

From the DSM-5 to OATS: Outcomes & Assessment- Informed Treatment Services

Prevention and Recovery Conference

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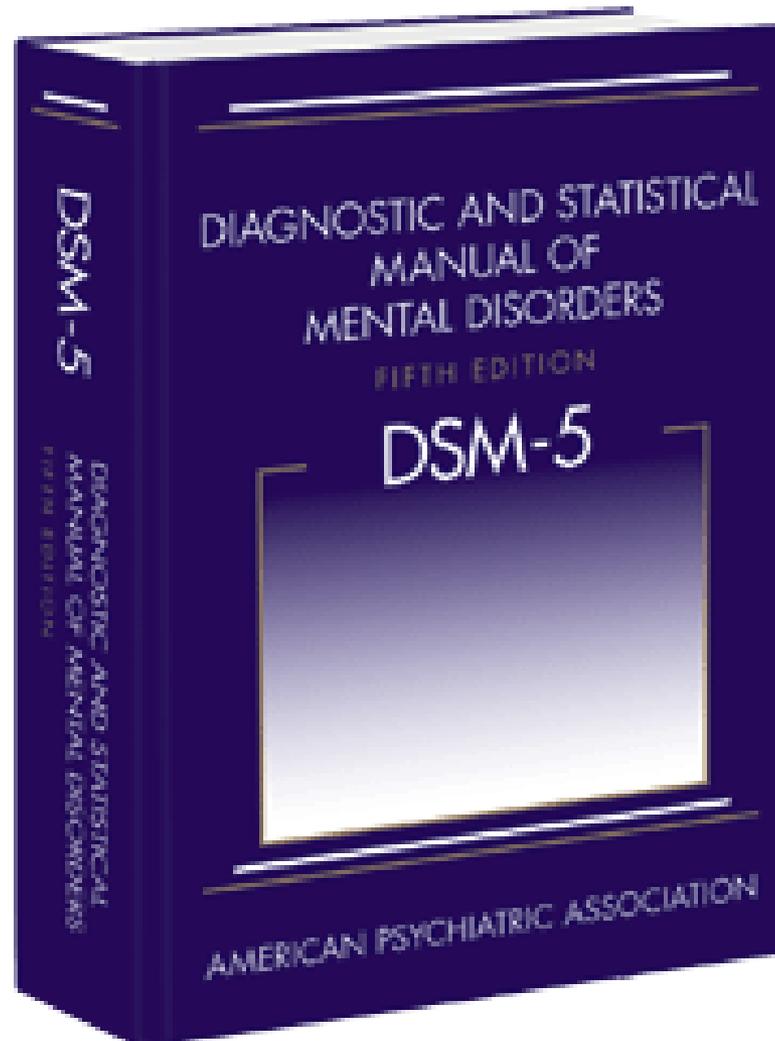
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The Blue Pill Book



Comments on “the Book”

- Criteria on individual disorders tend to be clearly articulated and complete
- Structural editing would have improved the utility of the book
- As a quick reference it is “unhelpful”
 - Table of contents is minimalistic
 - Index is idiosyncratic: e.g., caffeine has four major headings in the index, but cocaine is not to be found at all – not as a major heading nor as a subheading under stimulants – even though it has a unique ICD-10 code

Overview of the DSM-5

- The concept of “Axes” is eliminated – all conditions are on the same “axis”
- General dimensional vs. categorical orientation
- Most of the more common former Axis I conditions retain basically the same criteria as before
- The personality disorders remain unchanged with one set of general criteria plus specific criteria for each as before...
- But there is an alternative “research” formulation for personality disorders in the section for “Emerging Measures and Models”

Overview: Diagnostic Grouping

- A number of conditions are now in new or different groupings in the DSM-5
- Bipolar and Related Disorders are now a separate category between Schizophrenia and Affective Disorders
- New Trauma and Stressor Related Disorders section now includes conditions formerly listed under anxiety disorders; e.g., PTSD, Reactive Attachment Disorder

Overview: Grouping cont.

- Disorders formerly in the section on Infancy, childhood, and adolescents are not in one section
- Many are under Neurodevelopmental Disorders; e.g., Intellectual Disabilities, Autism Spectrum Disorder, & ADHD
- Some are under Trauma and Stressor related Disorders; e.g., Reactive Attachment Disorder
- Some are under the Anxiety Disorders; e.g., Separation Anxiety
- Some under Disruptive, Impulse-control and Conduct Disorders; e.g., ODD & CD

DSM-5 Controversies

- Criticisms of “over diagnosing” especially for youths
- Criticism of “selling out” to “big pharma”
- Questions as to whether dimensionality is over emphasized at the expense of qualitative differences
- NIMH research emphasis vs. clinical utility
 - Claim that NIMH has discredited the DSM-5 is not supported
 - Apparently NIMH research emphasis will essentially ignore diagnostic formulations and focus on genetic and biological research to define areas of concern

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

DSM-5 SUD Criteria continued

9. Continued use despite knowledge of having a physical or psychological problem caused or exacerbated by use

10. Tolerance

11. Withdrawal

Criteria 1-4 relate to use;

Criteria 5-8 relate to behavioral issues
associated with use;

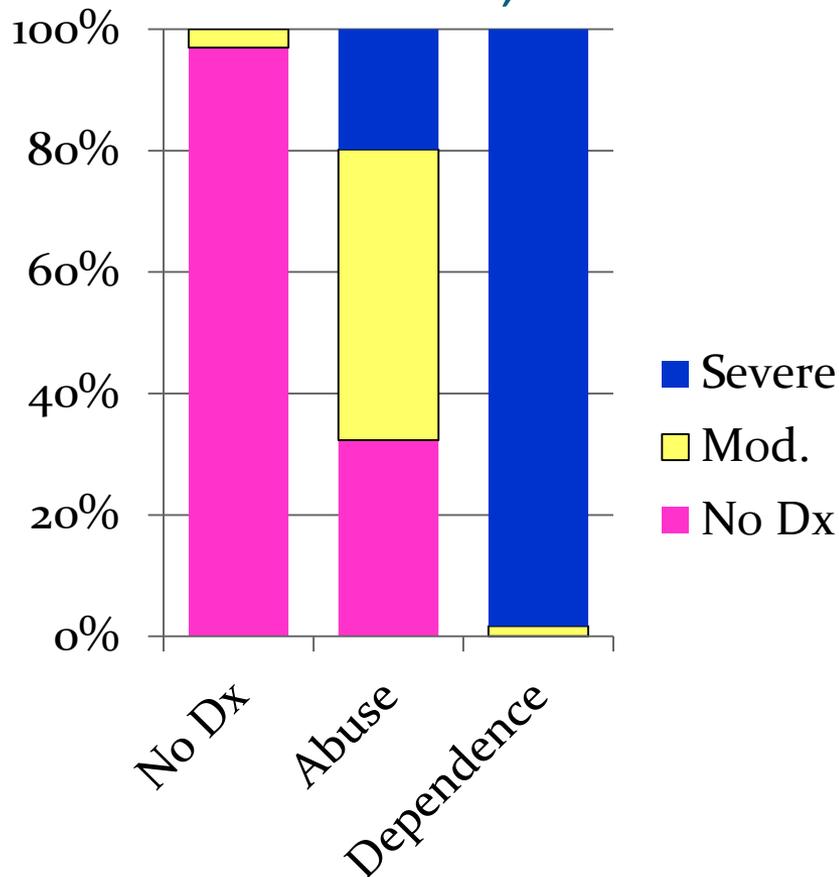
Criteria 9-11 relate to physical/emotional issues

