



## The ICD-10 Classification of Mental and Behavioural Disorders: Clinical descriptions and diagnostic guidelines

World Health  
Organization

### **F10 - F19**

### **Mental and behavioural disorders due to psychoactive substance use**

#### **Overview of this block**

**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 sedative 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 codes may be used to specify the clinical conditions, as follows:

F1x.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

F1x.1 Harmful use

F1x.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]

F1x.3 Withdrawal state

.30 Uncomplicated

.31 With convulsions

F1x.4 Withdrawal state with delirium

- .40 Without convulsions
- .41 With convulsions
  
- F1x.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
  
- F1x.6 Amnesic syndrome
  
- F1x.7 Residual and late-onset psychotic disorder
  - .70 Flashbacks
  - .71 Personality or behaviour disorder
  - .72 Residual affective behaviour
  - .73 Dementia
  - .74 Other persisting cognitive behaviour
  - .75 Late-onset psychotic disorder
  
- F1x.8 Other mental and behavioural disorders
  
- F1x.9 Unspecified mental and behavioural disorder

## **Introduction**

This block contains a wide variety of disorders that differ in severity (from uncomplicated intoxication and harmful use to obvious psychotic disorders and dementia), but that are all attributable to the use of one or more psychoactive substances (which may or may not have been medically prescribed).

The substance involved is indicated by means of the second and third characters (i.e. the first two digits after the letter F), and the fourth and fifth characters specify the clinical states. To save space, all the psychoactive substances are listed first, followed by the four-character codes; these should be used, as required, for each substance specified, but it should be noted that not all four-character codes are applicable to all substances.

### ***Diagnostic guidelines***

Identification of the psychoactive substance used may be made on the basis of self-report data, objective analysis of specimens of urine, blood, etc, or other evidence (presence of drug samples in the patient's possession, clinical signs and symptoms, or reports from informed third parties). It is always advisable to seek corroboration from more than one source of evidence relating to substance use.

Objective analyses provide the most compelling evidence of present or recent use, though these data have limitations with regard to past use and current levels of use.

Many drug users take more than one type of drug, but the diagnosis of the disorder should be classified, whenever possible, according to the most important single substance (or class of substances) used. This may usually be done with regard to the particular drug, or type of drug,

causing the presenting disorder. When in doubt, code the drug or type of drug most frequently misused, particularly in those cases involving continuous or daily use.

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

Misuse of other than psychoactive substances, such as laxatives or aspirin, should be coded by means of F55. – (abuse of non-dependence-producing substances), with a fourth character to specify the type of substance involved. Cases in which mental disorders (particularly delirium in the elderly) are due to psychoactive substances, but without the presence of one of the disorders in this block (e.g. harmful use or dependence syndrome), should be coded in F00 – F09. Where a state of delirium is superimposed upon such a disorder in this block, it should be coded by means of F1x.3 or F1X.4.

The level of alcohol involvement can be indicated by means of a supplementary code from Chapter XX of ICD-10: Y90. – (evidence of alcohol involvement determined by blood alcohol content) or Y91. – (evidence of alcohol involvement determined by level of intoxication).

### **F1x.0 Acute intoxication**

A transient condition following the administration of alcohol or other psychoactive substance, resulting in disturbances in level of consciousness, cognition, perception, affect or behaviour, or other psychophysiological functions and responses.

This should be a main diagnosis only in cases where intoxication occurs without more persistent alcohol- or drug-related problems being concomitantly present. Where there are such problems, precedence should be given to diagnoses of harmful use (F1x.1), dependence syndrome (F1x.2), or psychotic disorder (F1x.5).

#### ***Diagnostic guidelines***

Acute intoxication is usually closely related to dose levels (see ICD-10, Chapter XX). Exceptions to this may occur in individuals with certain underlying organic conditions (e.g. renal or hepatic insufficiency) in whom small doses of a substance may produce a disproportionately severe intoxicating effect. Disinhibition due to social context should also be taken into account (e.g. behavioural disinhibition at parties or carnivals). Acute intoxication is a transient phenomenon. Intensity of intoxication lessens with time, and effects eventually disappear in the absence of further use of the substance. Recovery is therefore complete except where tissue damage or another complication has arisen.

Symptoms of intoxication need not always reflect primary actions of the substance: for instance, depressant drugs may lead to symptoms of agitation or hyperactivity, and stimulant drugs may lead to socially withdrawn and introverted behaviour. Effects of substances such as cannabis and hallucinogens may be particularly unpredictable. Moreover, many psychoactive substances are capable of producing different types of effect at different levels. For example, alcohol may have apparently stimulant effects on behaviour at lower dose levels, lead to agitation and aggression with increasing dose levels, and produce clear sedation at very high levels.

