ESSENTIAL TREATMENTS
IN PSYCHIATRY

SUPPORT

DIVISION OF MENTAL HEALTH
WORLD HEALTH ORGANIZATION
GENEVA
ON THE INITIATIVE

WHO’s Initiative of Support to People Disabled by Mental Illness is part of WHO’s work on the prevention and treatment of mental disorders. It is an attempt to speed up the dissemination of information to governments and professionals about good community services for those with chronic mental illness and about new developments in this field.

The Initiative aims to help in reducing the disabling effects of chronic mental illness and to highlight social and environmental barriers which hinder treatment and rehabilitation efforts and which add to the stigma of chronic mental illness. It also stimulates consumer empowerment and involvement with planning, delivery and evaluation of mental health services.

The following sites have so far officially joined the Initiative and have participated in its various activities:

* The Queensland Northern Peninsula and Mackay Region Mental Health Service (centred in Townsville, Australia).

* British Columbia Ministry of Health - Mental Health Services (Vancouver, Canada).

* Centro Studi e Ricerche Salute Mentale - Regione Autonoma Friuli Venezia-Giulia (Trieste, Italy).

* Highland Health Board - Mental Health Unit and Highland Regional Council (Inverness, Scotland, UK).

* Stichting Overlegorgaan Geestelijke Gezondheidszorg (SOGG), (Rotterdam, the Netherlands)

The Dowakai Chiba Hospital (Funabashi, Japan) also takes part in some of the Initiative activities; other centres are at different levels of discussion concerning their joining the Initiative.

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ESSENTIAL TREATMENTS IN

PSYCHIATRY

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This document introduces the concept of essential treatment methods for the treatment of people with mental disorders. It also briefly describes those essential treatments, covering biological, psychological and social interventions.

It is the first in a series of four issues; the following three issues will deal with drug treatment, psychological and social essential interventions, respectively, in more detail.

This document is part of WHO’s Initiative of Support to People Disabled by Mental Illness.

Key-words: mental disorders, treatment, psychiatry, psychopharmacology, psychotherapy, psychosocial interventions.

DIVISION OF MENTAL HEALTH
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FOREWORD

The main objective of this book is to present a pragmatic view of treatment methods available for the treatment of people with mental disorders. Not all methods, though, that would be an almost impossible task. Instead, a few selected methods and procedures have been chosen based on the available scientific literature, on the experience and the opinions of leading experts in this field, and on feasibility of application in most countries/ settings.

The precursor of this booklet is WHO's experience with the Essential Drugs List (EDL) (WHO, 1977), from which several criteria were adopted and adapted to the field of mental disorders. Starting in 1975 from the experience gained in some countries, WHO produced a list of selected drugs essential for the treatment of the majority of diseases of public health importance. This EDL represented a considerable reduction of an almost endless and unmanageable list of all existing medicines.

From the very beginning medicines essential for the treatment of most mental disorders were included in the EDL. Most mental disorders, however, cannot be managed with medicines only; psychological and social interventions are essential for their management.

The original idea of expanding WHO's concept of essential drugs to cover all interventions aimed at caring for people with mental disorders should be credited to Dr N. Sartorius. As former Director of the WHO Division of Mental Health, he firmly supported activities to this end, by providing constant insightful advice and comments. The concept of essential treatments further benefited from discussions with Dr G. Andrews, before a first draft was available. Several experts were then invited to comment upon several versions of subsequent drafts.

Essential interventions for mental disorders can be classified in three groups, according to the nature of their mechanisms of action: biological, psychological and social interventions. In practice it is almost impossible to have a "pure" intervention, not "contaminated" by other types of intervention: how to eliminate or ignore both the social and psychological impact on the patient of the doctor who prescribes a medicine? As a matter of fact, for several mental disorders a combination of treatments in two or more categories (e.g. one biological plus one psychological; or one psychological and one social; or one biological plus one psychological plus one social) has proven to be better than a single treatment only.

This work, therefore, aims to:

i) present the rationale for the identification of essential treatments for mental disorders;

ii) identify psychological, biological and social interventions essential for the care of people with mental disorders;

iii) briefly describe those interventions.

However, this is only the first in a series of four documents. Three other issues will follow, each one concentrating on particular aspects of biological, psychological and social components, respectively, of this comprehensive approach. Specific elements of and information on each component should be sought in the forthcoming issues (respectively on biological, psychological and social essential interventions).

This document does not aim to represent a norm. It is rather an example of guidelines for the selection of essential treatments for mental disorders. The transformation of guidelines into norms with the necessary modifications can only be done at the local level, taking into consideration several socio-economic, epidemiological, cultural, historical and developmental factors, in addition to scientific background information. Comments and suggestions on this document should be sent to:

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The production of the series of documents on essential treatments for mental disorders involved contributions from several experts who graciously dedicated their time as well as their invaluable knowledge and expertise. We are therefore profoundly indebted to the experts indicated below who participated with different levels of involvement at different stages of the development of this document.

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GENERAL INTRODUCTION
1. THE PROBLEM

In the world today there are at least 400 million people suffering from a mental or neurological disorder or impairment that mars their lives and presents a heavy burden for their families and communities. In terms of amount of suffering, schizophrenia and the other psychoses affect 55 million people and some 120 million suffer from affective disorders. The senile dementias affect 5-8% of the population aged over 65, totalling at least 30 million old people. Epilepsy affects around 8 million people in developed countries and over 35 million in the rest of the world, while the mentally retarded are in the range of 90-130 million people. In addition, worldwide 15-35% of all first-level care consultations are mainly due to psychological disorders (1).

Trends in the care of people with mental disorders have varied across time and place. Like in other conditions similarly causing a high degree of suffering to patients, families and societies, practically everything has been tried out. Careful observation has indicated what should be retained and what could be discarded without major harm. However, more than what is reasonably warranted has been retained in everyday clinical practice in many countries. This is probably due to the lack of a definite cure for most mental disorders, in addition to the high degree of suffering associated with them, which is a source of misunderstanding and frustration.

We can identify at least four sources of treatment proposed for the care of people with mental disorders: one originating in the ancient times, when medicine - and the care of those with mental disorders - belonged to the mystical and religious world; another one based on popular superstition and beliefs, not necessarily associated with or approved by formal mystical and religious practices; a third one resulting from scientific observation and development; and finally a fourth derived from unwarranted commercial purposes. In practice, several of the techniques currently in use for the treatment of people with mental disorders involve various combinations of those four elements and it is not so easy to clearly pinpoint the contributing elements in a given technique.

At any rate, what is really relevant is the identification of cost-effective interventions, in the sense of interventions that successfully control mental disorders, at an affordable cost, and to peoples’ satisfaction; in other words, treatments that help in improving the quality of life of those affected by mental disorders, be they patients, their relatives or the society at large.

It should be stressed, however, that our main perspective is a public health one. Although treatment is delivered on an individual basis (or to small groups, at most) the public health perspective calls for the identification of both conditions and interventions relevant at the collective level. This implies a sound selection of target priorities and of effective interventions. In other words, not all disorders and not all interventions are included in this context. What is presented here is a model open to modification and adaptation according to the local situation. In this respect it should not be overlooked that a large part of the world population has no access to technological advancements. In fact, many of the inhabitants of our planet do not receive the basics in health care.
The objective of this work, conceived in the framework of the strategy of Health For All (2), is threefold:

- to put forward the concept of essential treatments in psychiatry;

- to present a brief description of selected interventions which have proven to be effective for the treatment of mental disorders; and

- to indicate specific interventions for specific mental disorders, in any given context.

In other words, to identify interventions necessary and sufficient for the care of the majority of people with mental disorders.

It should be said, however, that this is not a handbook describing in detail treatment methods, nor a practical guide useful for clinical work, much less a textbook on psychiatric treatment. It is rather a conceptual and operational proposal pointing out key issues and questions and indicating a general framework from which answers could be drawn.
3. CONCEPTS

3.1. The concept of essential treatments in psychiatry

Treatment here is understood in medical terms as the management and care of a person for the purpose of combating a disease or a disorder.

Essential treatments in psychiatry are those interventions both necessary and sufficient for the care of people with specific mental disorders.

It is clear that for the optimal use of limited financial resources the available treatments must be restricted to those proven to be therapeutically effective, to have acceptable safety, to satisfy the health needs of the population and to be affordable by the community. The selected treatments here are called "essential" treatments, indicating that they are of utmost importance, and are basic, indispensable and necessary for the health needs of the majority of the population.

Treatments included in such a list would differ from country to country depending on many conditions, such as the pattern of prevalent disorders, the type of health system and of health personnel available, financial resources, and genetic, cultural, social, demographic and environmental factors. Because of the great differences between countries as to these factors, the preparation of a list of treatments of general applicability and acceptability is not feasible or possible.

Therefore, each country has the direct responsibility of evaluating and adopting a list of essential treatments, according to its own policy in the field of health. The list of essential treatments based on the guidelines put forward in this document is a model which can provide a basis for countries in order to identify their own priorities and to make their own selection.

The identification of selected essential interventions does not mean that other interventions are not useful, but simply that in a given situation those interventions are the most needed for the health care of the majority, and should, therefore, be available at all times to all those who need them.

In establishing a list of essential treatments for mental disorders the following general principles were followed (3):

1) The adoption of a list of essential treatments for mental disorders is part of a national health policy. This implies that priority is given to the achievement of the widest possible coverage of the population with interventions of proven efficacy and safety, in order to meet the needs for prevention and treatment of the most prevalent disorders.

2) Only those treatments for which adequate scientific data are available from controlled studies should be selected.

3) Each selected treatment must meet adequate standards of quality.

4) Concise, accurate and yet comprehensive information on each different treatment drawn from unbiased sources should accompany each list of essential treatments.
The following guidelines were used, and are recommended, to ensure a process of fair selection of essential treatments based on the best available scientific information, yet allowing for a degree of variation to take into account local needs and requirements:

1) The list of essential treatments should be established at national level by an appointed committee of highly competent and respected professionals from the fields of clinical psychiatry, nursing, clinical psychology, social work, occupational therapy, psychotherapy, psychopharmacology, and social and behavioural sciences, as well as health workers at the peripheral level. Representatives of consumers and of consumer associations should also be included in the committee.

2) Treatment selection should be based on the results of well controlled clinical trials and follow-up studies.

3) Specific regulations and appropriate facilities should be available to ensure that selected treatments meet quality standards in terms of their delivery.

4) Costs represent a major selection criterion. In cost comparisons between treatments, the cost of the total treatment, and not only the unit cost, must be considered.

5) Local health authorities should decide the level of expertise required to provide a single treatment or groups of treatments. Consideration should also be given to the competence of the personnel to make a correct diagnostic assessment. In some instances, while individuals with advanced training are necessary to prescribe initial treatment, individuals with more limited training could be in charge of maintenance treatment, under qualified supervision.

6) The prevalence of local diseases and the specific living conditions should be considered when making the selections (e.g. malnutrition, liver disease, housing and employment levels, natural social networks).