DSM-5 Initial VS. DSM-5 Final

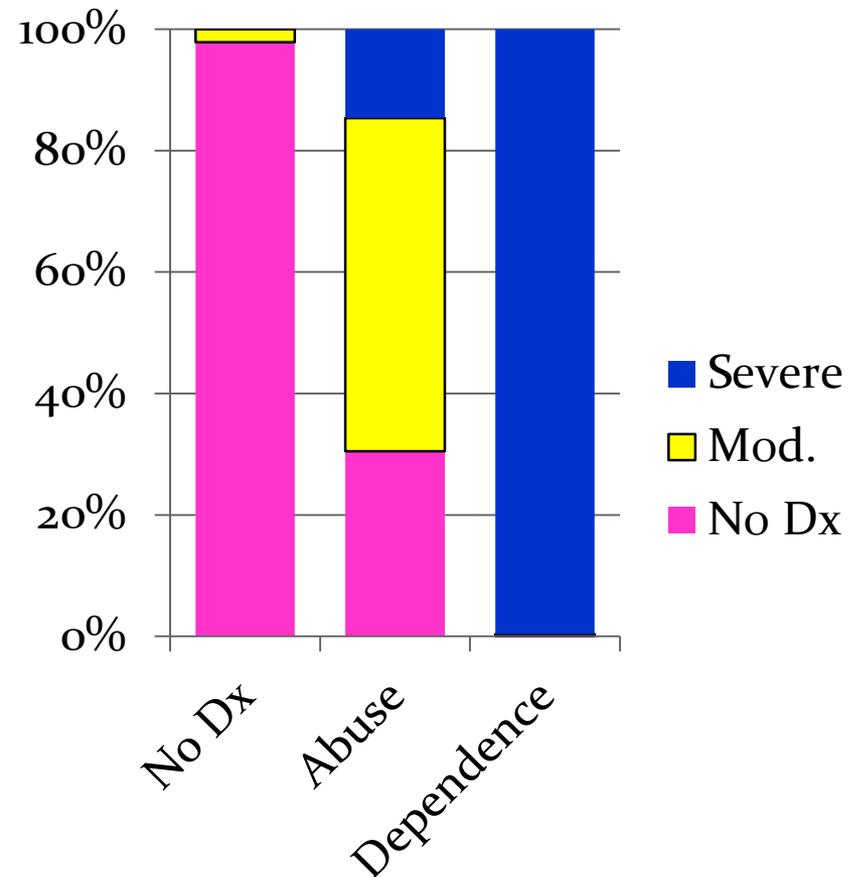
- Initially the proposed DSM-5 had two diagnostic categories: moderate and severe defined by 2-3 and 4+ positive criteria – this conformed more closely to the abuse vs. dependence distinction of DSM-IV-TR
- Final formulation has three categories: mild (2-3), moderate (4-5), and severe (6+ positive criteria)
- Original “moderate” becomes “mild”

