



## Office of National Drug Control Policy

# Changing the Language of Addiction: Announcement for Public Comment

October 4, 2016

The Office of National Drug Control Policy (ONDCP) in the Executive Office of the President is issuing for public comment a draft of *Changing the Language of Addiction*, a document addressing ways non-stigmatizing terminology can be used when discussing substance use and substance use disorders. Prepared in consultation with experts in the field of substance use, this guidance addresses the role stigma plays in preventing people from seeking and receiving quality care, identifies scientific and medical literature demonstrating how certain terminology adversely affects the quality of health care and treatment outcomes for individuals with substance use disorders, and promotes the use of *person-first* language and new terminology that aligns with the current edition of *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed., American Psychiatric Association, 2013).

Executive Branch agencies will be encouraged to consider the importance of language and the terminology discussed in the guidance in their internal and public facing communications. The document is not a Federal regulation and is not intended to change the statutory or regulatory definitions of terms or change any substantive or procedural rights under Federal law, to include the names of Federal agencies.

Substance use disorder (the severest form of which is commonly referred to as addiction), is a chronic brain disorder from which people can and do recover. Despite an increase in the understanding of the science of substance use disorders and their effect on the brain, research shows that people with substance use disorders are viewed more negatively than others. When certain terms are used, such as “abuser” instead of “individual with a substance use disorder,” health care providers are more likely to assign blame and believe that an individual should be subjected to more punitive (e.g., jail sentence) rather than therapeutic measures. Negative attitudes have been found to adversely affect the quality of health care and treatment outcomes. Because stigma and shame may deter help-seeking behavior among individuals with substance use disorders and their families, the guidance draws attention to terminology that may cause confusion or perpetuate stigma.

Specifically, we seek comment from stakeholders on the scope and depth of the guidance. We are especially interested in comments that address recent medical and scientific research or otherwise discuss the medical terminology used for other health care conditions. Where possible, please cite to the research or medical standard being referenced.

The draft document can be found here: <https://www.whitehouse.gov/ondcp/changing-the-language-draft>. To submit comments, please send an email to [feedback@ondcp.eop.gov](mailto:feedback@ondcp.eop.gov). Comments will be accepted until 5 p.m. Eastern Time on November 4, 2016. For further information, contact the Office of National Drug Control Policy at [feedback@ondcp.eop.gov](mailto:feedback@ondcp.eop.gov).



## Office of National Drug Control Policy

# DRAFT: Changing the Language of Addiction

Office of National Drug Control Policy, October 2016 Draft

Please submit comments by November 3, 2016 at [feedback@ondcp.eop.gov](mailto:feedback@ondcp.eop.gov)

### Background

Substance use, misuse, and substance use disorders<sup>[\*][†]</sup> impose a devastating health and emotional burden on individuals, families, communities, states, tribes, and our Nation as a whole, causing injury, illness, and death and endangering public safety. In 2015, an estimated 20.1 million Americans aged 12 or older had alcohol or other drug use disorders, while approximately 27.1 million people aged 12 or older reported past-month illegal drug use.<sup>[1]</sup> More Americans now die every year from drug overdoses than in motor vehicle crashes. Yet 89 percent of individuals estimated to be in need of treatment for a substance use disorder do not receive services.<sup>1</sup>

Substance use disorder (the severest form of which is commonly referred to as addiction) is a chronic brain disorder from which people can and do recover. Nonetheless, sometimes the terminology used in the discussion of substance use can suggest that problematic use of substances and substance use disorders are the result of a personal failing; that people choose the disorder, or they lack the willpower or character to control their substance use. The evidence is clear that this is not correct; instead, research has shown that substance use disorders are neurobiological disorders.

However, research also has shown that people with substance use disorders are viewed more negatively than people with physical or psychiatric disabilities.<sup>[2],[3]</sup> Researchers found that even highly trained substance use disorder and mental health clinicians were significantly more likely to assign blame and believe that an individual should be subjected to more punitive (e.g., jail sentence) rather than therapeutic measures, when the subject of a case vignette was referred to as a “substance abuser” rather than as a “person with a substance use disorder.”<sup>[4]</sup> In a public perception study the term “abuse” was found to have a high association with negative judgments and punishment.<sup>[5]</sup> Negative attitudes among health professionals have been found to adversely affect quality of care and subsequent treatment outcomes.<sup>6</sup> Shame and concerns about social, economic, and legal consequences of disclosing a substance use disorder may deter help-seeking among those with substance use disorders and their families.

The American Medical Association has called on physicians to help reduce stigma and support treatment for substance use disorders. The American Society of Addiction Medicine and major addiction journals have urged the adoption of clinical, non-stigmatizing language. The current Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, replaced the earlier categories of substance “abuse” and “dependence” with “substance use disorder.”

In addition, “person-first language” has been widely adopted by professional associations and scientific journals to replace negative terms that have been used to label people who have other types of health conditions and disabilities. For instance, expressions such as “person with a mental health condition” or “person with a disability” carry neutral rather than pejorative connotations, and help place the focus on individuals rather than on their health condition or perceived membership in a group.<sup>7</sup> Language related to substance use, misuse, and substance use disorders can do the same.