7) When two or more treatments or interventions are therapeutically equivalent, preference should be given to:
   i) the treatment which has been most thoroughly investigated;
   ii) the treatment with the most favourable properties, e.g., to improve compliance, to minimize risks in various pathophysiological states;
   iii) the least expensive treatment, which is the most convenient in terms of cost/effectiveness ratio.

8) Insofar as pharmacotherapy is concerned, preference should be given to:
   i) the international nonproprietary (generic) names of medicines;
   ii) the pharmaceutical product and dosage form that provide the highest benefit/risk ratio;
   iii) pharmaceutical products and dosage forms with favourable stability, or for which storage facilities exist.

9) The list should be reviewed periodically - at least once every two years and whenever necessary. New treatments should be introduced only if they offer distinct advantages over treatments previously selected; if new information becomes available on treatments already in the list, which clearly shows that they no longer have a favourable benefit/risk ratio, they should be deleted and replaced by a safer treatment. It should be remembered that for certain conditions no treatment at all may be preferable.

3.2 Public health concepts

Additional principles which can help to select essential treatments locally are represented by equity, efficiency and consumer satisfaction.

The equity principle refers to distribution of resources (4), and assessing its applicability involves measuring indicators such as:
the distribution of per capita expenditure on health between geographical areas or between the capital city and the rest of the country;

- the proportion of total health resources going to primary health care by region or district;

- the ratios of hospital beds, doctors and other health workers to population in different parts of the country, and available to people in different social classes.

Something for all, but more for those in need - in proportion to that need.

It also implies giving particular consideration to those in greatest need. This has led to the development of the risk approach, which consists of "identifying and devoting more care to individuals or groups who, for biological, environmental or socioeconomic reasons, are at special risk of having their health impaired, of contracting a specific disease, or of having inadequate attention paid to their health problems" (5).

Another central concept is that of efficiency, understood as the relationship between expenditure and results: how to obtain best results from given economic resources. This concept must be differentiated from two other related concepts, namely those of efficacy and of effectiveness. Efficacy measures the degree to which a given intervention produces a desired effect, whereas effectiveness indicates the distance between efficacy in an ideal situation (e.g. in a laboratory) and its actual impact, in real life situations. Effectiveness also indicates if the results obtained from a given intervention are in accordance with objectives and targets for reducing the dimension of a problem or improving an unsatisfactory situation.

Therefore, when selecting essential treatments the aim should be to identify those that have proven to be efficacious, and their application to be effective and efficient. Equity and efficiency can be seen as two sides of the same coin (6). However, the exact balance between the two can only be reached by asking the opinion of those concerned.

Consumer satisfaction, therefore, becomes another guiding principle, the one that adjusts the balance between equity (a political and ethical principle) and efficiency (an economic principle). Previous WHO documents have already discussed consumer involvement in mental health services and the role consumers have in planning, decision making, implementation and evaluation of those services (7). The following represent those who could strike a balance for an equitable and efficient allocation of resources, through the expression of their degree of satisfaction with services provided:

i) service users (those who may be current patients in mental health care facilities, or may have been patients in the past),

ii) family groups,

iii) community groups (such as women's groups, groups representing ethnic minorities or groups representing others who are disadvantaged; churches and other religious groups),

iv) representatives of local governments and health care organizations,

v) representatives of trade unions or other professional groups within the health and social care delivery system,

vi) special community agencies, and

vii) self- and citizen-advocacy groups specifically set up to assist consumers of mental health services.

3.3 Other concepts: disease, disorder, impairment, disability, handicap

Disease is a deviation from the normal structure or function of the body manifested by a characteristic set of symptoms and signs and whose etiology, pathology, and prognosis may be known or unknown.

Mental disorder is a clinically recognizable set of symptoms and/or behaviour associated in most cases with distress and with interference with personal
functions. Annex 1 shows the listing of mental disorders according to ICD-10 (8), whose alphanumeric codes are used in this text.

WHO (9) has defined impairment, disability and handicap as follows:

Impairment is "any loss or abnormality of psychological, physiological or anatomical structure or function", resulting from any cause. These losses or abnormalities may be temporary or permanent and, in principle, impairments represent disturbances at the organ level.

Disability reflects the consequences of impairment in terms of functional performance and activity by the individual. It is "any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being". It is characterized by excesses or deficiencies of customarily expected activity performance and behaviours, and these may be temporary or permanent. Disability is concerned with abilities, in the form of composite activities and behaviours, that are generally accepted as essential components of everyday life; it represents disturbances at the level of the person.

Handicaps are concerned with disadvantages experienced by "a given individual, resulting from an impairment or a disability, that limits or prevents the fulfilment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual". They reflect interactions with and adaptation to the individual's surroundings.

The concepts presented above can be linked as in Diagram 1.

It is obvious that impairment, disability and handicap may all result from mental disorders, but they may also exist only at certain times, for instance during an acute illness episode. Thus labelling those who have had episodes of severe mental disorder as impaired, disabled or handicapped may not always be accurate and further adds to the stigmatization of such people.

The degree to which people with mental diseases lose their ability to perform social roles appropriate to their social context, is not necessarily correlated with the severity of their disease. The external environment often plays a considerable role and societal stigmatization of those with chronic disorders contributes heavily to their level of handicap.

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**Diagram 1. Progression from disease to handicap**
4. THE APPROACH: TREATING DISEASES OR CARING FOR PEOPLE?

Medical treatment has amply concentrated on diseases or on impairments; it has been quite successful in relation to acute and infectious diseases. Effective treatments more appropriate to disabilities, however, have been disseminated in relation to only a few conditions, most of them physical ones, whereas specific effective interventions for handicaps remain scanty, particularly in the case of handicaps consequent to mental disorders.

CARE FOR PEOPLE
instead of just
TREATING DISEASES

Diseases may come and go but handicaps last longer - for life in many cases. Caring for people implies addressing the whole picture: diseases, impairments, disabilities and handicaps. No single treatment or intervention can do it alone. Therefore, it is strongly recommended that in each case the whole situation of the patient be explored and the best combination of different interventions be selected in order to achieve the best results.
PART I
5. PRINCIPLES OF RATIONAL PRESCRIBING

Although the overall literature on prescribing refers to prescribing medicines - and more particularly on prescribing psychoactive drugs (10) - in this chapter prescribing will refer to treatments in general, including the selection and indication of a particular type of treatment as well as its recommendation to the patient and its administration.

Treatment should have the shortest possible duration.

The Council on Medical Service of the American Medical Association (II) has indicated that care of high quality should:

# produce the optimal improvement and comfort at the earliest time possible consistent with the interest of the patient (and of families);
# emphasize the promotion of health, the prevention of diseases and disability, and the early detection and treatment of such conditions;
# be provided in a timely manner, without either undue delay in initiation of care, inappropriate curtailment or discontinuity, or unnecessary prolongation;
# seek to achieve the informed cooperation and participation of the patient in the care process and in decisions concerning the process;
# be based on accepted principles of medical science and the proficient use of appropriate technological and professional resources;
# There should be a clear target condition that the intervention is known to affect, e.g., insomnia, depression, phobia, social inadequacy etc.

# Posology (intensity of intervention or dosage of medicines) should be adjusted according to benefit/risk considerations, taking into account target condition and its severity; patient's characteristics such as sex, ethnic background, weight, other concomitant medical conditions and treatment; environmental factors such as temperature and availability and access to emergency care, if needed.
# be provided with sensitivity to the stress and anxiety that illness can generate and with concern for the patient's overall welfare;
# make efficient use of technology and other health system resources needed to achieve the desired treatment goal; and
# be sufficiently documented in the patient's record to enable continuity of care and peer evaluation.

The following, adapted from Ghodse & Khan (10), can be indicated as additional principles for the rational prescribing of interventions for mental disorders:

# The duration of the treatment should be clear to the patient: in some cases it may be for a limited period of time, e.g. until natural defenses can take over, or until the effects of the intervention are fully developed; in other cases it may have a much longer duration, or be eventually lifelong. In any case, treatment should have the shortest possible duration.
# The patient should be monitored for general progress, for compliance, for misuse of substances, and specifically, to assess the effects of medicines on target conditions. The response should be measured and regularly recorded.
# If at all possible, family members should be involved as part of both the management plan and the monitoring. They usually play an important part in adequate prescribing and monitoring.
In relation particularly to pharmacological treatments, the following principles also apply:

- The amount of prescribed medicine(s) should be as small as possible, based on an assessment of both how much of it is required to affect the target condition and the patient's social and geographical situation, e.g., distance and/or travel time to obtain a refill.
- The patient should be informed of possible side-effects, e.g., morning dullness after taking anti-insomnia medication; extrapyramidal effects or hypotension caused by some anti-psychotic medicines; effects on driving performance; and on the fetus, if pregnancy occurs whilst on medication.
- The health worker should be aware of all the drugs, both medical and non-medical, being taken by the patient and of possible interactions. Reading package inserts as a routine is good practice in this regard. History of substance abuse - including alcohol and illegal drugs - should also be routinely investigated.

**Prescribe**

**as few different drugs**

**as possible**

**as few doses per day**

**as possible.**

5.1. **Factors influencing prescribing**

Prescribing involves a number of decisions: when and how much to prescribe, what to prescribe and how to prescribe. The question of how to prescribe often includes technical, medical, pharmaceutical and economic issues, such as: insurance systems, adequacy of treatment chosen, posology and prices. These issues are important and sometimes crucial in health and cost terms. However, especially in the case of psychoactive drugs, the decision whether to prescribe or not is more important. Because much prescribing is a matter of re-filling or re-issuing a previous prescription, the process of stopping a patient's treatment is an important but rarely studied aspect. It may be that the factors that determine repeat prescribing are different from those that determine initial prescribing for a patient.

Factors influencing prescribing can be divided into medical and non-medical factors. Medical factors include the health status of the patient, the medical diagnosis and the specific effects of treatments and medicines.

Non-medical factors include general and social factors conditioning prescribing and individual factors, i.e., those relating to the individual physician. Non-medical factors are also influential in prescribing treatment for mental disorders, because the indications for some treatments (e.g., psychoactive drugs) are not always clear-cut (12). It is in this context that the issue of the medicalization of social problems, i.e., their conversion into individual health problems, arises.

Conditioning factors are represented by national legislation, drug manufacturing companies policies, market pressures and other similar macro-influences. Individual factors refer to health workers' personal characteristics (e.g., age, sex and personality), professional training (e.g., education, specialty and experience), working conditions, as well as to some patients' characteristics, both in isolation and in relation to those of the physician, their demand and their expectations of treatment. Age, sex, marital status, family role, family structure, education and ethnicity are some of the potentially important patient individual factors influencing prescribing.

The traditions and beliefs of the population may also influence patients' as well as physicians' views. What is considered health and illness by the local culture, and how they are differentiated, is affected by medical and other professional health training. Lack of physicians and other health workers, their maldistribution, or financial obstacles that prevent people from seeking health care, may limit access to prescriber, treatments and drugs (unless drugs are distributed by non-physicians, a
situation that exists in many developing countries). The demands and expectations of pressure groups and society at large should also be mentioned. Some mistakenly believe that prescribing many drugs at a time is an expression of great medical skills; similarly, some doctors assume that patients and families want medicines and injections because that is part of a "national" culture. Finally, in some countries, the media (television, radio, newspapers, magazines etc.) seem to be very influential in forming public opinion - as well as professional opinion - and in drawing the attention of the public to matters concerning health and treatment.

