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CURRENT COVERAGE OF TOPICS IN ADDICTION MEDICINE

David A. Frenz, MD
Editor-in-Chief

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IN THIS ISSUE

Focus of the Month:
Addiction in *DSM-5*

Learning objectives for this issue:
1. Describe how the concept of addiction has changed over time, including the newest shift in how clinicians diagnose substance use disorders (SUDs) with the release of *DSM-5*. **2.** Explain why the *DSM-5* changes concerning addiction are "closer to nature" or a better reflection of what is encountered clinically. **3.** Summarize the clinical and financial implications of the changes regarding SUDs in *DSM-5*. **4.** Understand some current research findings regarding addiction.

DSM-5: Clinical and Financial Implications

Norman G. Hoffmann, PhD, Adjunct professor of psychology
John W. Baley, MA candidate, clinical psychology
Western Carolina University

Dr. Hoffman and Mr. Baley have disclosed that they have no relevant financial or other interests in any commercial companies pertaining to this educational activity.

The new *DSM-5* will change the way clinicians diagnose substance use disorders (SUD) and could have far-reaching consequences for patients seeking treatment and clinicians and organizations offering that treatment.

Various proposals for addiction were batted around during the *DSM-5* revision process. The final version changed the diagnostic criteria for SUD from the time-honored categorical designations—abuse and dependence—into a dimensional construct involving mild (MiSUD), moderate (MSUD), and severe (SSUD) addiction.

We now have a single set of 11 criteria for diagnosing patients with addiction. (See "*DSM-5* Criteria for Substance Use Disorders" on p. 5.)

In Summary

- Substance use disorder: then (*DSM-IV*)—abuse and dependence; now (*DSM-5*)—mild (MiSUD), moderate (MSUD), and severe (SSUD) substance use disorder
- Bye-bye legal problems criteria; hello craving and compulsion to use
- In high-risk populations, 80%+ of those meeting *DSM-IV* criteria for alcohol dependence and 90% of cocaine or cannabis dependence fit within *DSM-5's* SSUD category

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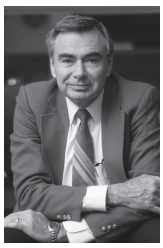
Q&A With the Expert

Substance Use Disorder in *DSM-5*
Charles P. O'Brien, MD, PhD

Kenneth Appel Professor, Department of Psychiatry
Director, Addiction Research Center
University of Pennsylvania
Chairman, substance use disorders work group, DSM-5

Dr. O'Brien has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.



CATR: As the chairman of the *DSM-5* substance use disorders work group, please tell us what motivated the addiction-related changes in the new manual.

Dr. O'Brien: Well, first of all, it was time to review the *DSM-IV-TR,* which was published 14 years ago. There were also a lot of mistakes in the *DSM-IV.* So my motivation for accepting the responsibility as chairman was to try to correct the mistakes in *DSM-IV* that were causing harm to patients.

CATR: Could you identify some of the mistakes?

Dr. O'Brien: The first and most egregious is that the word *dependence* was used when what we really meant was *addiction.* Instead of using the word addiction, the committee that wrote *DSM-III-R* voted by a narrow margin to use the word dependence (O'Brien C, *Addiction* 2011;106(5):866–887). This committee was dominated

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DSM-5: Clinical and Financial Implications
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Here's the breakdown for severity:

- Two to three positive criteria define MiSUD
- Four or five positive criteria result in MSUD designation
- Six or more positive criteria yield a SSUD diagnosis

The other big change in *DSM-5* is that the American Psychiatric Association dropped the legal problems criterion and replaced it with a criterion for craving or compulsion to use (*Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.* Arlington, VA: American Psychiatric Association; 2013, p. 483). The rationale for dropping the legal problems criterion was based on studies from general populations that found that those with addiction rarely endorsed legal problems (Hasin D et al, *Drug Alcohol Depend* 2012;122(1–2):28–37). Even when the criterion was fulfilled, it rarely altered the final diagnosis (Hasin op cit; Edwards AC et al, *Alcohol Clin Exp Res* 2013; 37(3):443–451).

