What's New in DSM-5 and the New ASAM Criteria?: Implications in an Era of Healthcare Reform

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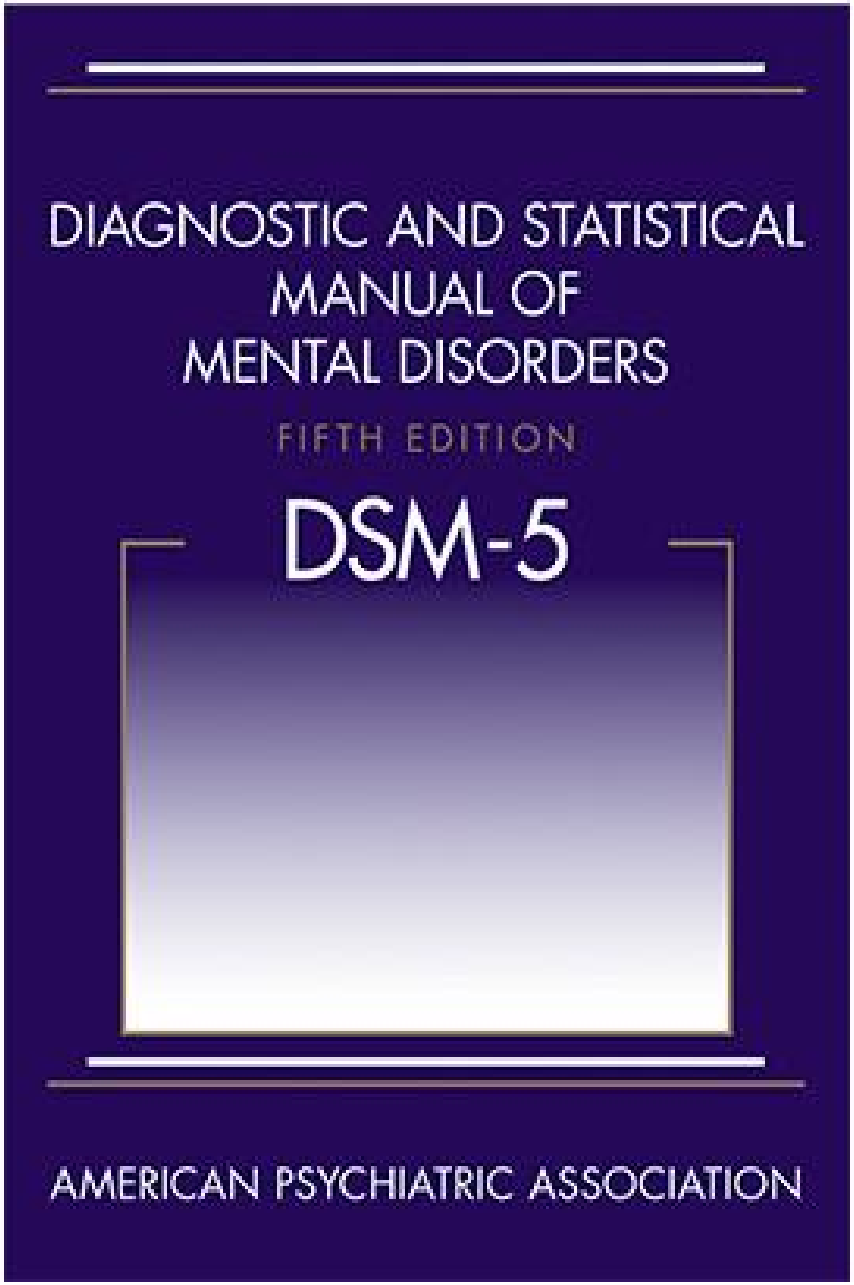

DIAGNOSTIC AND STATISTICAL
MANUAL OF
MENTAL DISORDERS
FIFTH EDITION
DSM-5
AMERICAN PSYCHIATRIC ASSOCIATION

AMERICAN SOCIETY OF ADDICTION MEDICINE
FOUNDED 1954
ASAM

Broader Perspective on Substance Use Problems and Addiction Illness

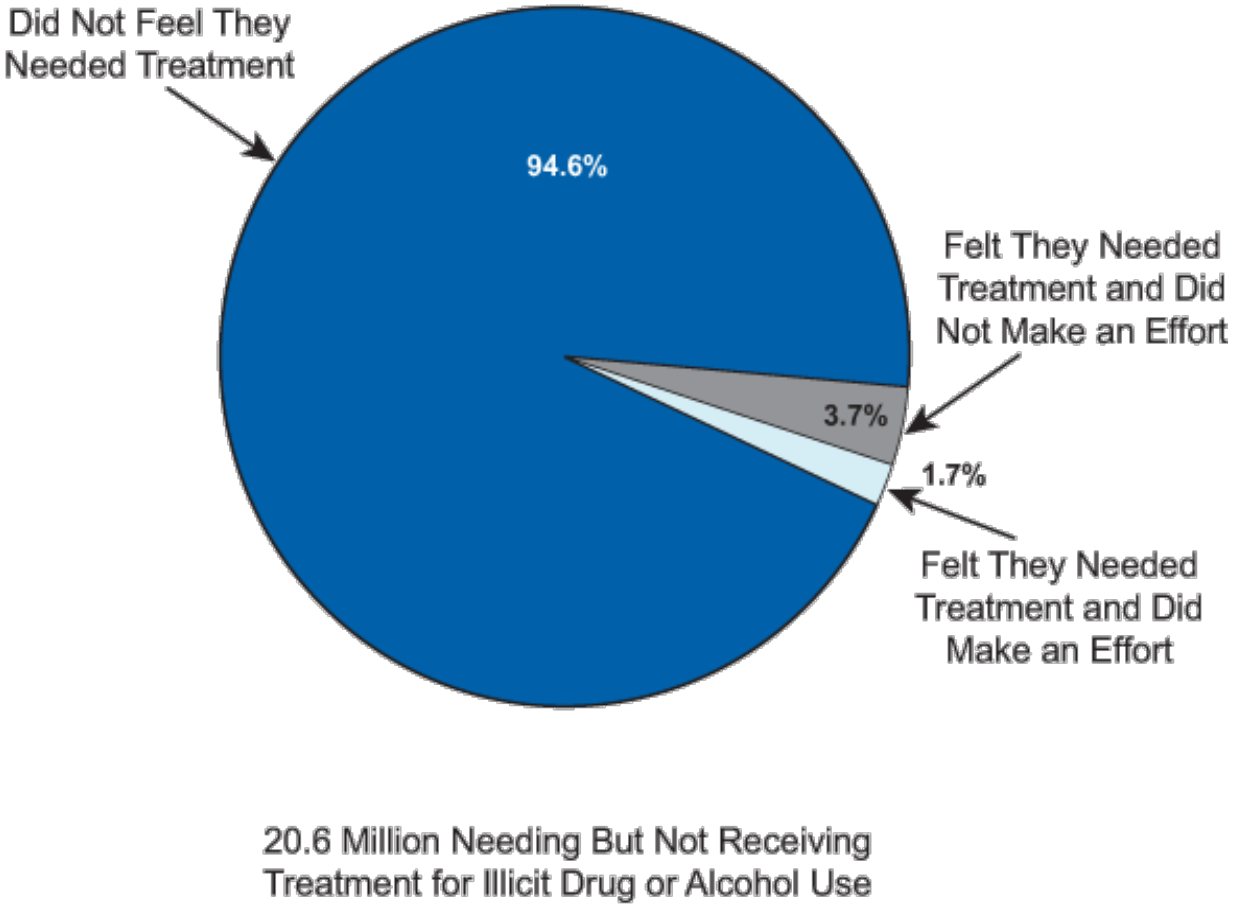
20.6 million

12 years and older

1.5%

National Survey on Drug Use and Health (NSDUH)

Past Year Perceived Need for and Effort Made to Receive Specialty Treatment Among Persons Aged 12 or Older Needing But Not Receiving Treatment for Illicit Drug or Alcohol Use: 2012 Data (September 2013 SAMHSA)



DSM - Why Diagnostic Criteria?

