ICD-11 Clinical Descriptions and Diagnostic Requirements

Disorders Due to Substance Use

Note: *This document contains a pre-publication version of the ICD-11 Clinical Descriptions and Diagnostic Requirements for Disorders Due to Substance Use, which is part of the grouping of Disorders Due to Substance Use or Addictive Behaviours. This document will be proofread for consistency with WHO style and edits made accordingly prior to its publication.*

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DISORDERS DUE TO SUBSTANCE USE

Disorders Due to Substance Use include disorders that result from a single occasion or repeated use of substances that have psychoactive properties, including certain medications. Disorders related to fourteen classes or groups of psychoactive substances that have important clinical and public health consequences are included, and categories are also available for other specified substances.

Typically, initial use of these substances produces pleasant or appealing psychoactive effects that are rewarding and reinforcing with repeated use. With continued use, many of the included substances have the capacity to produce dependence. They also have the potential to cause numerous forms of harm, both to mental and physical health. Disorders due to harmful non-medical use of non-psychoactive substances (e.g., laxatives, growth hormone, erythropoietin, and non-steroidal anti-inflammatory drugs) are also included in this grouping.

General Cultural Considerations for Disorders Due to Substance Use

- Use of psychoactive substances is influenced by strong cultural meanings and traditions, which may impact the risk for development of a Disorder Due to Substance Use. The cultural milieu in which the substance is used should be considered when determining risk and the presence or absence of pathology. For example, substances may be used regularly as part of religious rituals, celebrations (e.g., New Year's Eve), culturally sanctioned mystical experiences, specific events (e.g., wakes preceding funerals), or healing activities without resulting in a Disorder Due to Substance Use.
- Cultural values and interpretations related to the use of psychoactive substances in specific communities, and cultural terms used to describe the substance and its effects, vary greatly across cultures. Knowledge of specific terms and interpretations will improve communication with patients and determination of possible disorder. For example, traditional American Indians who use peyote during worship ceremonies may consider the substance a sacrament rather than a drug.
- Local availability of a substance affects the prevalence of disorders associated with it. For example, prevalence of Alcohol Dependence is lower in predominantly Muslim countries due to the religious prohibitions against alcohol consumption.
- Immigration may affect the person's pattern of substance use due to culture change, including gender roles. This change can lead to higher or lower risk of Disorders Due to Substance Use depending on the characteristics of the sending and receiving societies, the circumstances of migration, and the relative social position in each setting. For example, immigrants moving from a society with high alcohol consumption to one with low alcohol consumption tend to assume the lower risk of disorder of the host country.

Substance Classes

Disorders Due to Substance Use are classified by first identifying the substance used. Available substance classes included are listed below with a brief description of their properties, typical preparations and methods of use, as well as associated harms and disorders:

6C40 Disorders Due to Use of Alcohol

Disorders Due to Use of Alcohol are characterized by the pattern and consequences of alcohol use. Alcohol—more specifically termed ethyl alcohol or ethanol—is an intoxicating compound produced by fermentation of sugars usually in agricultural products such as fruits, cereals, and vegetables with or without subsequent distillation. There are a wide variety of alcoholic drinks, with alcohol concentrations typically ranging from 1.5% to 60%. Alcohol is predominantly a central nervous system depressant. Unlike most other substances, elimination of alcohol from the body occurs at a constant rate, such that its clearance follows a linear rather than a logarithmic course. In addition to ability to produce Alcohol Intoxication, alcohol has dependence-producing properties, resulting in Alcohol Dependence in some people and Alcohol Withdrawal when alcohol use is reduced or discontinued.

Alcohol is implicated in a wide range of harms affecting most organs and systems of the body (e.g., cirrhosis of the liver, gastrointestinal cancers, pancreatitis). Harm to others resulting from behaviour during Alcohol Intoxication is well recognized and is included in the definitions of harmful use of alcohol (i.e., Episode of Harmful Use of Alcohol and Harmful Pattern of Use of Alcohol). Several alcohol-induced mental disorders (e.g., Alcohol-Induced Psychotic Disorder) and alcohol-related forms of neurocognitive impairment (e.g., Dementia Due to Use of Alcohol) are recognized.

Alcohol use is one of the most common causes of premature death and illness among men and is still a substantial, though less common, cause of premature death and illness among women. The use of alcohol is implicated in millions of deaths per year (e.g., due to motor vehicle accidents).

Although alcohol is used worldwide and its use is legal among adults in most countries, there are substantial differences in cultural and religious acceptability of its use. Consequently, prevalence of alcohol use disorders shows substantial regional variation; the highest prevalence is observed in Eastern Europe and the lowest in Africa. Low prevalence of alcohol use in some countries is related to lower rates of Disorders Due to Use of Alcohol.

Polymorphisms of the genes for the alcohol-metabolizing enzymes alcohol dehydrogenase (ADH1B) and aldehyde dehydrogenase are seen more frequently in East Asians than other groups and affect the response to alcohol. Individuals with certain polymorphisms may develop facial flushing and palpitations when consuming alcohol, which may be so severe as to preclude alcohol consumption and thus lower the risk of alcohol use disorder.

6C41 Disorders Due to Use of Cannabis

Disorders Due to Use of Cannabis are characterized by the pattern and consequences of cannabis use. Cannabis is the collective term for a range of psychoactive preparations of the cannabis plant, *Cannabis sativa*, and related species and hybrids. Cannabis contains cannabinoids, a class of diverse chemical compounds that act on endogenous cannabinoid receptors that modulate neurotransmitter release in the brain. The principal psychoactive cannabinoid is δ-9-tetrahydrocannabinol (THC). Cannabis is typically smoked in the form of the flowering heads or leaves of the marijuana

plant; tobacco is often mixed with cannabis when smoked. There are also cannabis oils that are prepared from these same sources. These preparations vary considerably in their THC potency. Cannabis has predominantly central nervous system depressant effects and produces a characteristic euphoria that may be part of the presenting features of Cannabis Intoxication, which may also include impairment in cognitive and psychomotor functioning. Cannabis has dependence-producing properties resulting in Cannabis Dependence in some people and Cannabis Withdrawal when use is reduced or discontinued. Cannabis is associated with a range of Cannabis-Induced Mental Disorders. Other medical conditions are also associated with cannabis use, including some respiratory and cardiovascular diseases.

Cannabis is the most commonly used illicit drug worldwide but its legal status varies considerably; in certain countries it is legally available for medicinal or personal use. Acceptance of cannabis use also for recreational or medical purposes also varies widely by culture. Variations in legal status and cultural acceptability are related to differential consequences for detection of use (e.g., arrest, school suspensions, or employment suspension), affecting the probability the person may seek treatment.

6C42 Disorders Due to Use of Synthetic Cannabinoids

Disorders Due to Use of Synthetic Cannabinoids are characterized by the pattern and consequences of synthetic cannabinoid use. Synthetic cannabinoids are synthesized diverse chemical compounds that are potent agonists for endogenous cannabinoid receptors. There are several hundred such compounds. The synthetic compound is typically sprayed onto a vehicle such as cannabis or tea leaves and then smoked. The effect of these compounds is distinctly different from smoking naturally cultivated cannabis in that the euphoric effects are typically accompanied or dominated by psychotic-like symptoms (e.g., paranoia, hallucinations, and disorganized behaviour). Synthetic Cannabinoid Intoxication may therefore present more frequently with psychotic symptoms in addition to the more typical effects of cannabis. Synthetic cannabinoids are also dependence-producing and Synthetic Cannabinoid Dependence and Synthetic Cannabinoid Withdrawal are recognized. Synthetic Cannabinoid-Induced Mental Disorders also occur; in particular Synthetic Cannabinoid-Induced Psychotic Disorder is recognized. Much less is known about the effects of these drugs on other body organs and systems than is the case for naturally cultivated cannabis.

6C43 Disorders Due to Use of Opioids

Disorders Due to Use of Opioids are characterized by the pattern and consequences of opioid use. Opioids is a generic term that encompasses the constituents or derivatives of the opium poppy *Papaver somniferum* as well as a range of synthetic and semisynthetic compounds, some related to morphine and others chemically distinct but all having their primary actions on the μ opioid receptor. Examples of opioids include morphine, diacetylmorphine (heroin), fentanyl, pethidine, oxycodone, hydromorphone, methadone, buprenorphine, codeine and d-propoxyphene. The opioids all have analgesic properties of different potencies and are primarily central nervous system depressants. They suppress respiration as well as other vital functions and are a common cause of overdose and related deaths. Certain opioids are used or administered parenterally, including heroin, a common and potent opioid that is primarily used non-medically. Therapeutic opioids are prescribed for a range of

indications worldwide, and are essential for pain management in cancer pain and palliative care, although they are also used for non-therapeutic reasons. In some countries morbidity and mortality related to therapeutic opioids is greater than that related to heroin. All opioids may result in Opioid Intoxication, Opioid Dependence and Opioid Withdrawal. A range of Opioid-Induced Disorders occur, some of which occur following Opioid Withdrawal. Because certain opioids are commonly injected illicitly, their use is a potent mechanism of transmission of blood borne viral infections such as hepatitis B, hepatitis C and HIV/AIDS, as well as bacterial infections. Not including alcohol and tobacco, opioids are the most common cause of death from psychoactive drug use worldwide.

6C44 Disorders Due to Use of Sedatives, Hypnotics or Anxiolytics

Disorders Due to Use of Sedatives, Hypnotics or Anxiolytics are characterized by the pattern and consequences of use of these substances. Sedatives, hypnotics, and anxiolytics are typically prescribed for the short-term treatment of anxiety or insomnia and are also employed to provide sedation for medical procedures. They include the benzodiazepines and the non-benzodiazepine positive allosteric modulators of GABA receptors (i.e., 'Z-drugs') as well as many other compounds. Sedatives, hypnotics, and anxiolytics include barbiturates, which are available much less commonly now than in previous decades. Sedatives, hypnotics, and anxiolytics have dependence-inducing properties that are related to the dose and duration of their use. They may cause intoxication, dependence and withdrawal. Several other mental disorders induced by sedatives, hypnotics, or anxiolytics are recognized.

6C45 Disorders Due to Use of Cocaine

Disorders Due to Use of Cocaine are characterized by the pattern and consequences of cocaine use. Cocaine is a compound found in the leaves of the coca plant, *Erythroxylum coca*, which is indigenous to countries in northern regions of South America. Cocaine has a limited place in medical treatment as an anaesthetic and vasoconstrictive agent. It is commonly used illicitly and widely available across the world, where it is found in two main forms: cocaine hydrochloride and cocaine freebase (also known as 'crack'). Cocaine is a central nervous system stimulant, and Cocaine Intoxication typically includes a state of euphoria and hyperactivity. Cocaine has potent dependence-producing properties and Cocaine Dependence is a common cause of morbidity and of clinical presentations. Cocaine Withdrawal has a characteristic course that includes lethargy and depressed mood. A range of Cocaine-Induced Mental Disorders is described. Cocaine is also associated with several health sequelae, including myocardial infarction and stroke arising from coronary and cerebral artery spasm, respectively.

6C46 Disorders Due to Use of Stimulants including Amphetamines, Methamphetamine or Methcathinone

Disorders Due to Use of Stimulants including Amphetamines, Methamphetamine or Methcathinone are characterized by the pattern and consequences of use of these substances. There is a wide array of naturally occurring and synthetically produced psychostimulants other than cocaine. The most numerous of this group are the amphetamine-type substances, including methamphetamine. Prescribed stimulants

including dexamphetamine are indicated for a limited number of conditions such as for Attention Deficit Hyperactivity Disorder. Methcathinone, known in many countries as ephedrone, is a synthetic potent stimulant that is a structural analogue of methamphetamine and is related to cathinone. All these drugs have primarily psychostimulant properties and are also vasoconstrictors to a varying degree. They induce euphoria and hyperactivity as may be seen in Stimulant Intoxication. They have potent dependence-producing properties, which may lead to the diagnosis of Stimulant Dependence and Stimulant Withdrawal following the cessation of use. Several Stimulant-Induced Mental Disorders are described. Stimulants are a widespread cause of hospitalization and clinic attendance, and significant causes of morbidity and mortality, often due to violence related to Stimulant-Induced Psychotic Disorder.

6C47 Disorders Due to Use of Synthetic Cathinones

Disorders Due to Use of Synthetic Cathinones are characterized by the pattern and consequences of synthetic cathinone use. Synthetic cathinones (also known as 'bath salts') are synthetic compounds with stimulant properties related to cathinone found in the khat plant, *Catha edulis*. The use of synthetic cathinones is common in young populations in many countries. They may produce a range of disorders including Synthetic Cathinone Intoxication, Synthetic Cathinone Dependence and Synthetic Cathinone Withdrawal. Several Synthetic Cathinone-Induced Mental Disorders are recognised.

6C48 Disorders Due to Use of Caffeine

Disorders Due to Use of Caffeine are characterized by the pattern and consequences of caffeine use. Caffeine is a mild psychostimulant and diuretic that is found in the beans of the coffee plant (*Coffea* species) and is a constituent of coffee, cola drinks, chocolate, a range of proprietary 'energy drinks' and weight-loss aids. It is the most commonly used psychoactive substance worldwide and several clinical conditions related to its use are described, although severe disorders are comparatively rare considering its ubiquity. Caffeine Intoxication related to consumption of relatively higher doses (i.e., > 1 g per day) is described. Caffeine Withdrawal is common upon cessation of use among individuals who have used caffeine for a prolonged period or in large amounts. Caffeine-Induced Anxiety Disorder has been described, often following intoxication or heavy use.

6C49 Disorders Due to Use of Hallucinogens

Disorders Due to Use of Hallucinogens are characterized by the pattern and consequences of hallucinogen use. Several thousand compounds have hallucinogenic properties, many of which are found in plants (e.g., mescaline) and fungi (e.g., psilocybin) or are chemically synthesized (e.g., lysergic acid diethylamide [LSD]). These compounds have primarily hallucinogenic properties, but some may also be stimulants. Much of the morbidity associated with these compounds arises from the acute effects related to Hallucinogen Intoxication. Hallucinogen Dependence is rare and Hallucinogen Withdrawal is not described. Among the mental disorders related to hallucinogen use, Hallucinogen-Induced Psychotic Disorder is the most frequently seen, although worldwide it is still fairly uncommon.

6C4A Disorders Due to Use of Nicotine

Disorders Due to Use of Nicotine are characterized by the pattern and consequences of nicotine use. Nicotine is the active dependence-producing constituent of the tobacco plant, *Nicotiana tabacum*. Nicotine is used overwhelmingly through smoking cigarettes. Increasingly, it is also used in electronic cigarettes that vaporize nicotine dissolved in a carrier solvent for inhalation (i.e., 'vaping'). Pipe smoking, chewing tobacco and inhaling snuff are minor forms of use. Nicotine is a highly potent addictive compound and is the third most common psychoactive substance used worldwide after caffeine and alcohol. Nicotine Dependence and Nicotine Withdrawal are well described and Nicotine-Induced Mental Disorders are recognized. Tobacco, due to its addictive constituent nicotine, is by far the most important cause worldwide of morbidity and mortality of all the psychoactive substances and this is due in part to nicotine but more so to other constituents such as carcinogens and other hazardous and harmful compounds that are inhaled during smoking. Tobacco smoking is the leading cause of ill health and premature death among men and among the top ten causes in women.

6C4B Disorders Due to Use of Volatile Inhalants

Disorders Due to Use of Volatile Inhalants are characterized by the pattern and consequences of volatile inhalant use. Volatile inhalants include a range of compounds that are in the gaseous or vapour phase at ambient temperatures and include various organic solvents, glues, gasoline (petrol), nitrites and gases such as nitrous oxide, trichloroethane, butane, toluene, fluorocarbons, ether and halothane. They have a range of pharmacological properties but are predominantly central nervous system depressants, with many also having vasoactive effects. They tend to be used by younger persons and may be used when access to alternative psychoactive substances is difficult or impossible. Volatile Inhalant Intoxication is well recognized. Volatile inhalants have dependence-producing properties and Volatile Inhalant Dependence and Volatile Inhalant Withdrawal are recognized although comparatively uncommon worldwide. Volatile Inhalant-Induced Mental Disorders are described. They may also cause neurocognitive impairment, including Dementia.

6C4C Disorders Due to Use of MDMA or Related drugs, including MDA

Disorders Due to Use of MDMA or Related Drugs, including MDA are characterized by the pattern and consequences of MDMA or related drug use. MDMA is methylene-dioxymethamphetamine and is a common drug of abuse in many countries especially among young people. It is predominantly available in tablet form known as 'ecstasy'. Pharmacologically, MDMA has stimulant and empathogenic properties and these encourage its use among young people for social and other interactions. Considering its wide prevalence in many countries and among many sub-groups of young people, MDMA and Related Drug Dependence and MDMA and Related Drug Withdrawal are comparatively uncommon. Substance-Induced Mental Disorders may arise from its use and health sequelae are recognized, including liver disease and hyponatraemia, which may be fatal. Several analogues of MDMA exist, including MDA (methylene-dioxyamphetamine).

6C4D Disorders Due to Use of Dissociative Drugs including Ketamine and Phencyclidine (PCP)

Disorders Due to Use of Dissociative Drugs including Ketamine and Phencyclidine (PCP) are characterized by the pattern and consequences of dissociative drug use. Dissociative drugs include ketamine and phencyclidine (PCP) and their (comparatively rare) chemical analogues. Ketamine is an intravenous anaesthetic widely used in low- and middle-income countries, particularly in Africa, and in emergency situations. Ketamine is also undergoing evaluation for treatment of some mental disorders (e.g., treatment resistant Depressive Disorders). It is also a widespread drug of nonmedical use in many countries and may be taken by the oral or nasal routes or injected. It produces a sense of euphoria but depending on the dose, emergent hallucinations and dissociation are recognised as unpleasant side effects. Phencyclidine has a more restricted worldwide distribution and also has euphoric and dissociative effects. Its use may result in bizarre behaviour uncharacteristic for the individual, including self-harm. Dissociative Drug Dependence is described but a withdrawal syndrome is not recognized by most authorities. Several Dissociative Drug-Induced Mental Disorders are recognized.

