Agenda item 6.1

The development of terminology concerning psychoactive substance use and disorders: the treaties, scheduling decisions and public health

A primary task of the Expert Committee on Drug Dependence is to provide technical determinations concerning particular substances under the provisions of the 1961 Convention (as amended by the 1972 Protocol) and the 1971 Convention. These technical determinations are in terms of specific provisions and terms used in the two Conventions. In the half century since the 1961 Convention was adopted, there has been considerable development in the terminology used to describe psychoactive substance use, problems and diagnoses. This note reviews the terminology used in the conventions, discusses how the terms have been applied and interpreted, and considers the relationship between the terms in the Conventions and the terminology and definitions in use or currently under discussion in the major international diagnostic systems.

The note briefly discusses the main terminology used in the treaties and in applying them, with an expanded discussion including further terms as an Annex.

The determinations and recommendations of the Committees in carrying out their duties under the Conventions are actually in terms of a balancing between the negative elements which might suggest the need for international controls, and the fact that many of the substances considered continue “to be indispensable for the relief of pain and suffering”, as the Preamble to the 1961 Convention puts it. The focus here is on the potentially negative elements, rather than on the terminology concerning the usefulness of the substance for “medical” purposes. This side of the determination would also benefit from a more detailed examination; “medical” is nowhere defined in the treaties, and the system and the Committees appear to have operated exclusively within a frame of mainline western allopathic medicine.

Terms Used In The Conventions

The texts of the conventions use a limited vocabulary of terms with respect to psychoactive substances and the disorders or harm associated with them, and generally do not define the terms.

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1 Background paper prepared by Prof. Robin Room for the 35th Expert Committee on Drug Dependence; under responsibility of the Secretariat.
2 The one exception to this in the treaties is the provision for a 15-year grace period for “quasi-medical use of opium” in Art. 47 of the 1961 Convention.
In the 1961 Convention, the primary approach is to start with psychoactive substances derived from three plants – opium, cannabis (and its resin, extracts and tinctures) and coca leaf—and to specify that substances should be added to the Conventions schedules if they are “liable to similar abuse and productive of similar ill effects”. There is also reference to “measures against the abuse of drugs” and to “abusers of drugs”.

The 1971 Convention specifies as one of the criteria for scheduling under the Convention that the drug “has the capacity to produce a state of dependence,” as well as “central nervous system stimulation or depression, resulting in hallucinations or disturbances in motor function or thinking or behavior or perception or mood”. Alternatively, the drug may show “similar abuse and similar ill effects” as an already listed substance. In addition to satisfying one of these conditions, there must be “sufficient evidence that the substance is being or is likely to be abused so as to constitute a public health and social problem warranting the placing of the substance under international control”.

Meanings and equivalents of terms used in the conventions

Dependency. At the time of adoption of the 1971 Convention, the meaning of this term was in the process of change. As a technical psychopharmacological term, dependence had referred to the existence of a withdrawal syndrome if heavy use of the drug ceased. A 1964 Expert Committee report had proposed an expanded meaning, with “dependence” referring not only to the original meaning, renamed “physiological dependence”, but also to “psychic dependence” (now usually “psychological dependence”). The new meaning, in which the term more or less replaced “addiction” (see Annex 1), was eventually accepted in the International Classification of Diseases (ICD) in 1975. Presently the version of the ICD that is in force is the ICD-10, version 2012. For the pertinent definitions are represented in Annex 2.

In later usage and definitions, as discussed in Annex 1, there has been a tendency to give primacy to psychological dependence. In the ICD, the most-emphasized component of dependence disorder has also maintained a separate existence as a specific diagnosis, “withdrawal state”.