*Includes:* acute drunkenness in alcoholism  
“bad trips” (due to hallucinogenic drugs)  
drunkenness NOS

*Differential diagnosis.* Consider acute head injury and hypoglycaemia. Consider also the possibilities of intoxication as the result of mixed substance use.

The following five-character codes may be used to indicate whether the acute intoxication was associated with any complications:

**F1x.00 Uncomplicated**

Symptoms of varying severity, usually dose-dependent, particularly at high dose levels.

**F1x.01 With trauma or other bodily injury**

**F1x.02 With other medical complications**

Complications such as haematemesis, inhalation of vomitus.

**F1x.03 With delirium**

**F1x.04 With perceptual distortions**

**F1x.05 With coma**

**F1x.06 With convulsions**

**F1x.07 Pathological intoxication**

Applies only to alcohol. Sudden onset of aggression and often violent behaviour that is not typical of the individual when sober, very soon after drinking amounts of alcohol that would not produce intoxication in most people.

**F1x.1 Harmful use**

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

***Diagnostic guidelines***

The diagnosis requires that actual damage should have been caused to the mental or physical health of the user.

Harmful patterns of use are often criticized by others and frequently associated with adverse social consequences of various kinds. The fact that a pattern of use or a particular substance is disapproved of by another person or by the culture, or may have led to socially negative consequences such as arrest or marital arguments is not in itself evidence of harmful use.

Acute intoxication (see F1x.0), or “hangover” is not itself sufficient evidence of the damage to health required for coding harmful use.

Harmful use should not be diagnosed if dependence syndrome (F1x.2), a psychotic disorder (F1x.5), or another specific form of drug- or alcohol-related disorder is present.

**F1x.2 Dependence syndrome**

A cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value. A central descriptive characteristic of the dependence syndrome is the desire (often strong, sometimes overpowering) to take psychoactive drugs (which may or may not have been medically prescribed), alcohol, or tobacco. There may be evidence that return to substance use after a period of abstinence leads to a more rapid reappearance of other features of the syndrome than occurs with nondependent individuals.

### ***Diagnostic guidelines***

A definite diagnosis of dependence should usually be made only if three or more of the following have been present together at some time during the previous year:

- (a) a strong desire or sense of compulsion to take the substance;
- (b) difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use;
- (c) a physiological withdrawal state (see F1x.3 and F1x.4) when substance use has ceased or been reduced, as evidenced by: the characteristic withdrawal syndrome for the substance; or use of the same (or a closely related) substance with the intention of relieving or avoiding withdrawal symptoms;
- (d) evidence of tolerance, such that increased doses of the psychoactive substances are required in order to achieve effects originally produced by lower doses (clear examples of this are found in alcohol- and opiate-dependent individuals who may take daily doses sufficient to incapacitate or kill nontolerant users);
- (e) progressive neglect of alternative pleasures or interests because of psychoactive substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects;
- (f) persisting with substance use despite clear evidence of overtly harmful consequences, such as harm to the liver through excessive drinking, depressive mood states consequent to periods of heavy substance use, or drug-related impairment of cognitive functioning; efforts should be made to determine that the user was actually, or could be expected to be, aware of the nature and extent of the harm.

Narrowing of the personal repertoire of patterns of psychoactive substance use has also been described as a characteristic feature (e.g. a tendency to drink alcoholic drinks in the same way on weekdays and weekends, regardless of social constraints that determine appropriate drinking behaviour).

It is an essential characteristic of the dependence syndrome that either psychoactive substance taking or a desire to take a particular substance should be present; the subjective awareness of compulsion to use drugs is most commonly seen during attempts to stop or control substance use. This diagnostic requirement would exclude, for instance, surgical patients given opioid drugs for the relief of pain, who may show signs of an opioid withdrawal state when drugs are not given but who have no desire to continue taking drugs.

The dependence syndrome may be present for a specific substance (e.g. tobacco or diazepam), for a class of substances (e.g. opioid drugs), or for a wider range of different substances (as for those individuals who feel a sense of compulsion regularly to use whatever drugs are available and who show distress, agitation, and/or physical signs of a withdrawal state upon abstinence).

*Includes:* chronic alcoholism  
Dipsomania  
Drug addiction

The diagnosis of the dependence syndrome may be further specified by the following five-character codes:

F1x.20 Currently abstinent

F1x.21 Currently abstinent, but in a protected environment  
(e.g. in hospital, in a therapeutic community, in prison, etc.)

F1x.22 Currently on a clinically supervised maintenance or replacement regime [controlled dependence]  
(e.g. with methadone; nicotine gum or nicotine patch)

F1x.23 Currently abstinent, but receiving treatment with aversive or blocking drugs  
(e.g. naltrexone or disulfiram)

F1x.24 Currently using the substance [active dependence]

F1x.25 Continuous use

F1x.26 Episodic use [dipsomani]

### **F1x.3 Withdrawal state**

A group of symptoms of variable clustering and severity occurring on absolute or relative withdrawal of a substance after repeated, and usually prolonged and/or high-dose, use of that substance. Onset and course of the withdrawal state are time-limited and are related to the type of substance and the dose being used immediately before abstinence. The withdrawal state may be complicated by convulsions.