6C4E Disorders Due to Use of Other Specified Psychoactive Substances, including Medications

Disorders Due to Use of Other Specified Psychoactive Substances, including Medications are characterized by the pattern and consequences of psychoactive substances that are not included among the major substance classes specifically identified above. Examples include khat, anabolic steroids, corticosteroids, antidepressants, medications with anticholinergic properties (e.g., benztropine), and some antihistamines.

6C4F Disorders Due to Use of Multiple Specified Psychoactive Substances, including Medications

The categories in this grouping are provided for coding purposes. However, in most clinical situations it is recommended that multiple categories from Disorders Due to Substance Use be assigned if these can be discerned rather than using categories from this grouping. Doing so will provide more useful information for both clinical and coding purposes.

6C4G Disorders Due to Use of Unknown or Unspecified Psychoactive Substances

These categories apply in clinical situations in which it is clear that the disturbance is due to substance use but the specific substance or class of substances is unknown. As more information becomes available (e.g., laboratory results, report from a collateral informant) the diagnosis should be changed to indicate the relevant substance or substance class.

6C4H Disorders Due to Use of Non-Psychoactive Substances

Disorders due to use of non-psychoactive substances are characterized by the pattern and consequences of non-medical use of non-psychoactive substances. Non-

psychoactive substances include laxatives, growth hormone, erythropoietin, and non-steroidal anti-inflammatory drugs. They may also include proprietary or over-the-counter medicines and folk remedies. Non-medical use of these substances may be associated with harm to the individual due to the direct or secondary toxic effects of the non-psychoactive substance on body organs and systems, or a harmful route of administration (e.g., infections due to intravenous self-administration). They are not associated with intoxication or with a dependence or withdrawal syndrome and are not recognized causes of Substance-Induced Mental Disorders.

Diagnostic Categories that Apply to the Various Classes of Psychoactive Substances

Following is a list of specific diagnostic categories of that apply to the classes of psychoactive substances listed above:

- Episode of Harmful Psychoactive Substance Use
- Harmful Pattern of Psychoactive Substance Use
- Substance Dependence
- Substance Intoxication
- Substance Withdrawal
- Substance-Induced Delirium
- Substance-Induced Psychotic Disorder
- Substance-Induced Mood Disorder
- Substance-Induced Anxiety Disorder
- Substance-Induced Obsessive-Compulsive or Related Disorder
- Substance-Induced Impulse Control Disorder
- Other Specified Disorder Due to Substance Use
- Disorder Due to Substance Use, Unspecified

Additional categories of disorders induced by psychoactive substances are included in other parts of the ICD-11 chapter on Mental, Behavioural, and Neurodevelopmental Disorders. These categories relate to substance-induced catatonia, substance-induced amnestic disorder, and substance-induced dementia. They are cross-listed in the section below on Substance-Induced Mental Disorders for reference.

Note that not all possible combinations of disorder and substance class are included in the classification. For example, there is no category for Substance Withdrawal Due to Dissociative Drugs including Ketamine and PCP and no category for Nicotine-Induced Psychotic Disorder. Allowable categories by substance class for Episode of Harmful Psychoactive Substance Use, Harmful Pattern of Psychoactive Substance Use, Substance Dependence, Substance Intoxication, and Substance Withdrawal are shown in Table 6.13 (p. _). Allowable categories by substance class for Substance-Induced Mental Disorders (Substance-Induced Delirium, Substance-Induced Psychotic Disorder, Substance-Induced Mood Disorder, Substance-Induced Anxiety Disorder, Substance-Induced Obsessive-Compulsive or Related Disorder, and Substance-Induced Impulse Control Disorder) are shown in Table 6.14 (p. _).

CDDR are provided below for each type of disorder together with a list of applicable substance classes. Information specific to particular substance classes is also provided when applicable.

The first three diagnoses listed above (Episode of Harmful Psychoactive Substance Use, Harmful Pattern of Psychoactive Substance Use, and Substance Dependence) describe the use pattern of the substance. One of these three diagnoses, or Disorder Due to Substance Use, Unspecified, for cases in which the use pattern in unknown at the time of evaluation, is considered to be the primary diagnosis. That is, one of these four diagnoses should be assigned when making a diagnosis of a Disorder Due to Substance Use.

The remaining diagnoses reflect the impact of the substance use pattern and are thus considered to be associated with one of the primary use pattern diagnoses. These diagnoses should therefore be assigned together with the relevant primary diagnosis. For example, 6C49.1/ 6C49.5 is Harmful Pattern of Use of Hallucinogens associated with Hallucinogen-Induced Psychotic Disorder, 6C43.2/6C43.70 is Opioid Dependence associated with Opioid-Induced Mood Disorder, 6C4Z/6C40.3 is Disorders Due to Substance Use, Unspecified associated with Alcohol Intoxication (i.e., the pattern of use in this last case is unknown).

Also listed in this section of the manual are categories related to Hazardous Substance Use. These Hazardous Substance Use categories are not considered to be mental disorders, but may be used when the pattern of substance use appreciably increases the risk of harmful physical or mental health consequences to the user or to others to an extent that warrants attention and advice from health professionals, but no overt harm has yet occurred.

Table 6.13: Applicable Disorders Due to Substance Use by Substance Class

	Episode of Harmful Psychoactive Substance Use	Harmful Pattern of Psychoactive Substance Use [1]	Substance Dependence [2]	Substance Intoxication	Substance Withdrawal [3]
Alcohol	6C40.0	6C40.10 E 6C40.11 C	6C40.20 C 6C40.21 E 6C40.22 eF 6C40.23 sP 6C40.24 SF	6C40.3	6C40.40 U 6C40.41 PD 6C40.42 S 6C40.43 PD&S
Cannabis	6C41.0	6C41.10 E 6C41.11 C	6C41.20 C 6C41.21 eF 6C41.22 SP 6C41.23 SF	6C41.3	6C41.4
Synthetic Cannabinoids	6C42.0	6C42.10 E 6C42.11 C	6C42.20 C 6C42.21 eF 6C42.22 SP 6C42.23 SF	6C42.3	6C41.4
Opioids	6C43.0	6C43.10 E 6C43.11 C	6C43.20 C 6C43.21 eF 6C43.22 SP 6C43.23 SF	6C43.3	6C43.4
Sedatives, hypnotics or anxiolytics	6C44.0	6C44.10 E 6C44.11 C	6C44.20 C 6C44.21 eF 6C44.22 SP 6C44.23 SF	6C44.3	6C44.40 U 6C44.41 PD 6C44.42 S 6C44.43 PD&S
Cocaine	6C45.0	6C45.10 E 6C45.11 C	6C45.20 C 6C45.21 eF 6C45.22 SP 6C45.23 SF	6C45.3	6C45.4
Stimulants including amphetamine, methamphetamine or methcathinone	6C46.0	6C46.10 E 6C46.11 C	6C46.20 C 6C46.21 eF 6C46.22 SP 6C46.23 SF	6C46.3	6C46.4
Synthetic Cathinones	6C47.0	6C47.10 E 6C47.11 C	6C47.20 C 6C47.21 eF 6C47.22 SP 6C47.23 SF	6C47.3	6C47.4
Caffeine	6C48.0	6C48.10 E 6C48.11 C	N/A	6C48.2	6C48.3
Hallucinogens	6C49.0	6C49.10 E 6C49.11 C	6C49.20 C 6C49.21 eF 6C49.22 SP 6C49.23 SF	6C49.3	N/A
Nicotine	6C4A.0	6C4A.10 E 6C4A.11 C	6C4A.20 C 6C4A.21 eF 6C4A.22 SP 6C4A.23 SF	6C4A.3	6C4A.4
Volatile inhalants	6C4B.0	6C4B.10 E 6C4B.11 C	6C4B.20 C 6C4B.21 eF 6C4B.22 SP 6C4B.23 SF	6C4B.3	6C4B.4

	Episode of Harmful Psychoactive Substance Use	Harmful Pattern of Psychoactive Substance Use [1]	Substance Dependence [2]	Substance Intoxication	Substance Withdrawal [3]
MDMA or related drugs, including MDA	6C4C.0	6C4C.10 E 6C4C.11 C	6C4C.20 C 6C4C.21 eF 6C4C.22 SP 6C4C.23 SF	6C4C.3	6C4C.4
Dissociative drugs including ketamine and PCP	6C4D.0	6C4D.10 E 6C4D.11 C	6C4D.20 C 6C4D.21 eF 6C4D.22 SP 6C4D.23 SF	6C4D.3	N/A
Other specified	6C4E.0	6C4E.10 E 6C4E.11 C	6C4E.20 C 6C4E.21 eF 6C4E.22 SP 6C4E.23 SF	6C4E.3	6C4E.40 U 6C4E.41 PD 6C4E.42 S 6C4E.43 PD&S
Multiple specified	6C4F.0	6C4F.10 E 6C4F.11 C	6C4F.20 C 6C4F.21 eF 6C4F.22 SP 6C4F.23 SF	6C4F.3	6C4F.40 U 6C4F.41 PD 6C4F.42 S 6C4F.43 PD&S
Unknown or unspecified	6C4G.0	6C4G.10 E 6C4G.11 C	6C4G.20 C 6C4G.21 eF 6C4G.22 SP 6C4G.23 SF	6C4G.3	6C4G.40 U 6C4G.41 PD 6C4G.42 S 6C4G.43 PD&S
Non-psychoactive	6C4H.0	6C4H.10 E 6C4H.11 C	N/A	N/A	N/A

[1] E = Episodic; C = Continuous

[2] E = Episodic; C = Continuous; eF = Early Full Remission; Sp = Sustained Partial Remission; SF = Sustained Full Remission

[3] U = Uncomplicated; PD = with Perceptual Disturbances; S = with Seizures; PD&S = with Perceptual Disturbances and Seizures

Table 6.14: Applicable Substance-Induced Mental Disorders by Substance Class

	Delirium	[1]Psychotic	Mood	Anxiety	Obsessive-Compulsive	Impulse Control	Amnestic	Dementia
Alcohol	6C40.5	6C40.60 H 6C40.61 D 6C40.62 M	6C40.70	6C40.71	N/A	N/A	6D72.10	6D84.0
Cannabis	6C41.5	6C41.6	6C41.70	6C41.71	N/A	N/A	N/A	N/A
Synthetic Cannabinoids	6C42.5	6C42.6	6C42.70	6C42.71	N/A	N/A	N/A	N/A
Opioids	6C43.5	6C43.6	6C43.70	6C43.71	N/A	N/A	N/A	N/A
Sedatives, hypnotics or anxiolytics	6C44.5	6C44.6	6C44.70	6C44.71	N/A	N/A	6D72.11	6D84.1
Cocaine	6C45.5	6C45.60 H 6C45.61 D 6C45.62 M	6C45.70	6C45.71	6C45.72	6C45.73	N/A	N/A
Stimulants including amphetamine, methamphetamine or methcathinone	6C46.5	6C46.60 H 6C46.61 D 6C46.62 M	6C46.70	6C46.71	6C46.72	6C46.73	N/A	N/A
Synthetic Cathinones	6C47.5	6C47.60 H 6C47.61 D 6C47.62 M	6C47.70	6C47.71	6C47.72	6C47.73	N/A	N/A
Caffeine	N/A	N/A	N/A	6C48.40	N/A	N/A	N/A	N/A
Hallucinogens	6C49.4	6C49.5	6C49.60	6C49.61	N/A	N/A	N/A	N/A
Nicotine	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Volatile inhalants	6C4B.5	6C4B.6	6C4B.70	6C4B.71	N/A	N/A	6D72.13	6D84.2
MDMA or related drugs, including MDA	6C4C.5	6C4C.6	6C4C.70	6C4C.71	N/A	N/A	N/A	N/A
Dissociative drugs including ketamine and PCP	6C4D.4	6C4D.5	6C4D.60	6C4D.61	N/A	N/A	N/A	N/A
Other specified	6C4E.5	6C4E.6	6C4E.70	6C4E.71	6C4E.72	6C4E.73	6D72.12	6D84.Y
Multiple specified	6C4F.5	6C4F.6	6C4F.70	6C4F.71	6C4F.72	6C4F.73	N/A	N/A
Unknown or unspecified	6C4G.5	6C4G.6	6C4G.70	6C4G.71	6C4G.72	6C4G.73	N/A	N/A

	Delirium	[1]Psychotic	Mood	Anxiety	Obsessive-Compulsive	Impulse Control	Amnestic	Dementia
Non-psychoactive	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

[1] H = with Hallucinations, D = with Delusions, M = with Mixed psychotic symptoms

Clinical Descriptions and Diagnostic Requirements for Disorders Due to Psychoactive Substance Use

Episode of Harmful Psychoactive Substance Use

Available Categories by Substance Class:

- 6C40.0 Episode of Harmful Use of Alcohol
- 6C41.0 Episode of Harmful Use of Cannabis
- 6C42.0 Episode of Harmful Use of Synthetic Cannabinoids
- 6C43.0 Episode of Harmful Use of Opioids
- 6C44.0 Episode of Harmful Use of Sedatives, Hypnotics or Anxiolytics
- 6C45.0 Episode of Harmful Use of Cocaine
- 6C46.0 Episode of Harmful Use of Stimulants including Amphetamines, Methamphetamine or Methcathinone
- 6C47.0 Episode of Harmful Use of Synthetic Cathinones
- 6C48.0 Episode of Harmful Use of Caffeine
- 6C49.0 Episode of Harmful Use of Hallucinogens
- 6C4A.0 Episode of Harmful Use of Nicotine
- 6C4B.0 Episode of Harmful Use of Volatile Inhalants
- 6C4C.0 Episode of Harmful Use of MDMA or Related Drugs, including MDA
- 6C4D.0 Episode of Harmful Use of Dissociative Drugs including Ketamine or PCP
- 6C4E.0 Episode of Harmful Use of Other Specified Psychoactive Substance
- 6C4F.0 Episode of Harmful Use of Multiple Specified Psychoactive Substances, including Medications
- 6C4G.0 Episode of Harmful Use of Unknown or Unspecified Psychoactive Substances

Essential (Required) Features:

- An episode of use of a psychoactive substance that has caused clinically significant damage to a person's physical health (e.g., blood-borne infection from intravenous self-administration) or mental health (e.g., Substance-Induced Mood Disorder), or has resulted in behaviour leading to harm to the health of others.
- Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication (see Table 6.16, p. _); (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration.
- Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour due to substance intoxication on the part of the person to whom the diagnosis of Episode of Harmful Psychoactive Substance Use applies.
- Harm to health is not better accounted for by another medical condition or another mental disorder, including another Disorder Due to Substance Use (e.g., Substance Withdrawal).

Note: Harm to the health of the person to whom the diagnosis applies includes injuries caused by behaviour related to intoxication (e.g., impulsive aggressive behaviour,

psychomotor impairment leading to injury; see Table 6.16), acute health problems resulting from substance use (e.g., overdose, acute gastritis, the effects of hypoxia or prolonged hyperactivity or inactivity), and exacerbation or decompensation of pre-existing chronic health problems (e.g., hypertension, liver disease, or peptic ulceration). Harm may also result from a harmful route of administration (e.g., injecting drug use causing blood-borne virus infections, cocaine use causing a perforated nasal septum). The relevant diagnostic codes from other chapters of the ICD-11, including the chapter on Injury, Poisoning or Certain Other Consequences of External Causes, should be used to describe the specific health consequences of the harmful substance use.

Harm to the health of others includes any form of physical harm, including trauma (e.g., impaired driving causing a motor vehicle accident, assaultive behaviour leading to bodily harm to another person) or mental disorder (e.g., Post-Traumatic Stress Disorder arising from an assault by the intoxicated individual) that is directly attributable to behaviour due to substance intoxication on the part of the person to whom the diagnosis of Episode of Harmful Psychoactive Substance Use applies.

Additional Clinical Features:

- There must be explicit evidence of harm to the individual's physical or mental health, or of substance-related behaviour due to intoxication that has led to harm to the physical or mental health of others. There must also be a clear causal relationship between the harm to health and the episode of substance use in question.
- The likelihood of harm to self or others due behaviour related to intoxication varies substantially by substance (see Table 6.16). For example, such behaviour is unlikely to arise from caffeine or nicotine intoxication.
- Psychoactive substance use commonly occurs in the context of other mental disorders. An additional diagnosis of Episode of Harmful Psychoactive Substance Use can be made if the index episode of substance use has resulted in clinically significant harm to the individual's physical health or has exacerbated or triggered an episode of a pre-existing mental disorder (e.g., a Manic or Depressive Episode or a psychotic episode).
- A diagnosis of Episode of Harmful Psychoactive Substance Use often signals an opportunity for intervention, typically a low intensity intervention that can be implemented in a wide range of settings that is specifically aimed at reducing the likelihood of additional harmful episodes or of progression to Harmful Pattern of Use or Substance Dependence.
- A diagnosis of Episode of Harmful Psychoactive Substance Use of unknown or unspecified psychoactive substances can be assigned if the substance consumed is initially unknown. As more information becomes available (e.g., laboratory results, report from a collateral informant) the diagnosis should be changed to indicate the substance responsible for the episode of harm.
- As more information becomes available indicating that the episode is part of a continuous or recurrent pattern of substance use, or if additional harmful episodes occur, a diagnosis of Episode of Harmful Psychoactive Substance Use should be changed to Harmful Pattern of Psychoactive Substance Use or Substance Dependence, as appropriate.

