State of California
Office of Administrative Law

In re:
Department of State Hospitals

Regulatory Action:

Title 09, California Code of Regulations

Adopt sections: **4700, 4710, 4711, 4712, 4713, 4714, 4715, 4716, 4717**
Amend sections:
Repeal sections:

NOTICE OF APPROVAL OF REGULATORY ACTION

Government Code Section 11349.3

OAL Matter Number: 2017-1117-03

OAL Matter Type: Regular Resubmittal (SR)

The Department of State Hospitals submitted this action to adopt a new article and nine new sections in title 9, division 1, chapter 16 of the California Code of Regulations. The regulations address admissions to state hospitals of court-ordered commitments under Penal Code section 1370, which are made when a criminal defendant is determined by a court to be incompetent to stand trial (IST). The regulations are intended to clarify the process for admitting IST individuals by providing uniform admissions, procedures, and classification criteria applicable to all counties.

OAL approves this regulatory action pursuant to section 11349.3 of the Government Code. This regulatory action becomes effective on 11/22/2017 pursuant to section 11343.4(b)(3) of the Government Code.

Date: November 22, 2017

Richard L. Smith
Richard L. Smith
Senior Attorney

For: Debra M. Cornez
Director

Original: Pamela Ahlin, Director
Copy: Amy Whiting

RESUBMITTAL

STATE OF CALIFORNIA--OFFICE OF ADMINISTRATIVE LAW

NOTICE PUBLICATION/REGULATIONS SUBMISSION

(See instructions on reverse)

For use by Secretary of State only

STD. 400 (REV. 01-2013)

OAL FILE NUMBERS	NOTICE FILE NUMBER	REGULATORY ACTION NUMBER	EMERGENCY NUMBER
	Z-2016-1229-01	2017-1117-03SR	

ENDORSED - FILED
in the office of the Secretary of State
of the State of California
NOV 22 2017
1:42PM

For use by Office of Administrative Law (OAL) only

2017 NOV 17 P 3:52
OFFICE OF ADMINISTRATIVE LAW

NOTICE | REGULATIONS

AGENCY WITH RULEMAKING AUTHORITY
Department of State Hospitals

AGENCY FILE NUMBER (If any)

A. PUBLICATION OF NOTICE (Complete for publication in Notice Register)

1. SUBJECT OF NOTICE	TITLE(S)	FIRST SECTION AFFECTED	2. REQUESTED PUBLICATION DATE

3. NOTICE TYPE	4. AGENCY CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)
☐ Notice re Proposed Regulatory Action ☐ Other			

OAL USE ONLY	ACTION ON PROPOSED NOTICE	NOTICE REGISTER NUMBER	PUBLICATION DATE
	☐ Approved as Submitted ☐ Approved as Modified ☐ Disapproved/ Withdrawn	2017, Q-2	1/13/2017

B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S)	1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S)
Incompetent to Stand Trial Admissions Process	2017-0908-02C

2. SPECIFY CALIFORNIA CODE OF REGULATIONS TITLE(S) AND SECTION(S) **(Including title 26, if toxics related)**

SECTION(S) AFFECTED (List all section number(s) individually. Attach additional sheet if needed.)	ADOPT	AMEND	REPEAL
TITLE(S) 9	4700, 4710, 4711, 4712, 4713, 4714, 4715, 4716 and 4717		

3. TYPE OF FILING

- ☐ Regular Rulemaking (Gov. Code §11346)
- ☒ Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §§11349.3, 11349.4)
- ☐ Emergency (Gov. Code, §11346.1(b))
- ☐ Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Gov. Code §§11346.2-11347.3 either before the emergency regulation was adopted or within the time period required by statute.
- ☐ Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)
- ☐ Emergency Readopt (Gov. Code, §11346.1(h))
- ☐ File & Print
- ☐ Other (Specify) _____
- ☐ Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100)
- ☐ Print Only

4. ALL BEGINNING AND ENDING DATES OF AVAILABILITY OF MODIFIED REGULATIONS AND/OR MATERIAL ADDED TO THE RULEMAKING FILE (Cal. Code Regs. title 1, §44 and Gov. Code §11347.1)
4/21/2017--5/9/2017; 8/14/2017 -- 8/29/2017; and 10/26/2017 -- 11/10/2017

