DSM-5 May Change Categories on Substance Use

BY BETSY BATES

FROM THE ANNUAL MEETING OF THE AMERICAN PSYCHIATRIC ASSOCIATION

NEW ORLEANS — Proposed changes to the Diagnostic and Statistical Manual will likely put an end to separate diagnoses of substance "abuse" and "dependence," distinctions that puzzled even addiction experts, members of the DSM-5 work group on substance-related disorders said at the meeting.

An analysis found that 'there really wasn't a good rationale to keep abuse and dependence separate.'

DR. HASIN

On the basis of discussions held during the meeting, it seems probable that both categories will be subsumed within the general diagnosis, "substance use disorder," under an expanded DSM addiction section that will include for the first time a behavioral addiction, compulsive gambling.

"Change is good if change can be shown to do more good than bad and can be supported by data," commented Dr. Marc A. Schuckit during a progress report presented by the APA DSM-5 substance-related disorders work group at the meeting.

If the prime objectives for inclusion in the DSM are making diagnoses that are clear, straightforward, flexible enough to be clinically useful, valid, "moderately" reliable, predictable, and inclusive of "the people who need help," current substance use categories in the DSM-IV-R admittedly are "out of focus," said Dr. Schuckit, professor of psychiatry at the University of California, San Diego.

However, the committee wants to be cautious, so that they do not "go from one very useful but not perfectly focused image to another very useful but not very well-focused image," he said, noting that a rich database has been exceedingly useful in guiding directions for change.

For example, when data from studies representing more than 100,000 subjects were analyzed by the committee, DSM-IV diagnostic criteria for substance dependence were highly reliable and valid, but those for substance abuse were much lower and more variable, said Deborah S. Hasin, Ph.D., professor of clinical public health at Columbia University, New York, a work group committee member, and cochair of the meeting symposium.

The hierarchical relationship between abuse and dependence (with abuse only diagnosed in the absence of dependence) was "often misunderstood, even by people functioning at a very senior level [of the substance abuse research community]," she noted.

Confusion led to widely held, but false beliefs, such as the notion that abuse is a milder disorder than dependence, or that all individuals who are dependent also meet criteria for abuse, Dr. Hasin said.

The extensive data review conformed to what clinicians were seeing, that severity of dependence and of abuse, like other criteria, were intermixed, and that patients could have one of the disorders, or both.

A factor analysis of patient characteristics found "there really wasn't a good rationale to keep abuse and dependence separate," Dr. Hasin said.

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For the first time, an expanded DSM addiction section will include a behavioral addiction, compulsive gambling.

"The evidence seemed quite overwhelming."

The new DSM, then, will most likely contain 11 potential diagnostic criteria for combined substance use disorder, with severity gauged on the number of criteria met. A patient who meets two criteria would merit a diagnosis of a disorder; a patient who met four or more would be considered to have a severe form of the disorder.

The specific diagnostic criteria for a substance use disorder also will likely change in the DSM-5, with craving being considered a potentially core feature of addiction for the first time.

Likely to be dropped from the list of criteria will be recurrent substance-related legal problems, Dr. Hasin said in an interview.

Nicotine use disorder is highly likely to be included under the substance use disorder umbrella, again on the basis of analysis of characteristics of patients enrolled in many studies that show convergence with other substance use disorders.

The new inclusion of a behavioral disorder—compulsive gambling—might appear as an addiction alongside substance use disorders for the first time, based on years of study, said committee member Dr. Eric Hollander, director of the Compulsive, Impulsive, and Autism Spectrum Disorders Program at Montefiore Medical Center and Albert Einstein College of Medicine, New York.

Currently classified as an impulse control disorder, a large body of evidence now supports compulsive gambling as an addiction, he said in an interview.