In 1992, the ECDD discussed the use of terms and noted that the distinction between physical dependence and psychic dependence was difficult to make in clinical situations. It referred to the decision taken in the 13th ECDD (1963) to abandon these terms, and also the term “addiction”, in favour of the term “drug dependence” and it provided a definition of “drug dependence” as “A cluster of physiological, behavioural and cognitive phenomena of variable intensity, in which the use of a psychoactive drug (or drugs) takes on high priority. The necessary descriptive characteristics are preoccupation with a desire to obtain and take the drug and persistent drug-seeking behavior. Determinants and the problematic consequences of drug dependence may be biological, psychological or social and usually interact.” (WHO, 1993, p 7). This definition is the most recent definition of dependence provided by an Expert Committee on Drug Dependence.

In 2006, as revisions of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association were considered, an influential article argued that “dependence” should be returned to its earlier limited meaning, and “addiction” reinstated essentially to replace the wider meaning of “dependence” (O’Brien et al., 2006). The draft DSM-5 has dropped “dependence” in its wide meaning, substituting instead the broad term “substance use disorder”, in a chapter including “addiction” in its title. The WHO Working Group on Substance Use Disorders and Behavioural Addictions, in considering potential revisions for ICD-11, has
decided against following the DSM-5 lead, retaining the term “dependence” in a wider meaning emphasizing the psychological dimension. The Working Group’s decision stays close to the definition given by the 1993 Expert Committee cited above (WHO, 2010, p. 16).

Abuse. This was an ambiguous term at the time of adoption of the Conventions. In the context of the Expert Committees, it has been defined as “persistent or sporadic excessive drug use inconsistent with or unrelated to acceptable medical practice” (WHO, 2003, p. 23). In focusing on the pattern of drug use, this definition is more expansive than the DSM-IV definition of “substance abuse” in more psychological terms, as “a maladaptive pattern of substance use leading to clinically significant impairment or distress”.

In DSM-5, the term and concept of “substance abuse” has been abandoned, as had happened earlier with “non-dependent abuse” in ICD with the adoption of ICD-10 in 1993 (Room, 1998). While the content of “abuse” (in terms of its criteria) has been largely absorbed into the more generic “substance use disorder” in the draft DSM-5, ICD-10 instead adopted a more narrowly-defined term, “harmful use”, defined as “A pattern of psychoactive substance use that is causing damage to health”, physical or mental. The ECDD followed ICD-10 and adopted this definition in its 28th meeting, noting that for the sake of consistency “abuse” may be used in the context of the international control of dependence-producing psychoactive drugs. (WHO 1993, p6) The term is likely to be retained in ICD-11. The term “abuse”, which plays a central role in the drug conventions, thus no longer has a presence in the major diagnostic systems which structure thinking and terminology in public health.

Other terms and phrases used in the Conventions are further discussed in Annex 1.

Terms Used In Applying The Conventions

Annex 1 discusses two terms which are at the heart of the Expert Committee’s determinations concerning scheduling of psychoactive substances: “dependence potential” and “abuse potential”, together with variants which different Expert Committees have used. As in the current Guidelines (WHO, 2010), the two terms are often given equal status and listed side by side. However, it is argued in Annex 1 that Expert Committees have also at times treated “dependence potential” as a subordinate category of “abuse potential”. At other times, the distinction between the two terms has become blurred, particularly because the subdomain of drug liking or preference is treated sometimes as evidence of one and sometimes of the other.

Some Conclusions

The confusion between dependence and abuse liability, and the uncertainty about their relation to each other, reflects that in the end, the Committee is asked to make a single judgment, based on a balance between the medical utility of the substance and a single dimension of the social trouble the substance is causing or may cause. The findings from biomedical disciplines concerning withdrawal, tolerance and psychopharmacology offer pointers in the direction of how much trouble the substance might cause if widely used, but even then the language and interpretation of the conventions points in directions askew to the dimension of social trouble. For instance, it could be argued that the degree of acute intoxication associated with the drug as it is used, and the behaviours associated with intoxication from the particular drug, are more directly and proximately related to the level of social trouble caused than are such dimensions as
how much pleasure the drug use brings or how big the withdrawal effect is, or even how much craving the heavy user may have for the substance. Yet the dimension of intoxication is largely missing from the discussion. Also missing is the dimension of the risk of overdose, at the levels and mode of use of heavy users, although this dimension is clearly a substantial driver of societal concerns about drugs.
ANNEX 1: Terms used in the conventions and in applying them:
A more detailed discussion