Comparison of Initial DSM-5 vs. DSM-IV-TR Alcohol Diagnoses

Males N = 6,871

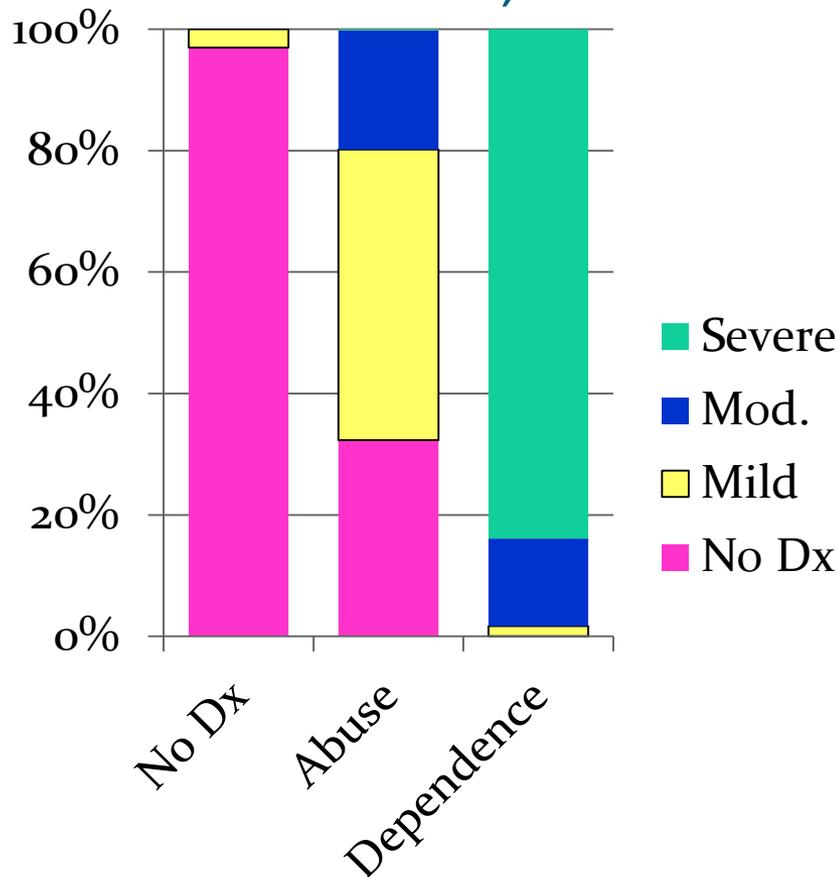


Females N = 801

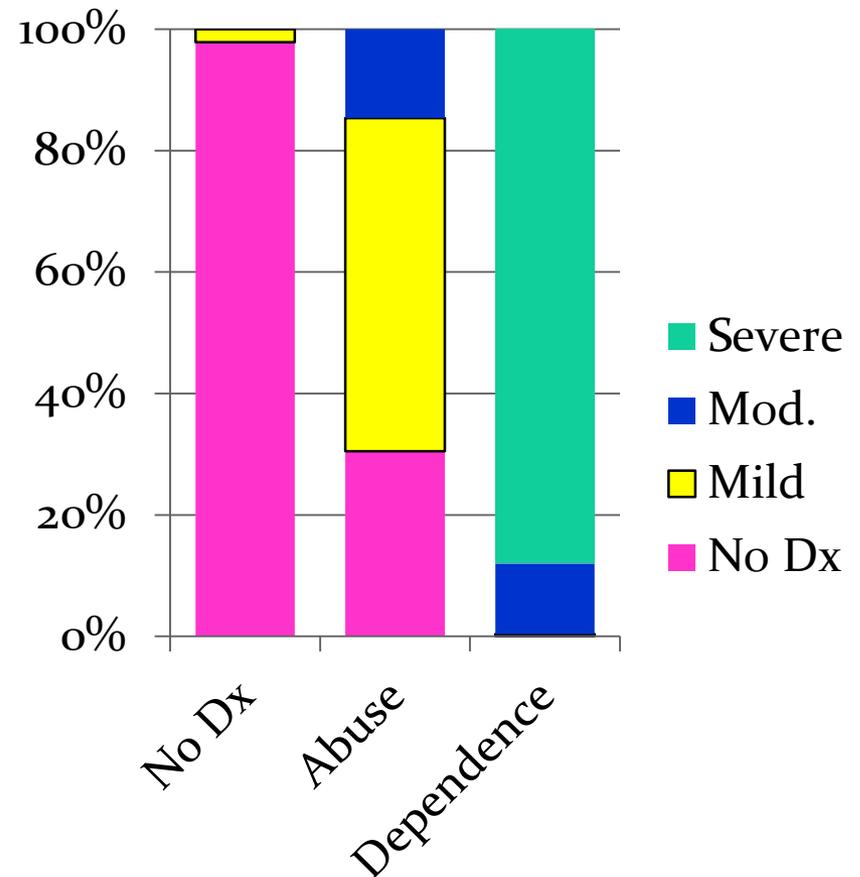


Comparison of Final DSM-5 vs. DSM-IV-TR Alcohol Diagnosis

Males N = 6,871

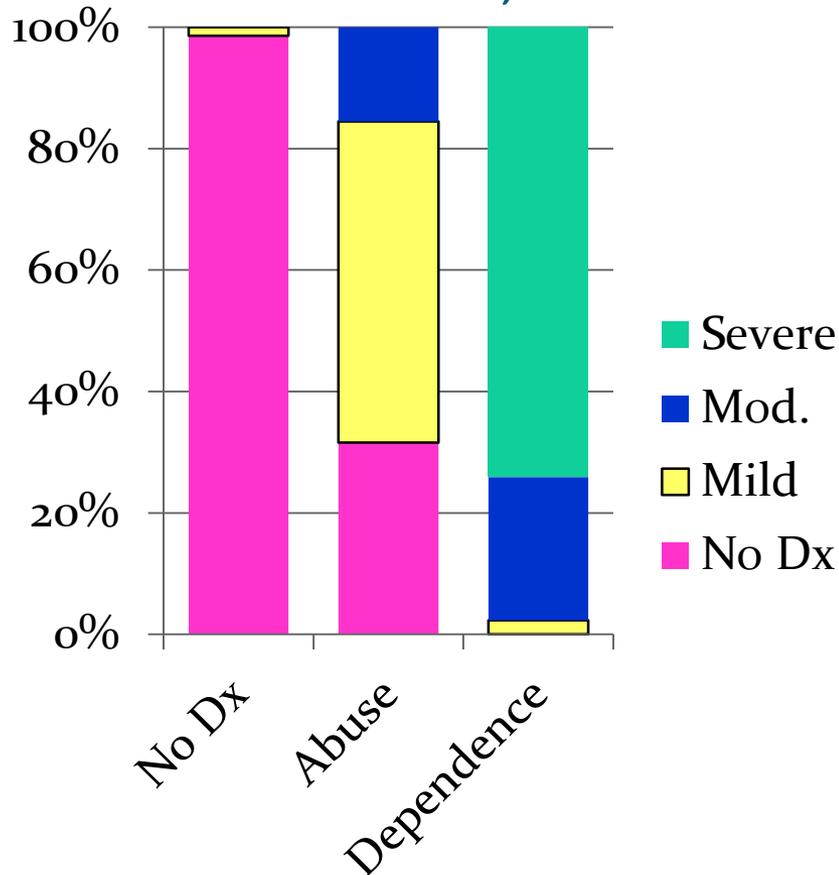


Females N = 801

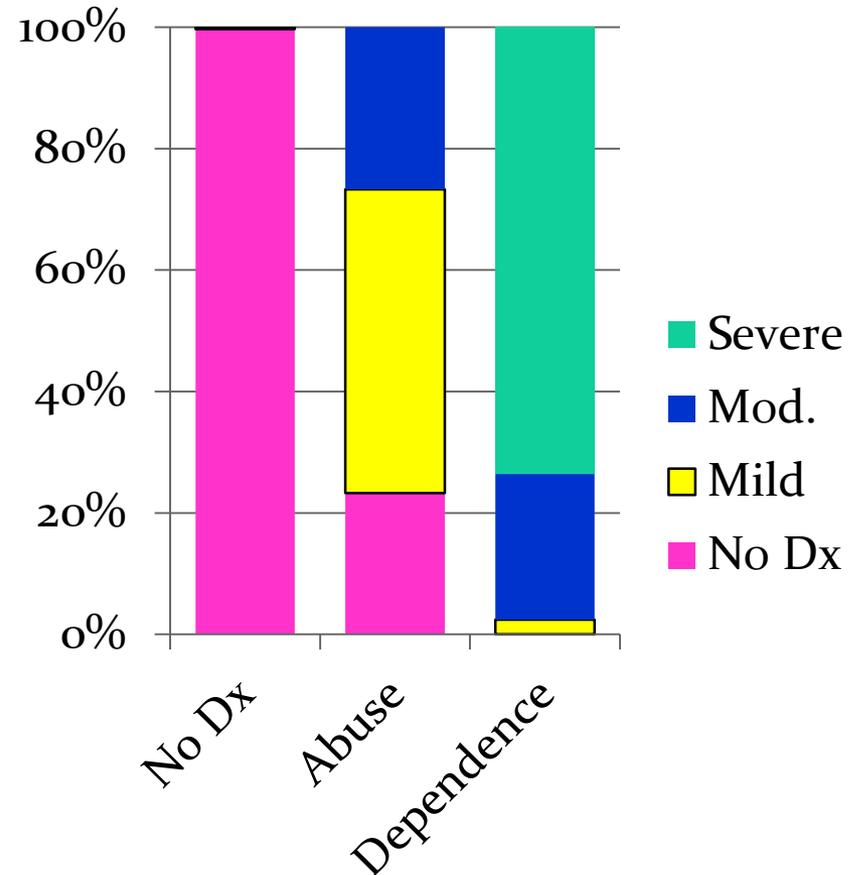