Boundary with Normality (Threshold):

- The diagnosis of Episode of Harmful Psychoactive Substance Use requires clinically significant harm to the individual's physical or mental health or that of others. Examples of impact on physical or mental health that would not be considered clinically significant include mild hangover, brief episodes of vomiting, or transient depressed mood.
- A range of social problems may be associated with an episode of substance use that are not sufficiently severe to constitute clinically significant harm to physical or mental health (e.g., missed appointments, arguments with loved ones). Such problems are not a sufficient basis for a diagnosis of Episode of Harmful Psychoactive Substance Use.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Hazardous Substance Use:*** Hazardous Substance Use is classified in the chapter on 'Factors Influencing Health Status or Contact with Health Services' in the ICD-11 and not in the chapter on Mental, Behavioural, and Neurodevelopmental Disorders. Hazardous Substance Use appreciably increases the risk of harmful physical or mental health consequences to the user or to others to an extent that warrants attention and advice from health professionals, but has not resulted in specific identifiable harm and therefore does not meet the diagnostic requirements for Episode of Harmful Psychoactive Substance Use.
- ***Boundary with Harmful Pattern of Psychoactive Substance Use:*** If the harm to health is a result of a known episodic or continuous pattern of substance use and all other diagnostic requirements are met, a diagnosis of Harmful Pattern of Psychoactive Substance Use should be assigned. Substance use is generally considered to be following a pattern if there has been at least episodic or intermittent use over a period of at least 12 months. If harm is caused by use of a substance but no information is available about the pattern or history of substance use, a diagnosis of Episode of Harmful Psychoactive Substance Use may be assigned until such time as evidence for a pattern of use is ascertained.
- ***Boundary with Substance Dependence:*** In Substance Dependence, individuals use a substance or substances persistently despite harm and adverse consequences. Harm caused by such use may be similar to that observed in Episode of Harmful Psychoactive Substance Use. However, Substance Dependence also includes additional features of impaired ability to control use and increasing priority given to the substance use over other activities. Physiological features (e.g., tolerance) may also be present for applicable substances. If all diagnostic requirements for Substance Dependence are met for a particular substance, Episode of Harmful Psychoactive Substance Use should not be assigned for that substance. ***Note:*** Substance Dependence is only applicable for some substances or substance classes (see Table 6.13).
- ***Boundary with Substance Intoxication:*** Substance Intoxication is defined by substance use that results in clinically significant transient substance-specific symptoms (see Table 6.16). Recovery from Substance Intoxication is generally complete and without physical or mental sequelae. If there is continuing damage or harm (e.g., the effects of hypoxia, the effects of prolonged hyperactivity or inactivity, tissue damage) due to an episode of Substance Intoxication, a diagnosis of Episode of Harmful Psychoactive Substance Use may be assigned. If relevant at the time of the clinical encounter (e.g., in emergency settings), Episode of Harmful Psychoactive Substance Use may be diagnosed with an associated diagnosis of Substance Intoxication.

- ***Boundary with Substance-Induced Mental Disorders:*** Substance-Induced Mental Disorders can be associated with a single episode of substance use. If a Substance-Induced Mental Disorder has occurred as a form of harm resulting from a single episode of substance use, both Episode of Harmful Psychoactive Substance Use and the relevant Substance-Induced Mental Disorder should be diagnosed (e.g., Episode of Harmful Cocaine Use with Cocaine-Induced Psychotic Disorder). ***Note:*** Specific Substance-Induced Mental Disorders are only applicable for some substances or substance classes (see Table 6.14).
- ***Boundary with overdose:*** When ingestion of psychoactive substances results in symptoms of overdose (e.g., coma; life-threatening cardiac or respiratory suppression), a diagnosis from the grouping of Harmful Effects of Substances in the chapter on Injury, Poisoning or Certain Other Consequences of External Causes should also be assigned.

Harmful Pattern of Psychoactive Substance Use

Available Categories by Substance Class:

- 6C40.1 Harmful Pattern of Use of Alcohol
- 6C41.1 Harmful Pattern of Use of Cannabis
- 6C42.1 Harmful Pattern of Use of Synthetic Cannabinoids
- 6C43.1 Harmful Pattern of Use of Opioids
- 6C44.1 Harmful Pattern of Use of Sedatives, Hypnotics or Anxiolytics
- 6C45.1 Harmful Pattern of Use of Cocaine
- 6C46.1 Harmful Pattern of Use of Stimulants including Amphetamines, Methamphetamine or Methcathinone
- 6C47.1 Harmful Pattern of Use of Synthetic Cathinones
- 6C48.1 Harmful Pattern of Use of Caffeine
- 6C49.1 Harmful Pattern of Use of Hallucinogens
- 6C4A.1 Harmful Pattern of Use of Nicotine
- 6C4B.1 Harmful Pattern of Use of Volatile Inhalants
- 6C4C.1 Harmful Pattern of Use of MDMA or Related Drugs, including MDA
- 6C4D.1 Harmful Pattern of Use of Dissociative Drugs including Ketamine or PCP
- 6C4E.1 Harmful Pattern of Use of Other Specified Psychoactive Substance
- 6C4F.1 Harmful Pattern of Use of Multiple Specified Psychoactive Substances
- 6C4G.1 Harmful Pattern of Use of Unknown or Unspecified Psychoactive Substances

Essential (Required) Features:

- A pattern of continuous, recurrent, or sporadic use of a psychoactive substance that has caused clinically significant damage to a person's physical health (e.g., blood-borne infection from intravenous self-administration) or mental health (e.g., Substance-Induced Mood Disorder), or has resulted in behaviour leading to harm to the health of others.
- Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication (see Table 6.16); (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration.
- Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to substance intoxication

on the part of the person to whom the diagnosis of Harmful Pattern of Psychoactive Substance Use applies.

- The pattern of use of the relevant substance is evident over a period of at least 12 months if substance use is episodic or at least 1 month if use is continuous.
- Harm to health is not better accounted for by another medical condition or another mental disorder, including another Disorder Due to Substance Use (e.g., Substance Withdrawal).

Note: Harm to the health of the person to whom the diagnosis applies includes injuries caused by behaviour related to intoxication (e.g., impulsive aggressive behaviour, psychomotor impairment leading to injury (see Table 6.16); acute health problems resulting from substance use (e.g., overdose, acute gastritis, the effects of hypoxia or prolonged hyperactivity or inactivity), and exacerbation or decompensation of pre-existing chronic health problems (e.g., hypertension, liver disease, or peptic ulceration). Harm may also result from a harmful route of administration (e.g., injecting drug use causing blood-borne virus infections, cocaine use causing a perforated nasal septum). The relevant diagnostic codes from other chapters of the ICD-11, including the chapter on Injury, Poisoning or Certain Other Consequences of External Causes, should be used to describe the specific health consequences of the harmful substance use.

Harm to the health of others includes any form of physical harm, including trauma (e.g., impaired driving causing a motor vehicle accident, assaultive behaviour leading to bodily harm to another person) or mental disorder (e.g., Post-Traumatic Stress Disorder arising from an assault by the intoxicated individual) that is directly attributable to behaviour due to substance intoxication on the part of the person to whom the diagnosis of Harmful Pattern of Psychoactive Substance Use applies.

Course Specifiers:

A specifier is used to further describe the harmful pattern of substance use, using a fifth-digit code. The *x* below corresponds to the fourth-digit code indicating the substance class (e.g., 0 for alcohol, 1 for cannabis, 2 for synthetic cannabinoids, etc.).

6C4*x*.10 Harmful Pattern of Psychoactive Substance Use, episodic

This category is assigned when all the diagnostic requirements for Harmful Pattern of Psychoactive Substance Use are met and there is evidence of a pattern of recurrent episodic or intermittent use of the relevant psychoactive substance over a period of at least 12 months that has caused clinically significant harm to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others.

6C4*x*.11 Harmful Pattern of Psychoactive Substance Use, continuous

This category is assigned when all the diagnostic requirements for Harmful Pattern of Psychoactive Substance Use are met and there is evidence of a pattern of continuous substance use (daily or almost daily) of the relevant psychoactive substance over a period of at least 1 month that has caused clinically significant

harm to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others.

6C4*x*.1Z Harmful Pattern of Psychoactive Substance Use, unspecified

Additional Clinical Features:

- There must be explicit evidence of harm to the individual's physical or mental health, or of behaviour due to Substance Intoxication that has led to harm to the physical or mental health of others. There must also be a clear causal relationship between the harm to health and the episodic or continuous use of a substance.
- The likelihood of harm to self or others due behaviour related to intoxication varies substantially by substance (see Table 6.16). For example, such behaviour is unlikely to arise from caffeine or nicotine intoxication.
- A diagnosis of Harmful Pattern of Use of Unknown or Unspecified Psychoactive Substances can be assigned if the substance consumed is initially unknown. As more information becomes available (e.g., laboratory results, report from a collateral informant) the diagnosis should be changed to indicate the substance(s) involved in the Harmful Pattern of Psychoactive Substance Use.
- As more information becomes available about symptoms and behaviours related to the pattern of substance use as well as physiological features indicative of neuroadaptation to the substance, the diagnosis may be changed to Substance Dependence if diagnostic requirements are met.

Boundary with Normality (Threshold):

- The diagnosis of Harmful Pattern of Psychoactive Substance Use requires clinically significant harm to the individual's physical or mental health or that of others. Examples of impact on physical or mental health that would not be considered clinically significant include mild hangovers, brief episodes of vomiting, or transient depressed mood.
- A pattern of psychoactive substance use may cause a range of problems in functioning (e.g., missed appointments, arguments with loved ones) that are not sufficiently severe to constitute clinically significant harm to physical or mental health. Such problems are not a sufficient basis for a diagnosis of Harmful Pattern of Psychoactive Substance Use.

Developmental Presentations:

- Harmful Pattern of Psychoactive Substance Use is often a characteristic of late adolescence and young adulthood, and injuries and the consequences of aggressive behaviour are particularly common in this age group.
- Harmful Pattern of Psychoactive Substance Use in older adults may cause injuries and fractures due to the combination of lowered tolerance, psychomotor impairment induced by a substance, and disorders associated with ageing such as osteoporosis and Dementia.

Sex- and/or Gender-Related Features:

- The prevalence of Harmful Pattern of Psychoactive Substance Use is higher in males than females, but the gender differential is smaller in countries where women play a

greater role in the workforce. Gender differences in injuries and other forms of harm due to substance use are recognized.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Hazardous Substance Use:*** Hazardous Substance Use is classified in the chapter on 'Factors Influencing Health Status or Contact with Health Services' in the ICD-11 and not in the chapter on Mental, Behavioural, and Neurodevelopmental Disorders. Hazardous Substance Use appreciably increases the risk of harmful physical or mental health consequences to the user or to others to an extent that warrants attention and advice from health professionals, but has not resulted in specific identifiable harm and therefore does not meet the diagnostic requirements for Harmful Pattern of Psychoactive Substance Use.
- ***Boundary with Episode of Harmful Psychoactive Substance Use:*** If the harm to health is a result of a single episode of use rather than a pattern of substance use, whether episodic or continuous, a diagnosis of Episode of Harmful Psychoactive Substance Use should be assigned. Substance use is generally considered to be following a pattern if there has been at least episodic or intermittent use over a period of at least 12 months. If harm is caused by use of a substance but no information is available about the pattern or history of substance use, a diagnosis of Episode of Harmful Psychoactive Substance Use may be assigned until such time as evidence for a pattern of use is ascertained.
- ***Boundary with Substance Dependence:*** In Substance Dependence, individuals use a substance or substances persistently despite harm and adverse consequences. Harm caused by such use may be similar to that observed in Harmful Pattern of Psychoactive Substance Use. However, Substance Dependence also includes additional features of impaired ability to control use and increasing priority given to the substance use over other activities. Physiological features (e.g., tolerance) may also be present for applicable substances. If all diagnostic requirements for Substance Dependence are met for a particular substance, Harmful Pattern of Psychoactive Substance Use should not be assigned for that substance. ***Note:*** Substance Dependence is only applicable for some substances or substance classes (see Table 6.13)..
- ***Boundary with Substance Intoxication:*** Substance Intoxication is defined by substance use that results in clinically significantly, transient substance-specific symptoms (see Table 6.16). Recovery from Substance Intoxication is generally complete and absent of physical or mental sequelae. A pattern or repeated intoxication may or may not result in harm to a person's physical or mental health or to the health of others. If there is continuing damage or harm (e.g., the effects of hypoxia, the effects of prolonged hyperactivity or inactivity, tissue damage) as a result of repeated or continuous use of a psychoactive substance, a diagnosis of Harmful Pattern of Psychoactive Substance Use may be assigned. If relevant at the time of the clinical encounter (e.g., in an emergency room), Harmful Pattern of Psychoactive Substance Use may be diagnosed with an associated diagnosis of Substance Intoxication.
- ***Boundary with Substance Withdrawal:*** Substance Withdrawal occurs upon cessation or reduction of a substance in the context of physiological dependence or when a substance has been taken for a prolonged period or in large amounts. Some features of substance withdrawal may include physical or mental harm (e.g., seizures, delusions, hallucinations, anxiety). If the symptoms are entirely explained by the withdrawal syndrome for the relevant substance (see Table 6.17, p. _), an additional diagnosis of

Harmful Pattern of Psychoactive Substance Use is not warranted. However, if the symptoms substantially exceed the expected withdrawal syndrome in duration or type or severity and the diagnostic requirements for Substance Dependence are not met, Harmful Pattern of Psychoactive Substance Use can be assigned as the primary diagnosis, with an associated diagnosis of Substance Withdrawal (e.g., Harmful Pattern of Use of Opioids with Opioid Withdrawal). ***Note:*** Substance Withdrawal is only applicable for some substances or substance classes (see Table 6.13).

- ***Boundary with Substance-Induced Mental Disorders:*** If a Substance-Induced Mental Disorder has occurred as a form of harm resulting from a pattern of substance use, both Harmful Pattern of Psychoactive Substance Use and the relevant Substance-Induced Mental Disorder should be diagnosed (e.g., Harmful Pattern of Cocaine Use with Cocaine-Induced Anxiety Disorder). ***Note:*** Specific Substance-Induced Mental Disorders are only applicable for some substances or substance classes (see Table 6.14).
- ***Boundary with other mental disorders and other medical conditions:*** Numerous mental disorders as well as subthreshold symptoms may co-occur with episodic or continuous patterns of substance use. Similarly, continuous or episodic substance use increases the risk for mental disorders as well as other medical conditions. Co-occurring mental disorders and comorbid medical conditions should be diagnosed separately, along with a diagnosis of Harmful Pattern of Psychoactive Substance Use.

Substance Dependence

Available Categories by Substance Class:

- 6C40.2 Alcohol Dependence
- 6C41.2 Cannabis Dependence
- 6C42.2 Synthetic Cannabinoid Dependence
- 6C43.2 Opioid Dependence
- 6C44.2 Sedative, Hypnotic or Anxiolytic Dependence
- 6C45.2 Cocaine Dependence
- 6C46.2 Stimulant Dependence including Amphetamines, Methamphetamine or Methcathinone
- 6C47.2 Synthetic Cathinone Dependence
- 6C49.2 Hallucinogen Dependence
- 6C4A.2 Nicotine Dependence
- 6C4B.2 Volatile Inhalant Dependence
- 6C4C.2 MDMA or Related Drug Dependence, including MDA
- 6C4D.2 Dissociative Drug Dependence including Ketamine or PCP
- 6C4E.2 Other Specified Psychoactive Substance Dependence
- 6C4F.2 Multiple Specified Psychoactive Substance Dependence
- 6C4G.2 Unknown or Unspecified Psychoactive Substance Dependence

Essential (Required) Features:

- A pattern of recurrent episodic or continuous use of a psychoactive substance with evidence of impaired regulation of use of that substance that is manifested by two or more of the following:

  - Impaired control over substance use (i.e., onset, frequency, intensity, duration, termination, context);
  - Increasing precedence of substance use over other aspects of life, including maintenance of health, and daily activities and responsibilities, such that substance use continues or escalates despite the occurrence of harm or negative consequences (e.g., repeated relationship disruption, occupational or scholastic consequences, negative impact on health);
  - Physiological features indicative of neuroadaptation to the substance, including: 1) tolerance to the effects of the substance or a need to use increasing amounts of the substance to achieve the same effect; 2) withdrawal symptoms following cessation or reduction in use of that substance, or 3) repeated use of the substance or pharmacologically similar substances to prevent or alleviate withdrawal symptoms. Physiological features are only applicable for certain substances. Note: Substance-specific features of withdrawal are described in Table 6.17.
- The features of dependence are usually evident over a period of at least 12 months but the diagnosis may be made if use is continuous (daily or almost daily) for at least 3 months.

Course Specifiers for Alcohol Dependence:

For alcohol, a specifier is used to describe the pattern of substance use or remission. Unlike for other substances, a distinction is made between continuous and episodic use, as follows:

6C40.20 Alcohol Dependence, current use, continuous

Alcohol Dependence with continuous consumption of alcohol (daily or almost daily) during at least the past 1 month.

6C40.21 Alcohol Dependence, current use, episodic

Alcohol Dependence with use during the past month with a history of intermittent heavy drinking with periods of abstinence during the past 12 months.

6C40.22 Alcohol Dependence, early full remission

After a diagnosis of Alcohol Dependence, and often following a treatment episode or other intervention (including self-help intervention), the individual has been abstinent from alcohol during a period lasting from between 1 and 12 months.

6C40.23 Alcohol Dependence, sustained partial remission

After a diagnosis of Alcohol Dependence, and often following a treatment episode or other intervention (including self-help intervention), there is a significant reduction in alcohol consumption for more than 12 months, such that even though intermittent or continuing drinking has occurred during this period, the definitional requirements for dependence have not been met.

6C40.24 Alcohol Dependence, sustained full remission

After a diagnosis of Alcohol Dependence, and often following a treatment episode or other intervention (including self-intervention), the person has been abstinent from alcohol for 12 months or longer.