Terms Used In The Conventions
The 1961 Convention is primarily oriented to three specific classes of psychoactive substances, derived from three named plant products: opium, cannabis (and its resin, extracts and tinctures), and coca leaf. Article 3, Sec. 3 spells out the required characteristics for adding substances to the Convention’s schedules: that they are “liable to similar abuse and productive of similar ill effects” as the substances already covered in the Schedules. Article 38 refers to “measures against the abuse of drugs” and to “abusers of drugs”. The Preamble also mentions “the abuse of narcotic drugs”.

The only other relevant term in the 1961 Convention is “addiction”, in the Preamble: “recognizing that addiction to narcotic drugs represents a serious evil for the individual and is fraught with social and economic danger to mankind”.

The 1971 Convention uses the term “dependence” as one of the criteria for applying the controls of the Convention to a substance: “if the World Health Organization finds that the substance has the capacity to produce a state of dependence” (Art. 2, Sec. 4). The Convention goes on to require, in addition to a “state of dependence”, that the drug has the capacity to produce “central nervous system stimulation or depression, resulting in hallucinations or disturbances in motor function or thinking or behavior or perception or mood”.

The most often used term in the 1971 Convention is “abuse”. By its context, abuse is associated with public health and social problems from the drug use: another criterion for control is “that there is sufficient evidence that the substance is likely to be abused so as to constitute a public health and social problem warranting the placing of the substance under international control” (Art. 2, Sec. 4(b); and the Preamble notes “with concern the public health and social problems resulting from the abuse of certain psychotropic substances”. As in the 1961 Convention, “abuse” is also paired with “ill effects” in a provision covering scheduling of substances similar to those already scheduled: “that the substance has the capacity to produce … similar abuse and similar ill effects as a substance in Schedules I, II, III or IV” (Art. 2, Sec. 4(a)(ii)).

Meanings And Equivalents Of The Terms Used In The Conventions

Addiction. At the time of the 1961 Convention, “addiction” was a term in use by the WHO Expert Committee. “Addiction-producing” was distinguished by it from “habit-forming” (WHO, 1957); in the Committee’s formulation, habit-forming drugs do not need to be subject to international control and “should not carry the stigma of addiction” (WHO, 1957, p. 14). The 1964 Expert Committee abandoned this distinction between addiction-producing and habit-forming drugs, and substituted the term “dependence”, a technical term given a new meaning, to cover both former categories (WHO, 1964).

The 2003 Expert Committee commented on the relationship between the terms “addiction” and “dependence”: Although the term drug addiction was eliminated from the technical terminology of WHO many years ago, it is still widely used as a general term. For example, the word addictive is commonly used to mean dependence-producing. Where drug
addiction is used as a technical term it seems to refer to severe cases of dependence. However, as there is no internationally accepted definition of addiction, it is impossible to be certain in what way addiction differs from dependence. (WHO, 2003, p. 23). It has been argued that addiction is stigmatizing terminology. WHO Policy is to not to use demeaning expressions when referring to people. (WHO, 2004, p56) Therefore alternatively, “dependence” should be used, and “addictive” should be replaced with “dependence-producing”.

Dependence. The exact denotation of “state of dependence” in the 1971 Convention at the time of its adoption is ambiguous. “Dependence” is a technical term in psychopharmacology, and in this context refers primarily to the “withdrawal syndrome”, also called the “abstinence syndrome”, which was identified particularly at that time with opioids and alcohol: the physical effects of abrupt cessation of heavy use of the substance. Terms such as “cross-dependence”, referring to the ability of one drug to relieve the withdrawal symptoms of another, still reflect this technical meaning. As noted above, the 1964 Expert Committee put forward a new meaning for “dependence”, with the term “dependence-producing” referring to drugs which had previously been characterized separately as “addiction-producing” or “habit-forming”. The new meaning encompassed both “physical dependence”, including both the withdrawal syndrome and tolerance, and “psychic dependence” (now usually “psychological dependence”), which referred to such phenomena as experienced loss of control of use and craving from the substance.