Comparison of DSM-5 vs. DSM-IV-TR Cannabis Diagnoses

Males N = 6,871

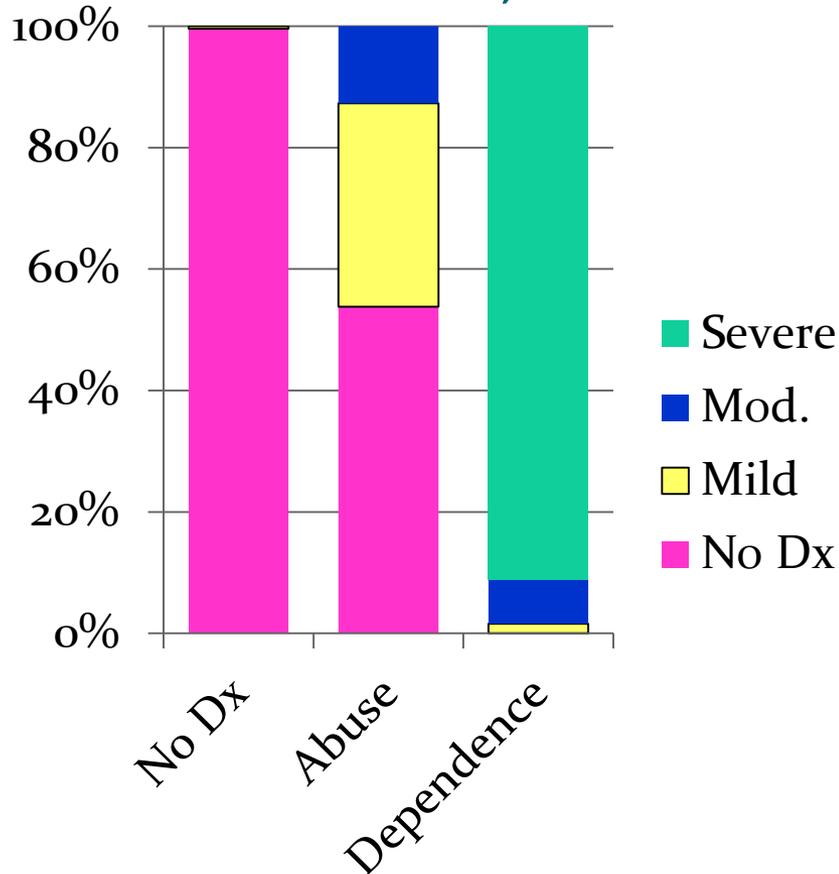


Females N = 801

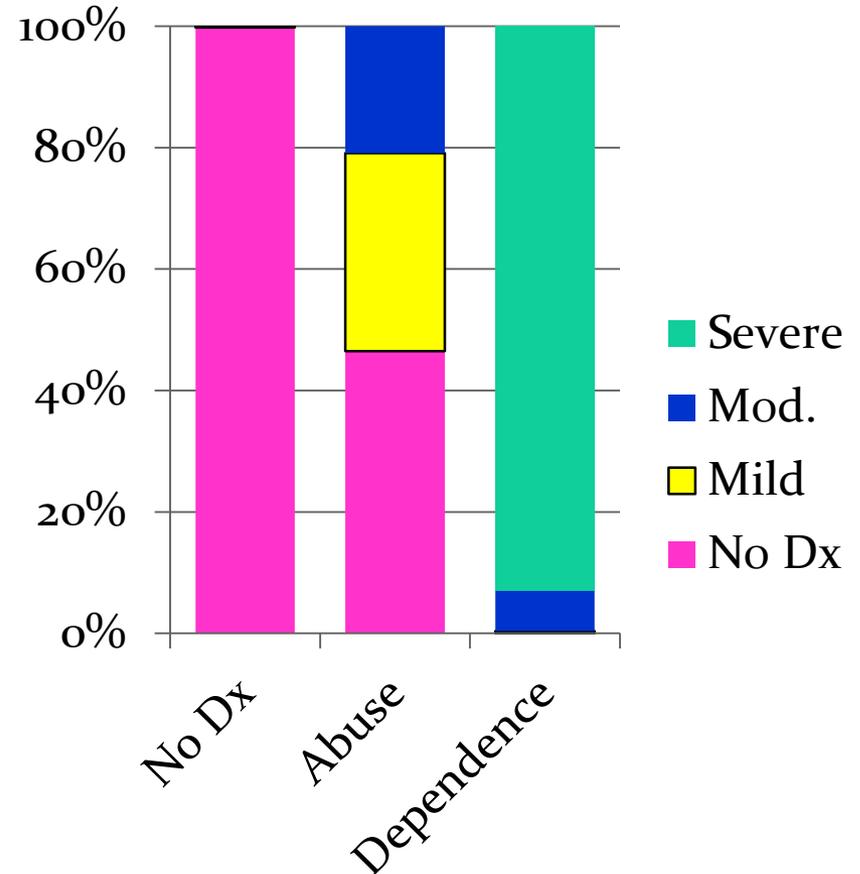


Comparison of DSM-5 vs. DSM-IV-TR Cocaine Diagnoses

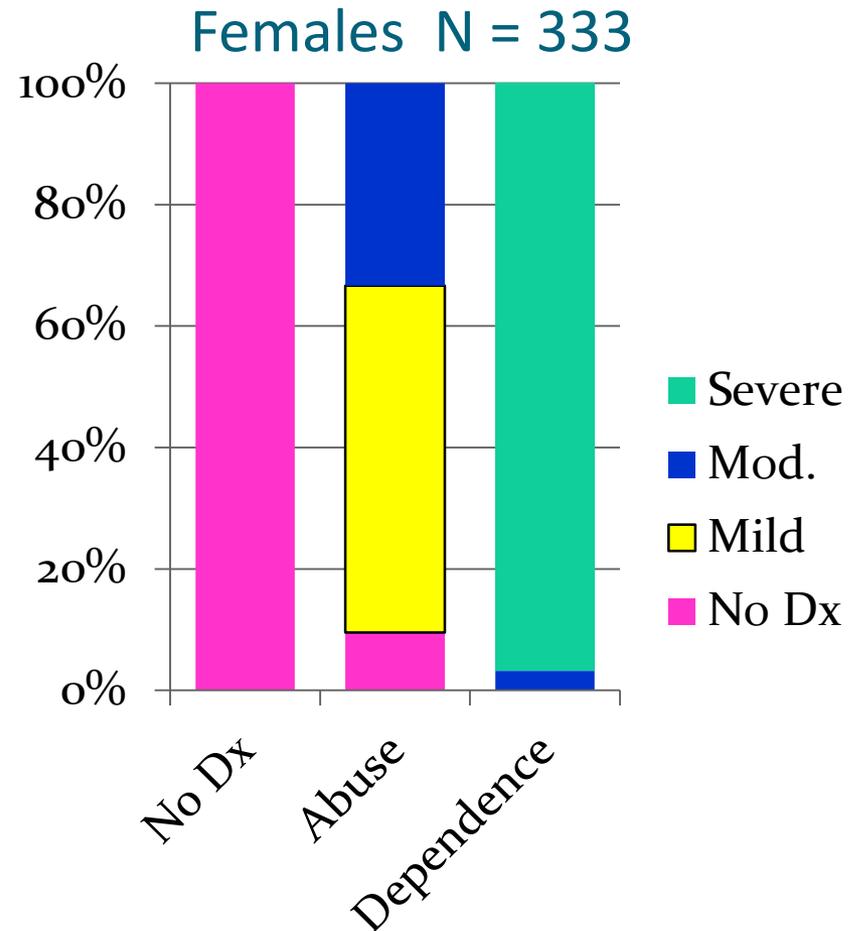
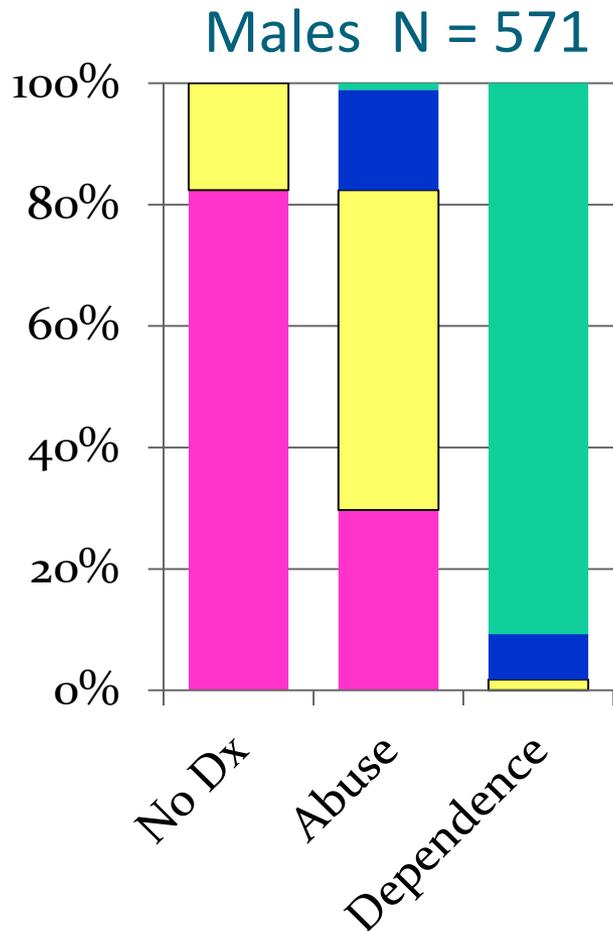
Males N = 6,871