6C40.2Z Alcohol Dependence, unspecified

Course Specifiers for Substance Dependence for substances other than alcohol:

For all psychoactive substance classes other than alcohol (see list above and Table 6.13), a specifier is also used to further describe the pattern of substance use or remission in the context of Substance Dependence, using a fifth-digit code. Unlike alcohol, separate codes for continuous and episodic current use are not provided. The *x* below corresponds to the fourth-digit code indicating the substance class (e.g., 1 for cannabis, 2 for synthetic cannabinoids, etc.).

6C4*x*.20 Substance Dependence, current use

Current Substance Dependence with episodic or continuous use of the substance within the past month.

6C4*x*.21 Substance Dependence, early full remission

After a diagnosis of Substance Dependence and often following a treatment episode or other intervention (including self-help intervention), the individual has been abstinent from the substance during a period lasting from between 1 and 12 months.

6C4*x*.22 Substance Dependence, sustained partial remission

After a diagnosis of Substance Dependence, and often following a treatment episode or other intervention (including self-help intervention), there is a significant reduction in substance use for more than 12 months, such that even though intermittent or continuous use has occurred during this period, the diagnostic requirements for dependence have not been met.

6C4*x*.22 Substance Dependence, sustained full remission

After a diagnosis of Substance Dependence, and often following a treatment episode or other intervention (including self-intervention), the person has been abstinent from the substance for 12 months or longer.

6C4*x*.2Z Substance Dependence, unspecified

Additional Clinical Features for Substance Dependence:

- A subjective sensation of urge or craving to use the substance often, but not always, accompanies the Essential Features of Substance Dependence.

- When present as an aspect of Substance Dependence, withdrawal symptoms must be consistent with the known withdrawal state for that substance (see Table 6.17). Onset and course of withdrawal are time-limited and are related to the type of substance and the dose used immediately before cessation or reduction in amount.
- Tolerance varies as a function of individual factors (e.g., substance use history, genetics) and should be differentiated from initial levels of response during intoxication, which also exhibit significant individual variability. Laboratory testing that reveals high levels of the substance in bodily fluids with no evidence of significant symptoms of intoxication may be suggestive of tolerance. Tolerance to the effects to substances as indicated by different psychophysiological responses can develop at varying rates (e.g., tolerance to respiratory depression caused by opioid intoxication may develop prior to tolerance to the sedating effects of the drug). With abstinence, tolerance effects diminish over time.
- Individuals with certain comorbid medical conditions (e.g., chronic liver disease) typically have reduced tolerances to substances.
- Physical or mental health consequences (beyond the Essential Features of Substance Dependence) typically occur in persons with Substance Dependence but are not required for the diagnosis. Similarly, functional impairment in one or several domains of life (e.g., work, domestic responsibilities, child-rearing) is commonly seen in persons with Substance Dependence, but is not required in order to assign the diagnosis.
- Individuals with Substance Dependence have elevated rates of many other mental disorders, including Conduct-Dissocial Disorder, Attention Deficit Hyperactivity Disorder, Impulse Control Disorders, Post-Traumatic Stress Disorder, Social Anxiety Disorder, Generalized Anxiety Disorder, Mood Disorders, Psychotic Disorders, and Personality Disorder with prominent dissocial features, as well as subthreshold symptoms. The specific pattern of co-occurrence depends on the specific substance involved, and reflects common risk factors and common causal pathways. These are distinguished from Substance-Induced Mental Disorders, in which the symptoms are a result of the direct physiological effects of the substance on the central nervous system.
- A pattern of substance use that includes frequent or high dose administration occurs more often among certain subgroups (e.g., adolescents). In these cases, peer group dynamics may contribute to the maintenance of substance use. Regardless of the social contributions to the behaviour, a pattern of substance use that is consistent with subgroup norms should not be considered as presumptive evidence of Substance Dependence unless all diagnostic requirements for the disorder are met.

Boundary with Normality (Threshold):

- Frequent or even daily substance use of a substance does not automatically imply a diagnosis of Substance Dependence. There must also be evidence of the Essential Features of Substance Dependence such as impaired control over use, increasing precedence of use over other life priorities, or physiological features.
- The presence of physiological features such as tolerance and withdrawal is sometimes referred to as ‘physiological dependence’. These features may occur, for example, in response to prolonged therapeutic use of certain medications, such as in patients who are appropriately prescribed opioid analgesics for cancer pain. By themselves, however, these features are not sufficient for a diagnosis of Substance Dependence, which also requires either impaired control over substance use or increasing precedence of substance use over other activities.

Course Features:

- The course of Substance Dependence varies by substance, frequency, intensity, and duration of use. The central features of the dependence syndrome may be overshadowed by the harms to physical and mental health that patients with dependence often experience and for which they frequently seek treatment. Numerous medical conditions can occur due to substance use in the course of Substance Dependence. These conditions tend to be specific for each substance, although some are shared across substances. Negative consequences to physical health reflect either the known pharmacological effects of the relevant substance, the toxic effects of the substance on tissues and organs, or the route of administration (e.g., intravenous self-administration). Examples include alcoholic cirrhosis, infective endocarditis, and HIV/AIDS. Medical conditions caused by substance use should be diagnosed separately.

Developmental Presentations:

- Substance Dependence may develop more rapidly during adolescence than is usual during adulthood, especially when there are familial or other risk factors for Substance Dependence.
- Tolerance to psychoactive substances may develop rapidly in adolescents and young adults, and decline equally rapidly when substance use ceases or is reduced in quantity or frequency.
- Withdrawal symptoms are well recognized in neonates born to women with Substance Dependence who have used psychoactive substances during pregnancy. However, the presence of a withdrawal state in a neonate should not be the sole basis for a diagnosis of Substance Dependence in the mother.
- Older adults often have reduced tolerance to substances.

Sex- and/or Gender-Related Features:

- Substance Dependence has similar features in men and women, although the intensity of substance use and duration of use necessary to result in dependence may differ by sex. For example, Alcohol Dependence may occur after a lower cumulative alcohol intake in women compared with men because of sex-related differences in body mass and composition.
- Women are less likely to be involved with the legal system in relation to substance use and therefore may be less likely to come to clinical attention than men. In clinical contexts, women may be reluctant to admit using substances due to prevailing social attitudes and proscriptions.
- In some societies it may be culturally unacceptable for women to admit to substance use. Specific probing may be necessary to elicit a history of substance use and dependence.

Boundaries with Other Disorders and with Normality:

- ***Boundary with Substance Intoxication:*** Episodic or continuous intoxication with substance(s) is a typical feature of Substance Dependence, but is not an Essential Feature. Conversely, even if frequent and severe, Substance Intoxication alone is not a basis for a diagnosis of Substance Dependence. If all diagnostic requirements of both conditions are met for the same episode of care, Substance Dependence should be

assigned as the primary diagnosis, with an associated diagnosis of Substance Intoxication (e.g., Opioid Dependence with Opioid Intoxication) if appropriate to the specific clinical situation (e.g., in emergency settings).

- ***Boundary with Harmful Substance Use:*** Substance Dependence is often associated with physical and mental health consequences, such as those seen in Harmful Pattern of Psychoactive Substance Use. In the absence of the Essential Features of Substance Dependence, a diagnosis of Harmful Substance Use can be given when there has been demonstrable harm to the individual's physical or mental health or that of others. Harmful Pattern of Psychoactive Substance Use and Substance Dependence should not be diagnosed together.
- ***Boundary with Substance Withdrawal:*** Depending on the substance, many individuals with Substance Dependence develop Substance Withdrawal upon cessation or reduction in the amount of a substance consumed. In such cases, both Substance Dependence and Substance Withdrawal should be diagnosed**.** However, Substance Withdrawal can be diagnosed in the absence of a diagnosis of Substance Dependence, for example in response to cessation of medically appropriate treatment with opioid analgesics that is not accompanied by the other Essential Features of Substance Dependence. ***Note:*** Substance Withdrawal is only applicable for some substances or substance classes (see Table 6.13).
- ***Boundary with Substance-Induced Mental Disorders:*** The impact of repeated or continuous use of substances characteristic of Substance Dependence may include Substance-Induced Mental Disorders, in which case both Substance Dependence and the relevant Substance-Induced Mental Disorder should be diagnosed (e.g., Alcohol Dependence with Alcohol-Induced Delirium). ***Note:*** Specific Substance-Induced Mental Disorders are only applicable for some substance classes (see Table 6.14).

Substance Intoxication

Available Categories by Substance Class:

- 6C40.3 Alcohol Intoxication
- 6C41.3 Cannabis Intoxication
- 6C42.3 Synthetic Cannabinoid Intoxication
- 6C43.3 Opioid Intoxication
- 6C44.3 Sedative, Hypnotic or Anxiolytic Intoxication
- 6C45.3 Cocaine Intoxication
- 6C46.3 Stimulant Intoxication including Amphetamines, Methamphetamine or Methcathinone
- 6C47.3 Synthetic Cathinone Intoxication
- 6C48.2 Caffeine Intoxication
- 6C49.3 Hallucinogen Intoxication
- 6C4A.3 Nicotine Intoxication
- 6C4B.3 Volatile Inhalant Intoxication
- 6C4C.3 MDMA or Related Drug Intoxication, including MDA
- 6C4D.3 Dissociative Drug Intoxication, including Ketamine or PCP
- 6C4E.3 Other Specified Psychoactive Substance Intoxication
- 6C4F.3 Intoxication Due to Multiple Specified Psychoactive Substances
- 6C4G.3 Intoxication Due to Unknown or Unspecified Psychoactive Substance

Essential (Required) Features:

- Transient and clinically significant disturbances in consciousness, cognition, perception, affect, behaviour, or coordination that develop during or shortly after the consumption or administration of a substance.
- The symptoms must be compatible with the known pharmacological effects of the substance, and their intensity is closely related to the amount of the substance consumed.
- The symptoms of intoxication are time-limited and abate as the substance is cleared from the body.
- Symptoms are not better accounted for by another medical condition (See Table 6.15, p. _) or another mental disorder, including another Disorder Due to Substance Use (e.g., Substance Withdrawal).

Note: Table 6.16 (p. _) lists clinically important presenting features of Substance Intoxication attributable to the pharmacological effects of each class of substance.

Table 6.15: Examples of Medical Conditions That May Present with Symptoms Similar to Substance Intoxication

- Head injury (with or without cerebral contusion or intracranial haemorrhage or haematoma)
- Meningitis and encephalitis
- Diabetic ketoacidosis or hypoglycaemia
- Hepatic or other metabolic encephalopathy
- Wernicke's encephalopathy
- Electrolyte disturbance
- Hypoxia or hypercapnia
- Systemic infection

Severity of Intoxication Specifier:

Depending on the specific clinical situation and the information available, Substance Intoxication may be classified according to the level of severity as mild, moderate, or severe. The level of intoxication is usually related to the dose, route of administration, half-life, and duration of action of the substance. Severity of intoxication is also affected by individual variability (e.g., differences in body weight, substance metabolism, or tolerance). Susceptibility to substance intoxication may also be greater in individuals with comorbid medical conditions affecting drug pharmacokinetics (e.g., renal or hepatic insufficiency).

For some substances, there are specific tests for detecting and determining the concentration of substances in bodily fluids (e.g., blood, urine), which can be important tools for clinical management. However, severity of intoxication should be determined on the basis of clinical assessment, as specified below, and not solely based on the presence and level of the substance in bodily fluids.

The level of medical attention that may be required in response to substance intoxication varies according to the severity of intoxication and the substance involved, and varies from precautionary observation to urgent intervention to prevent death or permanent harm (e.g., administration of antagonist treatment; intubation).

The severity of intoxication is classified using the following Extension (X) Codes in addition to the appropriate intoxication category.

XS5W Mild

Mild substance intoxication is a state in which there are clinically recognizable disturbances in psychophysiological functions and responses (e.g., motor coordination, attention and judgement) that vary by substance (see Table 6.16), but there is little or no disturbance in the level of consciousness.

XS0T Moderate

Moderate substance intoxication is a state in which there are marked disturbances in psychophysiological functions and responses (e.g., motor coordination, attention and judgement) that vary by substance (see Table 6.16), with substantial impairment on tasks that require these functions. There is some disturbance in level of consciousness.

XS25 Severe

Severe substance intoxication is a state in which there are obvious disturbances in psychophysiological functions and responses (e.g., motor coordination, attention and judgement) that vary by substance (see Table 6.16), with marked disturbance in level of consciousness. There is severe impairment to the extent that the person may not be capable of self-care or self-protection, and may be unable to communicate or cooperate with assessment and intervention.

Note: Extension codes are attached to the category to which they apply using an ampersand (&). For example, 6C40.3&XS0T is the code for Alcohol Intoxication, moderate and 6C41.3&XS5W is the code for Cannabis Intoxication, mild.

Additional Clinical Features for Substance Intoxication:

- Psychoactive substances, whether of the same or a different pharmacological class, may interact such that they exacerbate or modify the features of intoxication. In cases of multiple psychoactive substance use in which more than one specific substance can be identified as a cause of the intoxication, it is recommended that the corresponding specific Substance Intoxication categories for each relevant substance should be assigned (e.g., 6C40.3 Alcohol Intoxication and 6C41.3 Cannabis Intoxication) rather than 6C4F.3 Intoxication Due to Multiple Specified Psychoactive Substances.
- Substance Intoxication may occur in the presence of medical conditions that cause impairment of levels of consciousness, cognition, perception, affect, behaviour, or coordination, which should be diagnosed separately. Determination of the aetiology of the disturbances in psychophysiological functions or responses may require longitudinal assessment.

- A diagnosis of Intoxication Due to Unknown or Unspecified Psychoactive Substance can be assigned if the substance consumed is initially unknown to the clinician. As more information becomes available (e.g., laboratory results, report from a collateral informant) the diagnosis should be changed to indicate the substance responsible for intoxication.

Boundary with Normality (Threshold):

- Measurement of the presence or concentration of a substance in breath, blood, saliva, urine or other body fluids may be an important tool in the clinical management of Substance Intoxication. However, detection of a psychoactive substance in body fluids does not constitute a presumptive diagnosis of Substance Intoxication.

Course Features:

- The onset of Substance Intoxication varies according to the route of administration, the absorption of the substance and other pharmacokinetic factors. Generally, inhalation (smoking) and intravenous injecting routes lead to more rapid onset of intoxication, though oral ingestion may also lead to intoxication within minutes, depending on the substance.
- Substance Intoxication is a transient condition, with the duration of intoxication depending on multiple factors including: (1) the dose of the substance taken, (2) the half-life and duration of action of the particular substance, and (3) the formulation of the substance taken (e.g., for pharmaceutical preparations, whether a controlled-release drug has been taken). Intoxication may last from a few minutes up to several days following the episode of use. The intensity of intoxication lessens with time after reaching a peak of absorption, and the effects eventually disappear in the absence of further use of the substance.

Culture-Related Features:

- The degree and characteristics of intoxication displayed for a given amount of the substance varies considerably with circumstances, with beliefs and expectations about the effects of the substance, and with the cultural acceptability of displaying these effects. These factors result in cultural differences in the extent and manifestations of intoxication.
- There are also genetic differences in susceptibility to intoxication associated with certain ethnic groups. Cultural and ethnically linked genetic factors have been better documented for alcohol than for other substances.

Developmental Presentations:

- Naïve users including adolescents can show features of intoxication at lower levels of use, reflecting lower physical and learned tolerance.
- Older adults may have a lower tolerance than younger people to the effects of alcohol and other substances.

Sex- and/or Gender-Related Features:

- The amount of substance and duration of use necessary to cause intoxication differs by sex, reflecting differences in body weight and composition.
- Behaviour while intoxicated may vary by gender, reflecting not only physiological differences, but also cultural differences and role expectations.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Episode of Harmful Psychoactive Substance Use and Harmful Pattern of Psychoactive Substance Use:*** In Episode of Harmful Psychoactive Substance Use and Harmful Pattern of Psychoactive Substance Use, consumption or administration of a substance results in damage to the person's physical or mental health (including a Substance-Induced Mental Disorder) or in behaviour leading to harm to the health of others. Recovery from Substance Intoxication is generally complete. Complications due to such effects of intoxication such as injury, the effects of hypoxia, the effects of prolonged hyperactivity or inactivity, or other tissue damage should be diagnosed as Episode of Harmful Psychoactive Substance Use or Harmful Pattern of Psychoactive Substance Use, as appropriate. If relevant at the time of the clinical encounter (e.g., in emergency settings), Substance Intoxication can be given as an associated diagnosis, with Episode of Harmful Psychoactive Substance Use or Harmful Pattern of Psychoactive Substance Use as the primary diagnosis.
- ***Boundary with Substance Dependence:*** Episodic or continuous intoxication with a substance or substances is a typical feature of Substance Dependence. If all diagnostic requirements of both conditions are met for the same episode of care, Substance Dependence should be assigned as the primary diagnosis, with an associated diagnosis of Substance Intoxication (e.g., Opioid Dependence with Opioid Intoxication).
- ***Boundary with Substance Withdrawal:*** Substance Withdrawal occurs upon cessation or reduction of a substance in the context of physiological dependence or when a substance has been taken for a prolonged period or in large amounts. In contrast, the onset of Substance Intoxication occurs immediately or shortly after the consumption of a substance. Moreover, for a particular substance, the intoxication and withdrawal syndromes are typically quite distinct. See Table 6.16 for a description of the substance-specific features of Substance Intoxication and Table 6.17 for a description of the substance-specific features of Substance Withdrawal.
- ***Boundary with Substance-Induced Delirium:*** Delirium is characterized by disturbances in attention, orientation, and awareness that develop within a short period of time with symptoms that are transient and may fluctuate depending on the underlying aetiology. Delirium often includes disturbance of behaviour and emotion, and may include impairment in multiple cognitive domains. Disturbance of the sleep-wake cycle may also be present. Delirium can be caused by intoxication or withdrawal from substances. When symptoms of Delirium are attributable to Substance Intoxication, an associated diagnosis of Substance-Induced Delirium should be assigned in addition to the diagnosis of Substance Intoxication. ***Note:*** Substance-Induced Delirium is only applicable for some substances or substance classes (see Table 6.14).
- ***Boundary with other Substance-Induced Mental Disorders:*** Mental or behavioural symptoms that arise during Substance Intoxication should only be used as a basis for diagnosing a Substance-Induced Mental Disorder if the intensity or duration of the symptoms is substantially in excess of those that are characteristic of Substance

Intoxication due to the specified substance (see Table 6.16) and the symptoms are sufficiently severe to warrant specific clinical attention.