As these examples show, despite the obvious importance of non-medical factors, inferences about their effects on prescribing are based more on informed guesswork and speculation than on factual evidence. There are insufficient data to quantify the effects of each factor, either separately, or in relation to each other or to medical factors. The information is nevertheless kept here as a reminder to those who like to believe that their behaviour is scientific and is determined only by medical factors.

5.2. Topics relevant for rational prescribing

5.2.1 Doctor-patient relationship

The establishment of an effective doctor-patient relationship represents an essential step in any treatment; indeed, it is the core of the practice of medicine. A good relationship, even more than a cure, is expected by the patient; it is typical of patients to be tolerant of the therapeutic limitations of medicine (but not of abuses by doctors and other health professionals). It has often been stressed that there are no diseases; there are only sick people. Therefore failure of the health worker to establish a good rapport accounts for much of the ineffectiveness in the care of patients.

Therapeutic interventions can play an important role in the doctor-patient relationship (13). Health workers should make an effort to enlist, recruit and involve the patient and significant others in collaboration with them in relation to the prescribed treatment. In this way, by making the patient a partner in treatment, the health worker emphasizes and reinforces the patient's strengths as a person instead of his weaknesses in a dependent, sick role, thus opening the door for more flexible, appropriate, responsive, and responsible treatments.

Given the numerous and often disturbing side effects associated with biological treatment, it is important that a systematic inquiry be made into the patient's eating, eliminating, sleeping, and sexual functions. An open discussion about these aspects of the patient's life and the changes induced by the medication will reassure the patient and will prevent both a breakdown in the relationship and the non-compliance with treatment.

5.2.2 History taking

Interviewing is probably the oldest and most frequently used of the assessment procedures. As it usually takes place during the first meeting between patient and health care worker, the interview has a significant influence on the patient's expectations and on the outcome of subsequent interventions. The interview may vary from being highly structured, in which the topics discussed follow a questionnaire or a prearranged format, to being flexible or unstructured, in which the interviewer follows cues given by the patient and does not restrict questioning to specific topics. Often both techniques are used, background information about age, previous medical history etc., being elicited in the structured interview, while flexible questioning elicits additional information.

Before any treatment strategies can be initiated, patient and therapist must discuss and agree on the behavioural changes to be affected and the approach to be used. Such discussions are repeated periodically so that treatment effectiveness can be assessed and new goals for behavioural change may emerge. One aspect of a behavioural assessment based on a typical diagnostic interview is that not only are problem behaviours targeted but behavioural strengths are also identified; this is important, since they are useful in the treatment approach.

Apart from its value in assessment, the interview may be therapeutic in its own right, because helping the patient to identify the underlying problem can be very useful, as can the relationship between patient and
health care worker, initiated at the interview.

Other assessment procedures may also be used, including questionnaires, self-monitoring, behavioural observation and psychophysiological measurement. The importance of a thorough assessment cannot be overemphasized, because behavioural intervention is not like using a cookery book - there cannot be a single recipe for every symptom. Rather, the process is tailored to the individual's unique problems in their particular context, and these problems must be clearly defined. The purpose of all the different assessment procedures, therefore, is to specify and select target behaviours, identify antecedent and consequent variables relating to the target behaviour, and collect data about the target behaviour and the variables affecting it.

5.2.3 Diagnostic assessment

A careful diagnosis is the essential step for a rational prescribing and ensures that the treatment is being delivered to the disorder likely to be responsive to that treatment. Up to a few years ago, psychiatric practice has been hampered by the existence of different diagnostic criteria. In the field of treatment, this has led to marked differences in the choice of the target symptoms for treatment, in the selection of patients to be admitted to certain treatments and the assessment of treatment response. The recent introduction of the ICD-10 (8) will undoubtedly foster the adoption of uniform diagnostic criteria in all countries of the world and will facilitate the achievement of more homogeneous, adequate standards of drug treatment.

5.2.4 Problems of treatment compliance

There has always been a problem in making sure that patients follow the treatments prescribed to them by doctors and other health workers. The problem varies from the patients who forget the occasional tablet, to those who never even bother to get their treatments started. Not few simply drop out of treatment or stop it altogether. Among medical, non-psychiatric patients non-compliance ranged between 31 to 59% of patients in long-term drug treatment, as shown in a number of studies (14). Non-compliance can therefore represent a serious obstacle to the achievement of therapeutic objectives. It also can indicate a breakdown of confidence and mutual respect between the patient, the family and the doctor.

In psychiatry, non-compliance is made more problematic by the reduced insight which characterizes many mental disorders. The lack of adequate insight, especially in psychotic disorders, can function as an important obstacle to the patient's understanding of the need for a regular, careful compliance with the treatment administered, particularly drug treatment. In these cases, monthly depot injections can significantly improve compliance.

Compliance increases if less than three medicines are prescribed at the same time.

Among factors affecting compliance, the commonest factor recorded is the complexity of the drug regime. Several studies have found that, if three or more medicines are being prescribed concurrently, compliance falls significantly, especially if they need to be taken in various combinations several times a day. This fact shows the need for a simplification of the drug treatment schedule and the need to avoid polytherapy, in addition to the other reasons which induce refraining from such a practice. "One drug once a day" is a useful principle to be followed as much as possible.

Another important reason for explaining compliance, which is the most commonly quoted when interviewing patients for their missed adherence to treatment, is the occurrence of side effects or because the patients are feeling worse after the medicine. In psychiatry, where side effects, sometimes severe, are quite common during many pharmacological treatments, this is an especially important reason for non-compliance. Greater awareness by the health worker about this problem can therefore
minimize the risk of occurrence of side effects, through a more careful selection of the needed drug and the therapeutic regime, and can prevent many unnecessary cases of side effects. An improved communication between the health worker, the patient and the family can significantly reduce the non-compliance phenomenon and create the best climate for a shared inquiry about the treatment, the establishment of mutual goals and a mutual participation in both experiencing and observing the process. Health workers should be available to give patients and their significant others all information they may require about the drug treatment administered, and its possible or likely side effects.

5.2.5 Adverse effects

Patients will generally have less trouble with adverse effects if they have previously been told to expect them. It is not unreasonable to explain the appearance of adverse effects as evidence that the drug is working, but clinicians should distinguish between probable or expected adverse effects and rare or unexpected adverse effects.

An extreme adverse effect of drug treatment is an attempt by patients to kill themselves by overdosing a medicine. Whatever the motivation, health workers should be aware of this risk and attempt to prescribe the safest possible medicines. It is good practice to write non-refillable prescriptions for small quantities of drugs when suicide is a consideration. In extreme cases, attempts should be made to verify that patients are actually taking the medication and not hoarding the pills for a later overdose attempt. It is a common clinical observation that patients may attempt suicide just as they are beginning to get better. Clinicians, therefore, should continue to be careful about prescribing large quantities of medication until the patient is almost completely recovered. Another consideration for health workers is the possibility of accidental overdose, particularly by children in the household. Patients should always be advised to keep all medicines in a safe place.

5.2.6 Patients' attitudes toward medicines

Some patients' ambivalent attitudes toward medicines often depend on the feeling that taking them means that they are really sick or not in control of their lives or that they may become dependent on the drug and have to take it forever. A simplified approach to these concerns is to describe the mental disorder partially as medical disease. Health workers should explain the difference between "street drugs" of abuse that affect the normal brain and medicines that are used to treat emotional disorders. They should point out to patients that anti-psychotics, anti-depressant and prophylactic medicines (the latter used in some affective disorders) do not create dependence.
6. NON-SPECIFIC FACTORS AFFECTING THE EVALUATION OF TREATMENTS

The chief problem in evaluating treatment is that three non-specific factors can be associated with a reduction of symptoms and an increase in well-being, and thereby mimic a treatment effect.

First, some disorders, given time, remit completely in the absence of treatment. Second, other disorders, although chronic, vary in intensity. Patients tend to present themselves for treatment when their disorder is severe and do not come when it is mild; even without treatment the severity of symptoms is reduced with time. If a treatment is offered when the symptoms are severe, then it may appear more effective than it is simply because severe symptoms will, in due course, regress back to their mean level of severity.

Third, positive expectations of being treated can bring about improvement in many mental disorders. This non-specific effect of being on treatment can be time limited, and may affect the benefits of a specific treatment in an uneven manner. The very administration of a medication (regardless of its content) may also produce an effect (placebo effect) which must also be assessed and discounted in the evaluation of a treatment. These factors, spontaneous remission, regression to the mean, and the non-specific effect of being in treatment, together with the placebo effect, can confound results and make treatment evaluation complicated.

Another important indicator of the likely therapeutic value of a treatment is the shape of the dose-response curve. Where there is a significant correlation between the dose of a specified treatment (be this measured in hours of psychotherapy or in milligrams of a drug) and the amount of response, this argues that some element in the treatment has been of benefit in reducing the severity of the disorder. While detection of a dose-response relationship is of positive value, its absence does not establish that a treatment effect is lacking.

In any clinical situation the observed improvement is therefore due to the additive effect of non-specific benefits of being in treatment, together with the benefits which result from the skilled application of specific therapies. Good clinical treatment will seek to maximize the effects of both, whereas in treatment outcome research, the magnitude of the effect of the specific intervention must be isolated in a precise manner, and assessed, in addition to the total effect of the treatment in the particular setting, by a particular practitioner to a given patient. High drop-out rates sometimes invalidate treatment outcome studies. Investigations in which few patients complete the course of treatment are rightly held in disdain. It is not possible to estimate or measure the potential benefit of any treatment if only those who derived benefit stay to be assessed. In treatment-outcome research, it is sensible to be wary of studies with drop-out rates that exceed 40%; in fact high drop-out rates are more likely to be seen where the treatment effect, if any, is weak; low drop-out rates (below 20%), on the other hand, often identify good treatments. Patients can be good judges of where value lies, and administrators might usefully adopt drop-out rates as an early indicator of the utility and benefit of various treatment programmes.

6.1 Levels of evaluation

Techniques for evaluating the efficacy of treatment are often based on the assumption that single modes of treatment are the topic interest. In practice, however, treatment is multifaceted and involves several types of intervention aiming to achieve a variety of objectives which include: the removal or reduction of symptoms; stopping the disease process; preventing impairments and disabilities; restoring function; and
maintaining or improving the quality of life. Interventions required for adequate management of impairment, disability and handicap differ from acute treatment methods, if only in degree. They require continuing involvement on the part of the therapist, and necessitate that this involvement extends more comprehensively over the patient's life and relationships. They demand a slower pace of approach, with which more action-oriented practitioners may become impatient. And they require that consideration be given to a host of interacting variables (e.g., cultural considerations) which, although may have some relevance in acute treatment situations, assume much greater importance in the management and rehabilitation of disabilities etc which may permeate every aspect of a person's life.