5. EFFECTIVE DATE OF CHANGES (Gov. Code, §§ 11343.4, 11346.1(d); Cal. Code Regs., title 1, §100)

- ☐ Effective January 1, April 1, July 1, or October 1 (Gov. Code §11343.4(a))
- ☒ Effective on filing with Secretary of State
- ☐ §100 Changes Without Regulatory Effect
- ☐ Effective other (Specify) _____

6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY

- ☒ Department of Finance (Form STD. 399) (SAM §6660)
- ☐ Fair Political Practices Commission
- ☐ State Fire Marshal
- ☐ Other (Specify) _____

7. CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)	E-MAIL ADDRESS (Optional)
Amy Whiting	(916) 651-3247	(916) 651-3090	Amy.Whiting@dsh.ca.gov

8. **I certify that the attached copy of the regulation(s) is a true and correct copy of the regulation(s) identified on this form, that the information specified on this form is true and correct, and that I am the head of the agency taking this action, or a designee of the head of the agency, and am authorized to make this certification.**

SIGNATURE OF AGENCY HEAD OR DESIGNEE	DATE
Stephanie Clendenin	11/17/2017

TYPED NAME AND TITLE OF SIGNATORY
Stephanie Clendenin, Chief Deputy Director

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ENDORSED APPROVED
NOV 22 2017
Office of Administrative Law

DEPARTMENT OF STATE HOSPITALS
FINAL REGULATION ORDER

Incompetent to Stand Trial Admissions Process

California Code of Regulations
Title 9. Rehabilitative and Developmental Services
Division 1. Department of Mental Health
Chapter 16. State Hospital Operations

Adopt new Article 7 and new sections 4700, 4710, 4711, 4712, 4713, 4714, 4715, 4716 and 4717, Chapter 16, Division 1, Title 9, California Code of Regulations, to read as follows:

Article 7. Admissions

§ 4700. Definitions.

(a) "Low or moderate security risk" means that the individual, based on the assessment by the Department of State Hospitals of the factors described in Section 4714, is not highly likely to compromise the security of the particular state hospital under consideration for the individual's placement.

(b) "High security risk" means that the individual, based on the assessment by the Department of State Hospitals of the factors described in Section 4714, is likely or highly likely to compromise the security of the particular state hospital under consideration for the individual's placement.

(c) "Psychiatric acuity" means that an individual's mental illness is causing complications which put the individual at risk of death or serious injury while awaiting admission. An individual's aggressive behavior alone shall not be sufficient to support a finding of psychiatric acuity.

Note: Authority cited: Sections 4005.1 and 4027, Welfare and Institutions Code.
Reference: Sections 1370 and 1370.01, Penal Code; and Sections 7228 and 7230, Welfare and Institutions Code.

§ 4710. Date of Admission of Individuals Found Incompetent to Stand Trial.

(a) In scheduling the admission of individuals judicially committed to the Department of State Hospitals as Incompetent to Stand Trial, the Department shall admit each individual to a state hospital according to the date the court committed the individual to the Department. Actual date of admission may change upon consideration of any of the following factors:

(1) Bed availability at the facility under consideration for the individual's placement;

(2) Whether the individual exhibits psychiatric acuity which may indicate the need for admission to a facility, notwithstanding the date the court committed the individual to the Department;

(3) Whether the facility under consideration for the individual's placement can presently clinically accommodate the medical needs of the individual; or

(4) The ability of the committing county to reasonably timely transport the individual to the facility under consideration for the individual's placement.

(b) If an individual found Incompetent to Stand Trial is judicially committed to the Department of State Hospitals and placed in a jail-based competency program and that program determines that it cannot appropriately treat the individual, the individual shall be admitted to a state hospital according to the date the court committed the individual to the Department.

(c) In cases wherein an individual has been treated by the Department of State Hospitals, found competent, and returned to the committing county, and wherein the individual's competency is challenged by any party and the court subsequently commits the individual to the Department of State Hospitals as Incompetent to Stand Trial, the Department shall admit the individual according to the most recent date the court committed the individual to the Department.

