write about disability has the power to either uphold dignity or reinforce stereotypes. We also want to prioritize the voices of people with disabilities when writing anything that concerns them (see Principle 4: Respect "Nothing about us without us").

Disability is not something that needs to be overcome or fixed (Shew, 2025). People with disabilities are not broken. They deserve accommodations, support and acceptance, not judgement or pity.

Best practices for writing about and consulting with people with disabilities

Your writing projects may include consultations with diverse groups of people, including people with disabilities. Here are recommendations for using respectful, inclusive language in both your writing and in consultations.

- Avoid fixing and curing language and focus instead on strengths-based language (Linton, 1998). The medical model often assumes that disability is a problem to be solved or cured; however, within disability and neurodivergent communities, many people do not seek a cure—they seek understanding, accessibility and support. Language that centres autonomy, strength and lived experience allows people to define their own identities on their own terms. Table 18 gives examples of harmful language and strengths-based alternatives.

Table 18
Strengths-based language for writing about disability

Language to avoid	Language to consider	Why?
wheelchair-bound confined to a wheelchair	wheelchair user uses a wheelchair for mobility person who uses a wheelchair	Avoiding language that frames mobility aids as restrictive emphasizes their role in supporting freedom and independence.
suffers from [condition]	lives with [condition] has a diagnosis of [condition]	The word suffer implies victimhood. Neutral alternatives avoid implying helplessness.
victim of [condition]	person who has [condition]	First-person language avoids framing disability as something tragic or passive.
cure for autism fixing ADHD	support and accommodations for autistic people / people with ADHD	Many neurodivergent people don't want to be "fixed"—they want acceptance and support.
crippled/handicapped	person with a disability disabled person (if preferred)	Certain terms are outdated and offensive. Always ask for individual preference.

- Avoid being condescending toward people with disabilities or using overly sympathetic tones. Avoid speaking down on or paternalistically, like someone is a child.
- Don't assume you know what someone needs. Ask, don't assume.
- Recognize that energy is a limited resource for many people with chronic conditions (Miserandino, 2003). If someone says they're "out of spoons," that is a real barrier, not a lack of effort. (See Using the spoon theory to understand energy limits.)
- Avoid glorifying or pitying disabled people (e.g., calling them inspirational for doing everyday things).

- Use language that reflects a social model of disability, which means seeing the world, not the person, as needing to adapt (Linton, 1998).
- Use research and consultation to ensure you are being accurate about the way you are writing about disability and the supports someone may use.

  Example:

  You are writing a promotional email about an upcoming event. You write, "Sign language interpretation is available for those who are Deaf or hard of hearing." You receive an email from an advisory committee asking you to be more specific and accurate about accommodations in the future. You are surprised because you thought you were being proactive by offering the accommodation.

  Your writing contains two assumptions: that anyone with hearing loss is fluent in Sign and that only people who have hearing loss use Sign. In reality, people who are hard of hearing typically use oral communication and may prefer closed captioning or another method to help their understanding in meetings. Other people may be able to hear enough or they may read lips if they are close enough. In addition, people with other disabilities may use Sign:

  - Some Autistic people use Sign to help communicate if they are non-speaking or have periods when talking is more difficult for them.
  - Some people with intellectual disabilities or who are unable to speak due to another disability use Sign.

Tools and resources

A Way with Words and Images: Guide for Communicating with and About Persons with Disabilities (Employment and Social Development Canada)

Acknowledgements

This section was co-created at CAMH with patient advisors from the Patient Advisory Committee and the Azrieli Adult Neurodevelopmental Centre. Contributions and review were also made by staff from the Collaborative Learning College; Patient & Family Education and Mental Health Literary, Education at CAMH; the Office of Health Equity; and Equity & Engagement – Provincial System Support Program.

Language affecting people with autism and autistic people

Autism spectrum disorder (i.e., ASD, autism) is a neurodevelopmental disorder that affects social communication and interaction and involves extremely focused behaviours and interests (American Psychiatric Association, 2022). It also includes differences in sensory processing. Within the neurodiversity model, autism is considered a neurotype (see The Neurodiversity Model). Some people do not view autism as a disorder at all, but rather as a different way of experiencing, understanding and relating to the world (Bottema-Beutel et al., 2021).

Many people view being Autistic as an important part of their identity. Within the Autistic community, particularly among those focused on advocacy and disability rights, the word Autistic is capitalized when describing people diagnosed with autism. In recognition of this preference, this section uses identity-first language (e.g., Autistic person) and capitalizes Autistic when discussing people or the community.

Traditionally, autism was considered a linear spectrum relating to a person's level of independence (e.g., high-functioning versus low-functioning, or low support needs versus high support needs). However, more current and accurate representations of autism show that the spectrum includes many areas:

- social differences
- interests
- repetitive behaviour
- sensory sensitivities (leading to avoiding or seeking sensory experiences)
- emotional regulation
- perception
- executive functioning (e.g., planning, self-care, organization)

The *Diagnostic and Statistical Manual of Mental Disorders* categorizes ASD into three severity levels based on the amount of daily support a person requires: 1 = low

support needs, 2 = medium support needs and 3 = high support needs (American Psychiatric Association, 2022). While these categories can be helpful for advocating specific programs or supports, they do not reflect the complex variability of each person's support needs. The level of support that a person needs is not fixed. For example, it may change depending on life transitions, different settings and the activities the person is doing (Kapp, 2023).

Autistic traits and mental health

Appearing "more" or "less" autistic is not an indication of a person's health or well-being. Someone who hides their autistic behaviours or communication style (sometimes called masking) may be at increased risk of mental health concerns or burnout (Najeeb & Quadt, 2024).

Behaviours that are associated with autism, such as stimming, repetitive behaviours or intense focus, can also lead to intense pleasure, called autistic joy, which can support well-being (Wassell, 2024). Many Autistic people report also feeling immense joy from sensory experiences, the way they notice the world and engaging with their special interests (Authentically Emily Blog, 2024).

Avoiding stereotypes about autism

When writing about autism, be aware of myths and stereotypes because they invalidate the experiences of Autistic people. Inaccurate portrayals contribute to stigma, exclusion and worsened mental health.

The Autism Mental Health Literacy Project ([AM-HeLP], 2021) has highlighted common myths about autism.

Myth: Vaccines and certain medications cause autism.

Fact: Vaccines and medications like Tylenol don't cause autism. People are born Autistic, not made Autistic.

Myth: There is an autism epidemic.

Fact: There has been an increase in the ability to diagnose autism. Rising diagnosis rates are thought to reflect improved understanding of autism and more accurate

diagnostic practices, along with increased referrals as health care professionals become more aware of autism and how it presents in different cultures, genders and age groups.

Myth: The autism spectrum goes from severe or low-functioning to high-functioning.

Fact: Autism does not range from low to high—it is multidimensional. The traditional spectrum, with two extreme ends, is inaccurate and can be stigmatizing. Current diagnostic systems assign levels, where level 1 refers to low support needs and level 3 refers to high support needs. However, a person's functioning is often linked to the amount of stress they are experiencing. The same person can need more or less support depending on many factors, so fixed labels are not accurate definitions of a person's experience.

Myth: You should try to stop an Autistic person's repetitive behaviours.

Fact: These behaviours usually have a purpose, and that purpose usually contributes to positive mental health (e.g., helping to maintain focus or handle stress).

Myth: Only men can have autism.

Fact: People of all genders can have autism, but it can look different and be experienced differently between men, women and transgender and nonbinary people. A formal diagnosis is more likely to be missed in people assigned female at birth, as well as in transgender, nonbinary and racialized people.

Myth: Only children can have autism.

Fact: People don't outgrow autism. Autistic children grow up to be Autistic adults. As understanding of autism grows, many people are also getting diagnosed as adults after realizing they were misdiagnosed or not diagnosed as a child.

Myth: Autistic people are non-verbal or don't understand language.

Fact: Some Autistic people don't speak, but many still understand language and communicate in different ways, including through Sign language and technology. Some Autistic people have special interests in language, such as grammar, poetry or letters, and may have a very sensitive understanding of words and meaning.

Others may be hyperlexic, which means that they develop an early ability to recognize and read words, letters and numbers. Every Autistic person is different, with their own strengths and ways of communicating.

Myth: Autistic people are unable to work.

Fact: Autistic people can and do work, and many who don't work would like to. Autistic people experience high rates of unemployment and underemployment not by choice but because hiring practices often favour allistic (non-autistic) people who are more adept at promoting themselves.

Myth: All Autistic people have special interests, talents or savant skills.

Fact: Some Autistic people have savant skills, just as some non-Autistic people do, but it is not true that most have these skills. Savant skills, talents and special interests are not the same thing.

Myth: A person who is able to make eye contact or have friendships can't be Autistic.

Fact: Many Autistic people learn to mask or camouflage and follow allistic social rules. This does not mean they are not Autistic.

Myth: Autistic people don't like to socialize.

Fact: Many Autistic people want to socialize and are good at doing so, especially when other people understand their Autistic ways of interacting. Allistic people may assume that Autistic people lack interest in socializing because Autistic people communicate their social interests in ways that are distinct to Autistic/ neurodivergent culture.

Myth: Autistic people do not have the ability to empathize.

Fact: Autistic people feel empathy just as much—and sometimes more—than others, but they may not always communicate those emotions in the same way as non-Autistic people. There are different kinds and expressions of empathy. For example, many Autistic people mask around neurotypical people or in public, which is a highly-developed form of empathizing. Although masking is not something an Autistic person should need to do and often requires significant energy, it shows an awareness of someone else's needs, perspectives and expectations.

Myth: Autism can be cured with special diets, vitamins, bleach-based products or other treatments.

Fact: Autism is a neurological difference. Autism isn't something that needs to be cured, and eating or drinking something isn't going to change autistic neurology.

Myth: Everyone who is Autistic wants to be labelled as Autistic.

Fact: Some people identify as Autistic, but not everyone does. It is up to each person how they want to identify.

Myth: Autistic people are violent.

Fact: Having autism does not mean being violent or naturally aggressive. Autistic people may have physical reactions when they feel chronically overwhelmed, frustrated or misunderstood. Media stories sometimes focus on rare or extreme cases involving violence, which can make it seem like violence is common, when in fact these are exceptions. There is no evidence that Autistic people are more likely to behave violently than other people, and they are actually far more likely to be victims of violence. This myth harms Autistic people and puts them at greater risk, including from caregivers or police, especially if they are racialized.

Myth: Autistic people cannot parent.

Fact: Autistic parents are just like non-Autistic parents: there are parts of parenting that can be hard and other parts that may be easier.

Myth: Autistic people look or appear a certain way.

Fact: There is no one way that an Autistic person looks or appears, just like people who don't have autism do not look or appear a certain way.

Identity-first over person-first language

The *Mental Health Literacy Guide for Autism* (AM-HeLP, 2021) describes perspectives on identity-first and person-first language:

> There have been major changes in the last 30 years that have profoundly shaped the ways in which autism is discussed, defined, and described. Here are some recommendations for identity-first language (e.g., Autistic person) or for person-first language (e.g., people with autism).

> While traditionally, person-first language was the recommended method for describing autism, many advocates and authors have highlighted the issues with this approach for the Autistic community (Bottema-Beutel et al., 2021). There is relative consensus among disabled advocates in general, and those in the Autistic community in particular, that identity-first language is the preferred way of talking about autism. Autism is seen as an inseparable part of who Autistic people are. At the same time, some family members, service providers and Autistic people themselves may still prefer person-first language or the use of a different term other than Autistic. The use of identity-first language is meant to recognize, affirm and validate the ownership of an identity as an Autistic person. Autistic is not a derogatory term; instead, it is seen as a source of pride. (p. 2)

Although identity-first language has become the preference within disability advocacy, you may still work with people who prefer person-first language and describe themselves as "having autism." This language reflects their experiences and relationship to autism and should not be changed or corrected, especially if you are directly quoting them (see Principle 4: Respect "Nothing about us without us" and Principle 5: Use Dignity-First Language).

Best practices for writing about autism and for Autistic people

When writing about autism, make sure to follow these best practices (AM-HeLP, 2021, p. 58):

- Consult with Autistic people (see Principle 4: Respect "Nothing about us without us.").
- Do not focus on treating or correcting traits associated with autism. Focus instead on promoting well-being (Najeeb & Quadt, 2004; Wassell, 2024).
- Do not refer to traits or characteristics that are part of someone's autistic presentation as symptoms (see The Neurodiversity Model).
- Represent the strengths of Autistic people, not only areas of struggle.
- Avoid reinforcing stereotypes about autism and correct myths about autism.
- Do not reduce autism to a linear spectrum.

- Avoid ableist terms and use respectful language to describe traits, interests, communication and behaviours often seen in Autistic people (see Table 19 for examples).
- Include depictions of autistic joy.
- Due to communication differences of Autistic people, consider the following practices for accessible writing:
  - Ensure that the design and layout of the information is easy to understand, regardless of the person's experience, language, knowledge and concentration level.
  - Provide information in plain language (see Principle 8: Use Plain Language).
- Follow accessible practices in writing projects that involve working and consulting with Autistic people. Not everyone will disclose that they have autism, so using these practices consistently creates a supportive environment for everyone:
  - Make a schedule/agenda and send it to people in advance.
  - Provide options for accommodation requests.
  - Allow for space and time to take breaks.

Table 19
Respectful language for writing about autism

Language to avoid	Language to consider	Why?
the words fixation or obsession to describe something the person is intensely focused on	special interest, focused interest, passion, hobby	Terms such as fixation or obsession are associated with a negative mental health symptom, whereas special interests are often a source of joy and wellness for Autistic people. Many people in the Autistic community still refer to special interests. Some prefer the term focused interests because special interests sounds patronizing and childish. Some Autistic people have obsessive-compulsive concerns, but special

		interests and passions are not the same as obsessions or compulsions.
non-verbal	non-speaking Sign-user AAC-user (augmentative and alternative communication)	While some Autistic people may not use spoken words, they still communicate through gestures, behaviours, sounds, movements, Sign language or systems such as AAC, either using digital programs or visual picture systems.
has Asperger's	on the autistic spectrum diagnosed with autism spectrum disorder	Asperger's is an outdated term and is no longer a diagnosis. Asperger's was named after a Nazi researcher, Hans Asperger, and there is a desire to separate autism from his work. Some people who were diagnosed before the autism spectrum was updated may still identify with the term Asperger's.
special needs	Describe the specific needs.	This language is patronizing and outdated.
autism epidemic	Describe autism as increasingly recognized or diagnosed.	The word epidemic compares autism to a disease. Autism was under-diagnosed and the criteria have been broadened. There is not an increase in people with autism, just an increase in diagnosis.
superpower	strength, talent	Superpower is infantilizing. Just as you would for anyone, refer to strengths or talents when describing areas of skill. Referring to autism as a superpower is offensive because it may minimize the areas of difficulty many people with autism experience.

Note. Many of the terms described in this table are also discussed in Bottema-Beutel et al. (2021).

Tools and resources

Autism Mental Health Literacy Project (York University & CAMH Azrieli Adult Neurodevelopmental Centre)

Avoiding ableist language: Suggestions for autism researchers (*Autism in Adulthood*)

Identity-First Language (Autistic Self Advocacy Network)

Acknowledgements

Thank you to the Autism Mental Health Literacy Project led by York University and the Azrieli Adult Neurodevelopmental Centre at CAMH for contributing most of this section. Adaptations and additional contributions were made by Azrieli Centre staff; Equity and Engagement – Provincial System Support Program; the Collaborative Learning College; and members of the Azrieli Self-Advocate Advisory Group.

Language affecting people with attention-deficit/hyperactivity disorder

Historically, attention-deficit/hyperactivity disorder (ADHD) was framed as a childhood behavioural or learning disability rather than a life-long neurodevelopmental condition (Erk, 1995; Romeo et al., 2021). However, ADHD affects people of all ages, genders and races and is associated with difficulties related to motivation, attention, executive function, impulsivity and sensory processing. Its presentation varies depending on whether a person experiences hyperactivity, inattention or both, but it generally involves difficulty regulating attention and emotion.

Many people with ADHD are diagnosed with other mental health or neurodevelopmental conditions. Although autism and ADHD could not be diagnosed together until 2013, research now shows that many Autistic people also have ADHD (Carta et al., 2020).

Although ADHD is recognized as a disability and can qualify for disability benefits, accommodations or disability-specific programs (Redmond, 2016), it is often considered less debilitating than other disorders (Mahdi et al., 2017). This can feel invalidating for someone with ADHD, especially if they already need to self-advocate for accommodations (Patton, 2009).

Language preferences in ADHD identity

Communities of people with ADHD have only developed more recently, so there are fewer established language guidelines. The lack of guidance can make it difficult to use consistent terminology and identify the language preferences of people with ADHD, and the narrow clinical focus may reinforce incomplete or outdated views on the condition. This is changing as more research is focusing on adults and underdiagnosed populations, such as women.

Identity terms for ADHD reflect subtle differences in how people view their experiences. It is important to use the language a person prefers when you are quoting them or describing their experience:

- Most people currently use person-first language with ADHD, such as "person with ADHD," or they say, "I have ADHD."
- Some people use identify-first language, such as, "I'm ADHD" or "I'm an ADHD person." Recently, other terms have emerged, such as ADHDer.
- Someone with both autism and ADHD may say, "I'm an AuDHDer" or "I'm AuDHD," instead of "I have AuDHD." This reflects the trend toward identity-first language in Autistic communities. Some people say, "I have autism and ADHD."
- It is very common for people with ADHD to have other diagnoses or types of neurodivergence and they may choose different ways to discuss their identity depending on these factors (NeuroLaunch, 2026; Pehlivanidis et al., 2020).

Best practices for writing about people with ADHD

- Consult with people with ADHD (see Principle 4: Respect "Nothing about us without us").
- Avoid depicting people with ADHD as a uniform group. Instead, recognize their diversity and present them as having different traits, values and ways of describing themselves (Redmond, 2016).
- Respect identity preferences. Some people with ADHD identify strongly with the disability community and identify as Disabled. Other people with ADHD consider themselves neurodivergent and prefer that term rather than considering ADHD a disorder (see The Neurodiversity Model).
- Do not dismiss or minimize concerns a person with ADHD might have about their mental health, thinking and organization skills, or social and communication challenges. Avoid comparative language that downplays these experiences. For example, avoid writing "Although people with ADHD may face challenges with communication, these challenges are less serious than those experienced by Autistic people."
- When depicting someone with ADHD, aim for a strengths-based approach instead of reverting to stereotypes, such as depicting people as lazy, flaky, unproductive or unable to finish tasks. These portrayals do not represent the complexity of living with ADHD and are harmful to people living with it.

Tools and resources

ADHD Language Guide (Southern Alberta Institute of Technology)

Toward Neurodiversity-Affirming Language for ADHD (Center for Open Science)

Acknowledgements

This section was co-created at CAMH with patient advisors from the Patient Advisory Committee and the Azrieli Adult Neurodevelopmental Centre. Contributions and review were also made by staff from the Collaborative Learning College; Patient & Family Education and Mental Health Literary, Education at CAMH; Public Affairs; the Office of Health Equity; and Equity & Engagement – Provincial System Support Program.

The Language Guidelines

Language affecting people with intellectual disabilities

People with intellectual disabilities face severe ableism, even within disability communities. They are also often infantilized (i.e., treated as younger than their age), and there have even been eugenic campaigns throughout the years seeking to eradicate intellectual disabilities. It is important to use language that shows respect and upholds the dignity of people with intellectual disabilities and to communicate in ways that support their involvement in their care.

Best practices for using inclusive language about people with intellectual disabilities

- Use person-first language to describe people with an intellectual disability (Self-Advocate Leadership Network British Columbia, 2023):
  - Some people prefer "person labelled with an intellectual disability."
  - Others prefer "person who uses our services" or "person we support" to describe someone you are treating.
  - Rather than "person with disabilities," some people prefer "person with diverse abilities."
- Do not make assumptions about a person based on their disability or IQ. Everyone has different strengths and perspectives to contribute.
- Never make statements about intelligence that are based on age (e.g., "She's 36 but has the intelligence of a 15-year-old"). People with intellectual disabilities grow, age and accumulate experiences just like all people (Rogers & McGuire, 2024; Silverman, 2018).
- Avoid words such as idiot or other offensive terms related to intelligence.
- Avoid language that refers to functionality when discussing any disability. For example, some people use the terms high-functioning or low-support when describing a form of autism and may intend them as a compliment. These are microaggressions and insult people with intellectual disabilities because they imply that some people are less valued or worthy, rather than recognizing that all people have equal worth regardless of their support needs or abilities.

- When representing people with an intellectual disability, include a variety of disabilities. People with Down syndrome tend to be represented more often than people with other intellectual disabilities, so it helps people feel included if you use research and representation of people with other intellectual disabilities (Lunsky, personal communication, 2024).
- Represent people with intellectual disabilities as having strengths and being involved in their care.
    - Someone may refer to themselves as an advocate or self-advocate. The term advocate generally has a connotation of being involved in larger discussions about disability or patient rights, whereas self-advocate means someone advocating their own involvement in their care.

Communicating health information to people with intellectual disabilities

Inclusion Canada, People First of Canada and the Azrieli Adult Neurodevelopmental Centre have developed a collection of resources on how to best communicate information to people with intellectual disabilities. (See Using Easy Read to increase accessibility.)

In addition to providing easy-to-read public health materials, consider offering information in multiple formats, such as video. One self-advocate with intellectual disabilities who was consulted on these guidelines explained that being able to talk through information with someone rather than reading it makes it easier to understand. When writing, consider offering different ways for people to engage with the information. Each person has different needs and providing options ensures that most people can access the health care information they need.

Another advisor explained that having options—such as being able to access audio, read information with fewer points or have a conversation with someone about the content—improved their ability to understand their health information and certain content. They saw having options such as these as vital to their participation in their care.

It is also helpful to include resources that families and other support people can use to explain concepts to people with intellectual disabilities. For example, Books Beyond Words, developed in the United Kingdom, is a series of illustrated booklets designed for this purpose.

Tools and resources

Advancing Accessible Communication for People with an Intellectual Disability (Inclusion Canada, People First of Canada & CAMH Azrieli Centre for Adult Neurodevelopmental Disorders)

Against Technoableism: Rethinking Who Needs Improvement (W.W. Norton & Company)

Books Beyond Words

Thinking About Language (BC Self-Advocate Leadership Network)

What is Easy Read? (Photosymbols)

Acknowledgements

Thank you to Inclusion Canada, People First of Canada and the Azrieli Adult Neurodevelopmental Centre at CAMH for contributing pieces of this section showcasing their work on Easy Read, a method of accessibly communicating health information to people with intellectual disabilities.

This section was co-developed at CAMH with members of the Patient Advisory Committee; staff at the Azrieli Adult Neurodevelopmental Centre; members of the Azrieli Self-Advocate Advisory Group; Patient & Family Education and Mental Health Literacy, Education at CAMH; the Office of Health Equity; and Equity & Engagement – Provincial System Support Program.

Language affecting people with fetal alcohol spectrum disorder

Fetal alcohol spectrum disorder (FASD) is overlooked in research and discussions about intellectual and neurodevelopmental disabilities. It has often been mistakenly reported to be overrepresented in Indigenous and racialized communities (CanFASD, 2025). These issues, as well as the exclusion of people with FASD from discussions that involve them, make it essential to include people with FASD in developing resources about the disorder.

Use the CanFASD definition

CanFASD has developed a standard definition for FASD in consultation with clinical experts, people with lived experience and their caregivers (Harding et al., 2019). We recommend using this definition:

> Fetal Alcohol Spectrum Disorder (FASD) is a diagnostic term used to describe impacts on the brain and body of individuals prenatally exposed to alcohol. FASD is a lifelong disability. Individuals with FASD will experience some degree of challenges in their daily living, and need support with motor skills, physical health, learning, memory, attention, communication, emotional regulation, and social skills to reach their full potential. Each individual with FASD is unique and has areas of both strengths and challenges. (p. 3)

Using a shared definition has several advantages. It:

- points people to the thorough work being done to advocate for and strengthen FASD research
- creates consistent and respectful messaging around a spectrum disorder that is often misunderstood and stigmatized
- ensures the definition and language used to describe FASD has been developed with engagement of people with FASD

Avoid stereotypes about FASD

When writing about FASD, be aware of stereotypes and misconceptions because they can dismiss or undermine people's experiences. Inaccurate portrayals increase stigma and create barriers to understanding, diagnosis and access to appropriate support. Table 20 presents common stereotypes and more accurate ways of writing about FASD.

Table 20
Strategies for avoiding stereotypes about FASD

Stereotype	Fact	Writing guidance
FASD is an Indigenous issue. FASD only occurs in certain populations. FASD only occurs in people with low socioeconomic status.	FASD has been mistakenly associated with Indigenous Peoples. FASD occurs in all cultural populations and all income groups. It is a public health issue that affects up to four percent of Canadians. There is no safe amount of alcohol to drink in pregnancy for any population.[a]	Make it clear that FASD is mistakenly and disproportionately associated with Indigenous Peoples due to systemic stigma and historical misdiagnosis. Acknowledge broader factors that increase the risk for drinking in pregnancy (e.g., domestic violence; social pressures, including partners who use alcohol; stigma that discourages accessing education and support).[b]
FASD is 100% preventable.	Alcohol use in pregnancy can be prevented or reduced through education, support and policy improvement. There is no known safe amount of alcohol during pregnancy.	Avoid framing FASD as completely preventable because that message can increase stigma toward pregnant people. Focus instead on how to support people in reducing or stopping drinking during pregnancy.