Diagnosing Addiction

Every time the DSM is updated, there are concerns about pathologizing normal human experiences and behaviors (see, for example, Frances A, *Saving Normal.* New York: HarperCollins; 2013). In keeping with these fears, some studies suggested that *DSM-5* would tag more people with a diagnosis of addiction compared to older editions of DSM (Agrawal A et al, *Addiction* 2011;106(11):1935–1943; Peer K et al, *Drug Alcohol Depend* 2013;127(1–3):215–219).

However, existing data from adult correctional and juvenile justice populations paint a much different picture. In these high-risk populations, a substantial proportion of those previously diagnosed with substance abuse no longer received an addiction diagnosis with the new criteria (Kopak AM et al, *Int J Offender Ther Comp Criminol* 2013; in press). If *DSM-5 underdiagnoses* addiction in these settings, one could reasonably ask how it could *overdiagnose* it in the general population where the range and intensity of problems is typically less severe. The answer may be that dropping the legal problems criterion may have a disproportionate impact for correctional populations.

Substance Use, Abuse, and Dependence

Studies have compared *DSM-IV-TR* and *DSM-5* criteria for disorders involving alcohol, cocaine, and cannabis in a state prison population (see, for example, Kopak AM et al, *Subst Use Misuse* 2012;47(12):1328–1338). These studies were based on the Substance Use Disorder Diagnostic Schedule-IV (SUDDS-IV), a structured diagnostic interview that covers *DSM-IV-TR* criteria and has items that approximate *DSM-5*. In general, findings for both versions of DSM were relatively similar for all three classes of substances. Much the same was found in adolescents in the juvenile justice system using the Practical Adolescent Dual Diagnostic Interview (PADDI) (Malone MG and Hoffmann N, (Under Review), *A Comparison of DSM-IV vs. Proposed DSM-5 Substance Use Disorder Diagnoses in Adolescent Populations*).

Keep in mind that substance users in these settings often meet criteria for substance dependence and thus have sufficient problem severity to be classified as having a moderate or severe substance use disorder by *DSM-5.* Thus high-risk populations are likely to differ substantially from general populations in terms of problem severity.

Things appear to shake out much differently for inmates with a diagnosis of substance abuse. For alcohol, almost a third of both male and female inmates who met criteria for abuse failed to receive a *DSM-5* diagnosis (Kopak 2013 op.cit). With cannabis, the proportion is similar for males; in women, about 25% meeting abuse criteria no longer receive a diagnosis (Kopak 2012 op.cit). The changes are most dramatic for male cocaine users: more than half of those with an abuse diagnosis no longer meet *DSM-5* criteria for addiction (Proctor SL et al, *Psychol Addict Behav;* in press).

Relatively similar findings were found in juvenile justice settings. Some of the so-called "diagnostic orphans"—those who fulfill two dependence criteria but do not meet criteria for abuse—received a diagnosis, but almost a third of abuse cases no longer met *DSM-5* criteria for addiction. As with adults, those with a dependence diagnosis were typically retained and classified as SSUD (Malone op.cit).

The vast majority of those who received no diagnosis with *DSM-IV-TR* still receive no diagnosis with *DSM-5*. The one notable exception is diagnostic orphans, who will now be classified as MiSUD. On the flip side, most of those with a *DSM-IV-TR* dependence diagnosis will fall into the SSUD category: more than 80% of those meeting criteria for alcohol dependence (Kopak 2012 op.cit) and more than 90% of those meeting criteria for cocaine or cannabis dependence (Kopak 2012 op. cit; Proctor op.cit).

