“Words have power. They have the power to teach, the power to wound, the power to shape the way people think, feel, and act toward others.” Otto Wahl

My first job out of nursing school was as a staff nurse on 11 East, an HIV/infectious disease unit at the University of Maryland Medical Center in Baltimore. It was the late 1990’s and the HIV and injection drug use epidemics were in full swing; most of the patients I cared for were from West Baltimore, and in addition to having endocarditis, TB, cryptococcal meningitis, and PCP, most had active addiction issues as well as severe housing, legal, custody, employment, and other psychosocial problems. Because of the patients’ complex constellation of problems and the fact that family and legal issues often played themselves out in the hallways of the unit, 11 East was disparagingly known as the unit “full of frequent flyers”—a reference to the patients’ frequent recurring admissions with similar admitting diagnoses—and as the “Jerry Springer Show floor”—a reference to the old television talk show which frequently featured rowdy guests and shouting matches.

I hated hearing these (and lots of other) flippant, slang terms, first, because they were simply disrespectful and insensitive. Working on 11 East was emotionally and spiritually challenging beyond belief, and I understood my colleagues’ attempts at “black humor” to cope with those relentless challenges. But I also cared about, and cared for these patients, and after multiple admissions, knew the gnarly intimate details of their lives that had brought them to this place at the corner of HIV/AIDS, poverty, racism, and addiction. They were already “marked” and stigmatized in so many ways.
Directors’ Message (continued)

The word stigma supposedly originated in ancient Greece. One explanation is that slaves who were caught trying to escape were branded with the letter “F” for “fugitive,” and that the word for the “F” mark was stigma. A second explanation is that the ancient Greeks physically marked people who were deemed socially undesirable with brands or marks, indicating that these people were to be avoided. Since then, the meaning has been expanded to include any mark, or sign of a perceived deviation from the norm.

I also hated these terms because they carried implicit attitudes about choice, culpability, and deservedness of the clinical care we were offering. Our language choices say a lot about what we believe about the amount of personal choice and volition involved in addiction, which shapes the amount of culpability and blame we think people have for their substance use, and how much of a threat we think they are to us or to the social order. This matters because the amount to which we think people are blameworthy or threatening drives whether we think the right response to these individuals should be punitive or therapeutic, i.e., punishment or treatment.

Despite the regularity with which they were admitted, these patients were far from perceived as the preferred customers that a “frequent flyer” status earns you on the airlines. In fact, it was the opposite; marking these patients with the label “frequent flyers” tacitly meant that they deserved less, not more—that “those people” were unworthy of the care we were providing. So I quietly modeled alternative language and on the days I felt brave, gently called out colleagues, across professional disciplines, who continued to off-handedly use labels like “junkie,” “addict,” and “speedballer with a dirty urine.”

Flash forward 20 years to 2014, and I’m an Associate Editor for the journal Substance Abuse, under Dr. Adam Gordon, Editor in Chief. We routinely received manuscripts that used many of the same terms. And then, the straw that broke the camel’s back for me was when we received a manuscript that referred to the “depraved and degenerate lives” of the study participants. Really?

Depraved: marked by corruption or evil; especially: perverted; very evil: having or showing an evil and immoral character

Degenerate: having low moral standards: not honest, proper, or good; having sunk to a condition below that which is normal to a type; especially: having sunk to a lower and usually corrupt and vicious state (Merriam-Webster Dictionary)
And I thought, wow, 20 years, and not much has changed. Even those of us specializing in addiction are still using terms that moralize and stigmatize addiction. It has to be inadvertent; we’re the ones who work and advocate for affected individuals every single day. But it’s nonetheless slang and language choices that create a mark of being “deviant, flawed, limited, spoiled, or generally undesirable,” reflecting a “devalued and denigrated identity in society.” It’s nonetheless idioms and language that serve as a mark of dishonor, disgrace, and difference that depersonalizes people, depriving them of individual or personal qualities and a personal identity.

So in partnership with the journal’s editorial team, I wrote an editorial entitled “Confronting Inadvertent Stigma and Pejorative Language in Addiction Scholarship: A Recognition and Response,” calling for the use of language in addiction clinical care and scholarship that: (1) Respects the worth and dignity of all persons (“people-first language”); (2) Focuses on the medical nature of substance use disorders and treatment; (3) Promotes the recovery process, and (4) Avoids perpetuating negative stereotypes and biases through the use of slang and idioms. If you haven’t seen the article yet, please check it out:


Our goal is not to be “language police,” but to encourage thoughtful consideration of how we talk about, and write about, addiction. We acknowledge that there are caveats and considerations around the recommendations that we make. However, because of its focus on guiding principles, our editorial was the catalyst for similar guidelines adopted by the International Society of Addiction Journal Editors (ISAJE) as well as the Journal of Addiction Medicine (the journal for the American Society of Addiction Medicine—ASAM).

This fellowship is designed to create change agents. Change agents lead, often in simple but powerful ways. This is your chance to model intentional language choices that avoid generalizations and defining people by their disorders, promote evidence-based treatment, shun sensationalizing addiction and recovery, and challenge inaccuracies and stereotypes around addiction. For additional professional and lay literature on stigma, language, and addiction, check out the following reading list!