However, the “dependence syndrome” only made its appearance in the International Classification of Diseases in 1975, with the adoption of ICD-9. The 1971 treaty was thus written at a time of transition, and “state of dependence” in it might refer to physical dependence or to the broader meaning combining physical and psychological dependence. A third option is chosen by the current “Guidance on the WHO review of psychoactive substances for international control” (WHO, 2010, p. 16), which quotes a definition from the 1993 Expert Committee report in which psychological dependence is given primacy:

A cluster of physiological, behavioural and cognitive phenomena of variable intensity, in which the use of a psychoactive drug (or drugs) takes on a high priority. The necessary descriptive characteristics are preoccupation with a desire to obtain and take the drug and persistent drug-seeking behaviour.

The prioritization of the psychological dimension is consistent with present-day discussions of the “neurobiology of addiction”. Thus Koob (2006) defines “substance dependence” as a chronic relapsing disorder characterized by (1) compulsion to seek and take the drug, (2) loss of control in limiting intake, and (3) emergence of a negative emotional state (e.g., dysphoria, anxiety, irritability) when access to the drug is prevented.

Though the third criterion here might be construed as an indication of physical dependence, Koob chooses to characterize it in psychological terms, emphasizing dependent use as being to avoid negative feelings rather than for pleasure. Also giving priority to the psychological dimension, Hyman and Malenka (2001) state that “the defining characteristic of addiction is compulsive out-of-control drug use despite serious negative consequences”.

As further discussed below, there has been some ambiguity in the meaning of “dependence” as it has been used in the work of the Expert Committee in applying the 1971 Convention.

Further confusion has been added in recent months by the substantial effort in the U.S. to revert to a narrower meaning of “dependence”, referring only to “physical dependence” (O’Brien, 2011). Under this impulse, “dependence” has been abandoned as a term in the
provisional DSM-5, in favour of the term “substance use disorder”, although “addiction” makes a reappearance in the title of the section of the diagnostic manual.

**Drug.** The term drug is used both in the meaning of “medicine” and in that of “substance of misuse”. This is confusing, in particular in the context of improving access to essential medicines controlled under the international drug control conventions.

**Drug abuse.** “Abuse” in the context of the drug treaties at the time of their adoption had a wide scope of meanings, and was not then a diagnostic category in the International Classification of Diseases (ICD-8), although it became one in 1975 in ICD-9. In its widest meaning, it meant simply any use other than medical or scientific use. In 1973, the US National Commission on Marihuana and Drug Abuse (1973, p. 13) noted that “drug abuse may refer to any type of drug or chemical without regard to its pharmacologic actions. It is an eclectic concept having only one uniform connotation: societal disapproval”, and suggested that the term be “deleted from official pronouncements and public policy dialogue. The term has no functional utility and has become no more than an arbitrary code word for that drug use which is presently considered wrong.”

In the context of the Expert Committees, “drug abuse” has been defined a little more narrowly: “persistent or sporadic excessive drug use inconsistent with or unrelated to acceptable medical practice” (WHO, 1969, p. 4; repeated in WHO, 2003, p. 23). “Persistent or sporadic” seems to cover all possibilities in terms of frequency of use, but “excessive” clearly indicates that use per se is not abuse; rather, “abuse” is use of a substantial quantity, though no quantity is specified.