- ***Boundary with other medical conditions:*** A variety of medical conditions may produce symptoms that are similar to those of Substance Intoxication (see Table 6.15 for examples). Some of these medical conditions are life-threatening requiring immediate intervention. Evidence of substance use (e.g., positive laboratory results) does not rule out the possibility of a comorbid medical condition. These alternative diagnoses must be considered in assessing Substance Intoxication. Certain medical conditions may also augment or prolong the duration of intoxication. Symptoms of intoxication that persist after they can no longer be reasonably attributed to the pharmacological effects of the substance may suggest the presence of another medical condition. If it is determined that Substance Intoxication is comorbid with a medical condition, both diagnoses should be assigned.
- ***Boundary with overdose:*** When consumption or administration of psychoactive substances results in symptoms of overdose (e.g., coma; life-threatening cardiac or respiratory suppression), it is typically more appropriate to apply a diagnosis from the grouping of Harmful Effects of Substances in the chapter on Injury, Poisoning or Certain Other Consequences of External Causes rather than Substance Intoxication.

Table 6.16: Common substance-specific features of Substance Intoxication

Listed below are the disturbances in consciousness, cognition, perception, affect, behaviour, or coordination that are most characteristic of intoxication with each class of psychoactive substances in the grouping of Disorders Due to Substance Use. These features are caused by the known pharmacological effects of the substance. Their intensity is closely related to the amount of the substance consumed, as well as the route of administration, interaction of the substance with other substances, including medications, and the duration of action of the substance. They are time-limited and abate as the substance is cleared from the body.

Substance	Common substance-specific features
Alcohol	Presenting features of Alcohol Intoxication may include impaired attention, inappropriate or aggressive behaviour, lability of mood and emotions, impaired judgment, poor coordination, unsteady gait, and slurred speech. At more severe levels of intoxication, stupor or coma may occur. ***Additional Features:*** • Alcohol Intoxication may be associated with impaired social interaction. • Impaired coordination and judgment due to Alcohol Intoxication even at low doses may be sufficiently severe to affect faculties necessary to safely operate motorized vehicles and is an important risk factor for road accidents. • The disinhibiting effects of alcohol are associated with an increased risk of attempted and completed suicides. • Higher blood levels of alcohol (e.g., > 150 mg/dL) are associated with stupor and coma. Blood levels of alcohol above 250 mg/dL can cause respiratory depression, cardiac arrhythmias and death.

	• Stupor and coma are more likely to occur in individuals with low tolerance or comorbid medical conditions. • The more severe the intoxication, the greater the likelihood of amnesia for events. • Some symptoms of intoxication with other substances (e.g., sedatives, hypnotics or anxiolytics; opioids) may be similar to those of Alcohol Intoxication. Evidence of alcohol use (e.g., the smell of alcohol on the breath) does not rule out concomitant intoxication with other substances.
Cannabis or Synthetic cannabinoids	Presenting features of Cannabis Intoxication or Synthetic Cannabinoid Intoxication may include inappropriate euphoria, impaired attention, impaired judgment, perceptual alterations (such as the sensation of floating, altered perception of time), changes in sociability, increased appetite, anxiety, intensification of ordinary experiences, impaired short-term memory, and sluggishness. Physical signs include conjunctival injection (red or bloodshot eyes), dry mouth, and tachycardia. ***Additional Features:*** • The principal psychoactive cannabinoid is cannabis is δ-9-tetrahydrocannabinol (THC). Disturbances in consciousness, cognition, perception, affect, behaviour, or coordination typical of Cannabis Intoxication are primarily attributable to levels of THC, although various other cannabinoids are also present in cannabis preparations (e.g., dried leaves and buds, hashish, cannabis oil). • Synthetic Cannabinoid Intoxication may cause Delirium or acute psychosis. • Regular intoxication with high potency cannabis or synthetic cannabinoids may be associated with increased long-term risk for psychosis. ***Note:*** Medicinal cannabinoids such as cannabidiol and cannabinol, for example those used as antispasmodics, anxiolytics, or analgesics, typically have no or minimal intoxicating effects. However, standard laboratory testing for cannabinoids may not be able to differentiate among these different types of cannabinoids.
Opioids	Presenting features of Opioid Intoxication may include somnolence, stupor, mood changes (e.g., euphoria followed by apathy and dysphoria), psychomotor retardation, impaired judgment, respiratory depression, slurred speech, and impairment of memory and attention. In severe intoxication, coma may ensue. A characteristic physical sign is pupillary constriction but this sign may be absent when intoxication is due to synthetic opioids. ***Additional Features:*** • Severe Opioid Intoxication can lead to death due to excessive respiratory depression. Overdose is more likely to occur with higher potency opioids (e.g., fentanyl), when the person has reduced tolerance

	(e.g., after detoxification) or when an individual who has developed tolerance uses the opioid in a novel environment. • Opioid Intoxication shares certain features with Alcohol Intoxication and Sedative, Hypnotic or Anxiolytic Intoxication. Evidence of alcohol use (e.g., the smell of alcohol on the breath) does not rule out co-occurring Opioid Intoxication. • Where available, laboratory testing for substances that may be contributing to the intoxication or their metabolites may be necessary to identify the intoxicating substance. • Administration of an opioid antagonist (e.g., naloxone) may be used empirically in some settings (e.g., emergency settings) to differentiate Opioid Intoxication from intoxication with other substances.
Sedatives, hypnotics or anxiolytics	Presenting features of Sedative, Hypnotic or Anxiolytic Intoxication may include somnolence, impaired judgment, inappropriate behaviour (including sexual behaviour or aggression), slurred speech, impaired motor coordination, unsteady gait, mood changes, as well as impaired memory, attention and concentration. Nystagmus (repetitive, uncontrolled eye movements) is a common physical sign. In severe cases, stupor or coma may occur. ***Additional Features:*** • Impaired memory in Sedative, Hypnotic or Anxiolytic Intoxication is characterized by anterograde amnesia for the period of intoxication. • Sedatives, hypnotics or anxiolytics are commonly prescribed medications. They can cause intoxication even in therapeutic doses in older individuals as well as in those with medical comorbidities. • Some features of Sedative, Hypnotic or Anxiolytic Intoxication may be similar to those of Opioid Intoxication or Alcohol Intoxication. Evidence of alcohol use (e.g., the smell of alcohol on the breath) does not rule out concomitant Sedative, Hypnotic or Anxiolytic Intoxication. • Where available, laboratory testing for substances that may be contributing to the intoxication or their metabolites may be necessary to identify the intoxicating substance.
Cocaine	Presenting features of Cocaine Intoxication may include inappropriate euphoria, anxiety, anger, impaired attention, hypervigilance, psychomotor agitation, paranoid ideation (sometimes of delusional intensity), auditory hallucinations, confusion, and changes in sociability. Perspiration or chills, nausea or vomiting, and palpitations and chest pain may be experienced. Physical signs may include tachycardia, elevated blood pressure, and pupillary dilatation. ***Additional Features:*** • In rare instances, usually in severe intoxication, cocaine use can result in seizures, muscle weakness, dyskinesia and dystonia, and myocardial infarction or stroke arising from coronary or cerebral artery spasm, respectively.

Stimulants including amphetamines, methamphetamine and methcathinone	Presenting features of Stimulant Intoxication may include anxiety, anger, impaired attention, hypervigilance, psychomotor agitation, paranoid ideation (possibly of delusional intensity), transient auditory hallucinations, transient confusion, and changes in sociability. Perspiration or chills, nausea or vomiting, and palpitations may be experienced. Physical signs may include tachycardia, elevated blood pressure, pupillary dilatation, dyskinesia and dystonia, and skin sores. ***Additional Features:*** • In rare instances, usually in severe intoxication, use of stimulants including amphetamines, methamphetamine and methcathinone can result in seizures.
Synthetic cathinones	Presenting features of Synthetic Cathinone Intoxication may include anxiety, anger, impaired attention, hypervigilance, psychomotor agitation, paranoid ideation (possibly of delusional intensity), transient auditory hallucinations, transient confusion, and changes in sociability. Perspiration or chills, nausea or vomiting, and palpitations may be experienced. Physical signs may include tachycardia, elevated blood pressure, pupillary dilatation, dyskinesia and dystonia, and skin sores. ***Additional Features:*** • In rare instances, usually in severe intoxication, use of synthetic cathinones can result in seizures.
Caffeine	Presenting features of Caffeine Intoxication may include restlessness, anxiety, excitement, insomnia, flushed face, tachycardia, diuresis, gastrointestinal disturbances, muscle twitching, psychomotor agitation, perspiration or chills, and nausea or vomiting. Cardiac arrythmias may occur. Disturbances typical of Caffeine Intoxication tend to occur at relatively higher doses (e.g., > 1 g per day). ***Additional Features:*** • Caffeine and related alkaloids (e.g., theobromine in tea) are present in a variety of foods (e.g., chocolate, kola nuts), beverages (e.g., sodas, guarana), and supplements (e.g., tablets, vitamins) that are consumed regularly and pervasively. • Very high doses of caffeine (e.g., > 5 g) can result in respiratory distress or seizures and can be fatal.
Hallucinogens	Presenting features of Hallucinogen Intoxication may include hallucinations, illusions, perceptual changes such as depersonalization, derealization, synesthesias (blending of senses, such as a visual stimulus evoking a smell), anxiety, depressed or dysphoric mood, ideas of reference, paranoid ideation, impaired judgment, palpitations, sweating, blurred vision, tremors and lack of

	coordination. Physical signs may include tachycardia, elevated blood pressure, and pupillary dilatation. ***Additional Features:*** • In rare instances, Hallucinogen Intoxication may increase suicidal behaviour.
Nicotine	Presenting features of Nicotine Intoxication may include restlessness, psychomotor agitation, anxiety, cold sweats, headache, insomnia, palpitations, paresthesias, nausea or vomiting, abdominal cramps, confusion, bizarre dreams, burning sensations in the mouth, and salivation. ***Additional Features:*** • Nicotine Intoxication occurs more commonly in people who have recently started smoking or using other forms of nicotine (e.g., electronic cigarettes or 'vaping') and have therefore not developed tolerance. It may also occur in persons who receive nicotine therapeutically and take it in higher than recommended doses. • In rare instances, paranoid ideation, perceptual disturbances, convulsions, or coma may occur.
Volatile inhalants	Presenting features of Volatile Inhalant Intoxication may include euphoria, impaired judgment, aggression, somnolence, stupor or coma, dizziness, tremor, lack of coordination, slurred speech, unsteady gait, lethargy and apathy, psychomotor retardation, and visual disturbance. Muscle weakness and diplopia may occur. ***Additional Features:*** • Intentional or unintentional exposure to a variety of volatile inhalant substances (e.g., glue, petrol, butane, paint) can cause the symptoms of Volatile Inhalant Intoxication. • Intentional Volatile Inhalant Intoxication typically involves 'sniffing' or 'huffing' the substances from closed containers, a practice which may lead to hypoxia and hypoxic brain damage and other long-lasting neurological sequelae. • Use of volatile inhalants may cause cardiac arrythmias, cardiac arrest, and death. • Inhalants containing lead (e.g., some forms of petrol/gasoline) may cause confusion, irritability, coma and seizures. • Use of volatile inhalants is more common among adolescents and young adults due to greater ease of access as compared to other psychoactive substances.

MDMA or related drugs, including MDA	Presenting features of MDMA or Related Drug Intoxication may include increased or inappropriate sexual interest and activity, anxiety, restlessness, agitation, and sweating. ***Additional Features:*** • In rare instances, usually in severe intoxication, use of MDMA or related drugs, including MDA can result in dystonia and seizures. Sudden death is a rare but recognized complication.
Dissociative drugs including Ketamine and PCP	Presenting features of Dissociative Drug Intoxication may include aggression, impulsiveness, unpredictable behaviour, anxiety, psychomotor agitation, impaired judgment, numbness or diminished responsiveness to pain, slurred speech, and dystonia. Physical signs include nystagmus (repetitive, uncontrolled eye movements), tachycardia, elevated blood pressure, numbness, ataxia, dysarthria, and muscle rigidity. ***Additional Features:*** • In rare instances, use of dissociative drugs including Ketamine and PCP can result in seizures. • Laboratory tests to quantify PCP levels are only weakly correlated with disturbances in consciousness, cognition, perception, affect, behaviour, or coordination.

Substance Withdrawal

Available Categories by Substance Class:

- 6C40.4 Alcohol Withdrawal
- 6C41.4 Cannabis Withdrawal
- 6C42.4 Synthetic Cannabinoid Withdrawal
- 6C43.4 Opioid Withdrawal
- 6C44.4 Sedative, Hypnotic or Anxiolytic Withdrawal
- 6C45.4 Cocaine Withdrawal
- 6C46.4 Stimulant Withdrawal including Amphetamines, Methamphetamine or Methcathinone
- 6C47.4 Synthetic Cathinone Withdrawal
- 6C48.3 Caffeine Withdrawal
- 6C4A.4 Nicotine Withdrawal
- 6C4B.4 Volatile Inhalant Withdrawal
- 6C4C.4 MDMA or Related Drug Withdrawal, including MDA
- 6C4E.4 Other Specified Psychoactive Substance Withdrawal
- 6C4F.4 Multiple specified psychoactive substances Withdrawal
- 6C4G.4 Withdrawal Due to Unknown or Unspecified Psychoactive Substance

Essential (Required) Features:

- The presence of a clinically significant cluster of symptoms, behaviours, and/or physiological features that occurs upon cessation or reduction in the use of a substance in individuals who have developed dependence on that substance or have used the substance for a prolonged period or in large amounts. ***Note:*** Substance Withdrawal can occur when prescribed psychoactive medications (e.g., opioids, anxiolytics, stimulants) have been used in standard therapeutic doses.
- The specific features of Substance Withdrawal depend on the pharmacological properties of the specified substance (see Table 6.17) and are consistent with those recognized as occurring upon cessation or reduction of the particular substance or other members of the same pharmacological group of substances. The symptoms also vary in degree of severity and duration depending on the substance and the amount and pattern of prior use.
- The symptoms are not better accounted for by another medical condition or another mental disorder.

Note: Substance Withdrawal is only applicable for some substances or substance classes (see list above and Table 6.13). Table 6.17 lists the most common symptoms, behaviours and/or physiological features for each substance class.

Specifiers for clinical presentation of Substance Withdrawal:

Because of clinically important variation in their withdrawal syndromes, the following specifiers can be applied to Alcohol Withdrawal (6C40.4) and Sedatives, Hypnotics or Anxiolytics Withdrawal (6C44.4), as well as the Withdrawal syndrome for Other Specified (6C4E.4), Multiple (6C4F.4), and Unspecified (6C4G.4) Psychoactive Substance Categories. The *x* below corresponds to the fourth-digit code indicating the substance class (e.g., 0 for alcohol).

6C4x.40 Substance Withdrawal, uncomplicated

All diagnostic requirements for Substance Withdrawal are met and the withdrawal state is not accompanied by perceptual disturbances or seizures.

6C4x.41 Substance Withdrawal, with perceptual disturbances

All diagnostic requirements for Substance Withdrawal are met and the withdrawal state is accompanied by perceptual disturbances (e.g., visual or tactile hallucinations or illusions) with intact reality testing. There is no evidence of confusion and other diagnostic requirements for Delirium are not met. The withdrawal state is not accompanied by seizures.

6C4x.42 Substance Withdrawal, with seizures

All diagnostic requirements for Substance Withdrawal are met and the withdrawal state is accompanied by seizures (i.e., generalized tonic-clonic seizures) but not by perceptual disturbances.

6C4x.43 Substance Withdrawal, with perceptual disturbances and seizures

All diagnostic requirements for Substance Withdrawal are met and the withdrawal state is accompanied by both seizures (i.e., generalized tonic-clonic seizures) and perceptual disturbances (e.g., visual or tactile hallucinations or illusions) with intact reality testing. Diagnostic requirements for Delirium are not met.

6C4x.4Z Substance Withdrawal, unspecified

Additional Clinical Features for Substance Withdrawal:

- For some substances, characteristic features of Substance Withdrawal are opposite to the acute pharmacological effects of that substance (see Tables 6.16 and 6.17).
- Substance Withdrawal symptoms become more severe with repeated episodes of withdrawal (termed 'kindling'), with aging, or in the presence of comorbid medical conditions.
- A diagnosis of Substance Withdrawal due to Unknown or Unspecified Psychoactive Substance can be assigned if the substance consumed is initially unknown. As more information becomes available (e.g., laboratory results, report from a collateral informant) the diagnosis should be changed to indicate the substance responsible for the withdrawal symptoms.

Boundary with Normality (Threshold):

- Substance Withdrawal should only be diagnosed when symptoms are consistent with those recognized as occurring upon cessation or reduction in use of the particular substance or pharmacologically-related group of substances (see Table 6.17). Recent cessation or reduction of use and the presence of various non-specific transient symptoms is not sufficient to make the diagnosis of Substance Withdrawal.
- Withdrawal symptoms should be differentiated from the transient physiological aftereffects of intoxication ('hangover effect'). For example, if low mood and reduction in energy are reported following use of alcohol; sedatives, hypnotics or anxiolytics; stimulants; or MDMA or related drugs and other characteristic features of Substance Withdrawal are not present, a diagnosis of Substance Withdrawal should not be assigned. Presence of a set of associated symptoms specific for different classes of psychoactive substances (see Table 6.17), as well as the frequency, amount, and duration of its use and presence of Substance Dependence should be considered in distinguishing Substance Withdrawal from a 'hangover effect'.
- Some individuals who have previously had Substance Dependence may experience symptoms similar to those of Substance Withdrawal months after the last use of the substance, particularly when the individual encounters stimuli (e.g., drug paraphernalia) and contexts (e.g., location where use was frequent) previously associated with past substance use. These symptoms are more transient than those observed during Substance Withdrawal and occur exclusively when in contact with associated stimuli and contexts. A diagnosis of Substance Withdrawal should not be assigned under these circumstances.