Note: Authority cited: Sections 4005.1 and 4027, Welfare and Institutions Code.
Reference: Sections 1370, 1370.01 and 1372, Penal Code; Sections 7228 and 7230, Welfare and Institutions Code; *People v. Rells* (2000) 22 Cal.4th 860; and *People v. Mixon* (1990) 225 Cal.App.3d 1471.

§ 4711. Required Documentation for Admission of Individuals Found Incompetent to Stand Trial.

(a) A county judicially committing an individual to the Department of State Hospitals as Incompetent to Stand Trial shall submit a commitment packet to the Department for review and approval prior to the admission of the individual.

(b) The commitment packet shall include the following items:

(1) The commitment order, including a specification of the charges.

(2) A computation or statement setting forth the maximum term of commitment.

(3) A computation or statement setting forth the amount of credit for time served, if any, to be deducted from the maximum term of commitment.

(4) The State's summary of the individual's criminal history.

(5) Any arrest report from police departments or other law enforcement agencies.

(6) Any court-ordered psychiatric examination or evaluation reports.

(7) The placement recommendation report prepared by the community program director of the forensic conditional release program.

(8) Records of any finding of mental incompetence pursuant to this chapter arising out of a complaint charging a felony offense specified in Penal Code section 290 or any pending Penal Code section 1368 proceeding arising out of a charge of a Penal Code section 290 offense.

(9) Any medical records as described in section 4712.

Note: Authority cited: Sections 4005.1 and 4027, Welfare and Institutions Code.
Reference: Sections 1370 and 1370.01, Penal Code; and Section 7228, Welfare and Institutions Code.

§ 4712. Required Medical Records for Admission of Individuals Found Incompetent to Stand Trial.

(a) A county judicially committing an individual to the Department of State Hospitals as Incompetent to Stand Trial shall provide the following medical documentation of the individual, if applicable, with the individual's commitment packet:

(1) All progress notes that pertain to behavioral incidents;

(2) Current medications and dosage;

(3) Compliance with current or previous medication;

(4) Laboratory results and consultations;

(5) Psychiatric evaluation from the most recent admission;

(6) Records or incidences of self-injurious behavior, suicide watch, or use of safety cell;

(7) Any notes on recent physical exams or medical history;

(8) Any advance health care directive;

(9) Any consent forms for treatment; and

(10) Any other court-ordered medical treatment.

(b) If the individual presents with any of the following conditions, the committing county shall provide medical documentation including treatment plans, if applicable, with the individual's commitment packet:

(1) Renal dialysis (hemodialysis or peritoneal dialysis);

(2) Non-ambulation or the individual's need for prosthetics, walkers, or assistance to ambulate;

(3) Any stage of pregnancy or any prenatal care information or complications;

(4) Continuous oxygen, continuous respiratory monitoring, ventilator devices, or nebulizer for airway treatment;

(5) Cancer;

(6) Congestive heart failure;

(7) Blood or spinal fluid shunt currently in place or shunt for hydrocephalus;

(8) Any required injections;

(9) Any open wound not yet healed or any untreated open wound;

(10) Ostomy;

(11) Cirrhosis of the liver;

(12) Active inflammatory bowel diseases, complications by intestinal obstruction, subocclusion, severe fistulas, or active rectal bleeding;

(13) Inability of the individual to provide basic self-care or any other condition of the individual that requires skilled nursing level of care;

(14) Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS);

(15) Tuberculosis; or

(16) Any other significant medical condition.

(c) Prior to the individual's transport to the state hospital, the committing county shall provide updated medical records to the state hospital under consideration for the individual's placement.

(d) If any of the above documents in this section does not exist or is otherwise unavailable, the committing county shall advise the Department in writing of such nonexistence or unavailability.

Note: Authority cited: Sections 4005.1 and 4027, Welfare and Institutions Code.
Reference: Section 1370 and 1370.01, Penal Code; Section 7228, Welfare and Institutions Code; and *In re Loveton* (2016) 244 Cal.App.4th 1025.