The 4th edition of the Diagnostic and Statistical Manual of the American Psychiatric Association defined abuse yet more narrowly: “A maladaptive pattern of substance use leading to clinically significant impairment or distress”, and in the proposed DSM-5 the term is dropped altogether. The WHO’s International Classification of Diseases had earlier dropped the term with the adoption of ICD-10 in 1993. Already in 1975, a WHO publication had moved away from using the term: "Drug abuse" is a term in need of some clarification. … The term is really a convenient, but not very precise, way of indicating that (1) an unspecified drug is being used in an unspecified manner and amount … and (2) such use has been judged by some person or group to be wrong (illegal or immoral) and/or harmful to the user or society, or both. What might be called "drug abuse" by some would not necessarily be considered so by others. … For these reasons, the term "drug abuse" is avoided here. (Kramer & Cameron, 1975, p. 16)

In the language of the treaties, “abuse” is juxtaposed with the “production of ill effects”, and in the 1971 treaty with the emergence of “public health and social problem[s]” warranting international control. This language seems to invite interpreting “drug abuse” in the language of the treaties to mean drug use which causes substantial public health and social problems, which might well suggest a definition in terms of patterns of use which are found in risk-curve analyses to be causally related to health and social harm above defined thresholds. Empirical studies of the dangerousness of drugs and epidemiological analyses of risk curves have progressed to the point where such operational definitions have become possible.

**Ill effects.** This term is not further specified in the treaties. Presumably “ill” is used not as a synonym for “sick”, but in a more abstract adjectival sense. The most appropriate of several meanings offered by the Merriam-Webster dictionary is “causing suffering or distress”. The
focus of the phrase is clearly on adverse consequences of use of the substance. In this sense, it is closer than “abuse” to the ICD-10 diagnostic category, “harmful use”, although in the ICD-10 category the harm is specifically harm to physical and psychological health.

Central nervous system stimulation or depression, resulting in hallucinations or disturbances in motor function or thinking or behavior or perception or mood. This is an extraordinarily inclusive criterion if read literally. Almost any ingested substance, as well as any thought or action, can result in CNS stimulation or depression and in alterations which could be characterized as “disturbances” in one or more of the five named attributes. On the few occasions in which the Committee has addressed this criterion, it has explicitly or implicitly added “substantial” at the beginning of the phrase. This was explicit in the 1973 Committee report, which used the phrase with the added modifier to explain why some drugs were “generally recognized as having the capacity, in certain circumstances, to produce individual and public health and social problems” (WHO, 1973, pp. 16-17). The addition was implicit when the 1998 Expert Committee ruled out nicotine from consideration for scheduling on the grounds that it did not appear to meet this criterion (WHO, 1998, p. 44).

The treaty language may be regarded as in the same territory as the ICD-10 diagnostic category, “acute intoxication”. Discussion in the WHO Working Group on revisions to this category for ICD-11 has focused on the issue of specifying thresholds for “acute intoxication” as a diagnosis; this is even more an issue for the treaty language, given its inclusive character.

Public health and social problem. The official Commentary on the 1971 Convention offers a considerable gloss on the meanings of these two terms in the context of the treaty. The Commentary quotes the 16th Report of the Expert Committee on Drug Dependence (WHO, 1969) on the threshold of “whether a ‘public health’ problem exists”: If … drug abuse or dependence is likely to be, or is known to be, only sporadic or infrequent in the population, if there is little danger of its spread,… and if its adverse effects are likely to be, or are known to be, limited to the individual user, there is no public health problem…. On the other hand, if the drug dependence is associated with behavioural or other responses that adversely affect the user’s interpersonal relations or cause adverse physical, social or economic consequences to others as well as to himself, and if the problem is actually widespread in the population or has significant potential for becoming widespread, then a public health problem does exist. (WHO, 1969)

The Commentary continues. It is apparent that only a significant health problem appears to be a ‘public health’ problem as this phrase is used by the Vienna Convention; but it must be emphasized that a health problem becomes a ‘public health’ problem not only because a considerable number of people are already involved, but also if there is a risk that a considerable number of persons will be affected. It is submitted that a ‘public health’ problem in the sense of [Article 2, paragraph 4,] subparagraph (b) is therefore always a ‘social problem’. (UN, 1978, pp. 46-47)

