DIAGNOSING MENTAL ILLNESS
What Does the DSM-5 Mean for Corrections?

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The DSM-5 encourages clinicians to pay more attention to the presenting symptoms when diagnosing.

In the two decades since the last major revision to the Diagnostic and Statistical Manual of Mental Disorders, much has changed in the psychological landscape. Prior versions of the manual seem archaic by comparison to the newest iteration but reflect accurately what was going on in the culture at that time. (See page 9 for a brief history of the DSM.) As we move into the DSM-5, expected to be fully implemented in most major correctional systems by October, there are still questions as to its clinical utility and many more questions about how this implementation will affect our operations in correctional environments.

So, what does this new manual mean for those of us working in corrections? Well, for one, we could be in for a lot more work. The organizational structure of the manual has significantly changed. Many of us have been trained on the multiaxial system since its inception with the DSM-III. Inherent was the notion of distinguishing between major mental illnesses, which may be treated with psychotropics, and personality disorders or character flaws, which may be considered more treatment-resistant. How many times have we heard (or even said), "He isn't really sick; he is just a management problem—let security handle it"?

With the DSM-5 and its eradication of the multiaxial approach, mental health departments need to make a concerted effort to address both types of disorders given the high rate of comorbidity found in the incarcerated population. We need to forget making a distinction between Axis I vs. Axis II. Our focus has to be on the most salient presenting problem in front of us. With the advent of the DSM-5, the personality disorders and major mental illness have parity and warrant equal clinical attention depending on severity and impact on functioning.

Furthermore, eliminating Axis III takes the concept of parity even further and places mental health on similar footing as physical health. There is a strong mind—body connection, and in corrections understanding this interplay is paramount. We know that we get favorable outcomes when there is an integrated multidisciplinary team approach accounting for both physical and mental health.

More Careful Diagnosing

Initially, many of us felt the growing pains of having to learn a new system in the DSM-5. The old DSM-IV felt like a comfortable sweater, familiar and cozy. There were some drawbacks in that system, however, that tripped us up and led to sloppy diagnosing. For example, how many times have you seen the overuse of "not otherwise specified" (NOS) and the overdiagnosing of schizophrenia in corrections (which affects 1% of the population in the community)? The DSM-5 encourages clinicians to pay a little more
attention to the presenting symptoms when it comes to diagnosing.

Previous versions of the DSM tended to be too categorical and based on a somewhat arbitrary cutoff number of symptoms. To address this, the DSM-5 allows for a more streamlined method to diagnosing. Rather than having a collection of diagnoses that seem to “hang together,” the DSM-5 shows the connection among diagnoses, which may differ in terms of severity. So, for instance, with schizophrenia spectrum, the various subtypes have been removed. However, catatonia can be a specifier, and there is simply one code used for schizophrenia; severity can be rated as well, but the one code remains.

Why the drastic change? Well, there was very poor reliability with the subtypes and treatment was inconsistent as a result of the confusion. Now, when a patient is diagnosed with schizophrenia according to the DSM-5, there should be a confidence that the individual is in fact experiencing at least one positive symptom (i.e., delusion, hallucination, disorganized speech/behavior) and may be helped with the use of antipsychotic medication. This kind of refined system helps immensely with treatment planning.

In terms of reliability, how many of us working behind bars have seen wildly varying Global Assessment of Functioning scores? How clinically useful was this? The DSM-5 has replaced the GAF with the World Health Organization Disability Assessment Schedule. Yes, initially, the WHODAS 2.0 may take longer to complete than a GAF score, and there are understandable concerns about its practicality in corrections due to the volume of inmates we see, but the WHODAS may prove to be a clinical tool used to assess an inmate-patient’s progress over time given the trend toward quantitative outcome data using standardized measures.

**Lifespan Approach**

Do you remember taking a child development course in college back in the day? Currently, this course has been replaced with “lifespan development.” And the DSM-5 has caught up, too—no longer is there an exclusive chapter on disorders usually first diagnosed in infancy, childhood, or adolescence. This change reflects the growing realization that mental disorders may persist into later life, and that there are disorders that manifest themselves at earlier stages of development and the symptoms may look slightly different.

