HPPA 518 - Policy Brief

To: Jeff Wu, Deputy Director of Policy, Center for Consumer Information & Insurance Oversight
From: Emily Lancia
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Re: Federal Mandate for Improved Diagnosis and Classification of Psychiatric Disorders

Statement of Issue: What mandates can be implemented to improve the diagnosis and classification of psychiatric disorders?

As of 2021, nearly 60 million American adults live with a mental, behavioral, or emotional disorder. The real prevalence of psychiatric disorders is most likely even higher, as those who do not receive care due to lack of access or perceived stigma remain unaccounted for.[1] Despite a changing clinical landscape, the diagnostic approach of psychiatric disorders remains the same since the 1980s, relying on the Diagnostic and Statistical Manual of Mental Disorders (DSM). Many professionals consider the DSM to be outdated, unscientific, corrupt, or even harmful to patients.[2] Initiative to improve the diagnosis and classification of psychiatric disorders would be to the benefit of the millions of Americans affected by them.

The DSM has served as the sole basis for psychiatric diagnosis since the 1980s. Funded and developed by the American Psychiatric Association (APA), its implementation has allowed for uniformity in psychiatric education, jargon, and research. However, despite its advantages, the majority of mental health professionals have been dissatisfied with the DSM since its inception, evident in the large body of professional critiques written since. Multiple revisions have failed to address clinical concerns, as the majority of clinicians remain dissatisfied with the latest edition released in 2013, the DSM-5. Those not in favor of the DSM-5 most commonly cited uncertainty regarding its scientific applicability, as well as concern for the potential social and physical harms of its diagnoses and subsequent treatments on patients.[2]

The DSM has a longstanding history of backlash surrounding its failure to consider the effects of social context on the manifestations of psychiatric disease, as well as its potential pathologization of normal aspects of the human condition.[3] Furthermore, the DSM is a profitable venture for the APA, with sales generating millions for the organization each year. The DSM may also be profitable for the individual task-force members that develop it, with nearly 70% reporting financial conflicts of interest (FCOIs) secondary to ties with psychiatric pharmaceutical companies. The most conflicted panels were those who developed the diagnostic criterion for conditions where pharmacological therapy is the first-line treatment.[4]

Despite their concerns about its content, approximately 90% of modern mental health professionals report using the DSM-5 at least monthly, most commonly citing the unique validity of its diagnostic codes (which are coupled with ICD codes) for third-party payment as their primary reason for use. In other words, because third-party payers require use of the DSM-5 in

order for clinicians to receive reimbursement, its clinical use is essentially mandatory for those that do business with insurance companies. Alternatives to the DSM have been proposed, however, none of them have gained major traction.[2] The DSM and those who contribute to its publishing are deeply intertwined within the field of psychiatry and have strong influence in allied industries including pharmaceuticals, clinical education, and research. Therefore, any changes to the diagnosis and classification of psychiatric disorders would require drastic interdisciplinary oversight, planning, funding, and enforcement.[5]