Dropping Legal Problems

As one might expect, in correctional populations, dropping the legal problems criterion and requiring a minimum of two other criteria for addiction accounts

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DSM-5: Clinical and Financial Implications

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for the majority of people reclassified as *not* having a SUD. This is particularly true for those arrested for driving under the influence (DUI) or driving while intoxicated (DWI). Among first-time offenders, about half meet *DSM-IV-TR* abuse criteria because they have driven under the influence numerous times and experienced a legal consequence (Baley JW and Hoffman NG, unpublished manuscript, 2013). Other criteria for abuse and dependence are often absent. Under *DSM-5,* these individuals will not receive an addiction diagnosis.

The same is true for correctional populations where substance use resulted in arrests and only one additional *DSM-IV-TR* criterion was fulfilled (Kopak in press op cit; Malone op cit). Some argue that such individuals do not warrant a diagnosis while others maintain that "non-illness" precludes early intervention. Studies involving substance abuse treatment for these subthreshold cases are needed to resolve this particular question.

Financial Implications

Funding for substance abuse treatment largely hinges on diagnosis. *DSM-5* could effectively deny patients treatment if they no longer meet criteria for addiction. Proponents of *DSM-5,* however, would argue that subthreshold cases were previously misclassified and never had sufficient problems with substances to warrant rehabilitation.

On the other end of the spectrum, a dependence diagnosis is typically required to qualify for residential substance abuse treatment (Mee-Lee D et al, eds. *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition–Revised* [ASAM PPC-2]. Chevy Chase, Md: American Society of Addiction Medicine; 2001). Patients meeting four or five *DSM-5* criteria, thus classified as MSUD (moderate), may no longer be eligible for these placements. Some guidance may come from ASAM, which will be rolling out its updated placement criteria this fall (www.bit.ly/ 11X3Xsr). Ultimately, however, third party payers will likely make these determinations.

DSM-5 may not have much impact on some populations, such as those individuals arrested for driving under the influence of alcohol. In many states, these offenders are typically required to attend educational-type programs irrespective of diagnostic determinations. There is some evidence, however, that treatment delivered as a consequence of such events can be considered early intervention and produces good outcomes (Ninonuevo FG and Hoffmann NG, *Int J Offender Ther Comp Criminol* 1993;37:177–186).

CATR'S TAKE: *DSM-5* changed the way that patients are diagnosed with addiction and stratified for disease severity. Although some fear a higher rate of diagnosis, data from high-risk populations suggest that the opposite may actually occur, particularly for those with substance-related legal problems. *DSM-5* could also change how treatment dollars are allocated.

Expert Interview

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by non-clinicians, and they decided that they didn't want to use the word addiction because they thought this was pejorative or somehow marginalized patients. So now we say alcohol dependence, opiate dependence, cocaine dependence, and so forth. But what it really means is cocaine addiction, because patients are engaging in compulsive, drug-seeking behavior. This is different than if a person is being treated, for example, for high blood pressure and becomes dependent on that medication. If they stop taking it, there may be a rebound—but that is withdrawal, not addiction. So we fixed the confusion between dependence and addiction. Instead of using the word addiction, however, it is called "substance use disorder." For example, we say alcohol use disorder mild, moderate, or severe. If a person is in a legitimate medical program and taking medication prescribed by a doctor, developing a tolerance for that medication or experiencing withdrawal is normal; it is not pathological.

CATR: So the main harm was that people without addiction were being misclassified or mislabeled?

Dr. O'Brien: Misclassified, exactly. The difference between addiction and dependence was lost in this wrong terminology that we now corrected.

CATR: What other changes have occurred?

Dr. O'Brien: Under *DSM-IV,* a clinician could diagnose a patient with substance abuse with only one symptom and dependence with three symptoms. Now we have combined those symptoms for abuse and dependence and the diagnosis threshold is two symptoms [to define a mild substance use disorder].We also eliminated the symptom of substance-related legal problems, which we found was not useful in practice

CATR: Did you add any new diagnostic criteria?