- Need for classification of mental disorders has been clear throughout history of medicine
- Little agreement on which disorders should be included; and optimal method for their organization
- Many nomenclatures (naming systems) have been developed during past 2,000 years - differed in their relative emphasis on phenomenology, etiology, and course as defining features

Why Diagnostic Criteria? (cont.)

- Some systems have included only handful of diagnostic categories; others have included thousands
- Various systems for categorizing mental disorders have differed with their principal objective for use in clinical, research, or statistical settings
- Creates a common language for communication between clinicians about the diagnosis of disorders

History of DSM

- 1952 – First edition
- 1968 – Second Edition DSM-II – only 136 pages
- 1980 – DSM-III published after work had began on DSM-III in 1974
- 1987 – Publication of DSM-III-R after APA appointed Work Group to revise and correct DSM-III
- 1994 – Publication of DSM-IV
- 2000 – Publication of DSM-IV- Text Revision
- 2013 – Publication of DSM-5

Chapter Organization, Enhancements

- Lifespan approach – disorders diagnosed in childhood e.g., neurodevelopmental disorders placed at beginning of manual and disorders more applicable to older adulthood e.g., neurocognitive disorders at end

- Consolidation of Autistic, Rett's, Asperger's, Childhood Disintegrative Disorders (Pervasive Developmental Disorders) –

- Autism Spectrum Disorder(ASD)

- ASD severity based on impairments of social communication and social interaction versus restrictive, repetitive patterns of behavior

Chapter Organization, Enhancements

- **Streamlined classification** of bipolar and depressive disorders (most commonly diagnosed conditions in psychiatry). Rather than separating definition of manic, hypomanic and major depressive episodes from definition of bipolar I, bipolar II and major depressive disorder, all component criteria included within respective criteria for each disorder

- Transitioning in conceptualizing personality disorders – dimensional approach to personality disorders "Hybrid" model proposed in **Section III, Conditions for Further Study** -new disorders and features

Chapter Organization, Enhancements

Alternative model of Personality Disorders proposes:

- Criterion A: Level of **Personality Functioning** – disturbances in self and interpersonal functioning constitute the core of personality psychopathology, evaluated on a continuum
- Criterion B: Pathological **Personality Traits** organized into five broad domains: Negative Affectivity, Detachment, Antagonism, Disinhibition, and Psychoticism

Dimensional Approach to Diagnosis

- Structural problems in previous DSM - large number of narrow diagnostic categories in clinical practice, research
- Substantial use of "not otherwise specified" NOS diagnoses -When full criteria not met, consider whether symptom presentation meets criteria for "other specified" e.g., "other specified depressive disorders, depressive episode with insufficient symptoms or "unspecified" designation
- Previous DSM - each diagnosis categorically separate from health and from other diagnoses. Did not capture sharing of symptoms and risk factors across disorders (mood swings in bipolar and substance use disorders)
- Most human ills, mental disorders heterogenous - genetic risk factors to symptoms e.g., 65 yo social drinker forced to retire versus 20 yo whose family history and role models point to heavy addiction at young age

Elements of a Diagnosis
Diagnostic Criteria and Descriptors

- Diagnostic criteria offered as guidelines for making diagnoses, and use should be informed by clinical judgment
- After assessment of diagnostic criteria, clinicians should consider application of disorder subtypes and/or specifiers as appropriate
- Severity and course specifiers should be applied to denote individual's current presentation, but only when full criteria met
- Where applicable, specific criteria for defining severity (mild, moderate, severe, extreme), descriptive features (with good to fair insight; in a controlled environment; and course (in partial remission, in full remission, recurrent) provided with each diagnosis
- Combination of: clinical interview, text descriptions, criteria, and clinical judgment – a diagnosis

Elements of a Diagnosis (con't)
Subtypes and Specifiers

- DSM-5 diagnosis usually applied to individual's current presentation. Previous diagnoses from which individual has recovered should clearly be noted as such e.g., specifiers indicating *course* e.g., in partial remission, in full remission may be listed after the diagnosis
- Where available, *severity specifiers* provided to guide clinicians in rating intensity, frequency, duration symptom count, or other severity indicator of disorder. Indicated by instruction "*Specify* current severity".
- *Descriptive features specifiers* have also been provided in criteria set and convey additional information that can inform treatment planning e.g., obsessive-compulsive disorder, with poor insight.
- Not all disorders include course, severity, and/or descriptive features specifiers

No More Multiaxial System

- DSM-5 moved to **nonaxial** documentation of diagnosis
- Multiaxial distinction between Axis I, II and III did not imply fundamental differences - that mental disorders are unrelated to physical and biological factors or processes, or that general medical conditions unrelated to behavioral or psychosocial factors or processes
- In DSM-5 Axis III **combined** with Axes I and II, with separate notations for important psychosocial and contextual factors (formerly Axis IV) and disability (formerly Axis V)
- Elimination of multiaxial diagnoses enhances a more

holistic and integrative system

Principal Diagnosis

- When more than one diagnosis is given in inpatient setting, principal diagnosis is condition established after study to be

chiefly responsible for occasioning admission of individual

- When more than one diagnosis is given in an outpatient setting, reason for visit is condition that is chiefly responsible for ambulatory care medical services received during the visit

- In most cases, principal diagnosis or reason for visit is also main focus of attention or treatment

DSM-5 Substance-Related and Addictive Disorders (Gambling Disorder)

- "dependence" – as label for addiction confusing; only for physiological dependence
- Patients with normal tolerance and withdrawal labeled as "addicts.", which is normal response to repeated doses of many medications (beta-blockers, antidepressants, opioids, anti-anxiety agents and other drugs)
- Tolerance and withdrawal symptoms not counted as symptoms for diagnosis of substance use disorder when occurring in context of appropriate medical treatment with prescribed medications

DSM-5 Substance-Related and Addictive Disorders (Gambling Disorder)

- Organized according to substance

  versus according to diagnosis e.g., Hallucinogen Disorders vs Substance Intoxication or Substance Abuse or Dependence

- One criterion dropped, legal problems because: (a) very low prevalence in adult and many adolescent population samples; (b) low discrimination – legal problems doesn't separate out distinctly who has SUD versus just social problems (developmental risk taking or antisocial personality, psychosis, mania and other mental health issues); (c) poor fit with other SUD criteria; (d) little added information in item response theory analyses. No patients had legal problems as their only criterion and none "lost" a DSM-5 SUD Dx.