FASD is caused due to a choice or carelessness during pregnancy.	Some people in abusive relationships experience pressure or coercion to drink by their partner. Drinking alcohol may be a coping strategy. Some people may not realize they are pregnant in the early weeks or even later in pregnancy due to lack of prenatal and medical care or sexual and reproductive health education.	Use sensitivity when discussing alcohol use in pregnancy and avoid judgemental language.
People with FASD should focus on becoming more independent and autonomous. Level of autonomy or independence is a measure of health and well-being for someone with FASD.	All people, not just people with FSD, benefit from having systems of people who can give them support.	Acknowledge the concept of interdependence, which emphasizes the way people with FASD contribute to others while themselves receiving support and care.

Note. From *Common Messages: Guidelines for Talking and Writing About FASD* (pp. 8–23), by Canada FASD Research Network, 2025. Copyright 2025 by Canada FASD Research Network. Adapted with permission. Other sources from the table are listed in the footnote below.

[a] Canada FASD Research Network (2023); [b] Poole et al. (2025).

Use care in writing about people with FASD from racialized communities

When writing about a specific population and FASD, consider how you are including the specific population in your audience and purpose:

- Many Indigenous communities and activists are at the forefront of FASD approaches, advocacy and research (Badry & Goose, 2022; Cox, 2023). Indigenous communities draw upon cultural wisdom, community strengths and

Traditional Knowledge to share information about alcohol and FASD and to design community-based supports.

- There are gaps in other intersectional identities in research and representation, such as Black Canadians with FASD, due to inequitable research (Lennord & Harding, 2026).

Include the caregiver voice

Respect and consult caregivers of people with FASD, as well as people with FASD, because both groups bring valuable lived experience. For example, caregivers offer unique perspectives based on their daily support and advocacy:

- Many people with FASD have caregivers who work to improve circumstances for their child and other people with FASD (CanFASD, 2025).
- Caregivers often have strategies, ideas and resources for addressing challenges, such as those related to memory, reasoning, problem solving, understanding consequences and learning from experience.

Include strengths of people with FASD

In your writing, consider the uniqueness of each person with FASD:

- Discussions about FASD tend to focus on challenges, but people with FASD have many unique qualities and abilities. For example, Myles Himmelreich, an FASD advocate, notes that resilience and determination are key attributes of people with FASD (YourAlberta, 2013). He draws on his own lived experience to challenge stereotypes and showcase the contributions of people with FASD through his motivational speaking and community outreach work.
- Rather than only discussing areas in which people with FASD need support, highlight the ways they contribute and support others (e.g., as advocates, volunteers, workers, family members, community members).

Use preferred and respectful terms

- Respect the language people use to self-identify:
  - The general preference is to use person-first language (e.g., “person with FASD”)

  - Some people with FASD may also identify as neurodivergent or Disabled and prefer that descriptor.
  - As a rule, avoid putting FASD first when describing a person with FASD (e.g., don't use "FASD person").
- Avoid language that is dismissive, inaccurate and outdated. CanFASD (2025) provides guidance for using more empowering and accurate language:
  - Don't refer to FASD as an invisible or hidden disability because it minimizes the supports that people with FASD may need. FASD presents in many ways, and it may or may not include physical signs. Recognizing that FASD manifests in many ways supports early detection and intervention, which can improve outcomes.
  - Don't describe FASD as a syndrome or disease. Referring to FASD as a syndrome or disease does not reflect current understanding of the disorder. Instead, describe FASD as a disorder or disability.
  - Don't refer to primary or secondary disabilities. Comparative language makes it seem like some difficulties are more important than others. FASD is a spectrum disorder, so domains will be affected differently for different people. Instead, describe the person's strengths and challenges, and describe areas in which they may need support, using terms such as "difficulties in daily living" or "areas of need."

Tools and resources

Common Messages: Guidelines for Talking and Writing About Fetal Alcohol Spectrum Disorder (CanFASD)

FASD Media Resources (CanFASD)

Guidelines for Including People with Disabilities in Research (National Disability Authority, Ireland)

Health and Healing on the Edges of Canada (book chapter) (Polynypa Press)

Living with FASD: Myles Himmelreich (YourAlberta, YouTube)

Mental Health Resource and Practice Guide (CanFASD)

Reporting on Alcohol Use, Alcohol Use During Pregnancy, and Fetal Alcohol Spectrum Disorder (CanFASD)

Revitalizing Culture and Healing: Indigenous Approaches to FASD Prevention (Centre of Excellence for Women's Health, First Nations Health Authority & CanFASD)

Acknowledgements

This section draws on information from the Canadian FASD Research Network (CanFASD) and was reviewed by the CanFASD Adults with FASD Expert Collaboration Team and the CanFASD Family Advisory Committee. At CAMH, contributions were made by staff and lived experience advisors from Shkaabe Makwa and by the Patient & Family Education and Mental Health Literacy team in Education at CAMH. The Centre for Excellence in Women's Health at the BC Women's Hospital and Health Centre also provided expertise.

Language affecting people with chronic illness, chronic pain or rare diseases

People with chronic illnesses, chronic pain or rare diseases often experience dismissal, misunderstandings and disbelief of their symptoms, despite what is often a long and ongoing engagement with health care and treatment. When writing about these experiences, acceptance and validation are important, along with using person-first language.

Language related to chronic illnesses

Inclusive language about chronic illness should recognize that these conditions are not always visible and that a person can be seriously unwell without showing outward signs. Avoid minimizing, doubting or oversimplifying what a person with chronic illness experiences. A person who doesn't "look sick" may feel pressured to justify their symptoms, explain their limitations or prove their need for care or accommodations. This creates a cycle of self-monitoring, over-explaining and emotional exhaustion.

Using the spoon theory to understand energy limits

People with chronic illness often need to pace their energy throughout the day or week, even if they appear "fine" in the moment. In a culture that rewards productivity and constant action, people with chronic illness may feel invisible and isolated.

Referencing the spoon theory in your writing can help acknowledge these experiences and create a sense of validation, understanding and belonging. Many people with chronic illnesses use the spoon theory to describe the limits of their daily energy (Miserandino, 2003). In this metaphor, a spoon represents a unit of energy. Someone with chronic illness may wake up with fewer spoons than other people, and each activity—getting dressed, making food, attending appointments—can use up one or more spoons. Once those spoons are gone, their energy for the day is depleted.

Best practices for writing about chronic illness

- Use person-first language such as “person living with a chronic illness” or “person managing chronic pain.”
- Avoid statements such as “You don’t look sick” “or “At least it’s not [other condition].” When writing about health, respect that people have different needs when it comes to rest and activity.
- Validate people’s experiences even if they are outside your understanding.
- Don’t offer unsolicited advice or cures.

Language affecting people with chronic pain

Chronic pain is a complex and deeply personal experience. For people who live with it, the pain is not temporary—it is ongoing, often invisible and frequently misunderstood. The way we write about pain matters. It can validate someone’s experience or it can contribute to feelings of isolation, frustration and harm.

Because chronic pain doesn’t always come with visible signs, people living with it may face doubt, dismissal or minimization (Jordan et al., 2025). Their symptoms can be overlooked, attributed to psychological causes without proper investigation or met with assumptions that they are exaggerating or being difficult.

Pain scales and their limitations

People with chronic pain are routinely asked to rate their pain, for example, on a scale of 1 to 10, but scales are not always useful or accurate for someone who has adapted to high levels of daily pain. A person who has lived with intense pain for years may rate their pain as a 5, whereas someone else may rate that same pain as a 9 or 10.

This mismatch often leads to:

- under-treatment or dismissal of symptoms
- misdiagnosis or delays in accessing care
- increased emotional distress, including anxiety and depression
- medical trauma, particularly when people feel unheard or invalidated

The emotional toll of not being believed

Chronic pain often exists alongside a heavy emotional and psychological burden. When pain is dismissed or minimized, it can create a ripple effect:

- People may begin to doubt their own experiences, internalizing stigma and shame.
- Repeated dismissal from health care providers may lead to hypervigilance or distrust.
- The persistent nature of the pain can fuel feelings of hopelessness or despair, especially when paired with barriers to treatment or systemic discrimination.

There is also a validated scale called the Pain Catastrophizing Scale that asks people to rate their thoughts and feelings when they are experiencing pain. Some chronic pain researchers, people with lived experience and clinicians argue that the term catastrophizing contributes to the stigma and skeptism over the presence of chronic pain because it may be dismissive and question the person's trustworthiness and credibility (Connoy & Webster, 2024; Sullivan & Tripp, 2023).

When writing about this scale, use precise and intentional language to avoid reinforcing stereotypes related to people with chronic pain. Some clinics even avoid calling the scale by that name. For example, at CAMH's Interprofessional Pain and Addiction Recovery Clinic, clinicians refer to the Pain Catastrophizing Scale and Pain Self-Efficacy Questionnaire as Pain Scale 1 and Pain Scale 2 to avoid exposing patients to stigmatizing language. This simple change improves patient experiences and strengthens clinician−patient relationships.

Best practices for writing about chronic pain

- Use person-first language such as person living with chronic pain or person navigating ongoing pain.
- Avoid statements that minimize, such as "At least it's not cancer," "Maybe it's just stress" or "You just need to exercise more."
- Use validating and healing-centred language.
- Don't use language that equates pain with weakness or exaggeration.

- Ask how someone prefers to describe or communicate their pain.
- When writing about pain scales, acknowledge their limitations.

Language affecting people with rare diseases

The rare disease community is united by a shared experience of being misunderstood, overlooked and underrepresented in medicine. Rare diseases are often difficult to diagnose, and people may go years—sometimes decades—without answers.

This period is known as the diagnostic odyssey: a long and often traumatic journey to finally being diagnosed. During this time, many people are dismissed, misdiagnosed or told their symptoms are psychological. This repeated invalidation can lead to medical gaslighting, complex posttraumatic stress disorder and a deep erosion of trust in the health care system (Baynam et al., 2026).

Rebuilding trust through language

People with rare diseases often carry the emotional weight of needing to advocate for themselves constantly (Baynam et al., 2026). After years of not being believed, they may enter health care settings with guardedness, skepticism or fear. Inclusive communication must acknowledge this history and work to rebuild trust through compassion, transparency and partnership.

Using the zebra symbol—the official global symbol for rare diseases and conditions—in communication or care settings can signal allyship and awareness. Avoid referring to patients with rare diseases as mysteries or cases to be solved. These phrases can feel objectifying and dismissive.

Best practices for consulting with and writing about people who have rare diseases

- Use person-first language such as “person living with a rare disease” or “person navigating a diagnostic journey.”

- Avoid calling someone's condition weird, unknown or unusual in a way that sounds dismissive. Instead, say, "This condition is rare, but your experience is valid and important."
- Acknowledge the trauma of delayed diagnosis when discussing care plans.
- Avoid statements such as "At least you finally got a diagnosis"—the diagnosis may have come with grief, loss and years of harm.

Tools and resources

"Rarely talked about": A new paper calling for the use of empathetic and kind language in describing rare conditions (Fragile X International)

The spoon theory (But You Dont Look Sick?)

Talking About Pain (Painaustralia)

What to say to someone with a chronic illness (Xander Keller & TEDx Talk)

Acknowledgements

This section was co-created at CAMH with patient advisors from the Patient Advisory Committee. Contributions and review were also made by staff from the Collaborative Learning College; Patient & Family Education and Mental Health Literary, Education at CAMH; Research – Education; Everyday Ethics Lab at CAMH; the Office of Health Equity; and Equity & Engagement – Provincial System Support Program.

Language affecting people with disabilities that affect mobility

Disabilities that affect mobility come in many forms. A person may be born with these disabilities; acquire them through illness, injury, limb loss or amputation; or experience them due to a progressive condition. The terms you use while writing about these disabilities will likely reflect the many differences in language preferences. As always, ask the people you are writing about which terms they prefer for their identity, disability, devices and supports, and be open to feedback about the language you use.

Best practices for writing about people with limited mobility

- Avoid idioms or jokes that imply that limited mobility is lesser (e.g., the word lame to mean something uncool).
- Avoid ableist language because it excludes people with limited mobility. Instead of referring to a walk-in clinic, use the more inclusive term drop-in clinic.
- Use person-first language unless people prefer other terms.
- Avoid language or patterns that imply that people with limited mobility and bodies that do not conform to ableist ideas are less worthy or that they are incomplete or odd.
- Do not describe people with mobility disabilities as inspirational or as requiring pity or sympathy. They have strengths and difficulties like anyone else.
- In your writing, avoid mentioning or discussing a person's mobility device without their consent (Americans with Disabilities Act National Network, 2018). Just as it is inappropriate to ask intrusive questions in public, the visibility of a mobility device does not make it appropriate to comment on or write about it.
- Use the term residual limb to describe the body part remaining after an amputation (International Organization for Standardization, 2025). Avoid the terms stump and stub because most people find them offensive.
    - Some people with amputations use the terms stump or stub (Robinson, 2025). When quoting someone, honour their language.

- If you are unsure which terms to use in your own writing, check with an advisor or consultant.

Best practices for describing mobility devices

- Where possible, include mentions of mobility devices in writing. For example, if mentioning how people get around, be inclusive of all ways that people move (e.g., "Walk, run or roll to raise money for mental health.")
- Avoid describing mobility devices or prosthetics as improvements over a person's body without them (Shew, 2023). For some people, these devices are empowering, but for others, they may add weight, decrease speed or pose a different mobility challenge. They also create additional financial costs for the person. When writing about the devices a specific person uses, ask them how they view it so your writing will reflect their perspective.
- Do not write about mobility devices as limiting. Many people who use them see them as liberating—tools that promote freedom, safety and independence. For example, someone using an electric wheelchair because of arthritis may see it not as a last resort but as an empowering way to stay mobile and active.
- When depicting mobility devices, keep in mind that wheelchairs are often used as the default to signal a disability related to mobility even though many people use other supports, such as walkers, braces and other orthoses, crutches, canes and scooters. There are also devices that help with specific tasks or ensure safety (e.g., sock pullers, reachers, fall detectors) (Health Canada, n.d.; World Health Organization, 2016).
- Don't assume that everyone uses mobility devices in the same way. For example, a common misconception is that all people with wheelchairs must use their wheelchair all the time. This may be true for some people or disabilities, but other disabilities involve ambulatory wheelchair use, which means the person may be able to walk short distances but need their wheelchair for longer ones. Use may also vary according to situation (e.g., weather, energy levels, stress, specific medical conditions).
- Acknowledge that people may use devices in different contexts. For example, people may have times when they use a cane or walker but other times when

they do not use anything. Someone also may use a wheelchair in some situations but a walker in others.

Best practices for describing prosthetics

- Do not use the term artificial limb (or artificial arm, leg, etc.). Instead, use the term prosthetic limb. You may also describe someone as receiving prosthetics care (American Academy of Orthotists and Prosthetists, n.d.).
- Do not assume that everyone with limb loss uses prosthetics or uses them all of the time.
- Do not assume that all people who use prosthetics share the same experience. People have different reasons for using prosthetics, not all people who use prosthetics are amputees, and people have different feelings about their prosthetics.
- When writing about prosthetics, avoid ableist language that promotes an ideal of someone with all natural limbs (Shew, 2023). While some prosthetics aim to look more and more like a human limb, the cosmetic aspects may be unimportant to some. For example, some people may choose to use less high-tech prosthetics like hooks due to ease of use or prefer not to use prosthetics.
- Prosthetics should never be described as completing a person.

Tools and resources

Against Technoableism – Disability Deep Dive Podcast (Disability Rights Florida)

Against Technoableism: Rethinking Who Needs Improvement (W.W. Norton & Company)

Prosthetics and Orthotics — Limb Deficiencies (International Organization for Standardization)

Terms and Conditions: Why Language Matters After Limb Loss (Amplitude)

Acknowledgements

This section was co-created at CAMH with patient advisors from the Patient Advisory Committee. Contributions and review were also made by staff from the Collaborative Learning College; Patient & Family Education and Mental Health Literary, Education at CAMH; Research – Education; the Office of Health Equity; and Equity & Engagement – Provincial System Support Program.

The Language Guidelines

Language affecting people with visual disabilities

People who are blind tend to prefer person-first language. Visual disabilities exist on a spectrum, and people may use various terms to refer to themselves, depending on their abilities and identity (CNIB, 2024):

- **People who are blind:** Refers to people who cannot see. Some people with mild to severe vision disability use the term blind as an umbrella term and see this as part of their identity.
- **Deafblind or Deaf-blind:** Preferred term of many people who are both Deaf and blind and who belong to the Deaf community.
- **People with low vision / people who are partially sighted:** Refers to people who have some sight.
- **People with sight loss:** Refers to people who were not born with a visual disability but acquired one later.
- **People who are affected by blindness / impacted by blindness:** Includes family members and support systems for people who are blind.

Language to avoid

- Avoid the outdated term “the blind.” It is associated with paternalistic systems, which means systems dedicated to charity and care without inclusion and collaboration with people who are blind (CNIB, 2024).
- Don’t use identity-first language as the default. Some people prefer identity-first language (e.g., blind person), but most of the community prefers person-first language.
- Avoid idioms that use blind or sight-related metaphors (e.g., blind spot, turn a blind eye).

Tools and resources

Your Words Have Power: CNIB Inclusive Language Guidelines

Acknowledgements

This section was informed by *Words Matter: CNIB Inclusive Language Guidelines*. It was co-created at CAMH with patient advisors from the Patient Advisory Committee. Contributions and review were also made by staff from the Collaborative Learning College; Patient & Family Education and Mental Health Literary, Education at CAMH; Research – Education; the Office of Health Equity; and Equity & Engagement – Provincial System Support Program.

Language affecting d/Deaf and Deafblind people and people with hearing loss

Many people who are deaf prefer identity-first language (i.e., deaf person), but preferences may differ on whether the word deaf is capitalized. There are also different terms related to levels of hearing loss and the ways it may co-occur with other disabilities. These terms reflect distinct cultural groups and experiences, so accurate language in your writing is important (Canadian Association of the Deaf, 2015).

It is equally important to avoid inaccurate, outdated and offensive language, such as referring to a deaf person as mute or dumb because this is rooted in the false assumption that deaf people cannot speak. Deaf people communicate in many ways, such as through spoken language, Sign and other forms of expression.

Capitalization

- Some people use Deaf with a capital D (Canadian Association of the Deaf, 2015; Khalifa, 2018). This includes people who:
  - are strongly involved in the Deaf community
  - may have attended Deaf school
  - consider Sign to be their first language or preferred language
- Some people use deaf with a lowercase d. This includes people who:
  - are medically deaf but do not necessarily interact with the Deaf community
  - may or may not speak Sign

  Use of the lowercase does not mean that the experience of someone who uses the lowercase d is less important or valid than the experience of someone who uses the capital D. Instead, the capital indicates a specific cultural experience and identity.
- The term Sign language is always capitalized even if the type of Sign language (e.g., American Sign language) is not specified.

- Sign is considered the equivalent of "English language" or "French language" in terms of capitalization.

Accurate language about hearing loss

These terms are primarily from the Canadian Association of the Deaf terminology page.

- **Deaf:** A person with little to no hearing.
- **Hard of hearing:** A person with partial hearing loss, ranging from mild to profound; their main form of communication is spoken language.
- **Deaf-blind or Deafblind:** A person who is both deaf and blind. People who have other co-occurring disabilities or diagnoses tend to use "deaf with" (e.g., deaf with intellectual disability, deaf with bipolar disorder).
- **Deafened:** Refers to hearing loss that has occurred later in life.

Language to avoid

Examples are drawn from the Canadian Association of the Deaf terminology page and Eversa's Towards an Inclusive Language for Deaf, DeafBlind and Hard of Hearing Individuals.

- **Hearing-impaired:** This term is no longer acceptable to the Deaf community.
- **Deaf and dumb / deaf and mute:** These terms are offensive to the Deaf community. Use the word non-speaking to refer to someone who doesn't communicate with their voice, or describe how they communicate (e.g., they are Deaf and speak Sign).
- **Deaf plus:** This term was once used to mean deaf with another disability, but the preference now is to specify the disability.
- **Person who is deaf:** Most people don't find this term offensive, but identity-first language is the preference.
- **Fall on deaf ears:** This idiom uses deafness figuratively. Instead, use "not listening."
- **A deafening silence:** This idiom uses deafness for emphasis. Instead, use "a complete silence."

- **Tone deaf:** This term, especially when used in slang to mean an insensitive comment, uses deafness in a negative way. Instead, use the word inappropriate.

Tools and resources

Terminology page (Canadian Association of the Deaf)

Towards an Inclusive Language for Deaf, DeafBlind and Hard of Hearing Individuals (Eversa)

Acknowledgements

This section was co-created at CAMH with patient advisors from the Patient Advisory Committee. Contributions and review were also made by staff from the Collaborative Learning College; Patient & Family Education and Mental Health Literary, Education at CAMH; Research – Education; the Office of Health Equity; and Equity & Engagement – Provincial System Support Program.

Language affecting people who are institutionalized

Many equity-denied communities have experienced a difficult and painful history with institutions such as hospitals, schools, child welfare and the justice system.

Hospitals for mental health and substance use, including CAMH, also carry the ongoing history and weight of people being confined in psychiatric institutions against their will. When writing about institutionalization, be aware that some groups have experienced trauma related to institutionalization motivated by colonial systems, war, discrimination or genocide. For some groups, these experiences continue in the form of overrepresentation in institutional systems.

In general, writing should use a trauma-informed and healing-centred approach. Each person brings their own experiences, history and trauma with them, so it is important to keep language respectful, gentle and compassionate.

Communities that have trauma histories due to institutionalization

Many communities have experienced trauma due to institutionalization or forced confinement, including Indigenous Peoples, Black communities, people with disabilities, neurodivergent people and people with mental health or substance use concerns (LeFrançois, 2013). These experiences may live on as intergenerational trauma. For example, some Japanese-Canadian and Jewish people carry trauma related to family members who were confined in internment or concentration camps. Other people who have immigrated to Canada have trauma histories connected to war, genocide, institutionalization or forced confinement in the countries they left behind.

In Indigenous communities, many people have personal, familial or ancestral experiences of forced confinement in Residential Schools and Indian Hospitals (McGuire & Gudgihljiwah, 2022). Before and during the Sixties Scoop, many Indigenous children were taken from their parents and adopted by non-Indigenous families (Quinn et al., 2022).

Best practices for writing about institutionalization and trauma

- Use healing-centred language to avoid retraumatization (see Principle 6: Use Healing-Centred Language).
- Avoid sensationalism, which includes using graphic or upsetting details for entertainment.
- Be specific and direct about what occurred because institutions have often denied or failed to acknowledge these colonial harms over the years, leading to additional trauma (see Principle 1: Decolonize Language).
- Be specific about the population you are writing about (e.g., someone who is Japanese and has always lived in Japan does not have the same history with internment camps as someone who is Japanese-Canadian with family members who were interned in World War II).
- Name the systems and mindsets that caused the harms (e.g., colonialism, scientific racism, systemic racism, ableism, sanism). You may want to use the term colonial trauma" when referring to trauma caused by settler colonialism, depending on your audience (McGuire & Gudgihljiwah, 2022).
- Do not write as if all people of that population carry this trauma or feel the same way about it because every person is different.
- Be mindful that for certain groups, trauma persists in policies, practices and institutional interactions. For example, in health care settings, transgender and nonbinary patients still experience trauma and distress through misgendering and being forced into binary ways of thinking (Pilling, 2022).
- Recognize community movements and organizations such as the Indian Residential School Survivor Society that are working to address historical harms and heal trauma.

Best practices for consulting people with trauma related to institutionalization

Consultation and co-creation are beneficial when writing about people whose experiences are not your own, but conversations about colonial and institutional trauma can retraumatize people. Using healing-centred language practices establishes a safer space for this work:

- Do research before approaching a consultant. There are many firsthand accounts of traumatic experiences in institutions:
  - Many disability rights groups have written extensively about the harms done to disabled people by the medical system. (See The Social Model; Respect Nothing About Us Without Us; Language Affecting People with Disabilities.)
  - Mad scholars and researchers have provided an extensive history, research and documentation of the harms done to Mad and 2SLGBTQIA+ people in the mental health system. (See The Mad Model.)
  - Indigenous writers with firsthand experience of the Sixties Scoop, the Residential School System and Indian Hospitals have written detailed memoirs, contributed to research and spoken about their experiences.
  - These accounts already required labour and reliving trauma. By educating yourself and using these resources to inform your writing, you ensure that this labour does not go to waste and avoid retraumatizing someone else by having them redo this work.
- Be aware of the limits of consultation. Each consultant can speak only about events as they experienced them, not about the collective experience.
  - For example, a First Nations woman whose grandmother's child was taken as part of the Sixties Scoop would be able to speak about her experience in the family but would not have a firsthand account of events. Her grandmother would have a firsthand account but also would have had a different experience than the child or than family members who were able to remain with the family (Morais, personal communication, 2025).

Communities that are overrepresented in institutions

Certain communities, cultures and races are overrepresented in some institutionalized environments. When writing about this disparity, it is extremely important to acknowledge the following experiences:

- Overrepresentation in institutionalized environments is a continuation of historical trauma and colonialism.
  - For example, Indigenous Peoples are overrepresented in the child welfare system in Canada. This is a continuation of trauma from the Residential

School System and then the Sixties Scoop that separated Indigenous parents from their children (Quinn et al., 2022; TVO Today, 2024).