Females N = 801



Comparison of DSM-5 vs. DSM-IV Diagnoses for Adolescents



DSM-5 vs. DSM-IV Summary

- Almost all who do not get a DSM-IV diagnosis will still not have a diagnosis with the DSM-5
- The vast majority of those with a dependence diagnosis will fall into the severe designation of the DSM-5 – most of the rest get a moderate diagnosis
- Substantial changes will be seen for those now diagnosed with abuse
 - Most will receive a diagnosis of mild substance use disorder
 - A significant minority will no longer get a diagnosis
 - A smaller minority will get a moderate diagnosis
 - These findings may be specific to correctional samples

Pros vs. Cons of the DSM-5

■ Pros

- The severe diagnosis identifies people who in all probability need to set abstinence as a goal
- The mild diagnosis will in most cases be those who do NOT need to have abstinence as a goal
- Provides a framework for making better treatment decisions

■ Cons

- May give the impression that the severe diagnosis is simply a milder version of the moderate and mild diagnoses
- The distinctions between diagnoses are not empirically derived and may not be the optimal points of discrimination

DSM-5 CRITERIA Differentials

- All criteria are not equal in implications
- Some criteria are found almost exclusively among those in the severe alcohol or other substance use disorder diagnoses
- Other criteria are more common among the mild to moderate alcohol use disorder group
- **Tolerance** and **dangerous use** are actually common among those with no diagnosis

Distribution of Positive Alcohol Criteria for 6,871 Males

DSM-IV Criteria Based on SUDDS-IV Results	DSM-5 Designations				Pop. Prev.
	No Dx	Mild	Mod.	Sev.	
1. Unplanned use	2%	8%	11%	79%	27%
2. Unable to cut down	<1%	4%	7%	88%	21%
3. <i>Time spent using</i>	2%	6%	11%	81%	28%
4. Craving/compulsion	1%	3%	7%	89%	21%
5. Role failure	<1%	3%	9%	88%	25%
6. Social Conflicts	3%	13%	14%	70%	34%

Distribution of Positive Alcohol Criteria for 6,871 Males

DSM-IV Criteria Based on SUDDS-IV Results	DSM-5 Designations				Pop. Prev.
	No Dx	Mild	Mod.	Sev.	
7. Sacrifice activities	<1%	2%	9%	89%	23%
8. Dangerous use	8%	15%	15%	62%	36%
9. Contraindications	3%	10%	11%	76%	30%
10. Tolerance	12%	11%	11%	66%	33%
11. Withdrawal	<1%	3%	7%	90%	19%
Self-medication	5%	9%	11%	75%	27%

Distribution of Positive Alcohol Criteria for 801 Females

DSM-IV Criteria Based on SUDDS-IV Results	DSM-5 Designations				Pop. Prev.
	No Dx	Mild	Mod.	Sev.	
1. Unplanned use	3%	8%	9%	80%	31%
2. Unable to cut down	0%	2%	6%	92%	24%
3. Time spent using	0%	1%	7%	92%	26%
4. Craving/compulsion	<1%	<1%	3%	96%	23%
5. Role failure	<1%	5%	5%	90%	26%
6. Social Conflicts	3%	10%	10%	77%	33%

Distribution of Positive Alcohol Criteria for Females

DSM-IV Criteria Based on SUDDS-IV Results	DSM-5 Designations				Pop. Prev.
	No Dx	Mild	Mod.	Sev.	
7. Sacrifice activities	<1%	3%	4%	93%	25%
8. Dangerous use	6%	8%	9%	77%	29%
9. Contraindications	3%	9%	10%	78%	32%
10. Tolerance	10%	5%	10%	75%	32%
11. Withdrawal	0%	2%	3%	95%	20%
Self-medication	%	%	%	%	%

SUD CRITERIA PRIMARILY IN SEVERE DESIGNATION ONLY

The “Big Five”

- 2. Wanting to cut down/unable to do so
- 4. Craving with compulsion to use
- 5. Failure at role fulfillment due to use
- 7. Sacrifice activities to use
- 11. Withdrawal symptoms

General Findings

- These patterns of positive criteria apply to cannabis and cocaine as well as alcohol
- Tolerance and use in situations where impairment is dangerous are the two criteria most likely to be seen among those not meeting diagnostic criteria for a given substance
- Some variations in prevalence rates are seen on factors such as gender and may be manifested by other population differences

A New Approach via the DSM-5

- The pattern of positive criteria may be more important than the overall count of positive findings
- Appropriate assessment based on the severity as defined by the DSM-5 and the specific positive criteria lay the groundwork for truly empirically derived clinical decisions
- The DSM-5 can be a steppingstone to the new ASAM Criteria



**Assessment:
First Component in
Identifying Individualized
Treatment Needs, Goals,
and Relapse Risk**

SAMPLE HYPOTHESES FOR CLINICAL PRACTICE

- **Hypothesis #1:** Clients positive on three or more of the “big five” (rule setting, sacrificing activities, role fulfillment failure, craving/compulsion to use, and withdrawal) will require initial residential placement and/or more intensive and longer continuum of care to achieve good results
- **Hypothesis #2:** Clients in mild or moderate designations without any positive findings on the “big five” will be able to moderate use with less intensive and briefer services

Sample of Alcohol Diagnostic Documentation

Alcohol Diagnosis		Diagnostic Criteria										
		1	<u>2</u>	3	<u>4</u>	<u>5</u>	6	<u>7</u>	8	9	10	<u>11</u>
Case 1	Severe	X	X	X	X			X	X		X	X
Case 2	Mild	X		X							X	
Case 3	Moderate	X		X			X		X		X	
Case 4	Moderate	X	X		X	X		X				

Cases 3 & 4 with the same diagnosis may have different prognoses if the Big Five are related to outcomes

CASE 3: Positive DSM-5 Criteria

3. Great deal of time using
10. Tolerance
1. Unplanned use: more or longer use
8. Use in hazardous situation (impaired driving)
6. Recurrent interpersonal conflicts

Conclusions

- No loss of control indicated
- Misuse and possible irresponsible behavior
- Moderation may be a reasonable initial goal

CASE 4: Positive DSM-5 Criteria

4. Craving/compulsion to use

1. Unplanned use: more or longer use

5. Role obligation failures

2. Desire/efforts to cut down

7. Sacrificing activities to use

Conclusions

- Loss of control indicated

- Positive on 4 of the “Big Five”