#### ***Diagnostic guidelines***

Withdrawal state is one of the indicators of dependence syndrome (see F1x.2) and this latter diagnosis should also be considered.

Withdrawal state should be coded as the main diagnosis if it is the reason for referral and sufficiently severe to require medical attention in its own right.

Physical symptoms vary according to the substance being used. Psychological disturbances (e.g. anxiety, depression, and sleep disorders) are also common features of withdrawal. Typically, the patient is likely to report that withdrawal symptoms are relieved by further substance use.

It should be remembered that withdrawal symptoms can be induced by conditioned/learned stimuli in the absence of immediately preceding substance use. In such cases a diagnosis of withdrawal state should be made only if it is warranted in terms of severity.

*Differential diagnosis.* Many symptoms present in drug withdrawal state may also be caused by other psychiatric conditions, e.g. anxiety states, and depressive disorders. Simple “hangover” or tremor due to other conditions should not be confused with the symptoms of a withdrawal state.

The diagnosis of withdrawal state may be further specified by using the following five-character codes:

F1x.30 Uncomplicated

F1x.31 With convulsions

#### **F1x.4 Withdrawal state with delirium**

A condition in which the withdrawal state (see F1x.3) is complicated by delirium (see criteria for F05. - ).

Alcohol-induced *delirium tremens* should be coded here. *Delirium tremens* is a short-lived, but occasionally life-threatening, toxic-confusional state with accompanying somatic disturbances. It is usually a consequence of absolute or relative withdrawal of alcohol in severely dependent users with a long history of use. Onset usually occurs after withdrawal of alcohol. In some cases the disorder appears during an episode of heavy drinking, in which case it should be coded here.

Prodromal symptoms typically include insomnia, tremulousness, and fear. Onset may also be preceded by withdrawal convulsions. The classical triad of symptoms includes clouding of consciousness and confusion, vivid hallucinations and illusions affecting any sensory modality, and marked tremor. Delusions, agitation, insomnia or sleep-cycle reversal, and autonomic overactivity are usually also present.

*Excludes:* delirium, not induced by drugs and alcohol (F05. - )

The diagnosis of withdrawal state with delirium may be further specified by using the following five-character codes:

F1x.40 Without convulsions

F1x.41 With convulsions

#### **F1x.5 Psychotic disorder**

A cluster of psychotic phenomena that occur during or immediately after psychoactive substance use and are characterized by vivid hallucinations (typically auditory, but often in more than one sensory modality), misidentifications, delusions and/or ideas of reference (often of a paranoid or persecutory nature), psychomotor disturbances (excitement or stupor), and an abnormal affect, which may range from intense fear to ecstasy. The sensorium is usually clear but some degree of clouding of consciousness, though not severe confusion, may be present. The disorder typically resolves at least partially within 1 month and fully within 6 months.

*Diagnostic guidelines*

A psychotic disorder occurring during or immediately after drug use (usually within 48 hours) should be recorded here provided that it is not a manifestation of drug-withdrawal state with delirium (see F1x.4) or of late onset. Late-onset psychotic disorders (with onset more than 2 weeks after substance use) may occur, but should be coded as F1x.75.

Psychoactive substance-induced psychotic disorders may present with varying patterns of symptoms. These variations will be influenced by the type of substance involved and the personality of the user. For stimulant drugs such as cocaine and amphetamines, drug-induced psychotic disorders are generally closely related to high dose levels and/or prolonged use of the substance.

A diagnosis of psychotic disorder should not be made merely on the basis of perceptual distortions or hallucinatory experiences when substances having primary hallucinogenic effects (e.g. lysergic (LSD), mescaline, cannabis at high doses) have been taken. In such cases, and also for confusional states, a possible diagnoses of acute intoxication (F1x.0) should be considered.

Particular care should also be taken to avoid mistakenly diagnosing a more serious condition (e.g. schizophrenia) when a diagnosis of psychoactive substance-induced psychosis is appropriate. Many psychoactive substance-induced psychotic states are of short duration provided that no further amounts of the drug are taken (as in the case of amphetamine and cocaine psychoses). False diagnosis in such cases may have distressing and costly implications for the patient and for the health services.

*Includes:* alcoholic hallucinosis  
alcoholic jealousy  
alcoholic paranoia  
alcoholic psychosis NOS

*Differential diagnosis.* Consider the possibility of another mental disorder being aggravated or precipitated by psychoactive substance use (e.g. schizophrenia (F20. - ); mood [affective] disorder (F30-F39); paranoid or schizoid personality disorder (F60.0, F60.1). In such cases, a diagnosis of psychoactive substance-induced psychotic state may be inappropriate.