DSM-5 Substance-Related and Addictive Disorders (Gambling Disorder)

- One criterion added, craving

  because: (a) behavioral, imaging, pharmacology and genetic studies indirectly support this criterion; (b) craving and its reduction can be central to diagnosis and treatment; (c) craving is in ICD-10 dependence criteria so this increases consistency between the nosologies; (d) fits well with other SUD criteria; (e) clinically useful

- Also Internet Gaming Disorder for Section III. Substance-Induced Dissociative Disorder removed

DSM-5 Substance-Related and Addictive Disorders (Gambling Disorder)

- Cannabis withdrawal and Caffeine withdrawal both added, but not Caffeine Use Disorder (Section III)
- Tobacco Use Disorder aligned with criteria for other substance use disorders.
- New severity specifiers and updated remission specifiers

Substance Use Disorder

Substance use disorder is defined by the following criteria in DSM-5:

A. A problematic pattern of substance use leading to clinically significant impairment or distress as manifested by at least two of the following occurring in a 12-month period:

Substance Use Disorder Criteria

1. Use in larger amounts or longer than intended
2. Desire or unsuccessful effort to cut down
3. Great deal of time using or recovering
4. Craving or strong urge to use
5. Role obligation failure
6. Continued use despite social/interpersonal problems
7. Sacrificing activities to use or because of use
8. Use in situations where it is hazardous
9. Continued use despite knowledge of having physical or psychological problem caused or exacerbated by use
10. Tolerance
11. Withdrawal

SUD CRITERIA PRIMARILY IN SEVERE DESIGNATION ONLY

The "Big Five"

- Wanting to cut down/unable to do so
- Craving with compulsion to use
- Sacrifice activities to use
- Failure at role fulfillment due to use
- Withdrawal symptoms

(Norman G. Hoffmann, Ph.D.
President, Evince Clinical Assessments
evinceassessment@aol.com)

CRITERIA PREVALENT IN MILD & MODERATE GROUPS

- Unplanned use
- Time spent using
- Medical/psych. consequences of use
- Use where impairment is dangerous
- Interpersonal conflicts
- Legal problems and use to relieve emotional distress similar in distribution to these

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evinceassessment@aol.com)

CLINICAL IMPLICATIONS

- Most of those in the “mild” designation can probably benefit from moderation and related harm reduction strategies
- Those in the “severe” designation will require more intensive and extended services where abstinence is essential to recovery
- The “moderate” group may contain cases that fit the mild or severe characteristics

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President, Evince Clinical Assessments
evinceassessment@aol.com)

CLINICAL (Medical) NECESSITY

- Persons in the severe designation with positive “Big Five” findings will require a more intensive and longer continuum of care to achieved treatment effectiveness

- Persons in the mild designation typically will benefit from brief interventions to achieve treatment efficiency

- Each treatment plan can be informed by prior empirical outcome data on comparable cases and modified based on the individual’s treatment response

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evinceassessment@aol.com)

Severity Scale DSM-5

The Severity of each Substance Use Disorder is based on:

- 0 criteria or 1 criterion: No diagnosis
- 2-3 criteria: Mild Substance Use Disorder
- 4-5 criteria: Moderate Substance Use Disorder
- 6 or more criteria: Severe Substance Use Disorder

Severity and Course Specifiers

In early remission:

- Full criteria for SUD were previously met
- None of the criteria for SUD have been met for at least 3 months, but for less than 12 months
- Except for Criterion 4, “Craving or a strong desire or urge to use a specific substance”)

In a sustained remission:

- Full criteria for SUD were previously met
- None of the criteria for SUD have been met at any time during a period of 12 months or longer,
- Except for Criterion 4, “Craving or a strong desire or urge to use a specific substance”)

Severity and Course Specifiers

- The following specifier applies as a further specifier of remission (e.g. “early remission in a controlled environment”, and “sustained remission in a controlled environment”) if the individual is in remission and in a controlled environment:

- **In a Controlled Environment.** This additional specifier is used if the individual is in an environment where access to alcohol and controlled substances is restricted. Examples of these environments are closely supervised and substance-free jails, therapeutic communities, and locked hospital units.

Diagnostic Strategies

- Assessing for substance use disorder - In assessing for substance use disorder, one initially attempts to determine whether the patient's substance use is causing negative consequences. If such consequences are significant and recurrent in a 12 month-period, then diagnosis of substance use disorder is warranted

Diagnostic Strategies (cont.)

- Assessing for substance-induced disorders – Even if client does not meet criteria for substance use disorder, there may be substance-induced withdrawal or intoxication; or variety of substance-induced disorders including anxiety, depression, psychosis, sleep disorder or sexual dysfunction

Co-Occurring and Substance-Induced Mental Disorders

- SUD and mental disorders frequently co-occur - many symptoms e.g., insomnia being criteria for intoxication, withdrawal syndrome, or other mental disorders
- DSM-IV: “primary” mental disorders if began prior to substance use or persisted > than 4 weeks after cessation of acute withdrawal or severe intoxication
- DSM-IV: Substance-induced mental disorders defined: occur during periods of substance intoxication or withdrawal or remitting within 4 weeks thereafter; Sxs need exceed expected severity of intoxication or withdrawal; expected to remit within days to weeks of abstinence – to improve poor reliability and validity

Co-Occurring and Substance-Induced Mental Disorders

- DSM-5 reversed these DSM-IV standardization criteria and implemented flexible approach that lacked specific symptom duration requirements and included addition of disorder-specific approaches:

Criterion A: Disorder represents clinically significant symptomatic presentation of relevant mental disorder

Co-Occurring and Substance-Induced Mental Disorders

Criterion B: Evidence from history, physical exam, or laboratory findings of both of following:

1. The disorder developed during or within 1 month of substance intoxication or withdrawal or taking a medication; and

2. The involved substance/medication is capable of producing the mental disorder.

Co-Occurring and Substance-Induced Mental Disorders

Criterion C: Disorder not better explained by independent mental disorder (i.e. one that is not substance-or medication-induced). Such evidence of independent mental disorder could include following:

1. Disorder preceded onset of severe intoxication or withdrawal or exposure to the medication; or

2. Full mental disorder persisted for substantial period of time (e.g., at least 1 month) after cessation of acute withdrawal or severe intoxication or taking medication. Criterion does not apply to substance-induced neurocognitive or hallucinogen persisting perception disorders, which persist beyond cessation of acute intoxication or withdrawal

Co-Occurring and Substance-Induced Mental Disorders

Criterion D: The disorder does not occur exclusively during the course of a delirium

Criterion E: The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Example in DSM-5

Alcohol-Related Disorders:

305 Alcohol Use Disorder, severe

303 Alcohol Intoxication with use disorder, severe

291.81 Alcohol Withdrawal, with perceptual disturbances

Other Alcohol-Induced Disorder

291.9 Unspecified Alcohol-Related Disorder

DSM-5
Gambling Disorder

Persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress, as indicated by four (or more) of the following in a 12-month period.

1. Needs to gamble with increasing amounts of money in order to achieve the desired excitement.
2. Is restless or irritable when attempting to cut down or stop gambling.
3. Has made repeated unsuccessful efforts to control, cut back, or stop gambling.
4. Is often preoccupied with gambling (e.g., having persistent thoughts of reliving past gambling experiences, handicapping or planning the next venture, thinking of ways to get money with which to gamble).

DSM-5

Gambling Disorder (cont.)

5. Often gambles when feeling distressed (e.g., helpless, guilty, anxious, depressed).
6. After losing money gambling, often returns another day to get even ("chasing" one's losses).
7. Lies to conceal the extent of involvement with gambling.
8. Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling.
9. Relies on others to provide money to relieve desperate financial situations caused by gambling.

DSM-5
Gambling Disorder (cont.)