Different as they are from one another, conditions which are often chronic, such as schizophrenia and agoraphobia, can be used to illustrate this matter. In both syndromes, there is impairment in the patient's sense of well-being; in both, the impairment can result in patients being disabled, and to a very large extent, housebound; and in both, disability may result in leaving the workforce, and becoming socially isolated. Both conditions have, in randomized controlled trials, responded best to a combination of medication and behavioural therapy. But here the apparent similarity of these two conditions ends; the treatment of each patient, regardless of diagnosis, has to be considered on an individual basis if it is to be optimal.

It is therefore worth distinguishing between a number of different levels at which effectiveness can be tested. The simplest relates only to whether participants subjectively rate a particular experience as being of value to them. This subjective assessment is a relevant first step in evaluation. Similarly, peer review can contribute to this preliminary step of evaluation.

Two other important variables to be evaluated are efficiency and cost-effectiveness. The first can be measured by means of process-evaluation, where the roles of various participants are analyses and their interactions monitored in order to determine how well an attempt to generate improvements worked in terms of its operational functions.

Cost-effectiveness involves greater attention to comparability, both with other similar programmes and also with some more or less arbitrary standard of what the outlay should be (in terms of funding, person-hours, or transfer of resources) in order to achieve a stated outcome. It relies, therefore, on process evaluation as well as on another more objective assessment of the inputs which have been made, but also requires a clear understanding of what the outcome is.

To achieve this, an analysis of impact is also necessary. Indeed, there are those who argue that this is the only really important measure of the effectiveness of an intervention.

6.2 Indicators of treatment outcome

Occasionally, treatments produce such a large effect that no further research seems necessary. Benefits are self-evident. A striking example of this is the impact of streptomycin on tuberculous meningitis; a uniform mortality rate was cut so drastically that it would have been unethical to do a controlled trial. A large treatment effect, whereby the average treated patient is better than 99% of untreated patients, is almost certain to be due to the treatment that has been administered. If this effect can be shown to persist after treatment has concluded, and if the effect can be replicated, this provides robust evidence of the effectiveness of an element in the treatment package.

The issue of replication is important, and the advent of empirical techniques to aggregate the findings of many research studies has allowed the importance of small but significant treatment effects to emerge. Meta-analysis is the technique that has been used in psychiatry to add up the benefits to be expected from treatments used in cognitive impairment; schizophrenia; affective disorder; the anxiety disorders; and eating disorders. One can estimate from the average benefit, or effect size, and the number of studies, just how likely it is that the finding of significant benefit is real and not the result of a spurious effect.
7. ETHICAL ISSUES

In this section, some of the fundamental ethical principles which should govern the treatment relationship between health workers and the patients treated by them will be identified. The necessary careful compliance with the ethical requirements of treatment can prevent dissatisfaction by the patient and his relatives, minimize the risk of legal action against the caring staff and ensure the achievement of the desired health benefits in a situation of fair participation by all the agents involved in the treatment process.

7.1 Right and access to treatment

Patients should have the right to receive the best treatment available for their illnesses, as stressed by the U.N. General Assembly Resolution 46/119 of 17 December 1991. While health workers may not have control over many aspects of providing such treatment, they must, as agents of their patients, fight for that right.

All persons have the right to the best available mental health care, which should be part of the health and social care system.

Principle 1
UN Resolution 46/119

Insofar as health workers have control over the matter it is their responsibility to ensure, by all the means in their power, that their patients receive the best treatment.

The right to treatment needs to be backed by the availability and access to treatment: without the latter the former remains only theoretical. It is therefore necessary that efforts be made by the health authorities to make concretely available and accessible, treatment facilities and mental health personnel entitled to deliver the treatment.

If a patient is, in the health worker's opinion, incompetent to exercise this right, then it will be the health worker's ethical duty to ensure that necessary treatment is provided, especially in the face of incompetent refusal.

7.2 Right to information

Communication with the patient should be established as soon as possible. Attention needs to be paid to the probable unwillingness to complain which is so typical of patients in many situations. Clarification of issues relating to treatment and consent to treatment is particularly important, and demand painstaking attention to detail. In particular, benefits and risks of any given treatment need to be clearly explained to the patient and the significant others, if an informed consent has to be obtained. To do so, the language used has to be clear and comprehensible, and a too sophisticated technical language should be avoided as much as possible. The problem may sometimes be represented by the fact that doctors want to communicate medical technicalities whereas patients and families want to know what is going to happen to them. In particular, possible risks and harm consequences of the treatment to be administered have to be clearly spelled out and weighted against the evidence of the possible benefits.

What is meant by "harm" needs to be
elaborated. For most practitioners it means more than harm to life, or physical health, of patient or society, and includes the type of social and economic harm which can result from untreated psychotic behaviours - e.g., in mania. Such a wider concept is heavily dependent, for adequate understanding, on the extensive experience of psychotic behaviour which is usually found only in those with psychiatric experience. In such a situation it is unethical for the professional, guided by deeper and more extensive knowledge, to fail to make that knowledge available to families and communities in an appropriate way. Informed knowledge of the extent and diversity of harm which may befall a psychotic patient, imposes an ethical requirement on the practitioner, even in the absence of specific legislation. It is his responsibility to take adequate and appropriate steps to protect his patient from the disabling and harmful consequences of illness.

Patients and families want to know what is going to happen to them.

7.3 Consent to/refusal of treatment

This is a complex area. While issues of compulsory treatment, on the one hand, and compulsory detention on the other, need to be conceptualized separately, the right of the patient committed to hospital to refuse treatment for a severe mental illness will, if employed, almost certainly prolong the state of compulsory detention. Gradually legislation in many places have come to recognize this. In terms of ethics, it is vital that a balance be struck: it is as unethical to prolong incarceration, by taking shelter behind an apparent legal prohibition on treatment, as it is to arrogantly ignore protest, and press ahead with a treatment programme which ignores the concerns and wishes of the patient.

These ethical ambiguities are not unrecognized by most legal systems, however, prohibitions in these matters are rarely absolute. The right of the demonstrably informed medical practitioner or psychiatrist to act in good faith, in the interest of their patients, is given much respect and weight by tribunals and courts, provided that it can be shown that there was a proper weighing up of the issues, and a decision reached based on the primacy of ethical considerations. It is the unthinking exercise of unjustified authority which must be shown to have been avoided; and secondly, it is the priority and respect given to competent patient autonomy that needs to visibly characterize each step in the interaction with the patient.

The act of legal committal to a hospital does not establish a state of incompetence as regards autonomy to choose (or refuse) treatment; by the same token, persons living in the community, may in fact lack the autonomy to make decisions about treatment issues.

Consent to treatment, in any realistic sense, can only be given by an autonomous agent (i.e. not an unconscious person). This agent needs to have available, a body of information about the treatment and about the condition for which it is intended, sufficient to permit an act of assent which maximizes the self-benefit likely to be available, given varying circumstances, at that point in time and under the particular conditions which apply.

These qualifications are important, and need to be set against the simple-minded notion that subjects can only provide informed consent if they are fully aware of all the details; all the hazards; all the alternatives and their details and hazards; and all the possible outcomes of pathology, with or without treatment etc. To achieve such a level of knowledge, a basic medical degree is required as a starting point, which is hardly realistic. The best grounded informed consent is usually obtained most readily in the treatment of a problem which does not require immediate intervention; the patient in acute distress may for example be unable to assess alternatives realistically.

An important distinction which must be made is the crucial separation between accepted and experimental treatments, and
the related issue that a treatment procedure must be demonstrated to be of, at least, presumptive value: the risk of damage must be less than the likelihood of benefit. Such a distinction can only be based on scientific criteria; it owes nothing to ideology.

Consent to a treatment procedure is not for all-time, specially in the case of lengthy and risky treatments. It is unethical not to review with a patient matters of information, knowledge, and consent at regular intervals, and certainly at all times when treatment changes, or new treatment decisions are required.

Certain treatment approaches used in psychiatry literally involves accepting responsibility for other persons’ lives: the implications are numerous and of major importance. Psychiatrists are often requested and ready to assume much of this responsibility; patient permission, therefore, at each step and at regular intervals is an imperative.

The patient, however, has an unassailable right to refuse treatment, irrespective of the likely outcome of such refusal: this right can only be abrogated by mental incompetence, or some other manner of losing autonomy, such as loss of consciousness. In the case of minors, as defined in any particular society, the right is usually vested in the parent or legally recognized guardian. The criteria for establishing incompetence are usually laid down by society in appropriate legislation, which in most cases, recognizes emergency situations where the psychiatrist or other practitioner may use their own judgement, provided they can subsequently demonstrate that those actions were based on good faith.

These legal principles are based on the view that no person has the right to breach the autonomy of another, for whatever reason, while that autonomy can be demonstrated to exist. As a consequence, health workers must endeavour to meet their patients’ wishes rather than their own, other things (competence, need for treatment, experiment versus treatment, assessment of hazard, and ongoing consent), having been duly and explicitly considered.

In this context, even where patients are judged to be incompetent and treatment has been authorized against their wishes, patients, as far as possible, must continue to be involved in choices about alternative treatment issues and should expect that their expressed wishes will be listened to with respect. The legal act of declaring individuals incompetent does not thereby deprive them of their humanity, nor does it imply that all of their capacity to make judgments has been suspended. The general rule must be that only minimal compulsion, in absolutely essential treatment issues, be used, and that as much latitude as possible be given to patients with respect to matters where they can continue to exercise their own judgement.

7.4 Clinical responsibility

Health workers have clinical responsibilities to their patients and to society as a whole. These include:

With regard to patients:

a. Commitment on the part of the health workers to equip themselves with the best and most critical information (on treatment and outcome etc) available, and to keep this knowledge up to date. This responsibility covers all treatment procedures which are within their expected competence, and includes responsibility not exceeding the boundaries of their skills;

b. Acceptance of the responsibility to constantly and accurately distinguish between what is scientifically established, and what is merely an ideological commitment to a particular mode of therapy, whatever the reasons. Authority to treat may be delegated but responsibility cannot be abrogated.

With regard to society:

a. Avoidance of harm to society generally;

b. Avoidance of misuse of public resources.

The scientific evaluation of treatment methods, and the avoidance of using those for which there is good evidence of non-effectiveness, are ethical requirements for medicine in general and for psychiatry as well.
PART II
8. PSYCHOLOGICAL INTERVENTIONS

Planned and structured interventions aiming at influencing behaviour, mood and emotional patterns of reaction to different stimuli through verbal or non-verbal psychological means are called psychotherapy; it excludes the utilization of biochemical or other biological means. A variety of techniques and approaches - derived from different theoretical foundations - have shown their effectiveness in relation to several mental disorders. In addition to these planned efforts, doctor-patient relationship and placebo effect (discussed previously) are important factors influencing the outcome of most psychological interventions. In this section the following main and most useful psychological interventions are described.

- supportive therapy (therapeutic counselling);
- cognitive therapy;
- behaviour therapy;
- token economy;
- relaxation.