§ 4713. Appropriate Placement of Individuals Found Incompetent to Stand Trial According to Medical Records Review.

(a) The Department of State Hospitals shall evaluate the medical records provided in the commitment packet to determine the appropriate facility for admission according to the medical needs of the individual.

(b) A triage nurse in the admissions unit of the state hospital under consideration for the individual's placement shall review the medical records provided in the commitment packet.

(c) Upon review, the triage nurse in the admissions unit of the state hospital under consideration for the individual's placement shall consult with the chief physician and surgeon or designee in that admissions unit to determine whether the particular state hospital is able to provide the necessary care or services to the individual.

(d) The chief physician and surgeon or designee in the admissions unit of the state hospital under consideration for the individual's placement shall determine whether the particular state hospital is able to provide the necessary care or services to the individual.

(e) If the chief physician and surgeon or designee in the admissions unit of the state hospital under consideration for the individual's placement determines that the particular state hospital is unable to provide the necessary care or services to the individual, the Department's Director or designee shall determine the appropriate facility for the individual's placement.

Note: Authority cited: Sections 4005.1 and 4027, Welfare and Institutions Code.
Reference: Sections 1370 and 1370.01, Penal Code; and Sections 7228 and 7230, Welfare and Institutions Code.

§ 4714. Security Risk Assessment of Individuals Found Incompetent to Stand Trial.

(a) To determine the appropriate facility for admission, the Department of State Hospitals shall assess the security risk of each individual judicially committed to the Department as Incompetent to Stand Trial.

(b) To determine the security risk of an individual, the Department shall consider the following:

(1) The individual's risk of escape, based on the individual's history of escape or attempted escape from any locked facility;

(2) Any new or additional information about the individual, including but not limited to a change in commitment status, divorce by spouse, death of a family member of the individual, or birth of the individual's child, received by the Department within 30 days prior to completion of the security risk assessment;

(3) The individual's age;

(4) Any diagnosis of the individual, based on the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (2013), hereby incorporated by reference, of an antisocial, borderline, or narcissistic personality disorder;

(5) The number of the individual's prior felony convictions;

(6) The individual's pending criminal charges and the maximum exposure the individual is facing for each pending charge, at the time of assessment; and

(7) The individual's current medical condition.

(c) Upon the Department's security risk assessment, the Department shall determine whether the individual is a low or moderate security risk or a high security risk.

Note: Authority cited: Sections 4005.1 and 4027, Welfare and Institutions Code.
Reference: Sections 7228 and 7230, Welfare and Institutions Code.

§ 4715. Appropriate Placement of Individuals Found Incompetent to Stand Trial According to Security Risk Assessment.

(a) An individual judicially committed to the Department of State Hospitals as Incompetent to Stand Trial, who the Department has determined to be a low or moderate security risk pursuant to section 4714, shall be appropriate for admission to the following state hospitals: Department of State Hospitals - Atascadero, Department of State Hospitals - Patton, Department of State Hospitals - Napa, or Department of State Hospitals - Metropolitan.

(b) An individual judicially committed to the Department of State Hospitals as Incompetent to Stand Trial, who the Department has determined to be a high security risk pursuant to section 4714, shall be appropriate for admission only to Department of State Hospitals - Atascadero or Department of State Hospitals - Patton.

Note: Authority cited: Sections 4005.1, 4027 and 7225, Welfare and Institutions Code.
Reference: Sections 7228 and 7230, Welfare and Institutions Code.

§ 4716. Placement of Individuals Found Incompetent to Stand Trial Upon Completion of Commitment Packet.

(a) Except as provided for in subdivision (b), the Department of State Hospitals shall admit an individual judicially committed to the Department as Incompetent to Stand Trial only when a completed commitment packet as specified in section 4711 has been received, reviewed, and approved by the Department.

(b) In cases wherein the Department, upon review, discovers that a commitment packet is incomplete, it shall advise the committing county of any missing documentation within 14 calendar days of such discovery.