- Inequities exist in how the rules of systems are applied.
  - Indigenous Peoples are overrepresented in the justice system (Department of Justice Canada, 2024). They are also more likely to be accused of crimes due to racism and a long history of criminalizing Indigenous cultural practices (Assembly of First Nations, n.d.; Clark, 2023).
  - Black people are overrepresented in the criminal justice system and are carded and stopped by police more often than people of other races due to racial profiling (Canadian Civil Liberties Association, 2021; Department of Justice Canada, 2022).
- Experiencing poverty and having fewer economic opportunities are often linked to overrepresentation in the child welfare and justice systems, due to barriers to services and upward financial mobility for equity-denied groups.
- Communities affected by this overrepresentation often have a long history of working to improve or disrupt these systems to create a more equitable world. This commitment is reflected in:
  - restorative justice movements
  - prison abolition movements
  - community-run programs that focus on health
  - community-run child welfare organizations, such as the First Nations Child & Family Caring Society, that help families get the resources they need for their children to grow up within their families and First Nations communities (TVO Today, 2024)

Best practices for writing about overrepresentation in systems

- Use evidence rather than relying on assumptions when making claims about a community's overrepresentation in a particular system because some communities are overrepresented in one system, but not in another. Accuracy is essential in avoiding stereotypes.
- Acknowledge the structural aspects that contribute to the inequities faced by communities overrepresented in institutionalized environments because

ignoring these factors reinforces racial stereotypes (see Language Related to Race, Racism and Ethnicity).

Tools and resources

Anti-Black Racism in Canada's Criminal Justice System Fact Sheet (Canada Civil Liberties Association)

Decolonizing Trauma Work: Indigenous Stories and Strategies (Fernwood Publishing)

Justice & Policing (Assembly of First Nations)

Mad People's Movement: Reclaiming Collective Activist Histories webinar (Transforming Communities for Inclusion – Global)

Overrepresentation of Black People in the Canadian Criminal Justice System (Department of Justice Canada)

Overrepresentation of Indigenous People in the Canadian Criminal Justice System: Causes and Responses (Department of Justice Canada)

Trauma Informed Practice Guide (BC Provincial Mental Health and Substance Use Planning Council)

Truths of Institutionalization: Past and Present online course

Why Are Indigenous Children Overrepresented in Canada's Child Welfare System? (TVO Today)

Acknowledgements

This section was co-created at CAMH with patient advisors from the Patient Advisory Committee, Shkaabe Makwa and the Forensic Psychiatry Division. Contributions and review were also made by staff from the Collaborative Learning College; Patient & Family Education and Mental Health Literary, Education at CAMH; the Office of Health Equity; and Equity & Engagement – Provincial System Support Program.

Language related to criminal justice and forensic mental health

Language and incarceration

This section draws on the work of Tran et al. (2018).

The stigma surrounding incarceration is deeply rooted in language. Terms like correctional and penitentiary carry historical baggage—evoking forced labour and religious punishment—that reinforce moral judgement. Even respected institutions such as the World Health Organization have used stigmatizing terms such as prisoner, inmate and offender, contributing to the normalization of dehumanizing language.

Inclusive, person-centred language is essential in correctional health and social services because word choices affect well-being, dignity and access to care for people who are incarcerated. Common terms like criminal, felon or offender are often biased and reinforce harmful stereotypes.

This matters because people who are incarcerated already face higher rates of physical and mental health issues, as well as barriers to care due to stigma and discrimination. Labelling people by their legal status perpetuates their exclusion from social and economic opportunities and undermines recovery, reintegration and health equity.

Using person-first language—such as “person who is incarcerated”—acknowledges the individual beyond their circumstances and supports ethical, recovery-oriented and trauma-informed care. It also helps shift public attitudes and policy toward more inclusive, humane approaches to justice and health.

Some people may use reclaimed language or terms organizations should avoid to self-describe, such as inmate. Respect the language they use when quoting individual people because language choice often reflects their perspectives and experiences.

Language and forensic mental health settings

This section draws on the work of Penney et al. (2025).

Inclusive and unbiased language is essential in forensic mental health settings because the words we use have a significant impact on people, clinical care and legal outcomes. People often face double stigma stemming from both a mental health diagnosis and a history of involvement with the criminal justice system. The language used to describe and document their experiences plays a powerful role in shaping how they are perceived and treated.

Terms like criminally insane are outdated and stigmatizing, suggesting dangerousness and moral failing. In contrast, legally accurate terms such as not criminally responsible on account of mental disorder (NCR) are less judgemental and better reflect the clinical and legal context.

The language used in documentation also shapes attitudes and decisions. Research shows that exposure to biased clinical notes can make clinicians less likely to provide best-practice care or support therapeutic leave, which can hinder recovery. Clinical documentation also informs legal decisions about a person's liberties. Biased language can lead to a cascading bias, where negative framing follows the person through years of care and assessment.

Forensic mental health settings often prioritize risk reduction, which can lead to people being perceived mainly in terms of the risks they pose. Using recovery-oriented and strengths-based language helps to balance this emphasis by fostering hope and engagement. Stigmatizing language can limit access to housing, employment and services after release. Inclusive language is not just respectful—it is essential for ethical, accurate and person-centred care. Table 21 presents stigmatizing language and more accurate alternatives.

Navigating tensions between inclusive language and legal or clinical terminology

There are times when inclusive, person-first language conflicts with terminology used in legal or clinical contexts. One example is the term dangerous offender,

which is a formal legal designation under the Canadian Criminal Code. In Ontario, it is used to identify individuals who have been deemed by the courts to pose a significant and ongoing risk to public safety.

While legally accurate, this term does not align with person-first or recovery-oriented language and may contribute to stigma. In clinical and support settings, staff are encouraged to use person-first alternatives whenever possible—for example, referring to "a person designated as a dangerous offender" rather than using the label itself. However, when preparing formal reports or communicating within legal or statutory frameworks, it is necessary to use terminology as defined in current legislation to ensure legal clarity and precision.

Good/bad as moral judgement

Words like good and bad are commonly used to describe people and behaviour in criminal justice and forensic mental health settings, but their use extends beyond legal or clinical contexts. They are used in everyday language to make moral judgements about a person's character, worth or behaviour. For example, framing people as good immigrant versus bad immigrants, good people who change their lives versus bad people who do not or good girls who conform to patriarchal expectations versus bad girls who resist them reflect value judgements.

These narratives are not neutral; they are rooted in white, heterosexual, cisgender, middle- or upper-class, male, Protestant social norms. People who do not conform to these norms may be misrepresented, devalued and differentiated (Cerda-Jara et al., 2019). Avoid this kind of reductive language in any context and use respectful, accurate and descriptive language instead.

Table 21
Respectful language for writing about criminal justice and forensic mental health

Language to avoid	Language to consider	Why?
prisoner, inmate, convict, con, thug, felon	incarcerated person, person currently incarcerated, person detained, person in	These alternative terms make no claim about guilt or innocence (unlike convict), and they do not attach a permanent

criminal, offender	custody, person in detention/jail/prison person involved in the criminal justice system	identity to an often-temporary status (like prisoner). Defining people by their crime or legal status is unhelpful.[a, b]
violent offender drug offender sex offender repeat offender dangerous offender	person convicted of violent offences, person with a history of violence person convicted of drug violations person convicted of a sexual offence, person with a history of sexually offending behaviour person with multiple convictions person designated as a dangerous offender	Calling people violent offenders or drug offenders reduces their identity to a particular conviction. It is rarely necessary to specify the type of crime, in which case person-first language should be used.[a, b]
mentally ill offender, offender with schizophrenia	person with a mental health condition who has been charged with an offence, person with schizophrenia who has been convicted of an offence	Use person-first, recovery-oriented language.
criminally insane	person found not criminally responsible on account of a mental disorder (NCR-MD)	This is the correct legal term using person-first language.
prostitute or prostitution	person involved in sex work, or in sale or trade of sexual services; sex worker (A child cannot be considered a sex worker because this is sexual abuse of a minor.)	This refers to people voluntarily engaged in any legal or illegal work that centres around sex. It excludes exotic dancers who do not engage in off-stage sex work, as well as sex trafficking survivors.[a, b]
child prostitute	sex with an underage person, non-consensual sex, child	These alternatives clarify the exploitative or abusive nature

	who has been trafficked, child who has been raped	of the act, rather than implying agency on the part of the child.[b]
date rape, acquaintance rape	rape, sexual assault	The term date rape implies that this type of assault is somehow different or less serious than rape. It is better to name the crime directly.[b]
sex assault victim	sexual assault survivor	This refers to anyone who has experienced molestation, rape or other types of sexual assault. This experience does not make people victims (a passive identity) but survivors (an active identity).[a]
victim of sex trafficking	sex trafficking survivor	Sex trafficking survivors are also sexual assault survivors, with the added trauma of being kidnapped and exploited. They are often incarcerated for the very acts they were forced to do, exacerbating a cycle of abuse. Not all sex workers are trafficked, so don't conflate the two.[a]
guard, white shirt, blue shirt	correctional officer, corporal, sergeant, deputy superintendent	These terms are outdated and create a class division between those with power (white shirts, blue shirts) and those without (blue shirts, people who are incarcerated). Use accurate terms that reflect the person's role in the institution.
violent communities, bad or disadvantaged neighbourhoods	communities that experience high rates of violence	Labelling a community as violent demonizes everyone within it instead of highlighting systemic factors that cause a

		community to repeatedly experience trauma.[a]
violent vs. non-violent crime	Describe the event as specifically as possible.	Violent vs. non-violent crime is a pseudo-dichotomy. This binary oversimplifies complex behaviours, ignores systemic harms and misrepresents the true level of danger. Many "non-violent" offences cause devastating harm, while many legally "violent" acts involve no physical injury.[a]

[a] Cerda-Jara et al. (2019); [b] Penney et al. (2025).

Acknowledgements

This section was contributed at CAMH by the Forensic Equity, Diversity and Inclusion Documentation Working Group composed of members from the Forensic Psychiatry Division and the Empowerment Council, which advocates for people with lived experience of substance use and mental health concerns in Toronto and at CAMH. This project aims to address bias in clinical documentation that can affect people in the forensic system.

Language affecting people who are unhoused

The use of the term unhoused instead of homeless is a more recent shift toward inclusive language, driven by activists and members of communities disproportionately affected by housing instability (Kerman, n.d.). This change reflects a more compassionate approach and acknowledges the broader issues of housing insecurity and the lack of affordable housing in Canada (see Table 22).

Table 22
Respectful language for writing about people affected by housing insecurity

Language to avoid	Language to consider	Why
homeless	unhoused	The word homeless implies that the person is without a home or place of comfort. Some people feel this, but others have found spaces of comfort that are not conventional homes, such as their community, encampments or shelters.[a, b] This language also puts focus back on the housing crisis.
homeless person	person who is unhoused, person experiencing houselessness, person affected by the housing crisis, person experiencing housing insecurity unhoused person	Person-first, descriptive language centres the person while shifting the focus to the housing crisis.[b] Use the identity-first term unhoused people/unhoused person in direct quotes or if someone indicates that's how they would like to be referred to.

[a] Kerman (n.d.); [b] Ward King (2025).

Avoiding stereotypes about people who are unhoused

Be aware of stereotypes and myths about people who are unhoused because they invalidate their experiences.

Myth: Experiencing houselessness is within a person's control.

Fact: People in Canada are living through a time with less affordable housing and increased housing insecurity. Many situations can contribute to houselessness. Usually, a lack of social and system supports are bigger factors than the person's choices.

Myth: All people with mental health or substance use concerns have experienced houselessness.

Fact: Mental health and substance use concerns are complex, and there is no one way that someone who experiences them will live.

Myth: People become unhoused due to their mental health or substance use concerns.

Fact: Mental health or substance use concerns may contribute to experiences of houselessness, but this is not true for everyone.

Myth: Being unhoused exposes a person to substance use.

Fact: There are some environments where people may be exposed to more substance use, but the places where people live are very diverse (e.g., some people live in a community, some live alone, some use shelters, some sleep in camps). There is no way to predict substance use based on a person's housing situation.

Best practices for avoiding stereotypes about people who are unhoused

- Be specific about factors that contributed to someone being unhoused.
- Describe where a person who is unhoused lives rather than using generalizations or just saying they're homeless or living on the street.
- Support all claims about people who are unhoused with evidence.
- Acknowledge the systemic challenges and barriers to affordable housing that people face.

Tools and resources

Homeless, Houseless, and Unhoused: A Glossary of Terms Used to Talk About Homelessness (Blanchet House)

Acknowledgements

This section was co-created at CAMH with patient advisors from the Patient Advisory Committee. Contributions and review were also provided by staff from the Collaborative Learning College; Patient & Family Education and Mental Health Literary, Education at CAMH; the Office of Health Equity; and Equity & Engagement – Provincial System Support Program.

Language related to employment and work: Sex workers

When writing about types of employment and work, include sex work. Whether they disclose or not, people who access mental health and substance use services may include sex workers. This can involve a range of specializations such as erotic dancing (i.e., stripping); escorting; sugaring or sugar dating (i.e., developing a partnership where gifts and money are exchanged for companionship); taking erotic or sexual photos or videos; giving intimate massage; or doing live video sessions online.

All of these forms of work should be respected as legitimate work. People who do sex work are often excluded in discussions about employment, or their work is seen as illegitimate, which means they have less protection and safety (Bruckert et al., 2013).

Best practices for writing about sex work

When you are writing about sex work, approach it in a similar way to any other job—as something the person does rather than who they are (Otmar, 2023). When writing about one person, use person-first language unless you know that the person identifies as their job title (e.g., they describe themselves as an adult entertainer instead of someone who works in adult entertainment; see Principle 5: Use Dignity-First Language). When writing about workers as a group, you can use either sex workers or people who do sex work, with sex workers being the more common and accepted usage by people in the field. Table 23 provides examples of respectful, accurate language.

Table 23
Respectful language for writing about sex work

Language to avoid	Language to consider	Why
prostitution as an umbrella term	sex work	The term prostitution refers to only one type of sex work.

	When referring to one person or one type of work, be specific about that work.	Prostitution has become a stigmatized term and is more likely to tie the work to an image of crime.[a]
prostitute	If referring to someone who provides companionship (sexual or otherwise), use terms such as escort, service escort, service provider or other terms that clarify the type of arrangement (e.g., sugar baby). If referring to sex work in general, use terms such as someone who does sex work, sex worker, service provider or other terms specific to the type of work.	Terms like sex worker and service provider shift the focus to employment and work.
stripper	someone who works as an adult entertainer (or adult dancer), adult entertainer, adult dancer	The word stripper focuses only on the sexual aspect of the work, whereas adult entertainer focuses on the entertainment aspect and adult dancer focuses on the skillset. Some people identify with their work and don't mind being called an adult entertainer. Others prefer to separate their work from their identity.
low-class/high-class or dirty/clean to describe types of sex work	Describe the specific type of work.	These descriptors put value judgements on the type of service and increase stigma, especially about certain types of sex work.

[a] Bruckert et al. (2013).

Challenges and barriers faced by sex workers

When you are writing about people who do sex work, focus on systemic barriers to safety and support that they face. Shifting the perspective in this way also helps to challenge stereotypes (see Table 24).

Various social and structural challenges are associated with sex work:

- Sex work is stigmatized in society.
- People who do sex work have to decide whether it is safe to disclose their type of work.
- Engaging in health care or support services can often lead to unwanted conversations.
- There is a lack of resources to support sex worker safety.
- Sex work lacks regulation.
- Working irregular or long hours is common for some types of sex work.
- Some clients of sex workers take advantage of the lack of support that sex workers get, leading some sex workers to be harmed during work.

Table 24
Strategies for avoiding stereotypes about sex work

Stereotype	Fact	Writing guidance
The only type of sex work is escorting.	Escorting is the most high-risk form of sex work. Using this term associates all sex work with high levels of risk. Not being specific erases other forms of work and ignores various skills involved in the industry. This stereotype reinforces stigma about sex work and different types of sex work.	Be specific about the type of sex work you are describing. Do not use the words prostitute or prostitution to describe all types of sex work. Use the umbrella term sex work or sex work industry. Use person-first language to write about a specific person.

The Language Guidelines

Sex work is non-consensual.	Some non-consensual sex work does exist and some people may have these traumatic experiences, but most sex work is consensual. Many sex workers engage in the profession by choice and have many reasons for choosing this field, as with any profession.	Avoid representation of trafficking and non-consensual sex work unless that is your focus or you are representing or quoting someone with that experience. Do not make assumptions about why someone does sex work. Represent sex work as you would any other job.
All people who do sex work use substances or do sex work to fund their use.	Some people who do sex work use substances, but not all do. For sex workers seeking treatment for substance use, focusing only on their profession can miss other factors that contribute to substance use. People who do sex work have various experiences and attitudes toward substance use, just like people in any profession.	Do not only represent sex workers as using substances or having substance use concerns. If representing someone who has substance use concerns and is also a sex worker, make the case more realistic by including other risk factors.
Sex work causes trauma and mental health concerns. People who have mental health concerns or a trauma history will get involved in sex work.	Some people who do sex work have mental health concerns and seek treatment. This does not mean that sex work is a cause or a result of trauma or mental health concerns. Some sex workers experience trauma due to the nature of the work (especially the lack of protection), but don't make assumptions about what has triggered the trauma or mental health concerns.	Do not represent all sex workers as experiencing trauma or mental health concerns. If representing someone with trauma or mental health concerns who is a sex worker, make the portrayal more realistic by including other risk factors. Think about other professionals whose work may involve risk, such as nurses and first responders. Reflect on whether you would write the same way

		about them and make adjustments that show respect and dignity.

Best practices for promoting sex worker inclusion

Writing in a way that shows that you respect sex work as a profession helps to establish trust and create a sense of safety for people who are sex workers.

- Consult with people who do sex work and who are involved in community sex worker action projects.
- Don't assume that someone has not engaged in sex work because not everyone discloses this.
- When providing a list of example professions, include sex work as an option.
- When discussing different communities and populations, include sex workers.

  Example:

  You are running a drop-in information session about schizophrenia resources. On your poster, you write:

  We are holding a community information session for adults with schizophrenia. We will have resources for students, non-profit workers, corporate workers, migrant workers, sex workers, volunteers, caregivers and family members.
- Use clear, trauma-informed language about procedures, boundaries and consent. Many sex workers have experienced boundary violations, so it is important to describe physical interventions and what rights people have. Where relevant, acknowledge that people have different comfort levels with touch and personal space (see Principle 6: Use Healing-Centred Language).

Tools and resources

Butterfly Asian and Migrant Sex Workers Support Network

Language Matters: Talking About Sex Work (Stella Montreal)

Maggie's Toronto Sex Worker Action Project

Acknowledgements

This section was co-developed with members of Maggie's Toronto Sex Worker's Action Project and at CAMH with members of the Patient Advisory Committee and staff from Patient & Family Education and Mental Health Literacy, Education at CAMH.

Language related to employment and work: Migrant workers

Migrant and short-term international workers are often not included in discussions about work and employment, labour rights or occupations even though in Canada they make up between one and four per cent of paid workers a year—and up to 18 per cent of workers in some industries (Government of Canada, 2024). Migrant workers deserve to be recognized, treated equitably and represented using respectful language (Migrant Rights Network, 2026).

Best practices for writing about migrant workers

- Never use the word alien.
- Use the term migrant worker, not foreign worker.
- Use the term migration or labour migration, not labour import/export (TRIANGLE in ASEAN, n.d.).
- Consult with migrant workers if you are writing about work or labour rights.
- Do not devalue the work and contributions of migrant workers.
- Avoid stereotypes when you describe migrant workers.
- Include occupations such as domestic worker, farm/agriculture worker and care worker in examples or lists of jobs people may hold (International Labour Organization, 2025).
- Focus on the dignity, rights and protections of workers instead of immigration status and legality (International Labour Organization, 2025).
- If you must comment on status, use terms such as person without status, undocumented migrant or migrant with irregular status, and avoid the term illegal (TRIANGLE in ASEAN, n.d.).
- Be familiar with legal and institutional terminology:
  - The Canadian government may use the term foreign national for someone without citizenship, approved residency or temporary resident status (Canadian Council for Refugees, 2010).

- The Canadian government uses the terms temporary foreign worker or temporary worker instead of migrant worker, which is often used by rights-focused organizations (Canadian Council for Refugees, 2024; Immigration and Refugee Protection Regulations, 2025).

Tools and resources

Butterfly Asian and Migrant Sex Workers Support Network

Labour Migration (International Labour Organization)

Migrant Rights Network

Migrant Workers Alliance

Mind the Disruption podcast: Disrupting migrant work (National Collaborating Centre for Determinants of Health)

TRIANGLE in ASEAN (International Labour Organization)

Words Matter: Why Is Rights-Based Terminology Seen as Critical? (International Labour Organization, YouTube)

Acknowledgements

This section was co-created at CAMH with patient advisors from the Patient Advisory Committee. Contributions and review were also provided by staff from the Collaborative Learning College; Patient & Family Education and Mental Health Literary, Education at CAMH; the Office of Health Equity; and Equity & Engagement – Provincial System Support Program.

Language affecting people who are unemployed, underemployed or on disability assistance

There is often significant shame attached to unemployment, underemployment or being on disability assistance, even though employment status does not reflect a person's worth or character. This is tied to an assumption that a person's job and productivity are related to their worth. When writing about people in these situations, it is important to avoid stereotypes and use language that is respectful and accurate. While people may not have traditional employment, they contribute to their communities in many meaningful ways.

Best practices for writing about people who are unemployed or underemployed

- Use person-first language (e.g., people who are unemployed, people who are underemployed, people receiving social assistance, people receiving employment insurance; Otmar, 2023).
- Mention that different people have different limitations when it comes to employment (American Psychological Association, 2026). Often, these challenges are not due to unwillingness to work or laziness, but rather the result of systemic limitations or circumstances beyond the person's control.
    - Some people may not be able to work due to mental health or substance use concerns, disability or unpaid caring responsibilities for a family member.
    - Migration status may limit the type of work a person is eligible for.
- Mention structural barriers to gainful employment, especially for equity-denied groups, to avoid stereotypes about employment status and identity factors.
- Acknowledge that some people who are underemployed hold multiple part-time or gig jobs (Otmar, 2023). While this may mean that they work or earn as much or more than someone in a full-time job, it can also reflect unstable or insufficient work, including irregular income, limited benefits and unpredictable schedules.

- Do not conflate employment status with other socio-economic factors, such as level of education, income and social class (Diemer et al., 2012). Someone may be underemployed but still have a high income, or they may be highly educated but unemployed.
- When providing a list of example professions, include different types of employment, including non-traditional forms of employment (e.g., advisor, advocate, volunteer, artist).
- Only describe how a person supports themselves financially (e.g., employment insurance, family support, social assistance) if it is relevant to what you are writing. Otherwise, don't mention income sources.
- If referring to employment insurance, family support, social assistance or another form of financial support from the government, avoid the term welfare (American Psychological Association, 2026; Otmar, 2023).

Best practices for writing about people on disability assistance

- Include people on disability assistance when representing patients, and do so in a way that is meaningful.
- When referring to people on disability assistance, use person-first language, such as "person receiving disability assistance" (American Psychological Association, 2026).
- Avoid stereotypes.
- Consider structural factors such as inaccessible workplaces and lack of accommodations that can limit access to suitable employment.
- Acknowledge that many people who are on disability assistance contribute to their communities in many ways.
- When listing example professions, include non-traditional roles such as advocacy, volunteering and board membership.
- Cite disability activists and advocates when writing about disability.

Tools and resources

APA Style: Socioeconomic status (American Psychological Association)

Class Discrimination and Socio-Economic Status - Inclusive Writing Guide (McGill Library)

Socioeconomic Status (Conscious Style Guide)

Acknowledgements

This section was co-created at CAMH with patient advisors from the Patient Advisory Committee. Contributions and review were also made by staff from the Collaborative Learning College; Patient & Family Education and Mental Health Literary, Education at CAMH; the Office of Health Equity; and Equity & Engagement – Provincial System Support Program.

Language affecting older adults

CAMH uses the term older adults to refer to people aged 60 and above, replacing the terms seniors and senior citizens. However, terminology varies across regions and cultures, and some organizations still use the terms seniors or senior citizens.

Ageism is a form of discrimination that assumes people as less capable because of their age and attaches negative stereotypes to different age groups. Using respectful and accurate language helps to avoid stereotypes and reduces stigma toward people of all ages.

Different cultural views on aging

In Western Eurocentric cultures, older adults often experience ageism, especially through judgements about ability or strength or by ignoring and leaving older adults out of conversations. In comparison, some cultures celebrate older adults, associating age with wisdom, memory and history (Potamianou, 2024). When representing an older adult, be mindful of how different parts of their identity may intersect or change in different spaces (e.g., at home, the older adult is considered the key decision maker for the family, but at the store, a shopkeeper speaks down to them).

Best practices for writing about older adults

- Older adults are often not presented in materials representing the general population, so include them where possible to increase representation.
- Avoid language that reinforces stereotypes about older adults and aging, such as portraying older adults in general as frail, less capable or weak.

Be mindful when using the word elder. Using it as a homogenous label can perpetuate stereotypes of frailty or decline. Try to restrict use of this word to culturally specific contexts (see Shkaabe Makwa Suggests).

