

# **ICD-10 SYMPTOM CHECKLIST FOR MENTAL DISORDERS**

Psychoactive Substance Use Syndromes Module

## The ICD-10 Symptom Checklist

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## ICD-10 CHECKLIST

### Psychoactive Substance Use Syndromes Module

The following questions ask about symptoms associated with your heroin or other opioid use, for which you are currently being treated. The questions apply to the time period immediately before you started your current treatment.

*[For the following items, substitute the name of the opioid used for ‘substance’, where applicable]*

1.	Did you have a strong desire or sense of compulsion to use <i>substance</i> ? (‘craving’)	Yes	No
2.	Did you find it difficult or impossible to control your use of <i>substance</i> ?	Yes	No
3.	Did you experience withdrawal symptoms after going without <i>substance</i> for a while?	Yes	No
4.	Did you use <i>substance</i> to relieve or avoid withdrawal symptoms?	Yes	No
5.	Did you notice that you required more <i>substance</i> to achieve the same physical or mental effects? (‘tolerance’)	Yes	No
6.	Over time, did you tend not to vary your pattern of use of <i>substance</i> ?	Yes	No
7.	Did you increasingly neglect other pleasures or interests in favour of using <i>substance</i> ?	Yes	No
8.	Did you experience psychological or physical harm because of your <i>substance</i> use?	Yes	No
9.	Did you persist with using <i>substance</i> , despite clear evidence of harmful consequences?	Yes	No

10. How long did you experience this pattern of problem drug use?				
<i>a. in years</i>				
<i>b. in months</i>				

Dependence indicated if **3 or more** of the symptoms 1, 2, 3, 5, 7 and 9 are present.

11.	a. <b>Record whether opioid dependence syndrome (F11.2) is present</b>	Yes	No
	b. If “Yes”, record specific opioid: _____		