Lauren Broyles, PhD, RN
**Reading List on Stigma, Addition, and Language**

**Scholarly Literature and Federal Reports**


Reading List on Stigma, Addition, and Language (con’t)


Lay Press


https://www.bostonglobe.com/metro/2016/02/03/finding-right-words-for-addiction/EdNzUNS10KQ DinOEk3lQpN/story.html

HuffPost

http://www.huffingtonpost.com/2015/03/03/drug-addiction-language_n_6773246.html
http://www.huffingtonpost.com/yngvild-olsen/addiction-language_b_7097396.html
http://www.huffingtonpost.com/2015/04/17/mental-illness-vocabulary_n_7078984.html
http://www.huffingtonpost.com/jag-davies/ap-stylebook-drugs_b_6020672.html


Editorial Guidelines for Addiction Journals

http://www.parint.org/isajewebsite/terminology.htm
http://amersa.symmcomm.net/journal/instructions-for-authors/editorial-policies/
http://journals.lww.com/journaladdictionmedicine/Pages/informationforauthors.aspx#languageandterminologyguidance
The Buprenorphine In the VA Initiative

Formed as a response to a national increase in opioid dependence, a disproportionate of Veteran diagnoses, the introduction of buprenorphine in the U.S. in 2002, and a 2008 VA mandate for its use (Uniform Mental Health Services), The Buprenorphine In the VA Initiative began in 2007 with funding from VA CESATES, VISN 4 MIRECC, and SUD-QUERI. The goals of the BIV are to improve the implementation of office-based treatment of opioid dependence in the VA and to improve process of care and patient-level outcomes. The BIV accomplishes this by acting as a national consult service which may be utilized by providers. The main recurring vehicles for consults are VA listserv engagement (2,000+ members), a voluntary prescriber list (100+ national providers), hosting of an online resource repository, and inquiry triage (50+ monthly inquiries). BIV educates providers by publishing monthly newsletters on current events (80+ issues), monthly webinars (30+ produced, average live attendance of 40, plus additional downloads), and one-off projects such as guidelines and protocols (the most recent of which is an updated national VA informed consent). BIV members also enjoy a reputation for scholarship with 50+ peer-reviewed publications. BIV Sharepoint can be found here.

Addiction Medicine Approved as a Medical Specialty

As of mid-March, the American Board of Medical Specialties (ABMS) has formally recognized Addiction Medicine as a medical specialty. The formal announcement is located at http://www.abms.org/news-events/ .

All physicians are eligible to be credentialed as an Addiction Medicine physician (unlike Addiction Psychiatry specialists, who must have a primary board of psychiatry and training in an ACGME approved addiction psychiatry fellowship). Until Addiction Medicine fellowship programs are recognized by Accreditation Council for Graduate Medical Education (ACGME) (at that time all Addiction Medicine trainees/clinicians must go through an approved ACGME fellowship), there will be a pathway for new (and old) Addiction Medicine clinicians to be formally certified/recognized. Many ABAM-certified clinicians have already undergone a pathway to ABAM certification (called “practice pathway”).

There are five criteria required for a physician to be eligible to sit for the ABAM Board Certification Examination in Addiction Medicine: (1) a valid and unrestricted medical license; graduation from medical school; (3) board certified or completion of residency in any medical specialty; (4) one year of practice experience or fellowship in addiction medicine; and (5) fifty hours of CME in addiction or substance use disorders.

The VA has a rich history of promoting interdisciplinary addiction scholarship, trainees, and clinicians including being instrumental in the growth of Addiction Psychiatry as a specialty. I am sure the VA will also help promote Addiction Medicine as a specialty as well.
A major component of my fellowship training has involved helping with the implementation of the Opioid Overdose Education and Naloxone Distribution (OEND) initiative at VA Connecticut. The initiative aims to provide education to veterans regarding overdose prevention strategies and responding to an overdose, including administering naloxone. In collaboration with Dr. Ellen Edens and our clinical pharmacist, we developed educational materials for providers and veterans. Our local initiative began with education and naloxone kit prescriptions to veterans in the Substance Abuse Clinic in early 2015 and has since expanded hospital wide. We currently have 255 unique veterans with a naloxone rescue kit. Collaborating with other professionals has been key in the implementation of this program. I currently run a weekly overdose prevention group in our residential treatment program and also meet with veterans individually to provide the educational component. For the veterans who would like to receive a naloxone rescue kit, I work in conjunction with their prescribing clinician who places the order. I am also part of a VISN Naloxone Workgroup that is revising current policies to expand the availability of naloxone to outpatient clinics and VA police. At this time, we are collecting data for several research projects evaluating the impact of this initiative, identifying barriers to implementation, and evaluating provider and veteran knowledge and attitudes regarding OEND. Alyssa Peckham, PharmD., will be presenting some of the provider data at the CPNP conference in April and I will be presenting a poster on the effect of state naloxone access laws on the implementation of OEND at VAs across the country at the CPDD conference in June. Along with Dr. Elizabeth Oliva (National VA OEND Coordinator) and Dr. Rachel Winograd at St. Louis VA we started a monthly OEND call for clinicians and researchers to facilitate collaborations and discuss ways to better implement OEND at our local sites.

**Reminders**

**Monthly Directors’ Calls:** 3rd Wednesday of each month from 2:00PM-3:00PM EST  
**Monthly Fellows’ Curriculum Calls:** 1st Wednesday of each month from 2:00pm-3:30pm EST  
**National Calls:** [vaww.mentalhealth.va.gov/omhs-natconcalls.asp](vaww.mentalhealth.va.gov/omhs-natconcalls.asp)  
**National ATCC Sharepoint Site:** [goo.gl/662Ttb](goo.gl/662Ttb)  
**Fellowship Website:** [www.pittsburgh.va.gov/Trainee/ATF](www.pittsburgh.va.gov/Trainee/ATF)