Shkaabe Makwa suggests

Use the term Elder carefully

Indigenous Elder is a specific term given to a person by their community because of the spiritual and cultural knowledge that they have. When using the adjective elder (or elderly) to refer to an Indigenous person who is an older adult, you do not have to capitalize the word.

Examples:

"An Elder shares knowledge of cultural protocols during a ceremony."

"Older children often provide care for their elders

Tools and resources

Age-Friendly Communication: Facts, Tips and Ideas (Government of Canada)

Don't call me "old": Avoiding ageism when writing about aging (National Institute on Aging)

Acknowledgements

This section was co-created at CAMH with members the Family Advisory Committee and staff from Shkaabe Makwa, Black Health Strategy, Knowledge Mobilization – Provincial System Support Program, Office of Health Equity, and Inclusivity, Diversity, Equity and Accessibility – People and Experience.

Language affecting infants, children, youth and emerging adults

Ageism is a form of discrimination that assumes people are less capable because of their age and attaches negative stereotypes to different age groups, including infants, children, youth and emerging adults. Using respectful and accurate language helps to avoid stereotypes and reduces stigma toward people of all ages.

Infants and children

At CAMH, there is a growing emphasis on preventive care, early intervention and timely identification of mental health symptoms. Using inclusive language and being mindful of stereotypes related to children and mental health support the well-being of young children and promote awareness of mental care concerns that require intervention. Table 25 lists common stereotypes and more accurate ways of writing about children and mental health.

Table 25
Strategies for avoiding stereotypes about children and mental health

Stereotype/myth	Fact	Writing guidance
Infants and toddlers do not experience mental health symptoms.	Early intervention can make a huge difference for child and youth mental health. Some mental health concerns may appear during infancy and early childhood.	Acknowledge that mental health symptoms can exist even among infants and young children. Highlight that this issue is under-discussed.[a]
The only signs of mental health symptoms in children are challenging behaviours.	All behavioural changes can be a sign of mental health symptoms, even those associated with obedience (e.g., new perfectionism, wanting to please all adults).[b] When evaluating infant and early child mental health, behaviour changes are looked at alongside	Include multiple factors when discussing infant and early child mental health, including caregiver-child dynamics, the environment, culture and behaviour.

	diet, sleep routines, caregiver-child dynamics and environmental and cultural factors.[c]	
Infants and toddlers are not capable of being involved in their care.	Very young children can express preferences through words, sounds, gestures or other forms of communication.[d, e]	When writing about young patients, respect their autonomy and treat them as individuals with knowledge and understanding of their experience, not as extensions of their caregivers.
Children who are struggling with behaviour are "misbehaving," "rude" or "being bad."[f]	All behaviour is a form of communication. Behaviour looks different in many children based on neurotype, experiences or disability.	Validate the emotion and mental health concerns behind the behaviour. Don't use judgemental language to describe behaviour. Acknowledge that there is a difference between behaviours that are typical for children from time to time and behaviours that may be symptoms of mental health concerns.[g]
Children's mental health concerns are "just a phase" or are less significant than concerns that adults experience.[g]	Children's mental health concerns are just as valid as those of adults and discussing them openly increases awareness and reduces stigma.[h]	Never write in a way that dismisses children's mental health concerns. Use validating language instead.

[a] Stygar & Zadroga (2021); [b] ChildPsy Today (2024); [c] Simpson et al. (2016); [d] Coughlin (2018); [e] Lim et al. (2023); [f] Research Centre for Children and Families (n.d.); [g] Canadian Mental Health Association (2025); [h] Fritz (2022).

Youth

Writing openly and without judgement about the vast differences in youth mental health concerns reduces stigma, which may lead to early intervention (Fritz, 2022). Youth, which this guide defines as people aged 13 to 18, are becoming more vocal about their needs and opinions related to their care, but they are not represented with the same seriousness as adults who have mental health concerns.

Best practices for writing about youth mental health

- Avoid the terms childish and childlike as well as the phrase "acting like a child" when describing behaviour.
- Avoid using slang to try to identify with youth. Not all youth use the same slang, and you can offend or alienate them unintentionally. For example, the keynote speaker at a youth conference kept calling the audience kiddos, which participants found infantilizing.
- Avoid stereotypes and provide more specific, accurate portrayals of youth and youth mental health (see Table 26).

Table 26
Strategies for avoiding stereotypes about youth mental health

Stereotype/myth	Fact	Writing guidance
Youth will hate their therapist/have conflict with authority figures. Adult media often portrays therapists as stoic, unkind and automatically disliked by youth.[a]	Many youth are interested in receiving care for mental health or substance use concerns and prefer to be involved in their care. Youth are not resistant to authority figures in general. Like all people, some may feel more or less safe with a therapist or other health care professional.	Don't depict unnecessary conflict or negative attitudes unless it is factually accurate or a direct quote. Balance portraying youth as independent thinkers with acknowledging when family, cultural leaders or community members are integral to their care.
Youth share similar attitudes, concerns and beliefs.	Youth embody the same range of identities and	Represent a variety of identities, communities and perspectives and always be

	communities as adults discussed in this guide. While in some areas, a "youth culture" may evolve where values and politics are united among youth, even these youth have intersectional identities related to race, education, socioeconomic status, sexual orientation and gender.	clear that youth belong to many different communities with diverse backgrounds.
The mental health concerns that youth have are self-centred.	Many youth are concerned with social justice and global issues. Many youth experience mental health concerns specific to the climate crisis, called climate anxiety or environmental anxiety.	Recognize that youth mental health concerns may involve collective stressors (e.g., police violence), systemic discrimination (e.g., due to being racialized) or global crises (e.g., climate change).

[a] Eastonteardrop (2018).

Emerging adults

Emerging adulthood is a distinct developmental stage between adolescence and young adulthood. It is typically defined as ages 18 to 25 years, although some organizations use different age ranges.

There is a lot of pressure on this group to be productive, either in school or through work, and to take early steps toward building a life. Those who cannot work or who struggle with school may be labelled lazy, which can cause further harm to mental and physical health.

Best practices for writing about emerging adults and mental health

Nonjudgemental language helps to support emerging adults as they navigate the transition to adulthood.

- Avoid the term new adult because it suggests that a person has suddenly become an adult, whereas the term emerging adult reflects the process of gradually becoming an adult.
- When writing about emerging adults with mental health or substance use concerns who aren't working or attending school, make it clear that this situation is not due to laziness or a character flaw; instead, emphasize that it reflects what is healthy or possible for them at that time.
- When writing for emerging adults with mental health or substance use concerns, avoid language that puts pressure on them, such as "getting your life together," "getting your life started" and "getting ahead."
- Acknowledge that involvement of family and chosen support systems may be essential for some emerging adults:
    - Use welcoming and inclusive language in event signage, workshops and webinars.
    - If you are tailoring messaging to an emerging adult who is receiving care, consider whether it is appropriate to include a support person, such as a family member, personal support worker or advocate. For example, you could write, "You are welcome to bring a support person to the appointment" or "Please reach out to your counsellor if you need a support person to attend the appointment with you."

Tools and resources

Children and Youth (Mental Health Commission of Canada)

Introduction to Infant and Early Child Mental Health (Sick Kids Hospital)

INNOVATE Research: Youth Engagement Guidebook for Researchers (CAMH)

Talking to Children About a Suicide (Mental Health Commission of Canada)

Acknowledgements

This section was co-created at CAMH with staff from the Margaret and Wallace McCain Centre for Child, Youth & Family Mental Health; members of the McCain Centre Youth Advisory Group and the Family Advisory Committee; and staff from Shkaabe Makwa; Black Health Strategy; Knowledge Mobilization – Provincial System Support Program; Office of Health Equity; and Inclusivity, Diversity, Equity and Accessibility – People and Experience.

Language related to family, caregivers and chosen support systems

The way we write about family, caregivers and chosen support systems can either support or harm the people you are representing and your audience. Relationships are very personal and emotionally charged for many people, and there are many types of support systems that reflect different cultures, preferences and identities (Communicate Health, 2024).

The roles of parents, caregivers and chosen family members are not always clear because one person may have multiple roles. For example, a person can be a caregiver and also chosen family.

CAMH defines family as any person or group that someone considers part of their family or support network. This broad definition includes relatives, partners, friends, co-workers and others who provide meaningful support.

Best practices for writing about family, caregivers and support systems

- Include family and caregivers in communication and in descriptions of patient care to normalize the involvement of support systems in mental health and substance use treatment.
- Do not assume that everyone has the same type of family. Use inclusive language that avoids stereotypes and acknowledges different family structures and support networks (see Table 27).
- Do not assume that everyone feels the same way about their families or caregivers or about their involvement in care and support. For this reason, be careful about using the term loved one to refer to family members because it assumes a universal experience of affection that many people do not share (MacArtney, 2024). For some, family relationships are complicated, distant or abusive. Language that assumes closeness can feel invalidating or triggering. Instead, use neutral descriptions, such as family member or relative.

Table 27
Strategies for avoiding stereotypes about families

Stereotype	Fact	Writing guidance
All family structures include two parents with one parent who is a woman and one parent who is a man.	Family composition varies and can include parents who are single, same-sex, nonbinary, adoptive, platonic or polyamourous.	Use a more open definition of family and include the definition.
Chosen family and families that don't fit the traditional model are less valid and authentic than traditional families.	Someone's closest supports or family can come in many forms.	Recognize that these families and chosen family members play as essential a role in someone's well-being as those with traditional families.
Families that don't fit the traditional model are not as stable as traditional families.	This assumption can harm chosen families and make it difficult to care for someone with mental health concerns. It can cause stress and mental health concerns for people trying to support a family member. Avoid this stereotype when representing families. Just because families may differ from what is considered traditional does not mean a family is unable to provide support, stability and care.	Depict different family structures and consult people from different family structures.

Avoiding stereotypes about parents and caregivers

Stereotypes exist about parents and caregivers of children with mental health or substance use concerns, as well as about parents and caregivers who are themselves experiencing these difficulties. These assumptions lead to unfair judgements about parenting and caregiving ability, involvement or responsibility. They also overlook the complexity of family experiences, caregiving roles and factors that affect mental health and substance use (see Table 28 and Table 29).

Table 28
Strategies for avoiding stereotypes about caregivers of children with mental health and substance use concerns

Stereotype/assumption	Fact	Writing guidance
Parents or caregivers are "that parent" or are "interfering" with their child's treatment	Caregivers who advocate for their children and participate in their care are sometimes viewed as disruptive or overly involved.[a, b] Caregiver inclusion is sometimes not appropriate, but it is often essential for effective care planning and coordination.[c]	Acknowledge that caregivers are a key part of the care team and can help fill in treatment gaps, especially for minors. Represent caregivers with both young and adult children to normalize family inclusion in care.
"You don't know how to parent." "Your parenting or choices as a parent cause the behaviour."	While some children do have negative experiences, blaming parents or caregivers can lead to feelings of guilt and shame, increased family conflict, caregiver mental health concerns and more negative perceptions of the child's mental health or substance use concerns.	Be gentle when discussing caregiving. Many caregivers are coping with shame, guilt and stress. Acknowledge the cause of the concern (e.g., environmental, unknown) and emphasize that the caregiver is not the cause. Even if a caregiver may have contributed to the concerns, use judgement-free language.
"Your child is misbehaving."	Behaviour is communication. It is more useful to describe the specific behaviour because doing so focuses on the root of the behaviour and finding solutions.	Don't equate meltdowns or emotional dysregulation with misbehaving. Describe the behaviour, rather than using judgemental language.[d] Be gentle, acknowledging that both caregiver and child are experiencing intense emotions.

[a] Turner (2025); [b] Urone et al. (2024); [c] Saxena et al. (2013); [d] Research Centre for Children and Families (n.d.).

Table 29
Strategies for avoiding stereotypes about caregivers with mental health or substance use concerns

Stereotype	Fact	Writing guidance
A person with mental health and substance use concerns is not fit to be a parent.	Experiencing mental health or substance use concerns does not mean that a person is unable to care for their child.	Write about periods of hospitalization or treatment as the caregiving is taking care of their health and well-being. Never write or imply that they are unfit, "being a bad parent" or have morally failed. Avoid judgemental language when discussing caregivers with mental health or substance use concerns. Wherever possible, reflect that a caregiver looking after their health is a positive step for their child as well.
Caregivers who use substances are exposing their children to a rougher life and are morally corrupting their children.	People use substances for many reasons, and not all use leads to a substance use disorder or the need for treatment. Some substances are legal to use recreationally while others are not. Legal status can change. Legality does not mean something will cause more or fewer substance use concerns.	Never use language that implies moral judgement about substance use.

Tools and resources

When a Parent or Caregiver… series (CAMH)

Acknowledgements

This section was co-created at CAMH with staff from the Margaret and Wallace McCain Centre for Child, Youth & Family Mental Health; members of the McCain Centre Youth Advisory Group; and members of the Family Advisory Committee. Consultation was also provided by Shkaabe Makwa; the AMANI Mental Health & Substance Use Program; Knowledge Mobilization – Provincial System Support Program; the Office of Health Equity; and Inclusivity, Diversity, Equity and Accessibility – People and Experience.

The Effective Writing Guidelines

Introduction

The Effective Writing Guidelines contain writing, referencing and style tips for everyone working in communications at the Centre for Addiction and Mental Health (CAMH). They are not intended to contradict any of the inclusive language recommendations from the *Clear and Inclusive Writing Guidelines*. Instead, they update our house style and promote cohesion across the hospital so that our communications have consistency and one CAMH voice.

These guidelines do not apply to fundraising materials produced through the CAMH Foundation. They apply to public communications, educational material, and research reports and communications.

Clear writing of health materials

Clear writing helps you to develop material that is easily understood by the intended audience. It is efficient and accessible, and builds trust and transparency with your readers. The following best practices can guide you in the process:

- Know your audience. CAMH serves many different communities, which means that you will need to consider many different communities in your writing. With your project team, make sure to identify your audience. Tailor language to meet the needs of health care professionals, patients, caregivers and policy-makers.
- Use plain language. Avoid jargon or overly technical terms unless they are necessary. Always provide clear definitions when you are using complex terminology. Define abbreviations and acronyms in parentheses the first time they are mentioned, even for units of measurement.
- Avoid ambiguity. Each term should have only one interpretation. Define terms precisely but concisely. For complex concepts, always provide examples or additional context.
- Strive for inclusivity and accessibility. Follow guidelines such as these and make sure to consult with members of any of the identity groups or communities you are writing about.

- Collaborate with subject matter experts to verify accuracy and ensure the reliability of information. Back all definitions and references with current, credible sources (e.g., peer-reviewed journals, official guidelines).
- Be consistent. Use these guidelines to maintain a uniform style. You can also set up team or project guidelines to provide consistency. An editor can assist you with processes. (See Setting Up a Style Sheet.)
- Work with a designer. A graphic designer or digital design professional will help you to make sure your documents are accessible and easy to read. This process will often reveal areas where writing needs to be shortened, clarified or structured differently to meet the needs of the audience.

Disclaimers and notes about language

You will likely be writing for a large audience, with people from many backgrounds, perspectives and professional disciplines. At the beginning of the document, you can include a language disclaimer or note that outlines:

- what language choices you have made
- why you have chosen the words you have
- how to submit feedback on language

Editorial process

- Follow a clear and consistent editorial process and establish it as early in the project as possible.
- Where possible, consult with other editors about processes and challenges.
- If no internal editors are available, consider hiring an external editor.
- Discuss language choices, organization, audience and voice.

Audience, tone and voice

Consistency of voice refers to the way a writer addresses the audience with the information. The most common voice for communications that we develop at CAMH is either second-person (“You will notice …”) or third-person (“People will

notice …"). Second-person is friendliest; if a piece of writing is instructional in nature, choose this voice. Sometimes third-person is preferable, for example, when you are discussing a topic that may not apply to all readers.

Whatever voice you choose, try to avoid switching back and forth between second- and third-person.

Active and passive voice

Use active voice

Active voice emphasizes the performer of the action. It is clear, concise and direct.

Example: The nurse administered the wrong medication to the patient.

Passive voice emphasizes the receiver of the action, rather than the actor. It can be weak, wordy or vague.

Example: The wrong medication was administered to the patient.

Use passive voice selectively

Passive voice is appropriate in the following situations:

- When the actor is unknown, irrelevant or obvious.

  Example: Mindfulness meditation has been adapted to treat anxiety.
- When the recipient of the action is the main topic.

  Example: Insulin was first discovered in 1921.
- When you want to avoid blaming or hostile language.

  Example: Our expectations of this workshop aren't being met.
- When the writing needs variety.

  Example:

  Instead of: We discussed the writing guidelines for several weeks. We are now finalizing them. We will update them regularly.

  Write: We discussed the writing guidelines for several weeks. They are now being finalized and will be updated regularly.

Use active voice to challenge systems of oppression

Using active voice is especially important when discussing forms of oppression, such as racism, because it can function as an accountability mechanism. Passive voice can obscure the systems that perpetuate racism, whereas active voice requires that they be named (Black et al., 2022).

- *Passive:* Indigenous Peoples were relocated to uninhabitable land and many still live in areas with fewer resources.
- *Active:* Colonial settlers relocated Indigenous Peoples to uninhabitable land through force or treaty agreements. When the Government of Canada was established, it continued to relocate Indigenous Peoples and prevent them from living on their homelands.

Tone and voice for internal staff communications

Use plain language to make sure staff of all positions and backgrounds can easily read and understand the message.

The tone of your writing should be:

- friendly
- light (not too serious or heavy)
- to the point and direct

When appropriate, you can:

- include jokes that can be understood by the general CAMH staff population
- be clever and witty
- be playful

Avoid:

- stereotypes and stigmatizing or sanist language
- political statements, especially about funders, political figures or situations in Ontario

The Effective Writing Guidelines

When possible, use the second-person voice (addressing the audience as “you”). This helps you connect with your audience and shows how your message is relevant to them.

Tone and voice for public communications

Public communications at CAMH include social media, public health materials, website copy and press releases. Be sure to use plain language and keep concepts as concise and clear as possible.

The tone of your writing should be:

- friendly (e.g., do not use jargon or condescend to the reader)
- engaging
- credible (e.g., all claims should be something that can be supported by evidence)
- slightly more formal for press releases or formal announcements (on social media and elsewhere)

Avoid:

- stereotypes and stigmatizing or sanist language
- political statements, especially about funders, political figures or situations in Ontario
- jokes or quips because they might not resonate with some people in this broader audience
- overly technical language
- extensive detail

The voice you use may vary depending on the focus of the material. For instance, if you are writing about a specific clinic at CAMH, third-person may be most appropriate, but second-person may be better for an event announcement.

The Effective Writing Guidelines

Tone and voice for educational resources and training

Educational materials may be for the public, patients or families, or for a specific population of professionals. Knowing your audience will help you determine the appropriate tone and level of language. For the most part, use plain language and define specialized terms.

The tone of your writing should be:

- approachable
- confident
- informative

Avoid:

- stereotypes and stigmatizing or sanist language
- condescending language (instead, reinforce learners' existing knowledge)
- jokes or quips because they may not resonate with all learners

Educational materials often use both second- and third-person within the same resource, depending on the focus of the section. For example, use third-person for the main text and second-person for elements such as side bars that contain practice tips or instructions. First-person is appropriate when writing as a character, and for testimonials, dialogue or someone talking about their experiences. Don't alternate between the two points of view in the same section.

Tone and voice for research reports and communications

Depending on the audience, you may be able to use a higher vocabulary level, but your audience will still come from a broad range of cultural backgrounds, abilities and proficiency in English. Define terms wherever possible and keep sentences clear and well organized.

The tone of your writing should be:

- formal
- clear

- direct
- informative

For journal articles and conference presentations, refer to the style criteria of the journal or conference. Review other published articles to help you establish the appropriate tone for your writing.

In terms of voice, use third-person for reports and apply it as consistently as possible.

Avoiding plagiarism

Plagiarism means directly or indirectly using someone else's work or ideas without giving them proper credit (Scribbr, n.d.). It is important to give credit because it:

- acknowledges that the work is someone's intellectual property
- shows that you want to give credit to those who have created work before you
- improves your credibility as a writer
- helps people find more information, which in turn can continue to build knowledge

Usually, plagiarism is caused by rushing. It can occur when you are attempting to paraphrase content (e.g., writing an evidence brief, summarizing a theorist) or when you forget to include a citation. You have also plagiarized if you have reused your own past work without giving credit to the original source or if you use text-generation tools without providing a note or citation for the tool.

Best practices for avoiding plagiarism

Here are tips for avoiding plagiarism throughout the writing process.

Planning phase

Plagiarism often occurs when time does not allow for careful review of sources.

- Plan time to organize sources and review referencing.
- Identify content that may require permission to use.

Research phase

Plagiarism can occur when in-text citations or reference lists contain incorrect information. Tracking your sources will help and will also speed up the citation and referencing process so it is not an afterthought.

Track sources, including:

- authors
- titles
- content you may want to directly quote
- specific evidence
- page number
- URL or DOI

Use a tracking tool or spreadsheet if you need to keep track of many sources.

Drafting and development phase

Properly citing sources throughout the writing process and obtaining permissions when needed will help to avoid plagiarism and save time.

- Cite all the sources you use (e.g., article, book, website, presentation, AI tools) (see In-text citation and reference lists).
- Cite material that is informed by another source (see In-text citation and reference lists).
- Don’t cite common knowledge because it is generally known. Anything that is not common knowledge will likely need to be cited.
- Use your own words unless you are directly quoting from a source. Even if you paraphrase someone else’s work, you must cite it.
- Include the page number for directly quoted content.
- For directly quoted content under four lines, put quotation marks around it, followed by the citation with page number.
- For directly quoted content that is four lines or longer, indent it to set it apart from the main text. End with a period and then the citation and page number.

- Seek permissions if you are including diagrams, tables, images or large sections of writing that are not your own:
  - Ask an editor for assistance with this process if you need it.
  - Consult with your leadership about a budget for permissions.
  - If permission is granted, include language provided by the publisher.
  - If you do not receive permission, ask the publisher if you can adapt the material, and include adaptation language if the publisher provides it.
  - If permission to adapt is not granted, rework the material you are developing without that content.
- In some situations, permission is not required, but even then, always acknowledge the source. You may not need to get permission in these situations:
  - the material is in the public domain, which means that the copyright has expired (typically 70 years after the author has died)
  - you are using the material for specific purposes such as research, private study or education, and have met the criteria for fair use or fair dealing. This principle allows only limited use, typically short excerpts of text.
  - the material is licensed under Creative Commons, which grants the public permission to use the material under specified conditions (e.g., non-commercial use only)
  - the material is produced by the federal government
- Include a reference list at the end of the document that includes all the sources you have cited.

Editing phase

Having time for review helps to make sure all evidence from your sources is integrated and that it is presented in your own words.

- Flag any claims or other content that is missing citations.
- Rework sentences for order, flow and clarity to help avoid copying the structure of your source material.

- Make sure every source in the reference list is cited in the text, and vice versa.
- In reference lists, only include sources that you cite in the text (unlike bibliographies, which also list sources that were consulted but not used).
- Make sure all references in the list have all necessary parts.
- Working with an editor or having someone else review your work will help you avoid plagiarism.

Tools and resources

Access Copyright

Plagiarism Quick Guide (Scribbr)

Mechanics of style

This section describes spelling, formatting, punctuation and other elements that make up the CAMH style to ensure consistency in your writing. These style guidelines are adapted from the most recent version of the *Publication Manual of the American Psychological Association* (APA 7th; 2020), which reflects changes in the publishing world and the field of psychology. We have adapted the style to match best practices across CAMH and the Canadian context.

Where guidance is not provided, consult your editor, establish guidance for your team or project (see Setting Up a Style Sheet) or check with the guides and tools we mention in Other Guides to Consult on Writing and Language Rules.

Spelling

We use Canadian spelling at CAMH, so ensure that your spell checker, language settings and other assistive tools for writing and editing are set to English (Canada).

Here are some overarching rules in Canadian spelling:

- Include the “u” in honour, behaviour, favourite, colour, etc. (e.g., cognitive-behavioural therapy).
- Do not include the “u” in honorarium/honoraria.

- Use practise with the “s” as a verb and practice with the “c” as a noun (e.g., The students practised clinical skills. The doctor opened his practice late.). Similarly, use “defense” as a verb and “defence” as a noun.
- Double the letter “l” before the -ing or -ed ending for most verbs that end with an “l” (e.g., labelling, counselled).
- Use “ize” and “yze,” as in realize, analyze, paralyze.
- Use “re” not “er” in centre, fibre, metre, theatre.

When writing about specific communities, follow the spelling conventions they use or ask if there is a reason for a specific spelling (e.g., Wholistic vs. holistic).

CAMH spelling

Here is a selection of preferred spelling at CAMH:

- acknowledgement
- antiracist
- health care (as both a noun and an adjective; e.g., health care professional)
- judgment
- nonbinary
- per cent (use % in data-heavy documents)
- side effects
- well-being

For other words, use *Canadian Press Caps and Spelling* (Canadian Press, 2022) for general spelling and use APA 7th spelling and hyphenation principles for clinical terms.

The Effective Writing Guidelines

Titles and headings

Headings should be as consistent as possible. They can be complete sentences, sentence fragments or questions. Avoid end punctuation in headings except for question marks (Accessibility Standards Canada [CAN-ASC], 2025).