(c) The Department at its sole discretion may admit an individual whose commitment packet is incomplete only if the Department determines pursuant to section 4717 that the individual exhibits psychiatric acuity which may indicate the need for admission to a state hospital notwithstanding the date the court committed the individual to the Department.

(d) Upon review of the commitment packet, the Medical Director or designee of each state hospital under consideration for the individual's placement has the final authority to determine whether the individual shall be placed at that particular state hospital. If the Medical Director or designee determines that the individual is not appropriate for placement at that particular state hospital, the Department's Director or designee shall determine the appropriate facility for the individual's placement.

(e) The medical director of the Department of State Hospitals, or designee, will make a decision on whether to expedite admission of an individual due to his or her psychiatric acuity within 72 hours of contact by the committing county's clinician and when the department receives sufficient documentation.

Note: Authority cited: Sections 4005.1 and 4027, Welfare and Institutions Code.
Reference: Sections 1370 and 1370.01, Penal Code; Sections 7228, Welfare and Institutions Code.

§ 4717. Psychiatric Acuity Review of Individuals Found Incompetent to Stand Trial.

(a) An individual shall be admitted to a state hospital notwithstanding the date the court committed the individual to the Department if the Department determines that the individual is psychiatrically acute.

(b) The Department's medical director or designee has the final authority to determine whether the individual exhibits psychiatric acuity which may indicate the need for admission to a state hospital notwithstanding the date the court committed the individual to the Department.

(c) To request a psychiatric acuity review of an individual, the committing county's clinician who is responsible for the individual's clinical assessment or its designee shall contact the Department's medical director or designee about the individual's psychiatric acuity and the psychiatric acuity needs of the individual.

(d) The committing county or its clinician or designee shall provide the Department's medical director or designee medical information and documentation supporting psychiatric acuity. Such documentation may include but is not limited to:

(1) Any notes on use of safety cell;

(2) Current medication and dosage or lack of medication;

(3) Medical laboratory results; or

(4) Any additional treatment records from local health care providers.

(e) Within three business days after the committing county's clinician or designee contacts the Department's medical director or designee and after receipt of sufficient documentation, the Department's medical director or designee shall determine whether the individual's psychiatric acuity may indicate the need for admission to a state hospital notwithstanding the date the court committed the individual to the Department. The determination of the Department's medical director or designee shall be based only on medical documentation provided by the committing county pursuant to subsection (d) and, if warranted, discussions with the county's clinician or designee.

Note: Authority cited: Sections 4005.1, 4027 and 7225, Welfare and Institutions Code. Reference: Sections 1370 and 1370.01, Penal Code; and Sections 7228 and 7230, Welfare and Institutions Code.

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

FIFTH EDITION

DSM-5™

AMERICAN PSYCHIATRIC ASSOCIATION

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Section III
Emerging Measures and Models

Appendix

Preface

The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is a classification of mental disorders with associated criteria designed to facilitate more reliable diagnoses of these disorders. With successive editions over the past 60 years, it has become a standard reference for clinical practice in the mental health field. Since a complete description of the underlying pathological processes is not possible for most mental disorders, it is important to emphasize that the current diagnostic criteria are the best available description of how mental disorders are expressed and can be recognized by trained clinicians. DSM is intended to serve as a practical, functional, and flexible guide for organizing information that can aid in the accurate diagnosis and treatment of mental disorders. It is a tool for clinicians, an essential educational resource for students and practitioners, and a reference for researchers in the field.

Although this edition of DSM was designed first and foremost to be a useful guide to clinical practice, as an official nomenclature it must be applicable in a wide diversity of contexts. DSM has been used by clinicians and researchers from different orientations (biological, psychodynamic, cognitive, behavioral, interpersonal, family/systems), all of whom strive for a common language to communicate the essential characteristics of mental disorders presented by their patients. The information is of value to all professionals associated with various aspects of mental health care, including psychiatrists, other physicians, psychologists, social workers, nurses, counselors, forensic and legal specialists, occupational and rehabilitation therapists, and other health professionals. The criteria are concise and explicit and intended to facilitate an objective assessment of symptom presentations in a variety of clinical settings—inpatient, outpatient, partial hospital, consultation-liaison, clinical, private practice, and primary care—as well in general community epidemiological studies of mental disorders. DSM-5 is also a tool for collecting and communicating accurate public health statistics on mental disorder morbidity and mortality rates. Finally, the criteria and corresponding text serve as a textbook for students early in their profession who need a structured way to understand and diagnose mental disorders as well as for seasoned professionals encountering rare disorders for the first time. Fortunately, all of these uses are mutually compatible.