Dr. O'Brien: We added a new symptom, the craving to use a substance, which is possibly the only psychiatric symptom with a neurophysiological basis. Numerous studies have shown that when a person with addiction is taken off a drug, if they are in a situation months or even years later where they are exposed to stimuli that they link to the drug—for example the odor of a drug cooking or passing a bar where they used to drink—there is a strong urge to take the drug. We call that craving. The reward system in the brain is activated, which is demonstrated by increased blood flow to those specific parts of the brain, which can be seen using functional MRI, and with the release of dopamine, which can be seen using PET scanning. Anti-craving medications are currently in development as new treatments for addiction.

CATR: What are the advantages to physicians, psychologists, alcohol and drug counselors, and case managers who will

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Expert Interview

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now use this new criteria set?

Dr. O'Brien: They will be more reliable. *DSM-5* strives to use a classification system that describes what the patient is demonstrating. We don't have any biomarkers or lab tests to show addiction. Lab tests tell you if a person has used a drug, but not if they are addicted to the drug. We may someday be able to use reactivity in the brain as a biomarker of addiction. Right now clinicians can use the symptoms in the manual to make the diagnosis and treat the patient. Clinicians should know about the Addiction Severity Index, which was developed at the University of Pennsylvania and includes seven domains (McLellan AT et al, *J Nerv Ment Dis* 1980;168(1):26–33). [A copy is available at www.bit.ly/15G5Us8] The patients that we see have many different kinds of problems. The Addiction Severity Index can help determine if a patient is experiencing legal, family, marital, or job problems and help orient treatment. *DSM-5* lets clinicians accurately focus on whether a person has substance use disorder mild, moderate, or severe. We want to treat early when the substance use disorder is mild or moderate. It's good medical practice and it saves money. The earlier the diagnosis, the better the treatment, and the patient may avoid severe medical complications and relapses.

[In *DSM-5*] we fixed the confusion between dependence and addiction

Charles P. O'Brien, MD, PhD

CATR: Are there are any disadvantages that you see with the new criteria set?

Dr. O'Brien: Well, if there were we would change them. We have been working on this for over six years and we are just trying to make it better. Tom Insel, the head of NIMH [National Institute of Mental Health], has said that *DSM-5* is still not a biological-based classification system. (See Dr. Insel's blog at http://1.usa.gov/1WGDPg) That is absolutely true. But *DSM-5* is the best that we have. We expect to continually improve it, and if clinicians find problems, let us know in a letter or an e-mail to the APA [American Psychiatric Association], because we plan to make changes. There will be version 5.1—we don't have to wait until it is time for a *DSM-6*. We can do tweaks and improvements as the research is done. We are particularly interested in more research so that we can eventually develop biomarkers. With *DSM-5*, we followed the scientific literature. So anybody who can do a study and publish it—not just offer an opinion—it will have an impact and it might be incorporated into 5.1.

CATR: Is there a formal schedule for that?

Dr. O'Brien: It depends on what happens as time goes on, but any replicated research findings will be reviewed by a committee that will determine whether the finding is a significant enough change to put it in. Changes to the manual can be posted on the APA website, rather than reprinting the manual every time there is a change.

CATR: How about special populations? Were the elderly or adolescents part of your deliberations with this criteria set?

Dr. O'Brien: Yes, we actually made some changes as a result. We had intense discussions with the group that was working on childhood neurocognitive disorder—what we used to call mental retardation. Since the most common form of preventable mental retardation is fetal alcohol syndrome, we chose to include it. After much debate, it was placed in the substance use disorder category, even though it is the mother, not the fetus, abusing substances. Section 3, which is essentially the Appendix, describes this syndrome—which varies based on what time during the pregnancy the mother uses alcohol, the dose, and whether she continues it or not. Its inclusion will help parents of children with fetal alcohol syndrome to get insurance coverage.

CATR: Were there other additions?