8.1 Supportive therapy (therapeutic counselling)

Probably the simplest form of psychotherapy (15), it is largely based on the doctor-patient relationship. In addition to this element, other important techniques include reassurance, clarification, teaching, suggestion, advice and abreaction (discharge of and relief from painful emotions through their expression within the session) (16). Some authors (17) see this modality of treatment as the foundations of good clinical care. Therefore, it should be an intrinsic component of training programmes for all health workers involved in clinical duties.

Indications: some elements of supportive therapy are essential to the everyday care of most patients, not only those with mental disorders. Supportive therapy is also indicated in the management of normal or unexpected life crises, e.g., bereavement; and conduct disorders (F91) as well as with some types of personality disorders (F60-F62).

8.2 Cognitive therapy

This form of psychotherapy is based on the assumption that maladaptive ways of thinking derived from illogical, irrational or distorted ideas may lead to a great amount of unnecessary suffering which characterizes some forms of mental disorders, e.g. depressive states. According to its proponents, people with these ways of thinking can be taught more efficient ways of thinking and of problem-solving. Initially conceived as a specific therapy for depressive disorders (18) it was later combined with behavioural techniques (described below) becoming the so called cognitive-behaviour therapy (19) with a broadened set of indications and characterized by the following:

i) The focus of concern is on current problems identified as such by both patient and therapist.

ii) Both the rationale and the structure of the treatment are discussed with the patient in advance.

iii) Modification of emotional responses, modification of behaviour, and modification of irrational, distorted or unproductive thoughts or beliefs are the basic methods used.

The duration of this modality of therapy is brief (10-30 hours) compared to other forms of psychotherapy, and improvement usually persists after the end of the treatment. Of great importance, it can be delivered by appropriately trained staff other than psychiatrists.
Indications: cognitive therapy is especially indicated for patients with depressive disorders (F31-F39), but people with anxiety disorders (F40-F48) may also benefit from this technique, especially when used in combination with behavioural techniques. This combination is also widely used for the treatment of sexual dysfunctions (F52), and it has started to be used for the treatment of personality disorders and of schizophrenia.

8.3 Behaviour therapy

The main assumption of behaviour therapy is "that most behaviour is learned according to basic principles which have been established as a result of rigorous scientific studies." (20). Its main goal is to modify behaviour and eliminate symptoms directly, irrespective of their underlying causes. Several techniques belong to this category, and training needs will vary accordingly.

8.3.1 Exposure (desensitization)

This technique is useful for treating patients with a variety of anxiety and phobic disorders and basically consists of bringing, in a controlled way, patients into contact with a situation or object they irrationally fear or avoid. The exposure can be in imagination only or in vivo. Contact with the feared situation or object may be "modeled" by the therapist.

The patient, in a relaxed situation, is asked to imagine himself/herself in the anxiety provoking situation, and through the progressive control of both the degree of relaxation and the imagination of the anxiety provoking situation, the desensitization occurs. Once a reasonable degree of control (around 50%) over anxiety is reached the patient is submitted to in vivo exposure.

Indications: mostly used to treat anxiety (particularly phobic, F40) disorders and panic with or without agoraphobia.

8.3.2 Operant conditioning methods

Probably the most known and used example of these methods is token economy. It consists of reinforcing certain desirable (from the point of view of the therapists or clients) behaviours which are immediately rewarded with tokens that can be exchanged for privileges valued by the patient; at the same time undesirable behaviour is ignored. The desired behaviour is often "modelled" by the therapist.

Indications: mostly used in institutions, particularly with severely socially handicapped patients (e.g. F72-F73), to modify or eliminate inadequate, undesirable behaviour.

Another example of operant conditioning methods is represented by self-control methods. They comprise a variety of techniques intended to help the client to reduce or eliminate patterns of behaviour which are causing difficulties. The method involves self-recording, self-reinforcement, and rearrangement of the immediate environment to reduce the probability of occurrence of the problem behaviour.

Indications: excessive alcohol consumption, excessive gambling, smoking, poor study habits.

8.4 Relaxation (stress management)

The reduction of the arousal state - hence, of anxiety - to acceptable levels with an enhancement of homeostasis is the main goal of a variety of techniques with muscular relaxation as a common denominator. These vary from yoga, autohypnosis and transcendental meditation to autogenic training and biofeedback, with corresponding variations in relation to setting, time and circumstances of application. Several of these techniques are self-learned.

Indications: although relaxation alone cannot be considered a total treatment for severe anxiety or established anxiety disorders (F40-F48), it is an important adjunct to other modalities of treatment and is also helpful for the management of daily life stress.
9. BIOLOGICAL INTERVENTIONS

Biological interventions represent an ancient and widely practised treatment modality to deal with almost all mental disorders, especially the most severe ones.

9.1 Pharmacotherapy

Although some medicines useful for the control and treatment of some forms of mental disorders have been used since ancient times, it was only in the second half of the 20th century that a scientific era in the use of chemical substances for the treatment of mental disorders began. The main classes of psychotropic medicines used for psychiatric treatment include antipsychotic medicines, antidepressant medicines, anti-anxiety medicines, medicines for the treatment of nonorganic insomnia and medicines for the prophylaxis of mood disturbances.

9.1.1 Anti-psychotic medicines

Psychotic states refer to situations in which impairment of mental function has developed to a degree that interferes grossly with insight, ability to meet ordinary demands of life or to maintain adequate contact with reality (21).

In the second half of the XX century a series of medicines (neuroleptics) useful for controlling several forms of psychotic disorders, mainly schizophrenia and related disorders, were introduced. Today, these medicines constitute a standard treatment for people with those disorders, although none of them has proved effective for curing psychotic disorders. They are also effective in the prevention of relapse of mental disorders.

The two main classes of antipsychotic medicines are the phenothiazines (model drug: chlorpromazine) and the butyrophenones (model drug: haloperidol), also called neuroleptics. More recently a different type of antipsychotic medication (e.g. clozapine) has been shown to be effective in the management of some cases of severe schizophrenia resistant to treatment with other drugs.

Indications: psychotic states in general; more specifically schizophrenia (F20-F29) and mania (F30).

9.1.2 Anti-depressant medicines

Also in the second half of the XX century medicines effective for the treatment and control of depressive states were introduced. They belong to two main classes: tricyclics (TCA) and mono-amine oxidase inhibitors (MAOI). More recently some new classes of antidepressant drugs (e.g. tetracyclics) have been made available for the treatment of depression. Lithium salts have a prophylactic effect also in relation to some forms of depression, together with TCA.

Indications: depressive states (F31-F39), particularly severe depressive episodes.

9.1.3 Anti-anxiety medicines

Drugs with the property of allaying or sedating have been known for a long time (e.g. alcohol and opium). In the XX century several newly discovered drugs were added to this group (e.g. barbiturates, benzodiazepines (BDZ), and beta-blockers).
BDZ are currently the most widely used anti-anxiety drugs. The main problem associated with their use is represented by the development of tolerance to their effects and by the possible occurrence of withdrawal symptoms in case of an abrupt interruption during a long-term treatment. The establishment of a real dependence state is more equivocal. Similarly, some TCAs (e.g. amitriptyline) have a marked sedating effect (due to their anticholinergic properties), which makes them a good option in cases of anxiety associated with depression.

Some TCAs, such as inipramine and clomipramine, have been demonstrated to be effective in the treatment of panic attacks and of obsessive-compulsive disorder.

Indications: anxiety disorders are the main indications for this class of drugs; more specifically, F40-F43.

9.1.4 Medicines for the treatment of nonorganic insomnia

In clinical practice one can find both primary sleep disorders or - what is more frequently seen - sleep disorders associated with or caused by other mental disorders. For different types of insomnia, benefits can be obtained from short half-life benzodiazepines - in this instance also called hypnotics - used in a special posology (usually higher than the dosage used for anxiety sedation) and intake schedule, and for a short period of time.

Indications: non-organic sleep disorders (F51).

9.1.5 Prophylactic medicines

The prophylactic role of lithium salts - in addition to their effect in cases of acute mania - in preventing the recurrence of both manic and depressive episodes in bipolar patients is now well recognized; they are also used for the prevention of depressive episodes in patients with unipolar depressive disorder.

Indications: prophylaxis of manic and depressive episodes (F30-F33).

9.2 Electroconvulsive therapy (ECT)

Despite the strong ideological controversy around this form of therapy, it remains an useful therapeutic tool when appropriately utilized. Proper utilization includes careful diagnostic screening and preparation of patients (obtaining an informed consent), adequate technique (e.g., proper electrode placement and proper stimulus intensity and duration, preceded by anaesthesia and induced muscle relaxation), and posology (up to 6-10 applications at intervals of 48 hours). The main predictor of positive response to ECT is represented by the presence of delusions in depressed patients.

Indications: severe depressive disorders (F31-F33), particularly when there is a high imminent risk of suicide, or for patients with very severe states, who cannot tolerate appropriate medication or consistently failed to respond to it.
10. SOCIAL INTERVENTIONS

10.1 Independent living skills training

Interventions related to independent living skills training cover two major areas:

i) daily living basic activities (DLA), such as personal hygiene and care (toileting, combing, shaving, making up, etc.), dressing, feeding and medicine intake;

ii) more complex daily activities, such as cooking, cleaning, laundering, money handling, shopping, using public transport, etc.

Training for most of these activities is usually conducted individually using behavioural techniques. However, the same principles of shaping and modelling that are used to train children are the basis for this type of intervention. In fact, within this framework some programmes also offer educational activities ranging from basic reading, writing and arithmetic to more advanced formal learning.

Indications: Severity of disability rather than specific psychiatric diagnoses indicates the need for this intervention. Disability severe enough to benefit from this intervention can be found in many diagnostic categories, e.g., dementia (F00-F09), schizophrenia (F20-F29), depression (F31-F33), some neurotic disorders (F40-F43), and mental retardation (F70-F79).

10.2 Social skills training

Impairments due to disease processes or to long-term hospitalizations can lead to more or less severe social disabilities. In these cases patients can greatly benefit from
training for restoring or improving the skills for social interaction: socialization (e.g., how to introduce oneself), communication with others (e.g., how to maintain eye contact), respect for others' rights (e.g., how to politely interrupt others), withdrawing or relaxing when greatly stressed or excited. Patients' specific difficulties should be identified and approached step by step. Techniques based on behavioural principles are most frequently used to overcome social disabilities. Assertiveness training is a particular technique which deals with more complex behaviour.

10.2.1 Assertiveness training

The ultimate goal of assertiveness training is to "allow people to stand up for their own rights while respecting the rights of others. At the same time it aims to allow them, to express their feelings freely and appropriately, with respect for the feeling of others but not at the expense of their own feelings" (19).

Indications: the best results of social skills training have been found with patients with alcohol and drug problems (F10-F19), schizophrenia, anxiety and depressive disorders.

10.3 Vocational training

Although this is probably the most developed of all psychosocial interventions, given its well established role in psychiatric rehabilitation, its potential has not, however, been fully explored. Vocational training started in hospital settings; later it moved outside the mental hospital to protected workshops. More recently, innovative approaches have stretched it to supervised employment in the labour market, including transitional employment and continuous supported employment.