The diagnosis of psychotic state may be further specified by the following five-character codes:

F1x.50 Schizophrenia-like

F1x.51 Predominantly delusional

F1x.52 Predominantly hallucinatory  
(includes alcoholic hallucinosis)

F1x.53 Predominantly polymorphic

F1x.54 Predominantly depressive symptoms

F1x.55 Predominantly manic symptoms

F1x.56 Mixed



## **F1x.6 Amnesic syndrome**

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

### ***Diagnostic guidelines***

Amnesic syndrome induced by alcohol or other psychoactive substances coded here should meet the general criteria for organic amnesic syndrome (see F04). The primary requirements for this diagnosis are:

- (a) memory impairment as shown in impairment of recent memory (learning of new material); disturbances of time sense (rearrangements of chronological sequence, telescoping of repeated events into one, etc.);
- (b) absence of defect in immediate recall, impairment of consciousness, and of generalized cognitive impairment;
- (c) history or objective evidence of chronic (and particularly high-dose) use of alcohol or drugs.

Personality changes, often with apparent apathy and loss of initiative, and a tendency towards self-neglect may also be present, but should not be regarded as necessary conditions for diagnosis.

Although confabulation may be marked it should not be regarded as a necessary prerequisite for diagnosis.

*Includes:* Korsakov's psychosis or syndrome, alcohol- or other psychoactive substance-induced.

*Differential diagnosis.* Consider: organic amnesic syndrome (nonalcoholic) (see F04); other organic syndromes involving marked impairment of memory (e.g. dementia or delirium) (F00-F03; F05. - ); a depressive disorder (F31 – F33).

## **F1x.7 Residual and late-onset psychotic disorder**

A disorder in which alcohol- or psychoactive substance-induced changes of cognition, affect, personality, or behaviour persist beyond the period during which a direct psychoactive substance-related effect might reasonably be assumed to be operating.

### ***Diagnostic guidelines***

Onset of the disorder should be directly related to the use of alcohol or a psychoactive substance. Cases in which initial onset occurs later than episode(s) of substance use should be coded here only where clear and strong evidence is available to attribute the state to the residual effect of the substance. The disorder should represent a change from or marked exaggeration of prior and normal state of functioning.

The disorder should persist beyond any period of time during which direct effects of the psychoactive substance might be assumed to be operative (see F1x.0, acute intoxication). Alcohol- or psychoactive substance-induced dementia is not always

irreversible; after an extended period of total abstinence, intellectual functions and memory may improve.

The disorder should be carefully distinguished from withdrawal-related conditions (see F1x.3 and F1x.4). It should be remembered that, under certain conditions and for certain substances, withdrawal state phenomena may be present for a period of many days or weeks after discontinuation of the substance.

Conditions induced by a psychoactive substance, persisting after its use, and meeting the criteria for diagnosis of psychotic disorder should not be diagnosed here (use F1x.5, psychotic disorder). Patients who show the chronic end-state of Korsakov's syndrome should be coded under F1x.6.

*Differential diagnosis.* Consider: pre-existing mental disorder masked by substance use and re-emerging as psychoactive substance-related effects fade (for example, phobic anxiety, a depressive disorder, schizophrenia, or schizotypal disorder). In the case of flashbacks, consider acute and transient psychotic disorders (F23. - ). Consider also organic injury and mild or moderate mental retardation (F70 – F71), which may coexist with psychoactive substance misuse. This diagnostic rubric may be further subdivided by using the following five-character codes:

#### **F1x.70 Flashbacks**

May be distinguished from psychotic disorders partly by their episodic nature, frequently of very short duration (seconds or minutes) and by their duplication (sometimes exact) of previous drug-related experiences.

#### **F1x.71 Personality or behaviour disorder**

Meeting the criteria for organic personality disorder (F07.0).

#### **F1x.72 Residual affective disorder**

Meeting the criteria for organic mood [affective] disorders (F06.3).

#### **F1x.73 Dementia**

Meeting the general criteria for dementia as outlined in the introduction to F00-F09.

#### **F1x.74 Other persisting cognitive impairment**

A residual category for disorders with persisting cognitive impairment, which do not meet the criteria for psychoactive substance-induced amnesic syndrome (F1x.6) or dementia (F1x.73).

#### **F1x.75 Late-onset psychotic disorder**

### **F1x.8 Other mental and behavioural disorders**

Code here any other disorder in which the use of a substance can be identified as contributing directly to the condition, but which does not meet the criteria for inclusion in any of the above disorders.

### **F1x.9 Unspecified mental and behavioural disorder**