Course Features:

- Substance Withdrawal is time-limited. Factors that influence the features and time course of Substance Withdrawal include: (1) the severity of Substance Dependence, if

present, (2) the dose, frequency of use, and duration of use of the substance prior to cessation or reduction of that use, (3) the half-life and duration of action of the substance, and (4) the presence of comorbid medical conditions (e.g., metabolic disturbances).

Culture-Related Features:

- Symptoms of withdrawal depend largely on the psychotropic characteristics of the substance. However, specific cultures may emphasize certain symptoms of withdrawal over others, making it more difficult to conduct a differential diagnosis. In addition, vernacular terms for withdrawal vary greatly.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Substance Dependence:*** Depending on the substance, many individuals with Substance Dependence develop Substance Withdrawal upon cessation or reduction in the amount of the substance. In such cases, both Substance Dependence and Substance Withdrawal should be diagnosed**.** However, Substance Withdrawal can be diagnosed in the absence of a diagnosis of Substance Dependence, for example in response to cessation of medically appropriate treatment with opioid analgesics that is not accompanied by the other Essential Features of Substance Dependence.
- ***Boundary with Substance Intoxication:*** The onset of Substance Intoxication occurs immediately or shortly after the consumption of a substance. In contrast, Substance Withdrawal occurs upon cessation or reduction in the amount of a substance in the context of Substance Dependence or when a substance has been taken for a prolonged period or in large amounts. For a particular substance, the intoxication and withdrawal syndromes are typically distinct. See Table 6.16 for a description of the substance-specific features of Substance Intoxication and Table 6.17 for a description of the substance-specific features of Substance Withdrawal.
- ***Boundary with Substance-Induced Delirium:*** Delirium is characterized by disturbances in attention, orientation, and awareness that develop within a short period of time with symptoms that are transient and may fluctuate depending on the underlying etiology. Delirium often includes disturbance of behaviour and emotion, and may include impairment in multiple cognitive domains. Disturbance of the sleep-wake cycle may also be present. Delirium may occur as an aspect of Substance Withdrawal, particularly during later stages of withdrawal. In such cases, diagnoses of both Substance Withdrawal and Substance-Induced Delirium should be assigned. ***Note:*** Substance-Induced Delirium is only applicable for some substances or substance classes (see Table 6.14).
- ***Boundary with other Substance-Induced Mental Disorders:*** Mental or behavioural symptoms that arise during Substance Withdrawal should only be used as a basis for diagnosing a Substance-Induced Mental Disorder if the intensity or duration of the symptoms is substantially in excess of those that are characteristic of the Substance Withdrawal due to the specified substance (see Table 6.17) and the symptoms are sufficiently severe to warrant specific clinical attention. In such cases, if the withdrawal syndrome is ongoing, diagnoses of both Substance Withdrawal and a Substance-Induced Mental Disorder may be assigned.
- ***Boundary with other mental disorders:*** Various symptoms associated with Substance Withdrawal overlap with those that are characteristic of other mental disorders (e.g., depressive and anxiety symptoms). Symptoms of Substance Withdrawal occur in

specific temporal relationship to the cessation of use of a specific substance and diminish with the passage of time. Evidence supporting a mental disorder diagnosis would include the symptoms preceding the onset of the substance use, the symptoms persisting for a substantial period of time after cessation of the substance or medication use or withdrawal (e.g., 1 month or more, depending on the substance), or other evidence of a pre-existing mental disorder (e.g., a history of prior episodes not associated with substance use).

- ***Boundary with other medical conditions:*** It may be difficult to distinguish between various symptoms associated with Substance Withdrawal (e.g., nausea, retching or vomiting, seizures, abdominal cramps, diarrhea, perspiration, postural hypotension, decreased or increased heart rate, cough, sleep disruption) and those that are characteristic of other medical conditions. Symptoms of Substance Withdrawal occur in specific temporal relationship to the cessation of use of a specific substance and diminish with the passage of time.
- ***Boundary with Foetus or Newborn Affected by Maternal Use of Tobacco, Alcohol, or Other Drugs of Addiction:*** The ICD-11 chapter on Certain Conditions Arising During the Perinatal Period contains categories for 'Foetus or newborn affected by maternal use of tobacco, alcohol, and other drugs.' A neonate exhibiting signs of Substance Withdrawal related to a specific substance may also be assigned the appropriate Substance Withdrawal diagnosis in order to guide treatment together with appropriate diagnosis from the chapter on Certain Conditions Originating in the Perinatal Period.

Table 6.17: Common Substance-specific features of Substance Withdrawal

Substance withdrawal is a cluster of symptoms, behaviours and physiological features, varying in degree of severity and duration, that occur upon cessation or reduction of use of a psychoactive substance in individuals who have developed dependence on that substance or have taken the substance for a prolonged period or in large amounts. The diagnosis of Substance Withdrawal is applicable only to certain substances and substance groups (see Table 6.13). Specific presenting features that may occur as a part of Substance Withdrawal for each applicable class of psychoactive substances in the grouping of Disorders Due to Substance Use are listed below.

Substance	Substance-specific features of withdrawal
Alcohol	Presenting features of Alcohol Withdrawal may include autonomic hyperactivity (e.g., tachycardia, hypertension, perspiration), increased hand tremor, nausea, retching or vomiting, insomnia, anxiety, psychomotor agitation, depressed or dysphoric mood, transient visual, tactile or auditory illusions or hallucinations, and distractibility. Less commonly, Alcohol Withdrawal is complicated by seizures. ***Additional Features:*** • Onset of Alcohol Withdrawal typically occurs within 6 to 12 hours after last use, as blood alcohol concentrations decline. Symptoms vary in type, severity, onset and duration according to the duration and intensity of alcohol use prior to cessation or reduction of use. • Features of mild or moderate withdrawal typically last for 3 to 7 days after cessation of alcohol use and include autonomic hyperactivity, increased hand tremor, anxiety, insomnia, nausea, vomiting, and headache. Features of moderate withdrawal may also include transient visual, tactile or auditory illusions or hallucinations, distractibility and psychomotor agitation. • In 1-3% of cases, Alcohol Withdrawal is complicated by seizures of a tonic-clonic type. When seizures occur, they are usually single seizures with onset within 6 to 48 hours after last use. Evidence of a premorbid seizure disorder, other intracranial pathology, or co-occurring use of other substances does not preclude a presumptive Alcohol Withdrawal diagnosis. • Approximately 2% of cases of Alcohol Withdrawal progress to a very severe syndrome sometimes referred to as *delirium tremens* (DTs) characterized by confusion and disorientation, delusions, and prolonged visual, tactile or auditory hallucinations. When delirium is present, a separate diagnosis of Alcohol-Induced Delirium should also be assigned. Presence of seizures during withdrawal represents a risk factor for development of Delirium. If unrecognized or untreated, Delirium during Alcohol Withdrawal is associated with substantially increased mortality as compared to Alcohol Withdrawal without co-occurring Delirium. • Some symptoms associated with Alcohol Withdrawal such as autonomic hyperactivity, anxiety, and insomnia can recur or persist for several months after abstinence, particularly when the person is exposed to alcohol-associated cues (a conditioned withdrawal

Substance	Substance-specific features of withdrawal
	state). The presence of such persisting symptoms is not sufficient to meet diagnostic requirements for Alcohol Withdrawal.
Cannabis	Presenting features of Cannabis Withdrawal may include irritability, anger or aggressive behaviour, shakiness, insomnia, restlessness, anxiety, depressed or dysphoric mood, decreased appetite and weight loss, headache, sweating or chills, abdominal cramps and muscle aches. ***Additional Features:*** • The occurrence, severity and duration of Cannabis Withdrawal vary according to the type and potency of the cannabis preparation, as well as the amount, frequency and duration of use before cessation or reduction of use. • Onset of Cannabis Withdrawal typically occurs at some point between 12 hours and 3 days after cessation or reduction of use. Symptom severity typically peaks at 4 to 7 days and may last for 1 to 3 weeks after cessation of use. However, Cannabis Withdrawal may also be briefer, in some cases lasting only a few days. • When Cannabis Withdrawal occurs in the context of a co-occurring mental disorder, the features of the other disorder (e.g., fluctuation of mood) may be exacerbated.
Synthetic cannabinoids	Presenting features of Synthetic Cannabinoid Withdrawal may include irritability, anger, aggression, shakiness, insomnia and disturbing dreams, restlessness, anxiety, depressed or dysphoric mood and appetite disturbance. In the early phase, Synthetic Cannabinoid Withdrawal may be accompanied by residual features of intoxication from the drug, such as paranoid ideation and auditory and visual hallucinations. ***Additional Features:*** • The occurrence, severity and duration of Synthetic Cannabinoid Withdrawal vary according to the type and potency of the synthetic cannabinoid used, as well as the amount, frequency and duration of use before cessation or reduction of use. • Synthetic Cannabinoid Withdrawal typically lasts for 1 to 3 weeks after cessation of use.
Opioids	Presenting features of Opioid Withdrawal may include depressed or dysphoric mood, craving for an opioid, anxiety, nausea or vomiting, abdominal cramps, muscle aches, yawning, perspiration, hot and cold flushes, hypersomnia (typically in the initial phase) or insomnia, diarrhoea, piloerection, and pupillary dilation. ***Additional Features:*** • The severity and time course of Opioid Withdrawal is influenced by many factors that include the type of opioid taken, its half-life and duration of action, the amount, frequency and duration of opioid

Substance	Substance-specific features of withdrawal
	use before cessation or reduction of use, prior experience of opioid withdrawal, and expectations of the severity of the syndrome. • Opioid Withdrawal from short-acting opioids such as injected heroin or morphine typically begins within 4 to 12 hours of cessation of use and lasts for 4 to 10 days. • Opioid Withdrawal from longer-acting opioids such as codeine and oxycodone and similar pharmaceutical agents may not be evident for 2 to 4 days and may last for 1 to 2 weeks. • The withdrawal state from long-acting drugs such as methadone may persist for up to 2 months after cessation of use. • Opioid Withdrawal occurs in phases. The early phase typically includes lacrimation, rhinorrhoea and yawning. This is followed by hot and cold flashes, muscle aching and abdominal cramps, nausea and vomiting and diarrhoea; piloerection and pupillary dilatation may also occur. The later phase is dominated by craving for opioids. • Recurrence or worsening of pain may occur if the opioid was used to manage chronic pain. • Serious medical complications of Opioid Withdrawal are rare. Fluid depletion may occasionally lead to renal impairment. Death during Opioid Withdrawal is very uncommon.
Sedatives, hypnotics or anxiolytics	Presenting features of Sedative, Hypnotic or Anxiolytic Withdrawal may include anxiety, psychomotor agitation, insomnia, increased hand tremor, nausea or vomiting, and transient visual, tactile or auditory illusions or hallucinations. There may be signs of autonomic hyperactivity (e.g., tachycardia, hypertension, perspiration), or postural hypotension. The withdrawal state may be complicated by seizures. ***Additional Features:*** • The severity and time course of Sedative, Hypnotic or Anxiolytic Withdrawal is related to the particular substance taken, its half-life and duration of action, and the amount, frequency and duration of use before cessation or reduction of use. • The withdrawal state associated with short-acting drugs typically has its onset within 12 to 24 hours after cessation of use and has a course of up to 14 days. Withdrawal onset may be delayed by 3 to 5 days with longer-acting drugs and may persist for several weeks. • Sedative, Hypnotic or Anxiolytic Withdrawal may be complicated by seizures, which are of a tonic-clonic type and may be single or multiple. • Sedative, Hypnotic or Anxiolytic Withdrawal, especially when untreated, may progress to a very severe form of Delirium, characterized by confusion and disorientation, delusions, and more prolonged visual, tactile or auditory hallucinations. In such cases, a separate diagnosis of Sedative, Hypnotic or Anxiolytic-induced Delirium should also be assigned. • Medical sequelae of complicated withdrawal include status epilepticus, respiratory compromise, and renal failure.

Substance	Substance-specific features of withdrawal
	• Some features of Sedative, Hypnotic or Anxiolytic Withdrawal such as anxiety, transient illusions or hallucinations, and derealisation may persist for several months after cessation of use.
Cocaine	Presenting features of Cocaine Withdrawal may include depressed or dysphoric mood, irritability, fatigue, psychomotor agitation or retardation, vivid unpleasant dreams, insomnia or hypersomnia, increased appetite, anxiety, and craving for cocaine. ***Additional Features:*** • Initial symptoms of Cocaine Withdrawal include a dysphoric and low energy state manifested as depressed or dysphoric mood, irritability, fatigue, inertia and hypersomnia. This typically occurs within 6 to 24 hours of cessation of cocaine use. • The withdrawal state may last up to 7 days. Craving for cocaine is prominent in the later stages. • Suicidal ideation may occur, especially when dysphoric mood is marked. • At the onset of Cocaine Withdrawal there may be features that persist from the intoxicating effects of cocaine such as hyperactivity, paranoid ideation and auditory hallucinations.
Stimulants including amphetamines, methamphetamine and methcathinone	Presenting features of Stimulant Withdrawal may include depressed or dysphoric mood, irritability, fatigue, insomnia or (more commonly) hypersomnia, vivid and unpleasant dreams, increased appetite, psychomotor agitation or retardation, and craving for amphetamine and related stimulants. ***Additional Features:*** • Stimulant Withdrawal typically occurs within 24 hours to 4 days of cessation of stimulant use and is characterized by a dysphoric and low energy state manifested by depressed or dysphoric mood, irritability, fatigue, inertia and hypersomnia. • The severity and duration of the withdrawal state is widely variable based on the type of stimulant taken and the amount, frequency and duration of such use prior to its cessation. • In the first phase of Stimulant Withdrawal, which typically lasts for 7 to 14 days, low mood, lethargy and hypersomnia predominate. After this phase, irritability and craving for stimulants are prominent and may persist for 6 to 8 weeks. • At the onset of Stimulant Withdrawal there may be features that persist from the intoxicating effects of the stimulant such as hyperactivity, paranoid ideation and auditory hallucinations.
Synthetic cathinones	Presenting features of Synthetic Cathinone Withdrawal may include depressed or dysphoric mood, irritability, fatigue, insomnia or (more commonly) hypersomnia, vivid and unpleasant dreams, increased appetite, psychomotor agitation or retardation, and craving for stimulants, including synthetic cathinones.

Substance	Substance-specific features of withdrawal
Caffeine	Presenting features of Caffeine Withdrawal may include headache, marked fatigue or drowsiness, irritability, depressed or dysphoric mood, nausea or vomiting, and difficulty concentrating. ***Additional Features:*** • The severity and duration of Caffeine Withdrawal is related to the amount, frequency and duration of caffeine use prior to cessation of use. • Onset of Caffeine Withdrawal is typically 12 to 48 hours after the last use and may last up to 7 days.
Nicotine	Presenting features of Nicotine Withdrawal may include depressed or dysphoric mood, insomnia, irritability, anger, anxiety, difficulty concentrating, restlessness, bradycardia, increased appetite, and craving for tobacco or other nicotine-containing products. Other physical symptoms may include increased cough and mouth ulceration. ***Additional Features:*** • The severity and duration of Nicotine Withdrawal is variable, related to the amount, frequency and duration of tobacco smoked (or otherwise consumed) or of nicotine products taken prior to cessation of use. • Onset of Nicotine Withdrawal is typically 6 to 24 hours after cessation or reduction of use. Psychological and physiological features typically last up to 10 days. Physical features such as increased cough and mouth ulceration may persist for 2 to 3 weeks. • Craving for tobacco (or other nicotine-containing products) is prominent throughout the duration of Nicotine Withdrawal.
Volatile inhalants	Presenting features of Volatile Inhalant Withdrawal may include insomnia, anxiety, irritability, depressed or dysphoric mood, shakiness, perspiration, nausea, and transient illusions. ***Additional Features:*** • The severity and duration of Volatile Inhalant Withdrawal is related to the type of inhalant used and to the amount, frequency and duration of use of the specific inhalant. • Volatile Inhalant Withdrawal may be accompanied by persisting features of Volatile Inhalant Intoxication or its medical complications such as encephalopathy, especially when the inhalant used is lead-containing petrol/gasoline.
MDMA or related drugs, including MDA	Presenting features of MDMA or Related Drug Withdrawal may include fatigue, lethargy, hypersomnia or insomnia, depressed mood, anxiety, irritability, craving, difficulty in concentrating, and appetite disturbance.

Substance	Substance-specific features of withdrawal
	Additional Features: • The above information primarily concerns withdrawal from MDMA. There is insufficient information on the features and course of the withdrawal state from drugs related to MDMA, including MDA, to fully characterize the associated withdrawal states. • MDMA Withdrawal is uncommon, reflecting the comparative rarity of MDMA Dependence. • Onset of MDMA Withdrawal typically occurs within 12-24 hours after last use, as blood concentrations decline. The features vary in type, severity, onset and duration according to the amount, frequency and duration of MDMA use prior to cessation of use. • The duration of MDMA Withdrawal may be up to 10 days. Craving for MDMA may be prominent during the later stages.

Substance-Induced Mental Disorders

Substance-Induced Mental Disorders are characterized by psychological, cognitive, or behavioural symptoms that develop during or soon after psychoactive substance intoxication or withdrawal or use or discontinuation of a psychoactive medication. The duration or severity of the symptoms is substantially in excess of the characteristic syndrome of Substance Intoxication or Substance Withdrawal due to the specified substance.