Vocational training is done taking into consideration both the real and potential abilities as well as the limitations of patients. It aims at:

i) training (or re-training) patients to their optimal capacity to perform a given task;
ii) providing them with the necessary skills to be competitive in terms of finding and keeping a job.

This has to be done without endangering patients' mental status.

The content of the training programme will be specific for different types of tasks and jobs.

Indications: once again indications are more dependent upon the degree of disability than on specific psychiatric diagnoses. It has nevertheless been most used for people who have remained for long periods in mental hospitals, irrespective of diagnosis.

10.4 Social support network

As the trend towards dehospitalization has been growing in importance in many countries, it has become more and more evident that the establishment of social support networks represent an essential element for the treatment of people with mental disorders. This is reinforced by changes in the family structure, with its progressive nuclearization and weakening of traditional bonds. The essential network of support to people with mental disorders comprises two main areas: housing and small groups activities.

10.4.1 Sheltered housing

For many inpatients in mental hospitals the absence of alternative lodging is the only reason for explaining why they are still there. In some places a few alternatives have been developed with the aim of assisting people "to live as independently as possible in the community" (22). The most relevant of these alternatives are half-way houses (group homes) and supervised (sheltered) apartments. In half-way houses several patients (ideally between 10 and 20) live in a house, each 2 or 3 sharing a bedroom. They are provided with lodging and food, and are responsible for the cleaning of the premises and their personal hygiene; there is 24-hour staff supervision. In sheltered housing, 1 to 4 patients live together in an almost "normal" situation, except for the fact they receive a periodical visit (daily or less frequently) from a person responsible for this type of arrangement; residents also have the possibility of
contacting the responsible person - or a surrogate - on a 24-hour basis.

Indications: half-way houses are most useful for patients who spent long periods in institutions; they have been extensively used for people with alcohol or drug dependence leaving hospitals or detoxification units. Supervised apartments are indicated for people who have already acquired enough social skills in a half-way house to be able to move to a less structured environment or for people with behaviour disabilities, irrespective of the psychiatric diagnosis.

10.4.2 Self-help groups

The main characteristic of this type of intervention is the absence of staff participation in activities involving an usually homogeneous group of people, e.g. substance abusers, neurotics. Active participation in groups in which all members have lived through the same types of experiences and difficulties can, through acceptance, emotional support and availability, restore self-esteem and social ties, thus contributing to integration into the community, and ultimately to the improvement of quality of life.

Indications: for patients whose social networks have been disrupted, or who are going through a life crisis. They are also very useful for relatives of people with chronic mental disorders, particularly dementia (F00-F09), psychotic disorders (F20-F29), harmful use of alcohol or other drugs (F10-F19), mental retardation (F70-F79) and developmental disorders (F84) (see Family interventions, below).

10.4.3 Psychosocial clubs

Psychosocial clubs aim to provide their members with opportunities to exchange and gain experience particularly in areas related to creative, sport, leisure and other social activities. Staff members may be involved in its organization and management, but the clubs may also be run without any staff involvement. In addition to providing opportunities for self-development in any of the specific activity areas available in each club, they also greatly contribute to the establishment of social ties and to integration into the community.

Indications: the same indications as for self-help groups above.

10.5 Family interventions

Several different approaches involving relatives of people with mental disorders have been proposed (23). Psychoeducational approaches are shown to be effective in reducing relapse rates in schizophrenic patients; at the same time they improve distress or burden on their relatives. These approaches are based on cognitive-behavioural principles. Other approaches involving families follow the model of self-help groups (see above).

Indications: schizophrenia (F20-F29) is the main indication for psychoeducational approaches, whereas the self-help approach has been mostly successful in relation to harmful use of alcohol and other drugs (F10-F19), dementia (F00-F09) and mental retardation (F70-F79).
PART III
11. SPECIAL GROUPS: THE ELDERLY, CHILDREN, WOMEN, ETHNIC MINORITIES

The interventions and techniques mentioned in PART II are, in principle, applicable to the population as a whole. For some groups, however, some special remarks may be applicable; they include the elderly, children, women and ethnic groups.

Factors such as age, sex and genetic constitution may greatly modify the metabolism of some biological interventions. Therefore a more careful selection of a specific medicine, as well as an adjusted posology, may be needed when these interventions are indicated, e.g., for children or the elderly.

Women pose an additional concern, relating to childbearing. Some medicines (e.g., lithium salts) are potentially harmful to the fetus and are to be avoided during pregnancy and lactation; women taking these medicines should be warned of their potential risks and should discuss the issue with a health worker before getting pregnant, interrupting them as soon pregnancy is detected and immediately contacting a health service. In addition, oral contraceptives may interfere with the metabolism of some medicines (e.g., antidepressants) which will need some posology adjustment.

Several psychological interventions follow a learning model theory and are well adapted for children; the same applies to some social interventions, based on behavioural models.

For a long time it was believed that the elderly were not good candidates for psychological interventions. However, selected psychological interventions here proposed can be of great benefit to the elderly and can also represent a valid alternative to biological interventions, when these have important contraindications (e.g., cognitive psychotherapy for depression).

Ethnicity may interfere with psychiatric treatments in many ways. Genetic factors may interact with biological interventions and the knowledge of the response pattern to a particular medicine in the family may assist in indicating the same (or not) to a given patient.

As far as psychological interventions are concerned, an issue of great importance is the matching between therapist and patient: problems can vary from language to values. Generally speaking, patients will do better with therapists of similar background (24). The same applies for social interventions: sociocultural values, religion, family structure and social ties may seriously interfere with some types of intervention. If the therapist is not well familiarized with those patients' characteristics treatment may not work as well as it would with patients whose background is known to the therapist.
12. WHO DOES WHAT?

Some interventions have been closely associated with some professions, e.g. physicians prescribe medicines and conduct psychotherapy, psychologists conduct assessments and psychotherapy, occupational therapists conduct vocational rehabilitation, social workers counsel and conduct social interventions, and so on.

However, these attributions usually follow a kind of "natural legacy" and little has been questioned regarding the training these professionals have had to perform those activities. Whereas in some cases professionals have been adequately trained to deliver some types of essential interventions, their training has either not been updated or not adapted to public health care settings (25).

The report of a WHO meeting on the contributions of different professional roles to mental health (26) states that:

"when we talk about roles in mental health there are more common shared roles that specificities, with some variations depending on the type of action to be performed, e.g. promotion, prevention, treatment and rehabilitation."

The most commonly shared roles concern inter-personal relationships, counselling and education”.

The same report points out the need for strengthening team work. In the report's words:

"beyond the need for common goals, philosophy and models of action necessary for every team effort, in the field of mental health we have to face the additional problem of the ancient dichotomy between psychological and physical approaches to mental health and illness, more recently compounded by more strict social approaches".

It seems, therefore, that previous training and competence, more than professional identity, should be the criterion to indicate who delivers which type of intervention. In many cases this is determined by corporate pressures or law, which is frequently outdated and progress blocking. In these cases action should be taken to improve the situation, eventually modifying legislation with benefits for patients as the main concern.
13. EDUCATION, TRAINING AND RESEARCH

As has been mentioned in the previous chapter, basic education of health professionals and workers should include an updated component on the management of priority mental disorders, covering essential biological, psychological and social interventions. The amount, depth and complexity of this education should be commensurate with the specific degree of education. Nevertheless, this educational process should take into account the real conditions where practice will take place and prepare students accordingly.

As put forward by a previously mentioned WHO report:

"It is essential to use the real situation in which the practitioner finds himself or herself. For example, lectures by otherwise competent specialists who fail to enter the specific context in which practice actually takes place are usually of low effectiveness. Small group work, which starts from the actual problems of practitioners, such as Balint groups, is usually more valuable." (26).

Introducing appropriate modifications into a curriculum of a health care school is a long and difficult process. Depending on the type of career, results will be seen not before some 6-12 years after painstaking discussions started. Nevertheless, in most cases this has to be done. The most important modifications to be introduced are not necessarily related to the cognitive domain - where much remains to be done - but to the acquisition of psychosocial skills.

Patients tend to be more dissatisfied and plaintiff about the lack of such skills and sensitivity and understanding, than about lack of technical expertise. However,

"Acquisition of this type of skill and sensitivity is probably a more time-consuming and subtle process than learning how to treat mental illness, and relies heavily on the development of appropriate attitudes. These attitudes must be instilled early and reinforced throughout training. (...) Empathy with patients is essential, as is an holistic approach and appreciation of the interdependence of psychological, emotional and physical well-being." (25).

Continuing education is essential to help retain and develop competence, either as a complement to formal background education, or as an element of in-service training. There is now enough evidence that health workers - even those without a professional degree - can assimilate in-service training to identify and manage mental health problems in primary health care (26). It has been shown that in fact non-professional health workers are more apt than professional health workers to acquire psychosocial skills; no difference has been found in relation to the acquisition of cognitive skills (27).

In the process of planning for training activities, the nature and complexity of the local health system should be taken into account. The precise identification of mental disorder priorities and the level in the health system at which they should be dealt with will determine the nature of the training for each type of health worker. The following principles have shown their usefulness when planning this kind of training:

- focus on a limited number of conditions;
- availability of a limited range of interventions for defined situations;
- simplification of the division of tasks in
  the use on specific interventions; and
- coordinated training programmes (28).

This brings into careful consideration
the need for the development of supervisory
and consultative skills, which have not been
part of most training programmes. Supervision has been closely associated with
psychotherapy, a field in which it has
proved its value and importance. Local
conditions will indicate the best models for
supervision and consultanship, but an
emphasis on training in the community
rather than in hospitals, on the acquisition
of teaching skills, and of effective
supervision at a distance, should not be
overlooked.

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Training in the community
rather than in hospitals
should not be overlooked.
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As far as learning materials are
concerned, teaching aids should be
produced as far as possible for self-
instruction, taking into consideration local
needs and characteristics with minimal
input from teachers; flow-charts may be
useful teaching aids in this context (29).

Finally, given the role of stigma in the
development of handicap attached to people
with some mental disorders it is essential to
explore and tackle this issue as early as
possible in the training programmes.

Although research is not the main
concern of this publication, it must be said
that practice needs to be research-based and
practitioners need to have the ability of
critical evaluation about their own work
and the work of others. The goals, however,
should not initially be put at a too high
level. Even simple record-keeping and small
items of performance-review and service
evaluation - using both process and
outcome indicators (e.g. number of visits or
drop-out rates) - are all valuable.
Performance review, usually integrated into
the supervision process, helps both practice
and education and contributes to improve
patients' well-being.

Areas in which research activities
related to essential treatments for mental
disorders could be carried out include:

- evaluation of treatment methods;
- service evaluation;
- division of labour between professions
  and health workers; and
- the outcome of professional interactions
  between clients and professionals.
14. CONCLUSIONS

In this document an overall description of essential interventions for the treatment of people with mental disorders based on scientific evidence and on the experience of leading experts in this field, has been presented. As was said in the foreword, this is the first in a series of documents addressing treatment of mental disorders. Next issues will address separately biological, psychological and social interventions, detailing techniques and processes in each approach.