Policy Options

- A federal mandate blocking the APA from being the sole developer of the DSM on the basis of existing antitrust legislation. DSM-6 development and implementation will be rehauled secondary to government intervention to ensure the selection of contributors and investors unassociated with the APA. All diagnostic criteria will be externally reviewed before publishing. DSM-6 profits will not be the sole financial gain of the APA.
    - **Advantages:** Broadens patient-centered perspectives while developing diagnostic criteria by expanding oversight of development. Mitigates monopolistic influence of the APA. Improves scientific basis of diagnostic groundwork through expanded review. Allows for continuation of a nationally uniform diagnostic system, aiding education and public health. Relies on pre-existing frameworks guiding implementation of new DSM editions.
    - **Disadvantages:** High likelihood of resistance from clinical lobbying groups. Likely counter-litigation surrounding government right to intervene. Does not address FCOIs or demographics of individual task force members. The DSM remains for-profit. The DSM remains the sole option for clinical billing purposes. Development of new standard procedures for DSM development will require resources.
- A federal mandate codifying the sociopolitical requirements of all DSM task force members selected by the APA. The DSM remains the private domain of the APA, however, DSM-6 task forces will meet government requirements including that task forces should be free of FCOIs and demographically representative of the American population.
    - **Advantages:** Broadens patient-centered perspectives by expanding individual contributors. Eliminates FCOIs within task forces. Allows for continuation of a nationally uniform diagnostic system, aiding education and public health. Relies on pre-existing frameworks guiding both the implementation and development of new DSM editions.
    - **Disadvantages:** APA oversight has historically failed to improve areas of criticism. APA oversight has historically not relied on external peer-review. Likely resistance from clinical lobbying groups. The DSM remains for-profit, for the sole financial gain of the APA. The DSM remains the sole option for clinical billing purposes.

- A federal mandate expanding billable codes for psychiatric disorders, allowing clinicians to use other diagnostic modalities to receive third-party reimbursement if they want to. Other existing frameworks for psychiatric diagnosis may be preferred by clinicians and better equipped to guide patients, and their eligibility for reimbursement will allow clinicians to use them on an individually preferred basis.
    - **Advantages:** Increased flexibility of diagnostic process allows for subjective clinician preference. Alternative diagnostic modalities may better address patient context and/or may better rely on scientifically-backed, peer-reviewed diagnostic criteria. Mitigates monopolistic influence of the APA.
    - **Disadvantages:** Increased inconsistencies in diagnostic classifications and diagnoses amongst the population. Increased discrepancies in education and public health data tracking. Would require funding and academic rehaul to expand clinician diagnostic education. Would require funding to develop framework and legislation for implementation. Most likely would not have the strong support of any parties due to FCOIs or the substantial time and effort involved to revise individual clinical practice.
- A federal mandate enforcing exclusive use of an alternative mode of classification. Although other diagnostic systems have been developed to address the critiques of the DSM, they have not gained traction, most likely due to the powerful influence of the APA. After a government task force analyzes each pre-existing model (including the DSM) and considers the possibility of creating an entirely new system, the best choice for the American people will be implemented.
    - **Advantages:** Alternative diagnostic modalities may better address patient context and preferences and/or may better rely on scientifically-backed, peer-reviewed diagnostic criteria. Allows for a nationally uniform diagnostic system, aiding education and public health. Allows for use of the diagnostic system proven to be best suited for American patients and clinicians. A publicly-funded diagnostic system would mitigate FCOIs and monopolistic power of private groups.
    - **Disadvantages**: Research and analysis period would require significant time and funding. Research and analysis may be affected by influential groups or individual FCOIs. Subsequent clinical implementation would require significant time and funding, including the thorough education on the newly selected model for all clinicians. There is no guarantee that the new model would be patient-centered or address all clinician concerns.

Policy Recommendation:
Considering the deeply rooted foundational framework established by the DSM within the field of psychiatry and other associated interdisciplinary realms, its complete eradication and replacement would require efforts that seem unlikely, if not impossible, to achieve. Although multiple alternative diagnostic models have been developed and proposed in recent years, they

lack support. Furthermore, their implementation, whether as the sole modality or in conjunction with each other, would require a massive amount of oversight, time, and funding to implement. Replacing the DSM in any capacity would also result in societal and clinical confusion surrounding psychiatric diagnoses. Therefore, federal intervention and improvement of the existing processes to develop the DSM are not only the most realistic option, but would also require the least resources and result in the least amount of confusion. A federal mandate codifying the sociopolitical requirements of all DSM task force members selected by the APA is recommended, as this would improve existing frameworks to achieve a greater focus on patient-centered medicine rather than for-profit medicine. This mandate would be met with significantly less resistance and legal repercussions compared to a mandate that would block the power of the APA.

References

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