Higher-level headings should be as descriptive as possible (e.g., “Common Methadone Side Effects” rather than “Side Effects”). This is another example of being specific, and it makes it easier for the reader to navigate through a website or document.

Levels of headings

Try to use as few levels of headings as possible. Information that is organized more than three heading levels deep can become confusing for readers (CAN-ASC, 2025).

Title and heading tags and build-in styles

It makes it easier for the reader to navigate your document if the heading levels you use are clear. This is especially important for people who may be using screen readers and other assistive devices.

Microsoft Word has built-in styles that you can apply (e.g., Heading 1, Heading 2). These labels are particularly helpful for editors, typesetters and designers to understand the structure of your document. For digital documents, this also makes the sections easier to navigate for someone using assistive technology.

For print-only materials, if you do not use the built-in styles, make sure that each heading level you create looks different so that readers can follow the heading hierarchy.

For digital documents, courses and webpages built with code, use code tags to distinguish titles, headings and heading levels. For more information, visit the Web Accessibility Initiative’s tutorial on page structure.

The Effective Writing Guidelines

Capitalization of titles and headings

For standardization, CAMH has changed its capitalization of titles to title case (also called up style) to be consistent with other updated style guides, common practice and the CAMH website (APA, 2020). Headings continue to be sentence case (also called down style) as it is the most accessible option for people who use screen readers or who have certain disabilities that affect reading like dyslexia (CAN-ASC, 2025). Use of title case mid-document can disrupt the flow of reading.

While title case on occasion is okay, never use headings in all uppercase or small caps. Many screen readers will read each individual letter separately rather than the word or may mistake the words for acronyms. It is also harder to visually distinguish letters in this style.

Titles use title case

For titles, use title case (e.g., Common Methadone Side Effects).

- To use title case, capitalize the first letter of every major word (i.e., nouns, verbs, adjectives, adverbs).
- Do not capitalize minor words (i.e., conjunctions, articles, prepositions) unless they are five letters or longer.

Headings use sentence case

For all headings and figure and table labels, use sentence case:

- Capitalize only the first letter of the heading (e.g., “Side effects in older adults”).
- Capitalize proper nouns.

Capitalization

The new CAMH style, like APA 7th, remains a down style. This means that we tend not to capitalize terms based on importance. Instead, we follow grammatical rules of capitalization. However, we do capitalize certain terms when we write about equity-denied groups or people from these communities. This practice reflects equitable, inclusive language.

- Capital letters should only be used for proper nouns, such as names of people and places, brand names, and names of departments or programs.

The Effective Writing Guidelines

- In the name of a program, project or department, only capitalize words that are officially part of the name, not an additional word that explains what it is; for example, Gambling, Gaming and Technology Use (GGTU) program; Policy, Education and Health Promotion division; Immigrant and Refugee Mental Health Project (IRMHP).
- Capitalize a job title if it is the person's official title and also precedes the person's name (e.g., President Sarah Downey said …).
- Do not capitalize a job title if it is descriptive and comes after the person's name (e.g., Sarah Downey, president of CAMH, said …).
- Avoid putting a job title before a person's name with the exception of leadership titles such as president or prime minister (e.g., Prime Minister Mark Carney).
- When used in a signature, conference program and corporate communications, capitalize job titles (e.g., Jess Taylor-Calhoun, Communications Coordinator, Education).
- All treatments, diagnoses, procedures, therapies and therapeutic processes are down style unless they contain a proper noun (e.g., Socratic questioning not Socratic Questioning or socratic questioning; Down syndrome not down syndrome, autism not Autism).
    - The exceptions to this are scales and measures, which are often trademarked and proper nouns.
    - Some communities may also capitalize certain identity terms such as Autistic, Mad or Deaf. If you are writing about or quoting members of those communities, use the conventions they are using.
    - Capitalize important terms as defined by specific communities, as seen in this guide. For example, Indigenous style capitalizes important cultural and spiritual terms, and terms related to Traditional Knowledge, such as Pow Wow or Elder.
- Capitalize all countries, nationalities and ethnicities (e.g., Chinese, American).
- Capitalize Black and Indigenous, but lowercase white.

The Effective Writing Guidelines

Punctuation

CAMH style tries to be light on punctuation:

- Do not use the serial comma (Oxford comma) unless necessary. For example, write "Our clinic offers counselling, family support and child care."
  - If your list is longer than one line, consider using a serial comma.
  - Include the serial comma if omitting it will cause confusion:

    Example: "We consulted the patient's parents, the nurse and the social worker." Without the serial comma, it is unclear whether the parents are a nurse and a social worker or whether they are other people. Adding a serial comma makes it clear that the sentence refers to more than two people: "We consulted the patient's parents, the nurse, and the social worker."
- Insert one space, not two, after periods, colons, semicolons and question marks before starting a new sentence.
- Use the semicolon rarely. Instead try writing shorter, clear sentences.
- Use the word and instead of the ampersand (&) except if the ampersand appears in proper nouns and in referencing or graphics.

Quotation marks

- Use double quotation marks for a direct quote under 40 words.
- Use single quotation marks for quotations within quotations.
- When possible, don't use quotation marks for emphasis because it can distract the reader. If you need to emphasize words or phrases, use italics.
  - Be aware that putting words in quotation marks can indicate sarcasm, imply inferiority or convey a negative tone. Ask yourself whether the word or phrase needs to stand out and why. It may be more appropriate to use italics or to simply keep the text plain.

  - Use double quotation marks to separate words or phrases from the text when you are referring to them reflectively (e.g., “Quotation marks” refers to marks showing that something could be attributed elsewhere).
- Put periods and commas inside closing quotation marks.
- Put colons and semicolons outside quotation marks.
- If you have the choice, use “smart” (curly) quotation marks.

Dashes and hyphens

- Use em-dashes (long dashes that take the space of the letter M) to separate text, with no spaces on either side of the dash—like this.
- Use en-dashes (short dashes that take the space of the letter N) to separate numbers to indicate a range, with no spaces between the numbers and the dash (pages 31–34). It is preferable to use “to” in main text, except in material containing many references to measurements.
- Use numerals and dashes with abbreviations (6–15 mg/mL), but spell out numbers when not using abbreviations (six to 15 milligrams per millilitre).
- For a range of years, use an en-dash rather than a solidus (forward slash) to separate the years (2024–2025, not 2024/2025).
- Do not use hyphens to create em-dashes or en-dashes. Select the appropriate punctuation mark from the symbol list or use the keyboard shortcut:
  - em-dash: For PC, use Ctrl+Alt+num - (minus sign) in Microsoft Word. For Mac, use option+shift+- (hyphen)
  - en-dash: For PC, use Ctrl+num - (minus sign). For Mac, use option+-(hyphen).
  - You should be able to customize your shortcut keys on most programs and can adjust them if the shortcuts do not work.

Bulleted and numbered lists

We have changed our bulleted list style to match common practice across CAMH and to align with APA 7th. This means that some bulleted lists no longer use end punctuation.

Here are best practices for using lists in your writing projects:

- Decide what type of list is best. A numbered list is better when the order of items is important, for example, if you are giving step-by-step instructions. Use unnumbered bulleted lists if the order isn't important.
- If you use a numbered list, you may need to indicate how you ordered the items (e.g., in sequence, by importance).
- For unnumbered lists, consider organizing items alphabetically. If you don't use alphabetical order, you may need to explain the order you chose.
- Opt for several shorter, well-organized lists instead of one long list with different bullet levels. These are easier to read.
- Use parallel construction within a list, which means that each list item follows the same grammatical structure (e.g., all items are nouns or action sentences).
- With the exception of headings, always precede a list of bullets with a colon.

Bulleted lists when each item is a phrase

When the list items are not complete sentences, the first word of each item is lowercase. Don't use commas or semicolons after each item.

Here are examples of numbered and unnumbered bulleted lists.

Descriptions can be found in:

- books
- manuals
- brochures
- news releases

The Effective Writing Guidelines

Editors proceed through different rounds, each with a different focus:

1. Development and depth
2. Overall structure and organization
3. Sentence structure and flow
4. Grammar, clarity and style

Bulleted lists when each item is a sentence

When list items are complete sentences, use normal sentence style. (Capitalize the first word and place a period at the end of each item.) Introduce this kind of list with a complete sentence or put the list directly after the heading.

Here are examples of each option.

Working with an editor has several benefits:

- They can advise on organization.
- They can give insight on the writing and revising process.
- They can add professionalism and clarity to your language.
- They can flag inclusive language concerns and suggest alternatives.

Benefits to working with an editor

- They can advise on organization.
- They can give insight on the writing and revising process.
- They will be able add professionalism and clarity to your language.
- They can flag inclusive language concerns and suggest alternatives.

Bulleted lists when there is no lead-in sentence

If the list falls under a heading (i.e., it does not complete a lead-in sentence), capitalize the first letter of each item, whether it is a full sentence or not. Do not add a colon after the heading that introduces the list.

Here is an example:

Learning objectives

- Define antidepressants.
- List four common antidepressants.
- Explain the benefits of antidepressants.
- Describe possible side effects of antidepressants.

Other punctuation rules

- Use square brackets for parentheses inside parentheses.
- Telephone numbers follow Bell style: no parentheses/hyphen with area code, but use a hyphen for remaining numbers: 416 535-8501, 1 800 463-6273.

Crediting sources

Citing and referencing is essential for building knowledge and giving credit to people whose work has informed your own. It allows readers to validate your claims and to build on their own knowledge as well. (See Avoiding Plagiarism.)

In the past, the CAMH style only used an in-text author-date method similar to APA 7th for citing sources, but numbered styles using superscript with a numbered reference list have become more common. This section includes the new CAMH style recommendations for particular types of written products.

The Effective Writing Guidelines

In-text citations and reference lists

For all documents, we recommend following these guidelines when you are developing in-text citations and reference lists.

- List sources in an in-text citation alphabetically, not by year or relevance, for example, write (Taylor-Calhoun, 2011; Zerman, 2024).
- If you are citing material that is informed by another source, list the secondary source in the reference list and add "as cited in" in the in-text citation to acknowledge the original source (e.g., Taylor-Calhoun, 2011, as cited in Zerman, 2024).
- Place reference lists at the end of the document.
- In the reference list, include only sources that you cite in the text.
- Unless you have used a numbered referencing style (see For brief, public-focused projects), list the references alphabetically by author last name.
- Place references that don't provide an author name at the top of the list and organize them alphabetically by title. In some instances where no author is provided, the organization or publisher can be listed as the author.
- For a numbered reference style), list the references sequentially by the order in which the sources first appear in the text, not alphabetically (see For brief, public-focused projects). The reference number should match the number in its corresponding in-text citation.

For longer, more academic projects

- Use in-text citations in the format (Author last name, year), placing them after the first claim derived from that source. (See Figure 1 on p. 20.)
- For in-text citations with two authors, list both last names and join them with an ampersand (e.g., Taylor & Calhoun; see Figure 2 on p. 20).
- For in-text citations with three or more authors, provide the first author name followed by et al. (See Figure 3 on p. 20.)
- Try to place in-text citations at the end of the sentence to avoid interrupting the flow of the content.

- For a source that applies to an entire paragraph, place the in-text citation after the first claim, not at the end of the paragraph.

Figure 1
Anatomy of an in-text citation with single author

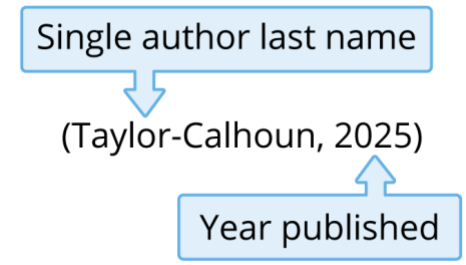


Figure 2
Anatomy of an in-text citation with two authors

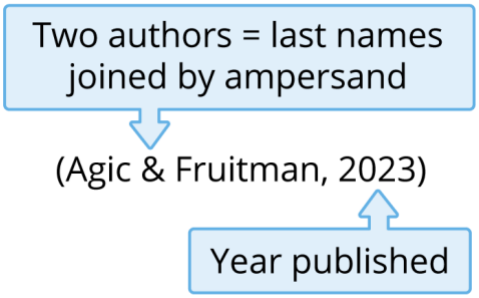
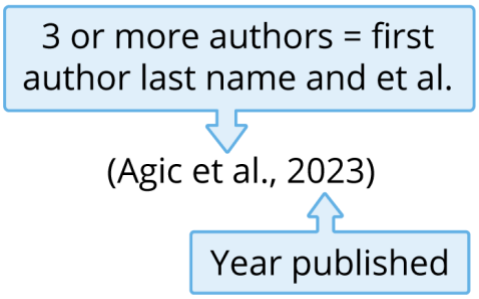


Figure 3
Anatomy of an in-text citation with three or more authors



The Effective Writing Guidelines

- To reference a book, include Author last name, first initial. (year). *Title.* Publisher.
- For a stand-alone document, like a PDF, follow the same format as for a book. (See Figure 4.)
- To reference a chapter in a book by the same author, include Author last name, first initial. (Year). Minor title. *Major Title* (pp. #s). Publisher. (See Figure 5 on p. 22.)
- To reference a chapter in an edited book, include Author last name, first initial. (year). Minor title. In Editor first initial and last name (Ed.), *Major Title* (pp. #s). Publisher. (See Figure 6 on p. 22.)
- To reference a journal article, include Author last name, first initial. (year). Article title. *Journal Title, volume*(issue), pp#. DOI or URL. (See Figure 7 on p. 22.)
- Use down style for anything that is a minor title (e.g., article, chapter) and Up Style for anything that is a major title (e.g., book, journal, PDF document).
- In the reference list, include the first six authors followed by et al. if there are seven or more authors.
- For other formats and reference types, refer to APA 7th.

Figure 4
The anatomy of a reference for a stand-alone document

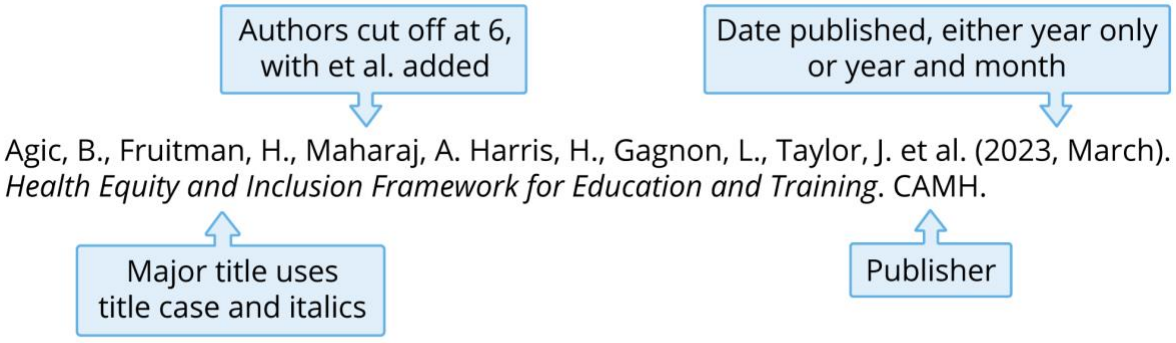


Figure 5
The anatomy of a reference for a book chapter (same author)

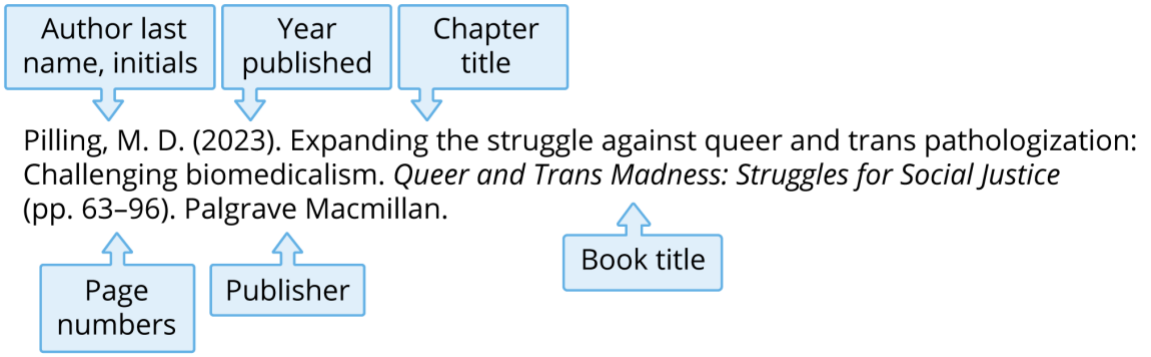


Figure 6
The anatomy of a reference for a chapter from an edited book

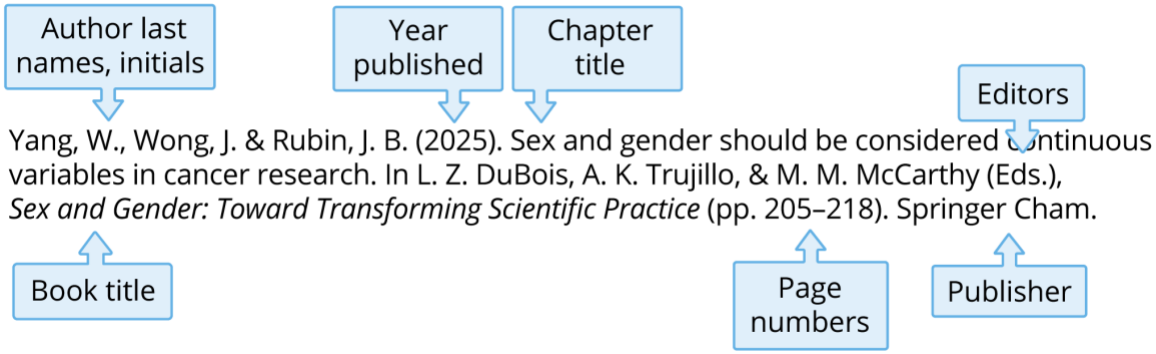
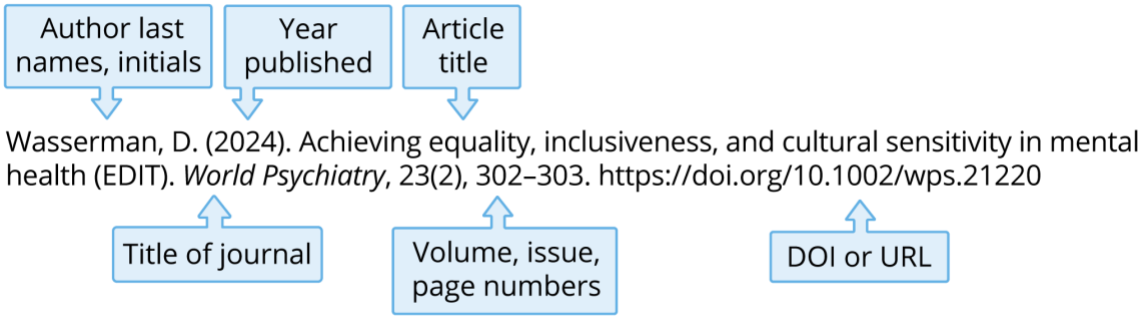


Figure 7
The anatomy of a reference for a journal article



The Effective Writing Guidelines

For brief, public-focused projects

While citations in longer documents use the typical author-year style with parentheses, as suggested by APA 7th, the norm at CAMH for material written for patients and families or the public is to use a numbered style similar to Vancouver style (International Committee of Medical Journal Editors, 2026) or the American Medical Association (2020) style guide.

- Assign consecutive numbers to each new source used in the text, and use that number each time you cite that source.

  Example: Cognitive-behavioural therapy has been proven to work in as little as a single session for specific phobias.[1] A recent study found that one session can reduce fear of heights,[2] and other research shows that it is effective for different age groups.[1]
- Superscript numbers go after periods and commas, but before colons and semicolons.
- Organize items in the reference list in the same order that they are cited in the text and use the same numbers.
- Follow the formatting instructions described in In-text citations and reference lists.

For social media and blog writing

- Use hyperlinks to refer to the original source or to support your claims.
- Put quotation marks around information that is being put in exact words to make it clear that it's quoted, and also provide a hyperlink.
- Try to provide a reference list at the end.

Setting up a style sheet

It may be useful to set up a style sheet for material that you are developing. This is a set of internal guidelines that helps you and your team be consistent in your writing.

Here are elements to include in the style sheet:

- specific word choices (e.g., use “youth service provider” not “youth therapist”)
- specific spelling (e.g., use “cognitive-behavioural therapy” instead of “cognitive behavioural therapy”)
- formatting choices (e.g., left align content in tables)
- technological tools or software to be used (e.g., AI, reference management software)
- references to consult
- process descriptions
- any style exceptions

Other guides to consult on writing and language rules

If you have questions about your writing or about language rules, these guides may help:

- *Canadian Press (CP) Stylebook:* The standard for media and communications writing in Canada, focusing on Canadian spelling, grammar and language usage
- *Oxford Canadian Dictionary:* Focuses on spelling, word usage and grammar
- *Publication Manual of the American Psychological Association* (APA), 7th edition: Historically, many of CAMH’s styles came from earlier versions of this guide. The guide gives advice on citation and referencing for a wider variety of sources than is included in our guide. APA also publishes a dictionary of clinical terms.
- *The Canadian Writer’s Handbook*: Offers guidance on academic and professional writing, including structuring clear, well-organized content and citing sources properly.

Acknowledgements

This section was co-created at CAMH with members of the Patient Advisory Committee and staff from Public Affairs; Editorial – CAMH Publications and Patient & Family Education and Mental Health Literacy; 9-8-8 Suicide Crisis Helpline; Education Research; and Library & Archives at CAMH.

Technological Considerations

Introduction

There are several options for incorporating technology into your writing. Artificial intelligence (AI) drafting software has become popular for brainstorming, drafting and supporting people who experience cognitive fatigue. Referencing and editing software can assist with organization and consistency and speed up the revision process. All of these tools are a support, not a substitute for human expertise. Instead, they allow you to focus your time on ensuring that the work is accurate, clear, inclusive and appropriate for the intended audience.

Artificial intelligence

Health care organizations have been exploring the integration of AI for improving health outcomes, and many communication professionals are integrating AI into their brainstorming, writing or editing processes. CAMH is in the process of developing a policy governing the use of AI at the hospital, as it continues to be clear and transparent in its belief that AI will support consistent care, improve access to information and speed up the development of programs, research and resources.

We encourage you to consider how AI may affect your writing projects:

- Be aware of the limitations of any AI tools you are using (e.g., potential for generating misinformation, referred to as hallucinations).
- Consult your organization's AI policies and follow guidance from the *Publication Manual of the American Psychological Association* (2025) for citing AI content.
- Discuss the use of AI and set up specific guidelines about when and how you will use it on team projects.
- Use or create fact-checking processes for all evidence provided.

- Be transparent about your use of AI because many people have concerns about:
  - the environmental effects of AI
  - the lack of compensation for artists and writers when training AI
  - privacy issues
  - accuracy of material generated by AI

Writing, editing and referencing software

Different non-AI software exists that may improve accuracy, quality and speed of creation. As with using AI, it is important to know the limitations of the tools you use so that you can identify errors. For instance, referencing software may misread numbers related to year, journal volume or page number, and put them in the incorrect order. We do not endorse any specific software, but here is a list of writing, editing and referencing software that may support your work.

- Overleaf: If scientific references require LaTeX for formatting, this tool can be helpful.
- Zotero or Mendeley: These tools are useful for managing citations and building a shared library of resources.
- PerfectIt: This tool allows you to upload style guidelines or build house style rules that can be flagged by software such as a spell checker. You can also use this tool to flag language choices (e.g., certain spelling, or replace the word therapist with clinician).

Using technology for accessibility and accommodations

For people with disabilities or people who are neurodivergent, AI can assist with cognitive load, such as overcoming drafting blocks or generating structural suggestions. Here are writing and editing tools that may be particularly helpful for people who need this kind of support:

- GrammarlyGO/Grammarly Business: This AI-powered editing tool improves grammar, tone, clarity and concision, which may be helpful for people who are

neurodivergent or who want support to ensure their writing uses an appropriate tone.

- ChatGPT and Microsoft Copilot (OpenAI-based): These tools provide drafting, brainstorming, summarizing and rewording support. They require significant human oversight for fact-checking and ensuring context.
- QuillBot: This tool paraphrases and simplifies text, which is useful for translating dense medical information into plain language.
- AI Scribes (e.g., Nuance DAX, Suki): These AI-powered documentation tools support clinicians by automatically drafting clinical notes from patient conversations. They may also be useful during meetings for people with processing disorders, people who are neurodivergent and people with intellectual disabilities.

Accessibility checkers

There are several accessibility checkers either built into existing writing software or available online. These tools can be used as a quick way to do an initial scan for accessibility issues (CNIB, 2020).

- Microsoft Word built-in accessibility check: This tool scans a document for missing alterative text for images (also called alt text), headings and tags, colour contrast and table set-up. It also explains the issue and suggests fixes.
- Adobe Acrobat accessibility check: This tool scans the document's structure including tags, reading order, headings; non-text content, including image alt text; tables and forms.
- Visme: This tool checks how accessible documents are, including infographics and presentations, to make sure they meet accessibility standards.
- Web Accessibility Initiative: This website lists web accessibility evaluation tools, which help you determine whether web content meets accessibility guidelines.

For more information on heading hierarchy, wording and tagging, see the Effective Writing Guidelines.