Dr. O'Brien: We added in some new things not previously in the *DSM-IV* because of research. For example, we added cannabis or marijuana withdrawal because it is a real problem demonstrated by good studies. We are seeing more cases of people who have been using marijuana for years and now they can't stop it. It is one of the major treatment problems today. We also added caffeine withdrawal. There is good evidence for that, but there was controversy because almost everybody has some dependency or tolerance to caffeine because caffeinated beverages are so widely used, and they rarely, if ever, cause any clinical problems. We added gambling disorder to the group of substance use disorders because of how it affects the brain reward system.

CATR: Please tell us more about the brain reward system?

Dr. O'Brien: Anything that reliably and intensely activates the reward system—be it sex, food, or any kind of pleasure—one could conceivably become addicted to. This is what we think is happening with gambling. There is a lot of evidence from brain imaging studies that compulsive gamblers are very much like drug addicts. We also added Internet gaming disorder. This is a huge problem in Asian countries, especially in young males. We decided that the science on this has not yet reached the level that it deserved to be a full-fledged disorder, so it is in Section 3 and we are trying to encourage research on it.

CATR: Do you have any idea how insurance companies and government agencies will respond to these changes?

Dr. O'Brien: I can tell you that we have thought about the fact that the *DSM-IV* terminology was tied to whether a person is eligible for methadone maintenance or Suboxone [buprenorphine] maintenance. We recommend a patient with a moderate or severe substance use disorder be eligible. So in other words, instead of saying the patient has to have "opioid dependence" we are saying the patient should be eligible with opioid use disorder moderate or severe. I think this is going to be accepted by the FDA [Food and Drug Administration] and the company that makes the medication is very agreeable at this point. I guess the major impact may be whether or not the insurance companies are going to pay for mild substance use disorder. I would encourage them to do so because they will save money in the long run. Many managed care organizations are paying for early treatment, because if they ignore the problem, then it will cost more in the end.

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Addiction Through the Decades: From *DSM-I* to *DSM-5*

David A. Frenz, MD
Medical Director, Addiction Medicine
HealthEast Care System
St. Paul, Minnesota

Dr. Frenz has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

Addiction has been around seemingly forever. However, how we have conceptualized it, has changed considerably over time.

The release of the fifth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* in May 2013 marks yet another shift in how clinicians diagnose substance use disorders (SUDs). This article will trace the evolution of the criteria sets in the DSM, starting with the first edition published way back in 1952.

DSM-I

DSM-I was a small handbook consisting of only 132 pages. SUDs were included under the section on personality disorders. Within this category, "alcoholism" and "drug addiction" were considered "sociopathic personality disturbances."

DSM-I was very light on specifics (formal criteria sets didn't appear until *DSM-III*). Alcoholism was simply defined as a "well-established addiction to alcohol without [a] recognizable underlying disorder" (Washington, DC: American Psychiatric Association 1952;39). The diagnosis was apparently self-evident or left to the discretion of the treating clinician. The manual further stated that "drug addiction is usually symptomatic of a personality disorder" but didn't indicate how one would arrive at a diagnosis.

DSM-II

DSM-II was published in 1968 and was even shorter—only 119 pages. Addiction was still considered a personality disturbance but no longer fell under the umbrella of antisocial or "sociopathic" personality disorder.

The text states that alcoholism is present when, "alcohol intake is great enough to damage [a person's] physical health, or their personal or social functioning, or when it has become a prerequisite to normal functioning" (Washington, DC: American Psychiatric Association, 1968;45). Within this category, three distinctions were made: episodic excessive drinking, habitual excessive drinking, and alcohol addiction. The first two diagnoses hinged on how frequently intoxication occurred, while the latter was suggested by withdrawal symptoms, daily drinking, or heavy drinking.