- Abstinence likely required for recovery

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



**More Sophisticated
Assessment and Detailed
Documentation of
Conditions Also Applies to
Co-occurring Conditions**

PTSD DSM-5 Criteria

Criterion A: Exposure(s) to traumatic event(s) (4)

Criterion B: Intrusion symptoms (5)

Criterion C: Avoidance behaviors (2)

Criterion D: Negative cognitions and mood (7)

Criterion E: Alternations in arousal/reactivity (6)

- Patterns of diagnostic criteria
- Nature, number, and duration of exposure
- Number and severity of other criteria

Posttraumatic Stress Disorder

Summary Documentation

- Criterion A: 1 2 3 4 Total: ____
- Criterion B: 1 2 3 4 5 Total: ____
- Criterion C: 1 2 Total: ____
- Criterion D: 1 2 3 4 5 6 7 Total: ____
- Criterion E: 1 2 3 4 5 6 Total: ____
- Duration in months: _____
- Totals for each criterion are sum of positive findings
- Can record yes-no for each symptom or just totals
- Patterns of findings can be matched to outcomes



Having Identified
Presenting Conditions,
Treatment Planning
Assessment Applies
the New ASAM Criteria

ASAM Criteria

Assessment Dimensions

- 1 Acute Intoxication/Withdrawal
- 2 Biomedical Conditions/Complications
- 3 Emotional, Behavioral, or Cognitive Conditions/Complications
- 4 Readiness to Change
- 5 Relapse/Continued Use/Problem Potential
- 6 Recovery Environment

Assessment-Informed Treatment

- Utilize systematic assessment to document nature and severity of conditions
- Systematically assess other dimensions relevant to treatment plan to identify risk and resiliency variables
- Integrate assessment data with initial treatment response – modify plan if needed
- Use findings to refine assessment and treatment decisions based on initial and longer term outcomes

Problem Statement

- Basic research on the etiology and mechanisms associated with MH/SUD conditions may or may not yield patient benefits in the near future
- NIMH emphasis on basic biological issues, while necessary and important, may or may not immediately benefit clinicians in their work
- Practical research on the specific characteristics defining conditions and their relationships to type of treatment response and prognosis is lacking – most clinical trials are only horse races between competing treatment models

Evidence-Based Treatment

- Utilize a treatment model documented to be effective in controlled clinical research
- Question of whether the model is implemented with fidelity
- No guarantees that it will work in routine clinical practice even if implemented properly
- No verification of outcomes

Outcomes-Informed Treatment

- Monitor baseline and initial relevant outcomes for all clients – outcomes can be clinical and/or societal
- Monitoring done during typical period of maintenance (aftercare)
- Uses information already required for quality care
- Retrieval of data for analyses

The Challenge

- A wealth of practical applied research and evaluations can be done by clinicians/clinics in the course of routine practice
- Electronic records, if properly designed, can provide a pragmatic foundation for such research and evaluation with little effort or expense
- How?
 - Consistent and objective measures of assessment results to the extent possible
 - Routine documentation of treatments delivered, treatment response, and initial outcomes
- **You are the solution for achieving progress**

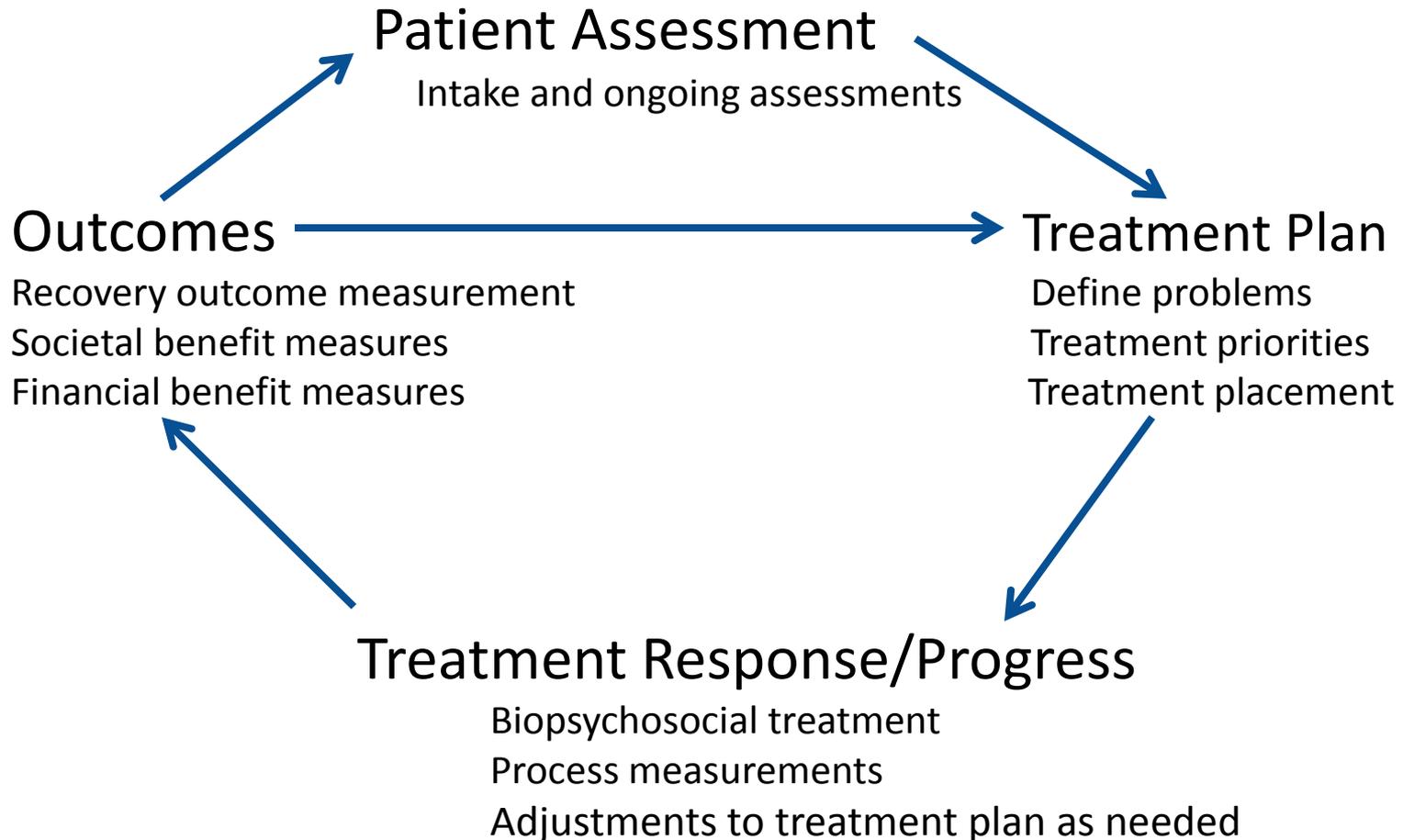
The Opportunity

- The focus of the DSM-5 on measurement and more quantitative delineation of symptoms sets the stage for opportunity to refine assessment
- Policy focus on documentable outcomes provides an opportunity to implement outcomes-informed strategies
- Providers and clinicians can now capitalize on the confluence of these trends for greater sophistication of assessment and treatment to yield greater effectiveness and efficiency in service delivery