Technological Considerations

Using accessible language for digital products

Excerpted from "How to avoid directional text: An accessibility guide for CAMH Education"

When we create digital products, such as online trainings, webpages or PDFs, we need to be mindful of the phrasing of on-screen instructions (e.g., "Click on the tab in the top left of the screen"). This is due to accessibility concerns.

For example, screen readers do not navigate by layout, colour or visual position, and clicking refers to physical movements that might not apply to some learners (Hein, 2025). If we use directions like "on the left," "above," or "green button," we can create issues for users who cannot see the screen, which can cause them to not be able to use the material (Office of Advocacy, n.d.).

A useful accessibility rule is to use directional language that describes the action, not the visual location.

Avoid: click here, see below, on the left, on the right, above, below, hover over.

Instead, use: select, choose, review, explore, reveal, continue.

For colour, do not use this as your main instruction (e.g., select the green button). Add a text element that can be read by a screen reader or more easily interpreted by someone who is colour blind.

Best practices for accessible word-choice in digital products

1. Be action-oriented

   Tell the user exactly what to do using the element's name and be specific. This avoids directional language entirely.

   Instead of this: "Click on the button below the image."

   Try this: "When you're ready, select the Continue button."

   Or: "Learn more by choosing one of the buttons from this list"

2. Focus on function, not location

Ask, "What does this button do?" rather than, "Where is this button sitting?"

3. What to do if a text refers to links on an image

   If users need to interact with a list that corresponds to points in an image, clarify the relationship directly. For example, we might have an image of a patient's room, containing items the learner can select.

   — "Explore the room and select items to learn about each one."

   — "Select an item in the room to learn more."

4. What to do if you need to indicate a specific position on screen

   If you must indicate position, use contextual references rather than visual directions:

   — "Select an item from the Resources menu."

   — "Use the items in the patient's room to learn how they're useful."

Best practices for using video

Whether developing a training or a communications campaign, video can often share ideas with the audience in a captivating way. To be accessible when including video on a webpage or in a course:

- include clear instructions prior to the video, such as how to interact with the video and how to access the transcript
- provide a transcript either on the screen or in a downloadable full-text version
- name the transcript link the same name as the video to help screen readers identify the correct link
- make sure your video's player has closed captions and transcript turned on
- keep the autoplay feature in your video player turned off

Tools and resources

Accessibility for Teams (Digital.gov, U.S. General Services Administration)

Describing alternative input methods (Microsoft Style Guide)

Technological Considerations

How People with Disabilities Use the Web (Web Accessibility Initiative)

How to Test Accessibility Beyond Compliance with Jacob Wood (How to Test Podcast)

Input - typing, writing, and clicking (Web Accessibility Initiative)

Writing for all abilities (Microsoft Style Guide)

Acknowledgements

This section was co-created at CAMH with members of the Patient Advisory Committee and staff from Public Affairs; Editorial – CAMH Publications and Patient & Family Education and Mental Health Literacy; Education Services; Education Research; Simulation and Digital Education; and Library & Archives at CAMH.

Contributors and Contributions

Contributors

The *Clear and Inclusive Writing Guidelines* project was led by:

Emily Foucault, Guidelines Co-Lead Writer & Member, Inclusive Writing Subcommittee, Patient Advisory Committee, CAMH

Andrew Johnson, Guidelines Project Supervisor; Manager, Patient & Family Education and Mental Health Literacy, Education at CAMH

Jess Taylor-Calhoun, Guidelines Project Coordinator & Co-Lead; Editor, Patient & Family Education and Mental Health Literacy, Education at CAMH

Leadership was also provided by members of the Inclusive Writing Subcommittee of the Patient Advisory Committee, CAMH:

Josh Fils

Mary Maio

Kylie Payne

Danielle T

These guidelines are the work of many people who provided expertise, guidance, consultation and review, as well as writing and editing support. Thank you to:

Krystine Abel, Director, Wellness Innovation, Shkaabe Makwa, CAMH

Branka Agic, Independent Scientist, CAMH

Sabeeha Ahmed, Project Coordinator, Office of Health Equity, CAMH

Miguel Amante, Communications Coordinator, Public Affairs, CAMH

Anurada U. Amarasekera, Advisor, Youth Advisory Group, Margaret and Wallace McCain Centre for Child, Youth & Family Mental Health, CAMH

Mirella B, Advocate, Azrieli Self-Advocate Advisory Group, Azrieli Adult Neurodevelopmental Centre, CAMH

Jewel Bailey, Knowledge Broker, Immigrant and Refugee Project, Office of Health Equity, CAMH

Contributors and Contributions

Alanna Bodnar, Self-Advocate, Azrieli Self-Advocate Advisory Group, Azrieli Adult Neurodevelopmental Centre, CAMH

Benn Brisland, Social Worker, Gender Identity Clinic, CAMH

Daniel Buchman, Senior Scientist, Everyday Ethics Lab, Education Research, CAMH

Leslie Buckley, Chief, Addictions Division, CAMH

Zac Caldwell, Manager, Communications, Public Affairs, CAMH

Bart Campbell, Program Engagement Co-Facilitator, Patient & Family Education, CAMH

Julia Clements, HR IDEA Advisor, Inclusion, Diversity, Equity and Accessibility – People & Experience, CAMH

Iris Coates Mccall, Research Analyst, Everyday Ethics Lab, Education, CAMH

Marnie Cornett, Social Worker, Interprofessional Pain and Addiction Recovery Clinic, CAMH

Rossana Coriandoli, Research Methods Specialist, Knowledge Mobilization – Provincial System Support Program, CAMH

Lucy Costa, Deputy Executive Director, Empowerment Council, CAMH

Helen Davies, Manager, Communications and Marketing, 9-8-8 Suicide Crisis Helpline

Mahalia Dixon, Project Manager, AMANI Mental Health & Substance Use Program – Black Health Strategy, CAMH

Melissa Dobson, Member, Family Advisory Committee, CanFASD

Leo Edwards, Senior Diversity and Equity Consultant, Inclusion, Diversity, Equity and Accessibility – People & Experience, CAMH

Christina Foisy, Community Health & Education Specialist (Health Equity Specialist), Equity & Engagement – Provincial System Support Program, CAMH

Marna Forsyth, Member, Family Advisory Committee, CanFASD

Jessica Fulmer, Member, Adults with FASD Expert Collaboration Team, CanFASD

Contributors and Contributions

Heather Gillespie, Patient Advisor, Azrieli Self-Advocate Advisory Group, Azrieli Adult Neurodevelopmental Centre, CAMH

Jennifer Grinfield, Manager, Patient & Family Experience, CAMH

Hinna Hafeez, Senior Health Policy Analyst, Provincial System Support Program, CAMH

Holly Harris, Research Coordinator, Education at CAMH

Claire Hastings, Communications Manager, Public Affairs & Communications, CAMH

Em Hayes, Research Assistant, Margaret and Wallace McCain Centre for Child, Youth & Family Mental Health, CAMH

Daphne Horn, Manager, Library & Archives, CAMH

Oliver Ho, Editor, Patient & Family Education and Mental Health Literacy, Education at CAMH

Kaitlyn Jackson, Program Officer, Clinical Research, Azrieli Adult Neurodevelopmental Centre, CAMH

Denise Johnson, Social Worker, Forensic Equity, Diversity and Inclusion Documentation Working Group, Forensic Psychiatry Division, CAMH

Galit Kaden, Community Health & Education Specialist, Education at CAMH

Tye Kenny, Social Worker, Gender Identity Clinic, CAMH

Anne Kirvan, Advanced Practice Clinical Leader, 9-8-8 Suicide Crisis Helpline

Eleanor Knowles, Editor, Patient & Family Education and Mental Health Literacy, Education at CAMH

Alexandra Lamoureux, Manager, Equity & Engagement, Provincial System Support Program, CAMH

Vincent LeClair, Communications Coordinator, Public Affairs, CAMH

Erin Lee, Communications Coordinator (UX/UI), Simulation & Digital Education, CAMH

Yona Lunsky, Senior Scientist, Dual Diagnosis Research, Azrieli Adult Neurodevelopmental Centre, CAMH

Contributors and Contributions

Taylor Maccarone, Social Work Student, Gender Identity Clinic, CAMH

Brooke Magel, Research Analyst, Education and Bioethics, CAMH

Asha Maharaj, Director, Community and Continuing Education, CAMH

Marissa, Self-Advocate, Azrieli Self-Advocate Advisory Group, Azrieli Adult Neurodevelopmental Centre, CAMH

Christine Miskonoodinkwe Smith, Advisor, Provincial Indigenous Lived Experience Advisory Circle

Hannah Monroe, Community Health & Education Coordinator, Azrieli Adult Neurodevelopmental Centre, CAMH

Chantell Morais, Project Manager, Planning and Strategy, Shkaabe Makwa, CAMH

Kim Mullens, Member, Forensic Equity, Diversity and Inclusion Documentation Working Group and Advanced Practice Clinical Leader, Forensic Psychiatry Division, CAMH

Ayesha Murtaza, Advisor, Youth Advisory Group, Margaret and Wallace McCain Centre for Child, Youth & Family Mental Health, CAMH

Josh Mvunga, Communications Coordinator, AMANI Mental Health & Substance Use Program – Black Health Strategy, CAMH

Allegra Netten, Psychologist, Gender Identity Clinic, CAMH

Aloha Narajos, Youth Engagement Specialist, Margaret and Wallace McCain Centre for Child, Youth & Family Mental Health, CAMH

Sandra Noel, Member, Adults with FASD Expert Collaboration Team, CanFASD

Hetvi Pancholi, Communications Coordinator, Digital, Public Affairs, CAMH

Laura Pastore, Editor, Patient & Family Education and Mental Health Literacy, Education at CAMH

Sean Patenaude, Recovery College Coordinator, Collaborative Learning College, Patient & Family Education and Mental Health Literacy, CAMH

Victor Oliveira Pereira, Self-Advocate, Azrieli Self-Advocate Advisory Group, Azrieli Adult Neurodevelopmental Centre, CAMH

Contributors and Contributions

David Phillips, Knowledge Broker, Knowledge Mobilization – Provincial System Support Program, CAMH

Mary Plasterer, Learning Experience Designer, Education at CAMH

Nancy Poole, Director, Centre for Excellence in Women's Health at the BC Women's Hospital and Health Centre

Maureen Pytlik, Advocate, Azrieli Self-Advocate Advisory Group, Azrieli Adult Neurodevelopmental Centre, CAMH

Terri Rodak, Librarian, Library & Archives, CAMH

Jennifer S, Self-Advocate, Azrieli Self-Advocate Advisory Group, Azrieli Adult Neurodevelopmental Centre, CAMH

Beth Sproule, Scientist, Institute for Mental Health Policy Research, CAMH

Laura Stanley, Communications Coordinator, Planning and Strategy, Shaakbe Makwa, CAMH

Shabnam Sukhdev, Member, Family Advisory Committee, CAMH

Jocelyn Tan, Research Analyst, Azrieli Adult Neurodevelopmental Centre, CAMH

Laura Thibeault, Director, Strategy & Planning, Shkaabe Makwa, CAMH

Kathy Unsworth, Executive Director, CanFASD Research Network

Teresa Vanderpost, Community Health & Education Coordinator, Community & Continuing Education, CAMH

Cindy W, Self-Advocate, Azrieli Self-Advocate Advisory Group, Azrieli Adult Neurodevelopmental Centre, CAMH

Caroline Walker, Community Health & Education Assistant, Collaborative Learning Collage, Patient & Family Education, CAMH

Courtney Weaver, Patient Advisor, Azrieli Self-Advocate Advisory Group, Azrieli Adult Neurodevelopmental Centre, CAMH

Miriam Wohl, Member, Family Advisory Committee, CAMH

Dave Whitton, Editor, 9-8-8 Suicide Crisis Helpline and Patient & Family Education and Mental Health Literacy, Education at CAMH

Contributors and Contributions

Jacob Wolframe, Consultant, Equity Practice – Provincial System Support Program, CAMH

Hema Žbogar, Editor, CAMH Publications and Patient & Family Education and Mental Health Literacy, Education at CAMH

We are also grateful for the collaboration of anonymous advisors from Maggie's Sex Workers Action Project.

Contributions

We thank the following CAMH departments and external organizations for contributing to the *Clear and Inclusive Writing Guidelines*:

The 9-8-8 Suicide Crisis Helpline contributed sections from their *Understanding Suicide* guidelines. The content has been adapted slightly.

York University, the Azrieli Adult Neurodevelopmental Centre at CAMH and the Autism Mental Health Literacy Project Group (AM-HeLP) contributed excerpts from *Mental Health Literacy Guide for Autism*, which were adapted with consultation in this guide.

Inclusion Canada, People First Canada and the Azrieli Adult Neurodevelopmental Centre at CAMH contributed excerpts from *Advancing Accessible Communication for People with an Intellectual Disability*. The content has been adapted slightly.

The Canadian FASD Research Network contributed excerpts from *Language Guide: Promoting Dignity for Those Impacted by FASD*, which have been adapted slightly. *Common Messages: Guidelines for Talking and Writing About Fetal Alcohol Spectrum Disorder* informed the section on fetal alcohol spectrum disorder.

Equity & Engagement in the Provincial System Support Program at CAMH contributed content from *Pronoun and Language Guidelines for Trans-Affirming Workplaces in the Mental Health and Addictions Sector.* The content was adapted slightly with consultation.

The Indigenous Primary Health Care Council contributed the Model of Wholistic Health and Wellbeing and the video of the same title.

Contributors and Contributions

The Needle Syringe Program Community of Practice, EENet, in the Provincial System Support Program at CAMH contributed content from *Briefing Note on Opioid Use Terminology*.

Shkaabe Makwa contributed excerpts from *Literature Review Summary: First Nations, Inuit, and Métis Models of Healing and Wellness*. The content has been adapted slightly.

The Thunderbird Partnership Foundation contributed the First Nations Mental Wellness Continuum. It would like to thank all the individuals, families and communities that donated several hours of their time to participate in the regional focus groups. The insight, advice, knowledge and recommendations generously offered during the discussions are invaluable for the development of public health tools and recommendations focused on supporting the existing strengths and needs of First Nations communities across Canada.

Tungasvivvingat Inuit contributed the figure representing the Inuit Qaujimajatuqangit (IQ) principles that were developed by Inuit Elders and knowledge holders over thousands of years as a living system of knowledge, philosophy, and societal values.

References

References

9-8-8: Suicide Crisis Helpline. (2024). Suicide-Safe Language. https://988.ca/understanding-suicide/suicide-safe-language

Abler, T. (2019). Kanyen'kehà:ka (Mohawk). *The Canadian Encyclopedia.* https://thecanadianencyclopedia.ca/en/article/mohawk

Accessibility Standards Canada (CAN-ASC). (2025). *Plain Language Standard* (CAN-ASC-3.1:2025). https://accessible.canada.ca/standards-and-technical-guides/standards-and-technical-guides-database/can-asc-312025-plain-language

Agic, B., Fruitman, H., Maharaj, A. Harris, H., Gagnon, L., Taylor, J. et al. (2023). *Health Equity and Inclusion Framework for Training and Education*. Centre for Addiction and Mental Health. https://www.camh.ca/-/media/education-files/camh-health-equity-inclusion-education-training2023-pdf.pdf

Akl, E. A., Khabsa, J., Petkovic, J., Magwood, O., Lytvyn, L., Motilall, A. et al. (2024). "Interest-holders": A new term to replace "stakeholders" in the context of health research and policy. *Cochrane Evidence Synthesis and Methods, 2*(11), e70007. https://doi.org/10.1002/cesm.70007

American Academy of Orthotists and Prosthetists. (n.d.). *Do/Don't Language Guide (Quick Reference)*. https://assets.noviams.com/novi-file-uploads/aaop/Advocay_Templates/Language_Guide.pdf

American Medical Association. (2020). *AMA Manual of Style: A Guide for Authors and Editors* (11th ed.).

American Psychiatric Association. (2022). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.).

American Psychological Association (APA). (2020). *Publication Manual of the American Psychological Association* (7th ed.).

American Psychological Association (APA). (2023). *Inclusive Language Guide* (2nd ed.). https://www.apa.org/about/apa/equity-diversity-inclusion/language-guidelines

References

American Psychological Association (APA). (2025, September 9). Citing generative AI in APA Style: Part 1—Reference formats. *APA Style Blog*. https://apastyle.apa.org/blog/cite-generative-ai-references

American Psychological Association (APA). (2026). Socioeconomic status. https://apastyle.apa.org/style-grammar-guidelines/bias-free-language/socioeconomic-status

Americans with Disabilities Act National Network. (2018). *Guidelines for Writing About People with Disabilities*. https://adata.org/factsheet/ADANN-writing

Andrews, K. (2018, August 14). "Urban" sounds: It's time to stop using this hackneyed term for black music. *The Guardian*. https://www.theguardian.com/music/shortcuts/2018/aug/14/urban-time-stop-hackneyed-term-black-music

Archibald, L. (2021, September 23). Mad activists: The language we use reflects our desire for change. *Mad in America Blog*. https://www.madinamerica.com/2021/09/mad-activists-langauge

Archie, A. (2025). How "neurodivergent" became a word for many types of minds. *NPR*. https://www.npr.org/2025/10/29/nx-s1-5585292/word-of-week-neurodivergent

Assembly of First Nations. (n.d.). *Justice & Policing*. https://afn.ca/rights-justice/justice-policing

Atira. (2025). Overdose vs safe consumption sites. https://atira.bc.ca/overdose-vs-safe-consumption-sites

Authentically Emily Blog. (2024, December 4). Autistic joy: My favourite part of autism. https://www.authenticallyemily.uk/blog/autistic-joy

Autism Mental Health Literacy Project (AM-HeLP) Group. (2021). *Mental Health Literacy Guide for Autism*. https://www.yorku.ca/health/lab/ddmh/wp-content/uploads/sites/407/2021/04/Mental-Health-Literacy-Guide-for-Autism.pdf

References

Barry, C. L., Susan G. Sherman, S. G. & McGinty, E. E. (2018). Language matters in combatting the opioid epidemic: Safe consumption sites versus overdose prevention sites. *American Journal of Public Health, 108*, 1157–1159. https://doi.org/10.2105/AJPH.2018.304588

Bath, R. & Willson, M. (2025, May 25). Understanding "Nothing about us without us." Canadian Council on Rehabilitation and Work. https://ccrw.org/understanding-nothing-about-us-without-us

Baynam, G., Boycott, K., Johnson, K. & McKay, L. (2026). Language in rare disease: a call for systemic and empathetic action. *The Lancet, 407,* 1216–1218. https://doi.org/10.1016/S0140-6736(26)00359-4

BC Refugee Hub. (2018). Glossary of terms – refugees and refugee claimants in Canada. https://bcrefugeehub.ca/glossary-of-terms-refugees-and-refugees-claimants-in-canada

Bednarek, M., Bray, C., Vanichkina, D. P., Brookes, G., Bonfiglioli, C., Coltman-Patel, T. et al. (2024). Weight stigma: Towards a language-informed analytical framework. *Applied Linguistics, 45*(3), 424–448. https://doi.org/10.1093/applin/amad033

Black, C., Pondugula, N. & Spearman-McCarthy, E. V. (2022). Words matter: Stylistic writing strategies for racial health equity in academic medicine. *Journal of Racial and Ethnic Health Disparities, 9*(6), 2071–2076. https://doi.org/10.1007/s40615-022-01424-1

Botha, M., Chapman, R., Giwa Onaiwu, M., Kapp, S. K., Stannard Ashley, A. & Walker, N. (2024). The neurodiversity concept was developed collectively: An overdue correction on the origins of neurodiversity theory. *Autism, 28*(6), 1591–1594. https://doi.org/10.1177/13623613241237871

Bottema-Beutel, K., Kapp, S. K., Lester, J. N., Sasson, N. J. & Hand, B. N. (2021). Avoiding ableist language: Suggestions for autism researchers. *Autism in Adulthood, 3*(1), 18–29. https://doi.org/10.1089/aut.2020.0014

Bruckert, C., Caouette, A. A., Clamen, J., Gillies, K., Members of the Downtown Eastside Sex Workers United Against Violence, Kiselbach, S. et al. (2013). *Language*

References

Matters: Talking About Sex Work. Stella. https://www.nswp.org/sites/default/files/StellaInfoSheetLanguageMatters.pdf

Burrage, R., Momper, S. & Gone, J. (2022). Beyond trauma: Decolonizing understandings of loss and healing in the Indian Residential School System of Canada. *Journal of Social Issue, 78*(1), 27–52. https://doi.org/10.1111/josi.12455

CAMH Reconciliation Working Group Land Acknowledgement Subcommittee. (2022). *Guidance for Honouring the Land and Ancestors Through Land Acknowledgements*. Centre for Addiction and Mental Health. https://www.camh.ca/-/media/files/camh-landacknowledgements-2022.pdf

Can, A. T., Lagopoulos, J., Fitzgerald, P. B., Bailey, N. W. & Dutton, M. (2025). Ketamine in psychiatry: Ethical imperatives in harnessing a controversial yet promising therapy. *Australian & New Zealand Journal of Psychiatry, 60*(2), 110–114. https://doi.org/10.1177/00048674251396009

Canada FASD Research Network. (2017). *Language Guide: Promoting Dignity for Those Impacted by FASD*. https://canfasd.ca/wp-content/uploads/2018/01/LAEO-Language-Guide.pdf

Canada FASD Research Network. (2023). *Reporting on Alcohol Use, Alcohol Use During Pregnancy, and Fetal Alcohol Spectrum Disorder*. https://canfasd.ca/wp-content/uploads/publications/Reporting-on-alcohol-use-alcohol-use-during-pregnancy-and-fetal-alcohol-spectrum-disorder-6.pdf

Canada FASD Research Network. (2025). *Common Messages: Guidelines for Talking and Writing About FASD*. https://canfasd.ca/wp-content/uploads/publications/2025-CMG-Refs-Embedded-FINAL.pdf

Canada Research Coordinating Committee. (2025). *Best Practices in Equity, Diversity and Inclusion in Research Practice and Design*. Government of Canada. https://sshrc-crsh.canada.ca/funding-financement/nfrf-fnfr/edi-eng.aspx

Canadian Association of the Deaf. (2015). Terminology. https://cad-asc.ca/issues-positions/terminology

References

Canadian Civil Liberties Association. (2021). *Anti-Black Racism in Canada's Criminal Justice System: Fact Sheet*. https://ccla.org/wp-content/uploads/2021/12/Anti-Black-Racism-Fact-Sheet-2021.pdf

Canadian Council for Refugees. (2010). *Talking About Refugees and Immigrants: A Glossary*. https://ccrweb.ca/sites/ccrweb.ca/files/glossary_en.pdf

Canadian Council for Refugees. (2024). *National Migrant Workers Forum Report*. https://ccrweb.ca/sites/ccrweb.ca/files/2025-05/Migrant%20Workers%20Forum%20Report%202024_EN.pdf

Canadian Cultural Mosaic Foundation. (2018). *Language Decoded: Canadian Inclusive Language Glossary*. https://acaging.ca/wp-content/uploads/2020/12/Language-Decoded.pdf

Canadian Mental Health Association. (2025). Child and youth mental health: Signs and symptoms. https://ontario.cmha.ca/documents/child-and-youth-mental-health-signs-and-symptoms

Canadian Press. (2022). *Canadian Press Caps and Spelling* (23rd ed.).

Canucks Autism Network. (2024). *Autism Language Guide*. https://canucksautism.ca/wp-content/uploads/2024/06/Autism-Language-Guide-March-2024.pdf

Cariou, W., Reder, D., Fountaine, L. S. & Abel, J. (2025a). Editorial relationships. In G. Younging & W. Cariou (Eds.), *Elements of Indigenous Style* (2nd ed., pp. 103–112). Brush Education.

Cariou, W., Reder, D., Fountaine, L. S. & Abel, J. (2025b). Two-Spirit, trans, and Indigiqueer contexts. In G. Younging & W. Cariou (Eds.), *Elements of Indigenous Style* (2nd ed., 121–124). Brush Education.

Carta, A., Fucà, E., Guerrera, S., Napoli, E., Valeri, G. & Vicari, S. (2020). Characterization of clinical manifestations in the co-occurring phenotype of attention deficit/hyperactivity disorder and autism spectrum disorder. *Frontiers in Psychology, 11*, 861. https://doi.org/10.3389/fpsyg.2020.00861

References

Centre for Addiction and Mental Health (CAMH). (2023). *Aging and Mental Health Policy Framework*. https://www.camh.ca/-/media/files/pdfs---public-policy-submissions/camh-aging-and-mental-health-policy-framework-pdf.pdf

Centre for Addiction and Mental Health (CAMH). (2024). *Foundational Knowledge on Anti-Black Racism* [Online course]. https://campus.camh.ca/learn/learning-plans/10/learning-plan-foundational-knowledge-on-anti-black-racism

Centre for Addiction and Mental Health (CAMH). (2025). *Do You Know … Cannabis*. https://www.camh.ca/-/media/health-info-files/publications/cannabis-dyk-flat-2025-pdf.pdf

Centre for Addiction and Mental Health (CAMH). (2026a). *Words Matter: Language Guidelines*. https://www.camh.ca/en/today-campaign/help-and-resources/words-matter

Centre for Addiction and Mental Health (CAMH). (2026b). Alcohol. https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/alcohol

Centre for Addiction and Mental Health (CAMH). (2026c). Psychedelics and mental health: Investigating the evidence. https://www.camh.ca/en/camh-news-and-stories/rsch-psychedelics-and-mental-health-investigating-the-evidence

Centre for Addiction and Mental Health (CAMH). (2026d). Ketamine. https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/ketamine

Cerda-Jara, M., Czifra, S., Galindo, A., Mason, J., Ricks, C. & Zohrabi, A. (2019). *Language Guide for Communicating About Those Involved in the Carceral System*. Underground Scholars Initiative, UC Berkeley. https://americancultures.berkeley.edu/faculty/teaching-resources/language-guide-communicating-about-those-involved-carceral-system

Charlton, J. I. (2000). *Nothing About Us Without Us: Disability Oppression and Empowerment*. University of California Press.