B. The gambling behavior is not better accounted for by a manic episode.

Course Specifiers

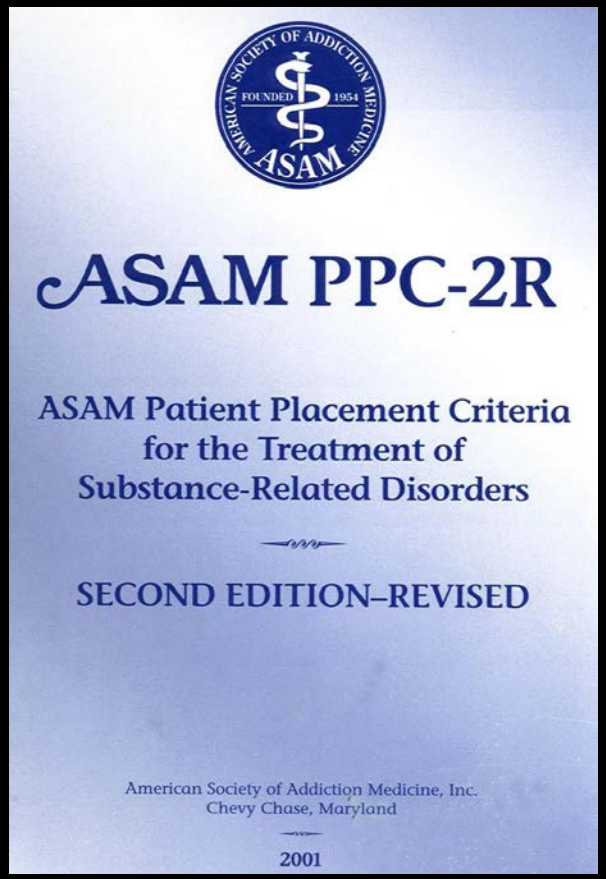
- Episodic
- Persistent
- In early remission
- In sustained remission

Current Severity:

Mild: 4-5 criteria met

Moderate: 6-7 criteria met

Severe: 8-9 criteria met


ASAM PPC-2R
ASAM Patient Placement Criteria
for the Treatment of
Substance-Related Disorders
SECOND EDITION–REVISED
American Society of Addiction Medicine, Inc.
Chevy Chase, Maryland
2001

THE ASAM CRITERIA
Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions
American Society of Addiction Medicine
Third Edition, 2013

Goal of *The ASAM Criteria*:

To unify the addiction field around a single set of criteria

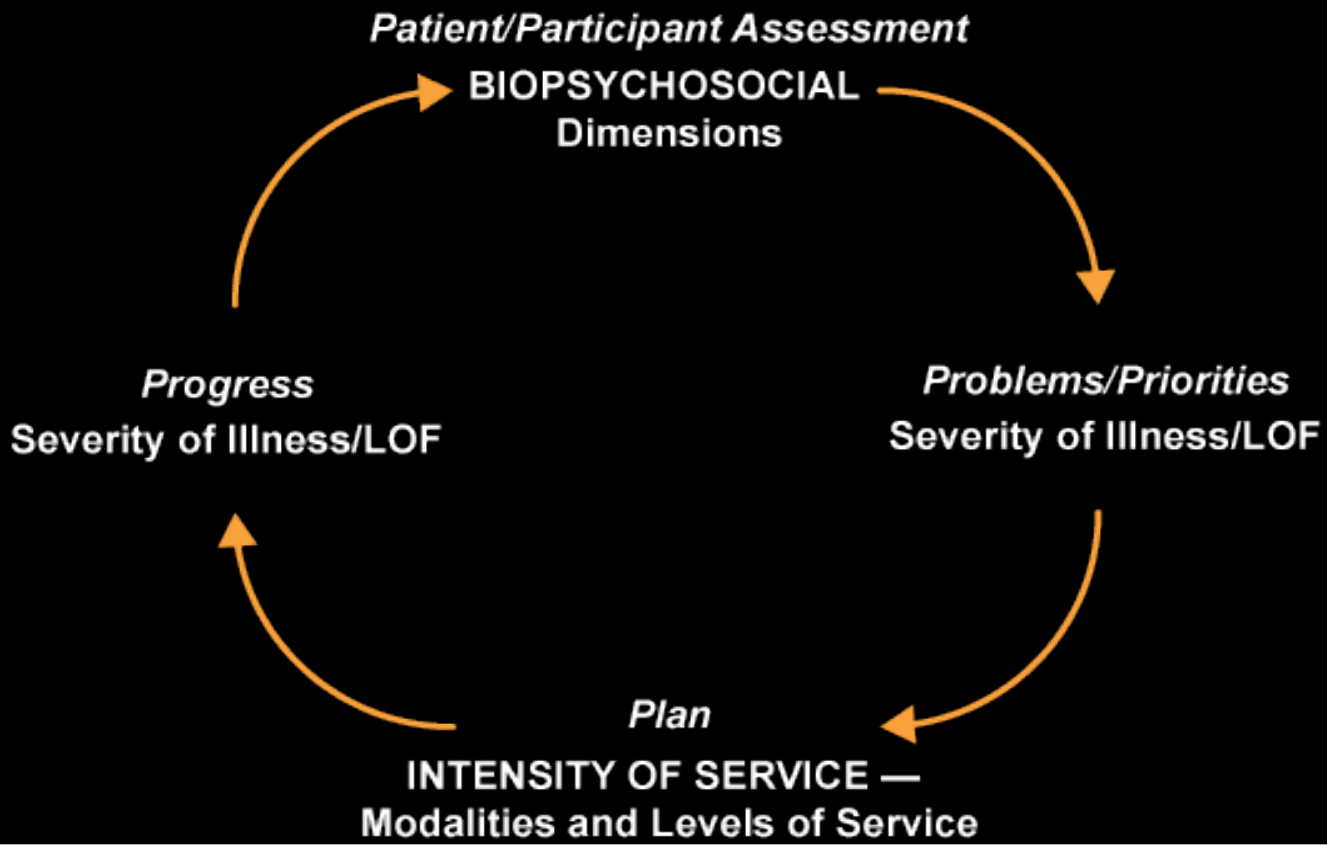
ASAM Criteria Background

- Previous Editions
  - *Patient Placement Criteria* (1991)
  - *Patient Placement Criteria-2* (1996)
  - *Patient Placement Criteria-2R* (2001)

ASAM Criteria Background

- Upcoming Edition:
  - *The ASAM Criteria – Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*
  - Released in Fall 2013
  - Editor-in-Chief: David Mee-Lee, MD

Underlying Concepts of *The ASAM Criteria*: Individualized, Clinically-driven Treatment