This document draws attention to terminology that may cause confusion or perpetuate stigma around substance use disorders. It is not intended to serve as a glossary of clinical terminology, nor does it offer a comprehensive list of all the potentially stigmatizing words used in association with substance use disorders. Many casual and slang terms are so clearly negative and stigmatizing that they need not be repeated here. In addition, while this document aims to promote non-stigmatizing language in the Federal Government, individuals who have substance use disorders or those in recovery may choose to identify themselves with different terminology.

Executive Branch agencies are encouraged to consider the importance of language and the terminology discussed below in their communications related to substance use or substance use disorders. (Examples of communications developed by agencies include grants, contracts, fact sheets, reports and publications, press releases, presentations, newsletters, web-based [including social media], and other materials).

### **Substance Use Disorder**

The current Diagnostic and Statistical Manual of Mental Disorders replaced older categories of substance “abuse” and “dependence” with a single classification of “substance use disorder.” Alternatives include “misuse” or “unhealthy/harmful use” of a substance.

Similarly, terms such as “drug habit” inaccurately imply that a person is choosing to use substances or can choose to stop. However, science shows that a substance use disorder is a chronic brain disease. “Substance use disorder” is the clinically accurate term.

### **Person with a Substance Use Disorder**

Person-first language is the accepted standard for discussing people with disabilities and/or chronic conditions. Research shows that use of the terms “abuse” and “abuser” negatively affects perceptions and judgments about people with substance use disorders, including whether they should receive punishment rather than medical care for their disease.<sup>4,5</sup> Terms such as “addict” and “alcoholic” can have similar effects. As a result, terms such as person with a substance (or replace with specific substance) use disorder are preferred.

## Person in Recovery

Various terms are used colloquially to label people with substance use disorders, including the terms “clean” and “dirty.” Clinically accurate, non-stigmatizing terminology that is similar to how we describe other medical conditions is strongly preferred.<sup>7-9</sup> Instead of “clean,” the terms “negative” (for a toxicology screen) or “person in recovery” or “not currently using substances” are preferred when describing a person. Instead of “dirty,” the term “positive” (for a toxicology screen) or “a person who is currently using substances” may be used.

## Medication Assisted Treatment

With respect to the use of medications in the treatment of substance use disorders, the terms “replacement” and “substitution” have been used to imply that medications merely “substitute” one drug or “one addiction” for another. This runs counter to the evidence that medication-assisted treatment improves outcomes for patients.<sup>10,11,12,13</sup> Preferred terms include “medication-assisted treatment” or “medicine/medication,” or simply “treatment.”<sup>9</sup>

[\*] Throughout this document, the expression “substance misuse and substance use disorders” refers to all of the following: alcohol consumption that exceeds the National Institute on Alcohol Abuse and Alcoholism’s “low-risk” guidelines for developing alcohol use disorder; underage drinking; drinking during pregnancy; any use of illegal drugs; any non-medical use of prescription medication; and, alcohol or other drug use disorder.

[†] Note that some statutory provisions continue to use older language, including certain agency or organization names. We would encourage the use of updated language as these provisions are periodically revised and in other legislation addressing these issues.

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# Changing the Language of Addiction

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**Words matter.** In the scientific arena, the routine vocabulary of health care professionals and researchers frames illness<sup>1</sup> and shapes medical judgments. When these terms then enter the public arena, they convey social norms and attitudes. As part of their professional duty, clinicians strive to use language that accurately reflects science, promotes evidence-based treatment, and demonstrates respect for patients.

However, history has also demonstrated how language can cloud understanding and perpetuate societal bias. For example, in the past, people with mental illness were derided as “lunatics” and segregated to “insane asylums.” In the early days of human immunodeficiency virus, patients were labeled as having “gay-related immune deficiency,” with public discourse dominated by moral judgments. Other examples apply to disability and some infectious diseases. In all of these cases, stigma and discrimination can arise when patients are labeled, linked to undesirable characteristics, or placed in categories to separate “us” from “them.”

Today, these complex themes have special relevance for addiction. Scientific evidence shows that addiction to alcohol or drugs is a chronic brain disorder with potential for recurrence. However, as with many other chronic conditions, people with substance use disorders (SUDs) can be effectively treated and can enter recovery. For example, medication-assisted treatment such as buprenorphine hydrochloride, methadone hydrochloride, and naltrexone hydrochloride—provided in conjunction with behavioral counseling—can be life extending for patients with an opioid use disorder.