These diverse needs and interests were taken into consideration in planning DSM-5. The classification of disorders is harmonized with the World Health Organization's *International Classification of Diseases* (ICD), the official coding system used in the United States, so that the DSM criteria define disorders identified by ICD diagnostic names and code numbers. In DSM-5, both ICD-9-CM and ICD-10-CM codes (the latter scheduled for adoption in October 2014) are attached to the relevant disorders in the classification.

Although DSM-5 remains a categorical classification of separate disorders, we recognize that mental disorders do not always fit completely within the boundaries of a single disorder. Some symptom domains, such as depression and anxiety, involve multiple diagnostic categories and may reflect common underlying vulnerabilities for a larger group of disorders. In recognition of this reality, the disorders included in DSM-5 were reordered into a revised organizational structure meant to stimulate new clinical perspectives. This new structure corresponds with the organizational arrangement of disorders planned for ICD-11 scheduled for release in 2015. Other enhancements have been introduced to promote ease of use across all settings:

- **Representation of developmental issues related to diagnosis.** The change in chapter organization better reflects a lifespan approach, with disorders more frequently diagnosed in childhood (e.g., neurodevelopmental disorders) at the beginning of the manual and disorders more applicable to older adulthood (e.g., neurocognitive disorders) at the end of the manual. Also, within the text, subheadings on development and course provide descriptions of how disorder presentations may change across the lifespan. Age-related factors specific to diagnosis (e.g., symptom presentation and prevalence differences in certain age groups) are also included in the text. For added emphasis, these age-related factors have been added to the criteria themselves where applicable (e.g., in the criteria sets for insomnia disorder and posttraumatic stress disorder, specific criteria describe how symptoms might be expressed in children). Likewise, gender and cultural issues have been integrated into the disorders where applicable.
- **Integration of scientific findings from the latest research in genetics and neuroimaging.** The revised chapter structure was informed by recent research in neuroscience and by emerging genetic linkages between diagnostic groups. Genetic and physiological risk factors, prognostic indicators, and some putative diagnostic markers are highlighted in the text. This new structure should improve clinicians' ability to identify diagnoses in a disorder spectrum based on common neurocircuitry, genetic vulnerability, and environmental exposures.
- **Consolidation of autistic disorder, Asperger's disorder, and pervasive developmental disorder into autism spectrum disorder.** Symptoms of these disorders represent a single continuum of mild to severe impairments in the two domains of social communication and restrictive repetitive behaviors/interests rather than being distinct disorders. This change is designed to improve the sensitivity and specificity of the criteria for the diagnosis of autism spectrum disorder and to identify more focused treatment targets for the specific impairments identified.
- **Streamlined classification of bipolar and depressive disorders.** Bipolar and depressive disorders are the most commonly diagnosed conditions in psychiatry. It was therefore important to streamline the presentation of these disorders to enhance both clinical and educational use. Rather than separating the definition of manic, hypomanic, and major depressive episodes from the definition of bipolar I disorder, bipolar II disorder, and major depressive disorder as in the previous edition, we included all of the component criteria within the respective criteria for each disorder. This approach will facilitate bedside diagnosis and treatment of these important disorders. Likewise, the explanatory notes for differentiating bereavement and major depressive disorders will provide far greater clinical guidance than was previously provided in the simple bereavement exclusion criterion. The new specifiers of anxious distress and mixed features are now fully described in the narrative on specifier variations that accompanies the criteria for these disorders.
- **Restructuring of substance use disorders for consistency and clarity.** The categories of substance abuse and substance dependence have been eliminated and replaced with an overarching new category of substance use disorders—with the specific substance used defining the specific disorders. "Dependence" has been easily confused with the term "addiction" when, in fact, the tolerance and withdrawal that previously defined dependence are actually very normal responses to prescribed medications that affect the central nervous system and do not necessarily indicate the presence of an addiction. By revising and clarifying these criteria in DSM-5, we hope to alleviate some of the widespread misunderstanding about these issues.
- **Enhanced specificity for major and mild neurocognitive disorders.** Given the explosion in neuroscience, neuropsychology, and brain imaging over the past 20 years, it was critical to convey the current state-of-the-art in the diagnosis of specific types of disorders that were previously referred to as the "dementias" or organic brain diseases. Biological markers identified by imaging for vascular and traumatic brain disorders and