Assessment of Biopsychosocial Severity and Level of Function

1. Acute Intoxication and/or Withdrawal Potential

2. Biomedical conditions and complications

3. Emotional/Behavioral/Cognitive conditions and complications

Assessment of Biopsychosocial Severity and Level of Function

4. Readiness to Change

5. Relapse/Continued Use/Continued Problem potential

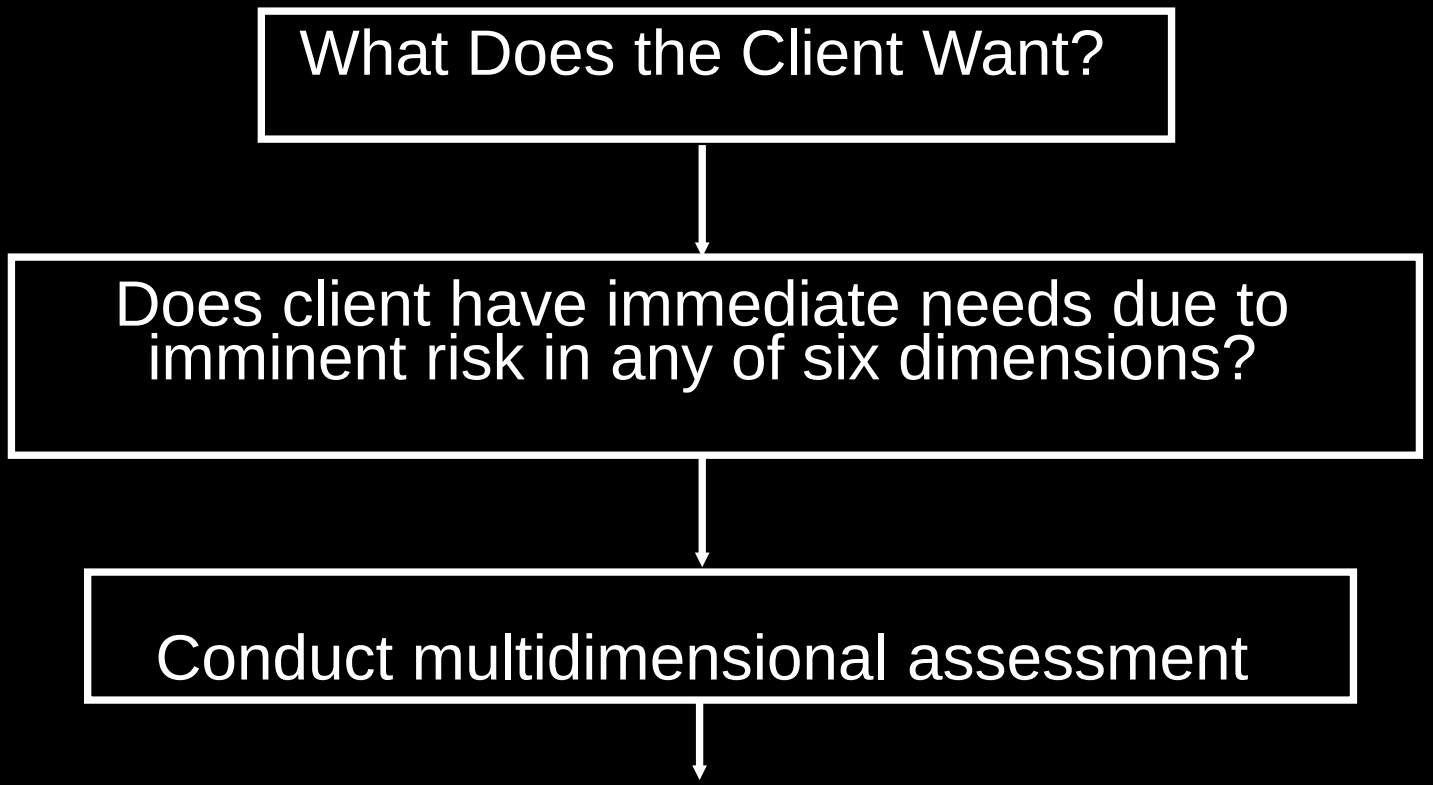
6. Recovery Environment

Broad Treatment Levels of Service: A Description of the Continuum of Care

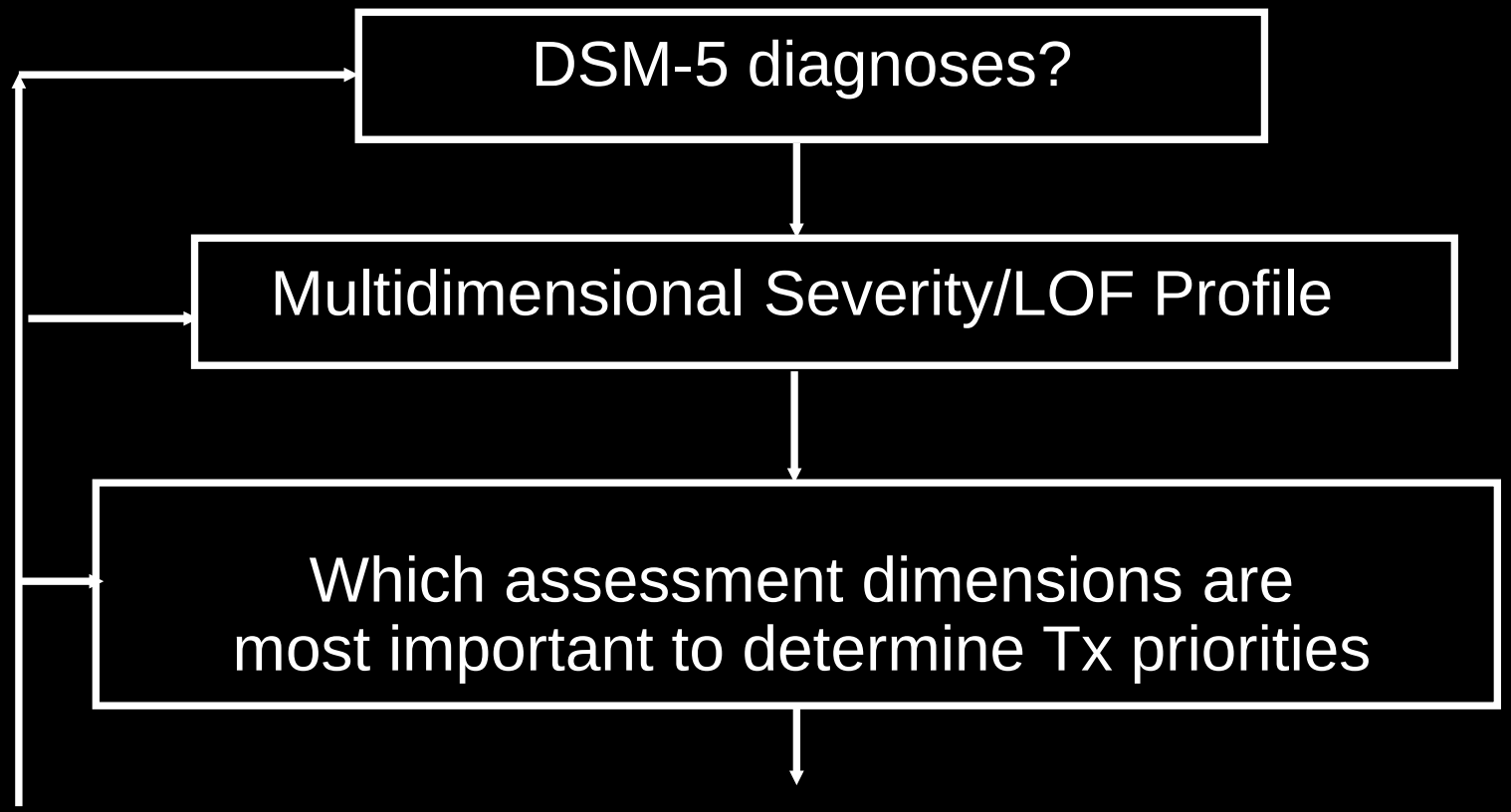
Levels of Service

1. Outpatient Treatment
2. Intensive Outpatient and Partial Hospitalization
3. Residential/Inpatient Treatment
4. Medically-Managed Intensive Inpatient Treatment

Focus Assessment and Treatment



Focus Assessment and Treatment (cont.)