DSM-II also introduced a category for drug dependence. It noted that the "diagnosis requires evidence of habitual use or clear sense of need for the drug." It also recognized various classes of substances associated with addiction: opioids, barbiturates, sedative-hypnotics, cocaine, cannabis, and hallucinogens. Tobacco and "ordinary caffeine-containing beverages" were excluded, as were prescription medications, so long as "intake is proportionate to the medical need."

DSM-III

DSM-III, a watershed document, was published in 1980. The manual ballooned to 494 pages, focused on symptoms and behaviors (rather than putative causes of mental disorders), and introduced the now-familiar format involving criteria sets.

The manual made major changes when it came to addiction. For starters, the word "addiction" was edited out of the manual. Problematic substance use was removed from the realm of personality disorders and placed in a new category called "substance use disorders." Within this category, two criteria sets were created—"substance abuse" and "substance dependence"—which were the progenitors for everything that followed in subsequent editions of the DSM.

Substance abuse was characterized by a pattern of pathological substance use and social or occupational impairment due to the substance (Washington, DC: American Psychiatric Association, 1980;163–167). Symptoms were required to be present for at least one month. Substance dependence was considered a more severe form of addiction and required "physiological dependence, evidenced by either tolerance or withdrawal."

DSM-III also introduced various course specifiers—the extensions to a diagnosis that further clarify the course, severity, or special features of a disorder: continuous, episodic, and remission. Continuous was described as "more or less regular maladaptive use for over six months" whereas remission represented

DSM-5 Criteria for Substance Use Disorders

Under *DSM-5,* clinicians will now use a set of 11 criteria to diagnose patients with substance use disorders:

1. The substance is often taken in larger amounts or over a longer period of time than was intended
2. There is a persistent desire or unsuccessful efforts to cut down or control substance use
3. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects
4. Craving, or a strong desire or urge to use the substance
5. Recurrent substance use resulting in failure to fulfill major role obligations at work, school, or home
6. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance
7. Important social, occupational, or recreational activities are given up or reduced because of substance use
8. Recurrent substance use in situations in which is it physically hazardous
9. Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance
10. Tolerance
11. Withdrawal

Source: *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.* Arlington, VA: American Psychiatric Association; 2013.

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Research Updates

OPIOID TREATMENT

CBT Doesn't Improve Effectiveness of Office-Based Buprenorphine Treatment

The ability of primary care and other office-based physicians to prescribe buprenorphine has more than doubled the capacity of the US healthcare system to treat patients addicted to prescription opioids and heroin. One barrier to expanding access to this treatment is that some physicians cite a lack of available counseling services as reason not to offer buprenorphine treatment in their offices.

A new study, however, shows that adding cognitive behavioral therapy (CBT) did not make treatment more effective. Researchers at Yale University School of Medicine conducted a 24-week randomized controlled trial in 141 opioid-dependent patients in a primary care clinic at Yale-New Haven Hospital. All of the patients received the buprenorphine/naloxone combination tablet (Suboxone). The researchers randomly assigned patients to receive physician management alone or physician management plus CBT for the first 12 weeks of treatment. Patients assigned to only physician management received 15- to 20-minute sessions spent with internal medicine physicians—with sessions provided weekly for the first two weeks, every two weeks for the next four weeks, and then monthly. Patients receiving physician management plus CBT received up to 12, 50-minute weekly sessions of CBT provided by masters- and doctoral-level clinicians trained in providing the therapy. Patients self-reported the frequency of illicit opioid use and the maximum number of consecutive weeks of abstinence, as well as undergoing urine toxicology.

Researchers reported the two treatments had similar effectiveness in reducing the self-reported frequency of opioid use, from 5.3 day per week at baseline to 0.4 for the second half of maintenance. There was no difference between the two groups or between the two treatments over time. The researchers concluded that CBT did not improve either abstinence or treatment retention when added to physician management (Fiellin DA et al, *Am J Med* 2013;126(1):74.e11–17).