Treatment, however, is only one of the facets of a comprehensive mental health programme; promotion of mental health and prevention of mental disorders complete it.

Ideally, before any treatment programme is started, priority disorders should be identified and health workers trained both for the identification of those priorities and for their management.

Finally it is never enough to say that the ultimate goal of any mental health action - including treatment of mental disorders - is both to contribute to social development and to improve peoples’ quality of life. Therefore peoples' opinion should be constantly sought in order to avoid the development of programmes not linked to that goal and isolated from the social fabric.


3. The expression *doctor-patient relationship* is kept given its traditional usage. In this context, however, *doctor* is meant to cover all staff providing care (health workers) and *patient*, all those receiving such care. WHO document Doctor-patient interaction and communication (MNH/PSF/93.11) examines both basic and advanced skills central to doctor and patient satisfaction, to the clinical competence, and to the health outcomes of their patients. It also looks particularly at teaching methods that are learner-centred and experiential in nature.

4. This section is adapted from the WHO Scientific Group Report on Evaluation of Methods for the Treatment of Mental Disorders (WHO, 1991).

5. This section is based on a chapter on ethic issues included in the WHO Scientific Group Report on Evaluation of Methods for the Treatment of Mental Disorders (WHO, 1991).

6. Not included in the WHO List of Essential Drugs.

7. See forthcoming WHO document Essential Psychological Interventions for Mental Disorders.


16. REFERENCES


22. Stroul B. Models of community support services: approaches to helping persons with long-term mental illness. Boston, Center for Psychiatric Rehabilitation (University of Boston), 1986.


ANNEX 1
The ICD-10 Classification of Mental and Behavioral Disorders

List of categories

F00-F09 Organic, including symptomatic, mental disorders

F00 Dementia in Alzheimer’s disease
  F00.0 Dementia in Alzheimer’s disease with early onset
  F00.1 Dementia in Alzheimer’s disease with late onset
  F00.2 Dementia in Alzheimer’s disease, atypical or mixed type
  F00.9 Dementia in Alzheimer’s disease, unspecified

F01 Vascular dementia
  F01.0 Vascular dementia of acute onset
  F01.1 Multi-infarct dementia
  F01.2 Subcortical vascular dementia
  F01.3 Mixed cortical and subcortical vascular dementia
  F01.8 Other vascular dementia
  F01.9 Vascular dementia, unspecified

F02 Dementia in other diseases classified elsewhere
  F02.0 Dementia in Pick’s disease
  F02.1 Dementia in Creutzfeldt-Jakob disease
  F02.2 Dementia in Huntington’s disease
  F02.3 Dementia in Parkinson’s disease
  F02.4 Dementia in human immunodeficiency virus [HIV] disease
  F02.8 Dementia in other specified diseases classified elsewhere

F03 Unspecified dementia

A fifth character may be added to specify dementia in F00-F03, as follows:

0 Without additional symptoms
1 Other symptoms, predominantly delusional
2 Other symptoms, predominantly hallucinatory
3 Other symptoms, predominantly depressive
4 Other mixed symptoms

F04 Organic amnestic syndrome, not induced by alcohol and other psychoactive substances

F05 Delirium, not induced by alcohol and other psychoactive substances
  F05.0 Delirium, not superimposed on dementia, so described
  F05.1 Delirium, superimposed on dementia
  F05.8 Other delirium
  F05.9 Delirium, unspecified

F06 Other mental disorders due to brain damage and dysfunction and to physical disease
  F06.0 Organic hallucinosis
  F06.1 Organic catatonic disorder
  F06.2 Organic delusional [schizophrenia-like] disorder
  F06.3 Organic mood [affective] disorders
    .30 Organic manic disorder
    .31 Organic bipolar disorder
    .32 Organic depressive disorder
    .33 Organic mixed affective disorder
  F06.4 Organic anxiety disorder
  F06.5 Organic dissociative disorder
  F06.6 Organic emotionally labile [asthenic] disorder
  F06.7 Mild cognitive disorder
  F06.8 Other specified mental disorders due to brain damage and dysfunction and to physical disease
  F06.9 Unspecified mental disorder due to brain damage and dysfunction and to physical disease

F07 Personality and behavioural disorders due to brain disease, damage and dysfunction
  F07.0 Organic personality disorder
  F07.1 Postencephalitic syndrome
  F07.2 Postconcussional syndrome
  F07.8 Other organic personality and behavioural disorders due to brain disease, damage and dysfunction
  F07.9 Unspecified organic personality and behavioural disorder due to brain disease, damage and dysfunction

F09 Unspecified organic or symptomatic mental disorder
F10-F19 Mental and behavioural disorders due to psychoactive substance use

F10.- Mental and behavioural disorders due to use of alcohol

F11.- Mental and behavioural disorders due to use of opioids

F12.- Mental and behavioural disorders due to use of cannabinoids

F13.- Mental and behavioural disorders due to use of sedatives or hypnotics

F14.- Mental and behavioural disorders due to use of cocaine

F15.- Mental and behavioural disorders due to use of other stimulants, including caffeine

F16.- Mental and behavioural disorders due to use of hallucinogens

F17.- Mental and behavioural disorders due to use of tobacco

F18.- Mental and behavioural disorders due to use of volatile solvents

F19.- Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances

Four- and five-character categories may be used to specify the clinical conditions, as follows:

.0 Acute intoxication
.00 Uncomplicated
.01 With trauma or other bodily injury
.02 With other medical complications
.03 With delirium
.04 With perceptual distortions
.05 With coma
.06 With convulsions
.07 Pathological intoxication

.1 Harmful use

.2 Dependence syndrome
.20 Currently abstinent
.21 Currently abstinent, but in a protected environment

.22 Currently on a clinically supervised maintenance or replacement regime [controlled dependence]
.23 Currently abstinent, but receiving treatment with aversive or blocking drugs
.24 Currently using the substance [active dependence]
.25 Continuous use
.26 Episodic use [dipsomania]

.3 Withdrawal state
.30 Uncomplicated
.31 Convulsions

.4 Withdrawal state with delirium
.40 Without convulsions
.41 With convulsions

.5 Psychotic disorder
.50 Schizophrenia-like
.51 Predominantly delusional
.52 Predominantly hallucinatory
.53 Predominantly polymorphic
.54 Predominantly depressive symptoms
.55 Predominantly manic symptoms
.56 Mixed

.6 Amnestic syndrome

.7 Residual and late-onset psychotic disorder
.70 Flashbacks
.71 Personality or behaviour disorder
.72 Residual affective disorder
.73 Dementia
.74 Other persisting cognitive impairment
.75 Late-onset psychotic disorder

.8 Other mental and behavioural disorders

.9 Unspecified mental and behavioural disorder

F20-F29 Schizophrenia, schizotypal and delusional disorders

F20 Schizophrenia
F20.0 Paranoid schizophrenia
F20.1 Hebephrenic schizophrenia
F20.2 Catatonic schizophrenia
F20.3 Undifferentiated schizophrenia
F20.4 Post-schizophrenic depression
F20.5 Residual schizophrenia
F20.6 Simple schizophrenia
F20.8 Other schizophrenia
F20.9 Schizophrenia, unspecified

A fifth character may be used to classify course:
.x0 Continuous
.x1 Episodic with progressive deficit
.x2 Episodic with stable deficit
.x3 Episodic remittent
.x4 Incomplete remission
.x5 Complete remission
.x8 Other
.x9 Course uncertain, period of observation too short

F21 Schizotypal disorder
F22 Persistent delusional disorders
F22.0 Delusional disorder
F22.8 Other persistent delusional disorders
F22.9 Persistent delusional disorder, unspecified

F23 Acute and transient psychotic disorders
F23.0 Acute polymorphic psychotic disorder without symptoms of schizophrenia
F23.1 Acute polymorphic psychotic disorder with symptoms of schizophrenia
F23.2 Acute schizophrenia-like psychotic disorder
F23.3 Other acute predominantly delusional psychotic disorders
F23.8 Other acute and transient psychotic disorders
F23.9 Acute and transient psychotic disorders unspecified

A fifth character may be used to identify the presence or absence of associated acute stress:
.x0 Without associated acute stress
.x1 With associated acute stress

F24 Induced delusional disorder
F25 Schizoaffective disorders
F25.0 Schizoaffective disorder, manic type
F25.1 Schizoaffective disorder, depressive type
F25.2 Schizoaffective disorder, mixed type

F25.8 Other schizoaffective disorders
F25.9 Schizoaffective disorder, unspecified

F28 Other nonorganic psychotic disorders

F29 Unspecified nonorganic psychosis
F30-F39 Mood (affective) disorders
F30 Manic episode
F30.0 Hypomania
F30.1 Mania without psychotic symptoms
F30.2 Mania with psychotic symptoms
F30.8 Other manic episodes
F30.9 Manic episode, unspecified

F31 Bipolar affective disorder
F31.0 Bipolar affective disorder, current episode hypomanic
F31.1 Bipolar affective disorder, current episode manic without psychotic symptoms
F31.2 Bipolar affective disorder, current episode manic with psychotic symptoms
F31.3 Bipolar affective disorder, current episode mild or moderate depression
.x0 Without somatic syndrome
.x1 With somatic syndrome
F31.4 Bipolar affective disorder, current episode severe depression without psychotic symptoms
F31.5 Bipolar affective disorder, current episode severe depression with psychotic symptoms
F31.6 Bipolar affective disorder, current episode mixed
F31.7 Bipolar affective disorder, currently in remission
F31.8 Other bipolar affective disorders
F31.9 Bipolar affective disorder, unspecified

F32 Depressive episode
F32.0 Mild depressive episode
.x0 Without somatic syndrome
.x1 With somatic syndrome
F32.1 Moderate depressive episode
.x0 Without somatic syndrome
.x1 With somatic syndrome
F32.2 Severe depressive episode without psychotic symptoms
F32.3 Severe depressive episode with psychotic symptoms