**Systematic
Documentation for
Treatment
Improvement and
Investment
Justification**

CLINICAL CONTINUOUS IMPROVEMENT COMPONENTS





Employing Outcomes-
informed Treatment
Services Does NOT
Require Research
Instruments

Outcomes-Based Treatment Monitoring Requirements

- Demographic description
- Relevant clinical SUD severity and prognostic indications – DSM-5 + ASAM Criteria
- Determination of co-occurring conditions requiring services
- Monitoring of recovery efforts – e.g., continuing care and peer-support utilization
- Recovery relevant outcome measures – e.g., no longer meeting diagnostic criteria

Defining the Case-mix: The Population Served

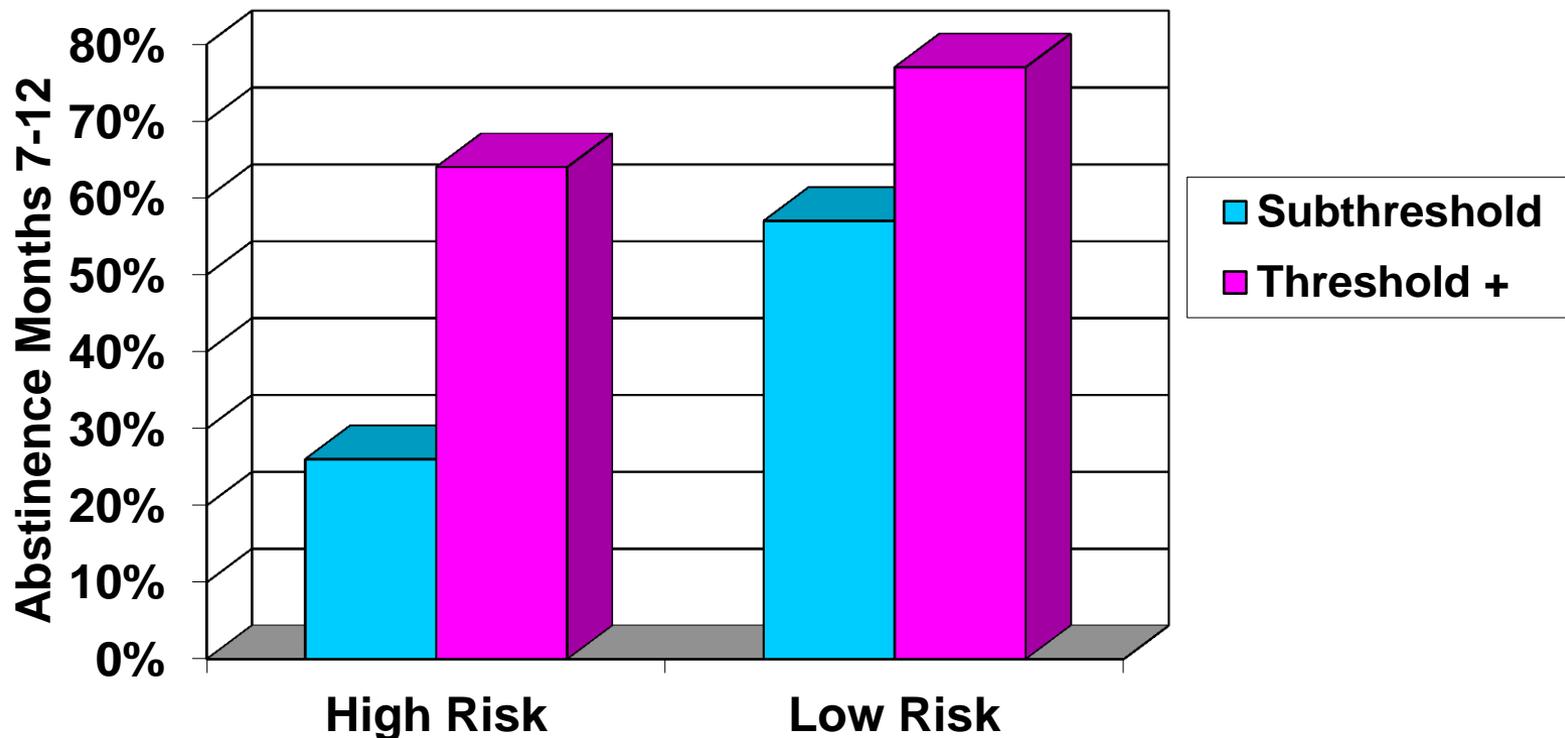
- Prognostic indicators or scales and their relative prevalence in a treatment population
- Influences treatment type and duration required to produce outcome goal
- Frames expectations for treatment
- Levels the playing field for making program comparisons

Demographic Risk Scale

- Less than 25 years of age.
- No high school diploma or GED.
- Unemployed.
- Never married.

Three or more positive characteristics increases expected relapse rate by about 20%

Demographic Risk Scale and Observed Outcomes



35 Unites of service = threshold for low risk group
75 Unites of service = threshold for high risk group

Zywiak, Hoffmann, & Floyd, 1999

Feedback on Helpfulness of Program Components

- Helpfulness in recovery – not satisfaction with the component
- Low scores indicate opportunities for improvement
- High scores indicate potential areas of excellence

TREATMENT RATINGS [asked by follow-up interviewer]

Rate how helpful the following treatment components have been for your recovery?

