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April 27, 2023

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National Institutes of Health National Institute of Drug Abuse and National Institute of Alcohol Abuse and Alcoholism

Attention: NIH Preaddiction Group
11601 Landsdown Street
North Bethesda, MD 20852

Re: Inviting input on use of a term like “preaddiction” for identifying and intervening in substance misuse and mild/early-stage substance use disorder (NOT-DA-23-019)

Dear Director Volkow,

The American Psychiatric Association (APA), the national medical society representing over 38,000 psychiatric physicians and their patients, appreciate the opportunity to comment on the use of the term “preaddiction” for identifying and intervening in potentially clinically significant substance misuse and/or early-stage substance use disorder within healthcare settings. APA recognizes the National Institute of Drug Abuse (NIDA) and National Institute of Alcohol Abuse and Alcoholism’s (NIAAA) commitment to the development of novel preventive measures for substance use disorders (SUDs) through it’s proposed “preaddiction” terminology. **However, the potential for increased stigmatization of effected individuals, combined with a lack of a conclusive research on the criteria for “preaddiction”, would suggest the term should not be utilized without further studies and alternative preventive strategies should be considered.**

APA’s key recommendations for NIDA and NIAAA’s proposal of use of “preaddiction” are:

1. Conducting research around the efficacy of “preaddiction” as a preventive measure for SUD development.
2. Extensive analysis on the effects of the term “preaddiction” for patients, including unintended consequences.
3. Consideration of alternative preventive measures such as education and training of PCPs on early addiction risk screening through integrated behavioral care models such as Collaborative Care.

1. Conducting research around the efficacy of “preaddiction” as a preventive measure for SUD development.

There currently exists little to no research on the efficacy of using “preaddiction” to prevent or mitigate SUD development. A JAMA Psychiatry article on potential implementation of “preaddiction” into health care settings was published in June of 2022, however the article provides no evidence base for this intervention.¹ Instead, the publication makes a comparison to the use of “prediabetes” as an argument

¹ McLellan AT, Koob GF, Volkow ND. Preaddiction—A Missing Concept for Treating Substance Use Disorders. *JAMA Psychiatry*. 2022;79(8):749–751. doi:10.1001/jamapsychiatry.2022.1652

for why “preaddiction” could positively reduce SUD prevalence. This example falls short, as standardized physiological measures can be taken to confirm prediabetes and diabetes risk, whereas there is no such standard that currently exists for “preaddiction” testing. In fact, the article concedes that implementation of the “prediabetes” diagnosis was made easier by the pre-existence of “easy-to-use, insurance-reimbursed laboratory tests to define and detect prediabetes.”² Outside of this article, there has been no significant publication base for “preaddiction” efficacy, and until more clinical research is done on this term, formal introduction into resources such as the DSM would be premature.

2. Extensive analysis on the effects of the term “preaddiction” for patients, including unintended consequences

Introduction of the term “preaddiction” as a diagnosis could cause several harmful effects including further stigmatization of diagnosed individuals, equity issues, and discriminatory insurance practices. In terms of stigma, the American Disabilities Act (ADA) currently does not provide protection from termination for individuals currently engaged in illicit drug use, thus a diagnosis of “preaddiction” could place employees in a vulnerable position.³ Moreover, research demonstrates that persons of color with identified SUDs experience higher rates of discrimination, as well as more limited access to recovery resources. Introducing “preaddiction” could further these inequities. Establishment of the term “preaddiction” provides an unnecessary new diagnosis and based on existing evidence, it would likely increase stigmatization for those diagnosed.

Outside of stigmatization, new diagnoses like “preaddiction” could lead to discriminatory actions from health insurance providers. Currently, many health insurance plans exclude coverage for evidence-based OUD medications, as well as require prior authorization for all out-patient SUD services.³ Nonquantitative treatment limitations (NQTLs) have been used by insurance companies to delay or reduce SUD treatment options. Health insurance companies could use this same framework to deny or delay care for individuals with diagnosed “preaddiction”. The criminal justice system is another area in which the diagnosis of “preaddiction” could be problematic. Additional rule making would need to ensure that no part of the “preaddiction” notes in the medical record could be used against a person in an administrative, criminal, employment, or domestic proceedings.

Given the significant number of factors to consider around stigma and discrimination with potential “preaddiction” diagnosis, comprehensive analysis of the subject should occur prior to any formalizing of “preaddiction” within a clinical context.

3. Consideration of alternative preventive measures such as education and training of PCPs on early addiction risk screening through collaborative care and integrated care models.

Until more research is conducted, the addition of “preaddiction” as a diagnosis may not be the solution for preventing SUD development. APA supports the goals of developing meaningful and feasible screening tools for risk of SUDs together with brief, early interventions that are broadly accessible and may alter

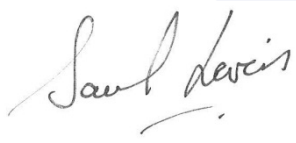
² Earnshaw, V. A. (2020, December). *Stigma and substance use disorders: A clinical, research, and advocacy agenda*. The American psychologist. Retrieved April 21, 2023, from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8168446/>

³ Robeznieks, Andis *Insurer accountability on mental health parity is long overdue*. American Medical Association. Retrieved April 21, 2023, from <https://www.ama-assn.org/delivering-care/patient-support-advocacy/insurer-accountability-mental-health-parity-long-overdue>

trajectories toward SUDs. These tools may be most effective in integrated care models, where primary care physicians (PCPs) are educated on how to best use these resources for their patients, in consultation with a mental health professional. APA supports increasing preventive tools within the evidence-based Collaborative Care Model, to help mitigate SUD development and mitigate SUDs risk.

APA appreciates NIDA and NIAAA's commitment to the prevention of SUDs development, and continued support for individuals at high risk for SUDs. APA encourages further research on the efficacy of the utilization of this term, as well as the evaluation of potential harmful effects. Thank you for your review and consideration of these comments. If you have any questions or would like to discuss any of these comments further, please contact Kristin Kroeger, Chief of Policy, Program and Partnerships kkroeger@psych.org.

Sincerely,

A handwritten signature in black ink that reads "Saul Levin". The signature is written in a cursive style and is contained within a white rectangular box.

Saul M. Levin, M.D., M.P.A., FRCP-E, FRCPsych
CEO and Medical Director
American Psychiatric Association