The Commentary then goes on to note that there can also be “social problems” which would not qualify as public health problems, mentioning in this regard illicit traffic in the substance, along with labour productivity, traffic accidents, and public expenditure costs. In the view of the Commentary, a substance causing a “more limited health problem” still qualifies for a WHO recommendation for international control if the “actual or potential social consequences” of use are not minor. One potential consequences of this formulation, which includes illicit traffic in the “social problems”, might be the application of international control to a substance
with minor health and other consequences on the grounds of an existing or projected substantial illicit traffic in the substance.\(^3\)

The Commentary notes that, to qualify for international control, the “public health and social problem” must be international in character. Offering a gloss on the treaty’s phrase “warranting the placing of the substance under international control”, the Commentary proposes that this is not simply a matter of whether the problems exist in more than one country. What is required is that the controls of the Vienna Convention are suitable to solve or at least alleviate the problem and that the lack of these controls in one country, no matter whether it has itself the public health and social problems caused by the substance under examination, weakens the control in other countries which have such a problem. (UN, 1978, p. 47)

No reference or authority is offered for this proposition. The relevant meaning of “warrant” in the Merriam-Webster dictionary is “to give adequate ground or reason for”, and the Commentary’s exegesis appears to go considerably beyond the language of the Convention.\(^4\)

**Terms Used In Applying The Conventions**

In the current Guidance for Expert Committee reviews, two crucial headings in the Critical Review document are “dependence potential” and “abuse potential”. We will consider each of these in terms of usage and comments by Expert Committees, and the development of scientific and professional thought on each.

It should first be recognized that Committees have on occasion recognized some divergence between the language of the treaties and the development of common usage of the terms.

It must be emphasized that drug dependence and drug abuse, as used by the Committee, are general terms and carry no connotation of the degree of risk to public health or of the need for drug control or for a particular type of drug control. (WHO, 1965, p. 8)

The Committee was of the opinion that adherence to the definition or usage of such terminology as given in the Convention should be the rule. (WHO, 1978, p. 8)

**Dependence potential.** In general discussions of “dependence”, there has been a fairly consistent pattern in Expert Committee reports, as in the footnote from the current Guidance quoted above, to give priority to the psychological dimensions. “All of these drugs have one effect in common: they are capable of creating, in certain individuals, a particular state of mind that is termed ‘psychic dependence’” (WHO, 1965, p. 7). A definition of dependence often repeated in the Reports is as “a state, psychic and sometimes also physical [that] always include[s] a compulsion to take the drug on a continuous or periodic basis in order to experience

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\(^3\) Since the traffic becomes a social problem because of its illicitness, and the illicitness results from the international control, the Commentary’s formulation here is rather circular – a kind of Catch-22 outcome.

\(^4\) The Commentary then proceeds to draw on this exegesis in a three-paragraph discussion of why alcohol and tobacco do not, in the writer’s view, qualify for control under the Convention. Many of the arguments made in the course of this discussion would not be credible if made today.
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Use of Terms

its psychic effects…. Tolerance many or may not be present” (WHO, 1969, p. 6). This definition is contrasted in that report with the “physical dependence capacity” of a drug.5

On the other hand, the evidence assembled in critical reviews of drugs concerning scheduling almost always includes something about physical dependence, even if only to note that there is no evidence concerning it. And the evidence concerning psychological dependence is mostly not about loss of control or compulsion, but rather about such dimensions as liking or preferring and feelings of euphoria. Thus, for instance, the 1987 Committee Report specifies the kind of information which would be needed for a determination of dependence potential: it “would include experimental studies on physical dependence, drug self-administration (psychic dependence) in animals and man, and experimental studies on subjective effects in man” (WHO, 1987, p. 10). The kind of information which is available, particularly for a drug which is not in common use, is not so much about loss of control and craving, but rather about how pleasurable the use is, in relative terms, to an experienced drug user. Scholars with a welfare economics orientation have complained that consumer preference is not taken into account in drug policy considerations (Caulkins et al., 2011) – but in fact it is, though against the economists’ assumptions it is counted negatively rather than positively.