References

Cheves, A. & Lopez, Q. (2025, June 16). 9 LGBTQ+ people explain how they love, hate, and understand the word "Queer." *Them Magazine*. https://www.them.us/story/what-does-queer-mean

ChildPsy Today. (2024, June 1). Early signs of mental health issues in children and how to address them. Child Psychiatry Today. https://childpsy.org/signs-of-mental-health-issues-in-children/

Clark, S. (2023). *Overrepresentation of Indigenous People in the Canadian Criminal Justice System: Causes and Responses*. Department of Justice Canada. https://canada.justice.gc.ca/eng/rp-pr/jr/oip-cjs/e.html

CNIB. (2020). Student research volunteer accessibility training [online]. https://www.cnib.ca/en

CNIB. (2024). *Your Words Have Power: CNIB Inclusive Language Guidelines*. https://www.cnib.ca/sites/default/files/2024-10/24-0432-CNIB_Inclusive%20Language%20Guidelines_ENG_FINAL-s.pdf

Collins, C. (2019, February 11). Is queer okay to say? Here's why we use it. *Learning for Justice*. https://www.learningforjustice.org/magazine/is-queer-ok-to-say-heres-why-we-use-it

Communicate Health. (2024). Inclusive language tips for writing about families. https://communicatehealth.com/wehearthealthliteracy/inclusive-language-tips-for-writing-about-families

Connoy, L. & Webster, F. (2023). Why language matters in chronic pain: the example of pain catastrophizing. *Journal of Pain, 25,* 588–590. https://doi.org/10.1016/j.jpain.2023.12.012

Constitution Act, 1982, s 35, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11. https://laws-lois.justice.gc.ca/eng/const/page-12.html#h-41

Cornum, L. (2017, June 12). How the shorthand term "ndn" signals new ways of conceptualizing Indigeneity. *Real Life*. https://reallifemag.com/domain-name/

References

Coughlin, K. W. (2018). Medical decision-making in paediatrics: Infancy to adolescence. *Paediatrics & Child Health, 23*(2), 138–146. https://academic.oup.com/pch/article-pdf/23/2/138/26677029/pxx127.pdf

CounterPoint News. (2025, April 15). The plantation illusion: How slavery is sanitised and still shapes the present. https://esheru.substack.com/p/the-plantation-illusion-how-slavery

Cox, L. V. (2023). The Eastern Door Center: Re-balancing the wheel: A Two-Eyed Seeing approach to FASD and other disorders related to transgenerational adversity. *Frontiers in Sociology, 8*, 910153. https://doi.org/10.3389/fsoc.2023.910153

Crenshaw, K. (1991) Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*, 1241–1299. http://doi.org/10.2307/1229039

Crowley, A. (2025). "And it just becomes queer slang": Race, linguistic innovation, and appropriation within trans communities in the US south. *Journal of Linguistic Anthropology, 35*(2), e70008. https://doi.org/10.1111/jola.70008

Dahlke, S., Butler, J. I., Hunter, K. F., Toubiana, M., Kalogirou, M. R., Shrestha, S. et al. (2024). The effects of stigma: Older persons and medicinal cannabis. *Qualitative Health Research, 34*(8–9). https://doi.org/10.1177/10497323241227419

Department of Justice Canada. (2022). *Overrepresentation of Black People in the Canadian Criminal Justice System. Justice Research and Data*. https://www.justice.gc.ca/eng/rp-pr/jr/obpccjs-spnsjpc/index.html

Department of Justice Canada. (2024). *Indigenous Overrepresentation in the Criminal Justice System*. https://open.canada.ca/data/info/db4b8d8c-dee2-451b-9ef2-559a8ed702c2

Diemer, M. A., Mistry, R. S., Wadsworth, M. E., López, I. & Reimer, F. (2012). Best practices in conceptualizing and measuring social class in psychological research. *Analyses of Social Issues and Public Policy, 13*(1), 77–113. https://doi.org/10.1111/asap.12001

References

Diversity Style Guide. (2025). White, white. https://www.diversitystyleguide.com/glossary/white-white

Dobson, C. & Schmidt, G. (2015). Traditional carrier approaches to mental health. *Canadian Journal of Community Mental Health, 34*(2), 23–35. https://doi.org/10.7870/cjcmh-2015-018

Duvasic, S. (2022). *Decolonize! What Does It Mean?* Oxfam International. https://oxfamilibrary.openrepository.com/bitstream/handle/10546/621456/rr-decolonize-what-does-it-mean-151222-en.pdf;jsessionid=7358D175CCAA3E61421BC885A4D71B55?sequence=1

Dwornik, A. (2021). The interface of Mad studies and Indigenous ways of knowing: Innovation, co-creation, and decolonization. *Critical Social Work, 22*(2), 25–39. https://doi.org/10.22329/csw.v22i2.7097

Eastonteardrop. (2018, July 11). Mental health tropes in young adult media. *Teardrop Teens Blog*. https://teardropteens.wordpress.com/2018/06/18/mental-health-tropes-in-young-adult-media

Erk, R. R. (1995). The evolution of attention deficit disorders terminology. *Elementary School Guidance & Counseling, 29*(4), 243–248. https://www.jstor.org/stable/42871175?mag=adhd-the-history-of-a-diagnosis&seq=2

Eversa. (2025, January 17). Towards an inclusive language for Deaf, DeafBlind and hard of hearing individuals. https://eversa.co/en/inclusive-language-deaf-deafblind-hard-of-hearing

Feingold, M. (1969). Unusual appearing child. *JAMA Pediatrics, 118*(4), 669.

Feng, Y.R., Krygsman, A., Vaillancourt, T. & Vitoroulis, I. (2023). Experiences of racial microaggression among immigrant and Canadian-born young adults: Effects of double stigma on mental health and service use. *International Journal of Social Psychiatry, 69*(7), 1723–1735. https://doi.org/10.1177/00207640231174374

References

First Nations Health Authority. (2023, April 21). FNHA releases 2022 toxic drug poisoning crisis data. https://www.fnha.ca/about/news-and-events/news/fnha-releases-2022-toxic-drug-poisoning-crisis-data

Fischer, B., Russell, C., Sabioni, P., van den Brink, W., Le Foll, B., Hall, W. et al. (2017). Lower-Risk Cannabis Use Guidelines (LRCUG): An evidence-based update. *American Journal of Public Health, 107*(8). https://doi.org/10.2105/AJPH.2017.303818

Fritz, G. K. (2022, May 5). Stigma and mental illness. Brown University Health. https://www.brownhealth.org/be-well/stigma-and-mental-illness

Future Ancestors Services. (2024). Why we say “in what is currently Canada”? [Social media campaign]. https://www.futureancestors.ca

GLAAD. (2026). Glossary of terms: LGBTQ. *GLAAD Media Reference Guide* (11th ed.). https://www.glaad.org/reference/terms

Goodwin, G. M., Aaronson, S. T., Alvarez, O., Arden, P. C., Baker, A., Bennett, J. C. et al. (2022). Single-dose psilocybin for a treatment-resistant episode of major depression. *New England Journal of Medicine, 387*(18), 1637–1648. https://doi.org/10.1056/NEJMoa2206443

Government of Canada. (2023, June 26). Opioid- and stimulant-related harms in Canada. https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants

Government of Canada. (2024). *Research to Insights: Temporary Foreign Workers in Canada. Statistics Canada*. https://www150.statcan.gc.ca/n1/pub/11-631-x/11-631-x2024006-eng.htm

Government of Canada. (2025). *Immigration and Citizenship: Glossary*. https://www.canada.ca/en/services/immigration-citizenship/helpcentre/glossary.html#c

Greenhalgh, T., Hinton, L., Finlay, T., Macfarlane, A., Fahy, N., Clyde, B. & Chant, A. (2019). Frameworks for supporting patient and public involvement in research:

References

Systematic review and co-design pilot. *Health Expectations, 22*(4), 785–801. https://doi.org/10.1111/hex.12888

Hamou, Y. (2022). What does it mean to be sapphic? *Them Magazine.* https://www.them.us/story/what-does-sapphic-mean

Harding, K., Flannigan, K. & McFarlane, A. (2019). *Policy Action Paper: Toward a Standard Definition of Fetal Alcohol Spectrum Disorder in Canada*. CanFASD. https://canfasd.ca/wp-content/uploads/2019/08/Toward-a-Standard-Definition-of-FASD-Final.pdf

Harris, H., Wolframe, J. & Agic, B. (2024.) Lived and learned: Equity and inclusion through discursive resistance and critical reflexivity. *CE News*. Society for Academic Continuing Medical Education. https://resources.sacme.org/ce-news/2024/07/the-lived-experience-in-cpd

Health and Wellness Equity Research Group Carleton (2023, May 29). *Trauma- and Violence-Informed Language* [Video]. YouTube. https://www.youtube.com/watch?v=tLvVRmRG5bU

Health Canada. (n.d.). *Seniors and Aging – Assistive Devices*. https://www.canada.ca/en/health-canada/services/healthy-living/your-health/lifestyles/seniors-aging-assistive-devices.html

Hearing Voices Network. (n.d.). HVN – A positive approach to voices & visions. https://www.hearing-voices.org/about-us/hvn-values/#content

Hein, T. (2025, July 28). Why screen readers experience websites differently. *Arc Inclusion*. https://www.arcinclusion.com/accessibility-for-screen-reader-users/

Hodges, B. D. (2020). Introduction: Technology, compassion, and the future of healthcare. In B. D. Hodges, G. Paech & J. Bennett (Eds.), *Without Compassion, There Is No Healthcare: Leading with Care in a Technological Age* (pp. 3–32). McGill-Queen's University Press.

Immigration and Refugee Protection Regulations. (2025). SOR/2002-227; SOR/2024-284. https://laws-lois.justice.gc.ca/eng/regulations/sor-2002-227/FullText.html

References

Immigration Partnership Winnipeg. (2024). Immigration terminology factsheet. https://lipw.ca/2023/07/18/understanding-immigration-terminology-a-key-to-inclusive-integration

Inclusion Canada, People First of Canada & CAMH Azrieli Adult Neurodevelopmental Centre. (2024). *Advancing Accessible Communication for People with an Intellectual Disability*. https://bb0210de-b4cc-4d03-a2e5-651ab6f496ef.usrfiles.com/ugd/f3a50a_126ff365bca44bf1ad02c9ab7d664654.pdf

Indigenous Primary Health Care Council. (2024). About IPHCC: Model of Wholistic Health & Wellbeing. https://iphcc.ca/about-the-iphcc/

Interact. (2021). What Is Intersex? https://interactadvocates.org/faq/

Interdepartmental Terminology Committee on Equity, Diversity and Inclusion. (2024). *Guide on Equity, Diversity and Inclusion Terminology*. Government of Canada. https://nos-langues.canada.ca/en/publications/equite-diversite-inclusion-equity-diversity-inclusion-eng

International Committee of Medical Journal Editors. (2026). *ICMJE Recommendations*. https://www.icmje.org/recommendations/

International Labour Organization. (2025). Labour Migration. https://www.ilo.org/topics-and-sectors/labour-migration

International Organization for Standardization. (2025). *Prosthetics and Orthotics — Limb Deficiencies*. Part 3: Method of describing the residual limb after upper limb amputation. (ISO Standard no. 8548-3:2025). https://www.iso.org/obp/ui/en/#iso:std:iso:8548:-3:ed-2:v1:en

Johnson, B., Thomas, N. & Salom, C. (2025). Motivations and experiences of prescription stimulant use: An analysis of reddit discussions. *Journal of Drug Issues.* https://doi.org/10.1177/0022042625137

Jordon, A., Brook-Rowland, P., Noel, M. & Gauntlett-Gilbert, J. (2025). Harmful words: A qualitative survey of pain clinicians' perspectives on unhelpful messages in chronic pain. *Journal of Pain, 35.* https://doi.org/10.1016/j.jpain.2025.105524

References

Kanyen'keha:ka Nation. (n.d.). About us. https://kanyenkehaka.com

Kapp, S. K. (2023). Profound concerns about "profound autism": Dangers of severity scales and functioning labels for support needs. *Education Sciences, 13*(2), 106 https://doi.org/10.3390/educsci13020106

Kendi, I. X. (2019). *How to Be an Antiracist*. Penguin Random House.

Khalifa, A. (2018). What's the difference between Deaf with a capital "D" and deaf with a small "d"? *Hear Me Out Blog*. https://hearmeoutcc.com/capital-d-small-d-deaf

Kingston, Frontenac and Lennox & Addington Public Health. (2023, March 9). Increased detection of xylazine and benzodiazepines in Ontario's unregulated drug supply. https://www.kflaph.ca/en/news/increased-detection-of-xylazine-and-benzodiazepines-in-ontarios-unregulated-drug-supply.aspx

Kyoon Achan, G., Eni, R., Avery Kinew, K., Phillips-Beck, W., Lavoie, J. & Katz, A. (2021). The two great healing traditions: Issues, opportunities, and recommendations for an Integrated First Nations healthcare system in Canada. *Health Systems & Reform, 7*(1). https://doi.org/10.1080/23288604.2021.194381

Language, Please. (2025). Style guidance: white/White. https://languageplease.org/white

Laws, M. (2000, June 16). Why we capitalize "Black" (and not "white"). *Columbia Journalism Review*. https://www.cjr.org/analysis/capital-b-black-styleguide.php

LeBlanc, A. (2020). No longer a selling point, some residents want "plantation" removed. *NPR*. https://www.npr.org/2020/07/17/892195713/the-word-plantation-is-under-scrutiny-amid-u-s-racial-unrest

LeFrançois, B. A. (2013). The psychiatrization of our children, or, an autoethnographic narrative of perpetuating First Nations genocide through "benevolent" institutions. *Decolonization: Indigeneity, Education & Society, 2*(1), 108–123.

References

Lehmiller, J. (2020). How asexuals define sex – and when and why they sometimes have sex. *Kinsey Institute Blog*. https://news.iu.edu/kinseyinstitute/live/news/45740-how-asexuals-define-sex-and-when-and-why-they-sometime

Lennord, E. & Harding, K. D. (2026). *Gap Analysis: Black Identity and Fetal Alcohol Spectrum Disorder*. CanFASD. https://canfasd.ca/wp-content/uploads/publications/Black-Identity-and-FASD-Issue-Paper_FINAL.pdf

Levine, S., Heiden-Rootes, K. & Salas, J. (2022). Associations between healthcare experiences, mental health outcomes, and substance use among transgender adults. *Journal of the American Board of Family Medicine, 35*(6), 1092–1102. https://doi.org/10.3122/jabfm.2022.220–186R1

Lim, I., Korfmacher, J., Steier, A., Zeanah, C. & Zeanah, P. D. (2023). The ethics of infant and early childhood mental health practice. *Infant Mental Health Journal, 44*(5), 651–662. https://doi.org/10.1002/imhj.22055

Linton, S. (1998). Disability Studies/Not Disability Studies. *Disability & Society, 13*(4), 525–539. https://bpb-us-w2.wpmucdn.com/hawksites.newpaltz.edu/dist/7/800/files/2021/03/Disability-Studies-Linton-1998b-PDF-OCR-version.pdf

Lowik, A. (2018). *Trans-Inclusive Abortion Services: A Manual for Operationalizing Trans-Inclusive Policies and Practices in an Abortion Setting*. Fédération du Québec pour le planning des naissances and National Abortion Federation. https://static1.squarespace.com/static/5cef632e66e9b80001f24e05/t/612150e57e2040250c122c49/1629573364955/FQPN21-Manual-EN-NTL-PRESS+2021+Update.pdf

MacArtney, J. (2024, April 16). Is everyone a “loved one”? *End of Life Studies Blog*, University of Glasgow. https://endoflifestudies.academicblogs.co.uk/is-everyone-a-loved-one/

Mack, C., Ross, K., Colizza, K., Ranger, C. & Staines, A. (2023, June 9). Opinion: Multi-pronged response to toxic drugs crisis must include safe supply. *Edmonton Journal*. https://edmontonjournal.com/opinion/columnists/opinion-multi-pronged-

References

response-to-toxic-drugs-crisis-must-include-safe-supply?fbclid=IwAR20RNI49r-94r65BPKXV-IJ17EHn_JbJi7w77pQJhgZF6oFsTsYNCwAy4E

Mahdi, S., Viljoen, M., Massuti, R., Selb, M., Almodayfer, O., Karande, S. et al. (2017). An international qualitative study of ability and disability in ADHD using the WHO-ICF framework. *European Child and Adolescent Psychiatry, 26*, 1219–1231. https://doi.org/10.1007/s00787-017-0983-1

McGuire, M. & Gudgihljiwah, J. (2022*). Let's Talk about Indigenous Mental Health: Trauma, Suicide & Settler Colonialism*. Yellowhead Institute. https://yellowheadinstitute.org/wp-content/uploads/2022/02/indigenous-mental-health-yi-brief-mcguire-1.22.pdf

Meir, N. (2020, July 20). Why we will lowercase white. Associated Press. https://www.ap.org/the-definitive-source/announcements/why-we-will-lowercase-white/

Mental Health Coordinating Council. (2023). *Trauma-Informed Language Tips*. https://mhcc.org.au/wp-content/uploads/2023/10/mhcc_Trauma-IRL-Tips_A4-2.pdf

Métis Nation of Ontario. (2025). About the Métis Nation of Ontario. https://www.metisnation.org/about-the-mno

Migrant Rights Network (2026). About Migrant Rights Network. https://migrantrights.ca/about

Miserandino, C. (2003). The spoon theory. *But You Don't Look Sick.* https://web.archive.org/web/20191117210039/https://butyoudontlooksick.com/articles/written-by-christine/the-spoon-theory/

Mok, J., Milloy, M.-J., Grant, C., Lake, S., DeBeck, K., Hayashi, K. et al. (2023). Use of cannabis as a harm reduction strategy among people who use drugs: A cohort study. *Cannabis and Cannabinoid Research, 8*(4), 670–678. https://doi.org/10.1089/can.2021.0

References

Morris, J., Boness, C. & Hartwell, M. (2025). Key terms and concepts in alcohol use and problems: A critical evaluation. *Substance Use: Research and Treatment, 19.* https://doi.org/10.1177/29768357241312555

Morris, M. & Etitiq, Q. (2021). *The Complexities of Tobacco Use Among Inuit in Canada*. Canadian Cancer Society. https://marika-morris-consulting.org/?portfolio=inuit-needs-for-tobacco-cessation-services

National Association for Black Journalists. (2020, June 11). NABJ statement on capitalizing Black and other racial identifiers. https://nabjonline.org/blog/nabj-statement-on-capitalizing-black-and-other-racial-identifiers

National Institutes of Health. (2025). Race and national origin. *NIH Style Guide*. https://www.nih.gov/nih-style-guide/race-national-origin

Native Americans in Philanthropy. (n.d.). Glossary. https://nativephilanthropy.org/glossary

Natri, H., Abubakare, A., Beaud, F., Botha, M., Bottema-Beutel, K., Burr, D.A. et al. (2023). Anti-ableist language is fully compatible with high-quality autism research: Response to Singer et al. *Autism Research, 16*(4), 673–676. https://doi.org/10.1002/aur.2928

Needle Syringe Program Community of Practice. (2023). *Briefing Note on Opioid Use Terminology*. EENET, Provincial System Support Program, Centre for Addiction and Mental Health. https://kmb.camh.ca/uploads/222c60b5-8c6e-4aaa-b2d9-f0287092291a.pdf

NeuroLaunch. (2026). *ADHD Comorbidity List: Complete Guide to Co-Occurring Conditions and Their Prevalence Rates*. https://neurolaunch.com/adhd-comorbidity-list

Office of Advocacy. (n.d.). Writing accessible content. *Office of Advocacy Style Guide*. U.S. Small Business Administration. https://advocacy.sba.gov/office-of-advocacy-content-style-guide/writing-accessible-content/

References

O'Gorman, L. & Wolframe, J. (2024). *Pronoun and Language Guidelines for Trans-Affirming Workplaces in the Mental Health and Addictions Sector*. Centre for Addiction and Mental Health. https://kmb.camh.ca/uploads/15836a75-f15f-44bc-b2bf-cde552098b6f.pdf

Ontario Human Rights Commission. (2014). *Policy on Preventing Discrimination Because of Gender Identity and Gender Expression*. https://www.ohrc.on.ca/en/policy-preventing-discrimination-because-gender-identity-and-gender-expression

Otmar, R. (2023). *Editing for Sensitivity, Diversity and Inclusion: A Guide for Professional Editors* (2nd ed.). Cambridge University Press.

Pappas, S. (2023, April 1). Psychologists are working to increase the number of opioid overdose prevention centers. *American Psychological Association*. https://www.apa.org/monitor/2023/04/opioid-overdose-prevention-centers

Parri, L. (2024). Understanding tokenism in patient and public involvement (PPI) research. Gibson Research Consultancy. https://www.grc-health.com/knowledge-centre/understanding-tokenism-in-patient-and-public-involvement-(ppi)-research

Patton, E. (2009). When diagnosis does not always mean disability: The challenge of employees with attention deficit hyperactivity disorder (ADHD). *Journal of Workplace Behavioral Health, 24*(3), 326–343. https://doi.org/10.1080/15555240903176161

Pawlowski, M., Riva, M., Fletcher, C., Lyonnais. M.-C. & Arsenault-Hudon, D. (2024). Youth perspectives on community health in Nunavik: A community-engaged photovoice project. *Canadian Journal of Public Health, 115* (Suppl. 1), 31–43. https://doi.org/10.17269/s41997-022-00687-9

Pawson, C. (2023, May 18). 206 people suspected to have died of toxic drugs in April, B.C. coroner reports. *CBC*. https://www.cbc.ca/news/canada/british-columbia/toxic-drug-deaths-bcapril-2023-numbers-coroners-service-1.6847706

Pehlivanidis, A., Papanikolaou, K., Mantas, V., Kalantzi, E., Korobili, K., Xenaki, L.-A. et al. (2020). Lifetime co-occurring psychiatric disorders in newly diagnosed adults with attention deficit hyperactivity disorder (ADHD) or/and autism spectrum disorder (ASD). *BMC Psychiatry, 20*, 423. https://doi.org/10.1186/s12888-020-02828-1

References

Penney, S., Norton, M, Wagner, K, Mullens, K. & Wilkie, T. (2025). Language and bias in clinical documentation: A scoping review. *Journal of Forensic Psychology Research and Practice*. https://doi.org/10.1080/24732850.2025.2576503

Pilling, M.D. (2022). The biomedical model in practice II: Psychiatric inpatient chart documentation on trans and non-binary people. In: *Queer and Trans Madness*. Palgrave Macmillan. https://doi.org/10.1007/978-3-030-90413-5_5

Poole, N., Wolfson, L. & Huber, E. (2025). Health promotion and support grounded in interconnected influences on alcohol use in pregnancy. *International Journal of Environmental Research and Public Health, 22*(8), 1–16.