However, individuals with or in recovery from SUDs continue to be viewed with stigma, sometimes greater than that seen with physical or psychiatric disabilities.<sup>2</sup> Commonly used terms can imply, or even explicitly convey, that the individuals with SUDs are morally at fault for their disease. Patients may be referred to as “junkies,” “crackheads,” or other pejorative terms that describe them solely through the lens of their addiction or their implied personal failings. These word choices matter. Language related to SUDs does influence perceptions and judgments, even among health care professionals with substantial experience and expertise. For example, in one study involving a case vignette, doctoral-level mental health and SUD clinicians were significantly more likely to assign blame and to concur with the need for punitive actions when an individual was described as a “substance abuser” rather than as a “person with a substance use disorder.”<sup>3</sup> In a second study, mental health care practitioners attending professional conferences were less likely to believe individuals deserved treatment when they were described as a “substance abuser” rather than as a “person with a substance use disorder.”<sup>1</sup>

Stigma isolates people, discourages people from coming forward for treatment, and leads some clinicians, knowingly or unknowingly, to resist delivering evidence-based treatment services. The 2014 National Survey on Drug Use and Health<sup>4</sup> estimates that of the 22.5 million people (aged  $\geq 12$  years) who need specialty treatment for a problem with alcohol or illicit drug use, only an estimated 2.6 million received treatment in the past year; of the 7.9 million specifically needing specialty treatment for illicit drug use, only 1.6 million received treatment. The survey noted that reasons for not seeking treatment included fears that receiving it would adversely affect the individual’s job or the opinion of neighbors or other community members. Lack of insurance coverage, cost concerns, and not perceiving a need for treatment also contributed. Among health care professionals, negative attitudes regarding people with SUDs have led to diminished feelings of empowerment among patients, lower levels of empathy and engagement among health care professionals, and poorer outcomes.<sup>5</sup> Not surprisingly, medication-assisted treatment remains isolated within SUD treatment systems, which in turn have historically been separated from the rest of health care.

To help address these concerns, the American Medical Association has called on physicians across the nation to reduce the stigma of SUDs and enhance access to comprehensive treatment.<sup>6</sup> The American Society of Addiction Medicine and major addiction journals have urged the adoption of clinical, nonstigmatizing language in communicating about addiction, as has the subspecialty of addiction medicine (established in 2015 by the American Board of Medical Specialties).<sup>7</sup> Also, the 2013 *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* has replaced earlier categories of substance “abuse” and “dependence” with a single classification of “substance use disorder.”

The federal government is now announcing new steps. The White House Office of National Drug Control Policy is releasing guidance entitled *Changing the Language of Addiction*.<sup>8</sup> Developed in consultation with the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, the Substance Abuse and Mental Health Services Administration, and other federal agencies and stakeholders, this document will guide federal agencies in the accurate use of language regarding SUDs. The guidance offers ways to replace commonly used stigmatizing terms with alternative language more aligned with science. For example, the guidance recommends the following: replacing “drug abuser” with “person with a substance use disorder,” consistent with *DSM-5*; referring to a person as “in recovery” rather than being “clean,” because the latter term implies that people with this disease are

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dirty or socially unacceptable; and avoiding use of the term “drug habit,” which inaccurately portrays SUDs as simply a matter of personal choice.

The new guidance will apply to internal and external forms of communication, including publications, press and web materials, and funding announcements. It will reach federal officials, contractors, and grantees, among others, and encourage wider use of nonstigmatizing language in future public discourse. The adoption of clinically accurate terminology could help serve as an impetus toward better science-based public health policies and more integrated SUD services within broader health systems.

Language changes alone are insufficient, of course. Education and policy must also reduce stigma and the historical isolation of patients with SUDs from the rest of health care. For example, the Mental Health Parity and Addiction Equity Act of 2008 requires that services for mental health and SUDs be offered at parity with those for other physical conditions; rules were finalized in 2012. However, a 2016 US Department of Labor report on its implementation found that health care plans were still imposing inconsistent preauthorization requirements for SUD treatment, not disclosing the criteria for determining medical necessity or reasons for benefit denials for patients with SUDs, and making patients endure less effective, “fail first” therapies

before providing the standard of care (eg, treatment with US Food and Drug Administration–approved medication for opioid use disorder).<sup>9</sup> A 2016 White House Mental Health and Substance Use Disorder Parity Task Force is now addressing how best to ensure adherence to the parity regulations.

Furthermore, the Patient Protection and Affordable Care Act requires most health insurance plans to offer SUD services as one of 10 essential benefits. In addition, a 2015 presidential memorandum requires federal agencies to review health care benefit requirements, drug formularies, program guidelines, medical management strategies, drug utilization review programs, and all other relevant policies and tools to identify barriers preventing individuals with opioid use disorders from accessing medication-assisted treatment.

Changing language and related policies and programs will take time. Some stigmatizing terms and stereotypes related to SUDs have been ingrained in society for generations. For instance, the word “abuse” continues to appear in the titles of highly respected addiction journals and in the names of federal government agencies. By beginning to change the language of addiction, it is possible to foster a better future for people with SUDs. Doing so could help remove barriers that continue to hold back too many people from the lifesaving treatment they need.

## ARTICLE INFORMATION

**Conflict of Interest Disclosures:** Both authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

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