Abuse potential. The terminology here has varied over the different Expert Committee reports. Some Reports (e.g., WHO, 1991, p. 5) have used “abuse liability”, others have preferred a longer formulation: “actual abuse and/or evidence of likelihood of abuse” (e.g., WHO, 2003, p. 9). “The Expert Committee preferred the term ‘likelihood of abuse’ to ‘abuse liability’” (WHO, 1987, p. 61). While “dependence potential” and “abuse potential” are listed side by side in the current Guidelines, at times they have been conceptualized in other relationships. Thus, for instance, the 1991 Committee (WHO, 1991, p. 5) rated the “abuse liability” of brotizolam on the basis of its “pharmacological profile, dependence potential, and possible abuse”, thus making dependence potential a constituent part of “abuse liability”, as an overarching concept. In the same vein, the Annex to the 2003 Report notes that it is “useful to stress that dependence liability alone is not sufficient reason for proposing the international control of a psychoactive drug. It is the abuse liability (likelihood of abuse) that must be considered” (WHO, 2003, p. 22).

The distinction between dependence potential and abuse potential has sometimes become blurred, particularly because drug liking or preference is sometimes treated as evidence of one and sometimes of the other. The 1987 Report complained about the materials it was presented with that

In the critical review document, although not in the original WHO guidelines, the phrase “abuse liability” was used. Thus, in the critical review, dependence potential and abuse liability were used interchangeably…. It should be noted that the term “abuse liability” is used in this section of the proposed format to mean likelihood of abuse, whereas in the critical review it was used to mean “dependence potential”. (WHO, 1987, pp. 10-11)

5 The 1973 Committee report included a footnote that “the Committee believes also there are some situations in which physical dependence may occur in the absence of significant psychological dependence (WHO, 1973, p. 16).

Mental and behavioural disorders due to psychoactive substance use (F10-F19)

Definition
This block contains a wide variety of disorders that differ in severity and clinical form but that are all attributable to the use of one or more psychoactive substances, which may or may not have been medically prescribed. The third character of the code identifies the substance involved, and the fourth character specifies the clinical state. The codes should be used, as required, for each substance specified, but it should be noted that not all fourth character codes are applicable to all substances.

Identification of the psychoactive substance should be based on as many sources of information as possible. These include self-report data, analysis of blood and other body fluids, characteristic physical and psychological symptoms, clinical signs and behaviour, and other evidence such as a drug being in the patient's possession or reports from informed third parties. Many drug users take more than one type of psychoactive substance. The main diagnosis should be classified, whenever possible, according to the substance or class of substances that has caused or contributed most to the presenting clinical syndrome. Other diagnoses should be coded when other psychoactive substances have been taken in intoxicating amounts (common fourth character .0) or to the extent of causing harm (common fourth character .1), dependence (common fourth character .2) or other disorders (common fourth character .3-.9).

Only in cases in which patterns of psychoactive substance-taking are chaotic and indiscriminate, or in which the contributions of different psychoactive substances are inextricably mixed, should the diagnosis of disorders resulting from multiple drug use (F19.-) be used.

Excl.: abuse of non-dependence-producing substances (F55)

Modifiers
The following fourth-character subdivisions are for use with categories F10-F19:

Code Title

.0 Acute intoxication
A condition that follows the administration of a psychoactive substance resulting in disturbances in level of consciousness, cognition, perception, affect or behaviour, or other psycho-physiological functions and responses. The disturbances are directly related to the acute
pharmacological effects of the substance and resolve with time, with complete recovery, except where tissue damage or other complications have arisen. Complications may include trauma, inhalation of vomitus, delirium, coma, convulsions, and other medical complications. The nature of these complications depends on the pharmacological class of substance and mode of administration.

_Incl._:
Acute drunkenness (in alcoholism)
"Bad trips" (drugs)
Drunkenness NOS
Pathological intoxication
Trance and possession disorders in psychoactive substance intoxication

_Excl._:
intoxication meaning poisoning (T36-T50)

.1 **Harmful use**
A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (as in cases of hepatitis from the self-administration of injected psychoactive substances) or mental (e.g. episodes of depressive disorder secondary to heavy consumption of alcohol).