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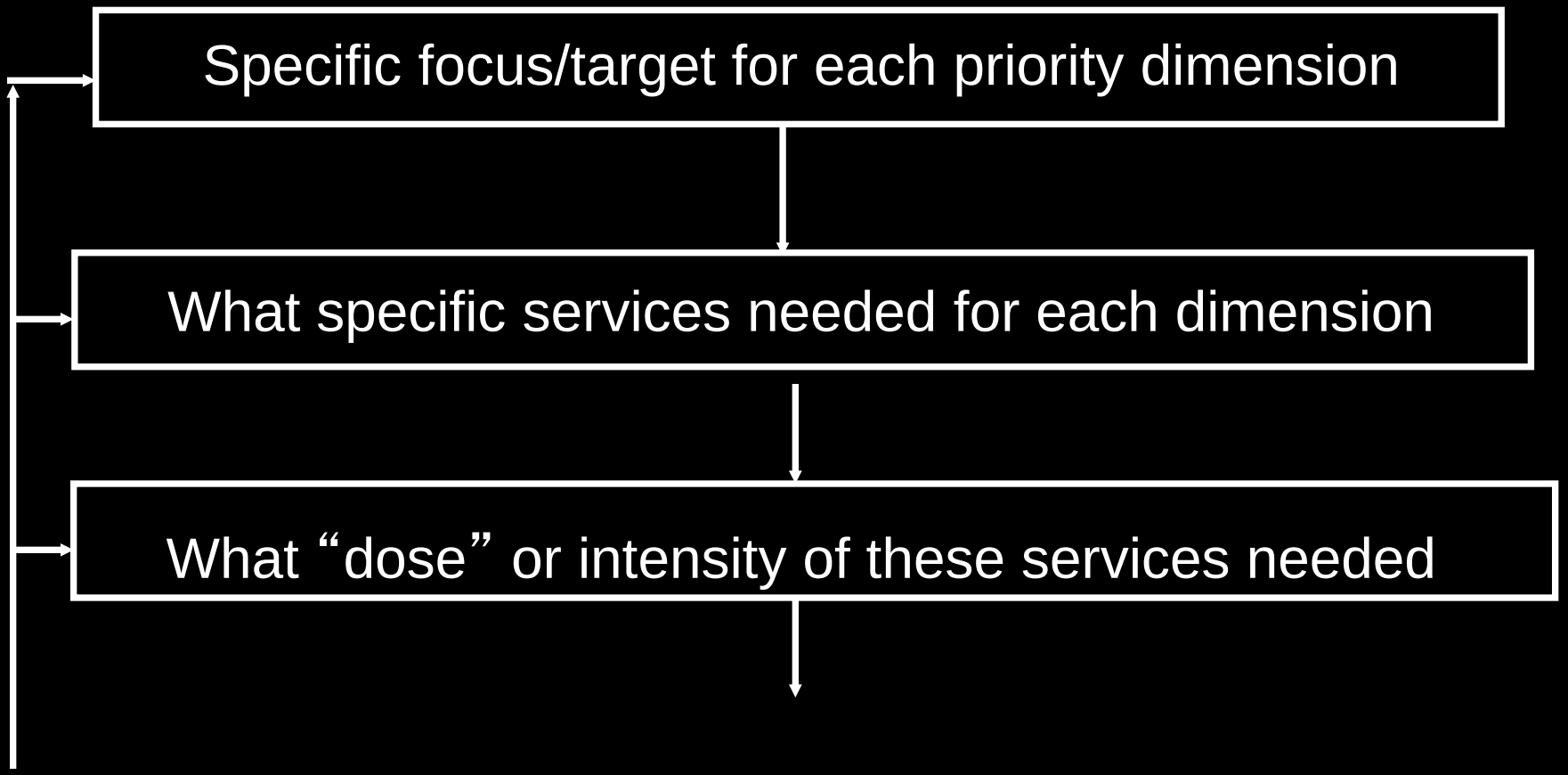
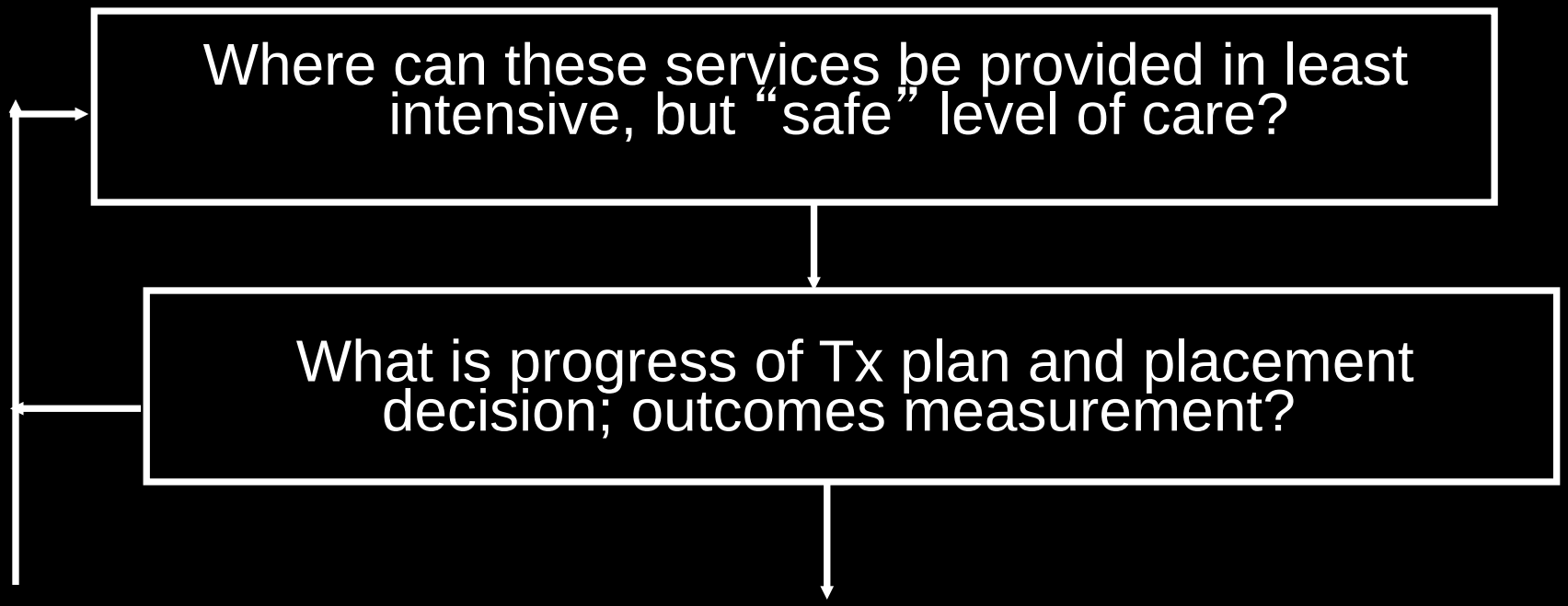
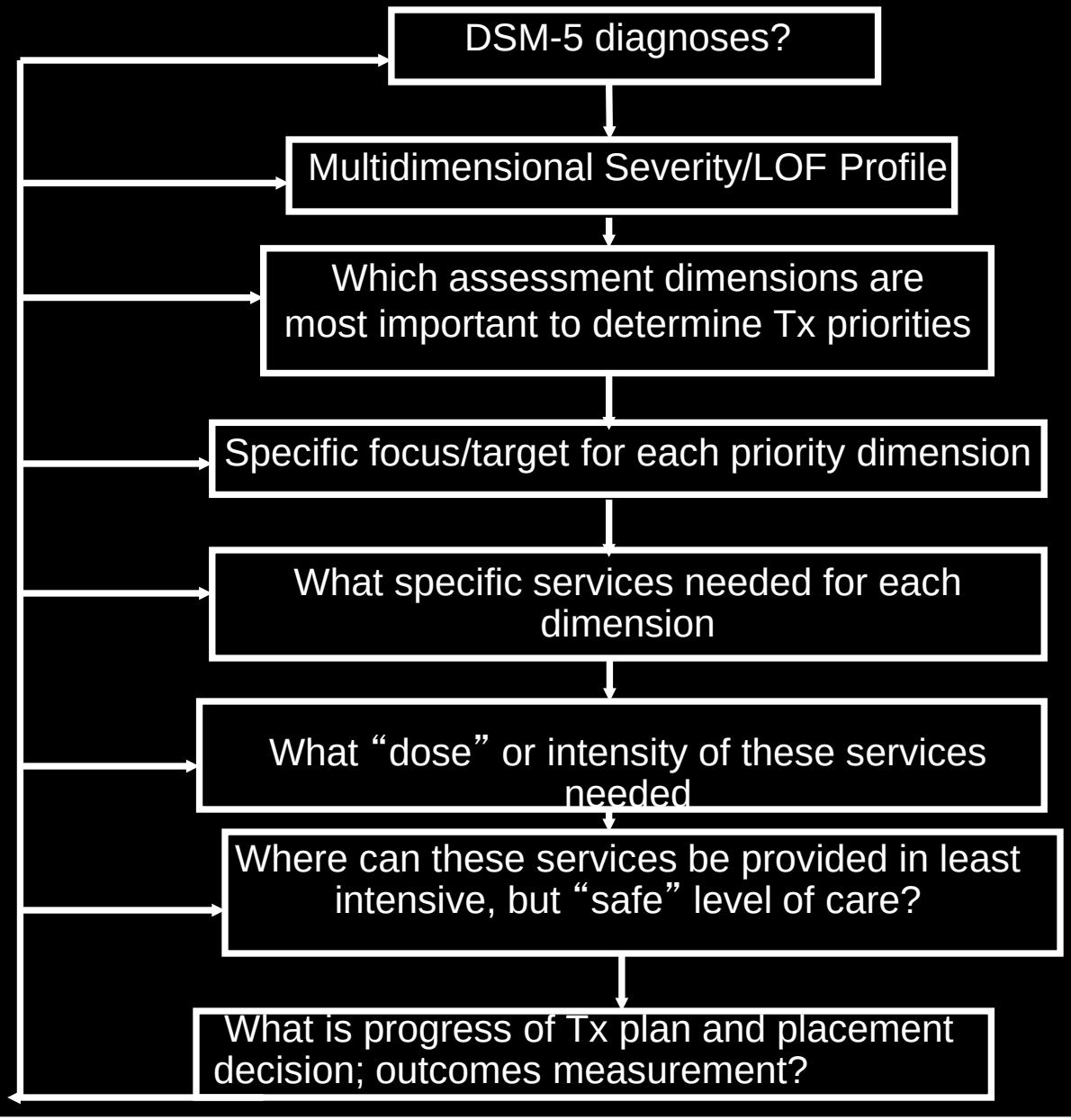