Substance-Induced Mental Disorders include:

- Substance-Induced Delirium
- Substance-Induced Psychotic Disorder
    - with hallucinations
    - with delusions
    - with mixed psychotic symptoms
- Substance-Induced Mood Disorder
    - with depressive symptoms
    - with manic symptoms
    - with mixed depressive and manic symptoms
- Substance-Induced Anxiety Disorder
- Substance-Induced Obsessive-Compulsive or Related Disorder
- Substance-Induced Impulse Control Disorder

Specific types of Substance-Induced Mental Disorders are only applicable for some substance classes, which are listed along with corresponding codes in the sections on specific Substance-Induced Mental Disorders below as well as in Table 6.14. Specific Substance-Induced Mental Disorders may characteristically have their onset during or soon after Substance Intoxication and/or Substance Withdrawal for specific substances or substance classes.

When making a diagnosis of Substance-Induced Mental Disorder, an additional diagnosis indicating the related pattern of substance use should also be assigned. These include Episode of Harmful Psychoactive Substance Use, Harmful Pattern of Psychoactive Substance Use, and Substance Dependence. A diagnosis of Substance Intoxication or Substance Withdrawal may also be assigned if applicable.

Additional categories of substance-induced disorders are included in other groupings of the ICD-11 chapter on Mental, Behavioural, and Neurodevelopmental Disorders and CDDR are provided in the corresponding sections. These categories are cross-listed in this section for reference. These categories include:

- 6A41 Catatonia Induced by Substances or Medications (p. _)
- 6D70.1 Delirium Due to Psychoactive Substances Including Medications (p. _)
- 6D72.1 Amnestic Disorder Due to Psychoactive Substances Including Medications (p. _)
- 6D84 Dementia Due to Psychoactive Substances Including Medications (p. _)

Essential Features for each Substance-Induced Mental Disorder category are provided below, as are any specifiers corresponding to specific disorders. Other CDDR elements—i.e., Additional Clinical Features, Boundary with Normality (Threshold) and Boundaries with Other Disorders and Conditions (Differential Diagnosis)—apply to all Substance-Induced Mental Disorder categories and are provided at the end of this section.

Substance-Induced Delirium

Available Categories by Substance Class:

Substance classes that may cause Substance-Induced Delirium include the following:

- 6C40.5 Alcohol-Induced Delirium
- 6C41.5 Cannabis-Induced Delirium
- 6C42.5 Synthetic Cannabinoid-Induced Delirium
- 6C43.5 Opioid-Induced Delirium
- 6C44.5 Sedative, Hypnotic or Anxiolytic-Induced Delirium
- 6C45.5 Cocaine-Induced Delirium
- 6C46.5 Stimulant-Induced Delirium including Amphetamines, Methamphetamine or Methcathinone
- 6C47.5 Synthetic Cathinone-Induced Delirium
- 6C49.4 Hallucinogen-Induced Delirium
- 6C4B.5 Volatile Inhalant-Induced Delirium
- 6C4C.5 MDMA or Related Drug-Induced Delirium, including MDA
- 6C4D.4 Dissociative Drug-Induced Delirium including Ketamine or PCP
- 6C4E.5 Delirium Induced by Other Specified Psychoactive Substance including Medications
- 6C4F.5 Delirium Induced by Multiple Specified Psychoactive Substances including Medications

- 6C4G.5 Delirium Induced by Unknown or Unspecified Psychoactive Substance

CDDR for Substance-Induced Delirium are provided as part of the grouping of Neurocognitive Disorders (Delirium Due to Psychoactive Substances including Medications, p. _).

Substance-Induced Psychotic Disorders

Available Categories by Substance Class:

Substance classes that may cause Substance-Induced Psychotic Disorders include the following:

- 6C40.6 Alcohol-Induced Psychotic Disorder
- 6C41.6 Cannabis-Induced Psychotic Disorder
- 6C42.6 Synthetic Cannabinoid-Induced Psychotic Disorder
- 6C43.6 Opioid-Induced Psychotic Disorder
- 6C44.6 Sedative, Hypnotic or Anxiolytic-Induced Psychotic Disorder
- 6C45.6 Cocaine-Induced Psychotic Disorder
- 6C46.6 Stimulant-Induced Psychotic Disorder Including Amphetamines, Methamphetamine or Methcathinone
- 6C47.6 Synthetic Cathinone-Induced Psychotic Disorder
- 6C49.5 Hallucinogen-Induced Psychotic Disorder
- 6C4B.6 Volatile Inhalant-Induced Psychotic Disorder
- 6C4C.6 MDMA or Related Drug-Induced Psychotic Disorder, Including MDA
- 6C4D.5 Dissociative Drug-Induced Psychotic Disorder Including Ketamine or PCP
- 6C4E.6 Psychotic Disorder Induced by Other Specified Psychoactive Substance
- 6C4F.6 Psychotic Disorder Induced by Multiple Specified Psychoactive Substances
- 6C4G.6 Psychotic Disorder Induced by Unknown or Unspecified Psychoactive Substance

Essential (Required) Features:

- The presentation is characterized by psychotic symptoms (e.g., delusions, hallucinations, or disorganized thinking or behaviour) that develop during or soon after intoxication with or withdrawal from a specified substance or use or discontinuation of a psychoactive medication.
- The intensity or duration of the psychotic symptoms is substantially in excess of psychotic-like disturbances of perception, cognition, or behaviour that are characteristic of intoxication or withdrawal due to the specified substance.
- The specified substance, as well as the amount and duration of its use, is known to be capable of producing psychotic symptoms. (See list above and Table 6.14.)
- The symptoms are not better accounted for by another mental disorder such as Schizophrenia or a Mood Disorder with psychotic symptoms. Evidence supporting a diagnosis of another mental disorder would include psychotic symptoms preceding the onset of the substance use, the symptoms persisting for a substantial period of time after cessation of the substance or medication use or withdrawal (e.g., 1 month or more

depending on the specific substance), or other evidence of a pre-existing mental disorder with psychotic symptoms (e.g., a history of prior episodes not associated with substance use).

- The symptoms are not a manifestation of another medical condition.
- The symptoms cause significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Specifiers for substance-induced psychotic symptoms:

An additional specifier can be added to denote the presence of hallucinations, delusions, or mixed psychotic symptoms for Alcohol-Induced Psychotic Disorder (6C40.6), Cocaine-Induced Psychotic Disorder (6C45.6), Stimulant-Induced Psychotic Disorder including Amphetamines, Methamphetamine or Methcathinone (6C46.6), and Synthetic Cathinone-Induced Psychotic Disorder (6C47.6). The *x* below represents the fourth character in the code, which indicates the substance class (e.g., 0 for alcohol). (See list above and Table 6.14.)

6C4x.60 Substance-Induced Psychotic Disorder with hallucinations

- All diagnostic requirements for Substance-Induced Psychotic Disorder are met.
- The presentation is characterized by hallucinations that are judged to be the direct consequence of the use of or withdrawal from a specified substance or medication.
- Neither delusions nor other psychotic symptoms are present.
- The symptoms do not occur exclusively during hypnogogic or hypnopompic states.

6C4x.61 Substance-Induced Psychotic Disorder with delusions

- All diagnostic requirements for Substance-Induced Psychotic Disorder are met.
- The presentation is characterized by delusions that are judged to be the direct consequence of use of or withdrawal from a specified substance or medication.
- Neither hallucinations nor other psychotic symptoms are present.

6C4x.62 Substance-Induced Psychotic Disorder with mixed psychotic symptoms

- All diagnostic requirements for Substance-Induced Psychotic Disorder are met.
- The presentation is characterized by multiple psychotic symptoms, primarily hallucinations and delusions, when these are judged to be the direct consequence of the use of or withdrawal from a specified substance or medication.

6C4*x*.6Z Substance-Induced Psychotic Disorder, unspecified

Substance-Induced Mood Disorders

Available Categories by Substance Class:

Substance classes that may cause Substance-Induced Mood Disorders include the following:

- 6C40.70 Alcohol-Induced Mood Disorder
- 6C41.70 Cannabis-Induced Mood Disorder
- 6C42.70 Synthetic Cannabinoid-Induced Mood Disorder
- 6C43.70 Opioid-Induced Mood Disorder
- 6C44.70 Sedative, Hypnotic or Anxiolytic-Induced Mood Disorder
- 6C45.70 Cocaine-Induced Mood Disorder
- 6C46.70 Stimulant-Induced Mood Disorder including Amphetamines, Methamphetamine or Methcathinone
- 6C47.70 Synthetic Cathinone-Induced Mood Disorder
- 6C49.60 Hallucinogen-Induced Mood Disorder
- 6C4B.70 Volatile Inhalant-Induced Mood Disorder
- 6C4C.70 MDMA or Related Drug-Induced Mood Disorder, including MDA
- 6C4D.60 Dissociative Drug-Induced Mood Disorder including Ketamine or PCP
- 6C4E.70 Mood Disorder Induced by Other Specified Psychoactive Substance
- 6C4F.70 Mood Disorder Induced by Multiple Specified Psychoactive Substances
- 6C4G.70 Mood Disorder Induced by Unknown or Unspecified Psychoactive Substance

Essential (Required) Features:

- The presentation is characterized by mood symptoms (e.g., depressed or elevated mood, decreased engagement in pleasurable activities, increased or decreased energy levels) that develop during or soon after intoxication with or withdrawal from a specified substance or use or discontinuation of a psychoactive medication.
- The intensity or duration of the mood symptoms is substantially in excess of mood symptoms that are characteristic of intoxication or withdrawal due to the specified substance.
- The specified substance, as well as the amount and duration of its use, is known to be capable of producing mood symptoms. (See list above and Table 6.14.)
- The symptoms are not better accounted for by another mental disorder such as a Depressive Disorder, a Bipolar Disorder, or Schizophrenia or Other Primary Psychotic Disorder. Evidence supporting a diagnosis of another mental disorder would include mood symptoms preceding the onset of the substance use, the symptoms persisting for a substantial period of time after cessation of the substance or medication use or withdrawal (e.g., 1 month or more depending on the specific substance), or other evidence of a pre-existing mental disorder with mood symptoms (e.g., a history of prior episodes not associated with substance use).
- The symptoms are not a manifestation of another medical condition.
- The symptoms cause significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Specifiers for substance-induced mood symptoms:

An additional specifier can be added to denote the presence of either depressive symptoms in the absence of manic symptoms, manic symptoms in the absence of depressive symptoms, or mixed manic and depressive symptoms. The *x* below represents the fourth character in the code, which indicates the substance class (e.g., 0 for alcohol, 1 for cannabis, etc.). The two *y*s represent the characters that corresponds to Substance-Induced Mood Disorder for that class of substances. (See list above and Table 6.14.)

6C4*x*.*yy*0 Substance-Induced Mood Disorder with depressive symptoms

- All diagnostic requirements for Substance-Induced Mood Disorder are met.
- The presentation is characterized by depressive symptoms judged to be the direct consequence of the use of or withdrawal from a specified substance or medication.
- Manic symptoms are not present.

6C4*x*.*yy*1 Substance-Induced Mood Disorder with manic symptoms

- All diagnostic requirements for Substance-Induced Mood Disorder are met.
- The presentation is characterized by manic symptoms judged to be the direct consequence of the use of or withdrawal from a specified substance or medication.
- Depressive symptoms are not present.

6C4*x*.*yy*2 Substance-Induced Mood Disorder with mixed depressive and manic symptoms

- All diagnostic requirements for Substance-Induced Mood Disorder are met.
- The presentation is characterized by both depressive and manic symptoms judged to be the direct consequence of the use of or withdrawal from a specified substance or medication.

6C4*x*.*yy*Z Substance-Induced Mood Disorder, unspecified

Substance-Induced Anxiety Disorders

Available Categories by Substance Class:

Substance classes that may cause Substance-Induced Anxiety Disorders include the following:

- 6C40.71 Alcohol-Induced Anxiety Disorder
- 6C41.71 Cannabis-Induced Anxiety Disorder
- 6C42.71 Synthetic Cannabinoid-Induced Anxiety Disorder
- 6C43.71 Opioid-Induced Anxiety Disorder
- 6C44.71 Sedative, Hypnotic or Anxiolytic-Induced Anxiety Disorder
- 6C45.71 Cocaine-Induced Anxiety Disorder

- 6C46.71 Stimulant-Induced Anxiety Disorder including Amphetamines, Methamphetamine or Methcathinone
- 6C47.71 Synthetic Cathinone-Induced Anxiety Disorder
- 6C48.40 Caffeine-Induced Anxiety Disorder
- 6C49.61 Hallucinogen-Induced Anxiety Disorder
- 6C4B.71 Volatile Inhalant-Induced Anxiety Disorder
- 6C4C.71 MDMA or Related Drug-Induced Anxiety Disorder, including MDA
- 6C4D.61 Dissociative-Induced Anxiety Disorder including Ketamine Or PCP
- 6C4E.71 Anxiety Disorder Induced by Other Specified Psychoactive Substance
- 6C4F.71 Anxiety Disorder Induced by Multiple Specified Psychoactive Substances
- 6C4G.71 Anxiety Disorder Induced by Unknown or Unspecified Psychoactive Substance

Essential (Required) Features:

- The presentation is characterized by anxiety symptoms (e.g., apprehension or worry, fear, physiological symptoms of excessive autonomic arousal, panic attacks, avoidance behaviour) that develop during or soon after intoxication with or withdrawal from a specified substance or use or discontinuation of a psychoactive medication.
- The intensity or duration of the anxiety symptoms is substantially in excess of anxiety symptoms that are characteristic of intoxication or withdrawal due to the specified substance.
- The specified substance, as well as the amount and duration of its use, is known to be capable of producing anxiety symptoms. (See list above and Table 6.14.)
- The symptoms are not better accounted for by another mental disorder such as an Anxiety or Fear-Related Disorder, a Depressive Disorder with prominent anxiety symptoms, or Post-Traumatic Stress Disorder. Evidence supporting a diagnosis of another mental disorder would include anxiety symptoms preceding the onset of the substance use, the symptoms persisting for a substantial period of time after cessation of the substance or medication use or withdrawal (e.g., 1 month or more depending on the specific substance), or other evidence of a pre-existing mental disorder with anxiety symptoms (e.g., a history of prior episodes not associated with substance use).
- The symptoms are not a manifestation of another medical condition.
- The symptoms cause significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Substance-Induced Obsessive-Compulsive or Related Disorders

Available Categories by Substance Class:

Substance classes that may cause Substance-Induced Obsessive-Compulsive or Related Disorders include the following:

- 6C45.72 Cocaine-Induced Obsessive-Compulsive or Related Disorder
- 6C46.72 Stimulant-Induced Obsessive-Compulsive or Related Disorder including Amphetamines, Methamphetamine or Methcathinone
- 6C47.72 Synthetic Cathinone-Induced Obsessive-Compulsive or Related Disorder

- 6C4E.72 Obsessive-Compulsive or Related Disorder Induced by Other Specified Psychoactive Substance
- 6C4F.72 Obsessive-Compulsive or Related Disorder Induced by Multiple Specified Psychoactive Substances
- 6C4G.72 Obsessive-Compulsive or Related Disorder Induced by Unknown or Unspecified Psychoactive Substance

Essential (Required) Features:

- The presentation is characterized by symptoms that share primary clinical features with Obsessive-Compulsive or Related Disorders (e.g., obsessions, intrusive thoughts and preoccupations, compulsions, recurrent and habitual actions directed at the integument).
- The obsessive-compulsive or related symptoms develop during or soon after intoxication with or withdrawal from a specified substance or use or discontinuation of a psychoactive medication.
- The intensity or duration of the repetitive preoccupations and behaviours is substantially in excess of analogous disturbances that are characteristic of intoxication or withdrawal due to the specified substance.
- The specified substance, as well as the amount and duration of its use, is known to be capable of producing obsessive-compulsive or related symptoms. (See list above and Table 6.14.)
- The symptoms and behaviours are not better accounted for by another mental disorder, in particular an Obsessive-Compulsive or Related Disorder. Evidence supporting a diagnosis of another mental disorder would include obsessive-compulsive or related symptoms preceding the onset of the substance use, the symptoms persisting for a substantial period of time after cessation of the substance or medication use or withdrawal (e.g., 1 month or more depending on the specific substance), or other evidence of a pre-existing mental disorder with obsessive-compulsive or related symptoms (e.g., a history of prior episodes not associated with substance use).
- The symptoms and behaviours are not a manifestation of another medical condition.
- The symptoms cause significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Substance-Induced Impulse Control Disorders

Available Categories by Substance Class:

Substance classes that may cause Substance-Induced Impulse Control Disorders include the following:

- 6C45.73 Cocaine-Induced Impulse Control Disorder
- 6C46.73 Stimulant-Induced Impulse Control Disorder including Amphetamines, Methamphetamine or Methcathinone
- 6C47.73 Synthetic Cathinone-Induced Impulse Control Disorder
- 6C4E.73 Impulse Control Disorder Induced by Other Specified Psychoactive Substance
- 6C4F.73 Impulse Control Disorder Induced by Multiple Specified Psychoactive Substances

- 6C4G.73 Impulse Control Disorder Induced by Unknown or Unspecified Psychoactive Substance

Essential (Required) Features:

- The presentation is characterized by persistently repeated behaviours in which there is recurrent failure to resist an impulse, drive, or urge to perform an act that is rewarding to the person, at least in the short-term, despite longer-term harm either to the individual or to others (e.g., fire setting or stealing without apparent motive, repetitive sexual behaviour, aggressive outbursts), or by behaviours similar to those seen in Disorders Due to Addictive Behaviours (i.e., excessive gambling or gaming).
- The disturbance in impulse control develops during or soon after intoxication with or withdrawal from a specified substance or use or discontinuation of a psychoactive medication.
- The intensity or duration of the disturbance in impulse control is substantially in excess of impulse control disturbances that are characteristic of intoxication or withdrawal due to the specified substance.
- The specified substance, as well as the amount and duration of its use, is known to be capable of producing disturbances in impulse control. (See list above and Table 6.14.)
- The symptoms and behaviours are not better accounted for by another mental disorder such as an Impulse Control Disorder or a Disorder Due to Addictive Behaviours. Evidence supporting a diagnosis of another mental disorder would include an impulse control disturbance preceding the onset of the substance use, the disturbance persisting for a substantial period of time after cessation of the substance or medication use or withdrawal (e.g., 1 month or more depending on the specific substance), or other evidence of a pre-existing mental disorder with impulse control disturbance (e.g., a history of prior episodes not associated with substance use).
- The symptoms and behaviours are not a manifestation of another medical condition.
- The symptoms cause significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Additional Clinical Features for Substance-Induced Mental Disorders:

- Substance-Induced Mental Disorders may present with varying patterns of symptoms, depending on the specific substance used as well as characteristics of the user (e.g., genetics, metabolism, personality factors). Substance use in higher amounts or over longer periods of time is more likely to be associated with the development of a Substance-Induced Mental Disorder.
- Symptoms of Substance-Induced Mental Disorder usually resolve or improve after sustained cessation of substance use. Longer lasting and in some cases permanent changes can occur in Amnestic Disorder Due to Psychoactive Substances, including Medications and Dementia Due to Psychoactive Substances, including Medications. Perceptual disturbances that last for weeks, months, or years (e.g., trails of images of moving objects, geometric illusions) can also occur as a result of hallucinogen use, primarily LSD, and are referred to as posthallucinogen perception disorder or hallucinogen-induced persisting perception disorder.
- The duration of Substance Withdrawal for some substances can be protracted. For substances with more protracted withdrawal periods, the onset of symptoms of Substance-Induced Mental Disorder can occur up to several weeks after the cessation of

substance use. Substance-Induced Mental Disorder symptoms related to substances with more protracted withdrawal periods may also last for correspondingly longer periods of time.