_Incl._:
Psychoactive substance abuse

.2 **Dependence syndrome**
A cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state.

The dependence syndrome may be present for a specific psychoactive substance (e.g. tobacco, alcohol, or diazepam), for a class of substances (e.g. opioid drugs), or for a wider range of pharmacologically different psychoactive substances.

_Incl._:
Chronic alcoholism
Dipsomania
Drug addiction

.3 **Withdrawal state**
A group of symptoms of variable clustering and severity occurring on absolute or relative withdrawal of a psychoactive substance after persistent use of that substance. The onset and course of the withdrawal state are time-limited and are related to the type of psychoactive
substance and dose being used immediately before cessation or reduction of use. The withdrawal state may be complicated by convulsions.

.4 Withdrawal state with delirium
A condition where the withdrawal state as defined in the common fourth character .3 is complicated by delirium as defined in F05.-. Convulsions may also occur. When organic factors are also considered to play a role in the etiology, the condition should be classified to F05.8.

Incl.:
Delirium tremens (alcohol-induced)

.5 Psychotic disorder
A cluster of psychotic phenomena that occur during or following psychoactive substance use but that are not explained on the basis of acute intoxication alone and do not form part of a withdrawal state. The disorder is characterized by hallucinations (typically auditory, but often in more than one sensory modality), perceptual distortions, delusions (often of a paranoid or persecutory nature), psychomotor disturbances (excitement or stupor), and an abnormal affect, which may range from intense fear to ecstasy. The sensorium is usually clear but some degree of clouding of consciousness, though not severe confusion, may be present.

Incl.:
Alcoholic:
•hallucinosis
•jealousy
•paranoia
•psychosis NOS

Excl.:
alcohol- or other psychoactive substance-induced residual and late-onset psychotic disorder (F10-F19 with common fourth character .7)

.6 Amnesic syndrome
A syndrome associated with chronic prominent impairment of recent and remote memory. Immediate recall is usually preserved and recent memory is characteristically more disturbed than remote memory. Disturbances of time sense and ordering of events are usually evident, as are difficulties in learning new material. Confabulation may be marked but is not invariably present. Other cognitive functions are usually relatively well preserved and amnesic defects are out of proportion to other disturbances.

Incl.:
Amnestic disorder, alcohol- or drug-induced
Korsakov's psychosis or syndrome, alcohol- or other psychoactive substance-induced or unspecified
Use additional code, (E51.2+, G32.8*) , if desired, when associated with Wernicke’s disease or syndrome.
Excl.:
nonalcoholic Korsakov's psychosis or syndrome (F04)

.7 Residual and late-onset psychotic disorder
A disorder in which alcohol- or psychoactive substance-induced changes of cognition, affect, personality, or behaviour persist beyond the period during which a direct psychoactive substance-related effect might reasonably be assumed to be operating. Onset of the disorder should be directly related to the use of the psychoactive substance. Cases in which initial onset of the state occurs later than episode(s) of such substance use should be coded here only where clear and strong evidence is available to attribute the state to the residual effect of the psychoactive substance. Flashbacks may be distinguished from psychotic state partly by their episodic nature, frequently of very short duration, and by their duplication of previous alcohol- or other psychoactive substance-related experiences.

Incl.:
Alcoholic dementia NOS
Chronic alcoholic brain syndrome
Dementia and other milder forms of persisting impairment of cognitive functions
Flashbacks
Late-onset psychoactive substance-induced psychotic disorder
Posthallucinogen perception disorder
Residual:
•affective disorder
•disorder of personality and behavior

Excl.:
alcohol- or psychoactive substance-induced:
•Korsakov’s syndrome (F10-F19 with common fourth character .6)
•psychotic state (F10-F19 with common fourth character .5)

.8 Other mental and behavioural disorders

.9 Unspecified mental and behavioural disorder

The full ICD-10 is available at:
http://apps.who.int/classifications/icd10/browse/2010/en
REFERENCES