Focus Assessment and Treatment (cont.)




DSM-5 diagnoses?
Multidimensional Severity/LOF Profile
Which assessment dimensions are most important to determine Tx priorities
Specific focus/target for each priority dimension
What specific services needed for each dimension
What "dose" or intensity of these services needed
Where can these services be provided in least intensive, but "safe" level of care?
What is progress of Tx plan and placement decision; outcomes measurement?

Broad Treatment Levels of Service: A Description of the Continuum of Care

- More levels of care within each of the broad levels
- Changes from Roman numerals to Arabic numerals, e.g.:
  - “Level I” becomes “Level 1”
  - “Level II.1” becomes “Level 2.1”
  - “Level II.5” becomes “Level 2.5”
  - “Level III.1” becomes “Level 3.1”

What's not new in *The ASAM Criteria*

- The six assessment dimensions
- The overall levels of care (though not Roman numerals) for addiction management
- The "decision rules," which link Intensity of Service back to the Severity of Illness maintained except for some updates in Withdrawal Management ("Detox")

What's not new in *The ASAM Criteria*

The Process: (from http://www.asam.org/publications/the-asam-criteria)

- Oversight and revision of the criteria is a collaborative process between ASAM leadership and the Steering Committee of the Coalition for National Clinical Criteria (CNCC)

What's not new in *The ASAM Criteria*

The Process: (from http://www.asam.org/publications/the-asam-criteria)

- The coalition represents major stakeholders in addiction treatment and has been meeting regularly since the development of the first ASAM *Patient Placement Criteria* in 1991

What's new in *The ASAM Criteria*?

- New Title: *The ASAM Criteria -- Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*
- Shift away from "placement" criteria to "treatment" criteria: it's more than just "placement"

What's new in *The ASAM Criteria*?

- Diagnostic Admission Criteria terminology changed to be compatible with *DSM-5*
- Section on working with managed care

What's new in *The ASAM Criteria*?

- Table of contents
  - Re-ordered to be more user-friendly
  - Follows the flow from Historical Foundations to Guiding Principles to Assessment, Service Planning, and Placement decisions

What's new in *The ASAM Criteria*?

- Adolescent Criteria
  - No longer separate/stand-alone
  - Consolidated Adult and Adolescent content to minimize redundancy while preserving adolescent-specific content

What's new in *The ASAM Criteria*?

- Appendices
  - Withdrawal Management instruments
  - Dimension 5 constructs
  - Glossary

What's new in *The ASAM Criteria*?

- Withdrawal Management
  - The wording in the Levels of Care
  - Former section "Detoxification" becomes "Withdrawal Management"
  - Levels are now called WM-1, WM-2, WM-3, and WM-4
  - New approaches described to support increased use of less intensive levels of care for safe/effective management of withdrawal

What's new in *The ASAM Criteria*?

- Updated/revised terminology
  - Contemporary, strength-based, recovery-oriented:
    - "dual diagnosis" becomes "co-occurring disorders"
    - "inappropriate use of substances" becomes "high risk use of substances"

What's new in *The ASAM Criteria*?

- Opioid use disorder specialized services
  - Opioid Maintenance Therapy" (OMT) becomes "Opioid Treatment Services" (OTS)
    - Opioid antagonist medications
    - Opioid agonist medications
    - Their use in OTPs (regulated "Opioid Treatment Programs") or in office-based opioid treatment (OBOT)

New Content and Sections

- Additional text to improve application to address addiction treatment for Special Populations:
  - Older Adults
  - Persons in Safety Sensitive Occupations
  - Parents with Children and Pregnant Women
  - Persons in the Criminal Justice System (CJS)

New Content and Sections

- Additional text to address treatment of conditions not traditionally included in specialty addiction treatment services:
  - Tobacco Use Disorder
  - Gambling Disorder

New Content and Sections

- Revision of the text to address emerging issues:
  - Healthcare Reform and the integration of addiction treatment into general medical care
  - The role of physicians on the care team, addiction specialist physicians in particular (addiction medicine physicians, addiction psychiatrists)

The ASAM Criteria Software

- *The ASAM Criteria* book and *The ASAM Criteria Software* are companion text and application
- The text delineates the dimensions, levels of care, and decision rules that comprise *The ASAM Criteria*

The ASAM Criteria Software

- The software provides an approved structured interview to guide adult assessment and calculate the complex decision tree to yield suggested levels of care, which are verified through the text

The ASAM Criteria Software

- The text and software are used in tandem:
  - The text provides background and instruction for proper use of software
  - The software enables comprehensive, standardized evaluation

The ASAM Criteria Software

- *The ASAM Criteria Software* is undergoing nationwide open-source release by U.S. Substance Abuse and Mental Health Services Administration (SAMHSA)

The ASAM Criteria

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The ASAM Criteria Software

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ASAM THE CRITERIA & SOFTWARE