- In cases in which multiple psychoactive substance are used, it is often challenging to distinguish which substance is the cause of the Substance-Induced Mental Disorder. When the specific etiological substance cannot be determined, a diagnosis of Substance-Induced Mental Disorder Due to Multiple Specified Psychoactive Substances including Medications may assigned. In cases of multiple psychoactive substance use in which more than one specific substance can be identified as a cause of the Substance-Induced Mental Disorder, the corresponding specific Substance-Induced Mental Disorder diagnoses should be given instead.

Boundary with Normality (Threshold) for Substance-Induced Mental Disorders:

- Symptoms of Substance-Induced Mental Disorders should be differentiated from known side effects of psychoactive medication that are not significantly impairing or distressing and from transient physiological aftereffects of intoxication ('hangover effect'). The duration or severity of the symptoms in Substance-Induced Mental Disorders must be in excess of side effects (e.g., transient jitteriness as a side effect of methylphenidate) or 'hangover effects' (e.g., transient low mood following alcohol use) of the specified substance and result in significant distress or impairment of functioning.

Boundaries with Other Disorders and Conditions (Differential Diagnosis) for Substance-Induced Mental Disorders:

- ***Boundary with Substance Intoxication and Substance Withdrawal:*** Mental or behavioural symptoms that occur during Substance Intoxication or Substance Withdrawal should only be used as a basis for diagnosing a Substance-Induced Mental Disorder if the intensity or duration of the symptoms is substantially in excess of those that are characteristic of Substance Intoxication or Substance Withdrawal due to the specified substance (see Table 6.17) and the symptoms are sufficiently severe to warrant specific clinical attention.
- ***Boundary with Episode of Harmful Psychoactive Substance Use, Harmful Pattern of Psychoactive Substance Use, or Substance Dependence:*** The impact of repeated or continuous use of substances characteristic of Harmful Pattern of Substance Use and Substance Dependence may include Substance-Induced Mental Disorders. Substance-Induced Mental Disorders can also be associated with a single episode of substance use. In such cases, a Substance-Induced Mental Disorder should be diagnosed together with a primary diagnosis of Episode of Harmful Psychoactive Substance Use, Harmful Pattern of Psychoactive Substance Use, or Substance Dependence.
- ***Boundary with mental disorders not induced by substances:*** Substance-Induced Mental Disorders are differentiated from mental disorders with similar features that are not induced by substances on the basis of their onset, course and clinical features. A diagnosis of Substance-Induced Mental Disorder requires evidence from history, physical or mental examination, or laboratory findings of recent substance use, intoxication or withdrawal. Most Substance-Induced Mental Disorders resolve or improve within several weeks of cessation of substance use. Mental disorders not induced by substances may precede the onset of substance use or may continue to be symptomatic during periods of sustained abstinence. The co-occurrence of substance use or withdrawal and onset of symptoms of mental disorders should not be taken as

evidence for a presumptive diagnosis of a Substance-Induced Mental Disorder. Some people use substances to suppress symptoms of mental disorders (e.g., Schizophrenia and Other Primary Psychotic Disorders, Mood Disorders, Anxiety and Fear-Related Disorders, Personality Disorders) and full symptomatic presentations only emerge upon cessation or reduction in substance use. Furthermore, substance use can exacerbate symptoms or precipitate an episode of a pre-existing mental disorder. Finally, substance use may be associated with but not aetiologic for new onset of symptoms of a mental disorder. Although a diagnosis of a Substance-Induced Mental Disorder should not be assigned under these circumstances, an additional diagnosis of Episode of Harmful Psychoactive Substance Use, Harmful Pattern of Psychoactive Substance Use, or Substance Dependence may still be appropriate.

Substance-Induced Mental Disorders Listed in Other Groupings

The following categories are included in other mental disorder groupings and CDDR are provided in those sections, but they are cross-listed here for reference.

The following category is included in the ICD-11 grouping of Catatonia:

Substance-Induced Catatonia

- 6A41 Catatonia induced by substances or medications (p. _)

The following categories are included in the ICD-11 grouping of Neurocognitive Disorders:

Substance-Induced Amnestic Disorder

- 6D72.1 Amnestic disorder due to psychoactive substances including medications (p. _)
    - 6D72.10 Amnestic Disorder Due to Use of Alcohol
    - 6D72.11 Amnestic Disorder Due to Use of Sedatives, Hypnotics or Anxiolytics
    - 6D72.13 Amnestic Disorder Due to Use of Volatile Inhalants
    - 6D72.12 Amnestic Disorder Due to Other Specified Psychoactive Substance Including Medications

Substance-Induced Dementia

- 6D84 Dementia due to psychoactive substances including medications (p. _)
    - 6D84.0 Dementia Due to Use of Alcohol
    - 6D84.1 Dementia Due to Use of Sedatives, Hypnotics or Anxiolytics
    - 6D84.2 Dementia Due to Use of Volatile Inhalants
    - 6D84.Y Dementia Due to Other Specified Psychoactive Substance

6C4H Disorders Due to Use of Non-Psychoactive Substances

Disorders Due to Use of Non-Psychoactive Substances are characterized by the pattern and consequences of non-psychoactive substance use. Non-psychoactive substances include laxatives, growth hormone, erythropoietin, and non-steroidal anti-inflammatory drugs. They may also include proprietary or over-the-counter medicines and folk remedies. Non-medical use of these substances may be associated with harm to the individual due to the direct or secondary toxic effects of the non-psychoactive substance on body organs and systems, or a harmful route of administration (e.g., infections due to intravenous self-administration). They are not associated with intoxication or with a dependence or withdrawal syndrome and are not recognized causes of Substance-Induced Mental Disorders.

Disorders Due to Use of Non-Psychoactive Substances do not include disorders related to psychoactive substances such as anabolic steroids, corticosteroids, antidepressants, medications with anticholinergic properties (e.g., benztropine), and some antihistamines. These should be classified under 6C4E Disorders Due to Use of Other Specified Psychoactive Substances, including Medications.

6C4H.0 Episode of Harmful Use of Non-Psychoactive Substances

Essential (Required) Features:

- An episode of use of a non-psychoactive substance that has caused clinically significant damage to a person's physical health or mental health.
- Harm to health of the individual occurs due to the direct or secondary toxic effects of the non-psychoactive substance on body organs and systems, or a harmful route of administration.
- Harm to health is not better accounted for by a medical condition not caused by the substance or by another mental disorder.

Note: Harm to physical health includes acute health problems resulting from non-psychoactive substance use such as dehydration, dyslipidemia, and exacerbation or decompensation of pre-existing chronic health problems such as hypertension, liver disease, or peptic ulceration. Harm may also result from a harmful route of administration (e.g., non-sterile intravenous self-administration causing infections). Harm to mental health refers to psychological and behavioural symptoms following non-psychoactive substance use (e.g., severe depressive symptoms following dehydration and mineral loss from inappropriate use of laxatives).

Additional Clinical Features:

- There must be explicit evidence of harm to the individual's physical or mental health. There must also be a clear causal relationship between the harm to health and the episode of non-psychoactive substance use in question.
- Non-psychoactive substance use may occur in the context of other mental disorders (e.g., use of laxatives in Anorexia Nervosa to reduce body weight, use of anabolic steroids in Body Dysmorphic Disorder to increase muscle mass). An additional diagnosis of Episode of Harmful Psychoactive Substance Use can be made if the specific episode of

non-psychoactive substance use in question has resulted in clinically significant harm to the individual's physical or mental health.

- A diagnosis of Episode of Harmful Use of Non-Psychoactive Substances often signals an opportunity for intervention, including lower-intensity interventions that can be implemented in a wide range of settings aimed at reducing the likelihood of additional harmful episodes or of progression to Harmful Pattern of Non-Psychoactive Substance Use.
- As more information becomes available indicating that an episode is part of a continuous or recurrent pattern of harmful non-psychoactive substance use, a diagnosis of Episode of Harmful Psychoactive Substance Use should be changed to Harmful Pattern of Non-Psychoactive Substance Use.

Boundary with Normality (Threshold):

- The diagnosis of Episode of Harmful Use of Non-Psychoactive Substances requires clinically significant harm to the individual's physical or mental health. Examples of impact on physical or mental health that would not be considered clinically significant include mild hangover, brief episodes of vomiting, or transient depressed mood.
- An episode of non-psychoactive substance use may also cause social problems that do not constitute clinically significant harm to physical or mental health (e.g., arguments with loved ones). A diagnosis of Episode of Harmful Use of Non-Psychoactive Substances should not be assigned in these circumstances.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Other Specified Hazardous Drug Use:*** The category Other Specified Hazardous Drug Use from the chapter on 'Factors Influencing Health Status or Contact with Health Services' may be assigned if the episode of non-psychoactive substance use in question appreciably increases the risk of harmful physical or mental health consequences to an extent that warrants attention and advice from health professionals, but has not resulted in specific identifiable harm to the individual's physical or mental health.
- ***Boundary with Harmful Pattern of Non-Psychoactive Substance Use:*** If the harm to health is a result of a known episodic or continuous pattern of non-psychoactive substance use, Harmful Pattern of Non-Psychoactive Substance Use is the appropriate diagnosis rather than Episode of Harmful Use of Non-Psychoactive Substances. Substance use is generally considered to be following a pattern if there has been at least episodic or intermittent use over a period of at least 12 months, or continuous use over at least 1 month. If harm is caused by use of a non-psychoactive substance but no information is available about the pattern or history of substance use, a diagnosis of Episode of Harmful Use of Non-Psychoactive Substances may be assigned until such time as evidence for a pattern of use is ascertained.
- ***Boundary with Injury, Poisoning, or Certain Other Consequences of External Causes:*** When use of a non-psychoactive substance results in injury or life-threatening symptoms (e.g., coma, severe cardiac or respiratory symptoms), a diagnosis from the grouping of Harmful Effects of Substances in the chapter on Injury, Poisoning or Certain Other Consequences of External Causes should also be assigned.

6C4H.1 Harmful Pattern of Use of Non-Psychoactive Substances

Essential (Required) Features:

- A pattern of repeated or continuous use of a non-psychoactive substance that has caused clinically significant damage to a person's physical health or mental health.
- Harm to health of the individual occurs due to the direct or secondary toxic effects of the non-psychoactive substance on body organs and systems, or a harmful route of administration.
- The pattern of use of the relevant substance is evident over a period of at least 12 months if substance use is episodic or at least 1 month if use is continuous.
- Harm to health is not better accounted for by a medical condition not caused by the substance or by another mental disorder.

Note: Harm to physical health includes acute or chronic health problems resulting from a pattern of non-psychoactive substance use such as testicular atrophy, cardiomegaly, and exacerbation or decompensation of pre-existing chronic health problems such as hypertension, liver disease, or peptic ulceration. Harm may also result from a harmful route of administration (e.g., non-sterile intravenous self-administration causing infections). Harm to mental health refers to psychological and behavioural symptoms following non-psychoactive substance use (e.g., severe depressive symptoms due to dehydration and mineral loss from inappropriate use of laxatives).

Course Specifiers:

6C4H.10 Harmful Pattern of Use of Non-Psychoactive Substances, episodic

This category is assigned when all the diagnostic requirements for Harmful Pattern of Use of Non-Psychoactive Substances are met and there is evidence of a pattern of recurrent episodic or intermittent use of the relevant non-psychoactive substance over a period of at least 12 months that has caused clinically significant harm to a person's physical or mental health.

6C4H.11 Harmful Pattern of Use of Non-Psychoactive Substances, continuous

This category is assigned when all the diagnostic requirements for Harmful Pattern of Use of Non-Psychoactive Substances are met and there is evidence of a pattern of continuous substance use (daily or almost daily) of the relevant non-psychoactive substance over a period of at least 1 month that has caused clinically significant harm to a person's physical or mental health.

6C4H.1Z Harmful Pattern of Use of Non-Psychoactive Substances, unspecified

Additional Clinical Features for Harmful Pattern of Use of Non-Psychoactive Substances:

- There must be explicit evidence of harm to the individual's physical or mental health. There must also be a clear causal relationship between the harm to health and the episode of non-psychoactive substance use in question.

- Non-psychoactive substance use may occur in the context of other mental disorders (e.g., use of laxatives in Anorexia Nervosa to reduce body weight, use of anabolic steroids in Body Dysmorphic Disorder to increase muscle mass). An additional diagnosis of Harmful Pattern of Non-Psychoactive Substance Use can be made if the pattern of non-psychoactive substance use has resulted in clinically significant harm to the individual's physical or mental health.

Boundary with Normality (Threshold):

- The diagnosis of Harmful Pattern of Use of Non-Psychoactive Substances requires clinically significant harm to the individual's physical or mental health. Examples of impact on physical or mental health that would not be considered clinically significant include mild hangover, brief episodes of vomiting, or transient depressed mood.
- A pattern of non-psychoactive substance use may also cause social problems that do not constitute clinically significant harm to physical or mental health (e.g., arguments with loved ones). A diagnosis of Harmful Pattern of Use of Non-Psychoactive Substances should not be assigned in these circumstances.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Episode of Harmful Non-Psychoactive Substance Use:*** If the harm to health is a result of a single episode of non-psychoactive substance use rather than an episodic or continuous pattern of substance use, Episode of Harmful Use of Non-Psychoactive Substances is the appropriate diagnosis rather than Harmful Pattern of Non-Psychoactive Substance Use. Substance use is generally considered to be following a pattern if there has been at least episodic or intermittent use over a period of at least 12 months, or continuous use over at least 1 month. If harm is caused by use of a non-psychoactive substance but no information is available about the pattern or history of substance use, a diagnosis of Episode of Harmful Use of Non-Psychoactive Substances may be assigned until such time as evidence for a pattern of use is ascertained.
- ***Boundary with Injury, Poisoning, or Certain Other Consequences of External Causes:*** When use of a non-psychoactive substance results in injury or life-threatening symptoms (e.g., coma, severe cardiac or respiratory symptoms), a diagnosis from the grouping of Harmful Effects of Substances in the chapter on Injury, Poisoning or Certain Other Consequences of External Causes should also be assigned.

Hazardous Substance Use

The ICD-11 also includes a listing of Hazardous Substance Use categories. These are not considered to be mental disorders, but rather are included in the grouping 'Problems associated with health behaviours' in the chapter on Factors Influencing Health Status or Contact with Health Services. Available categories for Hazardous Substance Use due to specific substance classes are as follows:

QE10 Hazardous Alcohol Use

QE11 Hazardous Drug Use
- QE11.0 Hazardous Use of Opioids
- QE11.1 Hazardous Use of Cannabis

- QE11.2 Hazardous Use of Sedatives, Hypnotics or Anxiolytics
- QE11.3 Hazardous Use of Cocaine
- QE11.4 Hazardous Use of Stimulants Including Amphetamines or Methamphetamine
- QE11.5 Hazardous Use of Caffeine
- QE11.6 Hazardous Use of MDMA or Related Drugs
- QE11.7 Hazardous Use of Dissociative Drugs Including Ketamine or PCP
- QE11.8 Hazardous Use of Other Specified Psychoactive Substances
- QE11.9 Hazardous Use of Unknown or Unspecified Psychoactive Substances
- QE11.Y Other Specified Hazardous Drug Use
- QE11.Z Hazardous Drug Use, Unspecified

QE12 Hazardous Nicotine Use

Hazardous Substance Use categories may be used when the pattern of substance use appreciably increases the risk of harmful physical or mental health consequences to the user or to others to an extent that warrants attention and advice from health professionals, but no overt harm has yet occurred.

In Hazardous Substance Use, the increased risk may be related to the frequency of substance use, to the amount used on a given occasion, or to risky behaviours associated with substance use or the context of use, from a harmful route of administration, or from a combination of these. The risk may be related to short-term effects of the substance or to longer-term cumulative effects on physical or mental health or functioning. Hazardous substance use has not yet reached the level of having caused harm to physical or mental health of the user or others around the user. The pattern of substance use often persists in spite of awareness of increased risk of harm to the user or to others.