For example, post-traumatic stress disorder, which was once thought of as an anxiety disorder, has been reconceptualized and now has its own chapter where the adjustment disorders are now included. Anxiety disorders are seen as stemming from increased worry about a possible future event, whereas PTSD, acute stress disorder and adjustment disorder are seen as a response to a traumatic event that has already occurred. So PTSD and its related diagnoses have become more explicit in terms of what constitutes experiencing a traumatic event. Unless job-related,

**The Evolution of the DSM**

The colorful history of the manual and the diagnoses contained therein speak to the ever-changing culture of the United States and now, with the DSM-5, we begin to broaden our focus more globally with the inclusion of the WHODAS and the universal ICD codes.

To begin any discussion of the DSM we must look at its origins. Prior to the DSM, the U.S. government was looking to find ways of classifying people for statistics gathering purposes and they did so through the census process. In 1840, only one diagnosis was classified: idiocy/insanity. U.S. corrections at this time was largely using a system called the Pennsylvania system that involved the notion that all inmates needed to be separated from all other inmates; essentially, all inmates were in solitary confinement. If you were lucky (and yet in prison), you were in a prison that used the Auburn or Congregate system, in which inmates slept in their individual cells at night but worked and labored throughout the days in prison workshops.

Punishment in those early days was quite barbaric and used behavioral deterrents such as the pulley, the iron cap, the lash and paddle, straightjackets, the brickbag and the water crib. Rather than explain each of those, just use your imagination and multiply that horror by a factor of 10.

By 1880, seven diagnoses had been identified: mania, melancholia, monomania (a sort of partial insanity), paresis (a precursor to catatonia and other movement disorders), dementia, dipomana (an uncontrolled craving for alcohol) and epilepsy. These diagnoses began a process of categorizing the types of disorders we would see in the early versions of the DSM.

The sixth version of the International Classification of Diseases was published in 1948, as the world was still recovering from WWII. This is the first time we would see official mental health diagnoses being listed in a formal way. These included psychoses, psychoneuroses and disorders of character, behavior and intelligence.

Three years later, the American Psychiatric Association published its Diagnostic and Statistical Manual using the U.S. Army’s Medical 203 Manual and ICD-6 as examples. This manual was the first document that focused on the clinical utility of using a diagnostic classification system. Ironically, it was during this time that the United States saw its first wave of the deinstitutionalization of psychiatric hospitals. In 1955, there were 340 psychiatric beds per every 100,000 U.S. citizens. That number would drop drastically through another wave of deinstitutionalization, seeing lows as low as 17 beds per 100,000 citizens in 2005.

By the time we reach the DSM-5, the manual has gone from 106 diagnoses and a categorical approach to more than 300 diagnoses and a dimensional/lifespan approach.

continued on page 10
Not all correctional healthcare providers are the same.

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the traumatic event does not apply if it is only through exposure via various media. In addition, the “feeling of horror” criterion has been eliminated due to its highly subjective nature.

Hopefully, these more explicit diagnostic changes will help clinicians tighten up on their diagnosing PTSD in corrections, as inmates tend not to be the most reliable historians. It should follow that the dispensation of medications for PTSD should be used judiciously as we begin to reduce polypharmacy and ensure clinically appropriate levels of care.

An additional benefit to adopting the DSM-5’s lifespan approach in corrections is its emphasis on continuity of care. How could we do a better job at this in corrections? How many times do we treat an inmate-patient without looking at his/her history when we all are familiar with the truism “the best predictor of future behavior is past behavior”? Having a lifespan approach encourages correctional workers to obtain previous health records from outside hospitals and community providers.

Thus, it would behoove those working in corrections to establish linkages with local mental health agencies in order to paint a more complete clinical picture and ultimately provide the best patient care possible.

Unseen Effects
There are many unseen effects that the new DSM will have on our work, too. Many of the nation’s jail and inmate management systems still use older versions of the DSM codes (if they used them at all). With the new changes, this means that our staff may have to go in and make mass changes, taking up precious clinical time. It also means that we’re going to be considering which code to use. Do we just use the DSM code or the ICD code or just some of the codes? It can get confusing.

A lot of training is going to be necessary as we move forward. All that training takes time, and time is something that we often lack in our work. Often we’re doing our best just to reach all of the inmates that need our help. Taking time out to train can cut into that time with patients, but it is essential that we do so.

We will certainly see a number of changes and challenges as the DSM-5 is rolled out across the country in various facilities. The one thing that is clear is that our field is continuing to evolve and we hope that the DSM-5 contributes to better diagnostic processes in the field of corrections. We think that it will.

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