0 = not used 1 = poor; 2 = fair; 3 = good; 4 = excellent

01. Group Therapy _____

02. Individual counseling _____

03. Lectures & education _____

04. Working the AA/NA steps _____

05. Peer-group meetings (e.g., AA) _____

06. Family portion of program _____

07. Talking with other clients _____

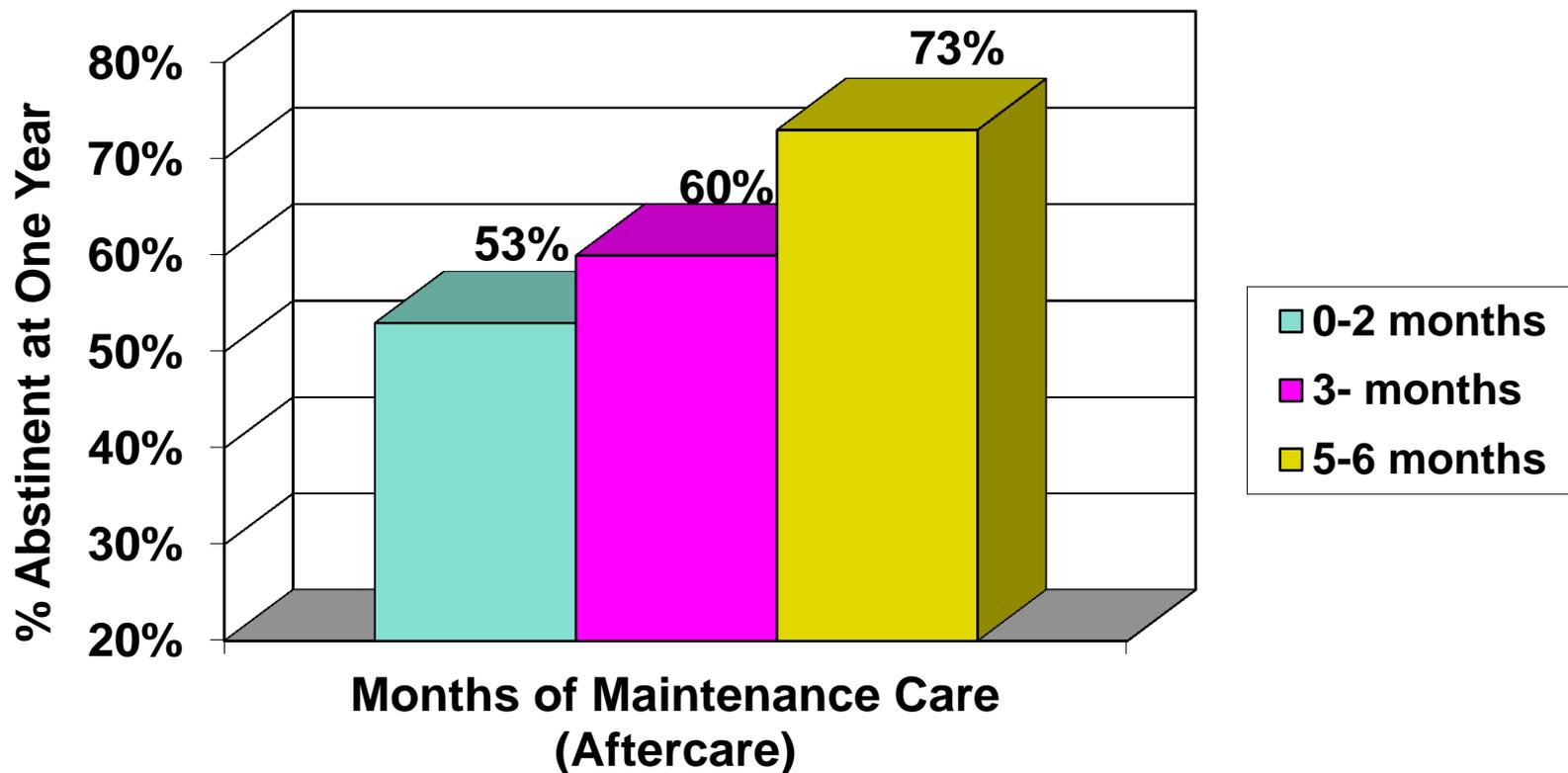
08. Overall rating for the program _____



Client Motivation and Empowerment

Maintenance Care Thresholds

N = 12,783 Treatment Completers

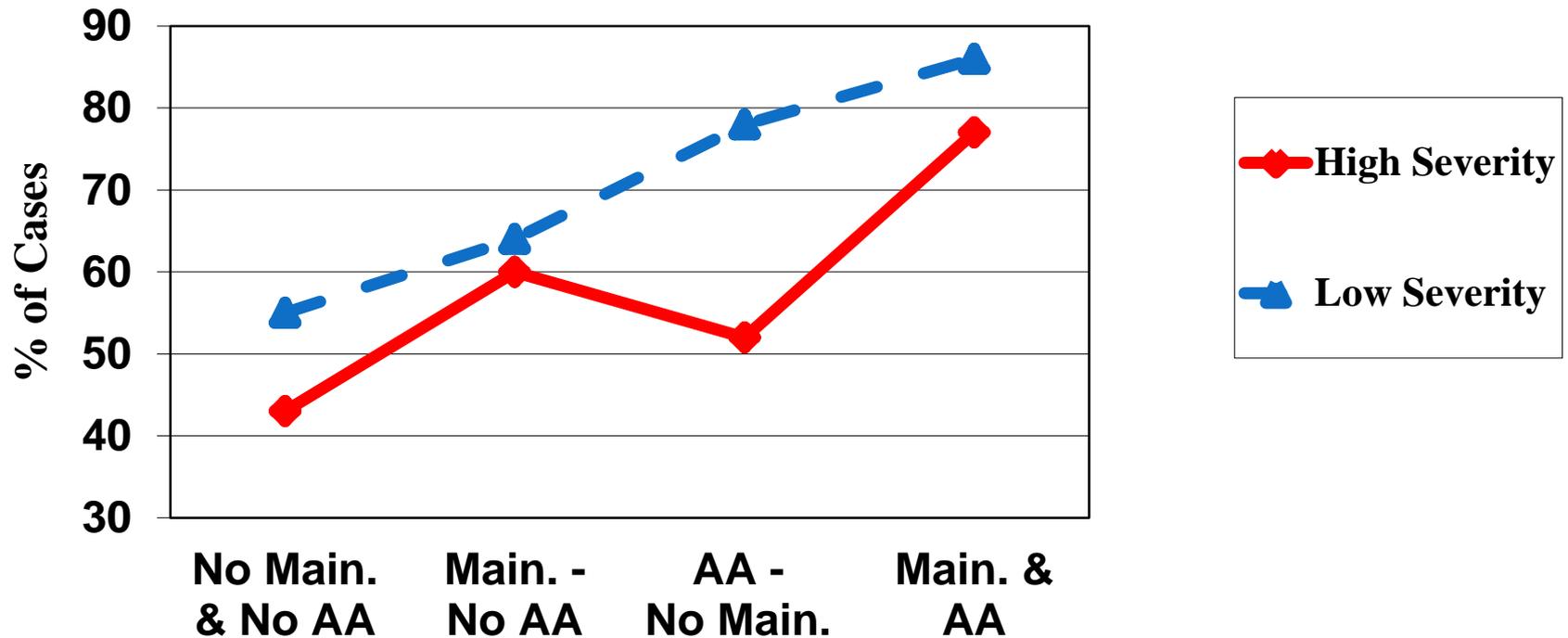


Hoffmann & DeHart (1996). CATOR Fact Sheet



Tailoring Treatment
and Recovery
Strategies to Match
Empirically Derived
Needs

One Year Abstinence Rates for Older Alcohol Dependent Clients



Combinations of 4+ months of Maintenance Care and/or Weekly AA Attendance for 1,350 treatment completers

Hoffmann, DeHart & Gogineni (1998). The Southwest Journal on Aging, 14(1), 57-64.

Data Required for Differential Outcome by Support/Continuing Care

CONTINUED CARE & SELF-HELP GROUPS

Rate attendance using the scale:

1 = never/stopped

3 = Several times a mo.

2 = Once a month or less

4 = At least once a week

How often did you attend the following during the past **three** months:

09. Formal aftercare

10. AA

11. NA

12. Other support group

Beware of Arbitrary Outcome Metrics

- Scientifically reliable and valid
- Irrelevant to the real world

Reference on arbitrary metrics:

Kazdin, A. E. (2006). *American Psychologist*, 61(1), 42-79.

- Addiction Treatment Examples:
 - Average days of use in past 30 days
 - Scores on a variety of psychological instruments

Arbitrary Metric Example

Programs A and B each treat 100 cases

Program A:

Before treatment average days of use = 25

After treatment average days of use = 10

Program B:

Before treatment average days of use = 25

After treatment average days of use = 8

Which program has the better outcomes?

Arbitrary Metric Example

Real world results:

Program A:

60 in full recovery; 40 minimal change

Program B:

All 100 still using just on weekends, but all still have continuing problems and meet current criteria for dependence (severe)

To which program would you refer a family member?