CATR's Take: This study demonstrated that office-based opioid agonist therapy without a significant psychological component is appropriate for some patients. It is unknown whether these results can be generalized to psychiatry or addiction medicine clinics where patients often have higher psychiatric acuity and myriad social problems.

Addiction Through the Decades: From *DSM-I* to *DSM-5*

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abstinence from the target substance.

DSM-III-R

DSM-III-R was published in 1987 and provided various updates. The category for addiction was retitled "psychoactive substance use disorders" and the criteria sets for abuse and dependence were further developed.

The core features of abuse were "continued use despite knowledge of having a persistent or recurrent social, occupational, psychological, or physical problem that is caused or exacerbated by the use of the psychoactive substance" and/or "recurrent use in situations in which use is physically hazardous" (Washington, DC: American Psychiatric Association, 1987;169).

The dependence criteria set was substantially revised to include non-physiologic features. These were the larger/longer, cut down/control, time, reduced activities, and use-despite-harm criteria that were propagated to subsequent editions. Tolerance and withdrawal were no longer required to make the diagnosis.

DSM-III-R also added some dimension to dependence with severity specifiers and further qualified remission as either partial or full. Finally, it recognized three new classes of addictive substances: amphetamines, phencyclidine, and tobacco.

DSM-IV

DSM-IV was published in 1994 and resulted in some minor housekeeping. Addiction was now described as "substance-related disorders." The manual preserved the abuse and dependence criteria in *DSM-III-R* with minor tweaks and some rearrangements. For example, failure to fulfill role obligations due to substance use, which was previously a feature of dependence, crossed over to abuse. Substance-related legal problems was also added as a new abuse criterion (Washington, DC: American Psychiatric Association, 1994;182).

DSM-IV also added some granularity to the remission specifiers—early versus sustained—and added course specifiers for agonist therapy (eg, methadone) and for patients residing in controlled environments (eg, prison). For reasons that aren't entirely clear, the severity specifiers from *DSM-II-R* were dropped.

DSM-IV-TR

DSM-IV-TR was published in 2000. The abuse and dependence criteria sets were unchanged compared to *DSM-IV*.

DSM-5

The much-anticipated *DSM-5* was released in late May, 2013. Depending on your perspective, the changes were either relatively modest or something close to seismic. On face value, there were more incremental refinements: the addiction category was re-titled "substance-related and addictive disorders" and abuse and dependence were collapsed into a single criteria set (Arlington, VA: American Psychiatric Association, 2013;481–589). A deeper look, however, reveals a shift from an artificial categorical construct—*either* abuse *or* dependence—to a dimensional model involving illness severity.

The combined criteria set is called "substance use disorder," where the patient's drug of choice replaces "substance" when a diagnosis is rendered (eg,

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CE/CME Post-Test

To earn CE or CME credit, you must read the articles and log on to www.CarletAddictionTreatment.com to take the post-test. You must answer at least four questions correctly to earn credit. You will be given two attempts to pass the test. Tests must be taken by July 31, 2014. As a subscriber to *CATR,* you already have a username and password to log on www.CarlatAddictionTreatment.com. To obtain your username and password or if you cannot take the test online, please email info@thecarlatreport.com or call 978-499-0583.

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Below are the questions for this month's CE/CME post-test. This page is intended as a study guide. Please complete the test online at www.carlataddictiontreatment.com. Note: Learning objectives are listed on page 1.