Potamianou, E. (2024). Inter-cultural perspectives on aging. *World Journal of Advanced Research and Reviews, 23*(02), 281–286. https://doi.org/10.30574/wjarr.2024.23.2.2348

Potenza, M. N. (2017). Clinical neuropsychiatric considerations regarding nonsubstance or behavioral addictions. *Dialogues in Clinical Neuroscience, 19*(3), 281–291. https://doi.org/10.31887/DCNS.2017.19.3/mpotenza

Pruysers, S., Banerjee, K. & Blais, J. (2024). Fear of crime and anti-refugee sentiments: Evidence from Canada. *Refuge: Canada's Journal on Refugees, 40*(5). https://doi.org/10.25071/1920-7336.41297

Public Health Agency of Canada. (2010). *Age-Friendly Communication Facts, Tips and Ideas*. https://www.canada.ca/en/public-health/services/publications/healthy-living/friendly-communication-facts-tips-ideas.html

Public Health Agency of Canada. (2020). *Communicating About Substance Use in Safe, Compassionate and Non-Stigmatizing Ways*. https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/healthy-living/communicating-about-substance-use-compassionate-safe-non-stigmatizing-ways-2019/guilding-rinciples-eng.pdf

Quinn, A., Fallon, B., Joh-Carnella, N. & Saint-Girons, M. (2022). The overrepresentation of First Nations children in the Ontario child welfare system: A

References

call for systemic change. *Children and Youth Services Review, 139*. https://doi.org/10.1016/j.childyouth.2022.106558

Redmond, S. M. (2016). Language impairment in the attention-deficit/hyperactivity disorder context. *Journal of Speech, Language, and Hearing Research, 59*(1), 133–142. https://doi.org/10.1044/2015_JSLHR-L-15-0038

Refugee Alberta. (n.d.). Myth vs fact. https://refugeealberta.ca/refugee-help/myth-vs-fact

Research Centre for Children and Families. (n.d.). *Words Matter: Trauma Sensitive Language with Children*. Sydney School of Education and Social Work, University of Sydney & Australia Childhood Foundation. https://www.sydney.edu.au/content/dam/corporate/documents/faculty-of-arts-and-social-sciences/research/research-centres-institutes-groups/rccf-words-matter-trauma-sensitive-language.pdf

Resource Centre for Sexual & Gender Diversity. (2025). Asexual/aromantic glossary. University of California at Santa Barbara. https://rcsgd.sa.ucsb.edu/resources/lgbtqia-informational-resources/asexualaromantic/asexualaromantic-glossary

Robinson, J. L. (2025, June 30). Terms and conditions: Why language matters after limb loss. *Amplitude*. https://livingwithamplitude.com/article/terms-and-conditions-why-language-matters-after-limb-loss/

Rogers, E. M. & McGuire, B. E. (2024). Mental age and intellectual disability: Psychologists' perspectives on the use of the term "mental age" as it relates to adults with an intellectual disability. *Journal of Policy and Practice in Intellectual Disabilities, 21(2)*, 1–13. https://doi.org/10.1111/jppi.12498

Romeo, J. (2021, July 20). ADHD: The history of a diagnosis. *JSTOR Daily*. https://daily.jstor.org/adhd-the-history-of-a-diagnosishttps://www.salnbc.com/wp-content/uploads/2020/11/SALN-Thinking-About-Language-August-2020.pdfhttps://www.disabilitywisdom.com/2018/12/21/whats-my-age-again-why-mental-age-theory-hurts-people-with-intellectual-and-developmental-disabilities/

References

Rowe, E. C., Coles, A. R. L., Harris-Lane, L. M., Harris, N., Bishop, L., Howells, R. & Donnan, J. (2025). Exploring cannabis consumption stigma in Canada with consideration of age and gender differences. *Addictive Behaviors Reports, 21*. https://doi.org/10.1016/j.abrep.2025.100608

Saxena, S., Funk, M. & Chisholm, D. (2013). World Health Assembly adopts Comprehensive Mental Health Action Plan 2013–2020. *The Lancet, 381*(9882), 1970–1971. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)61139-3/fulltexthttps://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)61139-3/fulltext

Scarff, J. R. (2021). What's in a name? The problematic term "provider." *Federal Practitioner, 38*(10), 446–448. https://doi.org/10.12788/fp.0188https://doi.org/10.12788/fp.0188https://doi.org/10.12788/fp.0188

Scribbr (n.d.). *Plagiarism Quick Guide*. https://www.scribbr.com/category/plagiarism/

Segers, J., Van Goidsenhoven, L., Bervoets, J., Bonnot-Briey, S., de Bont, N., de Klerk, S. et al. (2024). *Language Guide for Neurodiversity Research* [Developed for R2D2-Mental Health Consortium]. https://www.researchgate.net/publication/390833581_Language_Guide_for_Neurodiversity-research_-_Developed_for_the_R2D2-MH_consortium

Self-Advocate Leadership Network British Columbia. (2020). *Thinking About Language. Words Matter. Words Have Power. The Self-Advocate Leadership Network's Journey Through Thinking About Language*. https://www.salnbc.com/wp-content/uploads/2020/11/SALN-Thinking-About-Language-August-2020.pdf

Sergy, L. & Ball, T. (2021). *Diversity & Inclusion: Decolonizing Every Day Language in Our Workplaces*. [Video]. YouTube. https://www.youtube.com/watch?v=d3zQJewelUA

Shew, A. (2023). *Against Technoableism: Rethinking Who Needs Improvement.* W.W. Norton & Company.

Shim, S. R., Jeong, H. S., Bommersbach, T.J., Nierenberg, A. A., Zarete, C. A., Jr., Kaster, T. S. et al. (2026). Ketamine infusions and rapid reduction of suicidal and

References

depressive symptoms in major depressive episode: A systematic review and meta-analysis. *JAMA Psychiatry.* http://doi.org/10.1001/jamapsychiatry.2026.0612

Shkaabe Makwa. (2024). *Literature Review Summary: First Nations, Inuit, and Métis Models of Healing and Wellness* [unpublished manuscript].

Shkaabe Makwa & Centre for Addiction and Mental Health. (2026). Shkaabe Makwa. https://www.camh.ca/en/driving-change/shkaabe-makwa

Shum, D. (2017, April 20). Thousands expected to attend Toronto 4/20 marijuana rally at Yonge-Dundas Square. *Global News*. https://globalnews.ca/news/3391063/thousands-expected-to-attend-toronto-420-marijuana-rally-at-yonge-dundas-square

Silverman, A. (2018). What's my age again: Why mental age theory hurts people with intellectual and developmental disabilities. *Disability Wisdom*. https://www.disabilitywisdom.com/2018/12/21/whats-my-age-again-why-mental-age-theory-hurts-people-with-intellectual-and-developmental-disabilities

Simpson, T. E., Condon, E., Price, R. M., Finch, B. K., Sadler, L. S. & Ordway, M. R. (2016). Demystifying infant mental health: What the primary care provider needs to know. *Journal of Pediatric Health Care, 30*(1), 38–48. https://doi.org/10.1016/j.pedhc.2015.09.011

Sinclair, J. (1993). Don't mourn for us. *Our Voice, 1*(3). http://www.autreat.com/dont_mourn.html

Smith, L. (2018). *Glossary of Transgender Terms*. https://www.hopkinsmedicine.org/news/articles/2018/11/glossary-of-terms-1

Sonnenberg, L. K. & Alcantara, J. (2025). *Carefully Chosen Words: Language for Inclusive Care*. Bruyère Health Research Institute.

Statistics Canada. (2023a). Canada at a Glance: Indigenous Peoples. https://www150.statcan.gc.ca/n1/pub/12-581-x/2023001/sec3-eng.htm

Statistics Canada. (2023b). Immigrant. https://www23.statcan.gc.ca/imdb/p3Var.pl?Function=Unit&Id=85107

References

Statistics Canada. (2023c). Classification of admission category. https://www23.statcan.gc.ca/imdb/p3VD.pl?Function=getVD&TVD=323293&CVD=323295&CPV=32&CST=10102023&CLV=1&MLV=4&D=1

Still Bisexual. (2022). FAQs. https://stillbi.org/am-i-bisexual/

Stygar, K. & Zadroga, J. (2023, July 27). Infants have mental health needs, too. Mayo Clinic Health System. https://www.mayoclinichealthsystem.org/hometown-health/speaking-of-health/infants-have-mental-health-needs-too

Sullivan, M. J. L. & Tripp, D. D. (2024). Pain catastrophizing: controversies, misconceptions and future directions. *Journal of Pain, 25*(3), 575–587. https://doi.org/10.1016/j.jpain.2023.07.004

Support House Centre for Innovation in Peer Support (2021). *Compassionate Language for Mental Health and Substance Use*. https://supporthouse.ca/wp-content/uploads/2024/08/Compassionate-Language-for-Mental-Health-and-Substance-Use-1.pdf

The Trevor Project. (2023, November 15). *Affirming Actions and Gender Euphoria Among Transgender and Nonbinary Young People*. https://storage.googleapis.com/trevor-web-public/2023/11/The-Trevor-Project-Gender-Euphoria-Report-Nov-2023.pdf

Thunderbird Partnership Foundation. (2015). *First Nations Mental Wellness Continuum Framework*. https://thunderbirdpf.org/fnmwc

Tran, N. T., Baggio, S., Dawson, A., O'Moore, É., Williams, B., Bedell, P. et al. (2018). Words matter: A call for humanizing and respectful language to describe people who experience incarceration. *BMC International Health and Human Rights, 18*, 1–6. https://doi.org/10.1186/s12914-018-0180-4

TRIANGLE in ASEAN (n.d.). *Labour Migration: Inclusive Terminology*. International Labour Organization. https://www.ilo.org/media/300666/download

Tsuji, S. R. J., Zuk, A. M., Solomon, A., Edwards-Wheesk, R., Ahmed, F. & Tsuji, L. J. S. (2023). What is wellbeing, and what is important for wellbeing? Indigenous voices

References

from across Canada. *International Journal of Environmental Research and Public Health, 20* (17), 6656. https://doi.org/10.3390/ijerph20176656

Tungasvivvingat Inuit. (2023). *Inuit Qaujimajatuqangit (IQ) Principles*. https://tiontario.ca/wp-content/uploads/2023/06/IQ-Values.pdf

Turner, J. (2025). Ethical considerations when dealing with over-involved family members in a clinical setting. *Needle Tube*. https://www.needle.tube/resources-14/ethical-considerations-when-dealing-with-over-involved-family-members-in-a-clinical-setting

TVO Today. (2024, June 6). *Why Are Indigenous Children Overrepresented in Canada's Child Welfare System?* [Video]. YouTube. https://www.youtube.com/watch?v=fRN8kkuzU34

Tyyskä, V., Blower, J., DeBoer.S., Kawai, S. & Walcott. A. (2017). *The Syrian Refugee Crisis in Canadian Media*. Ryerson Centre for Immigration and Settlement. https://www.torontomu.ca/content/dam/centre-for-immigration-and-settlement/tmcis/publications/workingpapers/2017_3_Tyysk%C3%A4_Vappu_Blower_Jenna_DeBoer_Samantha_Kawai_Shunya_Walcott_Ashley_The_Syrian_Refugee_Crisis_in_Canadian_Media.pdf

University of Chicago. (2024). *The Chicago Manual of Style* (18th ed.). University of Chicago Press.

Urone, C., Verdi, C., Lo Iacono, C. & Miano, P. (2024, September 3). Dealing with overparenting: Developmental outcomes in emerging adults exposed to overprotection and overcontrol. *Trends in Psychology*. https://doi.org/10.1007/s43076-024-00407-x

U.S. Centers for Disease Control and Prevention (2024). *Tobacco – Health Equity: Unfair and Unjust Practices and Conditions Harm People with Low Socioeconomic Status and Drive Health Disparities*. https://www.cdc.gov/tobacco-health-equity/collection/low-ses-unfair-and-unjust.html

Vancouver Coastal Health. (2023). Harm reduction. https://www.vch.ca/en/health-topics/harmreduction

References

Vowel, C. (2016). *Indigenous Writes: A Guide to First Nations, Métis & Inuit Issues in Canada*. Highwater Press.

Washington, I. (2025). Yuck! Can we collectively move away from the term "equity-deserving" & "equity-seeking"? [Post). LinkedIn. https://www.linkedin.com/pulse/yuck-can-we-collectively-move-away-from-term-ika-washington-dbctc/?trackingId=NWs53c%2FNXixFDm8XygIOnQ%3D%3D

Watts, C., Rose, S., McGill, B. & Yazidjoglou, A. (2024). New image, same tactics: global tobacco and vaping industry strategies to promote youth vaping. *Health Promotion International, 39*(5). https://doi.org/10.1093/heapro/daae126

Wertheim, S. (2023. *The Inclusive Language Field Guide: 6 Simple Principles for Avoiding Painful Mistakes and Communicating Respectfully*. Berrett-Koehler Publishers.

Wiese, J. L., Watson, T. M., Owusu-Bempah, A., Hyshka, E., Wells, S., Robinson, M. et al. (2022). Overpoliced and underrepresented: Perspectives on cannabis legalization from members of racialized communities in Canada. *Contemporary Drug Problems, 50*(1), 25–45. https://doi.org/10.1177/00914509221142156

Wilder, Z. (2021, April 19). Does 4/20 still matter? *Rolling Stone*. https://www.rollingstone.com/culture/culture-features/does-4-20-still-matter-110210

World Health Organization. (2016). *Priority Assistive Products List*. https://iris.who.int/server/api/core/bitstreams/665850a1-6207-4c68-b1d2-b3b507ee77cd/content

Yafai, S. (2020). The case for cannabis: The racial undertones of marijuana. *Emergency Medicine News, 42*(7C). https://journals.lww.com/em-news/Fulltext/2020/07281/The_Case_for_Cannabis__The_Racial_Undertones_of.2.aspx

Yin, K. (2024). *The Conscious Style Guide: A Flexible Approach to Language That Includes, Respects, and Empowers*. Little, Brown Spark.

Younging, G. (2018). *Elements of Indigenous Style*. Brush Education.

References

YourAlberta. (2013). *Living with FASD: Myles Himmelreich* [Video]. YouTube. https://www.youtube.com/watch?v=6QgZKkv_Pck

Clear and Inclusive Writing Guidelines: The New CAMH Style

Introduction

This list contains tools and resources featured through sections of the *Clear and Inclusive Writing Guidelines*, along with overarching guides that informed its creation.

Articles

An introduction to anti-Black sanism (*Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice*)

Avoiding ableist language: Suggestions for autism researchers (*Autism in Adulthood*)

Embracing Neurodiversity in mental health: A new paradigm (NeuroLaunch)

Identity-first language (Autistic Self Advocacy Network)

Intersectionality and mental health: Identity's impact on wellbeing (Neurolaunch)

Mental illness and neurodivergence: Intersections and distinctions (NeuroLaunch)

New policy of people-first language to replace “smoker,” “‘vaper,” “‘tobacco user” and other behaviour-based labels (*Tobacco Control*)

Non-substance addiction: Exploring behavioral addictions and their impact (Neurolaunch)

“Rarely talked about”: A new paper calling for the use of empathetic and kind language in describing rare conditions (Fragile X International)

Terms and conditions: Why language matters after limb loss (Amplitude)

The language we use matters: Combatting stigmatizing language around problem gambling (National Council on Problem Gambling)

The intersectionality toolbox: A resource for teaching and applying an intersectional lens in public health (*Frontiers in Public Health*)

Appendix: Tools and Resources

The spoon theory (But You Don't Look Sick?)

Why we use the term "overdose" (International Overdose Awareness Day)

Books

Against Technoableism: Rethinking Who Needs Improvement (W.W. Norton & Company)

Carefully Chosen Words: Language for Inclusive Care (Equity in Health Systems Publishing)

Decolonizing Trauma Work: Indigenous Stories and Strategies (Fernwood Publishing)

Disability Politics: Understanding Our Past, Changing Our Future (Routledge)

Editing for Sensitivity, Diversity and Inclusion (Cambridge University Press)

Elements of Indigenous Style (Brush Education)

Health and healing on the edges of Canada (book chapter) (Polynypa Press)

How to Be an Antiracist (Penguin Random House)

Nothing About Us Without Us: Disability Oppression and Empowerment (Oxford Academic)

The Conscious Style Guide (Hachette Book Group)

The Inclusive Language Field Guide (Penguin Random House Canada)

Without Compassion, There Is No Healthcare (McGuill University Press)

Digital tools

Grammarly accessibility tools

Hemingway Editor app

Web Accessibility Initiative

Appendix: Tools and Resources

Fact sheets, quick guides and pamphlets

Anti-Black Racism in Canada's Criminal Justice System Fact Sheet (Canada Civil Liberties Association)

Cannabis: What Educators Need to Know (CAMH)

Cannabis: What Parents/Guardians and Caregivers Need to Know (CAMH)

Decolonize! What Does It Mean? (Oxfam)

Do You Know … Cannabis (CAMH)

Immigration Status Fact Sheet (Immigration Partnership Winnipeg)

Plagiarism Quick Guide (Scribbr)

Talking to Children About a Suicide (Mental Health Commission of Canada)

What Is Intersex? (Interact)

What Is Two Spirit, Indigiqueer, & LGBTQPAI+? (Indigenous Pride LA)

When a Parent or Caregiver… series (CAMH)

Frameworks

Clearing a Path: A Psychiatric Survivor Anti-Violence Framework (Empowerment Council, CAMH)

First Nations Mental Wellness Continuum Framework (Thunderbird Partnership Foundation)

Health Equity and Inclusion Framework for Training and Education (CAMH)

Learning Together: Evaluation Framework for Patient and Public Engagement (PPE) in Research (Centre of Excellence on Partnership with Patients and the Public)

Strategy for Patient-Oriented Research: Patient Engagement Framework (Canadian Institutes of Health Research)

Appendix: Tools and Resources

Glossaries

Glossary of Terms for Frontline Settlement Workers (Affiliation of Multicultural Societies and Service Agencies of British Columbia)

Glossary of Terms (The 519)

Glossary of Terms: LGBTQ (GLAAD)

Glossary of Transgender Terms (Johns Hopkins Medicine)

Homeless, Houseless, and Unhoused: A Glossary of Terms Used to Talk About Homelessness (Blanchet House)

Talking About Refugees and Immigrants: A Glossary of Terms (Canadian Council for Refugees)

Terminology page (Canadian Association of the Deaf)

Government documents

Changing Systems, Transforming Lives: Canada's Anti-Racism Strategy 2024–2028 (Government of Canada)

Overrepresentation of Black People in the Canadian Criminal Justice System (Department of Justice Canada)

Overrepresentation of Indigenous People in the Canadian Criminal Justice System: Causes and Responses (Department of Justice Canada)

Guiding documents

Accessibility for Teams (Digital.gov, U.S. General Services Administration)

Dismantling Structural Stigma in Health Care (Mental Health Commission of Canada)

Guidance for Honouring the Land and Ancestors Through Land Acknowledgements (CAMH Reconciliation Working Group Land Acknowledgement Subcommittee)

Appendix: Tools and Resources

Guidelines for Including People with Disabilities in Research (National Disability Authority, Ireland)

Hear Us, See Us, Respect Us: Respecting the Expertise of People Who Use Drugs (Canadian Drug Policy Coalition & Canadian Association of People Who Use Drugs)

INNOVATE Research: Youth Engagement Guidebook for Researchers (CAMH)

Key Practices for Community Engagement in Research on Mental Health or Substance Use (Re:searching for 2SLGBTQIA+ Health)

More Than Paint Colours (Empowerment Council, CAMH)

One Idea Per Line: A Guide to Making Easy Read Resources (Autistic Self Advocacy Network)

Revitalizing Culture and Healing: Indigenous Approaches to FASD Prevention (Centre of Excellence for Women's Health, First Nations Health Authority & CanFASD)

Trauma Informed Practice Guide (BC Provincial Mental Health and Substance Use Planning Council)

Inclusive writing guides: General

Conscious Style Guide

Inclusive writing – Guidelines and resources (Government of Canada)

Inclusive Language Guide (American Psychological Association)

Inclusive Language Manual (City of Oshawa)

Inclusive Language Guide (Regional Municipality of York)

Appendix: Tools and Resources

Inclusive writing guides: Specialized

Advancing Accessible Communication for People with an Intellectual Disability (Inclusion Canada, People First of Canada & CAMH Azrieli Adult Neurodevelopmental Centre)

Age-Friendly Communication: Facts, Tips and Ideas (Government of Canada)

APA Style: Socioeconomic status (American Psychological Association)

Asexual/aromantic glossary (Resource Center for Sexual & Gender Diversity)

Autismhttps://www.yorku.ca/health/lab/ddmh/am-help/ Mental Health Literacy Project (York University & CAMH Azrieli Adult Neurodevelopmental Centre)

A Way with Words and Images: Guide for Communicating with and About Persons with Disabilities (Employment and Social Development Canada)

Bisexual+ (Resource Center for Sexual & Gender Diversity)

Class Discrimination and Socio-Economic Status: Inclusive Writing Guide (McGill Library)

Common Messages: Guidelines for Talking and Writing About Fetal Alcohol Spectrum Disorder (CanFASD)

Communicating About Substance Use in Compassionate, Safe and Non-Stigmatizing Ways (Public Health Agency of Canada)

Compassionate Language for Mental Health and Substance Use (Support House Centre for Innovation in Peer Support)

Don't call me "old": Avoiding ageism when writing about aging (National Institute on Aging)

Editing 2SLGBTQIA+affirming terminology (Editors Toronto)

FASD Media Resources (CanFASD)

GLAAD Media Reference Guide (GLAAD)

Appendix: Tools and Resources

Guide for Communicating About Overdose Prevention (Berkeley Media Studies Group)

How People with Disabilities Use the Web (Web Accessibility Initiative)

How to Reduce the Stigma of Gambling Harms Through Language: A Language Guide (GambleAware)

Indigenous Peoples Editorial Resource (University of Alberta)

Language Guide for Neurodiversity-Research (R2D2-Mental Health Consortium)

Language Matters: Communicating About People, Alcohol, and Drugs (NHS Borders)

Language Matters: Safe Communication for Suicide Prevention (Government of Canada)

Language Matters: Talking About Sex Work (Stella Montreal)

Overcoming Stigma Through Language: A Primer (Canadian Centre for Substance Use and Addiction)

Pronoun and Language Guidelines for Trans-Affirming Workplaces in the Mental Health and Addictions Sector (CAMH)

Reporting on Alcohol Use, Alcohol Use During Pregnancy, and Fetal Alcohol Spectrum Disorder (CanFASD)

Talking About Pain (Painaustralia)

Thinking About Language (BC Self-Advocate Leadership Network)

Towards an Inclusive Language for Deaf, DeafBlind and Hard of Hearing Individuals (Eversa)

Two-Spirit Terminology Guide (Nation Builder)

Understanding Suicide: Suicide Safe Language (9-8-8 Suicide Crisis Helpline)

What is Easy Read? (Photosymbols)

Appendix: Tools and Resources

Writing for all abilities (Microsoft Style Guide)

Your Words Have Power: CNIB Inclusive Language Guidelines

Organizations and CAMH departments

9-8-8: Suicide Crisis Helpline

Access Copyright

AMANI Mental Health & Substance Use Program (CAMH)

Azrieli Adult Neurodevelopmental Centre (CAMH)

Butterfly Asian and Migrant Workers Action Project

Empowerment Council (CAMH)

Equity in Health Systems Lab | Health Equity & Social Accountability

Gender Identity Clinic (CAMH)

Immigrant and Refugee Mental Health Project (CAMH)

Indigenous Editors Association

Indigenous Primary Health Care Council

Intersex Canada

Maggie's Toronto Sex Worker Action Project

Margaret & Wallace McCain Centre for Child, Youth & Family Mental Health (CAMH)

Migrant Rights Network

Migrant Workers Alliance

Patient and Family Engagement (CAMH)

Patient and Family Partners Program (CAMH)

Rainbow Services (2SLGBTQ+) (CAMH)

Appendix: Tools and Resources

Shkaabe Makwa (CAMH)

Still Bisexual

Trans Care BC

Tungasuvvingat Inuit

Podcasts, videos and digital media

2SLGBTQ Health in Focus podcast (Rainbow Health Ontario)

Against Technoableism: Disability Deep Dive podcast (Disability Rights Florida)

How to Test Accessibility Beyond Compliance with Jacob Wood (How to Test Podcast)

Living with FASD: Myles Himmelreich (YourAlberta)

Mind the Disruption podcast: Disrupting migrant work (National Collaborating Centre for Determinants of Health)

Two Row Medicine: Smudging in Clinical Care video (Shkaabe Makwa)

What Is the Social Model of Disability? (Scope Video)

What To Say To Someone With A Chronic Illness (Xander Keller & TEDx Talk)

Why Are Indigenous Children Overrepresented in Canada's Child Welfare System? (TVO Today)

Words Matter: Why Is Rights-Based Terminology Seen as Critical? (International Labour Organization)

Policies

Anti-Racism, Harassment, and Discrimination Policy (CAMH)

People-first language policy (*Tobacco Control*)

Appendix: Tools and Resources

Research projects and studies

Peers Examining Experiences in Research (PEERS) Study (Re:searching for 2SLGBTQIA+ Health)

Standards

Plain Language (Accessibility Standards Canada)

Prosthetics and Orthotics — Limb Deficiencies (International Organization for Standardization)

The Easy Read Standard: Evidence-Based Framework for Accessible Information (Photosymbols)

W3C Accessibility Standards Overview (Web Accessibility Initiative)

Toolkits and resource collections

Books Beyond Words

Children and Youth (Mental Health Commission of Canada)

Conscious Style Guide

Intersectionality Resource Guide and Toolkit (UN Women)

Justice & Policing (Assembly of First Nations)

Labour Migration (International Labour Organization)

Making Your Events More Accessible and Inclusive: A Toolkit for the Mental Health and Addictions Sector (EENet, CAMH)

Mental Health Resource and Practice Guide (CanFASD)

Neurodiversity educational resources (Sonny Jane: Lived Experience Educator website)

Socioeconomic status (Conscious Style Guide)

Appendix: Tools and Resources

Structural stigma (Mental Health Commission of Canada)

TRIANGLE in ASEAN (International Labour Organization)

Training courses and programs

Anti-Racism Learning Path courses (Canada School of Public Service)

Creating Safe and Gender-Affirming Health Care Spaces online course (CAMH)

Education (Rainbow Health Ontario)

Foundational Knowledge on Anti-Black Racism online course (CAMH)

Immigrant and Refugee Mental Health Project webinars (CAMH)

Introduction to Infant and Early Child Mental Health (Sick Kids Hospital)

Mad People's Movement: Reclaiming Collective Activist Histories webinar (Transforming Communities for Inclusion – Global)

Mental Health 101 course (CAMH)

Reducing Stigma and Promoting Recovery for Opioid Use course (CAMH Global Learning Academy)

San'yas Indigenous-Specific Anti-Racism training

Shkaabe Makwa webinars and training (CAMH)

Truths of Institutionalization: Past and Present online course

Two Spirit and Indigiqueer Cultural Safety: Considerations for Relational Practice and Policy webinar (National Indigenous Cultural Safety Learning Series)

Understanding Stigma course (CAMH)

camh mental health is health © 2026

Appendix: Tools and Resources