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THE ASAM CRITERIA

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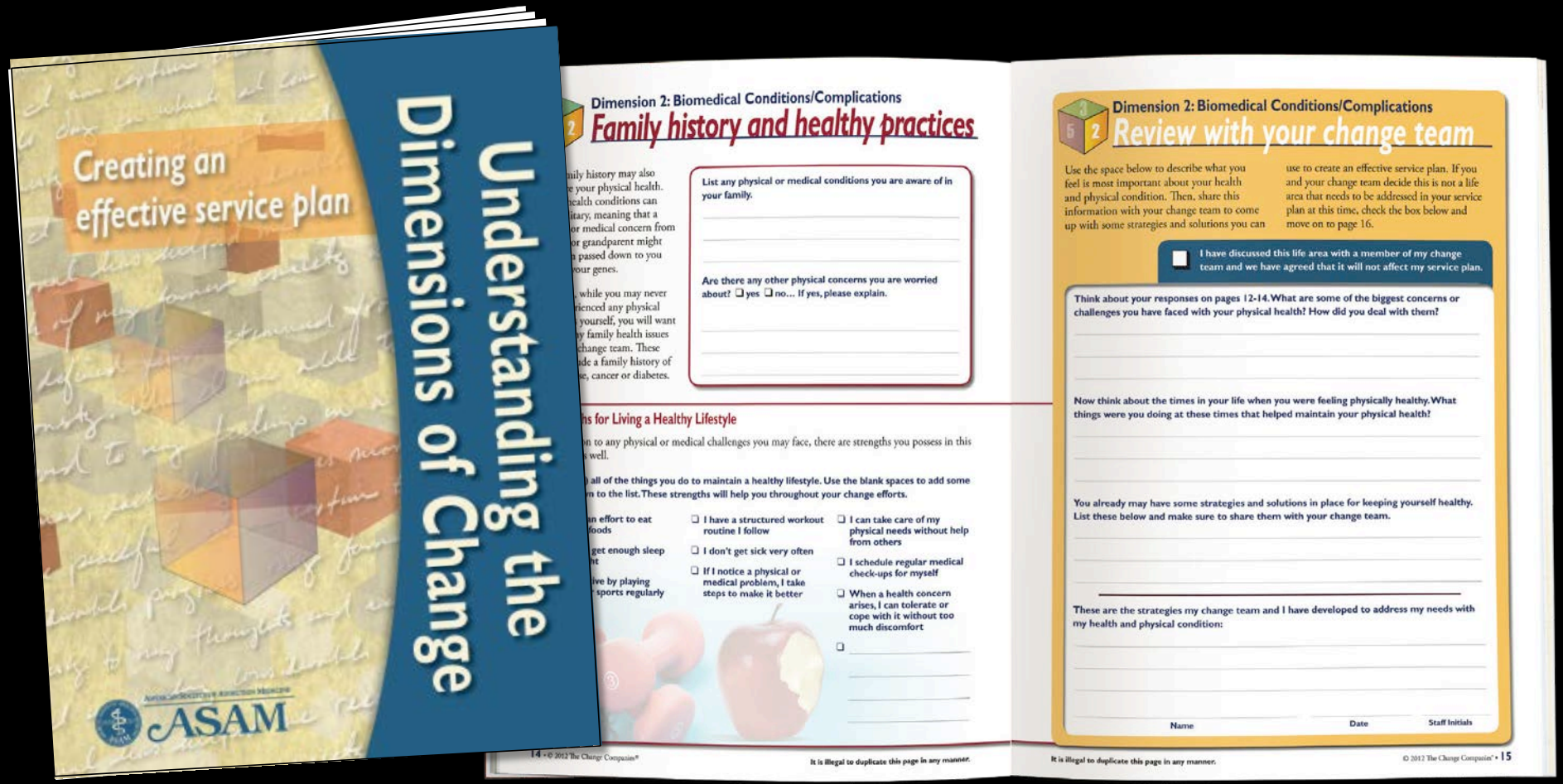
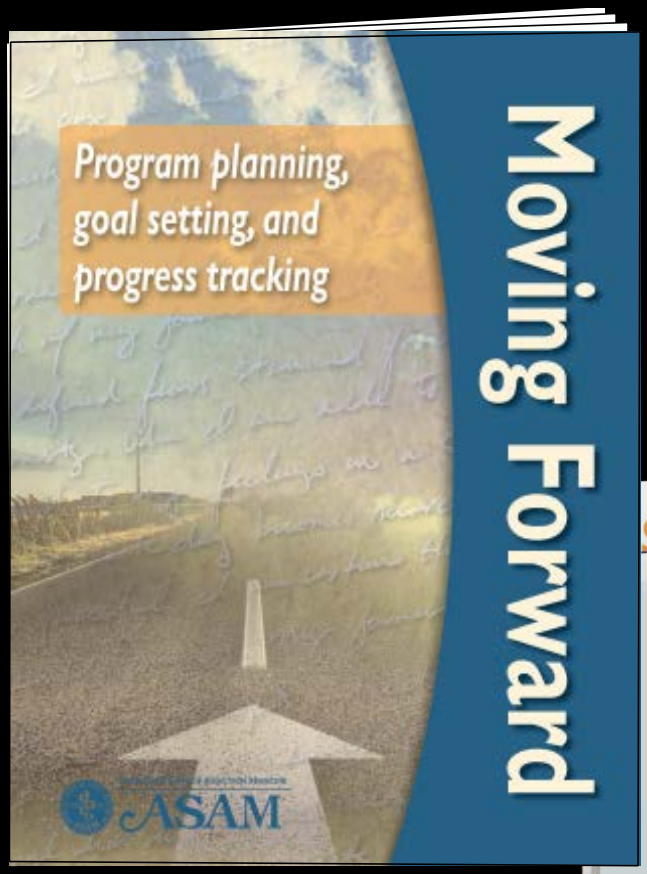
Understanding the Dimensions of Change



Moving Forward Participant Journal



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THE ASAM CRITERIA

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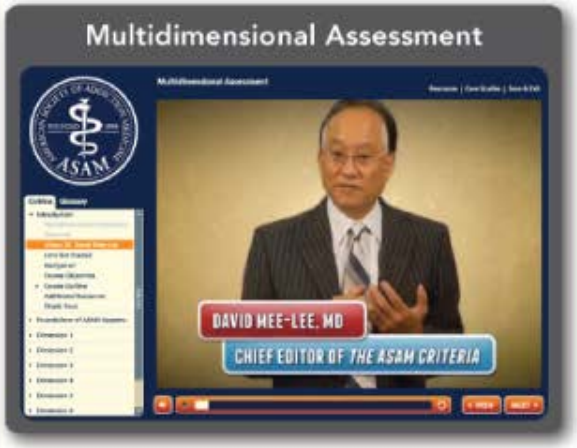

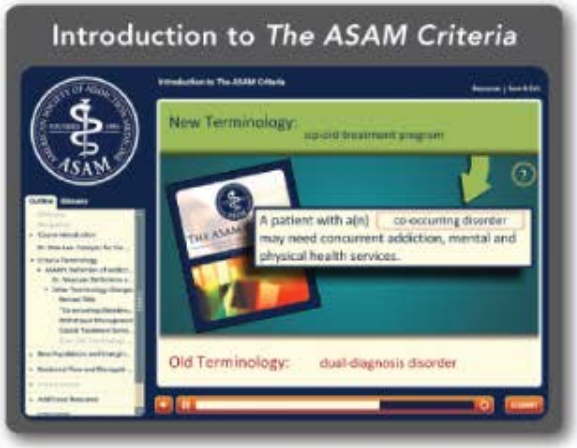

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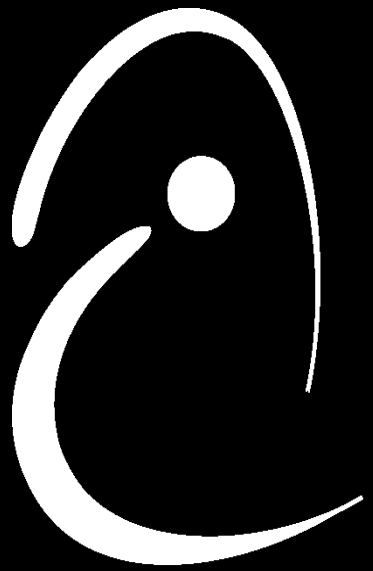

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