None of the working group members disclosed any relevant financial conflicts of interest with regard to the DSM-5. ■

Emergency Physicians See More Nonmedical Opioid Use

BY DIANA MAHONEY

FROM THE MORBIDITY AND MORTALITY WEEKLY REPORT

Emergency department visits for nonmedical use of opioids increased by nearly 112% between 2004 and 2008, with a 29% increase between 2007 and 2008 alone, according to the Centers for Disease Control and Prevention.

Together with the Substance Abuse and Mental Health Services Administration (SAMHSA), the CDC reviewed the latest available 5 years of data on emergency department (ED) visits for nonmedical use of prescription drugs from SAMHSA's Drug Abuse Warning Network (DAWN). ED visits involving nonmedical use of opioid analgesics rose from 144,600 in 2004 to 305,900 in 2008, according to the report published in the CDC's June 18 Morbidity and Mortality Weekly Report. By 2008, the number of ED visits for misused prescription and over-the-counter drugs matched the number of ED visits involving illicit drugs for that year, the report noted (MMWR 2010 June 18;59:705-9).

The DAWN definition of nonmedical use of a prescription or over-the-counter drug includes taking a higher-than-recommended dose, taking a drug that was prescribed for another person, drug-facilitated assault, and misuse or abuse—all of which must be documented in a patient's medical record. It does not include suicide attempts, patients seeking detoxification, and unintentional ingestions, which are tracked in other categories.

The highest numbers of ED visits involving prescription drugs in this review were for oxycodone, hydrocodone, and methadone, each of which showed significant increases during the 5-year study. Among these drugs, the greatest increase was noted for oxycodone, with an estimated 41,700 ED visits in 2004 and 105,200 ED visits in 2008, representing a 144% increase.

Additionally, ED visits for nonmedical use of benzodiazepines increased 89%, from 143,500 in 2004 to 271,700 in 2008, with significant increases observed for each of the individual benzodiazepine drugs reviewed, including alprazolam, clonazepam, diazepam, and lorazepam. Significant increases were also noted for ED visits involving the sleep aid zolpidem and the muscle relaxant carisoprodol.

VITALS

Major Finding: Emergency department visits for nonmedical use of prescription analgesics more than doubled during 2004-2008.

Data Source: A review by the Centers for Disease Control and Prevention of 5-year data on ED visits involving the nonmedical use of prescription drugs from the Substance Abuse and Mental Health Services Administration's Drug Abuse Warning Network.

Disclosures: None were reported.

Peak visit rates for both opioids and benzodiazepines were observed in the age ranges 21-24 and 25-29 years, which represents a shift from previous report periods, in which peak visit rates were seen in the 30- to 34- and 35- to 44-year age ranges, according to an editorial note accompanying the report.

"As late as 2006, the peak mortality rate for fatal drug overdoses involving opioid analgesics had been in the 35-54 years age group," according to the note.

The 5-year increase in ED visits probably reflects "substantial increases in the prescribing of these classes of drugs," the CDC authors suggested. "The increase also might reflect an increase in the rate of nonmedical use of prescription drugs per 1,000 prescriptions, as has been observed for selected opioids."

The report is limited by a number of factors, according to the authors. "First, the drugs involved in ED visits might not all be identified and documented. The extent to which ED staff members document drug involvement might have increased over time," they wrote.

Additionally, information on the motivation behind nonmedical drug use might be incomplete, for instance by not noting a suicide attempt; population-based rates cannot be used to establish per-patient or per-prescription risk; and the distinction between nonmedical and medical reasons for taking drugs is not always clear, particularly when other drugs are involved.

Despite these limitations, "these increases in nonmedical use of pharmaceuticals suggest that previous prevention measures, such as provider and patient education and restrictions on use of specific formulations, have not been adequate," the authors wrote.

Additional interventions, including more systematic provider education, universal use by providers of prescription-drug monitoring programs, routine monitoring of insurance claims information, and stepped up efforts by providers and insurers to intervene at signs of drug misuse are "urgently needed," they stressed. ■