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F32.8 Other depressive episodes
F32.9 Depressive episode, unspecified
F33 Recurrent depressive disorder
F33.0 Recurrent depressive disorder, current episode mild
.00 Without somatic syndrome
.01 With somatic syndrome
F33.1 Recurrent depressive disorder, current episode moderate
.10 Without somatic syndrome
.11 With somatic syndrome
F33.2 Recurrent depressive disorder, current episode severe without psychotic symptoms
F33.3 Recurrent depressive disorder, current episode severe with psychotic symptoms
F33.4 Recurrent depressive disorder, currently in remission
F33.8 Other recurrent depressive disorders
F33.9 Recurrent depressive disorder, unspecified
F34 Persistent mood [affective] disorders
F34.0 Cyclothymia
F34.1 Dysthymia
F34.8 Other persistent mood [affective] disorders
F34.9 Persistent mood [affective] disorder, unspecified
F38 Other mood [affective] disorders
F38.0 Other single mood [affective] disorders
.00 Mixed affective episode
F38.1 Other recurrent mood [affective] disorders
.10 Recurrent brief depressive disorder
F38.8 Other specified mood [affective] disorders
F39 Unspecified mood [affective] disorder
F40 Phobic anxiety disorders
F40.0 Agoraphobia
.00 Without panic disorder
.01 With panic disorder
F40.1 Social phobias
F40.2 Specific (isolated) phobias
F40.8 Other phobic anxiety disorders
F40.9 Phobic anxiety disorder, unspecified
F41 Other anxiety disorders
F41.0 Panic disorder [episodic paroxysmal anxiety]
F41.1 Generalized anxiety disorder
F41.2 Mixed anxiety and depressive disorder
F41.3 Other mixed anxiety disorders
F41.8 Other specified anxiety disorders
F41.9 Anxiety disorder, unspecified
F42 Obsessive-compulsive disorder
F42.0 Predominantly obsessional thoughts or ruminations
F42.1 Predominantly compulsive acts [obsessional rituals]
F42.2 Mixed obsessional thoughts and acts
F42.8 Other obsessive-compulsive disorders
F42.9 Obsessive-compulsive disorder, unspecified
F43 Reaction to severe stress, and adjustment disorders
F43.0 Acute stress reaction
F43.1 Post-traumatic stress disorder
F43.2 Adjustment disorders
.20 Brief depressive reaction
.21 Prolonged depressive reaction
.22 Mixed anxiety and depressive reaction
.23 With predominant disturbance of other emotions
.24 With predominant disturbance of conduct
.25 With mixed disturbance of emotions and conduct
.28 With other specified predominant symptoms
F43.8 Other reactions to severe stress
F43.9 Reaction to severe stress, unspecified
F44 Dissociative [conversion] disorders
F44.0 Dissociative amnesia
F44.1 Dissociative fugue
F44.2 Dissociative stupor
F44.3 Trance and possession disorders
F44.4 Dissociative motor disorders
F44.5 Dissociative convulsions
F44.6 Dissociative anaesthesia and sensory loss
F44.7 Mixed dissociative [conversion] disorders
F44.8 Other dissociative [conversion] disorders
Cancer's syndrome
Multiple personality disorder
Transient dissociative [conversion] disorders occurring in childhood and adolescence
Other specified dissociated [conversion] disorders
Dissociative [conversion] disorder, unspecified

Somatoform disorders
Somatization disorder
Undifferentiated somatoform disorder
Hypochondriacal disorder
Somatoform autonomic dysfunction
Heart and cardiovascular system
Upper gastrointestinal tract
Lower gastrointestinal tract
Respiratory system
Genitourinary system
Other organ or system
Persistent somatoform pain disorder
Other somatoform disorders
Somatoform disorder, unspecified

Other neurotic disorders
Neurasthenia
Depersonalization-derealization syndrome
Other specified neurotic disorders
Neurotic disorder, unspecified

Behavioural syndromes associated with physiological disturbances and physical factors
Eating disorders
Anorexia nervosa
Atypical anorexia nervosa
Bulimia nervosa
Atypical bulimia nervosa
Overeating associated with other psychological disturbances
Vomiting associated with other psychological disturbances
Other eating disorders
Eating disorder, unspecified

Nonorganic sleep disorders
Nonorganic insomnia
Nonorganic hypersomnia
Nonorganic disorder of the sleep-wake schedule
Sleepwalking [somnambulism]
Sleep terrors [night terrors]
Nightmares
Other nonorganic sleep disorders
Nonorganic sleep disorder, unspecified
Sexual dysfunction, not caused by organic disorder or disease
Lack or loss of sexual desire
Sexual aversion and lack of sexual enjoyment
Sexual aversion
Lack of sexual enjoyment
Failure of genital response
Orgasmic dysfunction
Premature ejaculation
Nonorganic vaginismus
Nonorganic dyspareunia
Excessive sexual drive
Other sexual dysfunction, not caused by organic disorders or disease
Unspecified sexual dysfunction, not caused by organic disorder or disease
Mental and behavioural disorders associated with the puerperium, not elsewhere classified
Mild mental and behavioural disorders associated with the puerperium, not elsewhere classified
Severe mental and behavioural disorders associated with the puerperium, not elsewhere classified
Other mental and behavioural disorders associated with the puerperium, not elsewhere classified
Puerperal mental disorder, unspecified
Psychological and behavioural factors associated with disorders or diseases classified elsewhere
Abuse of non-dependence-producing substances
Antidepressants
Laxatives
Analgescics
Antacids
Vitamins
Steroids or hormones
Specific herbal or folk remedies
Other substances that do not produce dependence
Unspecified
F59  Unspecified behavioural syndromes associated with physiological disturbances and physical factors

F60-F69 Disorders of adult personality and behaviour

F60  Specific personality disorders
F60.0  Paranoid personality disorder
F60.1  Schizoid personality disorder
F60.2  Dissocial personality disorder
F60.3  Emotionally unstable personality disorder
  .30  Impulsive type
  .31  Borderline type
F60.4  Histrionic personality disorder
F60.5  Anankastic personality disorder
F60.6  Anxious [avoidant] personality disorder
F60.7  Dependent personality disorder
F60.8  Other specific personality disorders
F60.9  Personality disorder, unspecified

F61  Mixed and other personality disorders
F61.0  Mixed personality disorders
F61.1  Troublesome personality changes

F62  Enduring personality changes, not attributable to brain damage and disease
F62.0  Enduring personality change after catastrophic experience
F62.1  Enduring personality change after psychiatric illness
F62.8  Other enduring personality changes
F62.9  Enduring personality change, unspecified

F63  Habit and impulse disorders
F63.0  Pathological gambling
F63.1  Pathological fire-setting [pyromania]
F63.2  Pathological stealing [kleptomania]
F63.3  Trichotillomania
F63.8  Other habit and impulse disorders
F63.9  Habit and impulse disorder, unspecified

F64  Gender identity disorders
F64.0  Transsexualism
F64.1  Dual-role transvestism
F64.2  Gender identity disorder of childhood
F64.8  Other gender identity disorders
F64.9  Gender identity disorder, unspecified

F65  Disorders of sexual preference
F65.0  Fetishism
F65.1  Fetishistic transvestism
F65.2  Exhibitionism
F65.3  Voyeurism
F65.4  Paedophilia
F65.5  Sadomasochism
F65.6  Multiple disorders of sexual preference
F65.8  Other disorders of sexual preference
F65.9  Disorder of sexual preference, unspecified

F66  Psychological and behavioural disorders associated with sexual development and orientation
F66.0  Sexual maturation disorder
F66.1  Egodystonic sexual orientation
F66.2  Sexual relationship disorder
F66.8  Other psychosexual development disorders
F66.9  Psychosexual development disorder, unspecified

A fifth character may be used to indicate association with:
  .0  Heterosexuality
  .1  Homosexuality
  .2  Bisexuality
  .8  Other, including prepubertal

F68  Other disorders of adult personality and behaviour
F68.0  Elaboration of physical symptoms for psychological reasons
F68.1  Intentional production or feigning of symptoms or disabilities, either physical or psychological [factitious disorder]
F68.8  Other specified disorders of adult personality and behaviour

F69  Unspecified disorder of adult personality and behaviour

F70-F79 Mental retardation

F70  Mild mental retardation
F71  Moderate mental retardation
F72  Severe mental retardation
F73  Profound mental retardation
F78  Other mental retardation
F79 Unspecified mental retardation

A fourth character may be used to specify the extent of associated behavioural impairment:

F7x.0 No, or minimal, impairment of behaviour
F7x.1 Significant impairment of behaviour requiring attention or treatment
F7x.8 Other impairments of behaviour
F7x.9 Without mention of impairment of behaviour

F80-F89 Disorders of psychological development

F80 Specific developmental disorders of speech and language
F80.0 Specific speech articulation disorder
F80.1 Expressive language disorder
F80.2 Receptive language disorder
F80.3 Acquired aphasia with epilepsy [Landau-Kleffner syndrome]
F80.8 Other developmental disorders of speech and language
F80.9 Developmental disorder of speech and language, unspecified

F81 Specific developmental disorders of scholastic skills
F81.0 Specific reading disorder
F81.1 Specific spelling disorder
F81.2 Specific disorder of arithmetical skills
F81.3 Mixed disorder of scholastic skills
F81.8 Other developmental disorders of scholastic skills
F81.9 Developmental disorder of scholastic skills, unspecified

F82 Specific developmental disorder of motor function

F83 Mixed specific developmental disorders

F84 Pervasive developmental disorders
F84.0 Childhood autism
F84.1 Atypical autism
F84.2 Rett's syndrome
F84.3 Other childhood disintegrative disorder

F84.4 Overactive disorder associated with mental retardation and stereotyped movements
F84.5 Asperger's syndrome
F84.8 Other pervasive developmental disorders
F84.9 Pervasive developmental disorder, unspecified

F88 Other disorders of psychological development

F89 Unspecified disorder of psychological development

F90-F98 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence

F90 Hyperkinetic disorders
F90.0 Disturbance of activity and attention
F90.1 Hyperkinetic conduct disorder
F90.8 Other hyperkinetic disorders
F90.9 Hyperkinetic disorder, unspecified

F91 Conduct disorders
F91.0 Conduct disorder confined to the family context
F91.1 Unsocialized conduct disorder
F91.2 Socialized conduct disorder
F91.3 Oppositional defiant disorder
F91.8 Other conduct disorders
F91.9 Conduct disorder, unspecified

F92 Mixed disorders of conduct and emotions
F92.0 Depressive conduct disorder
F92.8 Other mixed disorders of conduct and emotions
F92.9 Mixed disorder of conduct and emotions, unspecified

F93 Emotional disorders with onset specific to childhood
F93.0 Separation anxiety disorder of childhood
F93.1 Phobic anxiety disorder of childhood
F93.2 Social anxiety disorder of childhood
F93.3 Sibling rivalry disorder
F93.8 Other childhood emotional disorders
F93.9 Childhood emotional disorder, unspecified
F94  Disorders of social functioning with onset specific to childhood and adolescence
    F94.0  Elective mutism
    F94.1  Reactive attachment disorder of childhood
    F94.2  Disinhibited attachment disorder of childhood
    F94.8  Other childhood disorders of social functioning
    F94.9  Childhood disorders of social functioning, unspecified

F95  Tic disorders
    F95.0  Transient tic disorder
    F95.1  Chronic motor or vocal tic disorder
    F95.2  Combined vocal and multiple motor tic disorder [de la Tourette's syndrome]
    F95.8  Other tic disorders
    F95.9  Tic disorder, unspecified

F98  Other behavioural and emotional disorders with onset usually occurring in childhood and adolescence
    F98.0  Nonorganic enuresis
    F98.1  Nonorganic encopresis
    F98.2  Feeding disorder of infancy and childhood
    F98.3  Pica of infancy and childhood
    F98.4  Stereotyped movement disorders
    F98.5  Stuttering [stammering]
    F98.6  Cluttering
    F98.8  Other specified behavioural and emotional disorders with onset usually occurring in childhood and adolescence
    F98.9  Unspecified behavioural and emotional disorders with onset usually occurring in childhood and adolescence

F99  Unspecified mental disorder

F99  Mental disorder, not otherwise specified