specific molecular genetic findings for rare variants of Alzheimer's disease and Huntington's disease have greatly advanced clinical diagnoses, and these disorders and others have now been separated into specific subtypes.

- **Transition in conceptualizing personality disorders.** Although the benefits of a more dimensional approach to personality disorders have been identified in previous editions, the transition from a categorical diagnostic system of individual disorders to one based on the relative distribution of personality traits has not been widely accepted. In DSM-5, the categorical personality disorders are virtually unchanged from the previous edition. However, an alternative "hybrid" model has been proposed in Section III to guide future research that separates interpersonal functioning assessments and the expression of pathological personality traits for six specific disorders. A more dimensional profile of personality trait expression is also proposed for a trait-specified approach.
- **Section III: new disorders and features.** A new section (Section III) has been added to highlight disorders that require further study but are not sufficiently well established to be a part of the official classification of mental disorders for routine clinical use. Dimensional measures of symptom severity in 13 symptom domains have also been incorporated to allow for the measurement of symptom levels of varying severity across all diagnostic groups. Likewise, the WHO Disability Assessment Schedule (WHODAS), a standard method for assessing global disability levels for mental disorders that is based on the International Classification of Functioning, Disability and Health (ICF) and is applicable in all of medicine, has been provided to replace the more limited Global Assessment of Functioning scale. It is our hope that as these measures are implemented over time, they will provide greater accuracy and flexibility in the clinical description of individual symptomatic presentations and associated disability during diagnostic assessments.
- **Online enhancements.** DSM-5 features online supplemental information. Additional cross-cutting and diagnostic severity measures are available online (www.psychiatry.org/dsm5), linked to the relevant disorders. In addition, the Cultural Formulation Interview, Cultural Formulation Interview—Informant Version, and supplementary modules to the core Cultural Formulation Interview are also included online at www.psychiatry.org/dsm5.

These innovations were designed by the leading authorities on mental disorders in the world and were implemented on the basis of their expert review, public commentary, and independent peer review. The 13 work groups, under the direction of the DSM-5 Task Force, in conjunction with other review bodies and, eventually, the APA Board of Trustees, collectively represent the global expertise of the specialty. This effort was supported by an extensive base of advisors and by the professional staff of the APA Division of Research; the names of everyone involved are too numerous to mention here but are listed in the Appendix. We owe tremendous thanks to those who devoted countless hours and invaluable expertise to this effort to improve the diagnosis of mental disorders.

We would especially like to acknowledge the chairs, text coordinators, and members of the 13 work groups, listed in the front of the manual, who spent many hours in this volunteer effort to improve the scientific basis of clinical practice over a sustained 6-year period. Susan K. Schultz, M.D., who served as text editor, worked tirelessly with Emily A. Kuhl, Ph.D., senior science writer and DSM-5 staff text editor, to coordinate the efforts of the work groups into a cohesive whole. William E. Narrow, M.D., M.P.H., led the research group that developed the overall research strategy for DSM-5, including the field trials, that greatly enhanced the evidence base for this revision. In addition, we are grateful to those who contributed so much time to the independent review of the revision proposals, including Kenneth S. Kendler, M.D., and Robert Freedman, M.D., co-chairs of the Scientific Review Committee; John S. McIntyre, M.D., and Joel Yager, M.D., co-chairs of the Clinical and Public Health Committee; and Glenn Martin, M.D., chair of the APA Assem-

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