1. *DSM-5* marks the return of severity specifiers whereby clinicians diagnose patients with mild, moderate, or severe substance use disorders (Learning Objective #1).
   [ ] a) True [ ] b) False

2. Under *DSM-5*, clinicians now have a single set that includes how many criteria for diagnosing patients with addiction (LO #3)?
   [ ] a) Five [ ] b) Seven [ ] c) Eleven [ ] d) Fifteen

3. In *DSM-5,* how many positive criteria must a patient have for a clinician to diagnose a severe substance use disorder (SSUD) (LO #3)?
   [ ] a) Two or three [ ] b) Four or five
   [ ] c) Six or more [ ] d) Eight or more

4. According to Charles P. O'Brien, MD, PhD, *DSM-5* added which of the following new criteria, possibly the only psychiatric symptom that currently has a proven neurophysiological basis (LO #2)?
   [ ] a) Craving, or a strong desire or urge to use a substance [ ] b) Tolerance
   [ ] c) Withdrawal [ ] d) Recurrent substance use in situations in which is it physically hazardous

5. A recent study concluded that adding cognitive behavioral therapy to office-based treatment with buprenorphine was more effective than medical management alone (LO #4).
   [ ] a) True [ ] b) False

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alcohol use disorder).

The abuse and dependence criteria from *DSM-IV-TR* were preserved with the exception of the substance-related legal problems criterion, which was eliminated. It was replaced with a criterion for "craving, or a strong desire or urge" to use a substance. (See "*DSM-5* Criteria for Substance Use Disorder" on page 5.)

The threshold for diagnosis is that a patient must have at least two criteria during the same 12-month period. Severity, which is described as a "general estimate," consists of mild (2–3 criteria), moderate (4–5 criteria) and severe (≥ 6 criteria).

Remission specifiers also have been simplified to early and sustained (the additional qualifiers, partial and full, which were confusing and clinically dubious, were eliminated). Early remission now represents the complete absence of symptoms (except craving) for at least three months; for sustained remission, no criteria (except craving) have been met for at least 12 months.

Implications of Changes

DSM-5 should simplify the diagnosis and longitudinal care of patients with SUDs. Change, however, is never easy, and some sticky issues can immediately be anticipated.

Probably the biggest unknown is how and when third party payers—commercial insurers and government agencies—will operationalize the changes. Funding algorithms have been predicated on "abuse" and "dependence" for decades and this isn't going to change overnight. Until payers recalibrate, clinicians could reasonably ask why they should use the new *DSM-5* nomenclature.

Even if clinicians jump on board right away, they will need to reverse engineer their work for coding and billing purposes. In the United States, for example, we are still using the ninth revision of the *International Classification of Diseases* (ICD-9). As there are no ICD-9 codes of "alcohol use disorder," clinicians will need to convert back to abuse or dependence depending on severity (*DSM-5* recommends coding "mild" as abuse and "moderate" and "severe" as dependence).

CATR'S TAKE: *DSM-5* reminds us of the following adage: "Be not the first by whom the new is tried, nor yet the last to set the old aside." Although the changes related to addiction appear clinically sound, readers could reasonably defer using the new criteria until third party payers give us further direction.

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CATR: The American Society of Addiction Medicine (ASAM) is releasing their updated Patient Placement Criteria (www.bit.ly/11X3Xsr) later this year. Was there any coordination between your committee and the people at ASAM working on their update?

Dr. O'Brien: We certainly did go to the ASAM meetings and present our work. Actually, we not only went to the ASAM meetings but the APA meetings, and the College on Problems of Drug Dependence, and the Research Society on Alcoholism—all the scientific societies where people studying substance use disorder present their work. They listened to what we had to say and we accepted a lot of input from them. As far as the ASAM placement criteria, there have been a lot of studies and we will see how they turn out, but there wasn't any formal coordination with that committee.

CATR: Do you get a sense, even before those changes occur that *DSM-5* will interface well with the current Patient Placement Criteria?

Dr. O'Brien: Yes, I do. I think this will work at least as well, if not better, than *DSM-IV* because you don't have to say abuse or dependence. You've got a whole graded progressive diagnosis, which is I think closer to nature: this is what the patient truly presents. It doesn't have to be squeezed into a category.

CATR: Thank you, Dr. O'Brien.

Next month in *The Carlat Addiction Treatment Report: Cannabis*

This Month's Focus:
Addiction in *DSM-5*

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